The Rotherham NHS Foundation Trust

Council of Governors

The Rotherham NHS Foundation Trust

Schedule	Wednesday 15 May 2024, 5:00 PM — 7:00 PM BST
Venue	Board Room, Level D
Organiser	Angela Wendzicha

Agenda

5:00 PM	PROCEDURAL ITEMS	
	COG/18/24.	Chairman's Welcome and announcements - Verbal For Noting - Presented by Mike Richmond
	COG/19/24.	Apologies for absence and quoracy check - Verbal - Mrs H Craven - Dr R Shah - Ms H Watson Section 17.4 of Constitution; A meeting of the Council of Governors shall be quorate if not less than half of the elected Governors are present. For Noting - Presented by Mike Richmond
	COG/20/24.	Declarations of Interest - Verbal For Noting - Presented by Mike Richmond
	COG/21/24.	Minutes of the previous meeting held on 21 February 2024 For Approval - Presented by Mike Richmond
	COG/22/24.	Matters arising from the previous minutes (not covered elsewhere on the agenda) - Verbal For Discussion - Presented by Mike Richmond

	COG/23/24.	Action Log For Decision - Presented by Mike Richmond
	COG/24/24.	Chair's Report - Verbal For Noting - Presented by Mike Richmond
5:15 PM	REPORT FROM NON EXECUTIVE CHAIRS OF BOARD COMMITTEES	
	COG/25/24.	Report from the Non-Executive Director Chairs of the Board Assurance Committees: i. Quality Committee - Julia Burrows ii. People Committee - Martin Temple iii. Finance and Performance Committee inc. Finance Report - Martin Temple iv. Audit and Risk Committee - Kamran Malik v. Charitable Funds Committee - Steve Hackett For Noting
	COG/26/24.	Integrated Performance Report For Noting - Presented by Michael Wright
	COG/27/24.	Organisational Priorities 2023/24 – End of Year Report For Noting - Presented by Michael Wright
	COG/28/24.	Organisational Priorities 2024/25 For Noting - Presented by Michael Wright
	COG/29/24.	Five Year Strategy Refresh For Noting - Presented by Michael Wright
	COG/30/24.	Annual Quality Account 2023/24 For Noting - Presented by Helen Dobson
6:25 PM	GOVERNOR REGULATORY AND STATUTORY REQUIREMENTS	

	COG/31/24.	Governance Report : Governor Elections For Noting - Presented by Alan Wolfe
	COG/32/24.	Lead Governor Nomination : Results - Verbal For Ratification - Presented by Angela Wendzicha
6:35 PM	SUB GROUPS OF THE COUNCIL OF GOVERNORS	
	COG/33/24.	Member Engagement Group Report - Presented by Gavin Rimmer For Noting
6:45 PM	COMMITTEE GOVERNANCE	
	COG/34/24.	Issues to be escalated to Board of Directors - Verbal For Approval - Presented by Mike Richmond
	COG/35/24.	Council of Governors Work Plan For Noting - Presented by Mike Richmond
	COG/36/24.	Any Other Business For Discussion - Presented by Mike Richmond
	COG/37/24.	Next meeting to be held on Tuesday 10 September 2024 TBC

MINUTES OF THE MEETING OF THE COUNCIL OF GOVERNORS HELD ON WEDNESDAY, 21 FEBRUARY 2024 IN THE BOARDROOM, LEVEL D, ROTHERHAM FOUDATION TRUST AND MS TEAMS

Chair: Dr M Richmond, Chair

Public Governors: Mr G Rimmer, Public Governor Rotherham Wide & Lead Governor
Mr A Ball, Public Governor Rotherham Wide
Mrs M Gambles, Public Governor Rotherham Wide
Mr G Berry, Public Governor Rest of England
Mr M Skelding, Public Governor Rotherham Wide
Ms I Ogbolu, Public Governor Rotherham Wide

Staff Governors: Mrs P Keta, Staff Governor
Ms R Bell, Staff Governor
Mr M White, Staff Governor

Members of the Board of Directors, other Trust staff and invited guests in attendance either for the whole or part of the meeting:

Mr K Malik, Non-Executive Director
Ms H Watson, Non-Executive Director
Mrs H Craven, Senior Independent Director
Ms D Sissons, Non-Executive Director
Mr M Temple, Non-Executive Director
Mr S Hackett, Director of Finance
Mr A Wolfe, Deputy Director of Corporate Affairs
Ms A Wendzicha, Director of Corporate Affairs
Dr J Beahan, Medical Director
Mrs H Dobson, Chief Nurse
Mr M Wright, Deputy Chief Executive
Mr D Hartley, Director of People
Ms C Rimmer, Corporate Governance Manager (minutes)

Apologies: Dr R Jenkins, Chief Executive
Ms J Burrows, Non-Executive Director
Dr R Shah, Non-Executive Director
Cllr J Baker-Rogers, Partner Governor RMBC
Mr M Ukpe, Public Governor Rotherham Wide
Mr A Zaidi, Public Governor Rotherham Wide
Dr J Lidster, Partner Governor Sheffield Hallam University
Mr M Smith, Partner Governor Barnsley and Rotherham Chamber of Commerce

ITEM	PROCEDURAL ITEMS	ACTION
1/24	**CHAIRMAN'S WELCOME AND ANNOUNCEMENTS** Dr Richmond welcomed all those present, opening the meeting for the first time as Chair.	
2/24	**APOLOGIES FOR ABSENCE & QUORACY CHECK** The apologies were noted and the meeting was confirmed to be quorate.	
3/24	**DECLARATION OF CONFLICT OF INTEREST** Ms Wendzicha's interest, in terms of her joint role as Director of Corporate Affairs of both the Trust and Barnsley Hospital NHS Foundation Trust, was noted.	
4/24	**MINUTES OF THE PREVIOUS MEETING** The minutes of the meeting held on the 16 November 2023 were approved as a correct record.	
5/24	**MATTERS ARISING** There were no matters arising noted.	
6/24	**ACTION LOG** Ms Wendzicha detailed the updates in relation to the actions noted from the previous Council meetings. No further comments were received and the actions were agreed to be closed.	
7/24	**CHAIR'S REPORT** Dr Richmond provided a verbal report and began by thanking the Board and Executives for the warm welcome received as the new Chair. Dr Richmond highlighted the excellent work in the Trust and the strong leadership, supported by a workforce which is behind the leadership efforts. Reflecting on returning to the Health Service, Dr Richmond discussed the historic structures and responsibilities for Foundation Trusts that are still place yet are now overlaid and expanded into collaborative environments, which is difficult to navigate and brings substantial responsibility. Dr Richmond summarised that the Trust has a key part to play in taking a lead role with regards to the Integrated Care Board (ICB). Dr Richmond noted the challenging times for the Health Service and the shearing forces of uncontrolled demand, the tight financial	

	envelope, political instability, unprecedented waiting lists, as well as industrial action. Dr Richmond concluded that the Trust must pull together and be effective at working together to grow, move forwards and deliver a service of excellence.	
8/24	**REPORT FROM NON EXECUTIVE CHAIRS OF BOARD ASSURANCE COMMITTEES** i. Quality Committee Mrs Craven informed the Council that the Quality Committee continues to meet monthly with a full agenda and high volumes of information-dense content. Each month welcomes a different Division to present, giving opportunity to share good practice and challenges. Mrs Craven highlighted the progress from Divisions to identify key issues for the Committee to challenge, scrutinise and escalate and also noted the rolling programme of reporting from the Operational sub-committees to ensure regular oversight and scrutiny. Positive news that Mrs Craven brought to the Council's attention was that there are no longer any conditions on the Trust's CQC Licence and the Mortality Index for the Hospital Standardised Mortality Ratio (HSMR), for which the Trust has been an outlier for a number of years, is no longer a major area of concern. Mrs Craven noted that there is work ongoing to improve on Structured Judgement Reviews (SJRs) to develop and embed the learning from this aspect. Furthermore, it was discussed that the CQC Framework is undergoing a national change with the historic inspection structure no longer in place. The Trust will follow the new framework from April onwards and have also developed an internal accreditation system. The Quality Committee have discussed the development stages and will have full oversight of the new framework and internal accreditation. Mrs Craven noted challenges faced by the Trust where the Quality Committee will have high-level focus moving forwards: the Histopathology service, which is moving to a South Yorkshire-wide service from April, and also the lower benchmarking of Care Hours Per Patient Day (CHPPD), where a deep dive will be taking place to ensure reporting accuracy. Mr Rimmer commended the news regarding HSMR and requested further information be given to the Governors to help to understand how this has been achieved. Dr Beahan highlighted, for future reference, that NHSE is now moving away from HSMR and instead, utilising the Summary Hospital-level Mortality Indicator (SHMI). Mr Rimmer commented on the progress made by UECC and shared positive comments received from service users. Mrs Dobson echoed	Dr Beahan

	the progress, noting the vast decrease in complaints and praised the work of volunteers. Based on experience volunteering in the department, Ms Ogbolu noted that the presence of fellow volunteers and Healthcare Support Works will have had an impact here. ii. People Committee Ms Watson introduced the Committee report, on behalf of Dr Shah, drawing attention to the Divisional updates: Family Health reported real evidence of collaborative working and breaking down of silos, and UECC presented their connected leadership, detailing the empowerment in the Division and staff survey engagement success. Ms Watson discussed the involvement and oversight in the development of the People and Culture Strategy, highlighting the in-depth plan for stakeholder engagement and the benefit of the short term focus within the strategy to address current issues, as well as a longer term plan to develop the organisation and its people. Mr White queried whether the Committee should have more emphasis, within the Divisional Updates, on the issues and challenges. Mr Hartley explained that the task set for Senior Leadership Teams is to take the staff survey results and create a 'we said, we did' plan, with the aim to take a holistic approach to addressing issues and concerns. The Committee seeks to support Divisions and to also challenge plans; it is a tangible approach and can initiate wrap around support to the services that are in need. Mr Rimmer noted the new Staff App and challenged the relevance for staff. Mr Hartley explained that employees now expect interfaces used as part of daily life, within the work place. There is access to a number of internal HR management systems and it also provides a platform for the Trust to communicate instantly with its staff, for example, push notifications with emergency planning. Ms Bell questioned the number of staff that have downloaded the app and Mr Wright confirmed he would export the data to update the Council. Mr White suggested that Lone Working software could be incorporated here. iii. Finance and Performance Committee Mr Temple announced that the Committee continues to meet monthly, with Divisional updates where the Committee balances the challenge required to achieve the correct results, with the support and encouragement to understand issues, to help support the recovery needed. The committee feels confident that changes are visible as they occur, supported by the oversight of predicted challenges and emerging trends.	Mr Wright

Mr Temple highlighted concerns emanating from the Trust and the Healthcare Service overall, discussing the ICB deficit and lack of information on the impact on the Trust. Regarding the Cost Improvement Programme (CIP), Mr Temple noted that the Trust is likely not to meet its target, however, the level achieved and forecast, is a vast improvement on previous levels.

Mr Berry queried the impact on patients as a result of Industrial Action. Mr Temple discussed the increase in waiting lists and the wider impact here and Dr Beahan explained that the Trust does everything possible to maintain urgent and emergency care pathways and to mitigate the impact as much as possible. Mr Temple detailed the discussions in the Committee, regarding the impact of strikes, particularly on the complex planning process and delivery and the recovery.

Mr Berry questioned, in terms of long term planning, the strategic improvements when funding allowed and whether this would this be capital or revenue expenditure. Mr Hackett discussed that although it may start with a capital solution, it predominately results in both.

iv. Audit and Risk Committee

Mr Malik presented the Audit and Risk Committee report and highlighted three key aspects. Firstly, the progress made on the Trust's risk management journey and commending the work from Integrated Medicine to achieve 100% compliance in this aspect.

Secondly, Mr Malik discussed the internal audit in relation to Patient Safety Incident Response Framework (PSIRF); audits have taken place on the first two stages with the outcome of moderate assurance. The common theme identified which contributed to this scoring was the learning from events and, whilst this area has improved, there is more to do. A second theme noted was action tracking and the Committee have assurance that plans are in place to mitigate this swiftly.

Thirdly, Mr Malik highlighted the audit on Patient to Patient Experience and the deep dive into patient involvement in their care; overall there was significant assurance in this area.

v. Charitable Funds Committee

Mrs Craven presented the Committee report, describing the Charity's journey over the past three years, including a new three year strategy, new recruitment, new branding and updated policies. Mrs Craven highlighted the significant energy and momentum now

	in the Charity, as well as the Committee, portrayed in the multiple, positive news shared. The renewed approach has developed more engagement with the community and cemented the Charity as a true partner to the Trust. Furthermore, Mrs Craven drew attention to the progress of the Charity, in relation to fundraising and the year on year substantial increase. The Tiny Toes appeal was launched last August and has already had a significant impact in the refurbishment of the Neonatal Unit, further cementing the partnership with the Trust. Room sponsorships from local businesses have boosted donations and provided extra support for parents to be near to their babies on the unit. Mr Berry queried whether the Charity has attracted any grant funding and Mrs Craven explained that it has been discussed by the Committee and will be looked into in the future, however, it will be resource dependant.	
9/24	**FINANCE REPORT** Mr Hackett explained that the report details the position from April 2023 to November 2023, forecasting to achieve the year end positon. Due to this positive position, in December 2023, the Trust was asked to improve its financial deficit which was approved by the Board of Directors. However, this was prior to the announcements of Industrial Action which has had a detrimental financial impact, both on expenditure and the loss of revenue from elective procedures, reverting the forecasting for Year End to the original position, rather than the improved position. Looking ahead to 2024-2025, Mr Hackett informed the Council that planning is in progress. There are delays on guidance from NHSE due to ongoing negotiations regarding funded settlements, however there has been some draft guidance and indicative budgets (South Yorkshire-level) released, which highlight difficult settlement assumptions for next year. Mr Rimmer raised concerns due to the delay in the guidance from NHSE and Mr Hackett explained that there is still an expectation the Trust will put in an initial draft (South Yorkshire-level) by the end of February, with an initial firm plan by the end of March, to be finalised in April.	
10/24	**INTEGRATED PERFORMANCE REPORT** Mr Wright presented the paper, highlighting that the IPR is also covered in the Assurance Committees which provides a regular and robust review process. Mr Wright noted headlines from the data and report such as, staff sickness levels as it is higher than target yet an	

	improvement on the previous year, and also the HSMR data capture and coding improvements. Mr White queried the Audit and Accuracy detailing on the STAR scoring and negative theme throughout the report relating to this aspect. Mr Wright discussed that there is a programme of internal audit with opportunities for development and that it is an area that will receive more focus.	
11/24	**DRAFT QUALITY PRIORITIES 2024/25** Mrs Dobson introduced the paper which included a long list of potential quality priorities for 2024/25 for Governors to review and explained the process for final draft and approval. National guidance has not yet been published, however, the Quality Priority structure will follow on from last year (three key focuses in each three key areas). Mrs Dobson assured the Council that all the priorities listed are still monitored at high-level; the selected nine will be the focused Quality Priorities in the Trust's Quality Accounts. Mr White suggested that joined up care should be a priority to enhance patient care and connection between services. Mrs Dobson discussed that the list within the report is Trust controllable and that Rotherham PLACE and the ICS would be key for that development. Mr Rimmer requested that Governors should submit any further comments regarding the Quality Priorities directly to Mr Rimmer in order to collate and feedback to the Non-Executives and Executives to take into account Governor views in this forward planning.	**All Governors**
12/24	**DEVELOPING THE PEOPLE AND CULTURE STRATEGY 2024-2027** Mr Hartley introduced the report and presentation, inviting the Governors to engage and contribute to this strategy, suggesting this is actioned in a similar fashion to the Quality Priorities. Mr Hartley outlined the journey so far, highlighting the engagement from the Senior Leadership Teams, Board discussions, and the diverse Steering Group which has been set up with members of different grades and roles to ensure inclusivity. The process will also include reviewing the previous strategy to reflect and determine fundamentals to flow through, as well as, new elements. Secondly, Mr Hartley drew the Council's attention to the Engagement Pack, highlighting the focus on the 'Us' within the Trust's Strategic ambitions and developing culture which will impact our Patients, Rotherham, Our partners and Delivery. By designing the best strategy and culture, it brings the overall Vision of the Trust closer.	**All Governors**

	Furthermore, Mr Hartley outlined the research conducted and evidence based reviews, noting that advocacy scores are one of the best indicators. Mr Hartley discussed that the staff survey, alongside significant improvements in engagement, showcases crucial advocacy scores from staff recommending the Trust as a place to work and to be treated. Relating to CQC and the new framework from the Commission, Mr Hartley described how the strategy seeks to address the drivers of engagement to achieve better outcomes for patients. Mr White praised the basis of the strategy and encouraged the continued progress, noting that the average is a low bar and the Trust should strive for excellence. Ms Ogbolu suggested involving volunteers in the strategy development, highlighting their unbiased opinion as non-staff members, which could prompt more suggestions. Mr Ball challenged how the success of the strategy will be monitored and Mr Hartley detailed the annual staff survey and further pulse-type measures. Mr Rimmer suggested that measurement is incorporated into Staff Governor meetings with the Chief Executive to add a layer of monitoring and proposed that Mr Hartley attend the next Governors' Forum to continue engagement and discussions regarding the new strategy.	
13/24	**GOVERNOR ELECTIONS** Mr Wolfe presented the paper outlining the plans for the upcoming elections and updated the Council on recent meetings with the Election software provider and the Communications Team. Mr Wolfe requested that the Governors support engagement with the elections by sharing the news with their business networks, as well as family and friends in the Rotherham community.	
14/24	**MEMBER ENGAGEMENT GROUP SCHEDULE OF DATES** Ms Wendzicha highlighted the schedule of meetings for the Member Engagement Group and encouraged Governors to attend to refresh the membership. The current Membership Engagement Strategy will be reviewed and a plan put forward for the next year. Mr Rimmer noted that it would be beneficial for as many Governors as possible to attend.	
15/24	**ISSUES TO BE ESCALATED TO THE BOARD OF DIRECTORS**	

	Mr Rimmer noted the changes to the Council of Governors and Ms Wendzicha explained these changes in terms of holding Non-Executives to account for the performance of the Board, encouraging Governors to attend future public Board meetings. Mr Rimmer suggested more formal and informal meetings between Governors and Non-Executives and attendance at the Governors' Forum, to help triangulate views and which will also support the appraisal process. For further assurance, Mr Rimmer requested that Committee reports incorporate more detail in order to support more relevant questions, with the expectation the Non-Executives can answer questions posed.	
16/24	**COUNCIL OF GOVERNORS WORKPLAN** The Council noted that this was a work in progress.	
	NEXT MEETING TO BE HELD ON WEDNESDAY, 15 MAY 2024	

Council of Governors Action Log

Log No	Meeting date	Report/ agenda title	Min Ref	Action	Lead Officer	Time scale	Response	Open/close
	2024							
1	21.02.24	Report from Non-Executives, Quality Committee	8/24i	Further information to be presented to Governors on the achievements surrounding HSMR.	Dr Jo Beahan, Medical Director	May-24	Information on HSMR will be provided to the Governors separately by the end of the month.	Recommend to close
2	21.02.24	Report from Non-Executives, People Committee	8/24ii	Data on the number of Staff App downloads to be provided to Governors	Mr Michael Wright, Deputy Chief Executive	May-24	There had been 1547 downloads of the Staff App by the beginning of May 2024	Recommend to close
3	21.02.24	Draft Quality Priorities 2024/25	11/24	Governors to provide feedback on the draft quality priorities to Mr Rimmer.	Gavin Rimmer, Lead Governor	Mar-24	Governors were given the opportunity to feedback on the Quality Priorities 2024/25 - they have now been confirmed and approved by the Board of Directors.	Recommend to close
4	21.02.24	Developing the People and Culture Strategy 2024-27	12/24	Governors to provide feedback on the People Strategy to Mr Rimmer.	Gavin Rimmer, Lead Governor	Mar-24	Feedback provided to Director of People	Recommend to close

Open
Rec to close
Closed

COUNCIL OF GOVERNORS MEETING: 15 May 2024

Agenda item: **25/24i**

Report: **Report from Quality Committee (QC)**

Author and Presented by: Julia Burrows, Chair of Quality Committee

Action required: To note

1.0 The Quality Committee (QC) continues to meet monthly, with Chair's Assurance Logs from recent meetings provided to the Board of Directors to demonstrate the degree of assurance received on all key matters.

2.0 Divisional Updates

2.1 Since the last report to the Council of Governors, the QC have received presentations from the Senior Management Teams from the Division of UECC (February), Surgery (March) and Medicine (April).

2.2 The Committee were assured by the divisional presentation from UECC which detailed the reduction in complaints, the progress in managing concerns and highlighted that there were no outstanding CQC actions. The division also presented good MaST compliance noting 100% safeguarding compliance for consultants and that the CQC patient survey would launch in February to further improve patient experience and quality of care.

2.3 The Division of Surgery presented positive data on reducing patient safety incidents, comparing with the previous year and shared concerns over the increase in comorbidity making situations more complicated, which is reflective of the national picture.

2.4 The Committee received the presentation by the Division of Medicine and the Senior Leadership Team highlighted the difficulties in the last quarter due to the high number of unfunded beds open and pressure on nurses and medical staff leading to increased strain.

3.0 Chief Nurse and Medical Director Highlight Report

3.1 The Trust has largely operated at escalation level 3 in March and April 2024 with some periods of level 2 and 4.

3.2 There was additional focus on achieving 76% 4 hour performance and reported at 63.3% for March and projected at 66% in April. Whilst the target was not achieved, it should be noted that there were 1,000 more attendance to UECC in March than we would normally expect.

4.0 Quality Priorities 2024/25

4.1 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.

5.0 Organisational Priorities

5.1 The committee is tasked with monitoring delivery against this year's Operational Plan Priority 1: Focus on the quality of care the Trust provides. The year-end report highlighted the positive achievements, particularly the PSIRF implementation and the targets met throughout.

5.2 The Organisational Priorities for 2024/25 were presented to the committee in April, with focus on the section for QC monitoring. Feedback was given by the committee to ensure clarity of wording at all levels and succinct measures of delivery.

6.0 Integrated Performance

6.1 The Committee receives a monthly report on integrated performance. A new framework is in development, to be implemented from April onwards.

6.2 Care Hours Per Patient Day (CHPPD) is still currently benchmarking poorly compared to other trusts and this was discussed at the last Council of Governors meeting in February. A key issue with national benchmark data is the variance on CHPPD data between hospitals with more specialist or intensive care services which require a high ratio of staff to patients. To ensure the Quality Committee is monitoring CHPPD for TRFT, the information is triangulated with other key quality metrics for assurance that the lower CHPPD ratio (comparing nationally) does not have an adverse effect on patients. Furthermore, the reports presented to the committee are developing to include service specific benchmarking and targets to provide Non-Executives with clear oversight.

6.3 NHSE announced the decommissioning of the Hospital Standardised Morality Indicator (HSMI) and 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. The QC agreed the proposal to cease reporting on the HSMR, with focus now on SHMI.

7.0 Patient Experience Committee

7.1 The report presented information relating to all patient experience feedback received from Q3; there were 80 formal complaints and 540 concerns received. The themes included concerns about waiting times and attitude.

7.2 The Engagement and Inclusion Lead continued to build working relationships with local community groups to further complement the quality improvement in patient experience. The Armed Forces welfare officer has been recruited to following some fixed term external funding and work is also underway with the Health Inequalities Group on the prioritisation of waiting lists.

7.3 A new Patient Advice and Liaison Service (PALS) will be situated in the main foyer and will be staffed by two PALS advisors Monday to Friday 8-4. The aim of the new PALS centre is to provide front line resolution to patients and those important to them in real time and demonstrates that the Trust welcomes live feedback and wants to resolve issues before they become formal complaints.

7.4 The Committee commended the innovative work undertaken to move Patient Experience so far forward in the past year. It noted that the SMART action plan to achieve moderate assurance from 360 would be in place by the end of March but that completing those actions would be done in 2024/2025.

8.0 Safe Staffing and Quality

8.1 The bi-monthly report provides evidence that processes are in place to record and manage nurse staffing levels on a shift by shift basis across the hospital setting and that any concerns around safe staffing are reviewed and processes put in place to ensure delivery of safe care.

8.2 Work continues to analyse and monitor CHPPD data, triangulating with actual versus planned staffing, sickness and absence, unavailability of staff, incidents and harm for assurance.

8.3 The numbers of applications to nursing courses at UK universities has fallen sharply. To support interest in school leavers applying for under graduate courses in health and social care, the Education and Development team (EDT) have supported two open days at The University of Sheffield and two at Sheffield Hallam University, allowing prospective students and parents to discuss the benefits of these career choices.

9.0 Patient Safety

9.1 The quarterly report includes metrics around incidents, harm and duty of candour compliance. Emerging themes and trends are identified along with actions that are being taken in response.

9.2 There has been a positive improvement in patient safety throughout the Trust overall, however ongoing work has been identified in terms of ensuring that when incidents occur learning is captured in a timely manner and this will shape the Quality Improvement agenda moving forward into Q4.

10.0 Infection Prevention & Control Committee

10.1 The quarterly report presents a summary of the ongoing work, outcomes and impacts for Infection, Prevention and Control at TRFT over the past three months.

10.2 Although trajectories for some infection rates will not be met this year, the use of SPC in monitoring rates of alert organisms will help to understand changes in data over a two year period. Learning from the monthly harm free panels continues, with shared learning developed into action cards in the hub. One specific action to decant and deep clean ward A4 was achieved.

10.3 The Trust has been successful in the achievement of 26 Healthcare support workers completing the Florence Nightingale Foundation (FNF) IPC champions training.

11.0 Clinical Effectiveness Committee

11.1 The quarterly report provides an overview of NICE activity in respect of guidelines published and those outstanding by Divisions, as well as progress with the clinical audit plan 2023/24. Information in relation to Clinical Documents i.e. policies etc. is also highlighted, along with external visits/accreditation and inspections/GIRFT updates and the CQUIN scheme 2023-24.

11.2 March's report detailed that the Sentinel Stroke National Audit Programme (SSNAP) data has shown that the Trust has moved from a 'C' to a 'B' and also not far off achieving an 'A' rating for performance in delivering clinically effective stroke services.

12.0 Quality Assurance

12.1 All actions within the Quality Improvement Plan (derived from previous CQC inspections) are now complete with the majority being embedded. The CQC self-assessment documentation has now been completed and Divisions will be supported to complete this new format throughout Q1 and Q2. The Trust will be working towards the new self-assessment framework and the Exemplar Accreditation programme commenced in April.

12.2 Four adult inpatient wards completed their Exemplar accreditation assessment in April and B10 achieved Bronze Accreditation.

13.0 Board Assurance Framework and Risk Register

13.1 The Committee continues to receive monthly update reports regarding the risks rated at 15 or above, which have been monitored and checked at the monthly Risk Management Committee and also the Issues Register, which is managed by the Audit and Risk Committee.

13.2 The BAF continues to be monitored monthly, with meetings taking place with the relevant Executive Directors, and the updated BAF is presented to the Committee.

Julia Burrows
Non-Executive Director and Chair of Quality Committee

COUNCIL OF GOVERNORS MEETING: 15 May 2024

Agenda item:	**25/24ii**
Report:	**People and Culture Committee**
Presented by:	**Mr Martin Temple, Non-Executive Director and Member of the People & Culture Committee**
Author:	**Dr Rumit Shah, Non-Executive Director and Chair of the People & Culture Committee**
Action required:	**To note**

1.0 The People and Culture Committee meets bimonthly, with Chair's Assurance Logs from recent meetings provided to the Board of Directors meeting to demonstrate the degree of assurance received on all key matters.

1.1 Following a review of the Terms of Reference and to align with the new People and Culture Strategy, the Committee has been renamed 'People and Culture Committee' (P&CC) from April onwards.

2.0 Divisional Updates

2.1 Since the last report to the Council of Governors, the P&CC has received a presentation from the Senior Management Teams from the Division of Surgery and Division of Community at February's meeting, with Surgery returning with a follow up presentation in April.

2.2 The Division of Community presented their diverse and extensive range of services, the continued progression of the virtual ward, as well as, the staff survey engagement and initial feedback.

2.3 In February, the Division of Surgery presented the high levels of engagement in the staff survey, however, there was disappointment from the results and the Division's position versus the Trust; plans were outlined to the Committee to address the feedback and concerns were raised regarding the cultural changes needed. The Division also attended April's committee to provide more information on the challenges and concerns, the actions in progress and plans for the future, to initiate and embed the changes that are needed.

3.0 People and Culture Strategy

3.1 The new People and Culture Strategy (2024-2027) was presented to the committee in April, highlighting the engagement with numerous stakeholders, 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 recommendation to Board.

4.0 Staff Survey

4.1 The staff survey report in February detailed the overall national performance and breakdown reports issued by NHSE, which are now publically available. The results of the survey were celebrated and praise given for the leadership involved; ninety, out of one hundred, indicators have improved.

5.0 Organisational Priorities

5.1 The committee is tasked with monitoring delivery against this year's Operational Plan Priorities 2 and 3: P2 Improve Engagement with our Medical Colleagues, P3 Supporting our people. The committee were assured with the delivery in accordance with the plan.

5.2 The Organisational Priorities for 2024/25 were presented to the committee in April, with focus on the section for P&CC monitoring. The objectives agreed signal the ambition and measurements for the next year, and align with the new People and Culture Strategy.

6.0 Changes to the National Job Profiles for Agenda for Change Band 2 and 3 Healthcare Support Workers

6.1 The Committee supported the Trusts' robust approach to the changes and receive regular updates via the bi-monthly People Report.

6.2 Consultation with staff and unions has commenced; it continues to be a balance to achieve, recognising changes to job roles and no redundancies, whilst the affordability of the changes and financial limitations. The Trust will continue the strong partnership and consultations.

7.0 Engagement and Health and Wellbeing

7.1 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).

7.2 The work done for Menopause was highlighted and 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.

8.0 Board Assurance Framework (BAF) and Risk Register

8.1 The Committee continues to receive reports regarding the risks rated at 15 or above, which have been monitored and checked at the monthly Risk Management Committee, as well as the Issues Register which is managed by the Audit and Risk Committee.

8.2 The BAF continues to be monitored monthly, with meetings taking place with the relevant Executive Directors, and the updated BAF is presented to the Committee.

Dr Rumit Shah
Non-Executive Director and Chair of the People & Culture Committee

COUNCIL OF GOVERNORS MEETING: 15 May 2024

Agenda item:	**25/24**
Report:	**Finance and Performance Committee (FPC)**
Author and Presented by:	**Martin Temple, Chair of FPC**
Action required:	**To note**

1.0 FPC continues to meet monthly, with Chair's Assurance Logs from recent meetings provided to the Board of Directors at their meeting to demonstrate the degree of assurance received on all key matters.

2.0 Divisional Updates

2.1 Since the last report to the Council of Governors, the FPC have received a presentation from the Senior Management Teams from the Family Health Division (February), UECC Division (March) and Medicine (April).

2.2 Family Health – the Committee welcomed the presentation, noting the good financial position, reduced medical agency usage and good performance in a number of specialties. Challenges were recognised in Gynaecology and in meeting the Cost Improvement target.

2.3 UECC - the Committee noted the sheer scale of the challenge and the work that had been undertaken, whilst recognising that there are more challenges ahead. The Committee also highlighted the increased attendance rates in UECC and the continued prevalence of mental health patients.

2.4 Medicine - The Committee recognised the challenges experienced during the last financial year and the good work that had been done. It acknowledged the progress made within Medicine, the challenges the division had faced and the opportunity from coming together with UECC in the new care group and the positive feedback received from the team on working together.

3.0 Integrated Financial Performance Report

3.1 The monthly financial reports that the Committee receives provide an honest representation of the current financial position to understand what is happening and to identify the risks.

3.2 The Trust had delivered against all the business critical activities and had performed as it set out to do at the beginning of the financial year.

3.3 Difficulties in putting a financial plan together for the forthcoming year without the appropriate information being made available to the Trust from external organisations was highlighted.

4.0 Operational Update

4.1 A Year End Operational Report was received at the April meeting and it was recognised that a lot of good work had taken place last year, despite all the challenges faced including 33 days being lost due to industrial action.

5.0 Integrated Performance Report

5.1 A monthly update is received by the Committee and progress continues to be made.

5.2 The latest report highlighted that productivity is a key concern for the Trust and it was noted that there is interest SYICB-wide on productivity rates. It was noted that the 76% 4 hour target for UECC would not be met. Demand on emergency care remained high with activity above plan for both UECC and non-elective admissions. As a result, the Trust continued to see increased operational pressures. A command and control structure has been put in place in order to have increased focus on achieving the 4 hour performance target.

6.0 Cost Improvement Programme

6.1 A monthly update is received by the Committee and progress continues to be made.

6.2 The Trust had achieved £11.018m in 2023/24 which represented over 90% of target and the Committee recognised there had been good performance compared to the previous years.

7.0 Organisational Priorities

7.1 There were 3 operational priorities aligned to the Finance & Performance Committee in 2023/24 – Priority 4: Improve our Emergency Care Pathways to Deliver Faster Access to Care, Priority 5: Recover Elective Services and Priority 6: Work in Partnership to develop efficient services and a trust that is fit for the future. All key areas of focus in the three priorities made good progress in the final three months of the year despite relentless operational pressures as well as the impact of industrial action. A number of deliverables identified against the three priorities remain in place at the end of 2023/24 and would be carried over to 2024/25.

7.2 The Organisational Priorities for 2024/25 were presented to the committee in April, with two objectives aligned to FPC: Objective 1: Deliver the financial plan for 2024/25 and delivery year 1 of the plan to return the Trust to a break-even position for 2026/27 and Objective 2: Ensure significant improvement across the full range of system productivity metrics. It was noted that the priorities for 2024/25 would be taken to Board of Directors for final approval following discussion at all relevant committees.

7.0 Cyber Security/Digital Strategy

7.1 The Committee received the Cyber Security update which highlighted the on-going work undertaken in cyber and was assured that there are appropriate system controls in place.

7.2 An update on the Digital Strategy was received and the work undertaken to date was noted. The Trust is the first Trust in the UK where GP patients can book their Radiology appointments directly via an app. In addition, the Radiology chatbot has been shortlisted for a Health Service Journal award.

7.3 Multi-Factor Authentication has been rolled out across the Trust ahead of the June target date.

8.0 Board Assurance Framework and Risk Register

8.1 The Committee continues to consider the Board Assurance Framework (BAF) and risk register at each meeting noting this has continued to strengthen over the last 12 months.

8.2 A wider discussion on the Board Assurance Framework and Risk Appetite will take place at a Strategic Board meeting in June.

9.0 Acute Care Transformation – 4 Hour Standard

9.1 The Committee received a report on the work being undertaken with regard to the re-introduction of the 4 hour standard and acknowledged the progress that had been made so far, recognising that it is an ongoing process.

10. Emergency Preparedness, Resilience and Response (EPRR) Annual Statement of Compliance Core Standards Update

10.1 The Committee received the update acknowledging the progress against the action plan which has resulted in the compliance rate increasing from 35% to 42%. It was noted that it was expected to achieve compliance over a two year period.

11.0 Finance Report – March 2024

11.1 The latest finance report for March 2024 (Month 12 2023/24) is attached to the Chair's Log for reference.

11.2 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.

11.3 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.

11.4 In delivering a control total deficit of £4,715K, the Trust has also met its target improvement reported in November 2023.

11.5 Capital 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.

11.6 The capital programme has been reviewed and monitored at the Capital Monitoring Group, chaired by the Director of Finance.

11.7 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.

11.8 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.

Martin Temple
Non- Executive Director, Chair of Finance and Performance Committee

COUNCIL OF GOVERNORS MEETING:

Agenda item:	**25/24iii**
Report:	**Finance Report**
Presented by:	**Martin Temple, Chair of FPC**
Author:	**Steve Hackett, Director of Finance**
Action required:	**To note**

Introduction

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)
    - 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.
    - 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
    - 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.

- 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.

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			YTD			Prior Month Forecast variance £000s
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	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 £000s	Month			YTD			2023/2024 Monthly Trend / Variance
		Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	
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.

3. Capital Programme

3.1 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.

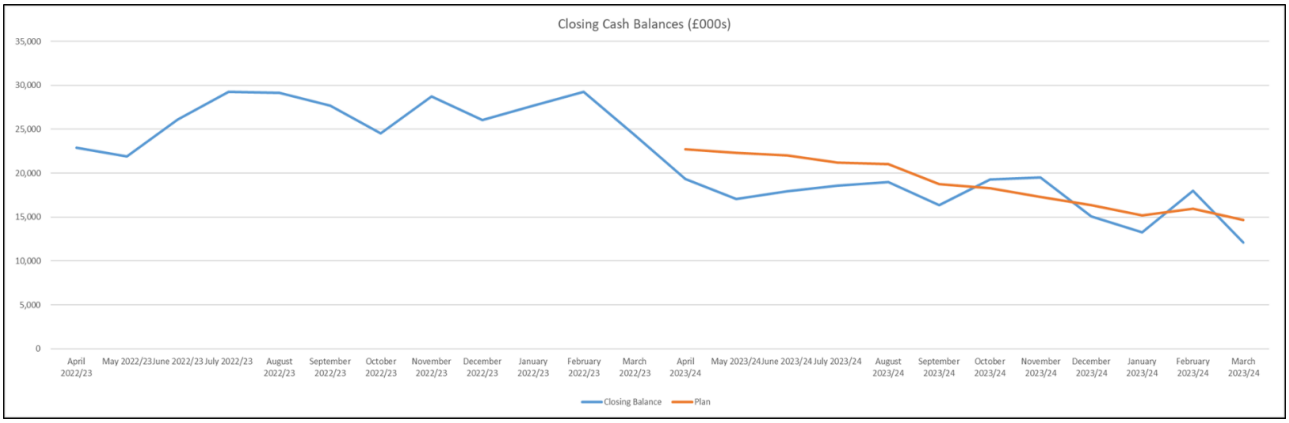
Capital Expenditure	Month			YTD				
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	In-year funding and PDC £'000s	Total funding £'000	Actual £000s	Variance £000s
Estates Strategy	254	901	(647)	4,316	(192)	4,124	4,014	110
Estates Maintenance	16	1,271	(1,255)	1,713	651	2,364	2,489	(125)
Information 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)

3.2 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.

3.3 The capital programme has been monitored at the Capital Monitoring Group, chaired by the Director of Finance and has fully delivered against its plan.

4. Cash Management

4.1 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.



4.2 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

COUNCIL OF GOVERNORS MEETING: 15 MAY 2024

Agenda item: 25/24

Report: **Report from Audit and Risk Committee (ARC)**

Presented by: **Mr Kamran Malik, Non-Executive Director and Chair of Audit & Risk Committee**

Author(s): **as above**

Action required: **To note**

1.0 The Audit and Risk Committee met in April 2024; the following report provides an update in several key areas. The ARC continues to meet quarterly, with Chair's Assurance Logs from recent meetings provided to the Board of Directors to demonstrate the degree of assurance received on all key matters.

2.0 Risk Register, Emerging Risks and Issues Log

2.1 The Committee noted and welcomed the continued improvement in the position with risks rated at 8 or above action plan compliance now at 91%.

2.2 Three divisions, UECC, Clinical Support and Medicine, were 100% compliant with their risk review dates, with the remaining two divisions, Family Health and Surgery, very close to full compliance.

2.3 The issues register contains 10 issues currently and it was agreed that one risk on the Emerging Risks report should now be added to the risk register.

2.4 The Committee recognised the maturity of risk management now in place at the Trust.

3.0 Breaches of Standards of Business Conduct

3.1 The Committee noted the current position with 227 staff completed out of a total of 372 required to complete a declaration of interest annual return. This was an increase on last year's position. Work is on-going by the Corporate Affairs team to raise the profile of the need for the completion of declarations.

4.0 Legal Report

4.1 The Committee noted the annual report. At the end of March 2024, there were 152 open clinical negligence claims. During 2023/24 67 claims had been closed with 23 successfully defended and closed with nil damages paid.

4.2 The Trust had been notified of 72 inquests during 2023/24 of which 16 required Trust attendance.

5.0 Internal Audit

5.1 The Committee received the 2024/25 Internal Audit plan which set out the plan for the forthcoming year. The plan was approved recognising that it was flexible and could be amended should it be required.

5.2 The Internal Audit progress report was noted and there were two audits where there had been moderate or limited assurance:

- IT Business Continuity – Governance and Learning from Incidents/Exercises – this had received a limited assurance
- Elective RTT Waiting Lists – Management and Data Quality.

Relevant Executive leads attended the Committee for the above audits to provide information on work that had already taken place and planned future work to mitigate those limited/moderate assurance.

6.0 External Audit

6.1 It was noted that the final accounts audit was on track. The initial risk assessment work had been undertaken for the Value For Money arrangements and based on the initial risk assessment, a risk of significant weakness had been identified with arrangements in relation to financial sustainability.

7.0 Counter Fraud

7.1 The Committee received and noted the Counter Fraud update on work undertaken to date.

7.2 The Committee received the Counter Fraud work plan for 2024/25.

7.3 The updated Counter Fraud, Bribery and Corruption Policy was received which had been updated to bring it in line with the latest current guidance.

8.0 Annual Report and Accounts Timetable

8.1 The timetable for the production, approval and submission of the Annual Report and Accounts was noted.

9.0 Draft Annual Accounts

9.1 The Committee received the draft Annual Accounts which were submitted to NHSE and External Audit on 24th April. The final version will be submitted as per the timetable in section 8.1 above.

Mr Kamran Malik
Non-Executive Director, Chair of Audit Committee

COUNCIL OF GOVERNORS MEETING: 15th May 2024

Agenda item: **25/24v**

Report: **Charitable Funds Committee (CFC) Chair's Report**

Presented by: **Steve Hackett, Director of Finance**
Author(s): **Heather Craven, Chair, Charitable Funds Committee**

Action required: **To note**

1.0 The Charitable Funds Committee continues to meet on a bi-monthly basis with Chair's Assurance Logs from recent meetings provided to the Corporate Trustee to demonstrate the degree of assurance received on all key matters.

2.0 Charity Strategy

2.1 Significant progress has been made against the Annual Plan and Strategy Objectives with increased awareness of the Charity and its aims within the wider community, the launch and success of a major appeal (Tiny Toes Appeal) and development of a Legacy Strategy.

3.0 Finance Report

3.1 The Committee noted the continuing positive position in relation to income and, whilst commitments are increasing as the Charity develops, the cash position remains good.

3.2 The Committee received the funding requests that had been approved in accordance with the mandate, noting they were in line with the Charity Objectives. 'Fund Stewards' are to be appointed for each Care Group, and will be the General Managers because of their expertise and experience of that area. In their roles, they are in a position to recommend the most appropriate use for charitable funds the department is responsible for, improving efficiency and clarity to the funding request process for the charity.

4.0 Annual Budget and Approval

4.1 The Committee received the Annual Budget for approval.

5.0 Charity Appeals and Fundraising

5.1 The Committee received updates on a number of appeals and fundraising initiatives currently taking place or planned for the future.

5.2 The Tiny Toes appeal has been the headline campaign since its launch seven months ago and has surpassed expectations despite resource limitations and challenges. The income and pledges have surpassed the £100K mark and with four months remaining, success is anticipated, demonstrating significant community support and effective fundraising efforts.

5.3 The Community Engagement and Events calendar for the charity is an evolving cluster of diverse activities and include events such as:

- Yorkshire Three Peaks Challenge
- Total Warrior Tough Mudder
- It's a Knockout event
- Great North Run
- Golf Day
- Rotherham Polar Plunge
- Christmas Wreath Making Workshop
- Tiny Toes Toddle

5.4 Alongside engagement with members of staff and the community, there has been increased corporate engagement with attendance at Rotherham Apprenticeship Live, the Mayors Charity Ball, Rotherham & Barnsley Chamber of Commerce Directors lunch and other networking events.

5.5 Grant fundraising is also being explored to bolster appeals and fundraising for the charity. An application for NHS Charities Together has been submitted collaboratively with South Yorkshire ICB to enhance support for Young People and their families, with a learning disability or have autism, and are also managing a chronic long term health condition. This further signifies the partnership working between the charity and the Trust, as well as the wider South Yorkshire partnership.

5.6 Furthermore, the committee are considering avenues to support donations from patients and families via Legacy Giving and In Memory Giving, and these initiatives form part of the 2024/25 strategy to further develop the charity.

6.0 Fund Stewards

6.1 A recent step change for the charity has been to improve the funding request process and introduce General Managers as 'Fund Stewards' to have better ownership of divisional funding pots. This commences from June onwards and further signifies the partnership working between the charity and the Trust.

7.0 Risk Information

7.1 Risks continued to be received and reviewed at each meeting and there were no escalations to note. All charity risks had been reviewed and were up to date with action plans in place.

Heather Craven
Non-Executive Director and Chair of Charitable Funds Committee

COUNCIL OF GOVERNORS MEETING: May 2023

Agenda item: Integrated Performance Report **26/24**

Report: Report from: Michael Wright – Managing Director

Author and Presented by: Louise Tuckett / Michael Wright

Action required: To note

1.0 Introduction

1.1 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.

1.2 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.

1.3 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.

Michael Wright
Managing Director
May 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		

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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	--		

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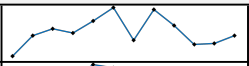
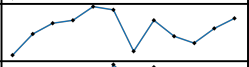
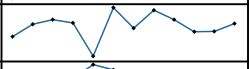
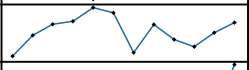
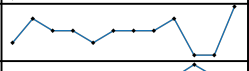
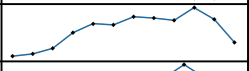
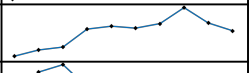
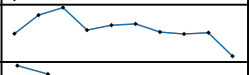
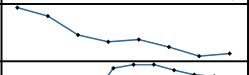
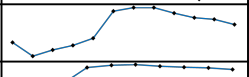
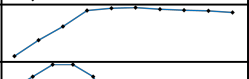
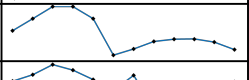
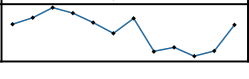
Trust Integrated Performance Dashboard - Workforce

	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%		

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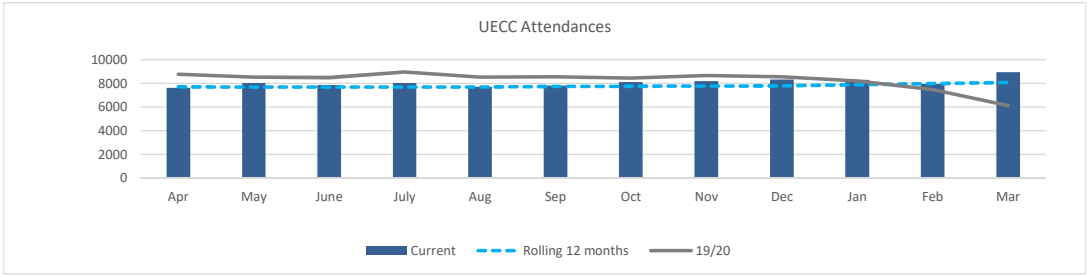
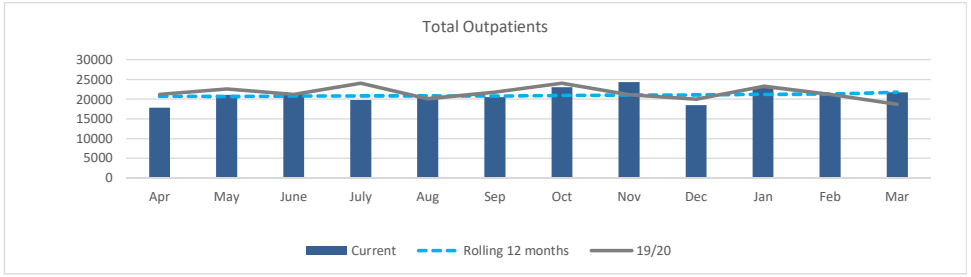
Trust Integrated Performance Dashboard - Finance

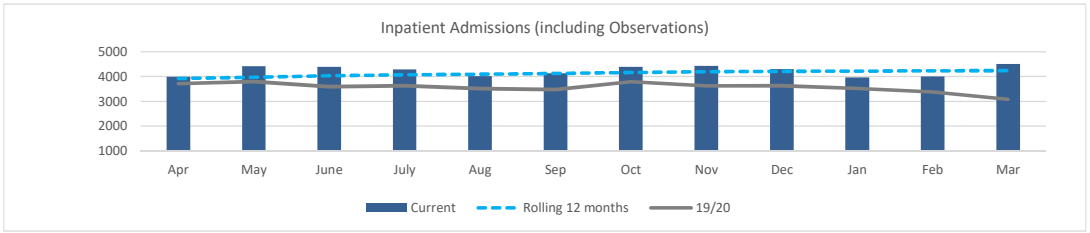
Apr 23 - Jan-24

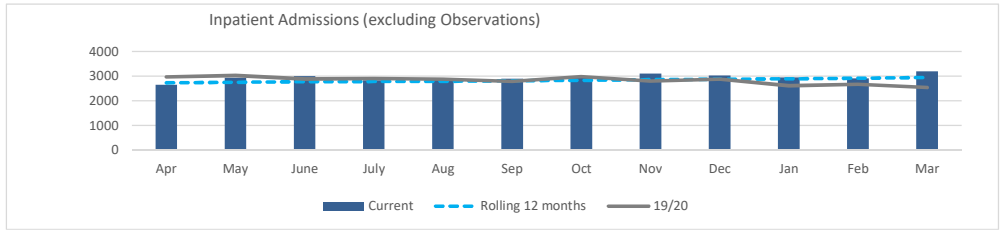
	In Month Plan £000s	In Month Actual £000s	In Month Variance £000s	YTD Plan £000s	YTD Actual £000s	YTD Variance £000s	Forecast V £000s
I&E Performance (Actual)	(377)	(601)	(224)	(6,725)	(8,666)	(1,941)	(2,092)
I&E Performance (Control Total)	(316)	2,025	2,341	(5,977)	(4,715)	1,262	(1,427)
Efficiency Programme (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)

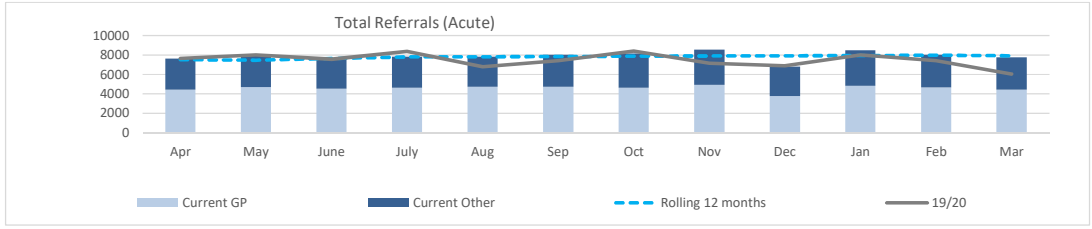
Trust Integrated Performance Dashboard - Activity

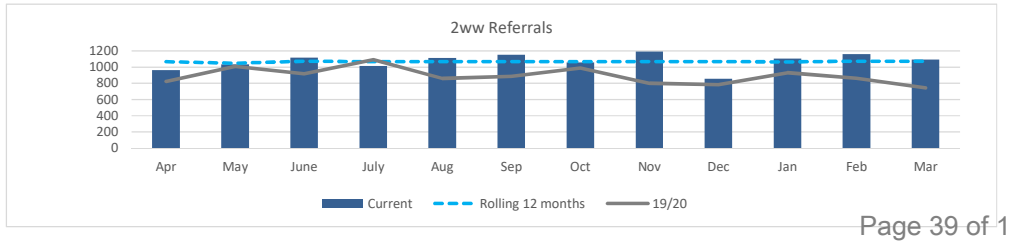












Trust Integrated Performance Dashboard - Activity

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%**

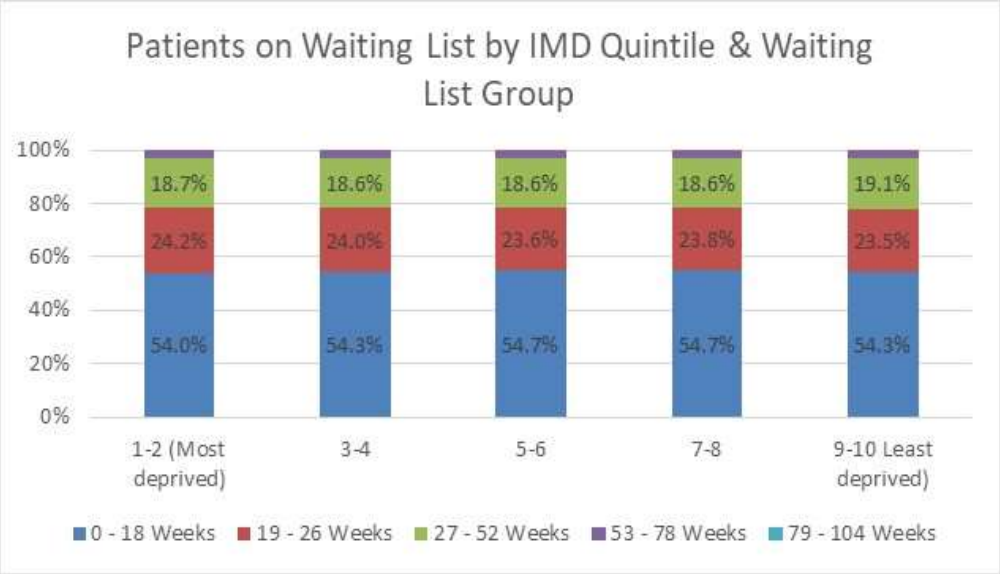
DAYCASES			
	Activity 19/20	Activity 23/24	As % of 2019/20 WDA
March	1,739	2,140	**135%**
YTD monthly average	2,160	2,021	**95%**

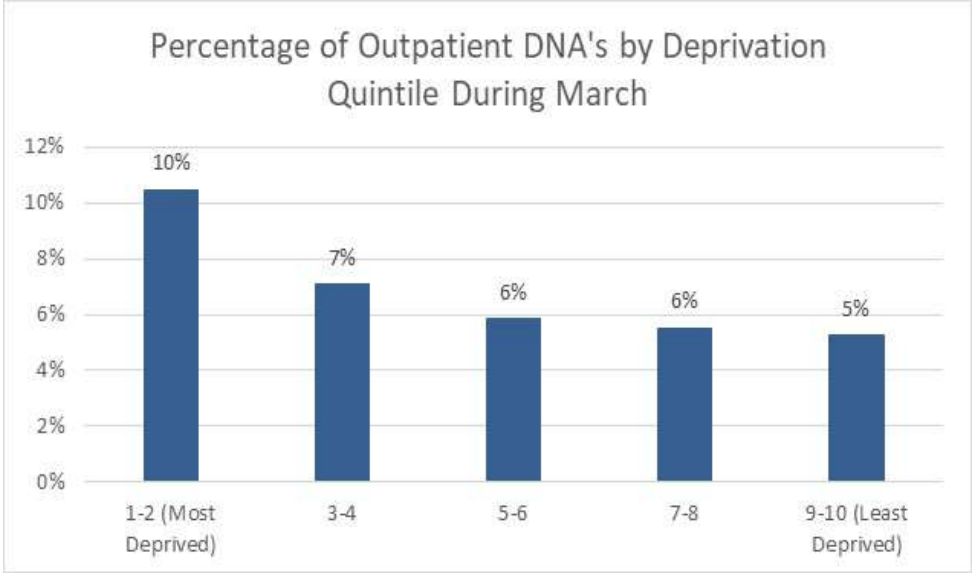
ELECTIVE ACTIVITY			
	Activity 19/20	Activity 23/24	As % of 2019/20 WDA
March	356	390	**121%**
YTD monthly average	403	341	**86%**

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

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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

The Rotherham
NHS Foundation Trust

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

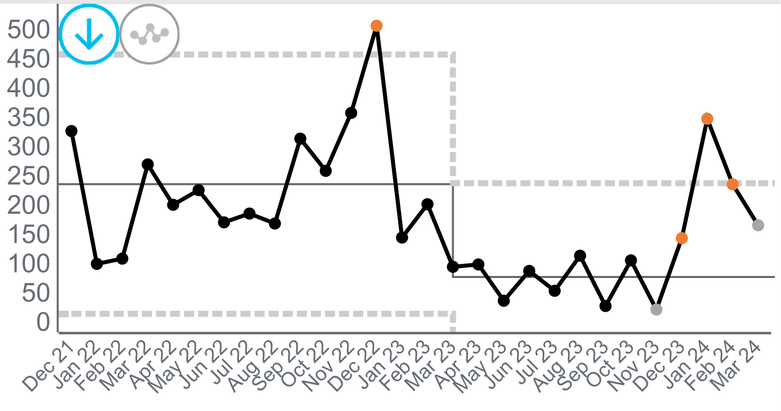
Two out of three points close to the process limits

A pattern of two points in any three consecutive points close (in the outer third to the process limits.

Statistical Process Control Charts
Operational Performance Page 1

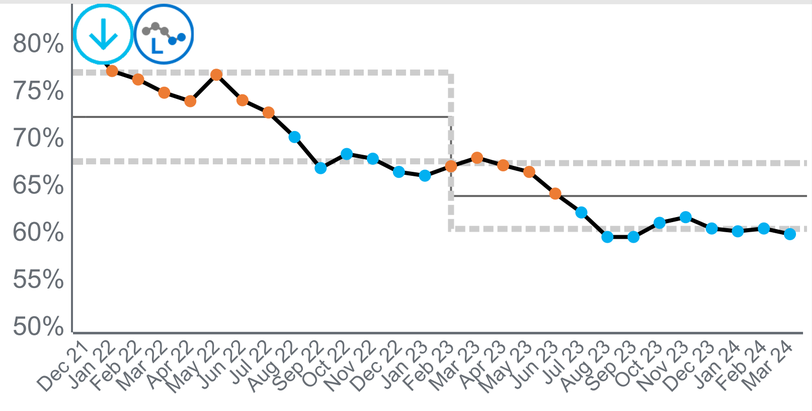
The Rotherham NHS Foundation Trust

Ambulance Handovers over 60 mins by Date



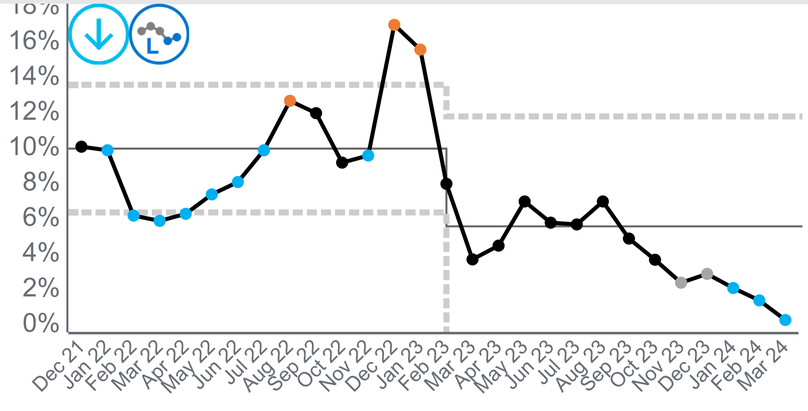
Improvement noted from Mar 23 of an average of 250 Handovers to 75 Handovers. Special cause noted in January with the increase to 348 decreasing to 236 in February and 166 in March.

RTT by Date



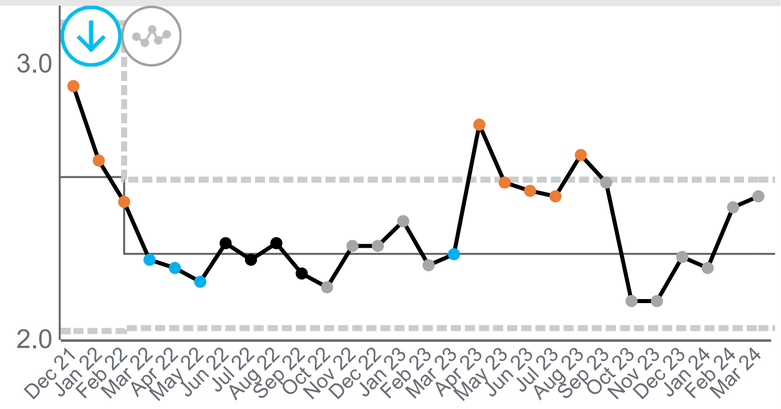
Continuous deterioration from 80% in Oct 21 to 60% in Jan 24, stabilising slightly from Aug 22 - Mar 23.

DM01 by Date



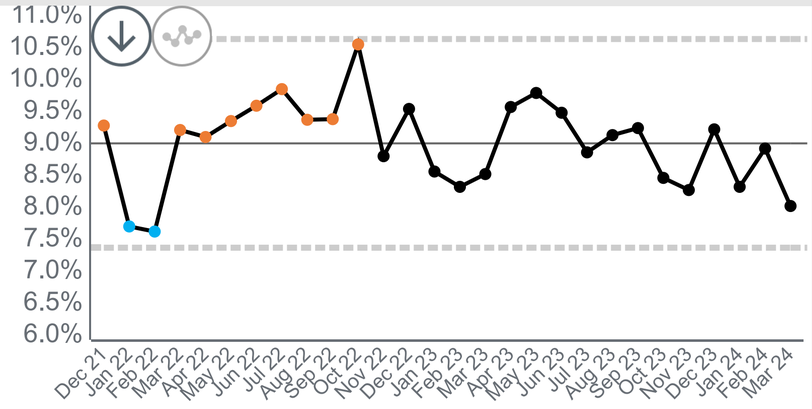
Significant improvement seen from an average of 10% to 6%. Meeting the target in March at 0.19%.

First to FU by Date



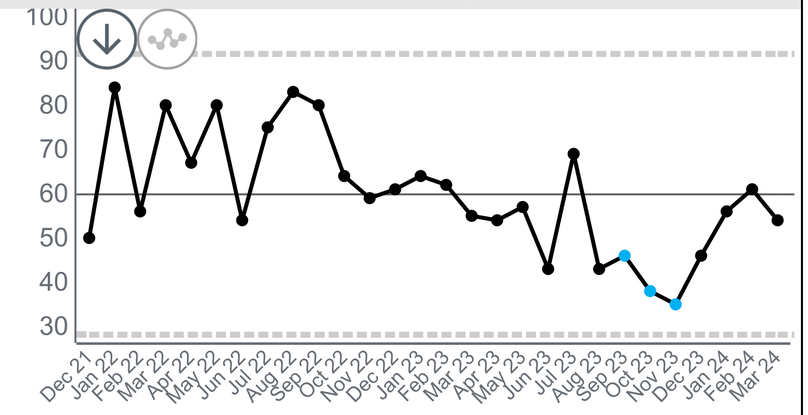
Common cause variation seen at an average of 2.2.

DNAs by Date



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

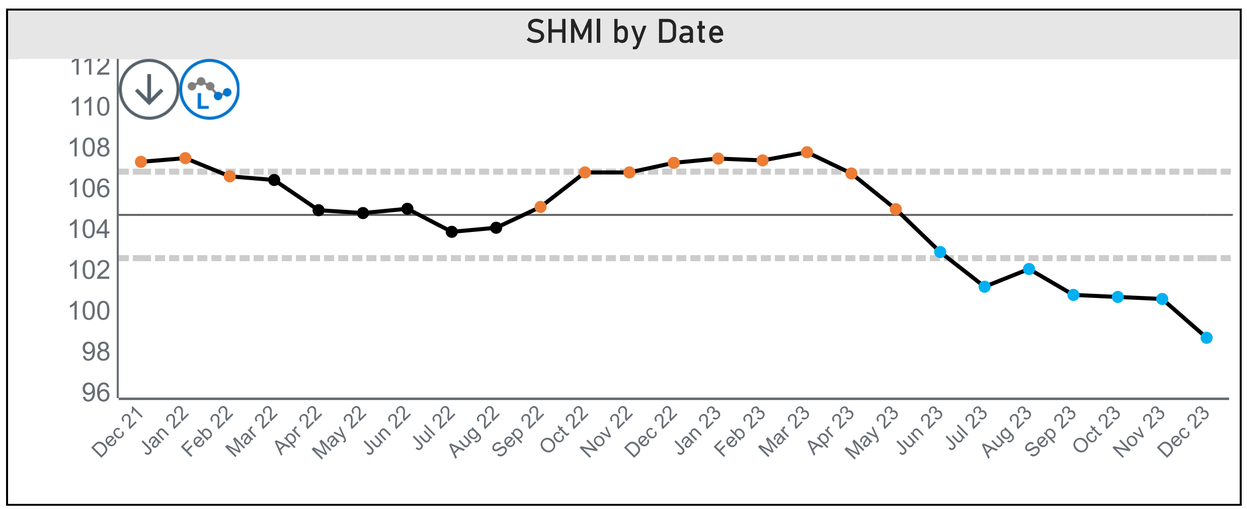
LOS > 21 DAYS by Date



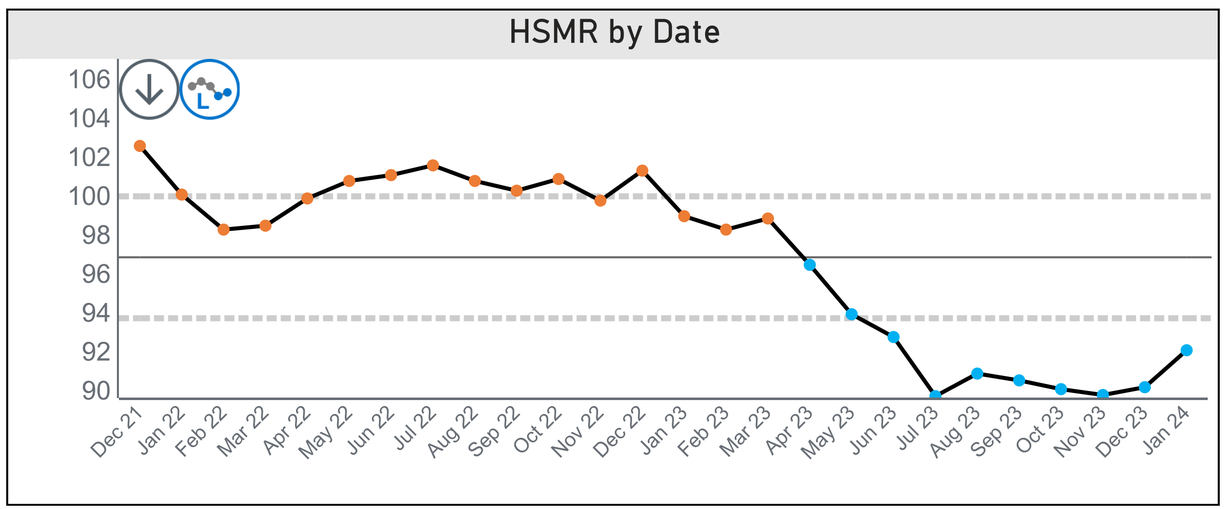
An average of 60 patients throughout the last 3 years. No significant variations noted.

Statistical Process Control Charts
Quality Performance Page 1

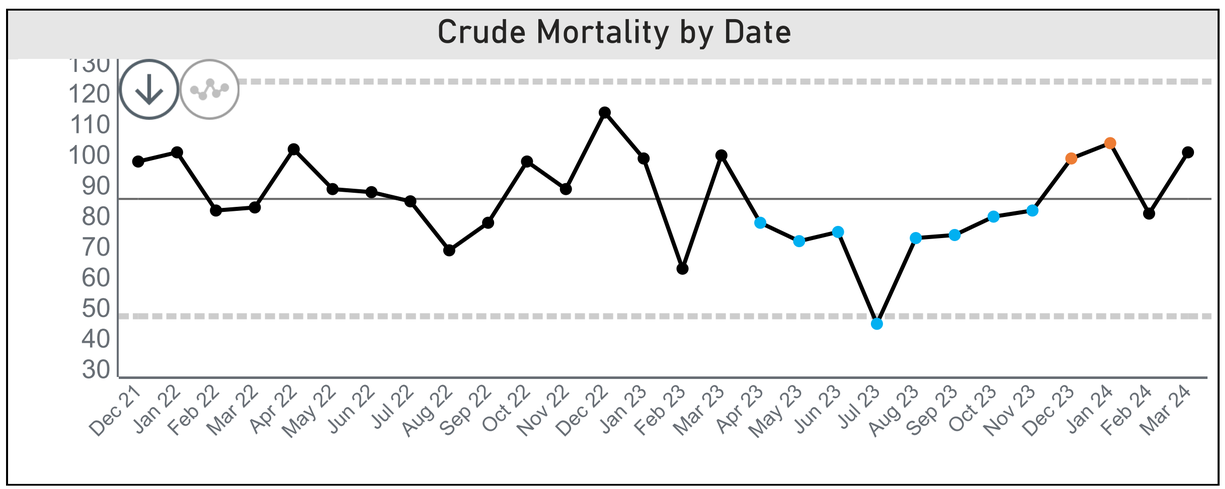
The Rotherham NHS Foundation Trust



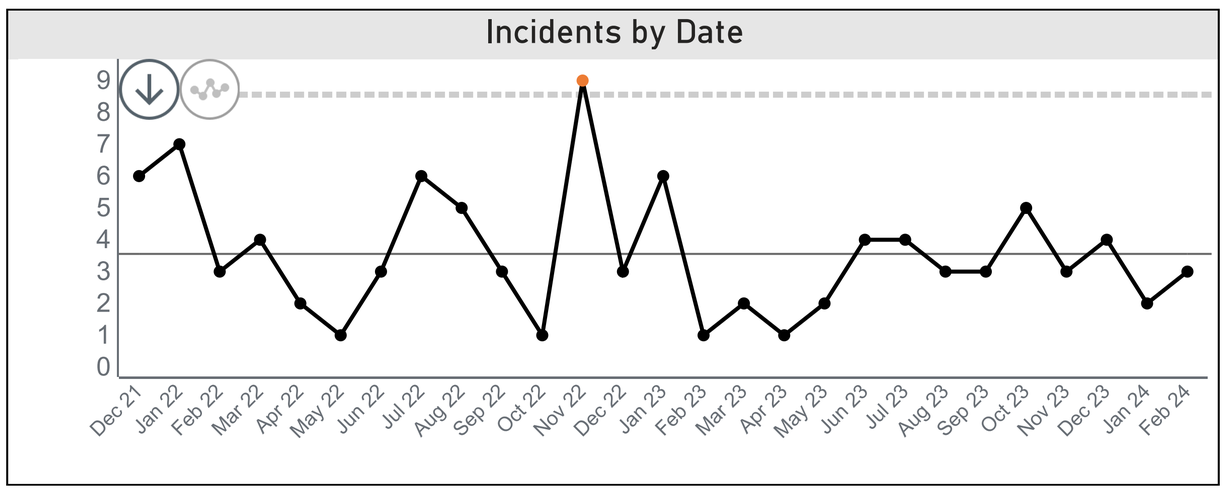
Significant improvement seen. Averaging at 105 over the last 3 years reducing to around 103 from June 23 and again to 96 in Dec 23.



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.

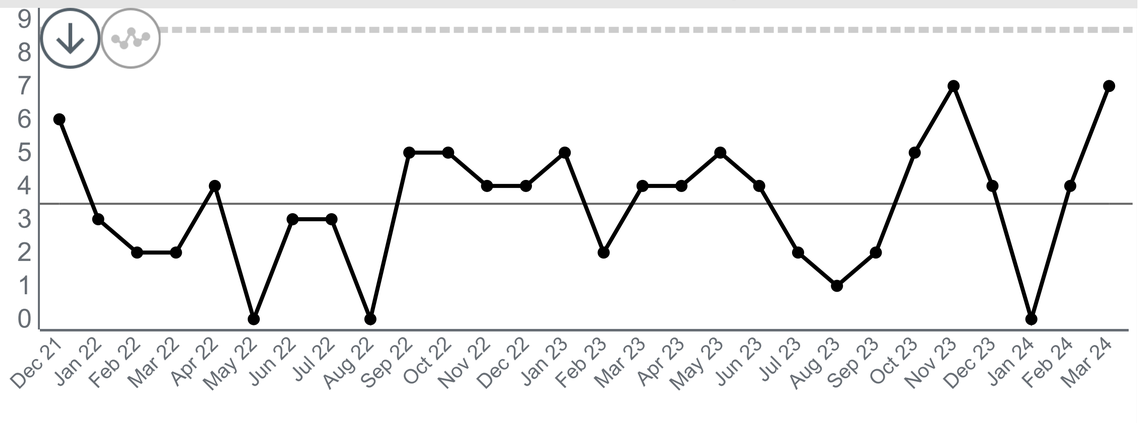


Averaging at 4 incidents a month, no significant change.

Statistical Process Control Charts
Quality Performance Page 2

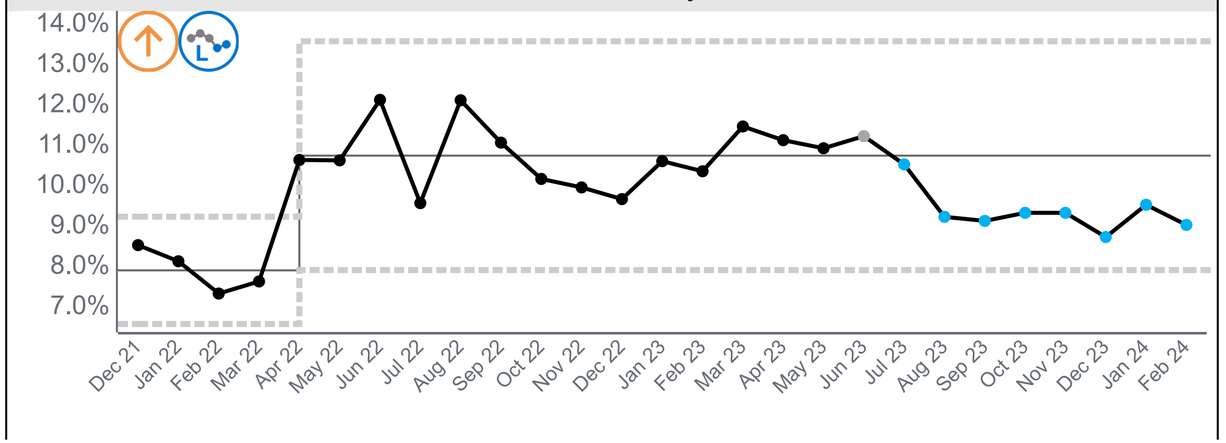
The Rotherham NHS Foundation Trust

Clostridium-difficile Infections by Date



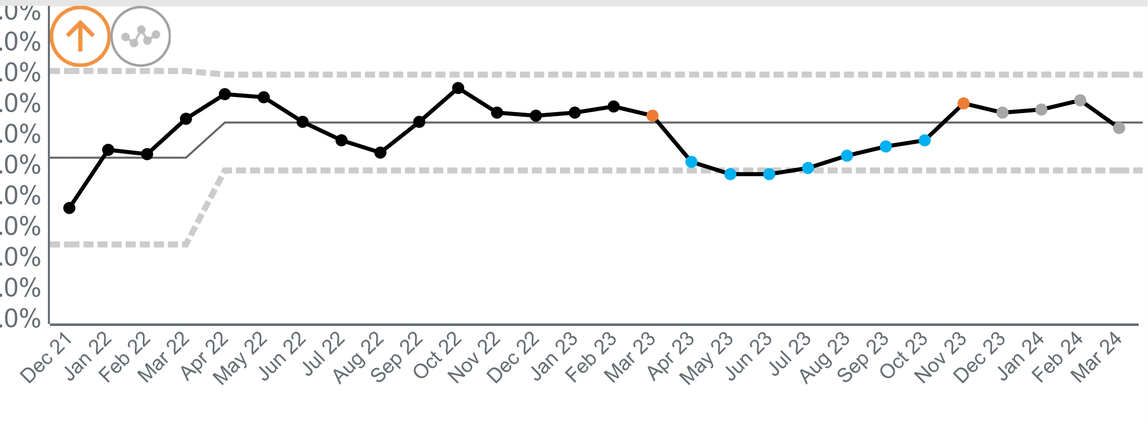
No significant change - averaging at 3 cases per month.

Readmissions by Date



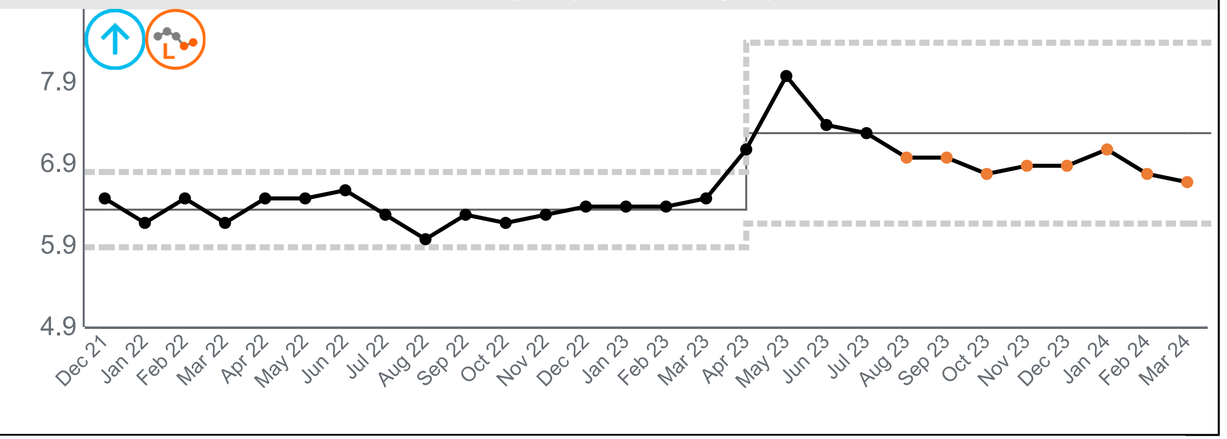
There was a measurement change in April 22 as per guidance. Improvement seen within the measurement change from Aug 23.

VTE % by Date



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

Care hours per patient day by Date

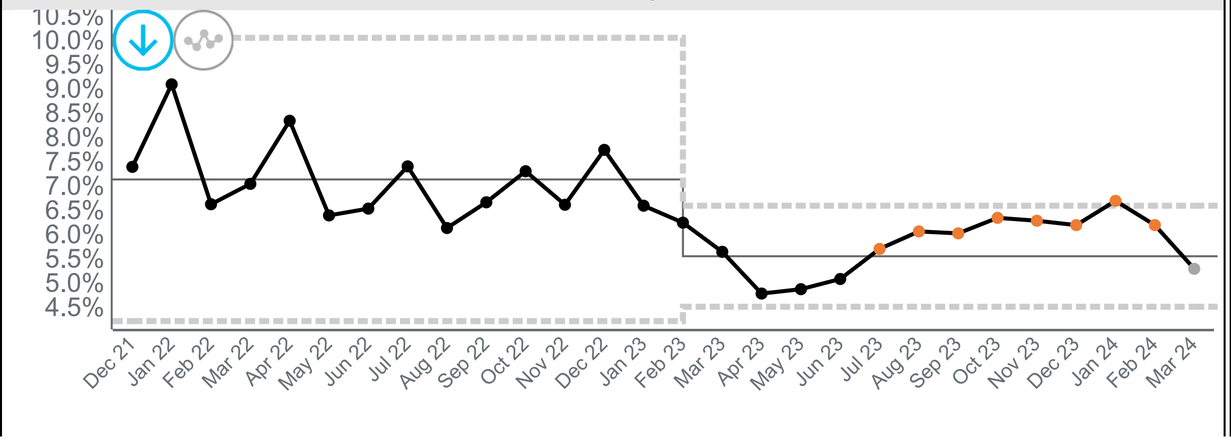


A significant improvement from an average of 6 within Oct 21 - Mar 23 to 7.1 from Apr 23.

Statistical Process Control Charts
Workforce Performance Page 1

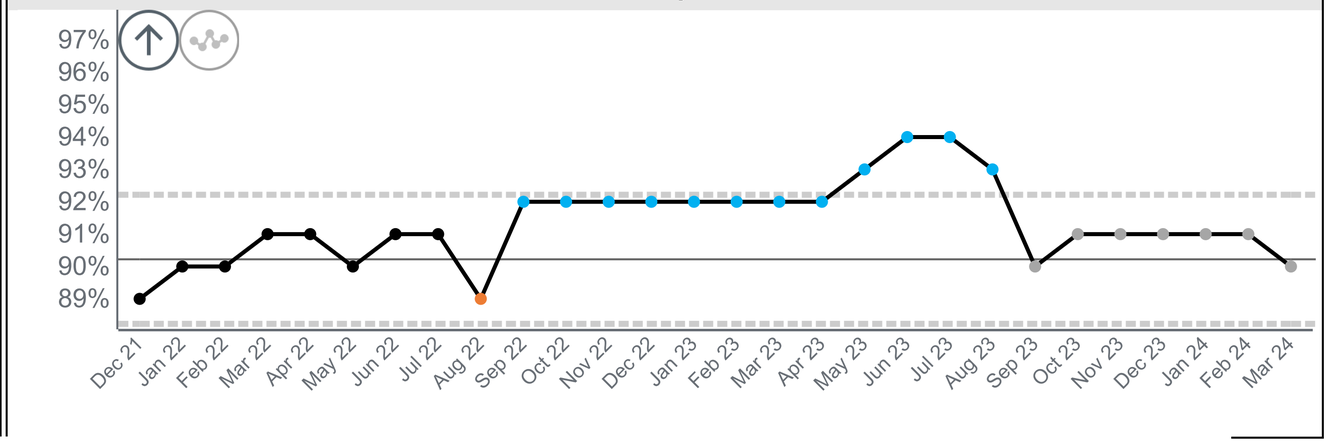
The Rotherham NHS Foundation Trust

Sickness by Date



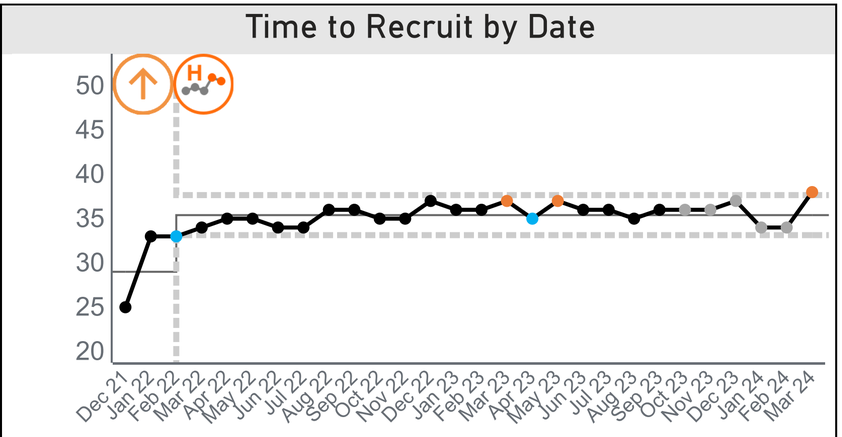
A significant improvement in sickness seen from an average of 7.2% to 5.5% although performance beginning to deteriorate showing a special cause variation.

MAST by Date



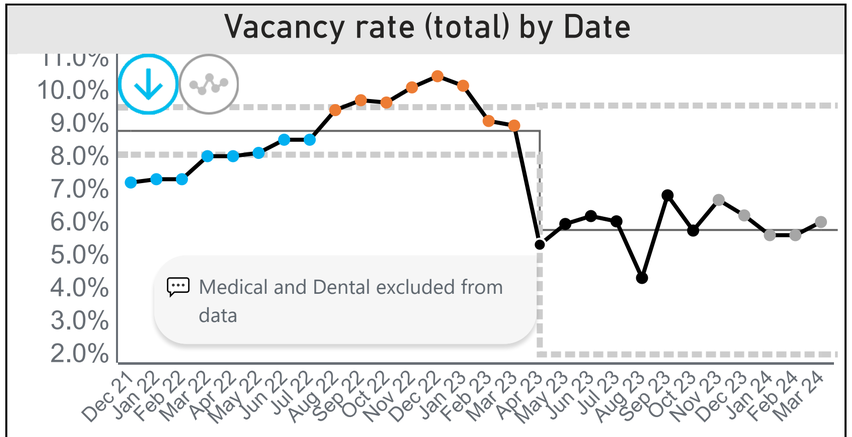
MAST is Averaging at 90%

Time to Recruit by Date



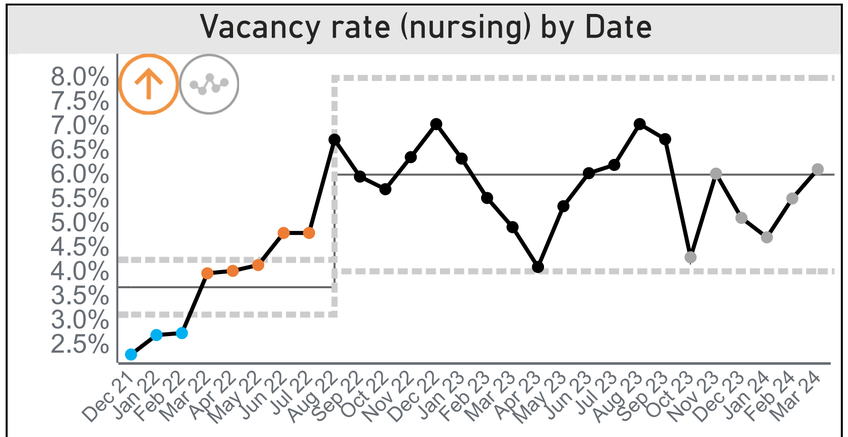
A significant deterioration seen from an average of 30 days at the end of Feb 22 to an average of 35 days throughout the remainder of 2022 and 2023.

Vacancy rate (total) by Date



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.

Vacancy rate (nursing) by Date



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.

COUNCIL OF GOVERNORS MEETING: May 2023

Agenda item: Organisational Priorities 2023/24 – End of Year Report 27/24

Report: Report from: Michael Wright – Managing Director

Author and Presented by: Louise Tuckett / Michael Wright

Action required: To note

1.0 Introduction

1.1 The purpose of this paper is to present 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

1.2 The highlight reports at Appendix 1 inform the Council of Governors of the key achievements and any delays to delivery during the most recent reporting period (Quarter 4).

1.3 The Council of Governors 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.

1.4 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.

1.5 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.

1.6 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.

Michael Wright
Managing Director
May 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

COUNCIL OF GOVERNORS MEETING: May 2023

Agenda item: Organisational Priorities 2024/25 **30/24**

Report: Report from: Michael Wright – Managing Director

Author and Presented by: Louise Tuckett / Michael Wright

Action required: To note

1.0 Introduction

1.1 Following initial review at the Board seminars in February 2024 and April 2024, the attached Trust Organisational Priorities have been developed and discussed in detail at the Board Assurance Committees. The Assurance Committees provided both scrutiny and challenge.

1.2 After discussion at the Assurance Committee, the Priorities were then further discussed at Trust Board on the 3rd May, with feedback provided. Subsequently, further amendments have been made.

1.3 The core focus of the Priorities for 2024/25 is as follows:

- Quality of Care
- People & Culture
- Operational Delivery
- Financial Sustainability

1.4 The 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 was 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.

Michael Wright
Managing Director
May 2024

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**

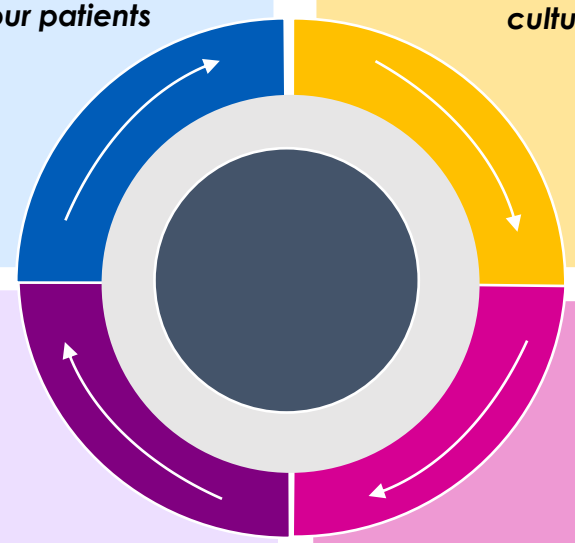
There are significant links between high levels of engagement and a number of positive staff and patient outcomes.

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.



Focus on our operational delivery and improving access to care

OPERATIONAL DELIVERY

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-waiting patients 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.

Focus on becoming a financially sustainable & productive organisation

FINANCIAL SUSTAINABILITY

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 of at least one quartile 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 <u>at least</u> 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 <u>no areas</u> 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-waiting patients 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 waiting patients is a national priority given the experience these patients have. 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 waiting patients 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 waits by July 2024. 50% reduction in 52 week waits for patients 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 Improvement Programme:** This programme will continue through 2024/25 and focus on driving improvement within FDS performance in our most challenged tumour sites **Endoscopy Improvement Programme:** The Trust plans to develop an Endoscopy Improvement Programme during 2024/25, which will link with the Cancer Improvement programme given the obvious overlap.		
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 of at least one quartile 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)	

COUNCIL OF GOVERNORS MEETING: May 2023

Agenda item: Strategy Refresh **29/24**

Report: Report from: Michael Wright – Managing Director

Author and Presented by: Louise Tuckett / Michael Wright

Action required: To note

1.0 Introduction

1.1 This paper summarises the discussions at the Board seminar in April 2024, whereby Board members participated in a workshop around a review and restatement of our five-year strategy, as we near the halfway point of the current strategy.

1.2 The paper reflects on the achievements to date. Having addressed a wide range of challenges in 2020-2021, the Trust is now on a course towards excellence in service delivery, consistent with the Ambition Value. The pursuit of excellence is the ultimate goal.

Michael Wright
Managing Director
May 2024

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.

COUNCIL OF GOVERNORS MEETING: 15 May 2024

Agenda item: 30/24

Report: **Annual Quality Account 2023/24**

Presented by: Helen Dobson, Chief Nurse
Author(s): Helen Dobson, Chief Nurse

Action required: For noting

1. Introduction

1.1 The Trust publishes a Quality Account each year. This year's Quality Account reviews progress against the quality priorities agreed for 2023/24 and outlines priorities for 2024/25.

1.2 Due to timings of meetings, the Council of Governors are asked to be aware that although broadly complete, there are some final pieces of information still being verified and therefore this draft version is subject to some minor amendments over the next month.

2. Purpose

2.1 The Quality Account brings together in one place qualitative and quantitative data that helps describe how the Trust approaches improving the quality of services for its patients. Due to COVID 19, the requirement for the report to be audited was removed.

2.2 Even though the report does not require external audit, the report has been written and inclusions based on the requirements provided by NHS Improvement.

2.3 It provides an opportunity for patients, carers, colleagues and the wider general public to review the work of the Trust and make comparisons with other NHS organisations.

2.4 This document was shared with the Lead Governor, NHS South Yorkshire ICB, Rotherham Healthwatch and Rotherham Council Health Select Commission. Statements in response from each party will be included in the final publication.

3. Benefits

3.1 The Quality Account provides a broad range of data relating to Trust performance in the areas of Quality and Safety. Because it is published annually, it enables comparisons to be made year on year.

3.2 Colleagues engaged with innovation and initiatives have an opportunity to see their work made available to a wider audience.

3.3 Timely publication ensures the Trust meets its Statutory and Regulatory obligations.

4. Conclusion

4.1 The Council of Governors are asked to note the draft Quality Account which is due to be published as required by 30 June 2024.

Helen Dobson
Chief Nurse
May 2024

DRAFT

QUALITY ACCOUNT 2023-2024

Black text = last year's

Blue text = updated but needs finalising

Red text = who requested update from/comments/responses etc

Green text – text checked and finalised as at year end

Part One: Statement on Quality from the Chief Executive

To be added

Part Two: Priorities for improvement and statements of assurance from the Board

2.1 Priorities for improvement during 2024/25

Our vision is to be an outstanding Trust, delivering excellent care at home, in our community and in hospital. To achieve this, every colleague and every team is expected to be involved in Quality Improvement (Qi) seeing it as part of everyday business. The Quality Improvement programme at the Trust has continued to grow over 2023/24, with 112 Quality Improvement Practitioners now successfully completing training. The new AMaT system is utilised to register and track progress of all quality improvement initiatives. There have been 93 projects registered through the system over the past year.

The team has expanded and there is now a quality improvement facilitator and practitioner in post to support the Head of Quality Improvement. 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.

The Patient Safety Incident Response Framework (PSIRF) has now been implemented at the Trust. The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents to learn and improve patient safety.

- A new way of responding to patient safety incidents – unintended or unexpected events in healthcare that could have or did harm one or more patients
- A data-driven approach to patient safety incident response
- Focused on learning and improvement
- Focused on systems, processes and human factors

Incident responses are the systematic approaches taken to address and manage patient safety incidents effectively. The key components are, Reporting and Recording incidents, Investigating and analysing, Learning and improvement, Communication and transparency and Monitoring outcomes. The responses create a safer healthcare environment by learning from past mistakes, implementing proactive measures, and fostering a culture of continuous improvement.

The Trust ensures that it keeps up to date with any changes to Quality Account requirements (Chapter 2 of the Health Act 2009) through notifications from NHS Improvement (NHSI) and other sources. These are reviewed by those leading on developing the report where required, and the implementation of the actions are monitored by the Quality Committee.

For 2024/25, the focus will be on the quality priorities outlined below. These have been agreed following a consultation process, including communication with colleagues and governors, who were given the opportunity to comment on the draft proposals and

shape how these priorities were delivered, along with using the findings from external reviews, incidents, complaints, patient feedback and risks.

Delivering continuous improvement is the responsibility of all colleagues. Clinical Trust services are delivered through Clinical Divisions, each ultimately accountable to the Board of Directors for its contribution to the performance of the Trust as a whole. Each Division is led by a Divisional Director (a Senior Clinician), with support from a General Manager, a Head of Nursing, and Finance and Human Resources Business Partners. They are responsible for maintaining the clinical governance structures that keep an overview of patient safety, patient experience, clinical effectiveness and quality of services in every clinical area and department.

Delivering Quality Improvement is a continuous process. Each year provides an opportunity to reflect on success and continuing challenges, but the Trust understands that achieving and sustaining improvement requires a long-term commitment. This year's priorities therefore reflect a mix of previous areas of focus where further quality improvements are needed and additional areas identified where improvements are required.

The quality priorities for 2024/25 are:

Patient Safety

- Diabetes Management

Patient Experience

- Acute Pain Management

Clinical Effectiveness

- Frailty Assessment

Patient Safety

Diabetes Management Improve the management of Diabetic patients admitted to the Acute Trust	Early identification of Diabetic patients admitted into hospital, with screening and rapid referral for those most at risk of developing complications. Structured programme of staff training on the safe use of insulin. Training to be provided for every healthcare professional who dispenses, prescribes and/or administers insulin, appropriate to their level of responsibility, including an assessment of competency.	GIRFT and National Diabetes Audit recommendations (2020, 2022-23).

	Clear, audited perioperative pathways for people with diabetes, broadly in line with the recommendations in the recent NCEPOD report Highs and Lows. Ensure there is a self-management policy, which supports patients who want to self-manage their diabetes to safely do so while in hospital, as clinically appropriate. Patients with a diabetic foot care emergency requiring admission should be assessed the same day by the MDFS (multi-disciplinary foot care service), and if vascular impairment is identified, they should have same day access to a vascular opinion. If the MDFS is not available, they may need to be transferred to a vascular service. Diabetes teams to work closely with coders to ensure diabetes is coded consistently and accurately – and ensure all inpatients who have diabetes are identified on admission to hospital. Consider an electronic system, integrated with web-linked blood glucose meters which provide an alert system for staff when any out-of-range reading is recorded.	

Patient Experience

Acute Pain Management	All people with acute pain must have an individualised analgesic plan appropriate to their clinical condition that is effective, safe and flexible with planned review. All in patients with acute pain must have regular pain and functional assessment using consistent and validated tools, with results recorded. There should be clear guidelines for communication with the pain team. For people in severe pain, action must be taken immediately and an intervention must take place within 30 minutes. The effectiveness of the	Derived from the Faculty of Pain Management (RCoA) core standards 2021.

	intervention must be reassessed after an appropriate interval. People with complex pain must be referred to the pain team and must be reviewed in a timely fashion. Hospital to community transition after surgery. On discharge from hospital, the discharge letter must include accurate details of all analgesia provided. The prescription of any opioid analgesia for use post-discharge must be included.	

Clinical Effectiveness

Frailty Assessments Frailty is a key priority for the NHS to identify frailty in a person early and for them to be seen at the right time by the right team in order for needs to be identified and managed.	There are a number of publications of national publications covering Frailty Assessments https://www.england.nhs.uk/long-read/frail-strategy/ CQUIN – CCG5 – Identification and response to frailty in Emergency Departments outcomes highlight poor compliance in frailty assessments and concern has been raised around the quality of completion Frailty is a theme for improvement in a number of National Clinical Audits; • National Clinical Audit of Dementia • Falls & Fragility Audit Programme NHSE Right Care Frailty Toolkit – based upon NICE and GIRFT recommendations offers a self assessment and guidance to improve care and services to support people living with frailty from patients accessing ED to providing care in patients own homes	NICE Guidance *implementation* fully achieved with metrics to evidence achieving full *compliance* Continuous improvement being achieved and sustained - evidenced within the National Clinical Audit Outcomes and the CQUIN – CCG5 Self Assessment completed, an improvement plan agreed and in progress of implementation for frailty assessments and personalised care across the organisation

2.2: Statements of Assurance from the Board of Directors

During 2023/4 The Trust provided and/or subcontracted 64 relevant health services, across community and acute services. The Rotherham NHS Foundation Trust has reviewed the data available to them on the quality of care in these relevant health services. The income generated by the relevant health services reviewed in 2023/24 represented 91.7% of the total income generated from the provision of relevant health services by The Rotherham NHS Foundation Trust for 2023/24.

Clinical Audit

Information on Participation in Clinical Audits during 2023-24:

During 2023-24, 50 national clinical audits and 10 national confidential enquiries covered NHS services that The Rotherham NHS Foundation Trust provides.

During that period the Trust participated in 93% of national clinical audits and 80% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Trust were eligible to participate in, and for which data collection was completed during 2023-24, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Programme Count	Workstream count	Programme	NCAPOP	Quality Account	Eligible to participate	Participated	% cases submitted
1	1	Adult Respiratory Support Audit	No	Yes	No	NA	NA
2	2	BAUS Urology Audits - BAUS Nephrostomy Audit	No	Yes	Yes	Yes	100% (7/7)
3	3	Breast and Cosmetic Implant Registry	No	Yes	Yes	Yes	Data not available on registry *
4	4	British Hernia Society Registry	No	Yes	Yes	No***	NA
5	5	Case Mix Programme (CMP)	No	Yes	Yes	Yes	100% (580/580)
6	National Confidential Enquiry into Patient Outcome and Death (NCEPOD) - Child Health Clinical Outcome Review Programme						
	6	Juvenile Idiopathic Arthritis	Yes	Yes	Yes	No eligible cases for the sample	
	7	Testicular torsion	Yes	Yes	Yes	No eligible cases for the sample	
7	8	Cleft Registry and Audit NEtwork (CRANE)	No	Yes	No	All local identified cases are referred to Trent Regional Cleft Network at Nottingham University Hospital, who notify CRANE of all cases	
8	9	Elective Surgery (National PROMs Programme)	No	Yes	Yes	Yes	45% (70/156)
9	Emergency Medicine QIPs						
	10	Care of Older People – year one	No	Yes	Yes	Yes	100% (105/105)
	11	Mental Health (Self-Harm) – year one	No	Yes	Yes	Yes	100% (267/267)
10	12	Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People1	Yes	Yes	Yes	Yes	100% (62/62)
11	Falls and Fragility Fracture Audit Programme (FFFAP)						
	13	Fracture Liaison Service Database (FLS-DB)	Yes	Yes	Yes	Yes	94.6% (1070/131)
	14	National Audit of Inpatient Falls (NAIF)	Yes	Yes	Yes	Yes	100% (8/8)
	15	National Hip Fracture Database (NHFD)	Yes	Yes	Yes	Yes	100% (291/291)
12	16	Improving Quality in Crohn's and Colitis (IQICC) [Note: previously named Inflammatory	No	Yes	Yes	No***	NA

		Bowel Disease (IBD) Audit]					
13	UK Renal Registry						
	17	Chronic Kidney Disease Audit	No	Yes	No	NA	NA
	18	Acute Kidney Injury Audit	No	Yes	Yes	Yes	100% (3235/3235)
14	19	Learning disability and autism Programme - Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)	No	Yes	Yes	Yes	100% (12/12)
15	MBRRACE UK Maternal, Newborn and Infant Clinical Outcome Review Programme						
	20	Maternal morbidity confidential enquiry - annual topic based serious maternal morbidity	Yes	Yes	Yes	Yes	100% (1/1)
	21	Maternal mortality confidential enquiries	Yes	Yes	Yes	Yes	100% (1/1)
	22	Maternal mortality surveillance	Yes	Yes	Yes	Yes	100% (1/1)
	23	Perinatal mortality and serious morbidity confidential enquiry	Yes	Yes	Yes	Yes	100% (13/13)
	24	Perinatal Mortality Surveillance	Yes	Yes	Yes	Yes	100% (13/13)
16	NCEPOD Medical and Surgical Clinical Outcome Review Programme						
	25	Community Acquired Pneumonia	Yes	Yes	Yes	Yes***	Organisational questionnaire only submitted
	26	Endometriosis	Yes	Yes	Yes	No***	0%
17	NCISH Mental Health Clinical Outcome Review Programme						
	27	Real-time surveillance of patient suicide	Yes	Yes	No	NA	NA
	28	Suicide (and homicide) by people under mental health care	Yes	Yes	No	NA	NA
	29	Suicide by people in contact with substance misuse services	Yes	Yes	No	NA	NA
18	National Adult Diabetes Audit (NDA)						
	30	National Core Diabetes Audit	Yes	Yes	Yes	Yes	100% (390/390)*
	31	National Diabetes Footcare Audit (NDFA)	Yes	Yes	Yes	Yes**	100% (28/28)*

	32	National Diabetes Inpatient Safety Audit (NDISA)	Yes	Yes	Yes	Yes	100% (1/1)
	33	National Pregnancy in Diabetes Audit (NPID)	Yes	Yes	Yes	Yes	100% (35/35)
	34	NDA Integrated Specialist Survey	Yes	NA	Yes	Annual Organisational Survey	
19	National Respiratory Audit Programme (NRAP)						
	35	Adult Asthma Secondary Care	Yes	Yes	Yes	Yes**	39.2% (75/191)*
	36	COPD Secondary Care	Yes	Yes	Yes	Yes**	58.5% (100/171)*
	37	Paediatric Asthma Secondary Care	Yes	Yes	Yes	Yes	100% (62/62)
	38	Pulmonary Rehabilitation	Yes	Yes	Yes	Yes	100% (266/266)*
	39	National Respiratory Audit Programme (NRAP) - Wales Primary Care Audit	Yes	Yes	No	NA	NA
20	40	National Audit of Cardiac Rehabilitation	No	Yes	Yes	Yes	100% (624/624)*
21	41	National Audit of Cardiovascular Disease Prevention in Primary Care (CVDPREVENT)	Yes	Yes	No	NA	NA
22	42	National Audit of Care at the End of Life (NACEL)	Yes	Yes	Yes	Yes	No data has been collected during 2023. Commenced Jan 24 and remains open currently.
23	43	National Audit of Dementia - Care in general hospitals	Yes	Yes	Yes	Yes	100% (78/78)
24	44	National Audit of Dementia - Spotlight audit in community-based memory assessment services	Yes	Yes	No	NA	NA
25	45	National Audit of Pulmonary Hypertension	No	Yes	No	NA	NA
26	46	National Bariatric Surgery Registry (NBSR)	No	Yes	No	NA	NA
27	47	National Cancer Audit Collaborating Centre - National Audit of Metastatic Breast Cancer	Yes	Yes	Case ascertainment to be published in 2024-25		

28	48	National Cancer Audit Collaborating Centre - National Audit of Primary Breast Cancer	Yes	Yes	Case ascertainment to be published in 2024-25		
29	49	National Cardiac Arrest Audit (NCAA)	No	Yes	Yes	No***	NA
30	National Cardiac Audit Programme (NCAP)						
	50	Myocardial Ischaemia National Audit Project (MINAP)	No	Yes	Yes	Yes**	100% (311/311)*
	51	National Adult Cardiac Surgery Audit (ACS)	No	Yes	No	NA	NA
	52	National Audit of Cardiac Rhythm Management (CRM)	No	Yes	Yes	Yes	100% (237/237)*
	53	National Audit of Mitral Valve Leaflet Repairs (MVLR	No	Yes	No	NA	NA
	54	National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	No	Yes	No	NA	NA
	55	National Congenital Heart Disease Audit (NCHDA)	No	Yes	No	NA	NA
	56	National Heart Failure Audit (NHFA)	No	Yes	Yes	Yes**	38.6% (177/458)*
31	57	The UK Transcatheter Aortic Valve Implantation (TAVI) Registry	No	Yes	No	NA	NA
32	58	National Child Mortality Database (NCMD) Programme	Yes	Yes	Yes	Yes	100% (13/13)
33	59	National Clinical Audit of Psychosis (NCAP)	Yes	Yes	No	NA	NA
34	60	National Clinical Audit of Psychosis (NCAP) - 2023 EIP audit (bespoke data) 2024 EIP audit (bespoke data	Yes	Yes	No	NA	NA
35	National Comparative Audit of Blood Transfusion						
	61	2023 Audit of Blood Transfusion against NICE	No	Yes	Yes	No***	NA

		Quality Standard QS138					
	62	2023 Bedside Transfusion Audit	No	Yes	Yes	Deferred nationally until April 24	
36	63	National Early Inflammatory Arthritis Audit (NEIAA)	Yes	Yes	Yes	Yes	70% (69/98)*
37	64	National Emergency Laparotomy Audit (NELA)	Yes	Yes	Yes	Yes	100% (102/88)
38	65	National Gastro-Intestinal Cancer Audit Programme (GICAP) - National Bowel Cancer Audit (NBOCA)	Yes	Yes	Yes	Yes	100% (198/198)
39	66	National Gastro-Intestinal Cancer Audit Programme (GICAP) - National Oesophago-Gastric Cancer Audit (NOGCA)	Yes	Yes	Yes	Yes	100% (59/59)
40	67	National Joint Registry	No	Yes	Yes	Yes	100% (803/803)
41	68	National Lung Cancer Audit (NLCA)	Yes	Yes	Yes	Yes	100% (449/449)
42	69	National Maternity and Perinatal Audit (NMPA)	Yes	Yes	Yes	Yes	*Data extracted by RCOG from NHSE.
41	70	National Neonatal Audit Programme (NNAP)	Yes	Yes	Yes	Yes	100% (270/270)
42	71	National Obesity Audit (NOA)	Yes	Yes	No	NA	NA
43	72	National Ophthalmology Database Audit (NOD) - National Cataract Audit	No	Yes	No**	NA	NA
44	73	National Paediatric Diabetes Audit (NPDA)	Yes	Yes	Yes	Yes	100% (131/131)
45	74	National Prostate Cancer Audit (NPCA)	Yes	Yes	Yes	Yes	100% (189/189)
46	75	National Vascular Registry (NVR)	Yes	Yes	No	NA	NA
47	76	Out-of-Hospital Cardiac Arrest Outcomes (OHCAO)	No	Yes	No	NA	NA

48	77	Paediatric Intensive Care Audit Network (PICANet)	Yes	Yes	No	NA	NA
49	78	Perinatal Mortality Review Tool (PMRT)	No	Yes	Yes	Yes	100% (13/13)
50	79	Perioperative Quality Improvement Programme (PQIP)	No	Yes	Yes	Yes	65.6% (180/247)
51	Prescribing Observatory for Mental Health						
	80	Use of medicines with anticholinergic (antimuscarinic) properties in older people's mental health services	No	Yes	No	NA	NA
	81	Monitoring of patients prescribed lithium	No	Yes	No	NA	NA
52	82	Sentinel Stroke National Audit Programme (SSNAP)	Yes	Yes	Yes	Yes	A 90%+
53	83	Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	No	Yes	Yes	Yes	100% (41/34)
54	84	Society for Acute Medicine Benchmarking Audit (SAMBA)	No	Yes	Yes	Yes	100% (72/72)
55	85	The Trauma Audit & Research Network (TARN)	No	Yes	Yes	Yes	Unable to report on case ascertainment due to the closure of the TARN submission portal in June 2023
56	86	UK Cystic Fibrosis Registry	No	Yes	No	NA	NA

**Data for projects marked with * require further validation. Where data has been provided these are best estimates at the time of compilation. Data for all continuous projects and confidential enquiries continues to be reviewed and validated during April, May or June 2024 and therefore final figures may change.*

* **Supporting Statements – data not available**

Quality Accounts - **Breast and Cosmetic Implant Registry (BCIR)** – data unavailable as Breast and Cosmetic Implant Registry is mid-migration to NHSE Outcomes registries platform

* **NCAPOP - National Maternity and Perinatal Audit (NMPA)** - data unavailable as the RCOG states that there have been delays in receiving the data from NHS England for the last 2 years.

****Supporting Statements – lower than expected case ascertainment**
NCAPOP – National Respiratory Audit Programme (NRAP) - Adult Asthma - There is no dedicated resource allocated to the collection of data for this audit, due to capacity within the Specialty. Discussions are being held with the Business Intelligence Team to ascertain which data fields can be automated to reduce data burden and increase case ascertainment. The asthma and COPD discharge bundles are being created on Meditech, which will also support automisation of data and reduce the data burden. The Medical Division continue to find a solution for increasing resources to effectively participate.

NCAPOP – National Respiratory Audit Programme (NRAP) - COPD - There is no dedicated resource allocated to the collection of data for this audit, due to capacity within the Specialty. Discussions are being held with the Business Intelligence Team to ascertain which data fields can be automated to reduce data burden and increase case ascertainment. The asthma and COPD discharge bundles are being created on Meditech, which will also support automisation of data and reduce the data burden. The Medical Division continue to find a solution for increasing resources to effectively participate.

NCAPOP – National Early Inflammatory Arthritis Audit (NEIAA) – National Clinical Audit Provider aware of and acknowledged the Trust's workforce challenges in Rheumatology impacting on case ascertainment. Additional support from the Clinical; Effectiveness Team has enabled further cases to be submitted during 2023-24 but lower than expected case ascertainment. Sustainable approaches for supporting the NEIAA are being agreed and it is expected that case ascertainment will significantly increase in 2024-25.

NCAPOP – National (Diabetes) Foot Care Audit (NFCA) - Workforce challenges within Podiatry has impacted on case ascertainment. In October 2023, the data collection tool was created in SystmOne, enabling the clinicians to record the data fields required for the audit electronically in real time. This can now be extracted electronically and uploaded to the Clinical Audit Platform. With this new way of working now embedded, an increase in case ascertainment should be seen during 2024-25.

Quality Accounts – National Cardiac Audit Programme (NCAP) - National Heart Failure Audit (NHFA) - Workforce challenges have impacted on case ascertainment for the NHFA. Discussions are being held with the Business Intelligence Team to ascertain which data fields can be automated to reduce data burden and increase case ascertainment. A one day a week post has been secured for 6 months to undertake data collection whilst a sustainable approach is agreed and embedded going forwards.

*****Supporting Statements – non participation**
NCAPOP – National Confidential Enquiries into Patient Outcomes and Death (NCEPOD) – Endometriosis – non submission of organisational questionnaire –

local work to be undertaken and will review national report & recommendations when published.

NCAPOP – National Confidential Enquiries into Patient Outcomes and Death (NCEPOD) – Community Acquired Pneumonia – NCEPOD team missed the Trust from the case sample and no patients were allocated. The Trust are currently reviewing the published national recommendations for improvements locally.

Quality Accounts – National Cardiac Arrest Audit (NCAA) - The data gained from the NCAA can be replicated in an interrogatable database stored locally without incurring any cost. Within the database, the data fields are limited and with the database created locally, far more information can be gained to understand and inform local improvements.

Quality Accounts – Improving Quality in Crohn's and Colitis (IQICC) - Non-participation in this audit is due to workforce challenges during 2023-24. The IQICC dataset is substantial, with data being collected and submitted manually overtime for each patient contact, including review and follow up, making this very resource intensive. A local database is maintained by the Gastroenterology team, which can be used for local quality improvement work. The IBD Registry – IQICC is closing as of 31st March 2024.

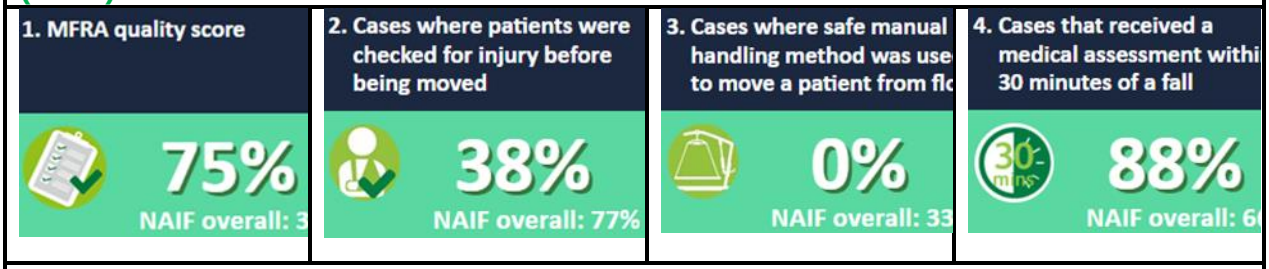
Quality Accounts - 2023 Audit of Blood Transfusion against NICE Quality Standard (QS138) – Workforce challenges impacted on the ability to collect and submit the data to the National Clinical Audit Provider before the data submission period closed. The National Report will be reviewed locally and recommendations for improvement considered alongside local data.
Quality Accounts - National Ophthalmology Database Audit (NOD) - National Cataract Audit – data submission requires Medisoft software, and the Trust have not procured this system. The Trust have approved non participation and internally local practice is audited to benchmark against the national outcomes when published.

Quality Accounts – British Hernia Society Registry – a new addition to the Quality Accounts for 2023-24 and the Trust were not participating previously. Consideration is currently being given to the dataset and participating for 2024-25.

The reports of 20 National Clinical Audits, published in the calendar year of 2023, were reviewed by the provider in the financial year 2023-24. The Trust intends to take actions to improve the quality of healthcare provided. Examples of which are detailed below;

NCAPOP - National Falls and Fragility Audit Programme (NFFAP) - National Audit of Inpatient Falls (NAIF)
Falls remain one of the leading causes of harm in hospital settings. The NAIF measures care given to patients who fell while they were in hospital and sustained a hip fracture. NAIF data is discussed at the Trust Falls Prevention Group, where areas for focussed improvement projects are agreed. The Trust has undertaken further work to improve the quality of care delivered:

National Falls and Fragility Audit Programme - National Audit of Inpatient Falls (NAIF):



Mobility Assessment - A review of the length of time taken for a referral to therapy services for patient's identified as being at risk of falls was undertaken. The process for referral to therapy services has now been integrated into the falls risk assessment in Meditech. Once a patient has been identified as requiring assessment, an automatic pop up appears for the referral to be completed at the point of identification.
A snapshot review of 16 patients referred to therapy services where referrals were completed using the new pop up showed that:

- 11 were identified earlier as not requiring input
- 4 had therapy referrals completed within 48 hours
- 1 referral was completed within 24 hours

Previously on average referrals took 3-4 days.
Lying & Standing Blood Pressure – The revised RCP guidelines have been added to Meditech to improve compliance with completing Lying & Standing blood pressures

Safely moving patients - Trust wide communications on the locations and how to access flat lift equipment was circulated in the ibulletin September 2023
Patient Safety 5in5 was circulated Trust wide on the safe use of and access to flat lift equipment September 2023
TRFT Slips, Trips and Falls Policy is being reviewed and updated to reflect the requirement of the use of flat lift equipment for patients with suspected fractures (February 2024)
TRFT Falls Prevention Competency package has been amended in-line with the Policy to demonstrate the national requirement. It will be uploaded and available on ESR. This enables local and Divisional management and Trust wide oversight of compliance
A business case is in development for the purchase of 2 new flat lift air systems to increase availability and access
The NAIF data and case studies of post falls care is shared in training and on the Nurse Preceptorship Programme
Trust wide manual handling training continues to include the safe use of flat lift equipment

What Next - Participation in the NAIF enables the Trust to stay abreast of common national themes and areas for focussed Quality Improvements projects, the Trust maintains an 'everybody's responsibility' approach to falls prevention, which is reflected in the increased divisional representation at the falls prevention group.

The NAIF annual report has highlighted the areas for improvement and KPI's for the 2023 data submitted - these include:

- KPI 1 - High-quality multi-factorial risk assessment (MFRA)
- KPI 2 – Check for injury before moving
- KPI 3 – Flat lifting equipment used to move the patient from the floor

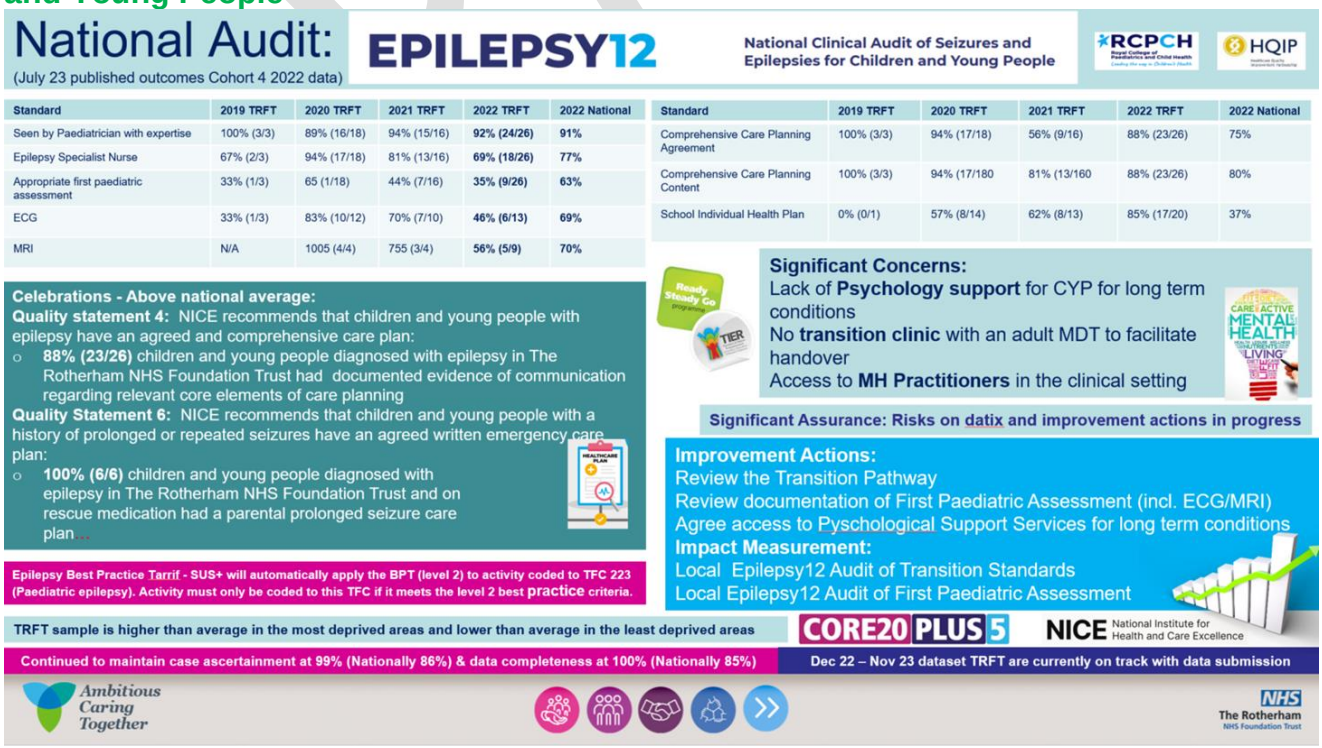
- KPI 4 – Medical assessment within 30 minutes of the fall

There is currently improvement work taking place throughout the organisation as mentioned above around KPI 1 & 3, there remains areas for improvement around KPI's 2 & 4. The falls Prevention Group continue to meet quarterly to review the NAIF data and annual report to ensure quality improvement projects are focussed around areas of concern.

KPI's 2 & 4 there is a planned review due to take place, looking closely at the post fall care our patients receive. This includes our average time for medical assessment to take place once a patient has fallen and the length of time taken to administer analgesia. The NAIF data reported an increase in the average time for the administration of analgesia for patients post fall. This is an area of concern that the falls prevention group will be addressing in next month's meeting.

Inpatient falls dashboard - Currently the number of falls within each inpatient area are reported on a monthly falls dashboard which is circulated to divisions at the end of each month. The dashboard is a representation of the number of falls within each area by harm only, it does not allow further analysis or the identification of themes and trends**.** A new PowerBI. dashboard is in development which will reflect the falls data in more depth, with various components and fields lifted from Datix and available on the dashboard. This will allow for greater thematic analysis into inpatient falls within particular areas.

Epilepsy12 – National Clinical Audit of Seizures and Epilepsies for Children and Young People



National Confidential Enquiry into Patient Outcome and Death (NCEPOD) - Patient Disordered Activity? A review of the quality of epilepsy care provided to adult patients presenting to hospital with a seizure

Disordered Activity? A review of the quality of epilepsy care provided to adult patients presenting to hospital with a seizure A review of the quality of epilepsy care provided to adult patients presenting to hospital with a seizure. The national report identified that action could be taken at all points of the patient pathway. The Trust are taking the following actions to improve the quality of care;		
	Have a system in place which enables emergency medicine/admitting clinicians to communicate with the patient's usual epilepsy clinical team (wherever the team is based) when the patient presents to hospital with a seizure	Communication by UECC and AMU with Neurology: For emergency advice - this is with the RHH On Call Neurology Service by telephone via RHH Switchboard. For routine advice - this is via the epilepsy nursing services To obtain latest correspondence letters with management plans - this is via the secretary of the Epilepsy Clinical Team To ensure epilepsy clinical team aware of a recent discharge from hospital, this requires AMU to send a copy of the discharge summary to the epilepsy specialist nurses
	Arrange follow-up plans before the patient is discharged from a hospital admission following a seizure	UECC and AMU to follow the First Fit Referral Pathway and Guidelines to book a patient with first seizure presentation into the correct Neurology OPD Attach a copy of the discharge summary with the First Fit Referral form For patients known to a clinical epilepsy team, discharge summary to be copied to the epilepsy specialist nurses

Review of Local Clinical Audits

The outcomes of 123 Local Clinical Audits were reviewed by the provider in 2023-24. The Trust intends to take actions to improve the quality of healthcare provided. Examples of which can be seen in Appendix 1.

CQUINs (Commissioning for Quality and Innovation)

In 2023/24 a total of 9 of the national CQUIN schemes were applicable to TRFT, of these TRFT selected 5 schemes against which to assign a financial incentive. Trust performance against each indicator has been submitted quarterly in line with the national CQUIN reporting timetable. The CQUIN schemes are listed below:

2023-24 National CQUIN Scheme

ID	Title	Financial Incentive Assigned
CCG1	Staff Flu Vaccinations	Yes
CCG2	Supporting patients to drink, eat and mobilise after surgery	Yes
CCG3	Prompt switching of intravenous antimicrobial treatment to the oral route of administration as soon as patients meet switch criteria	No
CCG4	Compliance with timed diagnostic pathways for cancer services	No
CCG5	Identification and response to frailty in emergency departments	No
CCG6	Timely communication of changes to medicines to community pharmacists via the Discharge Medicines Service	Yes
CCG7	Recording of and appropriate response to NEWS2 score for unplanned critical care admissions	Yes
CCG12	Assessment and documentation of pressure ulcer risk	Yes
CCG13	Assessment, diagnosis and treatment of lower leg wounds	No

The final submission of the quarterly CQUIN performance is due in June 2024 in line with the national CQUIN reporting timetable.

Care Quality Commission Registration and Periodic Reviews/Specialist Reviews

The Rotherham NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and ensure the registration status is accurate and updated as and when organisational changes affect the Trust Certificate of Registration.

CQC ratings

There have been no formal inspection visits during 2023/24. The current CQC ratings are illustrated below:

Domain	Rating
Safe	Requires Improvement
Effective	Requires Improvement
Caring	
Responsive	
Well Led	Requires Improvement

The tables below show the detailed ratings by domain and by core service:

CQC ratings for the Trust Hospital services

	Safe	Effective	Caring	Responsive	Well led
Urgent & Emergency Services	Requires Improvement	Requires Improvement		Requires Improvement	Inadequate
Medical Care	Requires Improvement				Requires Improvement
Surgery					
Critical Care					Requires Improvement
Maternity*					
Children and young people	Requires Improvement				
End of life care		Requires Improvement			

Outpatients and diagnostic imaging		(Inspected not rated)			

CQC ratings for Trust Community

	Safe	Effective	Caring	Responsive	Well Led
Adults		Requires Improvement			Requires Improvement
Children & Young People	Requires Improvement	Requires Improvement			Requires Improvement
Inpatients			Outstanding		
End of Life Care		Requires Improvement			Requires Improvement
Dental					

(Source: Care Quality Commission)

All reports from the Trust's inspection are available from the CQC website at: www.cqc.org.uk

How the Trust makes use of the CQC Inspection report

The Trust CQC Inspection Report provides a rich source of intelligence for the organisation, identifying where there is evidence of best practice but also where further intervention is required. The Trust also reviews Inspection Reports from other organisations to optimise further learning opportunities.

The Chief Nurse is the Trust nominated individual for registration with the CQC. A copy of the Trust's Registration Certificate can be viewed at:

http://www.cqc.org.uk/provider/RFR/registration-info or alternatively by requesting a copy from the Trust Company Secretary at the address below:

Company Secretary
General Management Department, Level D

The Rotherham NHS Foundation Trust
Moorgate Road
Rotherham, S60 2UD

Compliance with CQC standards is monitored internally through the Trust's clinical governance arrangements, which includes progress against all CQC Improvement Plans via the CQC Delivery Group, Patient Safety Committee, the Quality Committee and the Board of Directors. The Trust has completed all of the actions within the CQC improvement plan and continues to provide assurance that these are embedded.

The CQC have moved to the new Self-Assessment framework. All Core Services have previously completed a Quality Assurance Review and have now started to review against the new self-assessment framework. This will continue into the upcoming year and will be supported through a peer review programme.

CQC Engagement

The Trust has continued to build on their positive working relationship with the Trust CQC representatives. An engagement meeting takes place each month, attended by CQC colleagues, the Trust Executive and identified clinical teams. Issues and patient safety risks are discussed, in addition to opportunities for the clinical teams to present the work they are doing and the resulting improvements to patient care. CQC have sign posted a number of other Trusts to the organisation as the Trust is able to demonstrate a number of exemplary practices from which other healthcare providers can learn. The Trust has continued to work with other organisations and share good practice.

The Trust is also required to report any breaches of the **Ionising Radiation Regulations** to the CQC. Below is a summary of the radiation incidents that were reported to the CQC from 1 April 2023 to 1 April 2024.

The CQC only require employers to inform them about any exposures that are judged to be clinically significant, accidental or unintended exposures.

> The CQC say that:
>
> "When there is an accidental or unintended exposure to ionising radiation, and the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) employer knows or thinks it is significant or clinically significant, they must investigate the incident and report it to the appropriate UK IR(ME)R enforcing authority (under Regulation 8(4)."

We have reported 22 radiation incidents to our local Radiation Protection Advisor (RPA), for a dose report and recommendations.

Two of these incidents met the criteria to be reported to the CQC.

Reportable Incident 1 – nuclear medicine department incorrect patient referral meant that the patient had an injection of a radionuclide which was unintended. This has been discussed with the clinician and reflections have been made by the referrer. CQC has closed this incident after a report was submitted.

Reportable Incident 2 – Ct scanning main radiology department – a pregnant patient underwent a CT scan of chest abdomen and pelvis. There is no documentation to suggest the correct checks were completed prior to the examination. Action plan and full report has been sent to the CQC, awaiting feedback. Learning has been taken from this incident and the incident has been shared with team members to aid earning. Processes are being reviewed to mitigate the risk of this occurring again.

All Radiation incidents are recorded internally on DATIX and reported to the Radiation Protection Advisor (RPA) all radiation incidents are investigated and learning outcomes identified and shared. These are also discussed at Radiation Protection Committee meetings which are held quarterly and these feed into the Trust's Health and Safety meetings.

These incidents have been investigated and have been escalated through to the Clinical Support Services, Divisional Quality Governance Committee meetings. These are also discussed at Radiation Protection Committee meetings, which are held quarterly which feed into the Trusts Health and Safety meetings. This provides assurance as to the quality of the investigation and the robustness off the remedial actions taken.

Special Reviews and Investigations

The Trust has participated in two Specialist Reviews during 2023/24. The reviews were commissioned for the Endoscopic Retrograde Cholangio Pancreatography Service.

Data Quality – DATA NOT AVAILABLE UNTIL BEGINNING OF JUNE

The Rotherham NHS Foundation Trust submitted records during 2021/22 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics, which are included in the latest published data.

The percentage of records in the published data; which included the patient's valid NHS number was:

- 99.9% (99.8% for 2023/24) for admitted patient care
- 100.0% (100.00% for 2023/24) for outpatient care
- 99.8% (99.5% for 2023/24) for accident and emergency care

The percentage of records in the published data, which included the patient's valid General Medical Practice Code was:

- 100% (100% for 2023/24) for admitted patient care
- 100% (100% for 2023/24) for outpatient care
- 100% (100% for 2023/24) for accident and emergency care

For both data set (years) the data is reported for the period April – December as this is the most up to date position that we have available at time of publication.

Information Governance Toolkit (DSPT) attainment levels

The replacement of the Information Governance Toolkit, with the Data Security and Protection Toolkit (DSPT) during 2018/19, means that the Trust, like other organisations, is no longer able to produce an Information Governance Assessment report.

The DSPT demonstrates that the Trust is working towards the 10 National Data Guardian's data security standards as set out in the Data Security and Protection Standards for health and care.

Organisations are expected to achieve the 'standards met' assessment on the DSPT by 30 June each year.

The Trust's Data Security and Protection Toolkit Audit Report overall score for 2022/23 was 'Substantial Assurance' and Toolkit 'Standards Met'.

The Trust will submit again by 30 June 2024 and is aiming for full compliance – assurance will also be sought from the auditors prior to the end of May 2024.

Payment by Results – DATA NOT AVAILABLE UNTIL BEGINNING OF JUNE

The Trust was not subject to the Payment by Results clinical coding audit during 2023/24 by the Audit Commission. (Note: NHSI Comment: References to the Audit Commission are now out of date because it has closed. From 2014 responsibility for coding and costing assurance transferred to Monitor and then NHSI. From 2016/17 this programme has applied a new methodology and there is no longer a standalone 'coding audit', with error rates as envisaged by this time in the regulations. It is therefore likely that providers will be stating that they were not subject to "Payments by Results clinical coding audit").

The Trust will be taking the following actions to improve data quality and clinical coding – each clinical specialty that requires input from Clinical Coding now has an assigned Clinical Coder that acts as a point of liaison with that specialty, they attend monthly meetings with the specialty and raise any quality concerns with that service and work with them to improve their understanding of what is required to ensure good quality, accurate coding can take place. The Trust has appointed a Band 7 Coding Manager to assist with driving up standards and quality within the clinical coding department.

The Trust engaged in implementing the NHS Spine to the clinical information system MediTech in January 2018 and are the first Trust using Electronic Patient Record (MediTech) to transition to Patient Demographics Service in the country. The Trust has been attaining data completeness rates well above the national average, across all of its core commissioning data set submissions, and the evidence of this can be seen via the NHS England Data Quality Dashboards.

The Trust was subject to the mandatory Clinical Coding Information Governance audit in December 2023, during the 2023/24 reporting period as required by NHS England. The Trust again achieved an Information Governance rating of level three (Advisory), for the sixth year running, which is the highest possible rating that can be achieved. An aggregate percentage score of 97.74% was achieved across the four domains audited.

Data Quality Index (HRG4+ based) – DATA NOT AVAILABLE UNTIL BEGINNING OF JUNE

As the Trust no longer utilises CHKS for its external monitoring of data quality the department has transitioned to utilising the Data Quality Maturity Index (DQMI), which is published by NHS Digital and is readily available for the public to access and review the data outputs. These measures are different to the CHKS indicators, so a decision has been taken to establish a new baseline for measuring the data maturity, starting from the financial year 2021/22.

The Trust has been taking the following actions to improve data quality; development work in building commissioning data sets from a single source of data will be undertaken over the coming years improve the quality of the data submitted from systems thus ensuring that additional data quality activities can be performed prior to submission.

As a team the Data Quality Indicators are reviewed monthly both from a DQMI perspective and from the NHS England Data Quality Dashboard perspective. Any fluctuations in performance are identified and actions are put in place to resolve. If aide memoires, for staff understanding, are required the Data Quality Team will work with the Training Team to put the best possible processes in place to resolve these issues. The Data Quality Team also works closely with the Reporting Teams to ensure that they are aware of any errors that may be present from a submission perspective to ensure these are rectified at source, thus ensuring the Trust maintains its high standards with regards to the integrity of our data.

Clinical Coding – DATA NOT AVAILABLE UNTIL BEGINNING OF JUNE

The Trust was subject to the external clinical coding audit during the reporting period and the compliance rates (%) reported for a sample of 200 sets of case notes for diagnosis and treatment coding were:

Area audited	% Diagnoses Coded Correctly		% Procedures Coded Correctly	
	Primary	Secondary	Primary	Secondary
Overall	97.00%	98.16%	98.16%	99.03%

(Source: The Rotherham NHS FT Information Governance Audit Report 2023/2024)

These scores helped achieve assurance Level 3/Standards Exceeded of the Information Governance Toolkit for coding accuracy, this is the sixth consecutive year that the Trust has managed to achieve the highest grade for the Information Governance Audit.

In 2022/23 the Trust worked with the following actions to improve clinical coding and data quality and these continued throughout 2023/24:

- Reviewing coding processes across the organisation to benefit from coding at source and in near-real time wherever practicable

The Trust continues to be rated in the top quartile nationally for depth of coding, although this is not a clear indicator of clinical coding quality it does better demonstrate the complexity of the patients care for the respective episodes, and by also attaining the Information Governance level 3/Advisory the auditors are of the opinion that we are also rated in the

top quartile nationally from that perspective too. Combined these indicators demonstrate a continued improvement in the quality of the clinical coding.

Improvements and actions to further improve clinical coding during 2024/25 include:

- Working with Electronic Patient Record Team and Clinical Services to improve digital documentation and improve the data captured therein

	Areas selected for focussed improvement activity	Baseline period FY	Base line Value	Target	Qtr 1 2023-24	Qtr 2 2023-24	Qtr 3 2023-24	Qtr 4 2023-24	YTD 2023-24	Progress
IMPROVING DATA QUALITY	IDQ-1 DQMI ECDS	2021-22 **	69.2	Increase	85.5	85.3	84.9	84.9	84.9	
	IDQ-2 DQMI APC	2020-21 **	98.9	Increase	97.0	96.9	96.9	99.2	99.2	
	IDQ-3 DQMI CSDS	2020-21 **	93.0	Increase	94.1	94.0	94.0	94.1	94.1	
	IDQ-4 DQMI MSDS	2020-21 **	99.6	Increase	99.5	99.7	99.8	99.9	99.9	
	IDQ-5 DQMI OP	2020-21 **	99.2	Increase	98.6	98.7	98.7	98.6	98.6	
	IDQ-6 SUS Data Quality - Admitted Patient Care: NHS number validity (NHS Digital Dashboard)	2015-16	99.8%	Increase	99.8%	99.8%	99.9%	99.8%	99.8%	
	IDQ-7 SUS Data Quality - Admitted Patient Care: Postcode validity (NHS Digital Dashboard)	2015-16	100%	Maintain	100%	100%	100%	100%	100%	
	IDQ-8 SUS Data Quality - Outpatients: NHS number validity (NHS Digital Dashboard)	2015-16	99.9%	Increase	100%	100%	100%	100%	100%	
	IDQ-9 SUS Data Quality - Outpatients: Postcode validity (NHS Digital Dashboard)	2015-16	99.9%	Maintain	100%	100%	100%	100%	100%	
	IDQ-10 SUS Data Quality - Accident & Emergency: NHS number validity (NHS Digital Dashboard)	2015-16	86.6%	Increase	99.4%	99.6%	99.6%	99.5%	99.5%	
	IDQ-11 SUS Data Quality - Accident & Emergency: Postcode validity (NHS Digital Dashboard)	2015-16	99.1%	Increase	100%	100%	100%	100%	100%	

Learning from Deaths – data not calculated until 30 May

The Rotherham NHS Foundation Trust's Learning from Deaths policy for identifying deaths for detailed case review is based on the framework set out in the National Quality Board's publication, 'National guidance on learning from deaths', published in March 2017.

Detailed case record review is undertaken using the Royal College of Physician's Structured Judgement Review (SJR) methodology. Not all deaths have an SJR. SJRs should be completed for deaths which fit into nationally and/or locally defined criteria.

Deaths which require an SJR are either identified during the Medical Examiner Scrutiny, from locally held data, from Mortality Benchmarking data and/or after recommendation by any Trust Clinician/Clinical Team.

The Trust reviews Summary Hospital-level Mortality Indicator (SHMI) data each month at the Trust's Mortality Group meeting. This data includes reports which alert the Trust when

modelling has determined that there is a statistically significant level of excess deaths in a diagnostic group. The Mortality Group will use this information alongside past information, to determine how to investigate the alert. Investigations comprise of coding reviews, review of completed SJRs or the request of additional SJRs deaths in the diagnostic group.

Learning from Deaths - Medical Examiner Scrutiny – data not calculated until 30 May

This service provides independent scrutiny of all Trust non-coronial deaths. Part of this scrutiny involves escalating deaths to the Trust which should be considered for a SJR or for investigation.

The Medical Examiner Service have been working with primary care and community partners to create processes for the scrutiny of community deaths. These processes are being put in place for 2024/25 when the scrutiny all non-coronial deaths becomes mandated in law.

For 2023/24 the Service achieved its target of a 100% completion rate for scrutinies of Trust deaths. The service has a target for Trust scrutinies to be completed within 5 days of death. Whilst there will be circumstances when this is not possible, the rate for completions within 5 days is high at ##%.

Medical Examiner Scrutiny Figures for 2022/23: to be replaced in May 2024

Month of Death	No of Adult TRFT UECC & Inpatient Deaths	Medical Examiner Scrutinies Completed	Medical Examiner Scrutinies % Completed	Medical Examiner Scrutinies % Completed < 5 Days
Apr-22	110	108	100%	57%
May-22	98	98	100%	70%
Jun-22	97	97	100%	86%
Jul-22	93	93	100%	96%
Aug-22	79	79	100%	91%
Sep-22	92	92	100%	59%
Oct-22	111	100	100%	82%
Nov-22	100	100	100%	95%
Dec-22	133	133	100%	80%
Jan-23	122	122	100%	42%
Feb-23	76	76	100%	91%
Mar-23	105	105	100%	98%
2022/23 TD	**1216**	**1216**	**100%**	**Average 79%**

Learning from Deaths – Structured Judgment Review (SJR) – data not calculated until 30 May

The Trust aims to complete SJRs within 60 days of death, for those that are recommended for a review close to the date of death. This is to promote a rapid cycle of learning. The Trust estimates that 10% of death will be identified for SJR from Trust coded data or from national mortality indicator data, and therefore not close to the time of death. Therefore for 2023/24 a 90% target was set.

96% of SJR for deaths in 2023/24 have been completed. 60% were completed within 60 days. This represents a significant improvement on 2022/23 figures of 45% and 25% respectively. This is a result of the new SJR process for 2023/24. Improvement was seen during the year and ongoing work is continuing to improve the timeliness figure.

SJR Figures for 2022/23: to be replaced on 1st June 2024

Discharge Date	Adult Inpatient & UECC Deaths	SJR Requested	Completed	Outstanding	% Completed	Overall Care Score < 3	Preventability Score < 4
2023/24 YTD	549	100	88	12	88%	21	2
2023/24 Q1	247	41	39	2	95%	9	2
2023/24 Q2	214	45	39	6	87%	9	0

Month of Discharge	% Completed < 60 Days
2023/24 YTD	50%
2023/24 Q1	41%
2023/24 Q2	53%

Preventability Score	6 - Definitely not	5 - Slight evidence	4 - Possibly: less than 50-50	3 - Possibly: greater than 50-50	2 - Strong evidence	1 - Definitely preventable

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

All SJRs where the overall care has been judged to have been poor or likley preventable are added as incidents and reviewed following the Trust Governance processes. In addition these SHR are recommended for presentation at the appropriate Clinical Support Unit Clinical Governance meeting.

Intelligence and Learning

Thematic Analysis Reports have been produced quarterly whereby the informative freetext comments from SJRs are allocated to categories/themes based on the element of health care they refer to and whether they are positive, negative or neutral. In addition, these reports contain analysis and breakdown of the Phase of Care Scores and the Problems in Health Care sections.

These reports have been distributed to the various groups and teams in the Trust to review them in order to design and implement new/changes to health care processes that will prevent the reoccurrence of these problems or promote good practice for future patients.

Learning from Deaths – Reviewing Deaths for those with Learning Disabilites, Autism and Serious Mental Illness

In line with national guidelines TRFT completes SJRs for all of these deaths. The Trust has a robust system for identifying these.

Deaths for these patients are identified by using Trust clinical coded data and alert data, recorded in the patient's electronic patient record. The Medical Examiner will also flag these patients if they are identified during a scrunity.

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 frequently asked to assist with a LeDer review when they have been involved in the care provision for that patient.

All LeDer requests go to the Trust Matron for Learning Difficulties and Autism, who will assist the Integrated Care Board LeDer Team with the review. This can involve arranging on-site visits with the LeDer Review Team, to enable them to review appropriate Trust-held medical records. TRFT will supply the team with a completed SJR, or request one if the patient died within 14 days of a Trust discharge, or longer if appropriate.

Completed SJRs are distributed to the Matron for Learning Disabilities and Autism, the Head of Safeguarding and to the requesting Integrated care Board LeDer Team.

SJR Figures for Adults with a Learning Disability, Autism or Serious Mental Illness ##new table to be added 1st June 2024.

Month of Discharge	SJR Requested	SJR Completed	SJR Outstanding	Overall Care Score < 3	Avoidability Score < 4
Apr-22	0	0	0	0	0
May-22	1	1	0	0	0
Jun-22	3	3	0	1	0
Jul-22	1	1	0	1	0
Aug-22	1	1	0	0	0
Sep-22	1	1	0	0	0
Oct-22	3	2	1	0	0
Nov-22	1	0	1	0	0
Dec-22	4	4	0	0	0
Jan-23	0	0	0	0	0
Feb-23	2	2	0	0	0
Mar-23	1	1	0	0	0
2022/23	**18**	**16**	**2**	**2**	**0**

All SJRs have been allocated and completed for deaths in 2023/24.

2.3: Reporting against core indicators - **data not calculated until 30 May**

SHMI

The Department of Health asks all Trusts to include in their Quality Account information on a core set of indicators, including Patient Reported Outcome Measures (PROMS), using a standard format. This data is made available by NHS Digital and in providing this information the most up to date benchmarked data available to the Trust has been used and is shown in the table below, enabling comparison with peer acute and community Trusts. The Summary Hospital Level Mortality Indicator (SHMI) is a mortality measure produced by NHS Digital. The score is a ratio between the number of patients expected to die, based on England figures, and the actual number of deaths.

The SHMI takes account of a number of factors, including a patient's condition and age. It includes patients who have died while having treatment in hospital or within 30 days of being discharged from hospital. The SHMI score is measured against the England average, which is 100. Trusts are put into 3 bands based on statistical analysis of the score. Band 1 is 'Higher than Expected', Band 2 is 'As Expected', and Band 3 is 'Lower than Expected'. SHMI figures are released monthly. These are reviewed by the Trust and discussed at the Trust's Mortality Group. SHMI figures are broken down into diagnostic groups, of which 10 are given bandings. Any diagnostic group that has a statistically higher number of deaths than expected is discussed at this meeting.

SHMI Quarterly Figures

12 Month Period End Month	Sep-22	Dec-22	Mar-23	Jun-23	Sep-23
SHMI	105.1	107.3	107.5	103.4	102.4
Banding	As Expected	As Expected	As Expected	As Expected	As Expected
% of Deaths with Palliative Care Coding - TRFT	45	44	46	48	49
% of Deaths with Palliative Care Coding - England	40	40	40	41	42

The table above tells us that the Trust's SHMI has consistently been in the 'As Expected' band.

Patient Related Outcome Measures (PROMS)

Patient Reported Outcome Measures (PROMs) assess the quality of care delivered to NHS patients from the patient's perspective. Currently covering hip replacement and knee replacement surgery, PROMs calculate the health gains after surgical treatment using pre and post-operative surveys.

In 2021 significant changes were made to the processing of Hospital Episode Statistics (HES) data and its associated data fields which are used to link the PROMs-HES data. Redevelopment of an updated linkage process between these data are still outstanding with n00o definitive date for completion at this present time. This has unfortunately resulted in a pause in the current publication reporting series for PROMs at this time. We endeavour to update this linkage process and resume publication of this series as soon as we are able but unfortunately are unable to

provide a timeframe for this. We will provide further updates as soon as this is known (taken from NHSD Website).

Patient Reported Outcome Measures (PROMs) assess the quality of care delivered to NHS patients from the patient's perspective. Currently covering hip replacement and knee replacement surgery, PROMs calculate the health gains after surgical treatment using pre- and post-operative surveys.

Patient Related Outcome Measures (PROMS)

DOMAIN	Indicator Title	Modelled records	Average Pre-Op Q Score	Average Post-Op Q Score	Health Gain	Improved	Unchanged	Worsened
Domain 3 - Helping people to recover from episodes of ill health or following injury	**Primary hip replacement surgery (EQ-5D Index) - health gain**							
	1st April 2021 - 31st March 2022	18	0.319	0.821	0.502	15 (83.3%)	3 (16.7%)	0 (0.0%)
	1st April 2022 - 31st March 2023	1	-0.074	0.760	0.834	1	0	0
	Primary knee replacement surgery (EQ-5D Index) - health gain							
	1st April 2021 - 31st March 2022	29	0.228	0.768	0.540	27 (93.1%)	2 (6.9%)	0 (0.0%)
	1st April 2022 - 31st March 2023	5	0.153	0.542	0.389	4	0	1
	On the 1st October 2017, PROMs data for varicose veins and groin hernia surgery ceased collection, following on from the NHS England Consultation on the future of PROMs							

Please note: Results in this document are finalised for April 21 - March 22. Figures for April 2022 - March 2023 are Provisional. Casemix-adjusted figures are calculated only where there are at least 30 modelled record.
Data source = https://digital.nhs.uk/data-and-information/publications/statistical/patient-reported-outcome-measures-proms

Domain4: Ensuring that people have a positive experience of care.	Indicator name	Latest & previous reporting periods	TRFT value	Acute Trust average	Acute Trust highest value	Acute Trust lowest value
	*CQUIN: Responsiveness to patients personal needs	2017/18	68.6	68.6	85	60.5
		2018/19	64.9	67.2	85	58.9
	Staff who would recommend the Trust to their family or friends (Acute Trusts for comparison)	July 18 - Sept 18	68%	81%	100%	39%
		July 19 - Sept 19	76%	81.00%	100%	50.00%

The indicators were postponed during the pandemic and so no up to date information is available.

	Indicator name	Latest & previous reporting periods	TRFT value	Acute Trust average	Acute Trust highest value	Acute Trust lowest value	
Domain5: Treating and Carng for people in a safe place.	*Percentage of patients admitted to hospital and risk assessed for VTE	Apr 22 - Mar 23	94.91%	national data not available			
		Apr 23 - Mar 24	95.76%	national data not available			
	*Rate per 100,000 bed days of cases of C Diff amongst patients aged 2 or over (total cases)	Apr 21 - Mar 22	27.8	43.72	138.4	0	
		Apr 22 - Mar 23	32.5	43.5	133.64	0	
	*Patient safety incidents: rate per 100 admissions (medium acute for comparison)	Apr 21 - March 22	51.88	national data not yet available			Awaiting information
		Apr 22 - Dec 22	68.8	national data not yet available			Awaiting information
	Patient safety incidents: % resulting in severe harm or death (medium acute for comparison)	Apr 23 - March 24	0.28%	national data not yet available			
		Apr 23 - Dec 3	0.30%	national data not yet available			

***VTE No further national data to report as Collections were suspended March 2020 due to Covid-19**

*** Patient safety - collection system has now changed and data is not comparable. No updated national data available for reporting by Trust**

% of Admitted patients assessed for VTE													
Target = 95%	YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022/23	**96.59%**	97.31%	97.29%	96.41%	95.83%	95.36%	96.42%	97.49%	96.67%	96.61%	96.70%	96.89%	96.60%
2023/24	**95.90%**	95.11%	94.72%	94.67%	94.89%	95.30%	95.65%	95.81%	97.05%	96.69%	96.85%	97.10%	96.20%

The Trust considers the above data is as described for the following reasons, appearing in the (second column) of the table below.

The Trust intends to take the following actions (third column) to improve the outcomes above and so the quality of its services, a rationale for these figures is provided along with a brief description of proposed improvement actions as described in the table below.

Core Indicator	The Trust considers that this data is as described for the following reasons	The Trust intends to take or has taken the following actions to improve this score and so the quality of its services by:
12a. The value and banding of the summary hospital-level mortality indicator ("SHMI") for the Trust for the reporting period.	Data validated and published by NHS Digital.	The Trust has a Trust Mortality Group (TMG), which holds meetings each month. Divisional Mortality Leads hold monthly mortality meetings in their respective Division and

Core Indicator	The Trust considers that this data is as described for the following reasons	The Trust intends to take or has taken the following actions to improve this score and so the quality of its services by:
	The Trust's SHMI value has been consistently in the As Expected band.	feed into the TMG. The TMG in turn reports to the Clinical Effectiveness Committee, chaired by the Deputy Medical Director. SHMI Data, intelligence from SJRs and incidents are reviewed to help identify trends and areas of concern. A summary of the Trust's performance and mitigating actions taken is shared in Board reports. Mortality data and actions being taken are reported in the Mortality and Learning from Deaths Report to the Board.
12b. The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period.	The Trust's Consultant-led Specialist Palliative Care Team identifies and assesses all patients receiving palliative care. Only patients receiving care from the team are included in the data.	The Trust's Consultant-led Specialist Palliative Care Team continue to identify and assess all patients receiving palliative care.
18. Patient Reported Outcome Measures scores for (i) primary hip replacement surgery (ii) primary knee replacement surgery during the reporting period.	The data is considered to be accurate based on the number of returns received and the data validated and published by NHS Digital. The latest reporting periods vary between the types of surgery performed. Since October 2017 the outcome measures for Groin Hernia and Varicose veins are no longer a national requirement.	PROMS are measures recorded pre and postoperatively by patients. They measure changes in quality of life and health outcomes. The Trust will continue to collect PROMs data to help inform future service provision.

Core Indicator	The Trust considers that this data is as described for the following reasons	The Trust intends to take or has taken the following actions to improve this score and so the quality of its services by:
19. Percentage of patients aged— (i) 0 to 15; and (ii) 16 or over, Readmitted to any hospital within 30 days of discharge from the Trust (as per national reporting and benchmarking consistency).	Internal Trust data is used for reporting of re admissions for the performance reports for the Board of Directors, the Divisions, the CSUs and for the Service Line Monitoring reports. The methodology has been matched to the Model Hospital methodology to ensure consistency in benchmarking with other organisations.	The Indicator continues to be monitored through the Board Integrated Performance Report based on the Trust's own data. The Transfer of Care Team works to reduce readmission rates through better planning of discharge. The Care Home Team identifies factors leading to admission and readmission of care home patients and works with the sector to improve effectiveness. Readmissions are reviewed by divisional teams so the true readmissions can be investigated, and appropriate actions taken.
20. The Trust's responsiveness to the personal needs of its patients during the reporting period.	The Trust's performance is drawn from reviewing the position achieved, against the 10 sections and the 48 questions asked in the CQC national Inpatient Survey. The survey is mandatory and undertaken annually, the most recent data is from the survey conducted with patients who had an overnight stay in the Trust in November 2022. Full results are available later in this report.	The CQC published the 2022 patient survey results in September 2023. Picker were invited to deliver a facilitated feedback session with all divisions participating. From this, a Trust wide Quality improvement plan was developed with Divisions which included safe staffing, discharge, nutrition, hydration and pain management.
21. The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.	Department of Health conduct an annual independent survey of staff opinion.	58% of colleagues would be happy with the standard of care that the Trust provided to their family or friends, as detailed in the National Staff Survey. This is the largest increase in England, (up 8% from 2022).

Core Indicator	The Trust considers that this data is as described for the following reasons	The Trust intends to take or has taken the following actions to improve this score and so the quality of its services by:
21.1 The national change to the Friends and Family Test (FFT) questions is now made up of a single mandatory question, which is then followed by at least one open question to enable a free text response, so that users can provide their feedback in the detail they want and in their own words. Within the Trust, and in collaboration with stakeholders, the following questions were agreed. 1. Overall, how was your experience of our service (mandatory question)? 2. What worked well? 3. What could we do better?	The aim and objective of this change is that anyone using any service should be able to give quick and easy feedback to the provider of that service. FFT is designed to be a quick and simple mechanism for patients and users of NHS services to give their feedback, which will be in a format that enables the Trust as the provider, to hear what is working well and to focus upon all areas for attention that will improve the quality of an aspect of the patient's experience. In the settings for which we have previously published Trust level response rates (general, acute inpatient, UECC and the second maternity touch point – Labour and Birth), this is no longer possible because there is now no limit upon how often a patient or service user can give their feedback.	Numerical data is no longer comparable between NHS organisations; this was also a factor in the ending of national reporting on the percentage response rates achieved. Positive feedback, areas of improvement and actions taken as a result of feedback are discussed and recorded as part of Divisional governance meetings. Divisions have robust mechanisms in place to ensure that the feedback via the FFT dashboard is reviewed and acted upon where required. Following the introduction of the electronic survey, the FFT dashboard and Power BI has been used to provide data to the divisions, Patient Experience Group and Patient Experience Committee. Activity and learning also feature within the Divisional quarterly patient experience reports based around the framework of the Yorkshire Patient Experience Toolkit for Patient Experience Group.
23. Percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism (VTE) during the reporting period.	Data is no longer submitted nationally.	The Trust will continue to monitor VTE rates, and report through local performance meetings and the Divisional meetings.
24. The rate per 100,000 bed days of cases of C.Difficile infection reported within the Trust	Data is validated and published by NHS Digital and UK Health Security Agency. Reports are	The Trust has monitored rates through Post Infection Review presented at the Harm Free Care panel and the Infection,

Core Indicator	The Trust considers that this data is as described for the following reasons	The Trust intends to take or has taken the following actions to improve this score and so the quality of its services by:
amongst patients aged 2 or over during the reporting period.	issued on a quarter by quarter basis with the annual report issued during Quarter 1 of the following year.	Prevention and Control Group and Committee.
25. The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.	Data validated and published by NHS Digital (National Reporting and Learning System (NRLS)); latest data is for the period April 2023 to March 2024. This was the latest reporting period where the Trust has submitted its data and it has been validated by the NRLS Team. Number of NRLS reportable incidents occurring in this period was 9476. The percentage of severe harm or death was 0.28%.	The Trust will continue to investigate all serious incidents with learning shared through the divisional clinical governance structures, shared learning events and patient safety bulletins. As the Trust continues to transition into the Patient Safety Incident Response Framework (PSIRF) and Learning from Patient Safety Events (LFPSE), there will be more systems-based approaches to learning from incidents. Data may not be presented in the same way but there will be internal regulation to ensure there are no gaps.

(Source: Trust Information System)

His Majesty's Coroner's Inquests 2023/24

During the relevant period the Trust received 72 referrals from His Majesty's Coroner, compared with 54 referrals from the previous year, which represents a significant increase. These included both confirmed inquests and preliminary investigations.

His Majesty's Coroner heard 46 inquests during the last financial year, 16 of which required attendance by the Trust, 15 as Interested Parties and 1 where a clinician gave evidence as a witness of fact. The majority of the attended inquests were listed for 1-2 days. A total of 37 inquests were documentary (i.e. evidence was read under Rule 23). External solicitors were instructed to represent the Trust's interests.

The Trust is expected to attend approximately 26 inquests in 2024/25 which are referrals received during 2023/24.

His Majesty's Coroner issued one Prevention of Future Death Report in 2023/24 following an inquest heard in October 2023, pursuant to Schedule 5 of Coroners and Justice Act 2009 which imposes a statutory duty on Coroners to request for action to be taken to prevent future deaths.

The continued focus in the next financial year will be on divisional management oversight of inquests at an early stage to ensure that key themes can be identified and that there is no delay in lessons being learned.

Part Three: Other Information

3.1 Overview of quality of care based on performance in 2023/24

A summary of the Trust's nine quality priorities for 2023/24 is provided below.

Patient Safety

- Prevention of Pressure Ulcers
- Management of Sepsis
- Learning from Deaths

Patient Experience

- Holistic Needs Assessments for Cancer Patients
- End of Life Care
- Reducing Health Inequalities – Digital Weight Management/Tobacco Treatment Services

Clinical Effectiveness

- Virtual Ward
- Getting it Right First Time (GIRFT)
- Clinical Audit and Effectiveness

Details of the achievement against these in the year are included below.

Domain: Patient Safety

Title – Pressure Ulcers

Executive Lead – Chief Nurse
Operational Lead – Deputy Chief Nurse

Current position and why is it important?

Pressure ulcers remain a concerning and mainly avoidable harm associated with healthcare delivery. Treating pressure damage costs the NHS more than £3.8 million every day and is a significant cause of both physiological and psychological harm.

There were 47 SDTIs (suspected deep tissue injury), 144 deep unstageable pressure ulcers, 10 category 3 or 4 pressure ulcers and 559 category 2 pressure ulcers reported at the Trust (acute and community combined) in the year 2022/23.

The aim and objective(s) (including the measures/metrics)

The aim of the quality priority was to ensure that our staff were trained and able to give high quality, personalised wound care for adults, children and young people. This will improve patient experiences, save money, reduce the number of wounds and the chance of them coming back.

The objectives were identified as:

- There will be a 20% in Category 3, 4, unstageable and SDTI pressure ulcers from April 2023/ March 2024.
- There will be 10% reduction in Category 2 pressure ulcers from April 2023/March 2024.

There were a number of identified actions which the Trust has completed to support this work;

1. There will be a review of Datix information to establish a baseline of incidents across pressure ulcer categories of the past 2 years.
2. Implementation of the national wound care strategy and framework.
3. Review of current RCA documentation to be in line with the patient safety incident response framework.
4. Guidance and SOP for managing pressure ulcers.
5. Establishment of a harm free care panel for oversight and sign off of all pressure ulcer incidents at category 3, 4, unstageable and SDTI.
6. Utilisation of the SEIPS approach, identifying themes to drive quality improvement programmes of work.
7. Tissue viability education strategy for the Trust.
8. Monitoring of personalised care planning compliance via Tendable.
9. Action plans to be integrated into the OLAF framework.

What did we achieve?

All of the actions have been completed throughout the year and have contributed to the success in the overall reduction of harms from pressure ulcers at category 2. There has been no improvement of pressure ulcers at category 3, 4, SDTI and unstageable. Therefore, we will continue to work at the reduction of harm for these areas. Category 2 pressure ulcers have reduced by 18% and continues to demonstrate ongoing improvements.

How was progress monitored and reported?

Throughout the year progress was monitored through data collection, Tendable assurance and audit. This was reported to the Patient Safety Committee and Quality committee.

What further actions need to be undertaken?

An important part of pressure ulcer prevention is undertaking an assessment of the risk of a patient developing a pressure ulcer. This enables an effective pressure ulcer prevention/treatment plan to be developed and ensures effective use of resources.

An effective pressure injury risk assessment requires a structured approach that considers factors including but not limited to mobility, existing pressure injuries, co-morbidities such as diabetes, circulatory status, body temperature and nutrition.

The current pressure ulcer risk assessment in use in the Trust is the Waterlow Risk Assessment tool with the exception of UECC, Intensive Care Unit and Paediatrics who have service specific risk assessment tools. The Waterlow risk assessment tool has previously been the leading tool used within the NHS. However the limitations of the Waterlow have been documented as being:

- Poor sensitivity accuracy,
- Inadequate inter-rater reliability,
- Lack of clear definitions within the categories.
- Over prediction of risk and consequently over prescription of pressure relieving equipment

The Pressure Ulcer Risk Assessment Tool that is now recommended for use in NHS settings by the National Wound Care Strategy is the PURPOSE-T Risk Assessment Tool developed by The Leeds Teaching hospital Foundation Trust in conjunction with Leeds University.

The advantages of PURPOSE-T

- Purpose T has a screening stage allowing rapid identification of those who are not at risk preventing the need for a more detailed full assessment which saves time and clinical hours
- Colour is used to aid decision-making
- Includes pain as a risk factor and key indicator of pressure ulcer development
- Clearly distinguishes between primary and secondary prevention, so patients with an existing pressure ulcer or scarring are immediately allocated to a secondary prevention pathway, facilitating escalation of treatment and promoting healing
- Developed based on a systematic review of the risk factor evidence and pain cohort study, involving international and interdisciplinary experts and in partnership with service users.

The Trust will adopt the Trust wide use of the PURPOSE-T risk assessment tool with the exception of the Intensive Care Unit, UECC and Paediatrics who have service specific risk assessment tools.

Aims

- To improve the accuracy of the assessment of the risk of patients developing pressure ulcers
- To reduce patient harm caused by the development of avoidable pressure ulcers

Title – Management of Sepsis

Executive Lead – Medical Director
Operational Lead – Deputy Chief Nurse

Current position and why is it important?

Sepsis is a life-threatening condition that arises when the body's response to an infection injures its own tissues and organs. It occurs when the body's immune system – which normally helps to protect us and fight infection – goes into overdrive. It can lead to shock, multiple organ failure and sometimes death, especially if not recognised early and treated promptly. 5 people die with sepsis every hour in the UK (Sepsis UK, 2021).

Although the Trust has a low number of deaths associated with Sepsis, we remain committed to improving the response to patients who are showing signs of physiological deterioration with a possibility of developing sepsis to improve their outcomes.

The aim and objective(s) (including the measures/metrics)

The aim for the quality priority was to ensure that all patients showing signs of possible sepsis will get a senior clinical review earlier. This will then ensure they were on the right medications earlier, so that patients will get better faster.

Metrics:

- Baseline data intelligence for initial starting point and ongoing progress.
- >90% of all adult patients with a NEWS score >5 will have a sepsis screening completed.
- >90% of patients screened as high risk of sepsis will be escalated for a senior clinical review and this will be completed in 1 hour alongside appropriate diagnostic investigations.
- >90% of all patients receiving treatment for suspected sepsis should have early diagnostic testing, review of antibiotic requirement and targeted treatment to ensure best clinical outcomes and support antimicrobial stewardship.

The Actions associated with this priority are:

1. Review and revise the Sepsis policies (Adults, Paediatrics and Maternity)
2. Review and revise the NEWS 2 policy
3. Update the Sepsis and Deteriorating patient Power Bi dashboards
4. Establish the sepsis quality improvement group
5. Commission audit cycle and capture actions through the sepsis quality improvement group

What did we achieve?

Across all admission areas and the UECC it was demonstrated that >90% of patients showing signs of sepsis have early senior clinical reviews and have treatment started within 1 hour.

The policy for sepsis and Deteriorating patient have been updated to reflect the changes to national guidance. The work that is associated with sepsis improvement is now coordinated through the sepsis quality improvement group and an audit cycle for the acute Trust has been commissioned and started in 2 ward areas.

How was progress monitored and reported?

Progress against the metrics has been monitored monthly through the sepsis quality improvement group and report to the Patient Safety Committee and Quality Committee.

What further actions need to be undertaken?

The commissioned audit programme has started in 2 areas and will be ongoing throughout the 2024/25 financial year. The outcome of the audit will determine the work that is required to support improvement.

The success demonstrated in the admission areas and UECC will be monitored through a quarterly audit cycle and reported in the sepsis quality improvement group, Patient safety Committee and Quality Committee.

***Title* – *Learning from Deaths* - final data not calculated until 30 May**

Executive Lead – Medical Director
Operational Lead – Learning from Deaths and Mortality Manager

Current position and why is it important?

A major component of the Learning from Deaths programme is the case note reviews of selected deaths. The Trust 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 difficulty in the care process.

From April 2023, a new SJR completion process started at TRFT. This will ensure that the Trust has good quality, complete and timely SJRs. This will provide the Trust with good intelligence from the Learning from Deaths programme, in order to allow the better identification of themes and trends, for both good and poor care.

The new process for 2023/24 has emerged from the Trusts Learning from Deaths Improvement Programme with NHSE/I's Better Care Tomorrow Team and follows advice and best practice. The process has SJRs completed by a small team of trained SJR Reviewers who have protected time and complete reviews regularly. The SJR Review team be will trained in and use NHSE/I's national SJR+ system. SJR+ also provides the Trust with additional analytics.

2022/23 was about creating a process which produces good quality SJRs. 2023/24 will be about making sure the new process delivers and critically that the Trust has processes in place to make sure that this intelligence is viewed by the right groups within the Trust who can devise changes which reduce/prevent problems and promote good care for future patients.

The aim and objective(s) (including the measures/metrics)

Aim:

To have a Learning from Deaths Programme that creates a rapid cycle of learning by producing good timely intelligence from SJRs which can be used by the Trust to devise and implement changes to procedures/processes which reduce/prevent problems and promote good care for future patients.

Objectives:

The objectives of this work is to increase the Learning from SJRs by:

- Ensure that the Trust is selecting and completing appropriate SJRs
- Enhancing & improving the quality, and consistency and completeness of its SJRs.
- Have timely SJRs which can highlight potential good or bad care close to the time that the care was delivered
- Be able to analyse and determine trends and themes from SJRs
- Using intelligence gathered from the SJRs to deliver learning, improvement and change.

Metrics:

- Quality & Consistency of SJRs: All SJRs will have supportive freetext for care scores. 2023/24 Target = 100% (2022/23 attainment 21%)
- SJR Timeliness: SJRs to be completed with 60 Days of Death 2023/24 Target = 90% (2022/23 attainment 25%)
- Learning Dissemination: A Thematic Analysis report to be produced & distributed quarterly. 2023/24 Target = 100% (2022/23 attainment 2 per annum)

What did we achieve?

Ensure that the Trust is selecting and completing appropriate SJRs:

In 2023/24 there were ### adult Inpatient and UECC deaths at the Trust. ##% of these deaths had SJR requested. This is in line with the number expected and comfortable above the 15% recommended nationally. Cases are selected for SJR if they meet the criteria for any of the 6 national categories.

Cases are identified after a Medical Examiner Scrutiny and from searches of patient's electronic medical record data. These data searches has been enhanced during 2023/24 including the addition of a search for deaths of patient with a Serious Mental Illness, based on their diagnosis coding for their final admission.

TRFT is confident it has a robust systems and processes for its case selection process to identify deaths requiring a SJR.

Enhancing & improving the quality, and consistency and completeness of its SJRs:

Metric: Quality & Consistency of SJRs: All SJRs will have supportive freetext for care scores.

The target of 100% was reached for 2023/24. The Trusts SJRs are now completed by a team of trained SJR Reviewers. They are of a much higher quality and completeness. All care scores are backed up by supportive freetext, which is providing the Trust with more and better intelligence.

Have timely SJRs which can highlight potential good or bad care close to the time that the care was delivered

Metric: SJR Timeliness: SJRs to be completed with 60 Days of Death

The attainment figure for 2023/24 is ##%. This represents significant improvement on the previous year's figure (25%), however doesn't meet the 90% standard. This is in part due to more than 10% of deaths not being requested for SJR close to the time of death. Most of these are unavoidable such as those identified through national mortality indicator data or coded Trust data. This may mean that the 90% target is reduced. The biggest cause however is the timeliness of reviewers completing their allocated SJRs. Reviewers are encouraged to complete SJRs within 4 weeks of allocation and this has increases throughout the year.

Be able to analyse and determine trends and themes from SJRs:

Metric: A Thematic Analysis report to be produced & distributed quarterly.

The target figure of increasing the frequency of Thematic Analysis Report production and dissemination, from twice a year to quarterly has been reached.

Using intelligence gathered from the SJRs to deliver learning, improvement and change:

Individual SJRs

All completed SJRs are sent to the respective Division. The Divisional Mortality Leads selects SJRs with learning points, both good and bad, and sends these, together with SJRs that are judged to have had poor care or been preventable, to the appropriate Clinical Support Unit (CSU). These SJRs are then discussed individually at the CSU Clinical Governance meeting or separate CSU Mortality meeting.

All completed SJRs that are judged to have had poor care or been preventable are now entered as incidents onto the Trust's Datix system. These are reviewed by representative from the Patient Safety Team, staff from the clinical area and any colleagues for whom the incident is relevant. Learning points and actions are discussed. Actions can include instigating a Patient Safety Incident Investigation and referring the SJR and its leaning points to the appropriate CSU Clinical Governance meeting or directly to the Clinical Team involved in the care.

Thematic Analysis Reports (grouped SJRs)

The Trust's objective is to use intelligence from the Learning from Deaths programme 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.

Most completed SJRs do not require or meet a criteria for further investigation or review. However the majority of these do contain comments relating to good or poor care. This intelligence is much more valuable when this is grouped into themes.

One isolated incidence of an issue i.e. delay in antibiotic prescribing, suggests an issue for that individual case. If several instances of an incident are identified, then it suggest there may be a system or process problem.

TRFT produces a Thematic Analysis Report each quarter which groups the free texts comments into themes. These report are distributed widely within the Trust to groups and individuals.

How was progress monitored and reported?

Progress in monitored monthly by the Trust Mortality Group. Monthly reports are produced which include monitoring of the 3 performance metrics. These reports and their discussion are standing agenda item for this group.

The Trust Mortality Group reports progress to the Trust's Patient Safety Committee, Quality Committee and Board of Directors via a quarterly Learning from Deaths report.

What further actions need to be undertaken?

A new process for completing SJRs commenced in April 2023. The objective was to provide the Trust with good quality and timely SJR, providing valuable intelligence for the Trust. On the whole the objectives have been achieved. The process delivers much higher quality SJRs and closer to the time of death, when the clinical care was delivered.

2023/24 was about establishing this new process and delivering the intelligence from SJRs to the right people and groups with the Trust. The Trust now has robust processes to respond to SJRs where that individual case needs further review or investigation. Thematic Analysis Reports are now delivered to a wide range of Trust Groups with responsibility for patient safety and clinical effectiveness. In addition some Trust groups are requesting groups of SJRs that relate to their area of interest.

Processes are in place which means good intelligence for the Learning from Deaths programme is flowing within the Trusts. This will be built on in 2024/25, and there still improvements with regards to the timeliness of SJR completion. There are unlikely to be wholesale changes to the SJR process. Focus now must move how the Trust uses and responds to this information.

How Intelligence from SJRs is being Used

As a result of big improvements in 2023/24, the focus for 2024/25 and beyond is now able to move to the ultimate goal of the programme. This is for intelligence from the programme

to be used as a learning tool by the Trust, to devise and implement changes to care processes and procedures, which will reduce the occurrence of poor care for future patients and spread best practice of good care.

Intelligence from the Learning from Deaths SJR programme will have positive effects by adding to and strengthening already known intelligence available to the Trust. This will increase awareness and may give strength and further evidence to changes that are being or proposed to be made. This effect is difficult to measure when there are multi sources identifying the same issue. There will be some changes where they are derived or expedited directly as a result of intelligence from the Learning from Deaths SJR programme. These changes will be easier to measure.

A feedback process will begin in 2024/25. This will ask recipients of the Thematic Analysis Reports to inform how their Groups responds to these reports. Questions such as:

- Are these reports routinely discussed/reviewed
- What is the format for these discussions, full report/selected parts, routine agenda item
- Are the reports identifying any new issues?
- Have the reports highlighted some that some problems thought to be rare or solved are more common place?
- Have the reports led to any new initiatives for changed or given further evidence for initiatives already being undertaken?

In addition a feedback process will begin in 2024/25 to ask how can the Thematic Analysis be improved to help Trust groups derive benefit from them.

In essence these feedback processes will ask 2 questions for the Trust, how it is using the current Thematic Analysis Reports and how they can be improved to be used better. Whilst improvement suggests to reporting will always be considered and made, it is essential that the main focus has to be with the first part of this feedback process.

Domain: Patient Experience

Title – Holistic Needs Assessments for Cancer Patients

Executive Lead – Chief Nurse
Operational Lead – Lead Cancer Nurse

Impact Statement

The National Personalised Care and Support Programme across all cancer pathways is based on having conversations around “what matters” to people and identifying their individual strengths and needs. Through offering patients newly diagnosed with cancer, the opportunity to complete a Holistic Needs Assessment (HNA), to facilitate a discussion around what their individual concerns are, will begin the process of embedding personalised care into the care we deliver to our patients. The Trust will demonstrate that 85% of all patients newly diagnosed with cancer will be offered a Holistic Needs Assessment. This will improve the patient’s experience of care by enabling them to more fully engage in their care and facilitate choice and enables the patient to take greater control of what happens to them and supports them to self-manage their condition.

Objective

- There will be an increase in the overall numbers of HNA's offered to patients newly diagnosed with cancer to 85% across each individual cancer pathway by March 2024
- A planned trajectory will be to increase from 32% - 64% by September 2023 then from 64% - 85% by end of March 2024
- Where these objectives may not be met for each team to understand why this might be the case and to put plans in place to ensure objectives met.

Metrics

- Baseline data intelligence for initial starting point and ongoing progress for all tumour sites as a collective
- Baseline data intelligence for initial starting point and ongoing progress for each individualised tumour site teams
- Quarterly data to be analysed against proposed trajectory as a collective and for each individual tumour site
- Patients experience of personalised care both at the beginning of the time period and the end

Validated data for Q4 2024 of numbers of HNA's offered

Breast - 87%
Gynaecology - 90%
Head and Neck - 100%
Lung - 96%
UGI - 96%
Brain - 100%
CUP - 100%
Haematology - 89%
LGI - 98%
Skin - 79%
Urology - 94%

Total number of newly diagnosed patients with cancer in quarter 4 2023/2024= 421 with 92% being offered/discussed an HNA

Feedback from Patients

"Going through this process (HNA) and being asked about what I was concerned about helped me to be reassured that the staff who were looking after me really cared which built my confidence with the team and the NHS."

"When I was first asked I didn't know what to say I had just been diagnosed with cancer so my mind was a "shed" and didn't know what was concerning me. Sitting with the nurse and filling in the tick box really helped me to think about what I was really concerned about. I was then referred onto another service who really helped me to sort stuff out. I never realised that the medical team would be able to help me sort out some money problems I had but they did. Seeing this on the checklist gave me the ok to bring it up and talk about it."

"Felt it was too soon but after a few weeks had loads of things I needed sorting but thought I had missed having had this discussion until the nurse mentioned this again so asked if I could discuss this at that point."

"You have so much to think about it is really good that the staff who are looking after you think about more than just the medical treatment but think about all the other things that are going in in my life."

Actions Completed

- Guidance and SOP for the Holistic Needs Assessment process
- Training needs analysis to be conducted around the HNA process with a Learning and Development package to be in place
- Establish a quarterly Personalised Care and Support working group who will select 2 patients per speciality for case notes review and spot check on the value of the assessment for the patient and to provide peer review of the process. Share good practice.
- Recruit to a dedicated Personalised Care and Support Project Manager to support the process
- Recruit to the Macmillan Information and Support Service Manager and Cancer Support Worker role as these will be pivotal at extending the HNA offer
- To seek patients feedback on the offer of HNA and the provision of personalised care

The next steps are designed to answer the following questions

- Is there any themes/trends with patients who accept the HNA conversation?
- Is there any themes/trends with patients who decline the HNA conversation?
- How many of the HNA conversations that take place result in the development of a personalised care plan?
- What is the quality of these care plans?
- What are common concerns raised by our Rotherham patients and which services do we have available to sign post the patient to for support?
- What do patients feel regarding the experience of being offered a HNA and a Personalised Care plan?
- Develop a secure web based means to providing a HNA to patients to allow them to complete at home
- Utilising behavioural science "nudges" to promote the HNA process and empower patients to ask to complete
- To develop a Cancer Patient Engagement Group

Title* – *End of Life Care

Executive Lead – Chief Nurse
Operational Lead – Deputy Chief Nurse

Current position

The Supportive Care Team is supported by a Consultant in Palliative Medicine and Clinical Nurse Specialists in Palliative and End of Life Care. The Lead Nurse for the Supportive Care Team left the Trust in July 2024. Recruitment for a new Lead Nurse was successful with an experienced, compassionate Lead Nurse starting in the Trust in January 2024.

The aim and objectives

The aim of the team is to pick up referrals through Meditech or SystmOne, Monday – Friday between 08.00 – 18.00. Patients, families and clinical teams then seen and supported with their individualised needs to receive Person Centred Palliative and End of Life Care.

The Trust launched the six ambitions for Palliative and End of Life Care Strategy in May 2024 and this was ratified at the Board of Directors in summer 2024. There is now wider place and system work to build on the six ambitions and work collectively across South Yorkshire.

The team are also responsible for ensuring Role Specific Training across the Trust is delivered to the clinical workforce, ensuring there is a culture of learning and professional curiosity around end of life care.

What did we achieve?

Throughout 2023/4 there were 950 adult deaths in the Trust (excluding deaths in UECC) of these, 559 patients were given tailored care through the individualised plan of care (average 58.8%)

The team have delivered end of life education through the Person Centred Care study day to almost 400 Trust and place staff. Additional training to medical colleagues was delivered by the Consultant in Palliative Care.

The Rotherham Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) was also implemented across Rotherham place and this is being used well.

Every year, people around the country use Dying Matters Awareness Week as a moment to encourage communities to get talking in whatever way, shape or form works for them. In 2023, Dying Matters Week took place from 8 – 14 May and the team arranged a week of promotions to support these messages.

How was progress monitored and reported?

This year, End of Life was a Quality Priority so a performance dashboard was set up to start to collect data on referrals to the team and some outcomes. This work will evolve further with the new Lead Nurse working with informatics to continue to provide good data in the performance of the team.

In January 2024, the new National Audit for End of Life (NACEL) was launched. This includes a revised ongoing audit around the care patients have received, family feedback and staff feedback on their confidence for giving End of Life Care.

We currently have submitted 40 case note reviews and received 18 surveys back from relatives. The data will be published in a national dashboard around April 2024.

What further actions need to be undertaken?

The team are leading on several quality improvements, including Organ and Tissue donation, new bereavement books, guides to staff on how to care for people at the end of life and how to spread the new bereavement boxes introduced on Ward A5.

The family and staff feedback published by NACEL will further help to shape our services and this will be shared with all clinical teams.

Title **- Reducing Health Inequalities – Digital Weight Management/Tobacco Treatment Services**

Executive Lead – Chief Nurse
Operational Lead – Healthy Hospitals Programme Manager

Current position and why is it important?

Reducing smoking and promoting healthy weight are two of the most effective ways we have to tackle inequalities of health outcomes among our patients. The performance of the QUIT team in identifying smokers and supporting them in managing their tobacco addiction remains strong, despite a recent drop in performance precipitated by staffing shortages and technical issues. Take-up of the digital weight management pilot opportunity continues to grow, and is offering patients a new avenue of support in getting fit for surgery.

The aim and objective(s) (including the measures/metrics)

Impact Statement:
We will provide access to Tobacco Treatment Services and Digital Weight Management support to make sure our communities are supported to live long and healthy lives.

Objectives:
- To increase the number of TRFT patients who quit smoking.
- To provide enhanced tobacco treatment services to aid the reduction of local smoking prevalence and associated health care burden.
- To reduce weight management pre-operatively to improve recovery, wound healing, shorter hospital stay and reduce need for critical care.
- To establish secondary care access to the Digital Weight Management Programme for NHSE agreed surgical pathways - hysterectomy, laparoscopic cholecystectomy, hernia repair and hip/knee replacements.

Established metrics for QUIT programme: ICB KPIs and targets

90% of inpatient spells with LOS ≥ 1 day have smoking status recorded electronically within 24 hours of admission

45% of ALL inpatients smokers with LOS ≥ 1 day have NRT prescribed within 24 hours of admission

Local pilot metric: digital weight management

A numeric increase in the number of patients signing up for the Digital Weight Management programme.

What did we achieve?

Q4 Position: January – Feb 2024 (March PENDING)

89% of inpatient spells with LOS ≥ 1 day had smoking status recorded electronically within 24 hours of admission
However, 96% of inpatient spells with LOS ≥ 1 day had smoking status recorded electronically during admission

32% of ALL inpatients smokers with LOS ≥ 1 day had NRT prescribed within 24 hours of admission
However, 47% of ALL inpatients smokers with LOS ≥ 1 day had NRT prescribed during admission

412 (60%) of the 716 eligible patients triaged over the first ten months of the programme accepted digital weight management
This is represents both a numeric and a proportional increase compared to 49% in the previous quarter

How was progress monitored and reported?

Progress is monitored through our local business intelligence systems and monitored and reported internally to Clinical Effectiveness Committee and the Patient Experience Committee before being reported for external scrutiny to: the SYICB in the case of our QUIT programme outturns, and to NHSE in the case of DWM pilot returns.

What further actions need to be undertaken?

The work described here is subject to a continuous service improvement plan. Now that a new Healthy Hospitals Programme Manager has been recruited, the focus of this plan is broadly to:

- Recover staffing levels and improve the quality of electronic production of patient lists to enhance prompt interactions with inpatient smokers
- To collaborate more closely with the community stop smoking service to ensure that patients have a strong chance of sustaining quit attempts once they leave hospital
- To reach more outpatients, staff and visitors with support and signposting to quit smoking
- To broaden the offer of the Healthy Hospitals team to tackle a wider range of health inequalities and develop a coherent approach to preventative intervention, for example through the development of enhanced 'making every contact count' training.
- To feed in our experiences of the digital weight management pilot programme to the national evaluation team and ensure that lessons are learned and opportunities are taken to further develop our approach once the pilot concludes.

Domain: Clinical Effectiveness

Title – Virtual Ward

Executive Lead – Medical Director

Operational Lead – Divisional Director - Division of Therapies, Dietetics & Community Care

Current position and why is it important?

The essence of the Virtual Ward is to offer care in the sanctuary of a patient's home, a setting that is often more conducive to recovery than a hospital or community bed setting. This innovative model employs a multidisciplinary team (MDT) to deliver acute care to patients with complex medical needs, particularly those on respiratory or frailty pathways, directly in their home environments. The Virtual Ward's mission is to reduce unnecessary hospital admissions and support early discharges, ensuring patients receive optimal care through a collaborative approach involving senior clinicians, nurse consultants, Advanced Clinical Practitioners (ACP), therapists, support workers, social care, pharmacy, NHS 111, and the Yorkshire Ambulance Service. Referrals are triaged, with care plans tailored and adjustable to meet the evolving needs of each patient. The team's commitment to 24/7 availability via the Urgent Community Response Service and daily patient interaction underscores the Virtual Ward's dedication to a patient-centred care model.

The aim and objective(s) (including the measures/metrics)

The primary aim of our Virtual Ward is to enhance patient care quality and efficiency outside traditional hospital settings. The goal of the Virtual Ward is to provide acute care and treatment in patients' homes, as an alternative to hospital admission, utilising remote technology and existing multidisciplinary teams. This service is crucial for reducing hospital admissions and facilitating early discharges, particularly for patients on frailty and acute respiratory infection pathways.

Objectives include maintaining patient safety, improving health outcomes, and increasing the capacity for at-home care. Since its inception 12 months ago, metrics for success involved maintaining 80% for the scheduled trajectory of patient occupancy, patient satisfaction rates, maintaining a 14 day maximum length of stay whilst on the Virtual Ward, monitoring the number of avoided hospital admissions, and the effectiveness of remote monitoring technologies.

What did we achieve?

Throughout the last year, our Virtual Wards have showcased an exemplary commitment to providing patient-centred care, with a capacity firmly set at 100 patients. We have achieved a peak occupancy of 89 patients, which reflects our ability to deliver substantial and effective care remotely across various patient demographics. Maximum length of stay targets have always been maintained unless the patient becomes End of Life with only days to live.

How was progress monitored and reported?

All metrics have been monitored and reported via the VW Power BI Dashboard and fortnightly Situation Report has been submitted in line with national expectations for benchmarking.

What further actions need to be undertaken?

To continue improving clinical effectiveness, actions such as expanding service offerings to include more specific pathways (e.g. heart failure), implementation and integrating remote

monitoring technologies, and enhancing patient and wider healthcare provider education on Virtual Ward practices are needed.

Domain: Clinical Effectiveness

Title – Getting it Right First Time (GIRFT)

Executive Lead – Medical Director
Operational Lead – Business Manager

Current position and why is it important?

Getting It Right First Time (GIRFT) is a national programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change.

The programme undertakes clinically-led reviews of specialties, combining wide-ranging data analysis with the input and professional knowledge of senior clinicians to examine how things are currently being done and how they could be improved. The GIRFT programme is designed to improve medical care by reducing unwarranted variations.

GIRFT is part of an aligned set of programmes within NHS England. The programme has the backing of the Royal Colleges and professional associations.

The GIRFT Programme was identified as one of the Quality Priorities for 2023/24 and will be key to identifying the impact on patient care as a result of the changes in practice that have been made through the programme.

Delivery of the GIRFT programme is integral to the Trust achieving improved Use of Resources as well as other key efficiency directives.

In January 2024 the Trust also became part of Cohort 3 for the Further Faster Programme. The Further Faster Programme was launched to deliver rapid clinical transformation with the aim of eradicating 52 week waits by April 2024.

The GIRFT Support days scheduled in November 2023 unfortunately had to be stood down owing to Industrial Action. With the impact of Industrial action and operational pressures throughout December-March a decision was taken to stand down formal support days. These are due to restart in May 2024 as we work through the action plans of the Further Faster Programme.

The aim and objectives including the measures and the metrics

Objective:

- 50% of all specialities will have undergone a GIRFT review (16 specialities in total)
- All current GIRFT actions plan reviewed and updated to reflect new best practice guidance
- Clinical reviews linked to Quality Improvement Initiatives

Metrics/Targets:

1. Utilising Model System to provide baseline position for individual specialities
2. In-depth service review to benchmark against peers
3. Speciality deep dive programme to be piloted

What did we achieve?

- Establishment of Trust-wide GIRFT oversight group
- Relaunch of GIRFT programme
- Created a rolling programme of GIRFT reviews and action plans
- 8 speciality GIRFT Reviews with action plans in place and ongoing monitoring

How was progress monitored and reported?

The progress of the quality priority was monitored through the newly established GIRFT Oversight Group. Each speciality would provide regular updates on their 5 point action plans. The GIRFT Oversight Group also oversees the progress of the Further Faster Programme.

What further actions need to be undertaken?

- Ongoing monitoring of action plans for pathway reviews
- Ongoing monitoring of Further Faster Programme action plans
- Continuation of support days for remaining specialities

Domain – Clinical Effectiveness

Title – The Trust will effectively participate in local and national audits to evaluate the quality of care delivered and promote best practice by influencing quality improvements

Executive Lead – Medical Director
Operational Lead – Clinical Effectiveness Manager

Current position and why is it important?

The organisations' NHS Standard Contract and CQC license to practice include the requirement to monitor the quality and effectiveness of our care and services that we deliver every day to patients. In particular, to agree and implement an annual Clinical Audit Programme that evidences the impact of improvements made to patient's health outcomes. The clinical audit programme must:

- Evidence effective participation in the mandated National Clinical Audit Patient Outcomes Programme (NCAPOP) audits and the wider Quality Accounts topics relevant to the services provided and any locally agreed requirements such as Commissioning for Quality and Innovation (CQUIN) audits
- Use the findings from clinical audits to ensure that action is taken to improve healthcare and be able to evidence the impact
- Ensure healthcare professionals are enabled to participate in clinical audit in order to satisfy the demands of their relevant professional bodies (for example, for revalidation and professional development)

- Provide Board with the assurance they need to certify that they have effective arrangements in place for monitoring and continually improving the quality of healthcare provided to patients

The consequences of failing to deliver an effective system of monitoring and continually improving are significant and include:

- Failure to effectively participate could result in escalation to the CQC as a negative outlier (non-participation or lower than expected case ascertainment)
- Failure to evidence the impact of taking timely action to improve on clinical audit outcomes, not identifying concerns and/or risks and actions taken to address could result in CQC or Commissioner penalties being applied and at worse, licenses to practice removed

The above could result in a lack of public confidence, inability to provide a service if a license was revoked, poorer patient outcomes, failure to prevent harm and poorly reported patient experience.

Therefore, this work focussed on these main areas:

- Ensuring participation in all eligible Quality Accounts (NCAPOP and non NCAPOP) topics and CQUINs
- Utilising digital solutions for data collection and submission to reduce data burden
- Timely review of data to inform decision making and actions for improvement
- Evidence of the impact of improvements made
- Implementing an annual programme agreement process for 2024-25

The aim and objective(s) (including the measures/metrics)

- Ensure that the trust has a robust clinical audit programme that can deliver on national and organisational priorities – evidenced through:
    - participation
    - reporting
    - improved clinical audit outcomes

- Roll out a new clinical audit digital system to improve the engagement of clinical audit and provide greater autonomy and ownership at divisional/local level – evidenced through:
    - a procured system with trained and registered users
    - registered audits with information entered on outcomes, improvement actions and impact

What did we achieve?

The Trust have procured and implemented AMaT, a Programme Management Software tool, which has been introduced and is in use for tracking the progress of Clinical Audits and the implementation of NICE Guidance. Clinical Effectiveness Leads and wider key roles within Divisions have attended AMaT training.

Meeting with the National Clinical Audit leads to review:

- Metrics for each dataset and identify systems for extracting the data centrally (only reverting to case notes or proformas for any metrics where an electronic solution can not be achieved)
- The process for the audit data to be reviewed and understood so areas of concern and those of significance can be escalated and addressed
- The requirement to agree a SMART improvement action plan in response to any highlighted areas of concern for improvement

The national clinical audit progress table, has been revised to include a breakdown in progress against all datasets for each topic on the national clinical audit programme. This will provide clear and concise information for the regular oversight of progression against all national clinical audits by the Clinical Effectiveness Committee and the Quality Committee through year.

Development of a proforma for submission to gain approval for any non-participation in a Quality Accounts topic.

The Clinical Effectiveness Team have located live links to the National Clinical Audit data dashboards and reporting, sharing these widely with the Divisions and CSUs within progress reporting to facilitate discussion around review, highlighting successes, concerns and any risks where improvement is required. Further work needs to take place in strengthening these forums where this review takes place to ensure the right roles are involved to inform decision making for improvement.

Key Trust learning points resulting from National & Local Clinical Audits and wider quality measurements such as CQUINs are being shared as part of training sessions to reach a wider audience within the Trust. Alongside discussions with attendees on how best to share this information that ensures it reaches those that need to be aware in delivering patient care every day.

The 2024-25 Clinical Audit Programme Agreement process has been developed and approved by the Clinical Effectiveness Committee in October 2023 to further support the Quality Priority.

A Divisional Clinical Effectiveness Committee Report Template has been developed to guide inclusion of key information such as outcomes and actions taken on National & Local Clinical Audits to further evidence effective participation. NCAPOP Outcomes continue to be presented at Clinical Effectiveness Committee within the Divisional Reports for transparency.

The agendas for the Clinical Effectiveness Meetings have been further strengthened by including wider Clinical Effectiveness information for triangulation and context to inform decision making.

The Clinical Effectiveness Leads Network Meetings have been launched with the first meeting held in December 2023 - with a focus on the 2024-25 Clinical Audit Programme Agreements and Sharing & Learning together across TRFT.

How was progress monitored and reported?

Work was undertaken at Corporate, Divisional and Specialty levels and monitored and reported through:

- Specialty Clinical Effectiveness & Governance Meetings
- Divisional Clinical Effectiveness & Governance Meetings
- Clinical Effectiveness Committee
- Quality Committee

What further actions need to be undertaken?

The 2023-24 Quality Priority to Effectively Participate in Clinical Audits has made good progress but continues to need further development. Therefore, it is proposed that the Trust should:

- Further strengthen processes within specialties for review of outcomes and agreement of improvement plans. In particular;
    - Ensuring timely review & translation of data that is triangulated with wider information for context and understanding, root cause analysis is undertaken to identify why any *non-compliance* and the escalation of concern and any risk considered of significance takes place
    - Themes for improvement identified within clinical audit outcomes are taken forward in collaboration with Safety, Experience and Effectiveness, with support from the QI Faculty to improve patient care
- SMART action planning guidance is developed and disseminated as a resource ensuring that identified metrics for evaluating the effectiveness of each action in addressing any risk or areas where improvement was required are reviewed for impact on patient care
- Further measurement is agreed:
    - Audit for continuous improvement
    - Wider QI
    - Assurance monitoring of agreed metrics

3.1.2 Additional information about how we provide care

Friends and Family Test

The survey is well-established in all areas within the acute and community setting.

The Trust chose to continue with the paper survey but also has an online survey via the Trust Website or via a mobile phone Quick Response (QR) code. Posters and business cards (which both include the QR code) are provided to all in-patient and out-patient areas. The QR code has also been added to clinic letters. The Trust is also undertaking a pilot within Urgent and Emergency Care using text messaging, which has seen a significant increase in feedback.

The information and data are available on the hub and is directly shared with all divisions. Power BI soft wear service also allows coherent and visually immersive and interactive insight of Friends and Family Test (FFT) data.

Divisional quarterly patient experience reports based around the framework of the Yorkshire Patient Experience Toolkit and presented to the Patient Experience Group also includes FFT data.

Mixed-sex sleeping accommodation

The Trust has a zero tolerance to using mixed-sex sleeping accommodation and continues to have zero occurrences within inpatient wards. There is also an internal process for monitoring and reporting 'pass by' breaches of mixed sex accommodation.

In addition, the Trust is also required to monitor patients who are stepping down from High Dependency Unit level 2 care to base wards, this escalation process is now well embedded and supported by the Critical Care, Operational and Site teams. However, there has been 8 mixed gender breaches between April 2023 and March 2024 (2 in July 2023, 4 in January 2024 and 2 in March 2024). This has been due to the unavailability of an appropriate ward bed within the agreed 4 hour time period because of site pressures.

Never Events

The process for identification of a Never Event starts with the incident being identified on Datix. The Datix incident form has a specific section which identifies the list of Never Events which are on the NHSI Never Events policy and framework.

All Datix incidents are checked daily by the Quality Governance and Assurance Unit so any incident reported which has not been identified as a Never Event would be amended by the team.

Any incidents reported as Never Events are also reviewed daily to ensure they meet the criteria. Any incidents incorrectly reported as Never Events are amended and the reporter is informed of the changes.

All Never Event incidents are investigated as Serious Incidents and once these have been identified are presented at the Incident Review Panel for confirmation that this does meet the NHSI criteria.

During 2023/24 the Trust has reported no Never Events.

If a Never Event were to occur, a robust Root Cause Analysis would be carried out and an action plan created with monitoring through Divisional Governance processes to ensure completion. All action plans are also tracked through Datix action tracker to ensure corporate oversight. The Patient Safety communication bulletin is used to ensure Trust wide sharing of the learning from these incidents to improve the quality of care for patients and prevent future occurrences.

Patient-Led Assessments of the Care Environment (PLACE)

The PLACE assessment was reintroduced following Covid in Autumn 2022 as part of the drive towards business as usual. The table below shows the PLACE scores for 2023.

Inspected	TRFT score – 2022 (%)	TRFT score – 2023 (%)	National average score	Highest NHS Trust score	Lowest NHS Trust score
Cleanliness	**99.32**	**99.20**	98.1%	100%	56.1%
Food overall	**94.73**	**90.48**	90.9%	100%	72.6%
Organisation (of) Food	**95.49**	**100**	91.2%	100%	67.4%
Ward food	**94.51**	**87.65**	91%	100%	55.2%
Privacy, dignity & wellbeing	**81.33**	**89.42**	87.5%	100%	13.6%
Condition, appearance & maintenance (of buildings and facilities)	96.24	**97.62**	95.9%	100%	9.6%
Dementia (meeting needs)	75.81	**84.12**	82.5%	100%	31.7%
Disability (meeting needs)	80.41	**86.31**	84.3%	100%	30%

The National CQC Patient Experience Surveys for Acute Trusts

Maternity Survey

The Maternity Survey 2023 was published in February 2024 and looked at the experience of women and other pregnant people who had a live birth in early 2023, including ethnic minorities in January and March.

Responses were received from 148 people and the Trust scored better than most other Trusts in England in a number of areas. These are; women being included in decision making during their antenatal care, partners being included in labour care, women being treated with respect and dignity, and women sharing they had confidence and trust in the staff caring for them.

Adult Inpatient Survey

The Adult inpatient survey 2022 was published in September 2023 and looked at the experiences of patients who stayed at least one night in hospital as an inpatient.

Responses were received from 492 people out of 1250 people invited to take part. Out of the 11 different sections, six were worse than expected, two were somewhat worse than expected, two were about the same and one was much worse than expected.

Urgent and emergency care survey

The urgent and emergency care survey 2022 was published in July 2023 and looked at the experiences of people who received care from urgent and emergency care services.

Responses were received from 261 people out of 2220 people invited to take part. Out of the nine different sections, six were about the same and two were somewhat worse than expected.

Learning and improvement from patient experience surveys

Throughout 2023, divisions were invited and attended a facilitated workshop, provided by Picker to go through the results and statistical significance.

Findings from all of these surveys are triangulated against other sources of patient feedback including patient's giving compliments, raising concerns or complaints, data from the Friends and Family Test (FFT), feedback from local and national advocacy services, healthcare experience websites and social media.

Rather than each Division create action plans from this thematic analysis, a Quality improvement plan was developed to ensure all areas were working towards a coordinated improvement plan. These included:

Safe Staffing on Wards – Milestones achieved in 2023/4

To support an evidence base for the setting of establishments, we signed licences for Safer Nursing Care Tool (SNCT) for adult inpatient wards, adult assessment areas, Children and Young People and UECC. This was run four times this year and recommended establishments presented to the Chief Nurse for approval at People Committee and Board of Directors in January 2024.

Safe Staffing Matron leads on twice daily staffing huddles to oversee decisions on daily deployment of staff to ensure clinical areas are as safe as possible.

As part of the Retention improvement plan a series of interventions were developed including Leadership programmes for;

- 26 HCSW completed the FNF IPC champions
- 20 B6/7 RNs to undertake the RCN Clinical Leadership Programme (celebration event spring 24)
- 33 RNs are now Professional Nurse Advocates (celebration event September 2023)
- 20 Matrons/senior nurse/AHP leaders are on the FNF Matrons Development programme Reward and recognition of HCSW with three HCSW achieving the CNO award and celebrating national HCSW day in November

Speciality career pathways were developed for nursing colleagues using a tree symbol and these were printed for all areas where nursing staff work.

The Preceptorship accreditation as achieved for early career Registered Nurses and expansion of team-rostering has supported giving clinical staff a voice.

The Deputy Chief Nurse completed a successful business case for changing rooms, resulting in the new Rooftop Changing Rooms being opened. All Trust staff (including learners) now have access to showers, lockers and a safe space to get changed and store

belongings. This work was recognised by being shortlisted at the Nursing Times Workforce Awards.

The education offer was reviewed and shared with all colleagues for role specific training and the Pastoral Care Quality Award was achieved for Internationally Educated Nurses. The first Cultural Celebration event to celebrate our diverse workforce was help all supporting improvements in this work.
Huge improvements in the Retention of nursing workforce.

Discharge – What have we achieved?

The Chief Operating Officer commissioned a 'Rapid Improvement Discharge Event' in April 2023. This meant four days off site with average of 80 attendees per day.

Themes identified by teams for improvement included:

- Improve Person Centred Care/Reconditioning
- Standardise Board Rounds/ Ward Rounds
- Implement Discharge to Assess (DTA)
- Roll our Virtual Wards and develop In-reach service to facilitate early discharge
- Implement Criteria Led Discharge
- Develop Transfer of Care Hub

A multi-professional PCC/ reconditioning study day has been developed with over 200 staff attended. This will continue to run in 2024/5. Improvements from this work development of the phrase 'You Look You're Best When Your Up and Dressed' regular in patient tea-parties, new clothes store, hospital hairdresser and self-administration of medicines policy.

Working in partnership with South Yorkshire Transport – bespoke bus stop stations were developed for Wards A4 and A2 to encourage patients to walk from their beds and keep active.

Board Rounds/Ward Rounds – Working with the improvement academy – Achieving Reliable Care was launched on ward A5.

Discharge to Assess commenced and the virtual ward expanded. The in-reach service works really well with earlier discharges/admission avoidance being achieved.

Length of stay has reduced through this work with more patients also going through the Community Ready Unit.

Pain management – what have we achieved

The acute pain team have worked to refresh the audit on Tendable to have a greater understanding of learning oportunities in pain management across the Trust. Although there is a pain assessment tool for people who may not be able to verbalise their pain score – more work is required to consider how this is embedded in all areas.

Nutrition and Hydration – what have we achieved?

A Trust Wide Task and Finish Group has formed to look at the increased use of parental feeding across the Trust (Total Parental Nutrition) where enteral feeding may have been more appropriate. The benefits of early nutrition (and in some cases – pre-nutrition prior to planned admission) are well established but work continues to develop a naso-gastric feeding training plan and an updated policy. The work of the dietetics, pharmacy and speech and language therapists in this field is expanding annually.

Pictorial menus were developed and delivered to wards with electronic versions of the menus now on the Trust website. Four inpatient tea-parties were held this year with the King's Coronation seeing celebrations across the whole Trust.

Tea for Two was introduced to encourage any member of Trust staff to have a drink with a patient to demonstrate the values of social dining. This initiative has been supported by executive colleagues for the benefit of patients.

Involving people in decisions around care – what have we achieved?

To ensure patients were receiving excellent information and in formats that are accessible to them, the Trust has successfully invested in the EIDO library. This is an electronic library of information available to patients who may need that information in order to make an informed decision about their care. EIDO also has information that can be converted into e-consent.

Patient Advice and Liaison Service (PALS)

A business case to develop a new PALS was approved this year and building work is now complete. Once staff are in post and the appropriate training provided, the service will help support front line resolution for patients and families in real time.

Healthcare Associated Infections

The Chief Nurse is the Director of Infection Prevention and Control (DIPC), the Deputy Chief Nurse is Assistant DIPC and works closely with the Lead Nurse for the IPC team.

Clostridioides difficile infection (CDI)

45 incidents of CDI were reported in 2023/4 against a trajectory of 18 cases. Trends in Healthcare Associated CDI in the Trust are reported to the national data capture system.

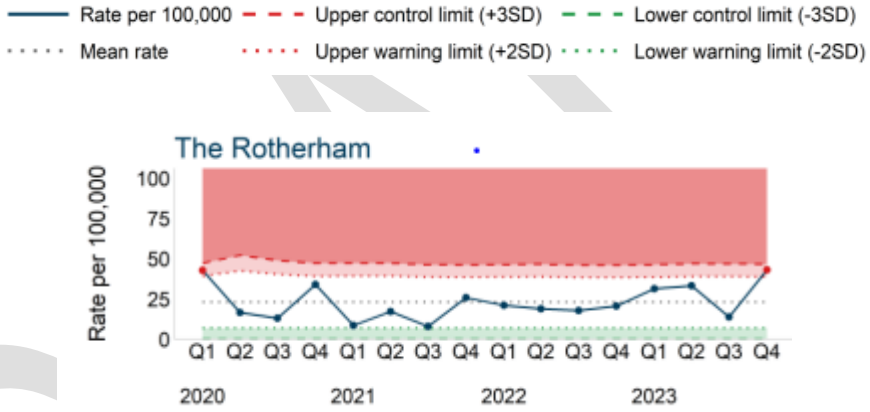
The rates are then calculated from data as stated in April 2024 on the UK Health Security Agency HCAI database using KHO3 occupied overnight beds per 100,000 as denominator for this parameter.

Data is shared via funnel plots and statistical process charts to identify existing variation in rates between Acute Trusts and Integrated Care Boards.

Number of reported cases of C.diff													
Target = Target <24 in 2023/24	YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022/23	37	4	0	3	3	0	5	5	2	4	5	2	4
2023/24	45	4	5	4	2	1	2	5	7	4	0	4	7

(Source: Trust Winpath System)

Figure 4: Trends in healthcare associated CDI incidence by NHS Acute Trust in Yorkshire and Humber: Quarterly rates of healthcare associated *Clostridioides difficile* infections per 100,000 bed days from January 2020 to December 2023



The new Trust Harm Free Care panel started in 2023 to have a facilitated learning discussion from the Post Infection Review (PIR) of all cases of Clostridioides Difficile (C.difficile) and MSSA bacteraemia. Learning is sent out via email to all senior clinicians (medical and nursing) for wider sharing.

Clostridioides Difficile (C.difficile) is cross referenced using time/space and Ribotype including where relevant enhanced DNA fingerprinting of the Ribotype, which resulted in one case of cross infection on ward A3. The whole ward was decanted for a thorough deep clean and use of Bioquell (hydrogen peroxide vapour) decontamination.

Other themes from the Post Infection Review process include:

- Antibiotic prescribing, including sepsis review and screening
- Adherence to the Trust antimicrobial policy
- Prompt isolation of patients
- Hand hygiene
- Environmental cleaning

Meticillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia

There was one case of MRSA bacteraemia this financial year against a trajectory of 'zero preventable cases.' Post Infection Review was held to establish opportunities for learning and established the probable cause was a contaminated sample.

Number of reported cases of MRSA bacteraemia													
Target = 0	YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022/23	0	0	0	0	0	0	0	0	0	0	0	0	0
2023/24	0	0	0	0	0	0	0	0	0	0	0	0	0

(Source: Trust Winpath System)

MSSA bacteraemia

There have been 15 cases of MSSA bacteraemia this year which does not have a trajectory. Learning from MSSA bacteraemia this year has focused on the care of venous cannula, hand hygiene and encouragement of clinical colleagues to reduce the use of plastic gloves.

Gram-negative bacteraemia

	Trajectory	Cases
E. coli bacteraemia	47	49
Pseudomonas aeruginosa bacteraemia	5	9
Klebsiella species bacteraemia	11	16

Key strategies for prevention and control focus on contact precautions, the management of invasive devices and maintaining a clean, dry environment to prevent the build-up of environmental reservoirs and cross-infection.

The importance of hydration in reduction of Gram-negative bacteraemia has also been integrated into Quality Improvement work throughout the year.

Influenza and Covid-19

During winter months, there are higher than average numbers of patients presenting with influenza, Covid-19. This puts additional pressure on the whole system and hospital premises with limited numbers of isolation facilities. Where appropriate patients are co-horted together with the clinical teams adhering to infection, prevention and control, practices.

Carbapenemase Producing Enterobacterales (CPE)

CPE is an antimicrobial resistant finding for some bowel organisms. The UK Health Security Agency (UKHSA) Field Epidemiology Team visited the hospital on 16 June 2023 to provide a 'fresh pair of eyes' on how cases of CPE are managed and risks of cross infection reduced.

Improvements the Trust has put in place were recognised by UKHSA, including an improved system for recognising and flagging CPE patients on admission, deep cleaning,

improvements in commode cleaning and audits and increased Infection Prevention and Control (IPC) training.

Areas for consideration included a long term plan for the ageing ward environments, including hand wash basins, ward environments and a review of the IPC team. A full action plan from this visit has been developed and is being monitored through the IPC Committee.

National Point Prevalence Survey

In 2023, the Trust took part in the National Point Prevalence Survey (PPS) on Healthcare-associated infections (HCAIs), Antimicrobial Use (AMU) and Antimicrobial Stewardship (AMS) 2023 in England. Recommendations for consideration include:

- Identify high risk areas
- Identify priorities for local surveillance
- Identify where IPC policies may need to be modified
- Identify where staff may need education/training
- Undertake benchmarking with peer group hospitals in England to understand quality of care locally and identify opportunities for improvement
- Provide information on appropriateness of AMU
- Establish a post-COVID-19 baseline

Quality Improvement (Qi)

Through the Florence Nightingale Foundation and the Regional workforce team, places were sought for Healthcare support workers (HCSW) to receive free leadership training in IPC. Over two separate cohorts, a total of 26 people have completed this course and were invited to the Board of Directors each time, to celebrate this achievement.

To maximise the additional leadership training for HCSW in IPC, the Golden Commode Award was launched. This is awarded to any clinical area achieving three consecutive months of 100% compliance with their commode audit. Acute Surgical Unit achieved seven months of 100% compliance and Ward A3 achieved six months of compliance in 2023/4 (this will roll on into 2024/5).

Overall seven clinical areas were awarded the Golden Commode Award during 2023/4

Health Education and Promotion

The team used IPC week and Hand Hygiene day to further promote good Infection, Prevention and Control practices, including the Gloves Off campaign.

The team led on Trust wide roadshows, taking IPC awareness to clinical areas. Hand Hygiene training was also provided at this time to ensure as many staff were in date as possible. A hydration prize was given to Fitzwilliam for the most informative ICP display board during this week.

Hydration

The Trust have been active members of the regional hydration network throughout the year, including presenting work on the traffic light water jug lids, inpatient tea parties. Additional new work included the removal of plastic spouted beakers and the purchasing of new cups for patients as well as the launch of #ButFirstADrink.

Reducing the incidence of Falls with Harm

A fall in hospital can be devastating. The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and increased morbidity and mortality. Falling also affects the family members and carers of people who fall, and has an impact on quality of life, health and social care costs. Falls represent significant cost to Trusts and the wider healthcare system, with annual total costs to the NHS alone from falls among older people estimated by the National Institute for Health and Care Excellence (NICE) in 2015 at £2.3 billion.

	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2024-24
Falls	741	799	796	892	921	1048	1044	1032
Bed Days	144,505	145,153	132,557	158,207	118,098	151, 353	152,201	156,783

Falls Rate per 1000 Bed Days	5.12	5.50	6.00	5.63	7.79	6.92	6.85	6.58

Monitoring of all falls is undertaken daily by the Quality Governance and Assurance Unit and the clinical areas are provided with data using a falls performance dashboard from Datix. Falls prevention and improvement is also monitored through the Trusts Falls Group who report into the Patient Safety Committee.

The Trust continues to participate in the mandatory National Inpatient Falls Survey, the results of which are used to inform the Falls group action plan, which is continually being amended to reflect the most recent falls management initiatives.

Duty of Candour

'Duty of Candour' requirements are set out in the Health and Social Care Act Regulation 20: Duty of Candour (Health and Social Care Act (2008). The introduction of Regulation 20 is a direct response to recommendation 181 of the Francis Inquiry report into Mid Staffordshire NHS Foundation Trust (Report of the Mid Staffordshire NHS Foundation Trust Enquiry, 2013), which recommended that a statutory duty of candour be introduced for health and care providers, to ensure a more honest and open culture in the NHS. From October 2014 there was a statutory requirement for Trusts to implement the Duty of Candour requirements.

Duty of Candour is monitored closely by the Quality Governance and Assurance Team.

An audit of compliance regarding the Duty of Candour discussion had been undertaken during 2021-22. Following on from this, the process for assurance on compliance to Duty of Candour has been strengthened through ongoing monthly monitoring by the Quality Governance and Assurance Team. This is reported through to local governance, Patient Safety Committee and Quality Committee. Non-compliance is reported onto the Datix system and reported through the Patient Safety Committee monthly. This is further supported through a rolling training programme delivered by the Quality Governance and Assurance Team.

Safeguarding Vulnerable Service Users

Safeguarding is everyone's business, and remains one of the Trusts key priorities. With executive leadership provided by the Chief Nurse, supported by the Deputy Chief Nurse and Head of Safeguarding, there is visible and active leadership all levels who drive a continuous improvement approach to safeguarding. TRFT has remained compliant throughout the year in discharging all contractual and legal safeguarding duties to keep patients, staff, and those who touch our services safe, and help them to live free from abuse and neglect.

Recognising that adults and children do not live in isolation, the co-located safeguarding and vulnerabilities team provide specialist advice and support across the spectrum of adult

and children's safeguarding. In addition to safeguarding, the team work across the public protection agenda including Domestic Abuse, Exploitation and Prevent. The team are consistent members at the Multi Agency Risk Assessment Conference to develop safety plans for those at high risk of harm from domestic abuse, attend Multiagency Public Protection Arrangements meetings, and although there little Prevent activity to report from the Trust, we continue to raise awareness of the risks of grooming for radicalisation, and share information when any concerns are raised. The Team is represented at the Multiagency Child Exploitation Meeting by the lead nurse for Child Exploitation.

The team includes a Learning Disabilities and Autism Matron, and two additional Nursing Associates who support those with a learning disability and autistic people to access health care. The Team have seen a 30% increase this year in the number of patients the team are supported, with bespoke pathways established in surgery, support with all in-patients, Children, and Community Patients. The team work closely with the Medical and Nursing leadership team to make reasonable adjustments to improve access to care and treatment, and through support from Rotherham Hospitals Charities, are able to provide resources to help individuals throughout their care and treatment, by providing, for example, ear defenders, sensory lights, or fiddle toys.

Although the Government has paused the work on the Liberty Protection Safeguards, at TRFT we have continued with planned work to strengthen the workforce confidence with Mental Capacity Act Assessments, and delivered targeted interventions across the Trust. Developed in Partnership with the Mental Health Steering Group, an all age Mental Health Strategy was launched in TRFT this year, which seeks to ensure that clinical staff take a 'whole person' person perspective, and that all patients presenting with mental health concerns have their physical and mental health care needs addressed.

The safeguarding annual work plan, and activity relating to safeguarding and vulnerability is monitored through robust safeguarding governance arrangements, with Safeguarding Group and Mental Health Steering Group both chaired by the Deputy Chief Nurse feeding upward into Safeguarding Committee which is chaired by the Chief Nurse.

There have been a number of small changes within the Team, aimed at moving away from focusing on adults or children, to the holistic Think Family approach, focusing on workforce development and succession planning, as well as increasing capability and capacity of the workforce across the safeguarding and vulnerability agenda. The Children's and Adult's safeguarding team are working as one team, with further team development planned over this next year.

Safeguarding Mandatory and Statutory Training compliance has remained a priority across the organisation, with compliance across the organisation 90%, and targeted interventions in place to support pockets of staff who are out of compliance. The Think Family training day continues to evaluate well, with staff attending gaining a lot from day. The Oliver McGowan tier 1 training has been launched and is available to staff on ESR, with 47% of staff completing this to date, and plans for tier 2 are being coordinated by the ICB, and this will be launched during April 2024/25. There is good compliance across the Trust with Mental Health (95.7%), Dementia (99%), and Prevent (93%) training, which forms part of the national CONTEST anti-terrorism strategy.

The safeguarding team are consistent and reliable partners across the Safer Rotherham Partnership, Rotherham Safeguarding Children's Partnership, and Rotherham Safeguarding Adult Board. TRFT is represented appropriately in all forums, including

chairing of meetings. TRFT has contributed to and participated in the SAB peer review, which has resulted in a new governance structure being developed. Safeguarding Partners attend Safeguarding Committee at TRFT which enables partners the opportunity to provide comment, support or constructive feedback on areas of safeguarding practice. This forum has been highlighted by partners in increasing the flow of information both ways and enables transparency with safeguarding practice.

TRFT are committed to protecting vulnerable patients by providing high quality healthcare services that are accessible and are delivered in a way that respects the different needs of individuals, and protecting children and adults from abuse and harm. We continue to learn from and embed best practice across the vulnerability agenda.

Dementia Care

Education on Dementia has been delivered to 387 Trust staff by one of our Divisional Directors and Consultant in Care of Older People. This is part of the Trust Person Centred Care day which is led by our Person Centred Care Practitioner.

From this work a series of improvement initiatives, such as Eyes, Ears Teeth boxes (to look after glasses, hearing aids and dentures) have been bought from the Trust charity and the Trust has adopted the initiative Call Me. This is work to ensure all patients are referred to by the name they wish to be called which is important for patients living with dementia.

The Trust continues to support and promote John's Campaign, which is a public declaration that the ward/ clinical area welcomes carers at all times to support patients living with dementia or experiencing delirium, including overnight if necessary.

On 23 November 2023, to celebrate National Healthcare Support worker day, the virtual Dementia Tour was organised through Train2Care for the second time. This interactive bus took colleagues through a virtual experience of what it would feel like for a patient to be living with Dementia and experience unfamiliar noises and environments. Another 60 colleagues took part in this learning experience in November 2023.

A tier one dementia awareness video has also been developed and will be available to support awareness for people who do not need to attend the PCC day.

Dementia & Delirium Screening

The Trust currently collates, and reports data based on the Dementia Screening guidance: (inpatient stays of longer than 72 hours and over the age of 65). Between April 2023 and March 2024, 8582 patients over the age of 65 with an inpatient stay longer than 72 hours were eligible for screening. Of those patients, 8139 were screened for both Dementia and Delirium (94.83%).

Learning Disability and Autism Team

The Rotherham NHS Foundation Trust is committed to improving the experience for both children and adults who have a learning disabilities and Autistic people. The Trust has a

Matron in Learning Disabilities and Autism one Nursing Associate specialising in Learning Disabilities and a specialist practitioner in learning disabilities and autism. The team remains under review to assess this staffing level and service need. The team focus on all aspects of the patient care pathway and experience within the Trust. The team supports both children and adults who are attending outpatients, inpatients, going through planned surgery, midwifery, are admitted through the UECC and includes the transitions of young people to adult services. The team also has a role to play in the prevention of re-admissions to hospital; visiting patients in the community to assess their needs, whilst liaising with Community Services to prevent admission to hospital where possible. The Learning Disability and Autism team ensure that the Trust are making reasonable adjustments for people with additional needs by undertaking the following:

We implemented an electronic flagging system to identify that a person has a learning disability from their medical records. This information then populates a live database for the Learning Disability team to access. The same electronic flagging system is now in place for people with Autism/Autistic people, should they consent to having this information flagged on their medical records. These flags populate a 'live' patient board, to enable our team to know which inpatient ward the patient who have a learning disability, or a patient with Autism is. The Learning disability and Autism team can then visit in order to enhance their care pathway in Trust.

At TRFT we champion the use of the Hospital passport, which is a person-centred assessment tool for people with Learning Disabilities. It can assist staff to learn about how to care appropriately for each individual. The Hospital passport, is based on a traffic light symbol of need, comprising of three sections, red, amber and green. A current initiative will be implementing the traffic light symbol as a magnet, on patient headboards, ward boards and medical notes. The symbol will raise awareness to staff needs the need to read the Hospital passport. For our patients with Autism, we also champion the use of the Autism passport, or a format which that person is comfortable in using. Both assessments are holistic guides to the previous care baseline of the individual and saves the patient from unnecessarily repeating information about themselves and their care needs which for many people can cause an increase in their anxiety.

The team have collaboratively produced staff resource files for people with a learning disability and autism. To enable our generally trained colleagues to have some help and information at their fingertips, in the absence of the team. The files are an excellent resource in prompting staff to read the Hospitals passports we have in place, communication aids, information about what a learning disability is and information around what Autism is – describing some of the areas that people may find difficult about coming into hospital. There are health and care related pictures within the file, to perhaps initiate better communication through pictures.

The team offers excellent outcomes for patients with a learning disability and autism coming through our Day Surgery Unit, on a bespoke pathway. This offers a full holistic assessment of the persons care needs, in order to set up a robust plan to enable that individual to safely and positively come to the hospital for their planned surgery, or investigations requiring anaesthetic. This may be for some patients, not attending pre op and only attending on the day of surgery/treatment. All the aspects of the admission process are covered in an MDT approach and planned for prior to the patient coming to Trust. Without such a pathway, many patients would simply not be able to tolerate coming to hospital, or having what are classed for some people as simple investigations/treatments within primary care.

The team has a specialist medic attached to the team who provides medical overview and expertise. They are currently undertaking a specialist qualifications in Learning Disability and Autism to enhance their knowledge within this specialist area of practice.

Our team currently provides bespoke training regarding learning disabilities and Autism in conjunction with the local advocacy organisation. This can take the format of formal training on the Midwifery MAST training programme for example, or attending the safety huddles on our AMU ward. We champion where possible, our training to be delivered by experts with experience. The team have provided training to the medical teams, social care colleagues within RMBC and the Trust's wards and departments.

We have created sensory boxes, which include light therapy to help to reduce perhaps anxious feelings of being in hospital. Distraction toys which can help with distraction and focus, noise cancelling headphones and weighted blankets. The equipment we have has come from the feedback which we have received from our patient group. We have a bi monthly patient experience meeting, which is attended by people with learning disability and people with autism, service providers, Healthwatch and other organisations across Rotherham. Within our meeting we discuss direct patient experience and look to learn and develop directly from those experiences. Our sensory boxes and equipment can be found on all wards and departments or by contacting our team for assistance.

Within both our adult and paediatric UECC departments we have portable sensory/bubble tube equipment to further help and reduce anxieties around being in such a busy environment.

As a team we continue to build links with established organisations to support learning, such as Speak Up, CHANGE organisation and NHSe. From a training perspective we facilitate a programme of mentorship for Learning Disability Nurse/Generic Social Work Students at Sheffield Hallam University, providing shadowing and training opportunities to the Trust's Trainee Nurse Associates and other staff members who have a special interest within the Trust.

We work closely and support our Volunteer Coordinator to mentor and support volunteers in the Trust who have a Learning Disability/Autism. Likewise we provide support to staff members who have a learning disability or who are autistic.

The team work closely with our Trust and community facilities to help reduce unnecessary admissions to hospital. We provide a nurse prescribing element to this and currently our Matron is undertaking a MSC in Advancing practice for people with a learning disability and Autism. These services include joint working with our Virtual ward teams, Community matrons, Fast Response and District Nurses.

We work with the process of complex care colleagues around the transition of young people from child to adult services within the Trust. This transition work involves acute colleagues in Sheffield Teaching Hospitals and Sheffield Children's Hospital, who are transitioning back over to Rotherham Adult services. This process involves complex MDT working across our partner organisations.

The team ensure work to and Implement relevant Learning Disability and Autism strategies within the Trust and working in conjunction with partnership organisations across Rotherham PLACE. This includes the Accessible Information Standard and the Annual Learning disability and Autism Standards for Acute Trusts.

We champion and support the learning coming from the Learning Disability Mortality Review programme (LeDeR) process. This is now centralised within Sheffield for our ICS.

Ensuring that reasonable adjustments are made to Trust care pathways. Examples of reasonable adjustments may include being listed as first on a surgical list to decrease potential anxiety around waiting, or having someone who knows the person really well, to support them on their journey into the Trust. We champion the use of the Mental Capacity Act (MCA), assisting with best interest processes and the use of Deprivation of Liberty Standards (DoLS) where appropriate.

We work to help reduce the length of stay in hospital by working with Medical Professionals, Allied Health Professionals and Social Care Professionals. On average a person with a learning disability and or Autism, may have a longer than average inpatient stay compared to the general population when treated for the same condition. This may be around on average 5-7 days longer. The discharge of patients with a learning disability remain complex in nature, due to the potential complex and specialist level of support the person may require and the continued challenge in service provision in the community.

The team engages with quarterly regional meetings for acute Trusts who have specialised teams for the care of people with a learning disability and or autism. These are important arenas to share best practice and look to directly improve our services at TRFT.

As a team we are always looking to plan for improved and better care for our patient group. Some of our future initiatives may include exploration of the learning disability and autism team workforce, incorporating different roles and working patterns. This could include out of hours working patterns, or weekend working. These potential changes also come from direct patient experience and suggested learning from complaints and serious incidents.

We continue to champion the role of the Learning Disability Champion and Autism champions on all wards and departments. This role is one of empowerment and advocacy. With staff members encouraging their peers to improve the patient experience for people with a learning disability and people with autism who are in attendance on their wards and departments.

From a training perspective as a Trust we have now started the implementation of the of the mandatory Oliver McGowan Learning disabilities and Autism awareness training. This is supported Trust wide and from a Trust executive level.

Continued use of the Traffic light magnet scheme – which champions and highlights the need to read the Hospital passport for patients with a learning disability. They are small Traffic light coloured magnets which attach on the back on the patient board above the patient bed. This initiative came from the learning following a complaint within the Trust.

Staff Experience and Engagement

The Trust had its highest ever response to the national staff survey with 67% of colleagues completing it, providing valuable feedback to the organisation as to how it can improve and make it a better place to work. All clinical divisions had increased engagement with their teams with lots of innovative ideas, incentives, and a small element of competition to achieve the high response rates. This was visibly led by the Executive team and supported

with targeted communications. In response to operational pressures we committed to continue to support our colleagues as we moved out of the pandemic phase into recovery and beyond. The demand on staff remains consistent and we are mindful of the need to address the treatment backlog faced across the NHS whilst continuing to support the workforce to be well and at work.

In response to last year's survey there was increased focus on the importance of wellbeing and self-care, improving the clinical environment, break out areas, changing facilities and provision of hot food has continued as an ambition to support staff. We have also continued to develop meaningful activities and health initiatives to promote colleagues to take care of their own health to enable them to care for others.

We have seen a consistent use of staff accessing our Employee Assistance Programme services, support through occupational health and ICB led initiatives and training both physical and online.

We have worked hard to embed good practice in line with the NHS People Promises such as our approach to supporting flexible working, to be compassionate and inclusive, understanding our colleague voice though emphasising the importance of the National Staff Survey.

We have worked with a number of regional stakeholders to showcase and recognise talent in the borough to plan for future healthcare roles and opportunities.

NHS staff survey

The NHS staff survey is conducted annually. From 2021/22 the survey questions align to the seven elements of the NHS 'People Promise' and retains the two previous themes of engagement and morale. These replaced the ten indicator themes used in 2020/21 and earlier years. All indicators are based on a score out of 10 for specific questions with the indicator score being the average of those.

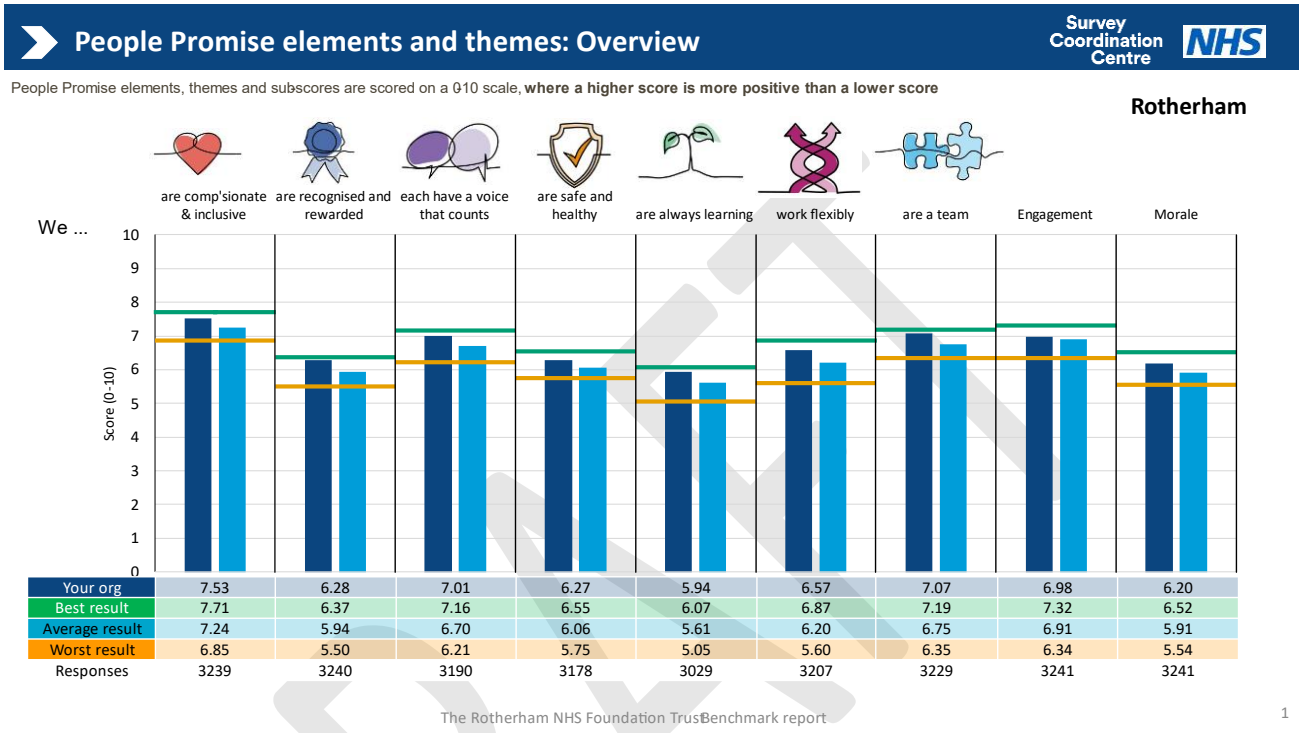
The response rate to the 2023/24 survey among trust staff was 67% (2022/23: 61%).

Scores for each indicator together with that of the survey benchmarking group (Acute and Acute & Community) are presented below.

Indicators ('People Promise' elements and themes)	**2023/24**		**2022/23**	
	Trust score	Benchmarking group score	Trust score	Benchmarking group score
People Promise:				
We are compassionate and inclusive	7.53	7.24	7.4	7.2
We are recognised and rewarded	6.28	5.94	6.0	5.7
We each have a voice that counts	7.01	6.70	6.8	6.6
We are safe and healthy	6.27	6.06	6.1	5.9
We are always learning	5.94	5.61	5.6	5.4

We work flexibly	6.57	6.20	6.2	6.0
We are a team	7.07	6.75	6.9	6.6
Staff engagement	6.98	6.91	6.7	6.8
Morale	6.20	5.91	5.9	5.7

The Trust has improved its score against all the staff survey domains and benchmarks above the national average for all domains when compared to the peer group.



The 2023/24 NSS results are very positive and demonstrate the progress that TRFT continues to make, particularly in relation to the three advocacy questions (25a, 25c, 25d) where the Trust now ranks in the top 3 most improved organisations across England.

Advocacy / Year	2022	Rank	Quartile	2023	Rank	Quartile	Change +/-
Q25a							
Care of patient/service users is my organisation's top priority	69%	93th	bottom quartile	74%	68th	3rd quartile	Ranking up 25 places 5% increase = **3rd biggest increase in England**
Q25c							
I would recommend my organisation as a place to work	54%	77th	3rd quartile	63%	43rd	2nd quartile	Ranking up 34 places 9% increase = **2nd biggest increase in England**
Q25d							
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	50%	98th	bottom quartile	58%	90th	3rd quartile	Ranking up 8 places 8% increase = **biggest increase in England**
Engagement (Advocacy, Motivation and Involvement)	6.73	71st	3rd quartile	6.98	37th	2nd quartile	Ranking up 34 places

NHS Response Rate

The table below highlights the Trust performance in relation to wider NHS organisations.

	2018	2019	2020	2021	2022	2023
Best	71.6%	76.0%	79.8%	79.4%	60.9%	69.5%
TRFT	38.5%	48.0%	52.2%	59.7%	61.0%	67.0%
Median	43.6%	46.9%	45.4%	51.1%	44.5%	45.8%
Worst	24.6%	27.2%	28.1%	36.5%	26.2%	21.4%

The Trust had excellent engagement with the 2023 national staff survey, with 67% of colleagues responding to the questionnaire and providing their valuable feedback; this is the highest return rate the Trust has ever achieved and well above the national average.

Future priorities and targets

Top 5 scores vs Organisation Average	Org	Picker Avg
q23a. Received appraisal in the past 12 months	93%	83%
q20b. Would feel confident that organisation would address concerns about unsafe clinical practice	65%	56%
q19d. Feedback given on changes made following errors/near misses/incidents	69%	60%
q6c. Achieve a good balance between work and home life	63%	56%
q18. Not seen any errors/near misses/incidents that could have hurt staff/patients/service users	73%	66%

Most improved scores	Org 2023	Org 2022
q25c. Would recommend organisation as place to work	63%	54%
q3i. Enough staff at organisation to do my job properly	34%	25%
q25d. If friend/relative needed treatment would be happy with standard of care provided by organisation	58%	50%
q4c. Satisfied with level of pay	35%	27%
q6b. Organisation is committed to helping balance work and home life	55%	47%

Key Areas for Improvement and Future Priorities

Bottom 5 scores vs Organisation Average	Org	Picker Avg
q25d. If friend/relative needed treatment would be happy with standard of care provided by organisation	58%	63%
q13a. Not experienced physical violence from patients/service users, their relatives or other members of the public	84%	87%
q12c. Never/rarely frustrated by work	20%	22%
24b. There are opportunities for me to develop my career in this organisation	54%	55%
q23b. Appraisal helped me improve how I do my job	25%	26%

Most declined scores	Org 2023	Org 2022
q2c. Time often/always passes quickly when I am working	72%	74%
q14a. Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public	74%	76%
q31b. Disability: organisation made reasonable adjustment(s) to enable me to carry out work	80%	81%
q13d. Last experience of physical violence reported	70%	71%
q16a. Not experienced discrimination from patients/service users, their relatives or other members of the public	94%	94%

Top 5 Priorities for 2024/25

Taking on board feedback from the 2023 staff survey and the free text comments from colleagues a number of areas have been identified for action during the new financial year. These priorities have been agreed by the Executive team with a lead Executive Director being assigned against each priority area. These will be developed into a branded “We Said, We Did” action plan during April/early May and shared across the Trust in May following the launch of the new People and Culture Strategy.

No.	Area	Lead Director
1	Appraisal	Director of People
2	Car Parking	Director of Estates & Facilities
3	Reasonable adjustments	Director of Finance
4	Sexual safety	Chief Nurse
5	Violence and Aggression	Managing Director

Monitoring arrangements - future priorities and how they will be measured

The Board of Directors will agree key milestones and delivery targets for the Trust; however, workforce related performance and people objectives will be monitored through the governance structures in place including the Operational Workforce Group, People & Culture Committee, the Executive Team and ultimately the Board of Directors.

Locally each Care Group will develop “We Said, We Did” improvement plans using key information from the national staff survey results, CQC feedback, People Pulse survey and other key Trust metrics. These will be managed through a monthly care group performance

meeting and dashboards, providing assurance to the Executive Team and Board of Directors.

The wider workforce and people engagement activities will be monitored through the Operational Workforce Group chaired by the Director of People. The actions of this group and any associated work plans will provide the appropriate levels of assurance to the People & Culture Committee.

Freedom to Speak up (FTSU) Guardians

The FTSU Guardian (FTSU) role was first introduced at the Trust in July 2015 in response to the Francis report, with the appointment of six FTSU Guardians (FTSUG). In September 2016 a Lead Guardian was appointed, which enabled the separation of the FTSUGs from the HR functions of the organisation. Subsequent to this appointment eight further FTSUGs have been recruited to ensure that all Divisions have representation. All the FTSUGs have a suitability interview and undertake the role on a voluntary basis in addition to their substantive post; one of these have also attended the National Guardians Office training session. The current FTSU lead was appointed in January 2024, and the time dedicated to the role increased to 0.6 Whole Time Equivalent.

Since the appointment of a National Guardian there has been increased direction from the National Office regarding the role of FTSUG. The regional network now meets virtually every two months and the annual national event, can now be attended In person or virtually; our FTSUG has been supported to attend. The Rotherham NHS Foundation Trust remains one of the only Trusts in the country to have FTSU training as a MaST subject with a three yearly refresher period as recommended by the National Guardians Office.

The FTSU Guardian Lead has direct access to the Chief Executive and other Board members and is line managed by the Chief Nurse. They have continued to meet quarterly via teams, together with the Senior Independent Director and Executive Director of Workforce.

In its response to the Gosport Independent Panel Report (2018), the Government committed to legislation requiring all NHS Trusts and NHS Foundation Trusts in England to report annually on staff who speak up. Staff at the Trust can raise concerns with their Trade Unions, line managers, colleagues or other supervisors, health and safety, security manager, Human Resources, professional regulator, Trust chaplains and to any of the FTSU team via face to face, telephone (including voicemail linked to e-mail address), e-mail, drop in clinic once a month at each site and anonymously via letter in the drop boxes to the FTSU Lead.

All concerns receive an initial response within 5 working days. If colleagues wish to meet with a guardian to discuss their concerns, meetings are arranged at a time and venue convenient to the person raising the concern. All staff who raise a concern with the FTSU team are contacted three months after a concern is raised to see if they have suffered a detriment as a result. The wellbeing check also requests feedback from concern raisers on the service provided by the FTSUGs. To date feedback has been mainly positive with colleagues finding it easy to contact a FTSUG and pleased with the support that has been received.

During 2023/24, the FTSUGs have received 7 concerns. The majority of the concerns have related to attitudes and behaviour, with colleagues being directed to HR or union support for further advice. The number of concerns shows a decrease on previous years, however responses to the relevant questions in the staff survey show a year on year increase which may be linked to the increased time dedicated to the role and staff experience from those who have accessed the service. It may also be due to The Rotherham NHS Foundation Trust being one of the only Trusts nationally to have FTSU as a mandatory training subject; this training ensures staff are aware of FTSU and what to do if they suffer a detriment and how to escalate it, if it does indeed occur. Robust reporting systems are in place through which the FTSUG Lead reports biannually to the Audit Committee and Board of Directors.

Key learning from the national reviews and cases raised locally have informed the content of our current approach.

Proud Awards: recognising the contribution of colleagues at The Rotherham NHS Foundation Trust

In 2023, the Trust's annual Proud Awards returned to celebrate our dedicated and caring colleagues who help ensure patients receive the care and compassionate treatment they deserve.

More than 700 nominations were received for the 2023 Proud Awards. The event was held at Magna and hosted by Liesl from Hallam FM's Big John at Breakfast with around 400 colleagues in attendance, alongside partner organisation representatives and sponsors. The award categories were announced by members of the Executive Team, Non-Executive Directors and representatives from the Council of Governors.

The 2023 winners were:

Chairman's Award
Lynsey Maton, Head of Nursing (UECC)

Chief Executive's Award
Amy Mills, eRoster

NHS75 Award for outstanding contribution to the NHS
Dr Bijoy Mondal

Public Recognition Award
Stroke Therapy Team

Non-Clinical Team of the Year
Sterile Services

Inspiring Leader
Tom Nield, Head of Nursing (Surgery)

Diversity and Inclusion Award
Day Surgery Bespoke Elective Pathway

Learner of the Year
Benjamin Proctor

Quality Improvement Award
Care Homes Team Occupational Therapists

Unsung Hero
Julie Foster

Clinical Team of the Year
Ward A1

Governors' Award for Living the Values
Hannah Hall

Outstanding Volunteer Award
Diane Schofield

Excellence Award - Team of the Year
Emergency Preparedness, Resilience and Response

Excellence Award - Individual of the Year
Munazza Shah

Excellence Award - Public Excellence
Maternity

Implementing the priority clinical standards for 7-day hospital services

Central reporting against 7-day services remains suspended. The last audit was completed in 2019.

Management of Rota Gaps – Doctors in Training

Junior doctor rotas are unfortunately often subject to gaps, which can occur for various reasons. Long-term placement gaps occur if the training scheme does not fill all available posts. Less than full time working also has a substantial impact on these training posts, and we are noticing a rapid increase in numbers of doctors wishing to work on a LTFT basis across the region. The current vacancy rate for training grades is 7.01%, the equivalent of 11.6 posts out of an establishment of 165.4 across all training grades and specialties. Taking into consideration ad hoc vacancies due to sickness/other absence, it is appreciated that rota management can become challenging. Despite any vacant posts there are a number of shifts, designated Red Flag Shifts, which must be filled e.g. Medical Registrar On-Call. Minimum staffing levels are set for ward areas in order to ensure that sufficient junior doctors are available to maintain the safety of patients and staff. Any vacancies which cause staffing levels to fall below minimum will require cover.

The Trust utilises a centralised rota co-ordination function, which currently supports rotas across Medicine, General Surgery, Urology and the UECC. This model provides business resilience in terms of rota co-ordination across the divisions. Management of rota gaps is required on a daily basis, with Rota Co-ordinators taking a proactive approach in order to ensure gaps are filled in a timely manner. If a gap cannot be filled by a substantive member of staff, there is a process in place in order to fill this, starting with cover via the Trust's Internal Bank. In June 2022, the Executive Team signed off approval for the Trust to join Care1Bank, which is the regional bank solution across a number of Trusts, and which is the preferred option over advertising to agency. If cover cannot be sourced internally or via Care1Bank, the next step is to seek agency cover, and the Trust utilises a Master Vendor in order to source agency locums.

Alternative staffing groups, such as ANP/ACPs can fill appropriate junior vacancies, and it is evident that our clinical workforce is now trending towards a more integrated approach. Rota design plays an important role in ensuring optimum cover is provided. Any modification to rotas involves the junior doctors, from design to signoff in respect of any revised work pattern. The Trust has adopted Good Rostering Guidance, produced jointly by NHS Employers and the British Medical Association in May 2018, along with adherence to contractual requirements of the 2016 Doctors in Training contract. Rota issues are a standing agenda item at the monthly Junior Doctor Forum, chaired by the Director of Medical Education, and attended by junior doctors across the Trust, along with management representatives and representatives from the Rota Co-ordination Team.

External Agency Visits, Inspections or Accreditations

During 2023/24 there have been 15 external agency visits. Details of these visits are included in Appendix 3. Action plans are developed, where required, and monitored through the Clinical Effectiveness Committee.

3.2 Performance against relevant indicators

Urgent and Emergency Care

2023/24 marked the return to the national four hour standard for the first time in over four years for the Trust, with our data reported again nationally from May 2023. This is a standard we had not worked to since early 2019, and as such, behaviours and processes had been adapted and embedded to ensure an appropriate clinical and operational response to the pilot standards. This meant a significant programme of work was required throughout 2023/24 to redesign processes and behaviours to align with the return to the core national standard. This included improving our urgent care pathways, developing our workforce model, continued focus on effective discharge processes and enhanced patient experience.

Whilst the Trust did deliver gradual improvements in performance across the year, we did not deliver the national expectation of 76% four hour performance by March 2024, and in particular, there were a number of very challenged weeks throughout the winter period. This meant significantly more patients waited over 4 hours to be admitted or

discharged than planned, and there were also a high number of patients who were in the department for over 12 hours. However, the improvements compared to the prior year were stark, with ambulance delays over an hour falling by 50% over the 12 month period.

The impact of the COVID-19 pandemic is now well controlled for the majority of the year, but the resurgence of influenza for a relatively drawn-out period, led to the Trust experiencing some of the longest and strongest operational pressures it has ever faced. The Trust continued to work closely with partner organisations to ensure an appropriate Place-based response to managing the increased risks during these times of heightened pressure, implementing full command and control structures as appropriate. The operational, medical and nursing teams coped admirably, continuing to work tirelessly to balance the management of our acute patients with the need to deliver wider healthcare services to the population.

Elective Care

The national ambition for patients waiting for elective care was to eliminate all patients waiting over 65 weeks by March 2024. However, with industrial action taking place almost monthly for the majority of the year, this became a more challenging target to deliver nationally than anticipated. Within the Trust, intensive work was carried out in advance of, during and after every period of industrial action to ensure as much elective activity as possible could take place in a safe manner and we could learn to adapt our processes for future periods of action. This took a phenomenal effort from all colleagues involved, and it is testament to their dedication to our patients that we were able to continue the majority of our activity despite these added challenges.

The Trust reported 22 patients still waiting over 65 weeks at the end of March. However, 5 of these were patients awaiting corneal grafts, with these procedures reliant on tissue from NHS Blood and Transplant which was not available before the end of the year. There were 4 further patients who were awaiting specialist procedures that could not be delivered before the end of the year. 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 five specialties presenting the most significant challenges 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. Despite the ongoing challenges we delivered some significant changes in 2023/24 which will support improvements in 2024/25. These included an internally-designed intelligent solution to theatres scheduling, implementation of patient-initiated follow-up pathways in all major specialties, rollout of automated text messaging for patients awaiting follow-up appointments and our place as one of ten sites selected for the National Digital Weight Management Programme pilot.

Cancer Care

During 2023/24, the previous 10 national cancer standards were reduced to just 3, which has enabled a much more targeted focus on performance. The Faster Diagnosis Standard remains paramount, with a new 62-day combined standard also now a clear priority nationally. These were introduced from October 2023, and as such these three

metrics became our primary measure of cancer performance for the second half of the year.

Whilst performance against the Faster Diagnosis Standard has shown improvement towards the end of the year, the Trust did not meet the 75% standard for the year. This was due to a number of factors, but performance was particularly brought down by poor performance within our Skin and Lower GI pathways. Skin performance is now achieving the standard consistently, and there is intensive work taking place within Lower GI in order to ensure the Trust can deliver a step-change improvement in performance in 2024/25.

The national standard for the new, combined 62-day metric remains at 85%. However, the national ambition for 2023/24 was to deliver 70% performance. The Trust achieved this in all but one month of the year, although performance worsened in the second half of the year due to some of the operational pressures experienced, so this will need additional focus going into 2024/25 as the national expectation increases.

Annex 1: Statements from Commissioners, the local Healthwatch organisation and the Overview and Scrutiny Committee

Statement on behalf of the Council of Governors

TO BE ADDED

Gavin Rimmer
Lead Governor, The Rotherham NHS Foundation Trust

Statement from NHS South Yorkshire ICB

South Yorkshire Integrated Care Board
Rotherham Place
Oak House
Moorhead Way
Rotherham
S66 1YY

TO BE ADDED

Andrew Russell
Chief Nurse
NHS SY ICB Rotherham Place

Jason Page
Medical Director
NHS SY ICB Rotherham Place

Statement from Healthwatch Rotherham

TO BE ADDED

Health Select Commission Stakeholder Statement

TO BE ADDED

Annex 2: Statement of Directors' Responsibilities for the Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS England has issued guidance to NHS Foundation Trust Boards on the form and content of annual quality accounts (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust Boards should put in place to support the data quality for the preparation of the quality account.

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- the content of the Quality Account meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2023/24
- the content of the Quality Account is not inconsistent with internal and external sources of information including:

    - Board minutes and papers for the period April 2023 to 31 March 2024
    - papers relating to quality reported to the Board over the period April 2023 to 31 March 2024
    - feedback from governors dated 15 May 2023
    - feedback from NHS South Yorkshire ICB received 4 May 2023
    - feedback from local Healthwatch organisation dated 11 May 2023
    - feedback from Health Select Commission received 16 May 2023
    - the Trust's complaints report (included within the Patient Experience and Inclusion Annual Report) published under regulation 18 of the Local Authority Social Services and NHS Complaints (England) Regulations 2009, dated April 2024
    - the National Patient Survey published July 2023
    - the National Staff Survey 2023 published 7 March 2024
    - the Head of Internal Audit's annual opinion of the Trust's control environment dated June 2023 (approved at Audit Committee on 20 June 2023)
    - CQC inspection report dated 29 September 2021

- the Quality Account presents a balanced picture of The Rotherham NHS Foundation Trust's performance over the period covered
- the performance information reported in the Quality Account is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- the Quality Account has been prepared in accordance with NHS England's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Account

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

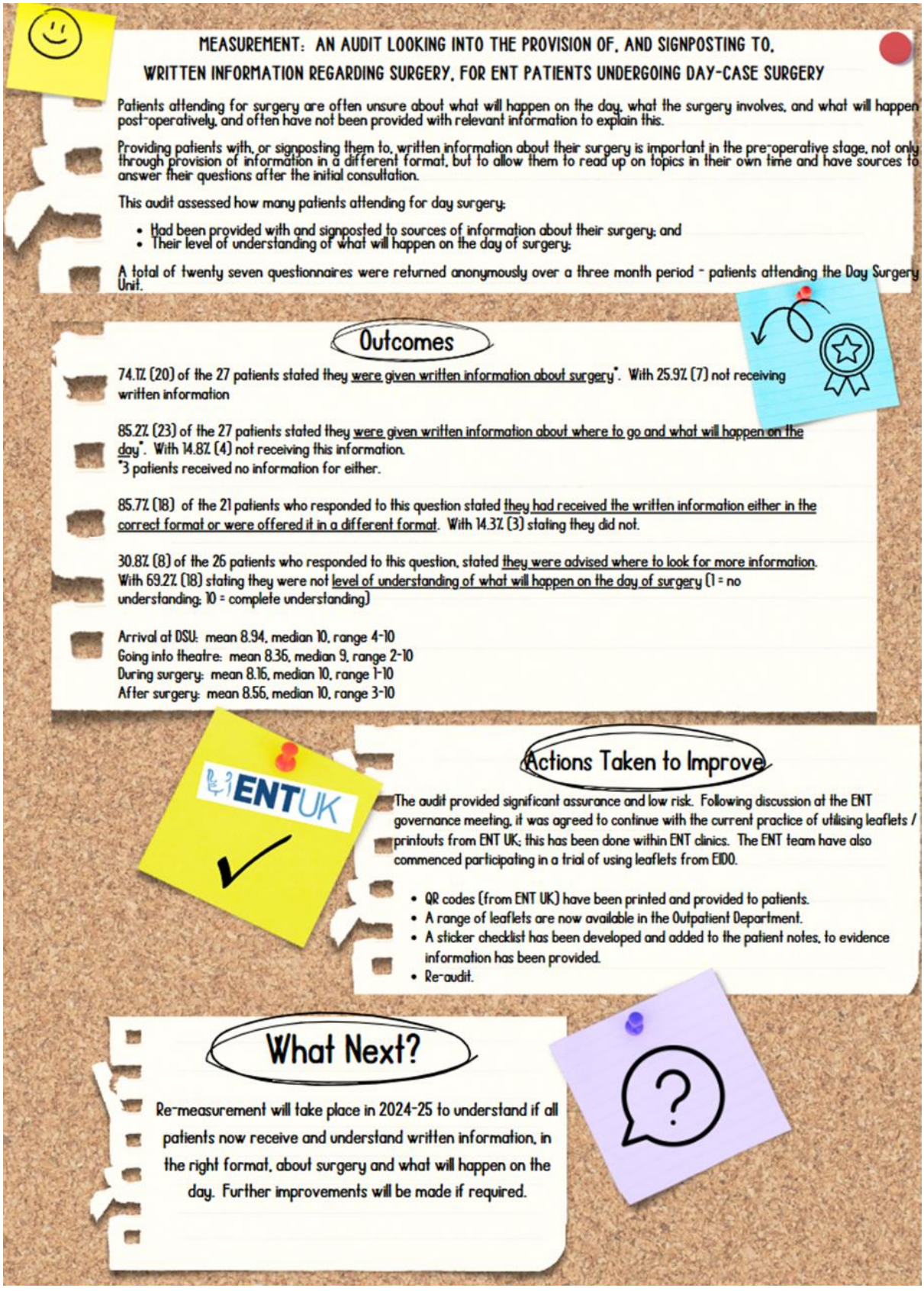
By order of the Board

Dr M Richmond
Chair
June 2024

Dr R Jenkins
Chief Executive
June 2024

Appendix 1: Review of Local Clinical Audits

The outcomes of 123 Local Clinical Audits were reviewed by the provider in 2023-24. The Trust intends to take actions to improve the quality of healthcare provided. Examples of which are detailed below;



Measurement: Palliative Care within the Urgent and Emergency Care Centre (UECC)

Whilst most view the emergency department as a place to seek urgent medical care, it is also a department which sees palliative patients and also start palliative care.

Whilst not considered the ideal place to start palliative care, we need to ensure these patients have the highest possible care during their final moments of life.

01 Outcomes

28 patients within three months who were known to be palliative or palliation was started in ED. Aged 64-97 (average age 81).

All patients were noted to have medical or social dependency e.g. lung cancer to frailty & from a care home.

The audit evidenced significant assurance that good care was provided, and no risks identified.

Actions Taken to Improve 02

There are always improvements that can be achieved. The UECC held its 2nd Annual Palliative Care Study Day which included presentations and discussion on:-

- ReSPECT & Advanced Care Planning
- Breathlessness & Out of Hour Support.
- Organ Donation
- Chaplaincy & their role in Palliative Care.
- Acute Oncology Service (AOS) & Cancer of Unknown Primary (CUP)
- Cultural consideration in Palliative Care.
- Conservations in Palliative Care - Case Based Review

03 What Next?

Continue to share and learn.

Re-measure to evidence delivering effective palliative care in an urgent and emergency care setting.

Measurement: Venous Thromboembolism (VTE) Prophylaxis in Elective Knee Replacement: Improving Compliance with NICE Guidelines

Venous thromboembolic events are a major cause of morbidity and mortality among patients in hospitals.

Surgical patients have been shown to have higher risk, particularly when they suffer prolonged immobilisation, such as in the case of knee joint replacement. The Trust is currently following the established NICE guidelines of aspirin for 14 days as the prophylactic drug of choice.

However, given the fact that the majority of the orthopaedic patients are on LMWH (Tinzaparin) prior to surgeries on admission, there is the potential in delay to switching to aspirin for the 14 days of prophylaxis.

This audit therefore aimed to ensure that the proper drug (aspirin) was prescribed immediately following elective knee surgeries and to provide corrective action if this was shown not to be the case.

NEXT ➡

Actions Taken to Improve

Clear documentation of VTE prophylaxis option – mandated the requirement to be documented in the operation note.

Revision of VTE assessment form on EPR – to allow prescription of aspirin.

Standardisation of VTE prophylaxis prescribers – VTE prophylaxis is now prescribed by the Orthopaedic Surgeon rather than Anaesthetists. Nursing staff to identify discrepancies – Briefing provided for nursing staff on appropriate VTE prophylaxis.

Timely administration – Ward Manager / Nurse in Charge oversight of surgery, VTE prophylaxis and timely administration.

Outcomes

92% (23) of the 25 patients were prescribed Aspirin, as per the NICE guideline, with the remaining 8% having good reasons (Peptic Ulcer Disease, High BMI) for an alternative (Apixaban)

Partial compliance (87% for same day / post-operative day 1) was noted with regards to starting Aspirin in a timely manner.

44% (11) of the 25 patients were also served Tinzaparin prior to commencing Aspirin / Apixaban.

52% (13) of the 25 patients evidenced post-operative plans specifying the drug to be prescribed (i.e. Aspirin), while the remaining 48% (12) did not specify.

What Next?

Re-measurement will be undertaken in 6 months time.

Taking further improvement action as required.

Appendix 2: Readmissions within 30 days

Emergency Re admissions within 30 days of discharge from Hospital		
Age Bands	**1st April 2022 – 31st March 23**	**1st April 2023 – 31st January 24**
Age 0 - 15 years	11.79%	12.98%
Age 16 years and above	10.48%	9.07%

Data source: TRFT Data Warehouse SQL Server Reporting Services - Re admissions - full year data will be available from 1st May.

The latest update available from NHS Digital is for the period 2011/12. Therefore, the internal TRFT data Warehouse is used for all reporting of re admissions for the performance reports for the Board, the Divisions, the clinical support units (CSU) and for the Service Line Monitoring reports.

The internal TRFT data has been aligned to the National Benchmarking reports - in this case Model Hospital. Model Hospital is an NHSI tool that uses HES (Hospital Episode Statistics) Data and contains some additional methodology on how they report readmissions. In 2020 the reports were re-written to align to National data, the reports include INO, same day readmissions and reporting within 30 days. We are also picking up if a patient has had multiple readmissions in the reporting period if within the time frame. This is all as per the National Methodology. - The report does however report readmissions - Same Treatment Function code back to Same Treatment Function Code. In April 2022 the data was amended to exclude all Day Cases from the Denominator, something that was included up to March 2022.

Appendix 3: External Agency Visits, Inspections or Accreditations

The table below details the external agency visits undertaken during 2023/24

Detail of Visits	Date of Visit
Clinical Service Excellence Programme (CSEP) Myeloma UK Accreditation	16 February 2024
UKAS WHO Assessment for Laboratory Medicine (Andrology)	13 April 2023
UKAS Surveillance visit 1 to Laboratory Medicine	10-12 May 2023, 13, 28 June 2023
Police Counter Terrorism Security Advisor visit to Laboratory Medicine	12 May 2023
Health & Safety Executive visit to Laboratory Medicine	23 June 2023, 16 November 2023
Human Tissue Authority visit to Laboratory Medicine	11 October 2023
Dangerous Goods Safety Advisor visit to Laboratory Medicine	30 November 2023
GIRFT Support Day – ENT, Gynaecology and Ophthalmology	17 May 2023
GIRFT Support Day – Urology, Anaesthetics and Perioperative Medicine, Cardiology and Dermatology	19 July 2023
GIRFT ENT Gateway Review	19 December 2023
GIRFT HVLC System Visit – Professor Tim Briggs	10 January 2024
Aseptic Unit inspections against QAAPS (Quality Assurance of Aseptic Preparation Services) standards	28 June 2023
LMNS assurance visit	23 January 2024
Paediatric audiology	29 February 2024
ERCP additional reviews – Painter and Woodward	January 2024

References – to be finalised once Quality Account finished

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Acronyms – to be finalised once Quality Account finished

A&E	Accident & Emergency Department
ACP	Advanced Clinical Practitioner
AMU	Acute Medical Unit
APC	Admitted Patient Care
C-DIFF	Clostridium Difficile
CHKS	Comparative Health Knowledge System
CMP	Case Mix Programme
CNST	Clinical Negligence Scheme for Trusts
COPD	Chronic Obstructive Pulmonary Disease
CPE	Carbapenemase Producing Enterobacterales
CSDS	Community Services Data Set
CSU	Clinical Support Unit
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CYP	Children and Young People
DCT	Dental Core Trainee
DIPC	Director of Infection Prevention and Control
DoLS	Deprivation of Liberty Safeguards
DQMI	Data Quality Maturity Index
DSPT	Data Security and Protection Toolkit
ECDS	Emergency Care Data Set
E.Coli	Escherichia coli
ED	Emergency Department
FFFAP	Falls and Fragility Fractures Audit Programme
FFT	Friends and Family Test
FTSU	Freedom to Speak Up
FTSUG	Freedom to Speak Up Guardian
GAfREC	Governance Arrangements for Research Ethics Committee
GDP	General Dental Practice
GIRFT	Getting it Right First Time
GP	General Practitioner
HIV	Human Immunodeficiency Virus
HSMR	Hospital Standardised Mortality Ratio
ICB	Integrated Care Board
ICS	Integrated Care System
IDQ	Improving Data Quality
IPC	Infection Prevention and Control
IR(ME)R	Ionising Radiation (Medical Exposure) Regulations
LeDeR	Learning Disabilities Mortality Review
LPS	Liberty Protection Safeguards
MaST	Mandatory and Statutory Training
MCA	Mental Capacity Act 2005
MDT	Multi Disciplinary Team
MRSA	Methicillin-Resistant Staphylococcus Aureus
MSDS	Maternity Services Data Set
NABCOP	National Audit of Breast Cancer in Older People
NACAP	National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme

NCAP	National Cardiac Audit Programme
NEWS	National Early Warning Score
NHS	National Health Service
NHSE	NHS England
NHSI	NHS Improvement
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
NRLS	National Reporting and Learning System
O&G	Obstetrics and Gynaecology
OMFS	Oral and Maxillofacial Surgery
PACU	Post Anaesthesia Care Unit
PET+	Patient Experience Toolkit
PIR	Post Infection Review
PLACE	Patient-led Assessment of the Care Environment
PROMs	Patient Reported Outcome Measures
PSIRF	Patient Safety Incident Response Framework
QI	Quality Improvement
QIP	Quality Improvement Programme
QR	Quick Response
QSIR	Quality, Service Improvement and Redesign
RCA	Root Cause Analysis
RPA	Radiation Protection Advisor
RTT	Referral to Treatment
Shh	Sleep Helps Healing
SHMI	Summary Hospital level Mortality Indicator
SHO	Senior House Officer
SJR	Structured Judgement Review
SOP	Standard Operating Procedure
SQAS	Safety & Quality Assessment for Sustainability
SQL	Structured Query Language
SUS	Secondary Uses Service
TMG	Trust Mortality Group
TRFT	The Rotherham NHS Foundation Trust
UECC	Urgent and Emergency Care Centre
UKAS	United Kingdom Accreditation Service
VTE	Venous Thromboembolism
WHO	World Health Organisation
YTD	Year To Date

Glossary – to be finalised once Quality Account finished

Acute Services	Include treatment for a severe injury, period of illness, urgent medical condition, or to recover from surgery. In the NHS, it often includes services such as accident and emergency (A&E) departments, inpatient and outpatient medicine and surgery.
AMaT	Audit Management and Tracking (AMaT) was created with NHS clinical audit teams to give more control over audit activity and provide real-time insight and reporting for clinicians, wards, audit departments and healthcare Trusts.
Care Quality Commission	The independent regulator of all health and social care services in England
CHA2DS2-VASc	CHA2DS2-VASc score, are clinical prediction rules for estimating the risk of stroke in people with non-rheumatic atrial fibrillation
Clinical Coding	The translation of medical terminology as written by the clinician to describe a patient's complaint, problem, diagnosis, treatment or reason for seeking medical attention, into a coded format which is nationally and internationally recognised.
Commissioning for Quality and Innovation (CQUIN)	A payment framework where commissioners reward excellence, by linking a proportion of income to the achievement of agreed quality improvement goals.
Data Quality Maturity Index	A monthly publication about data quality in the NHS
Datix	incident reporting and risk management software
Data Security and Protection Toolkit	An online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's 10 data security standards
Duty of Candour	A statutory (legal) duty to be open and honest with patients (or 'service users'), or their families, when something goes wrong that appears to have caused or could lead to significant harm in the future.
Employee Assistance Programme	An Employee Assistance Programme provides around-the-clock mental health support to your workforce and their immediate family.
Friends and Family Test	A feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.
Healthcare Associated Infection	Infections people get while they are receiving health care for another condition.
Hospital Episode Statistics	A database containing details of all admissions, A&E attendances and outpatient appointments at NHS hospitals in England.
Hospital Standardised Mortality Ratio	Broad system-level measure comparing observed to expected deaths
ICE	The system allows you to see pathology and radiology results held by the hospital, including ones not requested, and means the laboratory team can see all the information it needs. ICE also keeps an electronic record in a patient's notes so that there is full accountability.

Integrated Care Board	NHS organisations responsible for planning health services for their local population. There is one ICB in each ICS area. They manage the NHS budget and work with local providers of NHS services, such as hospitals and GP practices, to agree a joint five-year plan which says how the NHS will contribute to the ICP's integrated care strategy
Meditech	MEDITECH is an on-premise electronic health record system that enables healthcare providers to access patient records, communicate with patients virtually, enable pre-registration and perform administrative tasks
NHS Digital	NHS Digital is the trading name of the Health and Social Care Information Centre, which is the national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care in England, particularly those involved with the National Health Service of England.
Never Event	Defined by the Department of Health as a very serious, largely preventable, patient safety incident that should not occur if appropriate preventative measures have been put in place.
ORBIT	The ORBIT Score estimates the risk of major bleeding for patients on anticoagulation for atrial fibrillation.
Patient Reported Outcome Measures	Questionnaires measuring the patients' views of their health status
Power BI	Power BI is an interactive data visualization software product developed by Microsoft with a primary focus on business intelligence. It is part of the Microsoft Power Platform.
Quality Account	A report about the quality of services offered by an NHS healthcare provider.
Secondary Uses Service	A collection of health care data required by hospitals and used for planning health care, supporting payments, commissioning policy development and research.
SEPIA	A viewing tool which allows health care professionals to see an integrated patient record
Structured Judgement Review	Usually undertaken by an individual reviewing a patient's death and mainly comprises two specific aspects: explicit judgement comments being made about the care quality and care quality scores being applied. These aspects are applied to both specific phases of care and to the overall care received.
Summary Hospital-level Mortality Indicator	The ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there
SystmOne	Clinical Software System
Tendable	Tendable is a smart inspection app that replaces the manual pen and paper audit/inspections used to assess and improve quality across clinical areas.
UK Health Security Agency	The UK Health Security Agency is a government agency in the United Kingdom, responsible since April 2021 for England-wide public health protection and infectious disease capability, and replacing Public Health England. It is an executive agency of the Department of Health and Social Care.

UNICEF	UNICEF, originally called the United Nations International Children's Emergency Fund in full, now officially United Nations Children's Fund, is an agency of the United Nations responsible for providing humanitarian and developmental aid to children worldwide.

COUNCIL OF GOVERNORS MEETING: 15 May 2024

Agenda item: **COG/31/24**

Report: **Governance Report – Governor Elections 2024**

Presented by: **Alan Wolfe, Deputy Director of Corporate Affairs**
Author(s): **Alan Wolfe, Deputy Director of Corporate Affairs**

Action required: **For information**

1.0 Introduction

1.1 Governor Elections (Public and Staff) are currently in progress.

1.2 There are two Staff Governor seats open to election, which are currently vacant.

1.3 There are eight Public Governor seats open to election, seven of which are currently vacant, one which is currently held by Gavin Rimmer the Lead Governor.

1.4 The elections for the Council of Governors commenced on Tuesday 26th March, with a nominations deadline of Friday 12th April. The close of elections will be Thursday 23rd May.

2.0 Public Governor Vacancies

2.1 For Public Governors, the Trust received 4 nominations for Rotherham, and 1 nomination for the Rest of England.

2.2 These were uncontested and are elected as Public Governors. The new Governors will be announced at the Annual Members Meeting once the Trust is out of the election process.

3.0 Staff Governor Vacancies

3.1 For Staff Governors, the Trust received 4 nominations for 2 vacancies.

3.2 A notice of poll was published and a secret ballot has commenced with voting closing on Thursday 23rd May.

4.0 Recommendation

4.1 It is recommended that the Council note the information in this report and encourage all staff who are members to engage in the elections and vote for their chosen candidates.

Alan Wolfe
Deputy Director of Corporate Affairs
May 2024

COUNCIL OF GOVERNORS MEETING: 15 May 2024

Agenda item: **33/24**

Report: **Chairs Update from Governors Membership Engagement Group (GME)**

Author and Presented by: Gavin Rimmer, Lead Governor and Chair of GME

Action required: To note

1.0 The GME met for the first time since 2023 on 19th March 2024 and a schedule for this year's quarterly meetings has been confirmed.

2.0 **Membership Engagement**

2.1 The group received a report on the progress against the Membership Engagement Strategy 2022-2025 objectives. A copy of the position as at the conclusion of year two of the strategy (see comments in blue) are attached in Appendix 1 and includes a list of opportunities for Governor development and member engagement for 2024.

2.2 A key barrier to member engagement falls in the database and limited registration of email addresses. The group discussed options to bolster the membership, particularly in regards to staff members and reintroducing an opt-out framework.

2.3 The group reflected on the further clarity needed for the role of a member and the benefits, to inform promotional material and future engagement.

3.0 Governors Surgery

3.1 The group were informed that Governor engagement in the Governors' Surgery has decreased.

3.2 Options to uplift the initiative, such as re-branding and promotional material were discussed, as well as, ways to share the feedback to members of the public on their comments.

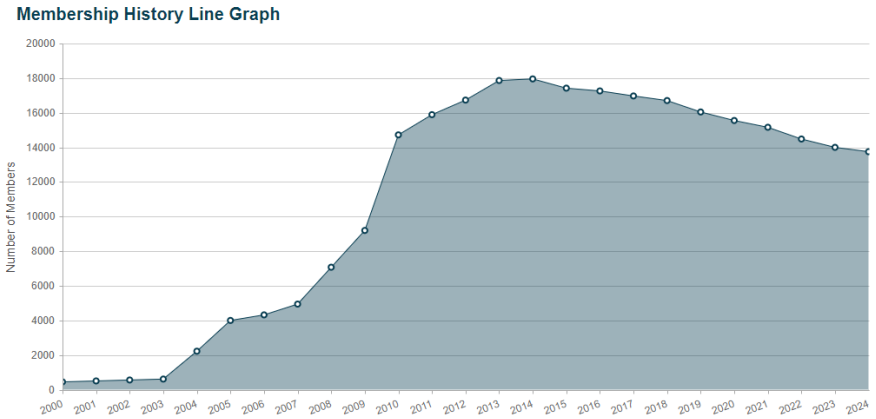
4.0 Recommendation

4.1 It is recommended that the Council note the update from the group.

4.2 It is also recommended that the Council review the group membership on completion of the Governor Elections and induction of the new Governors.

Gavin Rimmer
Lead Governor and Chair of Governors Membership Engagement Group

Objective 1: To build and maintain our membership numbers by actively recruiting and retaining our members.			
Milestone	**Current position**	**Next steps**	**Specific deadline**
a) Maintain an accurate membership database	Public - new applications or requests to be removed from the membership database are processed upon receipt. Public – new (paper format/email) applications are added to the CIVICA database manually and via the new (March 2024) digital sign up form. Requests to be removed from the membership database are processed upon receipt either by TRFT, CIVICA or via the membership portal. Staff – new applications and deletions processed weekly and monthly based upon information received from HR dept. CIVICA automatically audits the data against national databases, for example, the Bereavement Register and Royal Mail Postcode Address File (PAF).	Ongoing requirement Decide on targeted campaigns to Members with a postal address only (no email) to help cleanse the database and digitise to reduce costs and environmental impact.	Ongoing requirement Decisions on budget and campaign content by Sept 2024. Data cleanse post-campaign early 2025
b) **Recruiting and Retaining Members** This will include:			
i. Analysis of current membership to ensure our membership is representative of the diversity of the population that we serve	Current membership data provided routinely to Member Engagement Group 'Engagement Opportunities' report received at the October 2022 meeting contained an analysis of the current membership and identified the populations to be targeted in order to increase membership from these underrepresented groups. Membership engagement activities undertaken in October and November 2022 were aimed at increasing members and governors from these underrepresented populations.	Group to receive data at each meeting (added to forward work plan) to help inform the discussions of Member Engagement Group	Ongoing requirement

		Membership engagement activities undertaken in October and November 2022 do not show any overall increases in membership. There is a year on year decrease in membership since 2014 as can be seen below:  A key issue for recruitment, engagement and retention is the lack of email addresses attached to the member data. Work is in progress with the Information Governance Manager to update the staff data in order to attach email address to existing members that are still employed by the Trust.	A meeting has been scheduled with the Workforce Information Advisor to assist in updating the staff data.	
ii.	Develop recruitment material	New membership leaflets have been developed in the following languages and distributed across the main hospital and main buildings: ➢ Arabic ➢ Urdu ➢ Polish ➢ Slovak	Governors to distribute leaflets to other non NHS locations.	~~2023~~ - Completed

	➢ Chinese The electronic versions are also available on the Trust's website https://www.therotherhamft.nhs.uk/members/ Information about becoming a member has been added to the bottom of letter template to patients. Video of Lead Governor promoting the role of membership and Governor role produced	Applications received as a result to be processed in accordance with milestone a)	
	No reference to Membership in Your Health or on Screensavers.	Work with the Communications Team to develop screensavers, posters, and Governor highlights in Trust publications which include promotion of Membership.	~~April 2024~~ Completed
	Membership sign up form is now digitised and on the Trust website. There is also a members' portal where existing members can update their details.		
	Governor elections and membership are highlighted in February's Team brief and Proud News.	Continue the promotion monthly and develop media for Team Brief slide	March – May 2024

iii.	Plan and undertake targeted recruitment drives at key locations.	Recruitment material continues to form part of any engagement opportunities. Information to be added to the bottom of patient letter template. **COMPLETED** Membership recruitment activities undertaken in October and November 2022 were aimed at increasing members and governors from underrepresented populations within the current membership. No recruitment drives at key locations planned for 2024.	The Group to actively progress a targeted recruitment drive every 6 months. Group to confirm targeted area for recruitment up to June and from June to December 2023 Governor Membership Engagement Group to determine targeted areas for recruitment – staff membership was discussed to be targeted	First targeted recruitment Drive by end of June 2023 - Completed Continue through to 2024 As soon as possible
iv.	Identify initiatives to raise the profile of membership in our local communities	Co-ordinated by Head of Governance suggested locations for Governors to promote membership and role of Governors. Visits held in Q3 to such as Unity Centre and Breathing Space To enable Governors to attend (in pairs) in the future without Trust officers being present Conflict Resolution training provided. Governors requested to inform the Trust of potential community events to which Governors could attend.	The Group / Governors supported by Trust Officers to identify locations to visit to promote membership (linked back to iii).	

		Governors requested to inform the Trust of potential community events to which Governors could attend. Governor Engagement Calendar drafted, including internal patient engagement groups and external community meetings to attend. Governors have been directed to sign up to monthly newsletters from VAR to receive regular updates on events and meetings in the Rotherham community.	The Group / Governors supported by Trust Officers to identify locations to visit to promote membership (linked back to iii). Work with the Patient Engagement and Inclusion Lead to update and inform Governors of Trust meetings/groups. Cooperate Governance Team and Governors work together to develop and add to the calendar on a monthly basis.	Ongoing
v.	Develop a process of identifying and addressing under-representation, working with existing equality and diversity organisations	Group has discussed under presentation in relation to ethnic diversity, gender and age. Report presented to October 2022 meeting identifying underrepresented populations and membership engagement activities in Q3 2022/23 targeted these populations. Ongoing engagement with Rotherham Ethnic Minority Alliance (REMA) to increase the ethnic diversity of Members and the number of Members living in underrepresented constituencies.	The Group to proactively utilise the membership data provided to support delivery of milestones iii and iv.	Ongoing

		Public Governor linking with schools to try to increase number of younger Members. Staff Governor attended World Prematurity Day event in Rotherham on 17 November 2022 to build relationships with parents who already have a strong link with the Trust to try to increase the number of younger Members. Partner Governor from Rotherham Ethic Minority Alliance (REMA) could help to re-establish support to increase the ethnic diversity of Members and the number of Members living in underrepresented constituencies.	Chair to send letter to REMA to initiate appointment of Partner Governor	May/June 2024
vi.	Support Governors to engage with community groups to attract new members	Linked to iv The majority of Public Governors have undertaken Conflict Resolution training and are therefore able to lead engagement events (in pairs) without the support of the Governance Team. Membership leaflets now available in English and the top five languages used in Rotherham. A Governor banner is available for all Governor engagement events to raise the profile of Governors at engagement events. Waiting for feedback from ESR/L&D regarding conflict resolution training for Governors.	Linked to next steps for iii, iv and v Develop timetable for Governors to complete required training	As soon as possible (depending on Governor availability and training dates)
vii.	Develop processes of engaging with	Group has identified younger members as an area to target.	Link to next steps as in iii, iv and v	

younger members by holding specific events that maybe of interest to them.	HR team have indicated that they would facilitate membership leaflets being available at recruitment events Public Governor linking with schools to try to increase number of younger Members. Staff Governor attended World Prematurity Day event in Rotherham on 17 November 2022 to build relationships with parents who already have a strong link with the Trust to try to increase the number of younger Members. Partner Governor from 'Rotherham Partnerships' could be from Rotherham College which could help to engage and develop recruitment of younger members.	Chair to send letter to Rotherham College CEO to initiate appointment of Partner Governor	May/June 2024

Objective 2: To effectively engage and communicate with members			
Milestone	**Current position**	**Next steps**	**Target deadline**
c) Promote the work of the Governors and the Trust	No formal communication directly to members other than Governor Elections through election provider. Limited number of members have provided e-mail addresses despite targeted campaign in 2021. Activities promoted where possible, mostly via social media. Governors participate in the walkrounds with Senior Nurses and NED, thereby promoting the role and increasing their presence to patients and also staff. Website provides opportunities to promote activities of the Trust to the general population. Engagement activities in Q3 2022/23 showcased the work of the Governors to the public. Creation of a Governor banner will increase the profile of Governors at engagement events. Video of Lead Governor promoting the role of membership and Governor role produce. Lead Governor raised awareness of the role of Governors as part of the 2022 Annual Members' Meeting.	Utilise the Website /social media / written media more. Consider feasibility and cost of reintroducing an annual communication to members.	~~2023~~

	No formal communication directly to members other than Governor Elections through election provider (CES).	Utilise CIVICA platform to send out pre-election communications to members with email addresses listed. This will re-introduce the Trust and re-establish connections, prior to the election campaign emails.	~~March 2024~~ Elections now in progress
	Limited number of members have provided e-mail addresses despite targeted campaign in 2021 (approx. 900 out of 10,000)	Work with CIVICA and CES to tie in a 'call to action' for members to add their email address, in the postal communications for the elections.	In progress with upcoming elections
	Website and social media pages provide opportunities to promote activities to the general population but is not used.	Speak to Communications regarding using these platforms more regularly – tie in with b) ii.	Ongoing
	Monthly Governors' Surgery provides opportunity for Governors to meet and chat with visitors and patients.	Rebrand/refresh Governors Surgery	June/July 2024
d) Engage the expertise of the Trust communications department	Officer from the Communications Team attends the Member Engagement Group. Communications Team are involved in developing promotional material for such as Governor elections and Annual Members Meeting. Involved in production of videos for such as the website.	Continue to utilise the skills available through the Communications Team	Ongoing

e) To ensure that the views of the members are heard, understood and acted upon	Governors Surgery re-instated and are currently held monthly. Management have the opportunity to respond and take action. A number of Governors provided training in relation to tendable / friend and family (F&F) processes to provide real time information on which the wards can take action. Take up by Governors has not progressed. Governors Surgery are currently held monthly but attendance from Governors has reduced. Links with b) iv.	Increased participation from Governors to gather meaningful information and feedback from which the Trust can act upon. Through either the Governors Surgery or the F&F test Consider incorporating into recruitment events. Promote actions taken through "You Said, We Did" section of the website Rebrand/refresh of Governors Surgery	Build and increase during 2023 – Ongoing to 2024 June/July 2024
f) To ensure that a wide range of communication media and methods are explored to aid effectiveness.	The Trust currently utilises a wide range of communication media (website /social media / written).	Link to next steps in relation to c)	ongoing
g) **Communicating with Members** – This will include:			
i. Designing a members' specific webpage	Currently there are already a number of members pages on the website. https://www.therotherhamft.nhs.uk/GetInvolved/ Whole Trust website being redesigned.	Review the membership web pages once the redesign of the Trust website has been completed. More content is needed here. More links to	2023 Ongoing

			information, forms, and member's portal.	
ii.	Development of an events calendar hosted by Governors	Events calendar developed during 2022 and presented to both the Group and Council of Governors. Suggested events in the main have come from Trust officers As indicated in b)iv. Governors have been requested to inform the Trust of local events based upon their constituency knowledge to develop the same for 2023.	Governors required to provide their local knowledge to continue the ongoing development of the events calendar. Governors to provide their availability to hold engagement events to enable the planning of such events.	Ongoing
iii.	Utilisation of social media to communicate with members	We currently utilise social media to communicate with the general public who may also be members No recent reference to Members or Governors on social media.	 Link with recruitment material for members/governors.	Ongoing Ongoing
iv.	Work with our Patient Experience Team	The development of the Membership leaflets in other languages was undertaken in conjunction with the Engagement and Inclusion Lead for Patient Experience Working with Patient Engagement and Inclusion Lead to connect Governors with groups/meetings in the Trust.	Patient Experience Team have been invited to provide the training at October 2023 Governors Forum Add dates/events to the calendar when they are finalised.	 Ongoing
h)	**Effectively Engaging with Members –** This will include:			
i.	Promoting the work of the Trust on the website and	The Trust currently actively utilises the website to promote the work of the Trust.	Production of member newsletters will require input	Ongoing

	through member newsletters	The quarterly Trust publication distributed as part of the Rotherham Advertiser is in the process of being reinstated. Governors and Membership will be included in this publication. Your Health publication quarterly – link on the website	from the Governance and Communications Teams. Newsletter could promote the ability to contact the membership office to update details and provide e-mail address. Electronic communication to members would be limited due to low e-mail addresses. Option to utilise the membership database could be explored, which may require allocation of a budget. Send out quarterly Your Health directly to members (with email address only). Send out surveys to members for relative forward planning.	 Ongoing Ongoing
ii.	Facilitate opportunities for the membership to meet the Governors	Through events Calendar Governors Surgery Walk rounds	Engagement calendar requires local knowledge of governors to attend existing community events.	Ongoing

		Annual Members Meeting when return to in person event. Governors attending Public Panel sessions	Trust to be aware of involving and inviting Governors to events. Consideration in due course once believe that have an engaged membership to host Governor specific events.	
iii.	Provide all new members with relevant information about the Trust	No information pertaining to the Trust is provided to new members other than the Public Constituency they are in and where relevant links to the website pages regarding any forthcoming Public Governor elections. Welcome emails are sent out individually due to the small number of applicants.	To define what new members should receive. Where possible information to be sent electronically to reduce postal costs Using CIVICA, filter the data accordingly and email out new members a welcome email.	To implement ASAP Monthly
iv.	Provide opportunities for members to give their views on a range of issues / Identify with the Patient and Public Involvement Team initiatives where members can be a source of feedback on patient and quality issues.	Partially covered by Governor surgery. Public Panels (general public who may also be members) established and facilitated by Patient and Public Involvement Team Wider seeking of views would be limited in terms of electronic communication.	Consideration to be given as to any areas which would benefit from the views of members, which could link back to next steps for h)i. Utilise CIVCA to send out click emails with surveys.	Ongoing

v.	Invite members to engage in patient experience programmes within the Trust	Public Panels are being led by the Engagement and Inclusion Lead	Send invites to members via CIVICA Update the Trust website with dates Set up membership forms/QR codes to scan when attending meetings to sign up as members	Ongoing
vi.	Survey the members for their views	None undertaken as yes	Plan the content for survey. Send out via CIVICA.	TBC – could tie in with AMM

Governors' Engagement Timetable 2024

Please note: 360 Assurance learning events are aimed at Board members, but in the sense that they will be considering topics from a strategic viewpoint and considering what Board members might want to question and challenge in their own organisation, they may also be of interest to Governors too.

Month	Date	Engagement Activity	Facilitator
January	17th	Governor Surgery	
February	6th	The Health Equity Collaborative VCSE Workshop	Voluntary Action Rotherham (VAR) Link here
	21st	Governor Surgery	
	21st	Council of Governors meeting	
	28th	The Rotherham Place Leadership Team: 'What could a good falls and frailty offer look like for Rotherham?'	Voluntary Action Rotherham (VAR) Link Here
March	8th	Board of Directors Public Meeting	
	5th	Maternity and Neonatal Voices Partnership (MNVP) meeting	Woodside, 11- 1pm ellie@prettywords.co.uk
	11th	'Hearing the Patient Voice' learning event (Virtual)	360 Assurance Link here
	12th	Governor Nomination Committee	
	19th	Governor Member Engagement Group	
	20th	Governor Surgery	
	27th	Governor Nomination Committee	
April	17th	Governor Forum	
	17th	Governor Surgery	
May	3rd	Board of Directors Public Meeting	

	13th	Mental Health Awareness Week 13-19th webinars (including TRFT Introduction to Talking Therapies)	Voluntary Action Rotherham (VAR) Link Here
	15th	Governor Surgery	
	15th	Council of Governors meeting	
June	4th	Governor Nomination Committee	
	13th	'Hearing the Staff Voice' learning event (virtual)	360 Assurance Link here
	13th	Healthwatch Rotherham event – 'We're back at The Learning Community!'	88-90 Laughton Road, S25 2PS, 11-1pm. Link here
	14th	TRFT Proud Awards	Communications, TRFT
	18th	Governor Membership Engagement Group	
	19th	Governor Surgery	
July	5th	Board of Directors Public Meeting	
	9th	Governor Focus conference (Virtual)	NHS Providers Link here
	11th	Cancer Services – Head and Neck Launch Day	Fitzwilliam Hotel at 11am Rachel Holehouse r.holehouse@nhs.net
	17th	Governor Forum	
	17th	Governor Surgery	
August	21st	Governor Surgery	
	21st	Council of Governors meeting	
September	3rd	Governor Nominations Committee	
	6th	Board of Directors Public Meeting	

	12th	'Financial Planning at System Level' learning event (virtual)	360 Assurance Link here
	17th	Governor Membership Engagement Group	
	18th	Governor Surgery	
	19th	Annual Members' Meeting	
October	16th	Governor Surgery	
	16th	Governor Forum	
November	8th	Board of Directors Public Meeting	
	20th	Governor Surgery	
	20th	Council of Governors meeting	
December	3rd	Governor Nomination Committee	
	10th	'Governance and Risk Management' learning event (virtual)	360 Assurance Link here
	17th	Governor Membership Engagement Group	
	18th	Governor Surgery	

Calendar of Business for Council of Governors 2024

REPORT - ORDER		2024			
		Feb	May	Aug	Nov
		21	15	21	20
Procedural items					
Welcome and announcements	Chair	/	/	/	/
Apologies and quoracy check	Chair	/	/	/	/
Declaration of Interest	Chair	/	/	/	/
Minutes of the previous meeting	Chair	/	/	/	/
Matters arising and action log	Chair	/	/	/	/
Chairman's report	Chair	/	/	/	/
Report from the Non-Executive Chairs of Board Committees					
Report from Audit Committee	NED Chair	/	/	/	/
Report from Finance and Performance Committee (inc. Finance Report)	NED Chair	/	/	/	/
Report from Quality Committee	NED Chair	/	/	/	/
Report from People Committee	NED Chair	/	/	/	/
Report from Charitable Funds Committee	CFC Chair	/	/	/	/
Integrated Performance Report (for information)	Man. Dir.	/	/	/	/
Progress Report (for information)	Man. Dir.	/	/	/	/
Organisational Priorities 2024/25	CEO		/		
Five Year Strategy Update (every 6 months)	CEO		/		/
Quality Priorities	CN	/			
Quality Account	CN		/	/	
Annual Report (through Annual Members Meeting)	DoCA			/	
Annual Accounts (through Annual Members Meeting)	DoF			/	
Financial Plan	DoF			/	
Governor Regulatory and Statutory Requirements					
Governance Report	DoCA	/	/	/	/
Constitution – formal review Last review October 2018	DoCA			/	
Constitution – Partner Governors	DoCA			/	
Governors Standing Orders (linked to Constitution review) To be reviewed every 3 years as a minimum or in conjunction with any changes to Constitution. Last review October 2018	DoCA			/	
Appointment of Vice Chair (as needed)	DoCA				
Appointment of Senior Independent Director (as needed)	DoCA				
Appointment / Reappointment of NED's (as needed)	NomComm				
Appointment/Reappointment of Chair (as needed)	NomComm				
Outcome of Chair and NED Appraisals	NomComm			/	
External Auditors (contract renewal) Contract with Mazars LLP effective from 2024 for 3 years	DoCA				

Key:

CoCA (Director of Corporate Affairs)
DoF (Director of Finance)
NomComm (Nominations Committee)
MD (Medical Director)
CEO (Chief Executive)
CN (Chief Nurse)
NED (Non-Executive Director)

Calendar of Business for Council of Governors 2024

External Auditors Engagement report to CoG following closure of annual audit	DoCA				/
Lead Governor Appointment	DoCA		/		
Deputy Lead Governor Appointment	DoCA		/		
Governor Elections (part of Governance Report or Member Engagement Group Report)	DoCA	/	/	/	/
Council of Governors Annual Review of Effectiveness	DoCA			/	
Governor Engagement Strategy (current Strategy 2021-2023)	DoCA				
Member Engagement Strategy (current Strategy 2022 -2025)	DoCA				
Sub Groups of the Council of Governors					
Member Engagement Group Report/Chairs Log	Group Chair	/	/	/	/
Member Engagement Group Terms of Reference	Group Chair			/	
Audit & Risk Committee Terms of Reference Annual Review	Chair				/

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Calendar of Business for Council of Governors 2024

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REPORT - ORDER		2024			
		Feb	May	Aug	Nov
		21	15	21	20
Procedural items					
Nomination Committee Report (if held)	Chair	/	/	/	/
Nomination Committee Approved Minutes (if held)	Chair	/	/	/	/
Nomination Committee Terms of Reference	Chair				/

Key:

CoCA (Director of Corporate Affairs)
DoF (Director of Finance)
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MD (Medical Director)
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