Board of Directors (Public)

The Rotherham NHS Foundation Trust

Schedule	Friday 5 July 2024, 9:00 AM — 12:00 PM BST
Venue	Boardroom, Level D
Organiser	Angela Wendzicha

Agenda

9:00 AM	PROCEDURAL ITEMS	
	P95/24.	Chairman's welcome and apologies for absence For Information
	P96/24.	Quoracy Check For Assurance
	P97/24.	Declaration of interest For Assurance
	P98/24.	Minutes of the previous meeting held on 3rd May 2024 For Approval
	P99/24.	Matters arising from the previous minutes (not covered elsewhere in the agenda) For Assurance
	P100/24.	Action Log For Decision
9:05 AM	OVERVIEW AND CONTEXT	

	P101/24.	Board Committees Chairs Reports - Committee Chairs i. Quality Committee - Chair's Log - Julia Burrows ii. People & Culture Committee - Chair's Log - Rumit Shah iii. Finance & Performance Committee - Chair's Log - Martin Temple For Information
	P102/24.	Board Assurance Framework For Decision - Presented by Angela Wendzicha
	P103/24.	Corporate Risk Register Report For Information - Presented by Angela Wendzicha
	P104/24.	Report from the Chairman - Verbal For Information
	P105/24.	Report from the Chief Executive For Information
9:50 AM	CULTURE	
	P106/24.	Patient Story For Information - Presented by Helen Dobson
	P107/24.	Patient Experience Annual Report For Noting - Presented by Helen Dobson
	P108/24.	End of Life Care Annual Report For Noting - Presented by Helen Dobson
10:20 AM	BREAK	
10:25 AM	SYSTEM WORKING	

	P109/24.	National, Integrated Care Board and Rotherham Place Update For Information - Presented by Michael Wright
10:35 AM	PERFORMANCE	
	P110/24.	Finance Report For Assurance - Presented by Steve Hackett
	P111/24.	Integrated Performance Report For Assurance - Presented by Michael Wright
10:55 AM	ASSURANCE	
	P112/24.	Maternity and Neonatal Safety Report For Assurance - Presented by Helen Dobson
	P113/24.	Safe Staffing and Establishment Review For Decision - Presented by Helen Dobson
	P114/24.	Learning from Deaths Report For Assurance - Presented by Jo Beahan
	P115/24.	Organ and Tissue Donation Committee Annual Report For Information - Presented by Heather Craven
	P116/24.	Emergency Preparedness, Resilience and Response (EPRR) Annual Report For Assurance - Presented by Sally Kilgariff
11:45 AM	BOARD GOVERNANCE	
	P117/24.	Register of Seal Report For Assurance - Presented by Angela Wendzicha

P118/24. Annual Work Plan 2024-25
For Information

P119/24. Any Other Business
For Discussion

P120/24. Questions from Members of the Public on the Business of the Meeting
For Discussion

P121/24. Date of next meeting - 8th September 2024

CLOSE OF MEETING

Draft until approved at the 05 July 2024 meeting

The Rotherham NHS Foundation Trust

MINUTES OF THE BOARD OF DIRECTORS MEETING
Friday 03 May 2024, 09:00 – 12:30 pm
Boardroom

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

In attendance:
Mrs L Tuckett, Director of Strategy Planning and Performance
Ms A Wendzicha, Director of Corporate Affairs
Mrs J Roberts, Director of Operations/Deputy COO
Mrs E Parkes, Director of Communications
Mr J Rawlinson, Director of Health Informatics
Mr Alan Wolfe, Deputy Director of Corporate Affairs (minutes)
Ms S Petty, Head of Midwifery - for item P80/24
Dr G Lynch, Guardian for Safe Working - for item P88/24

Observers:
Laura Brookshaw, 360 Assurance
Lewis Swann, 360 Assurance
Ifechukwude Ogbolu, Governor
Andrew Ball, Governor
Rotherham Advertiser
Raj Purewal (C2-Ai.com – Healthcare Analytics company)
Patrick Hunter (Sodexo – Catering & Facilities company)

Apologies:
Dr R Shah, Non-Executive Director
Mrs L Martin, Director of Estates and Facilities

Item	Procedural Items	Action
P61/24	**CHAIRMAN'S WELCOME & APOLOGIES FOR ABSENCE**	
P62/24	**QUORACY CHECK**	

	The meeting was confirmed to be quorate.	
P63/24	**DECLARATIONS OF INTEREST** Dr Jenkins' interest in terms of his joint role as Chief Executive of both the Trust and Barnsley Hospital NHS Foundation Trust was noted. Ms Wendzicha's interest in terms of her role as Director of Corporate Affairs of the Trust and Director of Corporate Affairs at Barnsley Hospital NHS Foundation Trust was noted. Mrs Parkes' interest in terms of her role as Director of Communications of both the Trust and Barnsley Hospital NHS Foundation Trust was noted.	
P64/24	**MINUTES OF PREVIOUS MEETING** The minutes were approved subject to minor amendments.	
P65/24	**MATTERS ARISING** There were no matters arising which were not covered by either the action log or agenda items.	
P66/24	**ACTION LOG** The action log - agreed that all open actions to be closed.	
	CULTURE	
P67/24	**Staff Story** Daniel Hartley introduced the Staff Story which looked at the development of clinical colleagues into senior management roles spread across a number of specialities and divisions. Hannah, an Advanced Clinical Practitioner in A&E had expressed an interest in leadership and she started a Quality Improvement project collaboration to expedite the CT scan process and reduce waiting times. This resulted in new guidance for patients who could go to CT without escort as well as the introduction of wristband identification for porters guidance, this resulted in reduced waiting times. Hannah believed that the course had given her increased confidence and the chance to network with colleagues from other departments which could lead to increased improvements in the future. The next member of staff was Ghulam, a Paramedic who wanted to introduce a system for allowing medications to be given when the Pharmacy was closed. He had found the course to be very positive, the new process had worked well, he was pleasantly surprised by the number of people who wants to make things work, the course has he feels actually changed him personally and his family have noticed that he now listens to them. Rachel, a matron, had developed a project mobilization of service contract using system1 to improve support for families, she reported a number of good ideas after getting staff on board during engagement	

	sessions and implementation is due to start in June 2024. Rachel found the experience exciting and one that has allowed her to communicate better. The NEDs felt that it was important for staff to be given a safe space in which to propose ideas for quality improvement and to facilitate such staff coming together in future in order to continue the good work and expand into other spaces not involved previously.	
	OVERVIEW AND CONTEXT	
P68/24	**Report from the Chairman** Mr Richmond informed the Board that as this was the first board following the end of the financial year he believed it was timely that the Board reflected and gave compliments for the good work undertaken in the previous year. He declared that the role of the NEDs was not the last line of management but the first line of scrutiny and that the work of the executive team should be acknowledged and congratulated. The Trust finances had played a significant part of the bigger picture as it was important that once the Trust had set out a planned deficit as an organisation it should do its best to deliver over and above. So far it had been a job well done, with CIP delivering a good 3-3.5% over a couple of years. He cautioned that the Trust shouldn't let best get in the way of getting better, an example being reflected in a good staff survey with an upper quartile position from a historically poor starting point, to the second most improved Trust reported in the HSJ and this trajectory is to be truly celebrated. The lifting of the CQC black cloud he felt had allowed staff to be proactive in their thinking, freeing them up to be as good as we want to be. The HSMR data reduction that's occurred is exceptional, with mortality rates lower than expected a real achievement as well as being the lowest in the North West and Yorkshire. There had also been a significant improvement in staffing recruitment and retention, a total of 130 staff trained in QI methodology, the new People & Culture Strategy is a major hook to put our hat on and a development the Trust should be proud of. In spite of the brunt of 15% of days lost due to industrial action the Trust had managed to achieve a reduction in the 4 hour breaches by over 1100 patients in the last 12 months, the successful delivery of the constitutional standards of diagnostics, reduced long waiters and improved cancer targets, the Trust had strengthened its governance and the approach to risk management. Mr Richmond believed that the Strategy refresh was not a rewrite, but a starting point and the destination stays the same, the Trust was resetting the sails to reflect external background pressures and making sure the Strategy remained fit for purpose whilst including the pursuit of excellence through improvement. Mr Richmond thanked the Executive team on behalf of the Board.	
P69/24	**Report from the Chief Executive**	

	Dr Jenkins informed the Board members that he had been in London the previous week at the NHS leadership conference. It was a year-end review with the finding that the NHS as a whole had not made a lot of progress in regards recovery from the period of the epidemic, however there had been major progress in delivery at this Trust with it being the only Trust to achieve its diagnostic targets. Dr Jenkins announced that the Trust is the first trust in Yorkshire and the Humber to engage in the use of ROSA, an orthopaedic robot to assist the orthopaedic surgeons during surgery. Mr Richmond felt it would good for the Board to hear an after action review report including how the investment has worked out and Dr Jenkins proposed that it could be included within a Patient Story with the Lead Orthopaedic Surgeon attending Board along with a patient. The Board were informed that the Trust were looking at robots for other clinical areas. He also thanked Mrs Tuckett on what would be her last board adding that she had been a great colleague and congratulated Mrs Dobson for her nomination for the Queens Nursing Award.	
P70/24	**<u>Board Committees Chairs Reports</u>** i. Quality Committee Ms Burrows wished to highlight a few items, the first being the late presentation of the quality priorities which did constrain full discussion, as well as the limited scope around the diabetes priority. There was also the issue of the Divisional presentations which required improved preparation from the Divisions in order for the Committee to get more out of them, a template and discussions with Divisional management are in progress. The Committee also noted the comprehensive risk register, however there was the sense that some actions were stalling and they were not seeing real progress. The risk related to delay in 18 week waits for gynaecology was an example with only short term fixes being put forward when the Committee wanted to see more long term thinking. Ms Burrows also brought up a point regarding risks that spanned multiple Care Groups and how these risk subjects such as cardiology related risks were picked up centrally with Executive oversight. Ms Wendzicha recognised in terms of where we are with corporate risk register and was working with the Corporate Affairs team to get appropriate action plans in place. The next step is the ‘so what’, as it is clear that whilst risk owners are advising that some actions are complete the risk rating remains the same. These discussions with the Care Groups, Risk Management Committee, Audit & Risk Committee and the ETM are ongoing. Mr Malik confirmed that this was part of the maturity cycle of risk management within the Trust and the improvement in the past two and a half years to this date is clear. He gave the examples of now having details of Emerging Risks, an Issues Register and from a 2023 figure of 45% of risks having action plans to now where it is 95% compliance. He also	

agreed that if the risk owner has added the relevant actions to the system and they are complete then the risk rating must be reduced, if not then the question should be are they the correct actions.

Dr Jenkins felt that something more was required with the risks that had been a long time open and he would take to ETM for discussions on how to tackle this issue. There was also an update on the gynaecology waiting times risk in terms of actions being taken and the Executive leads involved, Mrs Craven applauded this, however pointed out that that information had not been entered into the risk database as per policy and as such was unavailable to the Committee for information, information that could have provided much more assurance on the day.

ii. People & Culture Committee

Mrs Watson announced that the Trust had a pastoral care quality award for international nurses starting into the Trust which was a combination of personal and professional support, however there was to be a change in the model with not as many international nurses being recruited going forward. Mr Hartley went through People and Culture Strategy, the NEDs felt that this was a good example of how to bring staff through the process of creating a strategy with a large amount of staff contributions into the end result. The organisational priorities and focus for 2024/25 will be around staff turnover, Health and Wellbeing support, with a reported positive impact on staff who have used the and job planning progress

Mr Temple noting the oversees nurses initiative being ceased wondered if this would lead to a shortage, Mrs Dobson confirmed that the training of home grown degree course nurses was now not a popular option following bursary withdrawal 5 years ago. There had been an initial decline with an uplift following the pandemic and an increase in numbers this year, however there will be steady decline from 2025 onwards. The Trust awaits additional funding for apprentices also. Mr Richmond asked for an update position to be brought back to Board in autumn 2024 including details of the potential shortfall in 18 months, Dr Beahan confirmed that this would be included within the Safe Staffing paper brought twice a year.

Mrs Craven commented on the position of the job planning which she recalled as previously being in poor state with staff often doing previous years job plans in the current year, she felt that the improvement was to a commendable situation and congratulated Dr Beahan.

iii. Finance & Performance Committee

Mr Temple presented a reflection of previous year, the UECC presentation clearly showed the sheer scale of the challenge they have faced and the massive response they have provided. There has also been an increase in patients in UECC presenting with mental health conditions which is disproportionate to service. He summarised that it was a rewarding and at the same time a worrying presentation. The presentation from Medicine included a full discussion regarding their impending coming together with

	the UECC as one combined Care Group, the team being very enthusiastic on the new joint approach to working. Mr Temple had posed the question to those present at the May committee of what had the members learnt in last year, he felt there were some rich views, with colleagues referring a lot to what they didn't do, possibly as a result of the 33 days lost to industrial action. There as though still the delivery against all of the business activities planned, however the financial plan for 2024/25 was very challenging with change to policies and incomplete information, the Finance Team doing very well to submit the plan on time. Mr Richmond also added with regards to the financial plan that the ICB were coordinating all trusts to an aggregated financial plan for 2024/25, which will be a challenge with most trusts in a deficit position, however internally we need to remain focused on our plan to get back to balance in the next few years.	
	STRATEGY AND PLANNING	
P71/24	**Five Year Strategy Refresh** Mr Wright introduced the paper, highlighting that whilst this was a new journey together it should incorporate the existing Strategy for years 2022-2027. It was agreed that while there had been a number of challenges the original Strategy still stood as a good document. It was agreed that certain elements required more traction, such as value and ambition, as did service delivery alongside the strap line of in pursuit of excellence. The paper includes a lot of ideas, however there was a need to take it away in order to add those elements mentioned and bring back in a few months. There was broad endorsement of the document pending an updated version being brought back to the July 2024 Board.	***MW***
P72/24	**People and Culture Strategy** The paper and Strategy were introduced by Mr Hartley who highlighted a number of aspects of the Strategy's development, the discussions held at the People & Culture Committee on how to improve engagement, this included the use of team meetings, videos, inclusion of a diverse group of staff and the various established networks. He explained that this had been an evolving iterative process involving positive discussions at the P&CC and also the Finance & Performance Committee and the Quality Committee. The Strategy itself Mr Hartley said honours the work undertaken over recent years and as such represents both continuity as well as an element of change. It is based on three themes, how the Trust retain and recruit staff, also a Trust priority, how it develops and leads inclusively across the whole Trust, and how it creates high levels of engagement and improvement in order to have positive outcomes for staff and patients. The Strategy sets out a really clear method of delivery and architecture for this. There will be six monthly updates presented to the P&CC who will monitor the actions, interventions and measures taken as part of the Strategy.	

	The NEDs were in agreement that the Strategy was a good example of how such a document should be developed, involved multiple stakeholders at a variety of meetings to increase engagement and inclusivity. They felt that it was a great piece of work that the Trust should be proud of, especially so as it was already landing well with the operational teams. Mr Richmond felt that it was important now to convert the Strategy into action that would improve the health of the population of Rotherham, the Trust and its staff need to be advocates of good health with the Trust reaching out into the wider population of Rotherham. The Strategy was approved.	
P73/24	**<u>Fire Safety Strategy</u>** Mr Hackett introduced the paper in Mrs Martin's absence that she had authored along with the Trust Fire Safety Advisor. This was not a new paper with it already being in place and it was a review and builds on the latest guidance. The paper had been through the Health & Safety Committee and does not sit in isolation as it is tied in with numerous risk assessments conducted on all areas and wards. Mrs Craven requested clarity as to whether the paper was a strategy, a review or a policy, she did not believe that it was clear and work was required before it could be approved, including the confusion as to whether the paper covered all Trust sites or only the Moorgate site. Mr Richmond agreed that further clarity was required so the item should be carried forward in terms of a decision and seeking clarity on whether it is an overarching document for whole Trust and all sites. Deferred approval pending additional clarity.	***LM***
P74/24	**<u>Organisational Priorities 2023/24 - End of Year Report</u>** Mr Wright presented the paper which was for Board approval. He highlighted that there were 6 priorities which had all been presented to the three Assurance Committees. There were 30 key milestones against the priorities, 24 had delivered in full, 2 were 'amber' and slightly off track with the remaining 4 which were 'red' and significantly off track. With regards to the national 4 hour standard Dr Jenkins can't say that some breaches are allowable, the mind-set should be that they are only justifiable when the safety of a patient is compromised. Mrs Kilgariff and Dr Jenkins both stated that there was a culture to change across the organisation also, this had been backed up by the earlier staff story from Hannah who reported issues may seem like small things but these are complex things to change due to the embedded ways of working. In the 48 months before adopting the standard the Trust achieved a level of 95% in only one month and there was cultural shift work required at the granular level as the issue was not confined to the UECC but the areas that the patients flow out to.	

	There were a lot of areas that have to be aligned at once and that's challenging but have made progress with fewer patients now breaching; but this needs to be done from a quality point of view as well as evidence from studies show that waits over 6 hours lead to higher mortality rates. The feeling was that this is achievable with the Trust achieving 80% in late summer early autumn 2023 against the 95% constitutional standard. Mr Richmond reiterated that the Trust should not be comfortable with any breaches and it was not a UECC issue but an organisational challenge to create capacity by earlier discharge and moving patients through the system. He declared an intention to focus on this as an organisation and as a Board, who need to raise a rallying call for the whole of the organisation for ongoing improvement. Mr Richmond requested further assurance and requested that a review of the position paper be brought back in September 2024.	
P75/24	**<u>Organisational Priorities 2024/25</u>** Mrs Tuckett introduced the paper, one she admitted the Board had already seen in various iterations previously, this time it was presented for approval. She added that Mrs Kilgariff and Dr Jenkins had presented it to senior leaders the previous week where there had been some minor amendments made. One was in the Operational Delivery section, Objective 2 required a slight wording change to include the wording 'long waiting patients' and also on the Operational Delivery page where cancer and endoscopy are connected but will be separated out. Mrs Watson pointed out that at the Finance & Performance Committee there had been a discussion regarding the need to have the EPR Transition as a separate segment due to its importance, Mrs Tuckett agreed to work up an additional page with more information around EPR. Mrs Craven stated that she liked being able to see all of the information on one page, however everything should be measureable and highlighted the use in the document of 'significant' in terms of an aim, but what does 'significant' mean. Likewise there was the use of the aim to 'focus' on EPR transition and what does that mean. Mrs Tuckett understood Mrs Craven's point, adding that this was most specific the Trust had ever been but there was a need to wait until full metrics are published so this is a work in progress and will come to FPC for monitoring and approval. The Trust has an ambitious mind-set and as such is trying to go beyond national targets and ambitions. With regards to the EPR it was agreed that further groundwork was still required, and a lot of this was external, thus preventing us being too directional at this point. Dr Jenkins believed that the Board needs to be clear this year about what the EPR plan should be, with the options that as a Trust procurement is sought on own or as a joint piece of work with external organisations around South Yorkshire. Mr Rawlinson said that a draft paper was in place with caveats. Dr Jenkins reiterated the need to be clear for Rotherham and that by the by end of the year the Board should be clear where were going	

	for the Trust EPR and it was deliverable this year to confirm course of action for the Trust. With regards to productivity it was felt that by using the basket of metrics for identifying gaps for each trust and South Yorkshire compared to the national benchmark position it would trigger a collaborative approach regionally. Mr Malik queried what the space in middle of the main visual poster was for and whether there should there be something in there, Mrs Tuckett advised that the finished document would will not look like this with the Communications Team still to work on the graphics. There was a NED query regarding the Financial Sustainability priority in the paper and the Trust's previous position regards PLICs/Costing system which it had not been good at previously. The NEDs were informed by Mr Hackett that in terms of what the Trust will do differently this time round it has employed to new posts, he described it as a small team in a smallish organisation but the Trust has managed to secure some good staff to progress financial benchmarking. Mr Richmond drew attention to the instances of generic types of improvement and that these needed tightening up with specifics, he felt that there was a need to finesse the document somewhat before this it was the final product. As the Communications Team were also to be involved there was a request to finesse what some of the achievements are anticipated to be. The document was approved pending the agreed amendments.	***MW***
	SYSTEM WORKING	
P76/24	**National, Integrated Care Board and Rotherham Place Update** Mr Wright wanted to call out a couple of points from the paper, he applauded the tangible differences being made with continued good work across the Rotherham Place regarding drugs and substance abuse and also the positive impact on breast feeding data. Work continues with South Yorkshire Police, in one instance resulting in a custodial sentence being given to offender following abuse of a staff member. Mrs Craven acknowledged the change of tone of the paper but would like to see some more measurement of the element of the 'so what' of the different collaborations and work undertaken. Mr Wright highlighted that a lot of this information is contained within the BAF report which highlights the partnership work, the impact of any actions and influence of what we are doing.	
P77/24	**Partnership Working - Joint Strategic Partnership Update** Mr Wright reported that the work was in train and gaining more traction, Mrs Tuckett had done a great job driving it over last few months and Mr Ben Grey would be taking over the work. Mrs Craven felt that sustainability reviews would be helpful for the Board to see, especially with some services who were fragile in past, Mrs Tuckett confirmed that the Acute	

	Federation were looking at this across South Yorkshire and Sheffield were being looked at first. Mr Richmond believed in the potential the Trust can gain from collaboration seeing the 'art of the possible' when opportunities that may arise that are mutually beneficial to both Barnsley and Rotherham. Mr Richmond and Dr Jenkins in terms of collaboration had held discussions with the Chair of Barnsley Trust and are planning to hold a Board to board meeting to include the concept of the 'art of the possible', with various work streams to be developed as the meeting outcome, the intention is for this to take place in the next few months.	
	CULTURE	
P78/24	**Freedom to Speak Up Guardian Quarter 3 & 4 Report** Mrs Dobson presented the paper which summarized activity for quarters 3 and 4 of the last financial year and that there had been very few concerns raised. She reported that the lack of concerns being raised was not currently an issue as the staff survey had shown a good understanding of staff on how to raise a concern and via the Guardian is not the only way to raise such concerns. She did however point out that there were still some areas of trust needs further review where levels of engagement were not at expected levels and work was being undertaken on these areas. Mrs Dobson added that the previous Guardian had now stepped down and the newly appointed Guardian was already involved in a number of groups and the community. There was also the release of the People and Culture Strategy which includes reference to the Freedom to Speak up work, as well as the use of videos as part of the Strategy which should help generate awareness, in regards to triangulation and its importance. It was confirmed that triangulation of data had been included as part of the scope of the job role.	
	ASSURANCE	
P79/24	**Integrated Performance Report** The paper was introduced by Mr Wright, as its details had featured heavily already in a number of other agenda items so Mr Wright requested questions or comments. Mrs Craven confirmed that whilst the paper goes to the Finance & Performance Committee for assurance she wondered where was the triangulation for issues such as UECC which is seeing increased patient numbers whilst activity remains stable on limited financial resource. Mrs Kilgariff informed the Board that the FPC planned to hold a workshop style review of the operational metrics, with focus on operational delivery, a paper including details on productivity would be brought back to Board in due course.	
P80/24	**Maternity and Neonatal Safety Report** Mrs Dobson introduced Ms Petty for her regular detailed report on maternity and neonatal data which is in line with national requirements for best practice. The main highlights included perinatal mortality data	

	remaining consistent at 2.7 per 100, there had been local maternity assurance visit to the neonatal unit with the findings overall very positive, as was the feedback provided. A Perinatal Quadrumvirate Culture and Leadership Development Programme was attended by the Senior Leadership who are now working on an action plan based on listening events held and further information will be presented in the next board paper. With regards to the training data there had been a decrease in the numbers of compliant anaesthetists and trainees was due to the new rotation, however actions were in hand with passports for trainees. NHS Resolution had confirmed that the Trust had achieved all 10 safety checks for CNST year 5 and the service had started work for year 6. Mrs Petty was asked about the data relating to smoking in pregnancy with it appearing to show that more smoked at birth than at booking, she explained that this was due to different data points in time although there is work ongoing regarding smoking cessation and that includes increased scope to help involving Public Health and other partners. She was also asked about the mortality rate which refers to the national rate data and whether the report could also include the local regional rate, she confirmed that she would include this in the next report. Mrs Watson queried if the new Neonatal unit had experienced any teething issues, also commenting on how lovely and calming she felt the unit was, Ms Petty confirmed that a 15 steps walk around with service users had actioned ay issues. The Board acknowledged the good work undertaken and thanked the Mrs Petty.	
P81/24	**<u>Paediatric Audiology CQC Response</u>** Dr Beahan presented the paper for approval of a response to the CQC following a national review -which identified systemic failures in hearing services leading to some significant delays on diagnosis and therapeutic management. The Trust currently has an overall rating of 83% compared to the South Yorkshire regional average of 70% and has been providing mutual aid to neighbouring trusts. Dr Beahan reported that there had been no local incidents reported but were reviewing logs and updating the risk register, she feels the Trust have a positive high quality service. The Board was asked to consider the assurance they have about the services offered. This is to be included in a response by the 30th June, as well as considering options such as IQIPS accreditation, however this was a costly option requiring significant extra staff resources, a paper was being put together for this. It was agreed that this matter could be delegated to an Executive team for an outcome and plan and will come back to the Quality Committee for scrutiny. Approved to send a positive response to the CQC.	
P82/24	**<u>Finance Report</u>** Mr Hackett presented the full 12 months financial report explaining that the Trust had improved on the Income & Expenditure Account by £1.2m	

	against its original planned deficit of £6m with a control total deficit of £4.7m, there was also a capital expenditure of £12m and a cash position £2.5m worse than the plan set. There had also been £1.5m of funding received to offset the industrial action held during the year. Mr Hackett applauded the Trust executives and the budget holders for all of their efforts in securing the final figures with the draft accounts submitted to Mazars and the NHSE on time, these accounts will then come back to the Board in June 2024 for final sign off. Mr Temple commented that he has found in the Finance & Performance Committee the members have a good hold on the numbers involved in the financial plan so there have been no surprises, which in itself is really quite reassuring. Mrs Craven offered her congratulations as she admitted to being sceptical at various points during the year due to external pressures but it had been well managed. The message going forward was the release of reserves during the year and non-recurrent CIPs, meaning that to get to where we need to is already a big ask and will be an even bigger ask on the Trust aim to get 'back to balance'. Mr Richmond also offered his congratulations on the delivery of what was planned to be delivered. Mr Hackett explained that there was a clear focus on the elective recovery with plans to go further faster in advance of winter and the likely general election. It was agreed that it would be good to have the Trust in good place for patient care as well as financially. Mrs Craven warned that the next year would be challenging with no spare cash and the likelihood that Trust will have to dip into borrowing quicker which will in turn be more expensive for the Trust, so good effective management was going to be even more important in 2024/25.	
P83/24	**<u>Operational Update Report - End of Year Review</u>** Mrs Kilgariff's paper provided the Board with a full year review, in terms of a small number of the metrics against the constitutional standards the Trust was not where it wanted to be with 69% delivery in March 2024. There has been maintained focus on 65 week delivery, with only 22 patients at the end of the year, which was an achievement when the extended periods of industrial action were taken into account. With regards to the cancer targets the Trust benchmarked in the middle of the patch being above the 77.5% target. The work and improvement in diagnostics was something the Trust should be proud of as it's such an important patient pathway, by March 2024 it was 0.19% within the target of 1%, the Trust being number 2 of combined trusts. Mr Richmond queried whether the Trust could exceed the target of 102% elective activity of 2019/20, if everything went right with a following wind would 103% be possible, or even 105% he asked, Mrs Kilgariff responded that the stretch is through productivity and the Trust was moving away from additional capacity. Mrs Craven added that there was a plan to hold a workshop at a future Finance & Performance Committee to look at what good means and is and there needed to be more activity to get figures improved. Mr Hackett believed that as Rotherham has a good reputation	

	there would be a good chance that it could attract more activity, this would be a conversation with the ICB to identify where the additional capacity is across the region and could it come to Rotherham. Mrs Kilgariff confirmed that what the Trust sets in priorities will be worked up at the specialty level in order to deliver 103% at least in order to meet financial plan being monitored month by month through each service. Mr Wright picked up on the movement from Divisional management into a Care Group structure, he admitted that this had been moved at pace, but this was only following good feedback from the then Divisional management for the move as they also believed that the Trust would see good improvements to productivity.	
	ASSURANCE FRAMEWORK	
P84/24	**Board Assurance Framework** Ms Wendzicha presented the paper outlining the process for the BAF and the need for an update in line with the discussion of the refresh of the Trust Strategy and the plan for a full review at next the next Strategic Board in June 2024. With regards to the BAF risk related to Rotherham partners which is currently rated at 8, given the earlier paper concerning the ICB and Place discussed earlier in the agenda with the long list of what the Trust are now doing with its partners it illustrates the need for a thorough reset of the BAF. Overall the recommendation is for the BAF ratings to remain the same, however there was some discussion at the last FPC around the ratings for BAF risks D5 and D7 with a view to reduce the ratings from 20 to 12 due to the commencement of the new financial year. Following discussion it was agreed not to reduce the ratings at that time. There was also some discussion about what is the environment we are working in now and what should the BAF risk look like in 2024, especially with external factors such as the potential of ongoing industrial action. Ms Wendzicha confirmed that all such queries and concerns should be part of the upcoming review of the Trust's Risk Appetite and BAF review. The Board accepted current position as stated in paper.	
P85/24	**Corporate Risk Register** The paper was presented by Ms Wendzicha who outlined that a number of the risks had already been discussed through the various Chair's Reports. All of the risks contained within the report were reviewed within their review dftes and the Corporate Affairs Team continued to work hard with the Care Groups and departments to take progress a stage further regarding action plans. There was now increased discussion with Risk Owners regarding SMART actions including realistic dates for achieving the actions identified. Dr Jenkins informed the Board that he intended on meeting with Executive leads in order to pick up on risks and review actions, mitigations and ratings; he gave the example of the overarching Trust Financial risk and queried why it was still open as it was a risk for 2023/24, he felt there needed to be more challenge and will take this up in the meetings.	

P86/24	**Quality Assurance Report** Mrs Dobson reminded the Board that it had only been two months since last time the paper was brought to Board, the intention was for the format to be changed to mirror the strategic direction the Trust is moving in, the next paper to the Board will contain four months of data. Mrs Dobson highlighted the following to the members, the performance against the Quality Improvement Plan has further improved, with only three actions rated as green remaining and these are expected to be completed in the following months. The Exemplar Accreditation programme has now commenced with four areas now having undergone the process and four more to commence in June 2024. The Trust have also moved away from the QSIR model of Quality Improvement to the 'Improvement Learning South Yorkshire' (ILSY) in collaboration with partners across the region.	
	REGULATORY AND STATUTORY REPORTING	
P87/24	**Responsible Officer Report Quarter 3** Dr Beahan confirmed that the figures remain in a good place with a high quality of appraisals and that job planning and revalidation were separate processes. Dr Beahan explained that appraisals for doctors were different to other staff appraisals and were undertaken by someone not working in same specialty.	
P88/24	**Guardian of Safe Working Annual Report** Dr Beahan introduced Dr Lynch the Responsible Officer who took the Board through the paper which was the annual report for 2023/24 and also some data from last quarter. He reported a mixed year for trainees due in part the amount of days lost to industrial action, there had been a number of exception reports for additional hours worked but Dr Lynch confirmed that these had not been found to be unsafe. There was now also reporting of missed educational opportunities but these had been low in number, there also appeared to have been an issue when reporting due to a drop down field on the system which Dr Lynch has investigated and says was due to user error. In terms of triangulating with the incident reporting system there had been seven incidents of a lack of training, these had involved no harm and were reported over the Easter period, a period Dr Beahan reported to have been the perfect storm for activity. There were plans for more active listening events for surgical trainees and improving junior doctors' lives, although more detail and guidance on what that means was being working through. Dr Lynch provided some positive actions and mitigations such as a 'floating doctor' who would be able to escalate issues for prompt resolve, as well as improved rostering following redesign and an issue with back pay had also been resolved.	

P89/24	**Learning from Deaths Quarterly Report** Dr Beahan highlighted that there was now a team of trained reviewers in place and that there continues to be movement in the right direction of numbers of and timeliness of reports completed. All reports concluding that there was a poor care score are recorded as incidents with an after action review. Now there has been a year of thematic analysis the plan is to go back to the specialities for the 'so what' element which will then be incorporated into future reports. Dr Beahan reported that the SHMI score was holding out well at 101.9 at the latest available month October 2023 and the ambition was to drive this down further. She confirmed that two consultants had started in the role of Associate Directors for Patient Safety, one being a medical examiner and the other with a Human Factors background. There had already been an agreement to move away from HSME. There was some query from the NEDs regarding a few common findings such as sepsis and neck of femur, and how lessons were going to be embedded, especially for sepsis that has been ongoing for a number of years. Dr Beahan reported that there was ongoing investigations as well as the need for further consideration into how to embed, this will be picked up by the new Associate Directors in due course and will also include other common themes such as medical staff communication.	
	BOARD GOVERNANCE	
P90/24	**Register of Interests Bi Annual Review** Ms Wendzicha confirmed to the Board that the Trust had a statutory obligation to maintain a complete register of interests and this will be put on the Trust public website.	
P91/24	**Any other business** There were no other items of business.	
P92/24	**Annual Work Plan 2024-25** No comments were received.	
P93/24	**Questions from Members of the Public** There was a question from a Public Governor asking if staff in the UECC have mental health first aid training, Mrs Dobson confirmed that they do and she will find out specific numbers to feed back to the next Council of Governors. The same Governor also commented that she felt it would be good if the positive work being undertaken around the Trust could be advertised externally more, she suggested in such areas like libraries across Rotherham, Mrs Parkes confirmed that the Communications Team will be looking into this in order to improve publicity.	

P94/24	**<u>Date of next meeting</u>** 05 July 2024	

Chair:

Date:

Board Meeting; Public action log

Log No	Meeting	Report/Agenda title	Minute Ref	Agenda item and Action	Lead Officer	Timescale/ Deadline	Comment/ Feedback from Lead Officer(s)	Open /Close
2024								
7	03.05.24	Five Year Strategy Refres	P71/24	Updated version to be brought to July Board	MW	Jul-24	On agenda	Recommend to close
8	03.05.24	Fire Safety Strategy	P73/24	Further clarity was required on whether it is an overarching document and would be carried forward in terms of a decision	LM	Sep-24		Open
9	03.05.24	Organisational Priorities	P75/24	Agreed amendments to be made to the final document	MW	Sep-24		Open

Open
Recommend to Close
Complete

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

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

Committee / Group: Quality Committee	**Date: 26 June 2024**	**Chair: Ms Julia Burrows**

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
1	Reporting on Quality Compliance - Care Group 4	The Committee received the presentation from Care Group 4 updating the committee on key aspects, such as the work with Care Homes and preventative work on hospital admissions and the collaborative discussions with PLACE to share pathways and learning. The Care Group also gave further clarity and reassurance on Mortality data from Virtual Ward.	Board of Directors
2	Maternity and Neonatal Safety Report	This report will also be presented to Board, however, the committee agreed to alert the Board to the following: • To achieve the 10/10 CNST, a Non-Executive Maternity Safety Champion must be established • The clear progression and achievements on Smoking, noting the local population data • The high risk regarding plastic wallets and the challenge in supply	Board of Directors
3	Board Assurance Framework	The committee received the report and agreed for the rating to remain at 12, subject to a full review of the scoring for next month; there were discussions surrounding the limited movement to the scoring over the year, reflecting on the number of gaps closed and the Trust's risk appetite for the risk. It was noted that the static nature was linked to the Trust's CQC rating, however, a CQC visit timeframe is unknown and this will be considered in the next review.	Board of Directors

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
4	Corporate Risks Aligned to the Quality Committee	The committee noted the report and discussed the need for clarity on actions and timescales from Care Groups and Risk Owners, for movement of risks. Concerns were raised over the operation of SDEC on AMU, referencing Risk 6762, and previous agreements on SDEC by the Board.	Board of Directors

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

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

Committee / Group: People Committee	Date: 21st June 2024	Chair: Dr Rumit Shah

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
1	Key Issues	The Committee agreed that the Board should be assured that the recently held Trust Proud Awards had been a great success with a lot of hard work being undertaken by a number of teams' arcos the Trust, especially Communications.	Board of Directors
2	People Performance Presentation – Care Group 1	The Committee wished to advise the Board that there were requests made to the Care Group that additional evidence in their next report covering workforce plans, sickness plans and Medical appraisal as they felt this was lacking at this time.	Board of Directors
3	Job Planning	The Committee agreed to advise the Board regarding the reported data, there is a requirement for increased context in that the figures have historically been reported by calendar year, however there is currently a switch occurring to report in financial year to align with the auditors, this has resulted in what looks like lower compliance rates. It was noted that the quality of the job plans has also improved recently.	Board of Directors

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

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

Committee / Group: Finance & Performance Committee	**Date:** 29th May 2024 & 26th June 2024	**Chair: Mr Martin Temple (May) Mr Kamran Malik (June)**

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
1	Care Group (Surgery)	The Committee welcomed the Care Group presentation and wished to advise the Board that there were a number of new staff in post, with the need for a period of consolidation.	Board of Directors
2	Integrated Performance Report	The members of the Committee agreed to advise the Board that the new format of the IPR and the Operational Update Report were a big step in the right direction to assist in discussion and understanding on IPR.	Board of Directors
3	Consortium agreement - Mexborough Elective Orthopaedic Centre	The agenda item had been deferred to June 2024 Committee, however there was agreement that the Board should be alerted to the frustrations on the lack of forums in which to raise concerns and issues with the equipment.	Board of Directors
4	Internal Audit Report	The Committee advise the Board that the Internal Audit report had highlighted concerns relating to the Elective RTT waiting lists, however there was evidence of an action plan and good progress in completing the actions identified.	Board of Directors

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
5	Care Group 3	The committee received the presentation from Care Group 3 were assured by the clear analysis and the clarity put forward in regard to the sizeable tasks and challenges, including specific targets to move forward.	Board of Directors
6	Operational Priorities Update - Cancer	The report focused on the Trust's cancer performance and the improvement work taking place in Cancer Services at TRFT. The committee would recommend an update is shared with Board members for information and awareness of the next steps to build on the advancements made in the first quarter of the year.	Board of Directors
7	Integrated Performance Report (IPR)	The committee received the IPR and discussed the development needed for the productivity section, for a clearer, overarching performance summary.	Board of Directors
8	Estates Strategy Update	The committee received a verbal update regarding the Estates Strategy and it was agreed to suggest to the Board that a prioritisation process is developed and agreed, for a proactive approach to future funding opportunities.	Board of Directors
9	Integrated Financial Performance Report (Month 2 2024/25)	The report detailed that the Trust has delivered a deficit to plan in May 2024 of £338K and the committee noted that a finance report will be shared to Board, including updates on potential funding and ICB updates. With regard to the ICB, submission of a recovery plan is required by the end of the month and the committee acknowledged the risk that this will have consequence on the finances of the Trust.	Board of Directors

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
10	Cyber Security	The committee received an update on cyber security, which gave clarity and context to the media reports on cyber-attacks at other Trusts and assurance on the protective ring for TRFT from NSHE. The discussions highlighted key areas of risk, specifically the external supply chain, and the effect on the Trust if an external provider was attacked. It was recommended for more planning in this aspect, linking with procurement and reflecting on continuity plans from previous adverse events.	Board of Directors

The Rotherham NHS Foundation Trust

Agenda item	P/102/24
Report	**Board Assurance Framework**
Executive Lead	Angela Wendzicha, Director of Corporate Affairs
Link with the BAF	Links with all BAF risks
How does this paper support Trust Values	The Board Assurance Framework is a key element that provides evidence of good governance and therefore supports all three core values, Ambitious, Caring and Together.
Purpose	**For decision** ☒ **For assurance** ☐ **For information** ☐
Executive Summary	The development of the new Board Assurance Framework has continued on a monthly basis. The People Committee, Quality Committee and Finance and Performance Committee have each reviewed the Strategic Board Assurance Risks aligned to them as follows: **People Committee:** Discussed and approved the position in relation to Strategic Risk U4. **Finance and Performance Committee:** Discussed and approved the position in relation Strategic Risk D5, as well as D7 and D8 relating to future financial risk. **Quality Committee:** Discussed and approved the position in relation to Strategic Risk P1. The Board will continue to review and approve the recommended scores for Strategic Risks R2 and OP3. The attached report illustrates the position in relation to the Board Assurance Framework for Quarter 1 2024/25.

Due Diligence	Since presentation at the last Board in May 2024, the relevant sections of the Board Assurance Framework has been discussed at the relevant Board Committees during May and June 2024.
Who, What and When	The Director of Corporate Affairs will continue to work with Executive colleagues in order to review and update the BAF on a monthly basis thus highlighting any risks or issues that have the potential to disrupt achieving our Strategic Ambitions.
Recommendations	It is recommended that the Board: • Discuss and note the progress made in the Board Assurance Framework; □ The rating for BAF Risk P1 to remain at 12; □ The rating for BAF Risk R2 to remain at 8; □ The rating for BAF Risk O3 to remain at 8; □ The rating for BAF Risk U4 to remain at 12; □ The rating for BAF Risk D5 to remain at 20; □ The rating for BAF Risk D7 to remain at 20, and □ The rating for BAF Risk D8 to remain at 20.
Appendices	Board Assurance Framework for Quarter 1 2024/25

1. **Introduction**

1.1 The development of the new Board Assurance Framework (BAF) to align with the 5 Year Strategy was commenced during Quarter 1 2022/23 when the Board approved a total of five Strategic Board Assurance Risks that would be monitored via the relevant Board Assurance Committees on the monthly basis with final approval by Trust Board on a quarterly basis.

1.2 The BAF is now entering its third year in 2024/25 and continues to be monitored on a monthly basis at the Assurance Committees and quarterly at Board.

1.3 The following report illustrates the discussion and decisions taken by the relevant Board Assurance Committees and the Executives during Quarter 1 2024/25. The corresponding BAF report contains all updates in red font, and where an action or gap is partially completed this appears in blue font.

2. **Outcome of the Reviews carried out in Quarter 1.**

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

Risk aligned to the Quality Committee

2.1 The Chief Nurse and the Medical Director are the Executive Director leads for Strategic Risk P1. As part of the continuing review of the BAF, monthly discussions take place with the Chief Nurse, Medical Director and Deputy Director of Corporate Affairs. There is also linkage with the BAF and the current Risk Register.

Updates to the Controls and Mitigations

2.2 Controls C1, C3, C4 and C5 have been updated with date of latest assurance received and additional forms of assurance confirmation.

2.3 **C1**: Meeting held and QDG to cease and contents to be added to other groups. Paper will go to Board clarifying new process.

Updates to the Gaps in Controls and Mitigations

2.11 **G1:** Archived – see version 1.1 2024/25.

2.12 **G4**: Archived – see version 1.1 2024/25.

2.13 **G18**: To respond to UKSHA by June 2024.

2.15 **G26**: Archived – see version 1.2 2024/25.

2.19 **G27:** Further IA dates announced for 27 June.

2.20 **G28**: Now also includes National Emergency Laparotomy Audit.

2.21 **G29:** Archived – see version 1.1 2024/25.

3. **Review of the Risk Score relating to P1**

3.1 The initial score agreed for Quarter 1 2022/23 was a score of 16 whereby the consequence was graded as a 4 (Major), defined in accordance with the 2008 Risk Matrix for Risk Managers as 'noncompliance with national standards with significant risk to patients if unresolved, low performance rating, critical report'. It is proposed the consequence score remains the same at 4 (Major).

3.2 The initial likelihood score agreed for Quarter 1 2022/23 was 4 (Likely) defined in accordance with the aforementioned matrix as 'will probably happen/recur but is not a persisting issue. This likelihood score was reduced to 3 (Possible) following the lifting of the CQC conditions in 2023. It is proposed that the likelihood score remains the same as the Medical Director and Chief Nurse are seeking external assurance before lowering the score, to this they continue to meet with the CQC in an attempt to promote a re-inspection of the Trust.

3.3 The Board approved the risk appetite pertaining the Quality is Very Low (Score 1-5). The Board is yet to agree the Trust Risk Appetite for 2024/25 and at this point the target will be reviewed.

3.4 Taking the above into consideration, it was recommended the risk score remains at **12** at Quarter 1**.**

4. **Risk aligned to the Board**

R2: There is a risk we will not establish ourselves as leaders in improving the lives of the population we serve because of insufficient influence at PLACE leading to increased health inequalities.

Updates to the Controls and Mitigations

4.1 There were no changes to the controls or gaps, the Managing Director continues to attend the various PLACE Commissions, Groups and Boards listed on the BAF report.

Updates to the Gaps in Controls and Mitigations

4.2 There were no changes to the controls or gaps, however the Managing Director is confident that the ethnicity data will soon be available on all electronic systems.

4.3 **Review of the Risk Score relating to R2**

It is recommended that the score remains at **8** however there is an expectation that the likelihood score will reduce the financial year 2024/25 thus reaching the target score.

O3: There is a risk that robust service configuration across the system will not progress and deliver seamless end to end patient care across the system because of lack of appetite for developing strong working relationships and mature governance processes leading to poor patient outcomes.

Update to the Controls and Mitigations

5.1 **G4:** Mexborough Elective Orthopaedic Centre (MEOC) - Not filling capacity leading to increased reputational and financial risk to TRFT. Director of Operations and COO meeting regularly with colleagues internally to increase fill rate.

Review of the Risk Score relating to O3

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

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

At the June 2024 People & Culture Committee (P&CC) a new form of wording for U4 was discussed and agreed, this follows the refresh of the Trust Strategy. All other BAF risks will over the next month also be refreshed by the risk owners. It was agreed that the Strategic Ambition for U4 would be as follows:

> **Us: We will be proud to work in a compassionate and inclusive organisation that delivers excellent healthcare for patients.**

It was also agreed at the P&CC that the new risk wording should be:

> **U4: there is a risk that we do not create and maintain a compassionate and inclusive culture which leads to an inability to retain and recruit staff and deliver excellent healthcare for patients.**

Risk aligned to People & Culture Committee (P&CC).

6.1 The Director of People is the Executive Director lead for the current BAF Risk U4. As part of the review process, the Deputy Director of Corporate met with the Director of People throughout Quarter 1 on a monthly basis with the last review being in June 2024.

Update to the Controls and Mitigations

6.2 **C19:** New People & Culture Strategy. There will be a 6 month and 12 month review presented to the P&CC.

6.3 **C20:** Integrated EDI (Equality Diversity Inclusion) Plan, the plan is for the EDI Plan to be presented at P&CC in September 2024 and Board in October 2024.

6.4 **C21:** Delivery of the People Promise – staff experience. Review progress against the Trust 'We said we did' plan and Care Groups to present progress on their 'We said we did' plans.

6.5 **C22:** Health wellbeing and attendance work is underway.

6.6 **C23:** Development of the Trust Workforce Plan. The current Workforce Plan for the period 2020-24 remains in place and is due to expire in December 2024. The review and development of the revised Plan is expected to be carried out during Quarters 2, 3 and 4 2024/25.

Updates to Gaps in Assurances

6.7 **G7**: There were no changes to the gap, with work ongoing via the Emergency Preparedness, Resilience and Response (EPRR) Group to put in place actions to mitigate the risks of industrial action.

Review of the Risk Score relating to U4

6.8 The BAF Risk U4 was initially graded with a consequence of 4, which in accordance with the aforementioned risk matrix relates to uncertain delivery of key objectives/service due to lack of staff, unsafe staffing levels or competence (>5 days), very low staff morale and no staff attending mandatory/key training. The likelihood target score is rated at 2 which is 'unlikely, do not expect it to happen/recur but it is possible it may do so. . The likelihood current score was deemed to be a score of 3 which is 'possible, might happen or recur occasionally.'

6.9 Following further discussions at the People & Culture Committee in June 2024 it is recommended that BAF Risk U4 remains at **12.**

6.10 The Committee will note that despite the risk score, the risk remains within the current approved risk appetite with a continuing acceptance of a greater degree of inherent risk in pursuing workforce innovation with the caveat that we could potentially improve the skills and capabilities of our workforce.

D5: There is a risk that we will not deliver safe and excellent performance because of insufficient resource (financial and human resource) leading to an increase in our patient waiting times and potential for patient deterioration and inability to deliver our Operational Plan.

Risk aligned to Finance and Performance Committee

7 The Director of Finance and the Chief Operating Officer are the Executive Director leads for Strategic Risk D5. The Deputy Director of Corporate Affairs met with the Director of Finance and Chief Operating Officer monthly during Quarter 1 resulting in the following amendments:

Update to the Controls and Mitigations

7.1 Controls **C1, C2, C3, C4, C5, C6, C7** and **C9** have been updated with date of latest assurance received and additional forms of assurance confirmation.

7.2 **C7 -** Weekly 4 hour performance meeting chaired by COO

Updates to Gaps in Assurances

7.3 **G4** - Regarding the review and validation of waiting lists there was positive feedback received from 360 Assurance in relation to revised governance arrangements.

7.4 **G6** - Further IA dates announced for 27 June - plans and mitigations in place. Clinical Fellows will commence in post UECC August 2024 with new rota giving extra capacity at evenings and weekends covered - agency spend to reduce

Review of the Risk Score relating to D5

7.5 The risk had been graded initially at **15** and following further discussion at December 2023 Board it was agreed that the rating should be increased to **20** due to the ongoing pressures of industrial action. A recommendation for a reduction of the risk rating was taken to the April 2024 Finance & Performance Committee for discussion and approval. Following the discussion it was agreed that the risk rating should remain at **20**, the risk will continue to be reviewed on a monthly basis.

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

8 BAF Risk D7 covered the financial situation for the Trust, 2023/24, this risk is to be closed once the Annual Accounts have been signed off by Internal Audit and replaced by D8 detailed below which covers the financial year 2024/25.

Update to the Controls and Mitigations

8.1 Controls **C1, C2, C3, C4, C5, C6, C7, C9, C10, C11** and **C14** have been updated with date of latest assurance received and additional forms of assurance confirmation.

Updates to Gaps in Assurances

8.2 There were no changes to the gaps, these have been transferred to D8.

Review of the Risk Score relating to D7

8.4 The risk had been graded initially at **20** mirroring D7 and will continue to be monitored on a monthly basis.

D8: There is a risk that we will not be able to sustain services in line with national and system requirements because of a potential deficit in 2023-24 leading to further financial instability.

9 BAF Risk D8 covers the financial situation for the Trust, 2024/25, this risk replaces D7 which covered the financial year 2023/24, as did risk D6 which covered the financial year 2022/23.

Update to the Controls and Mitigations

8.1 Controls **C1, C2, C3, C4, C5, C6, C7, C9, C10, C11** and **C14** have been updated with date of latest assurance received and additional forms of assurance confirmation.

Updates to Gaps in Assurances

8.2 There were no changes to the gaps, the Director of Finance continues to monitor these gaps and will be reviewed again at the July meeting.

Review of the Risk Score relating to D8

8.4 The risk had been graded initially at **20** mirroring D7 and will continue to be monitored on a monthly basis.

Recommendations

The Committee is asked to:

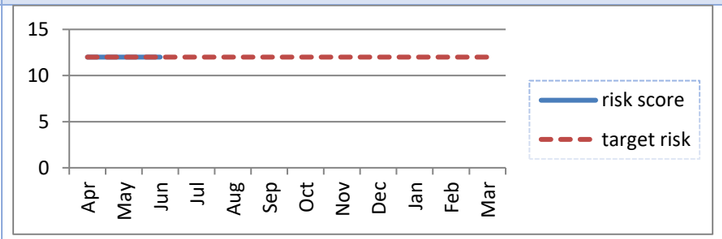
- Discuss and note the progress made in the development of the Board Assurance Framework during the last financial year;
- Note the recommendations from the Assurance Committees in relation to the risk scores Quarter 1 2024/25.
- Discuss and approve the recommended rewording of the BAF Risk U4.

Alan Wolfe

Deputy Director of Corporate Affairs

28 June 2024

Ambition	Strategic Risk			Original Score LxC	Score Q1	Score Q2	Score Q3	Score Q4	Target Risk Score	Movement	Risk Appetite/
	There is a Risk that….	Because…..	Leading to…..								
Patients: *We will be proud that the quality of care we provide is exceptional, tailored to people's needs and delivered in the most appropriate setting for them.*	P1: we will not embed quality care within the 5 year plan	..of lack of resource, capacity and capability	..poor clinical outcomes and patient experience	4(L)x 4(C)=16	12				3(L)x4(C)=12	⇔	Very low (1-5)
Rotherham: *We will be proud to act as a leader within Rotherham, building healthier communities and improving the life chances of the population we serve.*	R2:we will not establish ourselves as leaders in improving the lives of the population we serve	..of insufficient influence at PLACE	..increased ill health and increased health inequalities	2(L)x4(C)=8	8				2(L)x4(C)=8	⇔	Moderate (12-15)
Our Partners: *We will be proud to collaborate with local organisations to build strong and resilient partnerships that deliver exceptional, seamless patient care.*	OP3: robust service configuration across the system will not progress and deliver seamless end to end patient care across the system	..of lack of appetite for developing strong working relationships and mature governance processes	..poor patient outcomes	3(L)x4(C)=12	8				2(L)x4(C)=8	⇔	Moderate (12-15)
Us: *We will be proud to be colleagues in an inclusive, diverse and welcoming organisation that is simply a great place to work.*	U4: we do not develop and maintain a positive culture	..of insufficient resources and the lack of compassionate leadership	..an inability to recruit, retain and motivate staff.	3(L)x4(C)=12	12				2(L)x4(C)=8	⇔	Moderate (12-15)
Delivery: *We will be proud to deliver our best every day, providing high quality, timely and equitable access to care in an efficient and sustainable organisation*	D5: we will not deliver safe and excellent performance	..of insufficient resource (financial and human resource)	..an increase in our patient waiting times and potential for patient	4 (L)x3(C) = 12	20				5(L)x4(C)=20	⇔	Low (6-10)
	D7: we will not be able to sustain services in line with national and system requirements	…of a potential deficit in 2023/24	…further financial instability.	3(L)x 5(C) = 15	20				4(L)x5(c)=20	⇔	Low (6-10)
	D8: we will not be able to sustain services in line with national and system requirements	… of a potential deficit in 2024/25	… further financial instability.	5(L)x4(C)= 20	20				1(L)x4(c)=4	⇔	Low (6-10)

Strategic Theme: Patients	**Risk Scores**											
	BAF Risk Ref	**Initial Score**	**Current Score**	**Target Score**	**Risk Appetite/Risk Tolerance**	**Risk Movement**				**Board Assurance 2024-25**		
Strategic Ambition: **Patients:** ***We will be proud that the quality of care we provide is exceptional, tailored to people's needs and delivered in the most appropriate setting for them***	**P1**	**4(L)x4(C)=16**	**12** **3(L)x4(C)**	**3(L)x4(C) =12**	**Very Low (1-5)**				**Previous Score Q4 2023-24**	**Q1**	**Q2**	**Q3**	**Q4**
Link to Operational Plan: P1: Empower out teams to deliver improvements in care									**12**	**12**			
BAF Risk Description						**Linked Risks on the Risk Register & BAF Risks:** **RISK6623, RISK5761, RISK6809, RISK6800, RISK6630, RISK6762, RISK6627, RISK6886, RISK6284, RISK5238, RISK6723, RISK6958, RISK6857, RISK6801, RISK6888, RISK6718 and RISK6421**				**Assurance Committee & Lead Executive Director**		
P1: There is a risk that we will not embed quality care within the 5 year plan because of lack of resource, capacity and capability leading to poor clinical outcomes and patient experience for our patients.										**Quality Committee Chief Nurse and Medical Director**		
Controls and Mitigations ***(what have we in place to assist in securing delivery of our ambition)***		**Assurance Received** *(what evidence have we received to support the control)*	**Date Assurance Received**	**Confirmed By:**	**Assurance Level** *Level 1 = Operational* *Level 2 = Internal* *Level 3 - Independent*							
C1	Quality Delivery Group in place with remit to deliver against CQC standards	Receipt of monthly assurance reports relating to progress against actions Quality Assurance Report to Quality Committee (Quarterly) Monthly reporting to CQC in relation to Conditions on Registration.	December 2023 April 2024 Complete	Deputy CEO Chief Nurse Chief Nurse	Level 1 & Level 3 Level 1& Level 3 Level 1& Level 3					Future of Group to be reviewed by Managing Director, Chief Nurse and Medical Director. Met in May 24, awaiting approval of recommendation. Meeting held and QDG to cease and contents to be added to other groups. Paper will go to Board clarifying new process.		
C2	Established Tendable Audit Programme	Outcome reports received by Quality Committee on a rolling quarterly programme linked to specialist areas Audit reporting programme now included in Committee report to Quality Committee – on a rolling quarterly programme linked to specialist areas – Patient Safety, Safeguarding, Patient Experience, Infection Control as aligns with work plan	 January 2024	Chief Nurse Chief Nurse	Level 1 Level 2 – Medication Safety Audit completed					A new control for 2024/25 will relate to Quality Dashboard on Power BI with Tenable one element of the tool.		

		Monthly Quality Dashboard reported to Divisional Performance Meetings. Published Patient Experience Annual Report on Trust website.	Feb 2024	Chief Nurse					Transition to Power BI dashboard underway with fully functional for April 2024
C3	Agreed 2023/24 Quality Priorities in place	Progress reports received by Quality Committee quarterly Monthly metrics dashboard now presented for quantitive data. Clinical Effectiveness is a priority, Clinical Effectiveness Manager now in post.	April 2024	Chief Nurse	Level 1 Progress reports on Quality Priorities presented within each quarter Quarter 2 reports all received by Quality Committee				Work has commenced to produce the draft Quality Priorities for 2024/25 with the draft to go to Quality Committee in January 2024. Final selection to go in March 2024 Final selection of 3 priorities agreed, metrics details to be finalised - to April 2024 QC Year-end position to go to QC in May 24, new priorities now underway. COMPLETED
C4	Implementation of actions following Patient Surveys	Progress reports received by Patient Experience Committee and monitored via Quality Committee.	To go to QC February 2024	Chief Nurse	Level 1 Level 3				Recent inpatient survey results not as expected, an action plan has been developed and is in place. Maternity survey results published by CQC in Feb 24 showing positive outcome. Inpatient embargoed results expected May 2024 for publication in August 2024 now received
C5	Coordinated approach for learning from deaths	360 Assure Report with Limited Assurance – completed 13 of 15 actions from report. 360 Assure re-audit took place May 2023 – Split opinion with partial assurance. One outstanding action against learning from deaths being disseminated at CSU level. However report did note progress made overall. Learning from Deaths Report to Patient Safety Committee and Quality Committee and Board in November 2023. HSMR continuing to track downwards	May 2023 January 2024	Medical Director	Level 3 Outstanding actions – see G4 below: Learning from deaths at CSU level & Embedding SJR process Learning From Deaths Policy to be signed off by the Medical Director - Policy gone through Document Ratification Group and published on 24th November 2023. Last 6 months HSMR showing downward trend and now lowest in Y&H region				Learning from Deaths signed off. 2024/25 focus moving away from HMSR to SHMI. New Patient Safety Associate Medical Director to concentrate on learning from Deaths. 15 of 15 actions now completed.
C6	Partnership working with Barnsley NHSFT	Quarterly peer reviews carried out re Quality Assurance (Q1 – Surgery)	Quarter 1	Chief Nurse/Medical Director	Level 1 – Awaiting final outcome report Medicine will be reviewed in December 2022 - revised date Medicine and Outpatients in February 2023, Community in March 2023 (this occurred but was internal only with Barnsley unable to participate), meaning all services will have been reviewed in financial year 2022/23. Reviews now completed External assurance process being reset for 2023/24, will be reviewed in Quarter 2 2023/24.				Process currently paused whilst we transition to new CQC assessment framework from February 2024. Self-assessment approach Q1-Q3

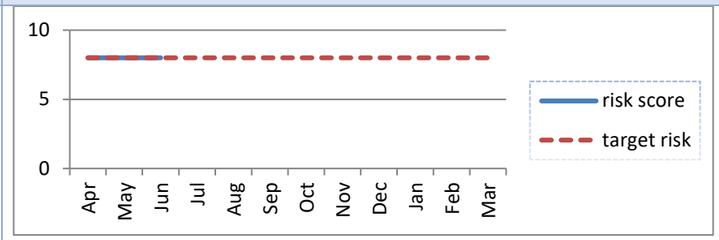
					Pharmacy in Barnsley have had a recent CQC report and TRFT are developing a plan to assure Medication Management. A paper will be presented to Quality Committee via the Medication Safety Committee.				
C7	Quality Improvement & Quality Governance Assurance Priority within Operational Plan	Quarterly updates to Quality Committee	January 2024	Chief Nurse	Revised Quality Improvement and Quality Assurance Report with new format from October 2022 incorporating the CQC assurance report. 2022/23 report to be signed off April 2023 and 2023/24 report to go to Quality Committee October 2023.				Presented quarterly. Next April 2024. Signed off as complete - went to April 2024 QC COMPLETE
C8	Implementation of PSIRF	Monthly meetings established	October 2023	Chief Nurse	Fully signed off action plan in place and monthly meetings established. Throughout May 2023 multiple PSIRF plan workshops have been held, Strategic Board session planned for 02/06/2023. Agreed priority themes for Patient Safety related to PSIRF. Quarterly PSIRF update to Quality Committee as part of Patient Safety reporting. PSIRF plan approved at Quality Committee and by ICB at Contract Quality Meeting It was reported at the Audit & Risk Committee that 360 Assurance had undertaken review of PSIRF implementation, report received and gave Moderate Assurance for PSIRF and the lack of an oversight group for learning actions. There was a significant opinion for patient experience work stream.				**Completed** Plan to go to Board March 24 and will be published on Trust website
C9	Implementation of agreed Strategy for Journey to CQC Outstanding rating	Quarterly progress reports to Quality Committee (links with Gap 14), next was October 2023 Meeting with CQC to discuss expectations 25/01/24 has been cancelled by CQC - next meeting scheduled 29/02/2024. Session held at April 2024 Strategic Board Session	October 2023	Chief Nurse	**Level 1**				Will become more embedded in Operational Plan 2024/25 Well Led Peer review planned 2024/25. New BAF will include development and implementation of a new Quality Strategy.
C10	Implementation of Safeguarding Improvement plan in conjunction with NHSE	Reports to Safeguarding Committee was July 2023	To go to QC Feb24	Chief Nurse	External review NHSE paediatrics and maternity occurred on 01/06/2023, report sent to TRFT August 2023 with positive assurance 12-17/07/2023 – Rotherham Adult Safeguarding Peer Review took place Adult plan with NHSE has been delayed until April 2024 due to internal capacity issues, NHS team attending Strategic Board February 2024.				Focus groups commencing May 2024
C11	Creation of a Quality Metrics Dashboard (including outcome of Tendable Audits) for all ward areas on Power BI platform.	Dashboard created and in use on specific wards.	To go live April 2024	Chief Nurse	Level 1				
	Plan to introduce an exemplar accreditation programme								

Gaps in Controls or Assurance Quarter 1 2023-24	**Actions Required**	**Action Owner**	**Date Action Commenced**	**Date Action Due**			**Progress Update**	
G1	**Archived – see version 1.1 2024/25**							
G2	**Archived – see version 1.1 2023/24**							
G3	**Archived – see version 1.1 2023/24**							
G4	**Archived – see version 1.1 2024/25**							
G5	**Archived – see version 1.1 2023/24**							

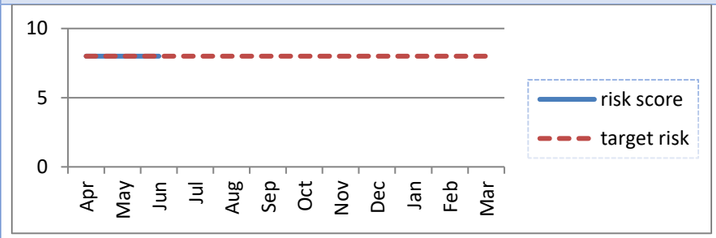
G6	Implementing new ways of working for the Quality Governance & Assurance Team.	Recruit into Quality Governance & Assurance 8c Lead Role to support the central Governance Team	Chief Nurse	August 2022	October 2022 ~~Extend to June 2023~~ ~~Extend to October 2023~~ ~~Extend to March 2024~~ Extend to July 2024			~~Business case approved Executive Team Meeting 15 September 2022, follow up paper to identify governance structure to ETM 20/10/2022~~. Business case approved in principle Established Quality Governance Assurance Unit and are recruiting to all posts except the lead role	
G7	**Archived – see version 1.1 2023/24**								
G8	**Archived – see version 1.1 2023/24**								
G9	**Archived – see version 1.1 2023/24**								
G10	**Archived – see version 1.1 2023/24**								
G11	**Archived – see version 2.2 2023/24 – Superseded by G27**								
G12	**Archived – see version 1.1 2023/24**								
G13	**Archived – see version 1.1 2023/24**								
G14	**Archived – see version 1.1 2023/24**								
G15	**Archived – see version 1.1 2023/24**								
G16	**Archived – see version 1.1 2023/24**								
G17	Potential outbreak of CPE Infection	Managed through the Infection Prevention Control of Decontamination Meeting. UKHSA and ICB have been asked to attend site in May 2023 to undertake an assurance visit	Chief Nurse Chief Nurse	Ongoing May 2023	April 2024 May 2023			Weekly oversight meetings have ceased and moved to Heads of Nursing with oversight at ETM. Deep clean process remains ongoing with Executive oversight. Visit complete, report received and will be presented at IP&C, ETM and in the Clinical Effectiveness quarterly and annual report. Aim respond to UKSHA in April 2024 To respond to UKSHA by June 2024	
G18	Lack of assurance regards quality of end of life care	Completion of action plan that has been created in response to 360 assurance report and NACEL 2022 alarm outlier status report Strategy went to May 2023 Quality Committee and Board of Directors September 2023	Medical Director and Chief Nurse	January 2023 September 2023	~~May 2023~~ September 2023 May 2023			Action plan created and shared internally and with external organisations Awaiting completion of NACEL and 360 audit action plan. NACEL to be four times per annum from 2024 NACEL 2024 has commenced, new Lead Nurse for End of Life now in post Paper to ETM regards restructure of team approved and End of Life will now sit Corporately - December 2023 NACEL to change to a rolling programme of audit All actions Completed - not archived as rolling programme	
G19	Uncertainty regards referral pathway for	Regular discussions between MD, COO, CEO.	Medical Director	March 2023	July 2023			Escalated to ETM and Board of Directors	

	some tertiary centre cancer services	ICB input required.						Temporary working arrangement agreed for provision of service	
G20	PSIRF preparation to go live in Autumn 2023.	Action plan developed following national guidance Quarterly reporting to Quality Committee and Patient Safety Committee. 360 Assure audit on PSIRF assurance to commence Qtr3. Need to complete transition to the LFPSE (Learning from Patient Safety Events) external reporting site	Medical Director and Chief Nurse Chief Nurse Chief Nurse	April 2022 March 2024 September 2023	March 2024 March 2024 June 2024			Monthly group meeting established. Patient representative to be agreed. Went live with PSIRF beginning of November – Operational plan and Policy to Patient Safety, then Quality Committee October 2023 and by ICB at Contract Quality Meeting. 360audit report to Audit & Risk Committee January 2024 Gone live - Operational plan presented at Board March 2024.	
G21	**Archived – see version 1.1 2023/24**								
G22	**Archived – see version 1.1 2023/24**								
G23	Plan to introduce an exemplar accreditation programme	Strategic planning session with Heads of Nursing	Chief Nurse	19/06/2023	December 2023 April 2025			To go live from April 2024, with raising awareness sessions to be held January to March 2024. Lead wards in three divisions identified. Initial planning sessions have taken place with ward managers from A7, A5, B10 and Rockingham. Programme gone live and on track, this will now be an ongoing process across trust with inpatient adult wards completed. Criteria to be agreed for other departments and teams, Children's and Maternity in October 2024 and UECC in April 2025.	
G24	**Archived – see version 1.1 2024/25**								
G25	**Archived – see version 2.1 Quarter 2**								
G26	**Archived – see version 1.2 2024/25**								
G27	Challenges around sufficient workforce to support the recovery plan (including industrial action).	Locum and Insourcing arranged Longer term plan required to recruit a sustainable workforce (link with BAF Risk U4 and D5) Ongoing negotiations with JLNC regards extra contractual payments for medical and dental staff. Regular industrial action meetings to mitigate impact. Rates of pay agreed with medical staff to provide cover for junior doctor's strike.	Divisional Leads & FPC Director of Workforce & FPC Director of Operations & FPC Director of Workforce & FPC	Completed Completed Commenced Completed Completed	Ongoing Ongoing March 2023			Director of Corporate Affairs discussed with Director of Workforce and will further assess need for a new BAF risk relating to a sustainable workforce. On the July FPC agenda for endorsement in respect of Extra Contractual work. To be reviewed for 2024/25. Discussion has taken place resulting in the agreement that the People Committee has sight of the BAF Risk and has oversight of the actions to mitigate this gap once confirmed with the Divisional leads. Development of workforce plan for UECC as a result of Acute Care	

		Specific challenges in relation to anaesthetic cover to support full theatre timetable impacting on elective recovery programme. Deep dive into underlying issues being undertaken with the division. Monitoring of all incidents for possible link to industrial action. Monitoring of cancellation of elective work leading to increased waits for treatment	Chief Operating Officer & FPC Chief Nurse & QC Director of Operations & FPC	Ongoing Ongoing				Transformation work, monthly meetings held with CEO and COO. Improvements seen in nursing, support and doctor recruitment and retention. Paper to ETM outlining issues and anaesthetic, medical workforce review commenced, potential workforce solutions to ETM Watchful eye on external factors patient harm being monitored and not believed to be at a level to increase risk rating at this time. Next round of junior doctor IA commenced over Christmas and New Year period Further industrial action confirmed for 24th to 29th February 2024. No further dates confirmed. Consultants have reached agreement. Potential for Junior Doctors and GP's ongoing action remains. Further IA dates announced for 27 June	
G28	GAPS in National Audit work	360 Assurance to audit in Qtr3, will also be looking at compliance with NICE Guidelines	Medical Director & QC	January 2024				Position for NELA now better, however other National Audits are challenged. 360 audit now signed off, significant assurance, audit plan update to April 2024 Audit & Risk Committee. Now also includes National Emergency Laparotomy Audit	
G29	**Archived – see version 1.1 2024/25**								
Archived Controls within month- Completed									
Archived Gaps within month - Completed									
G26	Emerging concern regards National Emergency Laparotomy Audit as trust is an outlier which could be flagged to CQC	Update the Executive Team Identification of resources and Submission of data	Medical Director Clinical Effectiveness Manager	Completed January 2024				Submitting retrospective data, not as much of a risk as initially thought as data is being submitted. Qtr3 will see a 360 Audit of National Audits & NICE Guidelines process. Position for NELA now better, however other National Audits are challenged. 360 in process of completing for quarter 1 2024/25 Submitting data now, awaiting results	

Strategic Theme: Patients	**Risk Scores**											
	BAF Risk Ref	**Initial Score**	**Current Score**	**Target Score**	**Risk Appetite/Risk Tolerance**	**Risk Movement**				**Board Assurance 2024-25**		
Strategic Ambition: **Rotherham:** ***We will be PROUD to act as a leader within Rotherham, building healthier communities and improving the life chances of the population we serve.***	**R2**	**2(L)x4(C)=8**	**8**	**2(L)x4(C) =8**	**Moderate (12-15)**			**Previous score Q4 2023-24**	**Q1**	**Q2**	**Q3**	**Q4**
Link to Operational Plan: ***R2: Ensure equal access to services***								**8**	**8**			
BAF Risk Description						**Linked Risks on the Risk Register & BAF Risks**				**Assurance Committee**		
R2: There is a risk that we will not establish ourselves as leaders in improving the lives of the population we serve because of insufficient influence at PLACE leading to increased ill health and increased health inequalities						**Risk**				**Trust Board Managing Director**		
Controls and Mitigations ***(what have we in place to assist in securing delivery of our ambition)***		**Assurance Received** *(what evidence have we received to support the control)*		**Date Assurance Received**	**Confirmed By:**	**Assurance Level** *Level 1 = Operational* *Level 2 = Internal* *Level 3 - Independent*						
C1	Trust is a current member at PLACE Board	Trust Board receives reports from PLACE Board PLACE reports summarized by MW and report to Trust Board every two months		~~December~~ September 2023	Board minutes	Level 1				Control remains ongoing		
C2	Trust is a member of Prevention and Health Inequalities Group	Public Health Consultant also now attends Group Public Health Consultant is 50/50 split with RMBC		**March 24**		Level 1				**Control remains ongoing**		
C3	Trust is a member of the Health and Wellbeing Board			**July 23**		Level 1				**Control remains ongoing**		
C4	Managing Director attends the Health Select Commission	Ran Workshop for Commission December 2023		**July 23**	**Minutes**	Level 3				**Control remains ongoing**		
C5	**Archived – see version 1.1 2024/25**											
C6	Meeting with PLACE colleagues to review IDT position.	Meet at least three times a week to review integrated discharge position.		**March 24**		Level 1						
C7	PLACE Leadership Team meeting every Wednesday morning	Managing Director attends along with other Rotherham PLACE members		**Weekly**		Level 1						
Gaps in Controls or Assurance Quarter 1 2022-23		**Actions Required**		**Action Owner**		**Date Action Commenced**		**Date Action Due**		**Progress Update**		
G1	**Archived – see version 1.1 2024/25**											
G2	**Archived – see version 1.1 2024/25**											

G3	**Archived – see version 1.1 2024/25**								
G4	Ethnicity details not on all electronic systems	Public Health Consultant identifying and working on solution.	Managing Director	Ongoing	End of Quarter 1				
Archived Controls within month – Completed									
Archived Gaps within month – Completed									

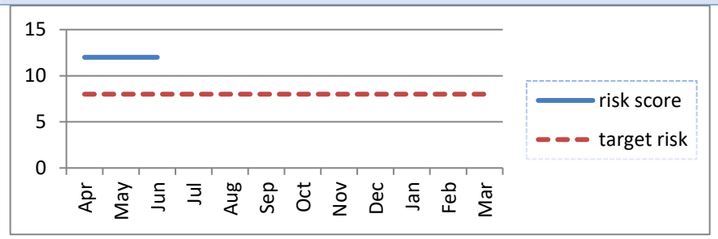
Strategic Theme: Patients	Risk Scores											
	BAF Risk Ref	**Initial Score**	**Current Score**	**Target Score**	**Risk Appetite/Risk Tolerance**	**Risk Movement**				**Board Assurance 2024-25**		
Strategic Ambition: **Our Partners: *We will be PROUD to collaborate with local organisations to build strong and resilient partnerships* that deliver exceptional, seamless patient care.**	**O3**	**2(L)x4(C) = 8**	**8**	**2(L)x4(C) =8**	**Moderate (12-15)**		**Previous score Q4 2023-24**	**Q1**		**Q2**	**Q3**	**Q4**
Link to Operational Plan: ***P3: Our Partners: Work together to succeed for our communities.***							**8**	**8**				
BAF Risk Description						**Linked Risks on the Risk Register & BAF Risks**				**Assurance Committee**		
O3: There is a risk that robust service configuration across the system will not progress and deliver seamless end to end patient care across the system because of lack of appetite for developing strong working relationships and mature governance processes leading to poor patient outcomes.						**Risk**				**Audit Committee and Trust Board** **Chief Executive & Managing Director**		

Controls and Mitigations ***(what have we in place to assist in securing delivery of our ambition)***		**Assurance Received** *(what evidence have we received to support the control)*	**Date Assurance Received**	**Confirmed By:**	**Assurance Level** *Level 1 = Operational* *Level 2 = Internal* *Level 3 - Independent*				
C1	The Trust is a member of the South Yorkshire & Bassetlaw Acute Federation	Reports received by the Trust Board every two months from Chief Executive Report	**March 24**		Level 1				
C2	**Archived – see version 1.1 2024/25**								
C3	Existing collaboration with Barnsley on some clinical services	Gastro service up and running, Haematology service in progress MEOC now opened.	**January 24**		Level 1				
C4	**Archived – see version 1.1 2024/25**								
C5	Joint Strategic Partnership and Joint Executive	Meetings of the Strategic Partnership every quarter, Monthly for Delivery Group.	**January 24**	**Reports to Boards on progress**	Level 1				

	Delivery Group established for oversight and delivery of partnership plan											
Gaps in Controls or Assurance Quarter 1 2022-23		**Actions Required**	**Action Owner**		**Date Action Commenced**	**Date Action Due**			**Progress Update**			
G1	. **Archived – see version 1.1 2024/25**											
G2	**Archived – see version 1.1 2024/25**											
G3	New Pathology Partnership model with new governance arrangements following TUPE. New arrangements will need to embed with assurance provided to TRFT	Identified colleague to lead on target operational model for TRFT, Managing Director to attend Governance meetings	Managing Director		Started 01/04/2024	End of Quarter 1 Head of Nursing (Governance & Quality) to be embedded in role and start receiving assurance from governance at Pathology Partnership						
G4	Mexborough Elective Orthopaedic Centre (MEOC) - Not filling capacity leading to increased reputational and financial risk to TRFT	Director of Operations and COO meeting regularly with colleagues internally to increase fill rate	Managing Director		April 2024	July 2024						
Archived Controls within month – Completed												
Archived Gaps within month – Completed												

Board Assurance Framework People Committee: 2024/25 Quarter 1: Version 1.3a

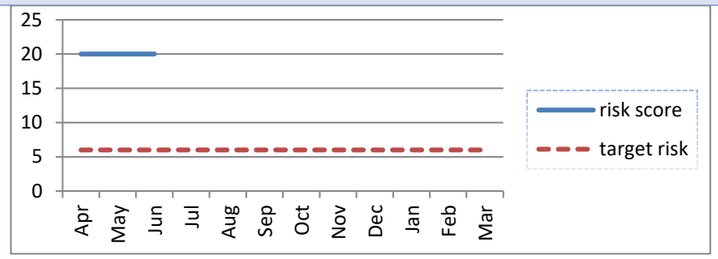
BAF Risk U4

Strategic Theme: Us	Risk Scores											
	BAF Risk Ref	**Initial Score**	**Current Score**	**Target Score**	**Risk Appetite/Risk Tolerance**	**Risk Movement**				**Board Assurance 2024-25**		
Strategic Ambition: Us: We will be proud to be colleagues in an inclusive, diverse and welcoming organisation that is simply a great place to work.	**U4**	**3(L)x4(C)=12**	**3(L) x 4(C) = 12**	**2(L)x4(C) =8**	**Moderate (12-15)**		**Previous score Q4 2023-24**	**Q1**	**Q2**	**Q3**	**Q4**
Link to Operational Plan: P3: Supporting our People P2: Improve engagement with our medical colleagues							**12**	**12**			
BAF Risk Description						**Linked Risks on the Risk Register & BAF Risks:** **RISK6801, RISK6888,a RISK6638, RISK6723, RISK6958 and RISK7069**				**Assurance Committee**		
There is a risk that we do not develop and maintain a positive culture because of insufficient financial resources and the lack of compassionate leadership leading to an inability to recruit, retain and motivate staff.										**People Committee Director of People**		

Controls and Mitigations ***(what have we in place to assist in securing delivery of our ambition)***		**Assurance Received** *(what evidence have we received to support the control)*	**Date Assurance Received**	**Confirmed By:**	**Assurance Level** *Level 1 = Operational* *Level 2 = Internal* *Level 3 - Independent*
C19	New People & Culture Strategy	There will be a 6 month and 12 month review presented to the P&CC	October 2024 and April 2025 P&CC		Level 1
C20	Integrated EDI (Equality Diversity Inclusion) Plan		EDI Plan to P&CC in September 2024 and Board October 2024		Level 1
C21	Delivery of the People Promise – staff experience	Review progress against the Trust 'We said we did' plan and Care Groups to present progress on their 'We said we did plans'. NHS Staff survey outcomes and scores to be presented at People Committee and then the March 2025 Board of Directors.	October 2024 and March 2025 February 2025 P&CC At Care Group P&CC presentations		Level 1
C22	Health wellbeing and attendance work	Underway	End of Quarter 3 2024/25		Level 1

C23	Development of the Trust Workforce Plan	Current Workforce Plan 2020-24 in place, expires December 2024. Review and development Quarters 2, 3 and 4 2024/25.	April 2024 P&CC and May 2025 Board		Level 1					
C17	Joint Leadership Programme	Delivery in train	October 2024 P&CC		Level 1					
Controls C1 to C18 all archived June 2024 - see version 1.2 2024/25 for detail										

Gaps in Controls or Assurance Quarter 1 2022-23		**Actions Required**	**Action Owner**	**Date Action Commenced**	**Date Action Due**			**Progress Update**	
G7	Challenges around sufficient workforce to support the recovery plan and mitigate industrial action.	High level risks from Care Groups regarding workforce challenges monitored via P&CC. Industrial action whilst ongoing will be subject to regular industrial action meetings to mitigate impact.	Divisional Leads & FPC	**Ongoing**					
Gaps G1 to G6 all archived June 2024 - see version 1.2 2024/25 for detail									
Archived Controls within month - Completed									
Controls C1 to C18 all archived June 2024 - see version 1.2 2024/25 for detail									
Archived Gaps within month - Completed									
Gaps G1 to G6 all archived June 2024 - see version 1.2 2024/25 for detail									

Strategic Theme: Delivery	Risk Scores											
	BAF Risk Ref	Initial Score	Current Score	Target Score	Risk Appetite/Risk Tolerance	Risk Movement				Board Assurance 2024-25		
Strategic Ambition: Delivery: We will be proud to deliver our best every day, providing high quality, timely and equitable access to care in an efficient and sustainable organisation	**D5**	**4(L)x3(C)=12**	**5(L)X4(C)=20**	**2x3=6**	**Very low (1-5)**					**Previous Score Q4 2023-24**	**Q1**	**Q2**	**Q3**	**Q4**
Link to Operational Plan: D5: Implement sustainable change to deliver high quality, timely and affordable care										**20**	**20**	
BAF Risk Description						**Linked Risks on the Risk Register & BAF Risks**						**Assurance Committee & Lead Executive Director**
D5: There is a risk we will not deliver safe and excellent performance because of insufficient resource (financial and human resource) leading to an increase in our patient waiting times and potential for patient deterioration and inability to deliver our Operational Plan.						**~~Risk 5761,~~ ~~Risk 6569~~, RISK6800, RISK6627, RISK6762 ~~RISK6414~~, RISK6755, RISK6638, RISK6718, RISK6723, RISK6958, RISK6888, RISK6598 , and RISK6801**						**Finance and Performance Committee** **Director of Finance & Chief Operating Officer**
Controls and Mitigations ***(what have we in place to assist in securing delivery of our ambition)***		**Assurance Received** *(what evidence have we received to support the control)*		**Date Assurance Received**	**Confirmed By:**	**Assurance Level** *Level 1 = Operational* *Level 2 = Internal* *Level 3 - Independent*						
C1	Monitoring waiting times of patients in UECC	Metric included in the Integrated Performance Report Weekly report to ETM Daily review of position and weekly through the acute care performance meeting and ETM 4 hour performance has been reintroduced Waiting times have improved in UECC and monitored against trajectory		**June 2024**	**Minutes of F&P** **ETM minutes** **ETM minutes** **ETM minutes**	Level 1						COO
C2	Divisional Performance meetings chaired by the Deputy CEO.	Monthly reports within IPR to Finance and Performance Committee and Board Divisional Performance meetings with each CSU		**April 2024 IPR**	**Chair's Log**	Level 1						Deputy CEO
C3	Monitoring right to reside and Length of Stay data	Monthly reports to Finance and Performance Committee and Board Weekly Length of Stay reviews Improvement with regards to right to reside and IDT caseload Escalation meetings with external partners. Now includes Medical Director		**April 2024 IPR** **April 2024 IPR** **April 2024 IPR**	**Minutes of F&P** **Weekly ETM minutes** **Weekly ETM minutes**	Level 1						COO

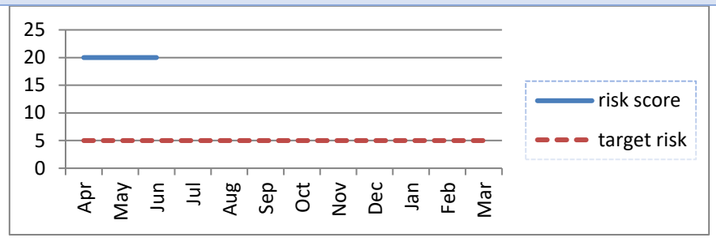
		Oversight through the new Rotherham Place Urgent and Emergency Care Group (Previously the A&E Delivery Board) Number of patients with no right to reside and number on IDT caseload has reduced.							
C4	Dental and medical workforce vacancy panel chaired by the Medical Director	Additional sessions for dental and medical workforce Additional sessions to address where there is greater need Report through to People Committee	**June 2024**	**Notes of the panel** **Notes of the panel**	Level 1				Deputy CEO to chair
C5	Admission avoidance work remains ongoing	The Rotherham Urgent and Emergency Care Group established from September 2022 (replaced A&E Delivery Board and Urgent and Community Transformation Group). It is chaired by the Deputy Pace Director and deputy chair COO, part 2 focuses on transformation and is led by TRFT Deputy CEO and Director of Adult Social for RMBC. Internal pathway group chaired by medical director focussing on emergency pathways Step up pathways to virtual ward have been implemented, admission avoidance work with YAS direct to Community Urgent Response has also commenced.	**June 2024**	**Minutes of meeting**	Level 1				Rotherham Urgent and Emergency Care Group Chief Operating Officer ACT Steering Group – emergency pathway workstream Medical Director
C6	Executive Team oversight	Weekly receipt of Performance Report and Recovery Report	**June 2024**	**ETM minutes Weekly** **ETM minutes Weekly**	**Level 1**				Weekly Executive Team Meeting Director of Strategy Planning & Performance
C7	Weekly 4 hour performance meeting chaired by COO ~~Twice per month Acute Performance Meeting chaired by CEO~~	Weekly oversight	**June 2024**	**Weekly agenda and action log**	**Level 1**				Weekly Acute Performance Meeting COO
C8	Archived as amalgamated into C3– see version 1.2 2023/24								
C9	Weekly access meetings with tracker for elective recovery schemes	To include financial allocation from ERF reserve. New weekly PTL for Elective and Cancer week commenced 27/11/2023	**June 2024**	**Ongoing**	**Level 1**				Elective Review Meeting COO DoF

Gaps in Controls or Assurance Quarter 1 2022-23	**Actions Required**	**Action Owner**	**Date Action Commenced**	**Date Action Due**			**Progress Update**	

G1	Insufficient acute inpatient beds resulting in high bed occupancy	Additional bed capacity utilising additional national G&A capacity funding. Bed reconfiguration to right size medicine and surgery based on bed modelling.	COO	Q1	Q3			Paper approved at ETM May 2023 supporting investment in additional capacity Sitwell to be opened as additional surge following winter de-escalation Bed reconfiguration to be undertaken in advance of winter. Virtual ward development underway. Paper to ETM re implementing bed reconfiguration in July 2023. Paper approved and consultation commenced and implementation due mid-September 2023. Beds now open w/c 25.09.23 in line with plan. Bed modelling rerun. Bed base right, bed occupancy improved to below 92% standard. Challenges due to winter pressures and IA in proximity to Christmas and New ear period and subsequent impact on bed capacity due to high acuity, above plan on A&E attendances and admissions.	
G2	Archived – see version 1.1 2023/24								
G3	Ring-fence interim frailty assessment beds	ICS SDEC pathways confirmed.	COO	Q1	Q4			Frailty model introduced with frailty service in reach – not dependent on ring-fenced beds. Assessments undertaken in UECC, 'time-out' session with the team to review further development of the service and model. Bed base for frailty to be identified as part of reconfiguration and then this risk can be closed and archived.	
G4	Review of validation and management of waiting lists Includes Diagnostic PTL	360 Assure audit to validate waiting lists underway, awaiting outcome. Validation of waiting list over 90% requirement. Awaiting formal report and verbal feedback provided Weekly position to be included in performance position Information for ETM IPR and development of Diagnostic PTL	Associate Director of Operations, Planning and Performance Associate Director of Operations, Planning and Performance	Q2 Q1	Q4 Q2			Validation of waiting lists being undertaken, planned review with 360 to be scheduled – to commence September 2023 including data quality audit – met with 360, plan being developed and scope agreed. Text validation and also admin validation. Waiting list review meeting established to oversee and implement actions in relation to 360 audit Positive feedback received from 360 in relation to revised governance arrangements Weekly diagnostic information available, forecasting of month end position to be introduced. Weekly data provided to weekly Access meeting 1st Draft 360 Assurance report received and actions identified included in response sent to 360.	

								Final report received and recommendations implemented. Access Policy implemented.	
~~**G5**~~	Archived – see version 1.1 2023/24								
G6	Challenges around sufficient workforce to support the recovery plan (including industrial action).	Locum and Insourcing arranged Longer term plan required to recruit a sustainable workforce (link with BAF Risk U4)	Divisional Leads	Ongoing				Director of Corporate Affairs discussed with Director of Workforce and will further assess need for a new BAF risk relating to a sustainable workforce.	
		Ongoing negotiations with JLNC regards extra contractual payments for medical and dental staff.	Director of Workforce	Commenced	Ongoing			On the July FPC agenda for endorsement in respect of Extra Contractual work. Rates now agreed and implemented. Sessions being undertaken at new rates, risk reduced.	
		Regular industrial action meetings to mitigate impact.	Director of Operations	Commenced	Ongoing			Discussion has taken place resulting in the agreement that the People Committee has sight of the BAF Risk and has oversight of the actions to mitigate this gap once confirmed with the Divisional leads. Impact of IA paper to go to ETM and then Confidential Board, as well as FPC, QC and PC.	
		Rates of pay agreed with medical staff to provide cover for junior doctor's strike.	Director of Workforce	Completed	March 2023			Development of workforce plan for UECC as a result of Acute Care Transformation work, monthly meetings held with CEO and COO. Improvements seen in nursing, support and doctor recruitment and retention.	
		Specific challenges in relation to anaesthetic cover to support full theatre timetable impacting on elective recovery programme. Deep dive into underlying issues being undertaken with the division.	Chief Operating Officer	June 2023				Paper to ETM outlining issues and anaesthetic, medical workforce review commenced, potential workforce solutions to ETM – time out with team planned and insourcing for the interim term. Further paper to ETM w/c 18.09.23 outlining further work to be undertaken. Good visibility through job plans. Phase 2 of work to be undertaken with external expertise - plans agreed. No further dates confirmed. Consultants agreed pay deal. Junior doctors re-balloted for further industrial action, no dates yet announced. Recovery schemes continuing into month 1 of 2024/25 Further IA dates announced for 27 June - plans and mitigations in place. Clinical Fellows will commence in post	

								UECC August 2024 with new rota giving extra capacity at evenings and weekends covered - agency spend to reduce	
G7	Financial investment/resources to support recovery of waiting lists	Financial allocation identified in plan for 2023/24 – risk in allocation of ERF given overall financial position	Chief Operating Officer					Agreement on schemes to support recovery for next 2-3 months. Currently being costed and implemented. Paper to ETM and July FPC regarding recovery plan. Paper agreed at ETM for July/August, schemes with an outline of schemes to inform allocation for remainder of the year. Plan in place for recovery schemes and investment in line with ERF allocation in 2023/24 plan - now being implemented. Positive impact on both activity and waiting times. Continuation of ERF schemes	
Archived Controls within month – Completed									
Archived Gaps within month - Completed									

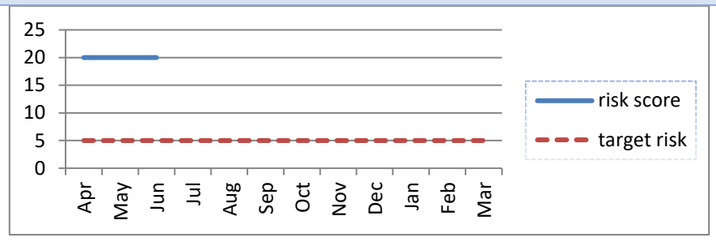
Strategic Theme: Us		Risk Scores										
		BAF Risk Ref	Initial Score	Current Score	Target Score	Risk Appetite/Risk Tolerance	Risk Movement				Board Assurance 2024-25	
Strategic Ambition: Delivery: We will be proud to deliver our best every day, providing high quality, timely and equitable access to care in an efficient and sustainable organisation.		**D7**	**3(L) X 4(C)=12**	**3(L) X 4(C)=12**	**1(L)x4(C) =4**	**Low (6-10)**						
											Previous Score Q4 2023-24	**Q1**	**Q2**	**Q3**	**Q4**
Link to Operational Plan: D7: Implement sustainable change to deliver high quality, timely and affordable care											**20**	**20**			
BAF Risk Description							**Linked Risks on the Risk Register & BAF Risks**				**Assurance Committee**	
							RISK6886, RISK6755 and RISK6801					
D7: There is a risk that we will not be able to sustain services in line with national and system requirements because of a potential deficit in 2023/24 leading to further financial instability.							**Risk**				**Finance and Performance Committee** **Director of Finance**	
Controls and Mitigations ***(what have we in place to assist in securing delivery of our ambition)***		**Assurance Received** *(what evidence have we received to support the control)*		**Date Assurance Received**	**Confirmed By:**		**Assurance Level** *Level 1 = Operational* *Level 2 = Internal* *Level 3 - Independent*					
C1	Improvement of clinical productivity to levels experienced in 2019/20 without central funding for outsourcing clinical activities	Monthly Elective Programme Meeting chaired by Chief Operating Officer		**November 2022**			L1					
C2	CIP Track and Challenge in place			**November 2022**	**ETM minutes**		L1					
C3	Contingency of £1.5m in place.				**Trust Board March 2024**		L1					
C4	Winter funding allocated in reserves of £2m.				**Trust Board March 2024**		L1					
C5	Elective recovery fund £5.2m				**Trust Board March 2024**		L1					
C6	TRFT received access to growth money allocated to PLACE.				**Trust Board March 2024**		L1					
C7	Financial plan sign off to NHSE by 04/05/2023	Submitted on time, still awaiting sign off by NHSE			**Trust Board March 2024**							
C8	Service developments held in reserve of £2.5m.				**Trust Board March 2024**							
C9	Finance and Performance Committee oversee budget reports	Budget reports presented to Finance and Performance Committee		December 2022	Minutes of F&P		Level 1					
C10	System wide delivery of Recovery	Director of Finance attends South Yorkshire DoF Group		December 2022			Level 1					

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

Gaps in Controls or Assurance Quarter 1 2022-23		**Actions Required**	**Action Owner**	**Date Action Commenced**	**Date Action Due**			**Progress Update**	
G1	Unsustainable agency spend (Risk Now)	Weekly Agency Group meets, chaired by Michael Wright	Deputy CEO	Q1	Ongoing				
G2	Recurrently deliver CIP in 2023/24 (Risk Now)	CIP Group Monthly. PMO tracking CIP delivery. CIP report to F&PC monthly.	Deputy CEO	Q1	Ongoing				

G3	Adherence to expenditure Run Rate as per financial plan (Risk Neutral)	Monthly budget reports. Expenditure profile produced monthly throughout year. Reserves Policy in place. F&PC oversight. Internal audit systems budgetary control audit. External audit annual accounts.	Director of Finance	Q1	Ongoing			**End of financial year £4.7m deficit, which was £1.2m better than plan.** **The main risk that remains is the potential cost of back Pay of B2 and B3 posts.**	
G4	Potential reduction of cash balances due to expenditure higher than income which would result in late payments to suppliers. Impact to invest in capital projects. (Future Risk)	Situation acceptable currently, future risk	Director of Finance					For Gaps G4-G7 awaiting further national guidance to fully assess the position. The Trust will run out of cash at some point during the second half of the financial year 2024/25.	
~~**G5**~~	**Archived – see version 1.1 2023/24 - Completed**								
G6	Increased cost improvement programme due to national reductions in funding to the South Yorkshire allocation linked to funding formula suggesting South Yorkshire is overfunded. (Future Risk)	Future income risk	Director of Finance						
~~**G7**~~	**Archived – see version 1.1 2023/24 - Completed**								
G8	Risk that payment by results returns on elective activity with a lack of understanding of the potential impact on elective activity.	Deputy Director of Finance assessing the potential impact in conjunction with the planning guidance expected by the end Quarter 3. Anticipated loss based on month 1 to month 6 achieving £3.5m ICB notified. Financial Plan predicted on no further loss.	Deputy Director of Finance						
~~**G9**~~	**Archived – see version 1.1 2023/24 – Completed**								
	Divisional Budgets signed off	Monitoring via Finance Reports	July 2022	Reports to F&P	Level 1				
	Financial forecasts come to fruition (Future Risk)	Monthly check and challenge with relevant Divisions and Corporate areas.	Director of Finance						
G10	Continuing industrial action leading to increased financial outlay in order to cover medical and clinical shifts. Also linked to challenges around sufficient workforce to support the recovery plan (including industrial action).	Regular industrial action meetings to mitigate impact. Finance team are currently working on a cost per day figure for future forecasting. Locum and Insourcing arranged Longer term plan required to recruit a sustainable workforce (link with BAF Risk U4)	Director of Finance. Divisional Leads & FPC Director of Workforce	Reports to F&P Ongoing Commenced	Ongoing			Director of Corporate Affairs discussed with Director of Workforce and will further assess need for a new BAF risk relating to a sustainable workforce. On the July FPC agenda for endorsement in respect of Extra Contractual work. To be reviewed for 2024/25. Discussion has taken place resulting in the agreement that the People Committee has sight of the BAF Risk	

		Ongoing negotiations with JLNC regards extra contractual payments for medical and dental staff. Regular industrial action meetings to mitigate impact. Rates of pay agreed with medical staff to provide cover for junior doctor's strike. Specific challenges in relation to anaesthetic cover to support full theatre timetable impacting on elective recovery programme. Deep dive into underlying issues being undertaken with the division.	& FPC Director of Operations & FPC Director of Workforce & FPC Chief Operating Officer & FPC	Commenced Completed June 2023	Ongoing March 2023			and has oversight of the actions to mitigate this gap once confirmed with the Divisional leads. Development of workforce plan for UECC as a result of Acute Care Transformation work, monthly meetings held with CEO and COO. Improvements seen in nursing, support and doctor recruitment and retention. Paper to ETM outlining issues and anaesthetic, medical workforce review commenced, potential workforce solutions to ETM Industrial action for junior doctors occurred over Christmas and New Year period. No further dates confirmed.	
G11	National calculation of ERF performance including amendments linked to IA	Letter has been sent to ICB requesting clarification of in-year performance given discrepancies between national calculations and local calculations. Trust has received a further £511,000 reduction to the ERF target. However ICB have requested the Trust to improve its financial plan by the same amount. No further funding for costs of Industrial Action will be given to the Trust.	Director of Finance	September 2023 letter sent	Awaiting ICB response				
G12	Revised Financial Plan is now £4.47m deficit which is an adjustment of £1.26m	Board approved revised Financial Plan with 3 actions on 20/11/2023	Director of Finance	November 2023	Monthly reviews to 31/03/2024				
Archived Controls within month – Completed									
Archived Gaps within month – Completed									

Strategic Theme: Us		Risk Scores										
		BAF Risk Ref	Initial Score	Current Score	Target Score	Risk Appetite/Risk Tolerance	Risk Movement				Board Assurance 2024-25	
Strategic Ambition: Delivery: We will be proud to deliver our best every day, providing high quality, timely and equitable access to care in an efficient and sustainable organisation.		**D8**	**5(L) X 4(C)=*20***	***5(L) X 4(C)=20***	***1(L)x4(C) =4***	***Low (6-10)***				**Previous Score Q4 2023-24, as D7**	**Q1**	**Q2**	**Q3**	**Q4**
Link to Operational Plan: D7: Implement sustainable change to deliver high quality, timely and affordable care											**20**	**20**			
BAF Risk Description							**Linked Risks on the Risk Register & BAF Risks**				**Assurance Committee**	
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C2	CIP Track and Challenge in place			**July 2024 Board**			Level 1					
C3	Contingency of £3m in place.			**July 2024 Board**			Level 1					
C4	Winter funding allocated in reserves of £1.2m.			**July 2024 Board**			Level 1					
C5	Elective recovery fund £6.0m			**July 2024 Board**			Level 1					
C6	TRFT received access to growth money allocated to PLACE.			**July 2024 Board**			Level 1					
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C8	Finance and Performance Committee oversee budget reports	Budget reports presented to Finance and Performance Committee		**July 2024 Board**			Level 1					
C9	System wide delivery of Recovery On plan with mitigations in place to	Director of Finance attends South Yorkshire DoF Group		**July 2024 Board**			Level 1					
		Monthly Finance Report to CEO Delivery Group		**July 2024 Board**			Level 1					

	manage winter pressures.	South Yorkshire Financial Plan Delivery Group			Level 1				
C10	Suitably qualified Finance Team in place	Team in place			Level 1				
C11	Established Capital Monitoring Group	Capital and Revenue Plan signed off by Board	June 2024						
C12	Current Standing Financial Instructions in place	Reviewed and approved by Board			Level 1				
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G2	Recurrently deliver CIP in 2024/25 (Risk Now)	CIP Group Monthly. PMO tracking CIP delivery. CIP report to F&PC monthly.	Managing Director	Q1	Ongoing				
G3	Adherence to expenditure Run Rate as per financial plan (Risk Neutral)	Monthly budget reports. Expenditure profile produced monthly throughout year. Reserves Policy in place. F&PC oversight. Internal audit systems budgetary control audit. External audit annual accounts.	Director of Finance	Q1	Ongoing				

G4	Potential reduction of cash balances due to expenditure higher than income which would result in late payments to suppliers. Impact to invest in capital projects. (Future Risk)	Situation acceptable currently, future risk	Director of Finance					For Gaps G4-G7 awaiting further national guidance to fully assess the position. The Trust will run out of cash at some point during the second half of the financial year 2024/25.	
G5	Increased cost improvement programme due to national reductions in funding to the South Yorkshire allocation linked to funding formula suggesting South Yorkshire is overfunded. (Future Risk)	Future income risk	Director of Finance						
G6	Risk that payment by results returns on elective activity with a lack of understanding of the potential impact on elective activity.		Deputy Director of Finance						
G7	Care Group Budgets not yet signed off	Monitoring via Finance Reports	July 2024	Reports to F&PC	Level 1				
G8	Financial forecasts come to fruition (Future Risk)	Monthly check and challenge with relevant Divisions and Corporate areas.	Director of Finance						
G9	Continuing industrial action leading to increased financial outlay in order to cover medical and clinical shifts. Also linked to challenges around sufficient workforce to support the recovery plan (including industrial action).	Regular industrial action meetings to mitigate impact. Finance team are currently working on a cost per day figure for future forecasting.	Director of Finance.	Reports to F&PC					
Archived Controls within month – Completed									
Archived Gaps within month – Completed									

BOARD OF DIRECTORS' MEETING
05th July 2024

The Rotherham NHS Foundation Trust

Agenda item	P103/24
Report	**Corporate Risk Register Report-** **Including the Risk Register (with risks scoring 15 and above), and all divisional risks rated 8+ with review date and action plans**
Executive Lead	Angela Wendzicha, Director of Corporate Affairs
Link with the BAF	The following paper links with all BAF Risks.
How does this paper support Trust Values	This paper supports the Trust Value of "Use and Evaluate Information to improve". By having up to date information on the Trust's risks we can use and evaluate this information to take actions and decisions that improve both patients' and staff experience.
Purpose	**For decision** ☐ **For assurance** ☐ **For information** ☒
Summary (including reason for the report, background, key issues and risks)	The key points arising from the report are: • The data has been reviewed and presented as four Care Groups and Corporate Services • Attention on Action Plans has now evolved to include scrutiny over plans with all actions completed (see Section 3) to address stagnation of risks and ensure reviews consider the work completed or still required • A review of progress note compliance is detailed in Section 4, highlighting the importance of this aspect to provide assurance and oversight of risk reviews and management • As at 21/06/2024 there are 24 risks out of a total of 272 Trust-wide Approved risks that are out of review date. This shows a compliance rate of 91% against the target of 100% • There has been movement on the Issues Register with issues deescalated back to risk status or closed, as well as additions of issues raised at Assurance Committees
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	All risks scoring 15 or above are approved by the Risk Management Committee. All risks rated 8 and above should have an action plan in line with the TRFT Risk Policy
Board powers to make this decision	Not Applicable

Who, What and When (What action is required, who is the lead and when should it be completed?)	Once presented, the Director of Corporate Affairs, as Executive Lead will continue to ensure that risks are appropriately identified, recorded, reviewed and managed.
Recommendations	It is recommended that the Risk Management Committee: • Note the content of the report; • Note the ongoing work required and • Support in principle the developments highlighted within the report
Appendices	1. Risk Register

1. Introduction

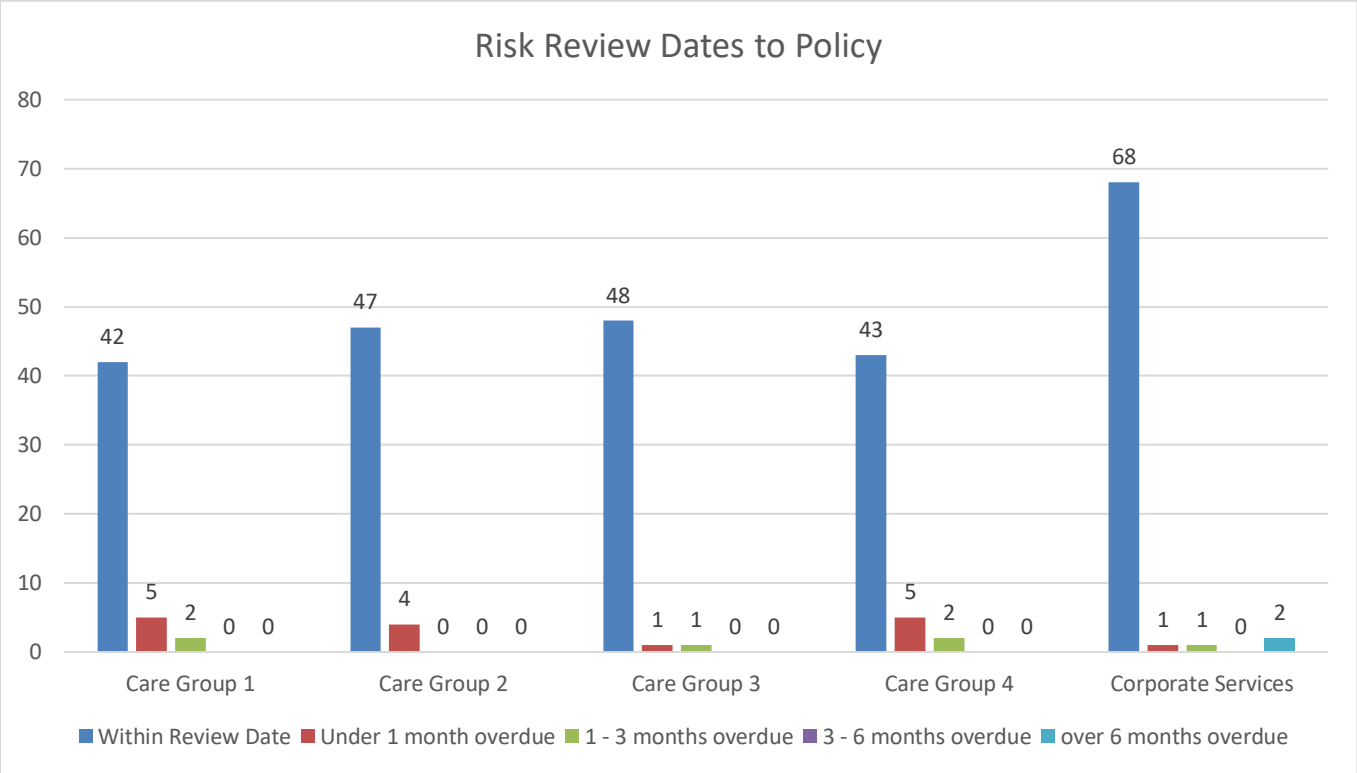
1.1 The following report provides an update to Executives for the review of all risks scoring 15 and above in addition to management information in relation to all open risks rated 8 and above. The data analysed within this report was exported from Datix on 21/06/24; any updates or changes subsequently within the database, will not be recorded in this report. Please note that whilst all of these risks have been approved at Care Group level, not all have yet been approved by the Risk Management Committee (RCM).

1.2 Datix remains in the process of realignment, following the restructure of some of the Trust services. The Corporate Affairs Team will continue to monitor the management of risks and assist colleagues on the transfer of ownership and or changes to risks to ensure relevance and oversight in the correct departments.

1.3 The data has been reviewed and presented as four Care Groups and Corporate Services. Risks rated 8 and above still registered under Clinical Support Services on Datix have been included in the Care Group risk data as follows: Pharmacy and Medicines Management Risks (a total of 4 risks) have been included in Care Group 3 data and Medical Imaging & Medical Physics Risks (a total of 33 risks) have been included in Care Group 4 data. 7 risks (rated 8 and above) under the CSU of Laboratory Medicine have been excluded from the data analysis but have been reviewed by the Acting Quality Manager for SYBP, and a meeting has been arranged with the Corporate Affairs team in July to finalise this risk register and its transfer.

2. Risk Review dates

2.1 In terms of compliance with risk review dates, the graph below shows all risks rated at 8 and above for all Care Groups. The graph is to provide Executives with a view regarding the current Trust position for the management and review of risks. Review date compliance has decreased this month with an increase of risks <1 month overdue for review, and a number of risks now falling behind >1 month for Care Groups 1, 3, 4 and Corporate Services.



2.2 At June RMC, all Care Groups and Corporate Services colleagues were made aware of these compliance issues. The Interim Director of Estates and the Medical Director requested involvement in the correspondence surrounding review dates for Corporate Services risk owners, to ensure non-compliance is addressed and this has been actioned.

2.3 The Risk Management Committee is presented monthly with review date data as part of the Committee's Terms of Reference to monitor Care Group management of risks, including meeting review date schedules.

3 Risk Action Plans

3.1 The Corporate Affairs Team distribute an 8+ Divisional Risk Register to all Care Groups monthly and contact individual risk owners, to highlight areas of non-compliance. Care Groups should not approve risks at Governance meetings without an action plan in place.

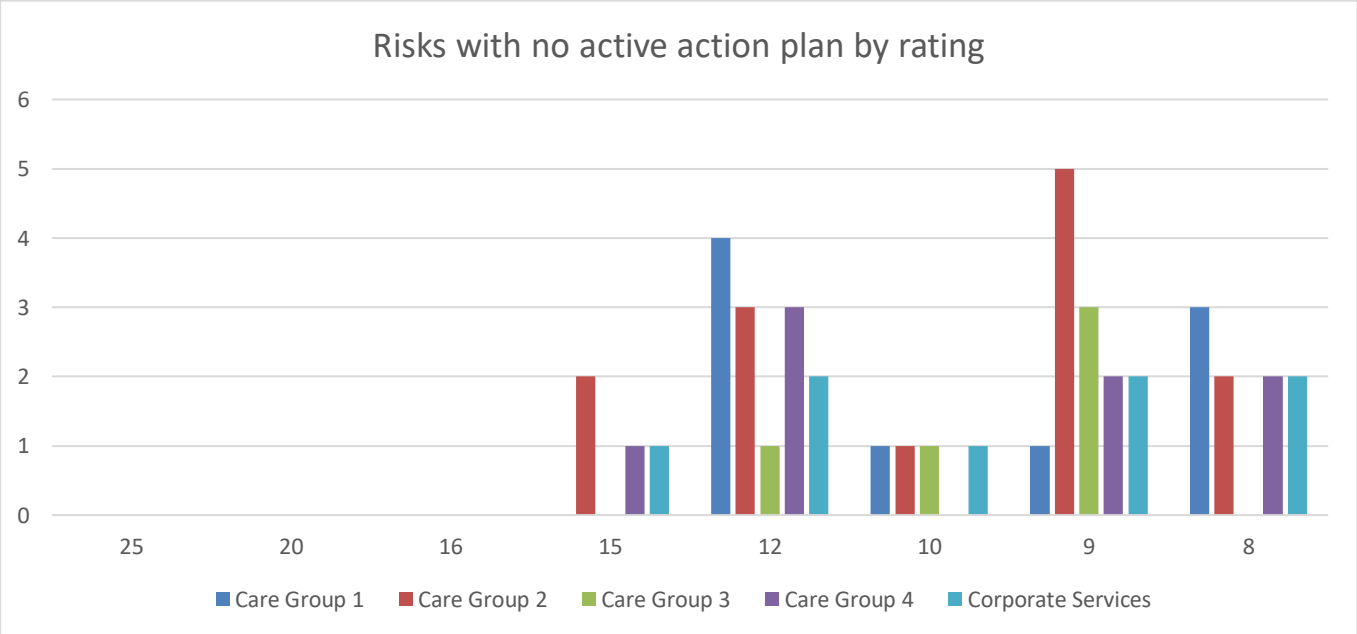
3.2 In May and June, RMC was presented with further analysis on actions plans; the scrutiny of action plans now includes focus on action plans in place that have all actions marked as completed, as well as risks with no action plan in place. To avoid stagnation of risks, risks should be reviewed with oversight of their action plans to ensure that their

completion has a consequent effect on the risk scoring. If there is no movement, there should be further scrutiny around the risk and actions, and whether it has evolved into an Issue or a revised plan is needed moving forwards. The table below includes the data on risks with no action plan, as well as those with no active action plan for information:

Groups	Total No. of Risks	Risks with No Action Plan	Risks with No Active Action Plan	Percentage of risks with compliant action plan
Care Group 1	49	2	9	78%
Care Group 2	51	7	13	61%
Care Group 3	50	3	5	84%
Care Group 4	50	7	8	70%
Corporate Services	72	2	8	86%

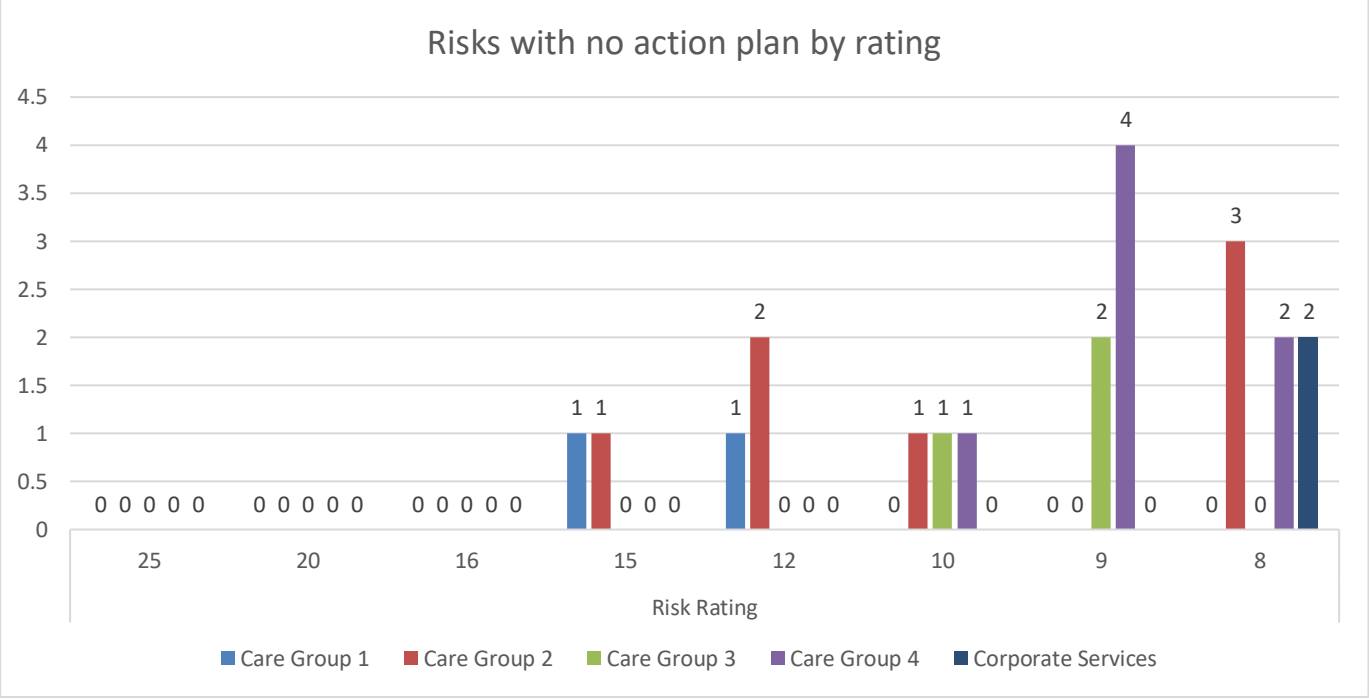
3.3 In this analysis, overall compliance is 84%, with a target of 100% to ensure effective and robust risk management. Care Groups were asked to take note to embed a comprehensive approach to reviewing risks.

3.4 Furthermore, the graph below details the risks with **no active action plan** from each Care Group and their rating:



There are 4 High risks that do not have an active action plan in place to mitigate the risk; these are not RMC approved. There are 39 Moderate risks that do not have an active action plan which should be reviewed and addressed at Governance meetings, and are highlighted in the monthly report sent the Care Groups.

3.5 For full oversight, the graph below details the risks with **no action plan** from each Care Group and their rating:



As can be seen there are two high risks with no action plan from Care Group 1 and 2, and several Moderate risks with no action plan from all Groups and Services. Risks should not be approved at Governance meetings without an action plan in place.

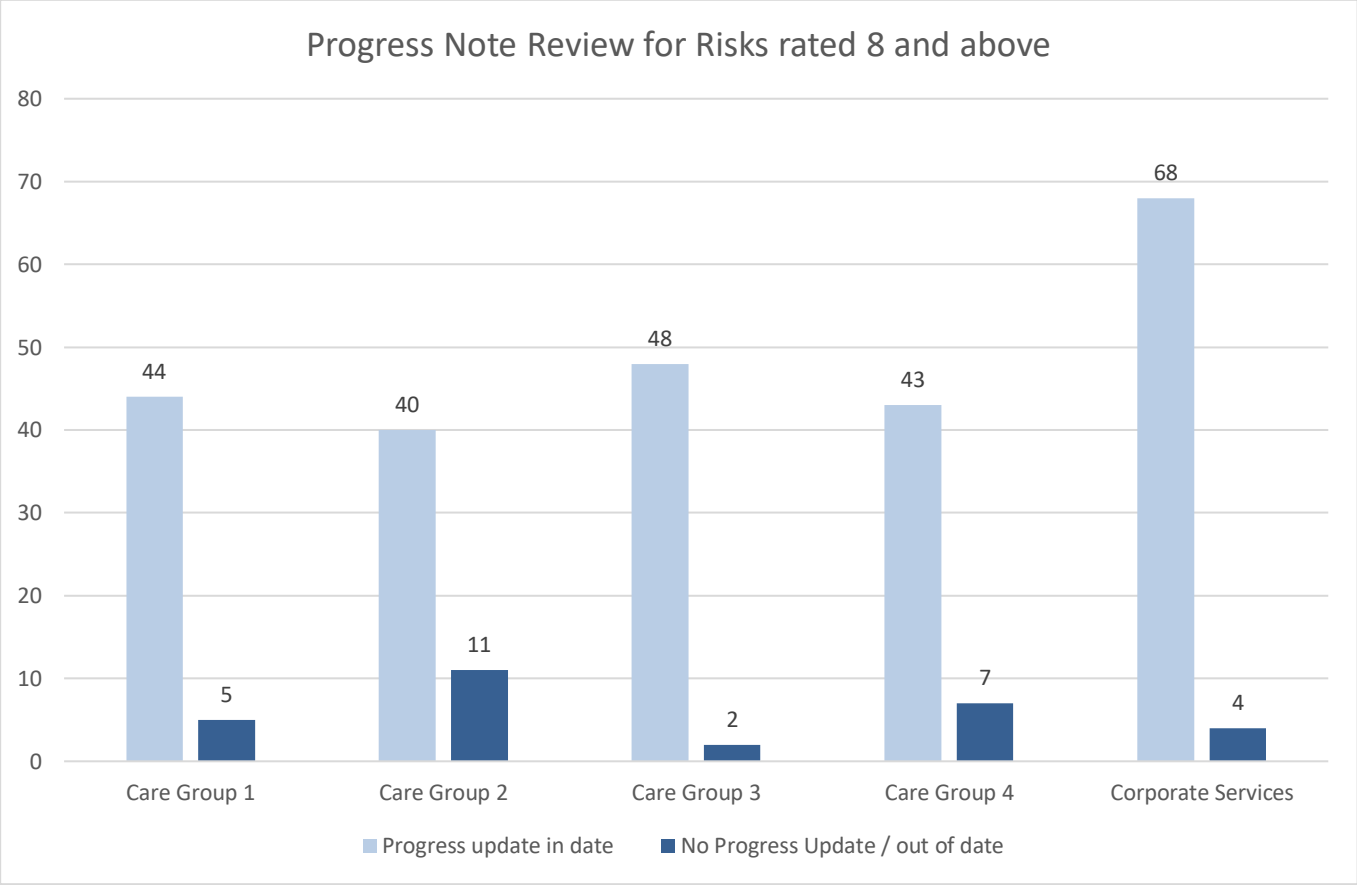
3.6 The Corporate Affairs team will liaise with the leadership teams and risk owners to ensure action plans are added to the risk database. Risk owners should be responsible and accountable for correct management of their risks, utilising support offered by the Corporate Affairs Team.

3.7 With regards to risk that are stalling or not being managed efficiently, these will now be taken to the monthly Care Group Performance meetings as well as the Risk Management Committee for scrutiny in an attempt to engage the risk owners into actively owning and managing their risks.

4 Review of Progress Note Updates

4.1 Progress notes are a vital element to provide assurance that risks are being reviewed in a comprehensive manner and to provide a clear audit trail. Notes are included in the reports to all Assurance Committees as well as the Board of Directors.

4.2 The graph below details progress note compliance for all Care Groups and Corporate Service. Care Group 3 have the highest compliance in this aspect with 96% of all risks rated 8 and above showing an up to date progress note in line with the review date.



5 Emerging Risks

5.1 The Audit & Risk Committee has previously requested that the trust identify emerging risks to the divisional services going forward. These are seen as risks that are not already recorded on Datix and could arise due to potential changes in service delivery, funding or national changes in regulations or NHSE/CQC initiatives.

5.2 A report was received and noted by the May Audit & Risk Committee detailing the following emerging risks for consideration:

- Second medical opinion – Martha's Rule
- Advanced Clinical Practitioners (ACPs) roles – financial impact and potential significant gaps in workforce in next few years.
- Surgical misogyny following recent media coverage, risk to current and past staff and potential reputational risk to trust.
- Decrease in number of student nurses and Allied Health Professionals (AHPs) at Sheffield Hallam University, signalling a potential shortfall in staff in 2-3 years' time. At April's Quality Committee, this was highlighted and the drop confirmed nationally as well as locally. Proactive approaches are ongoing with school visits and attending university open days to connect with future generations.

5.3 The Audit and Risk Committee discussed and requested an additional emerging risk to be included here surrounding the current Covid inquiry and the likelihood of claims against the NHS.

5.4 At May RMC, it was brought to the committee's attention the visa changes for salary thresholds for international staff, and this will be reported to the next Audit and Risk Committee for consideration.

5.5 This is not a limited or completed list and the Executive Team are asked to discuss and submit further examples to the Corporate Affairs department or July RMC.

6. Issues Register

6.1 The Issues Register, Appendix 1, highlights risks recorded on Datix that are now considered live issues to the Trust requiring management. A number of risks have been de-escalated from this register and include:

- Risk 6284 – Cardiac Physiology Staffing Levels. Overall, vacancies are slightly reduced in comparison to vacancies in June/July 2023 when the risk was elevated to a score of 15. Whilst serious concerns remain about staffing in this area and there has been no increase in establishment, it was approved at April RMC to reduce the

score to 12, noting that if the situation worsens, that risk score can be increased accordingly.

- Risk 6718 – Risk of Potential Omission of Care (Heart Failure patients). This risk has been linked with a duplicate risk in Care Group 1, for the team to carry forward as a Business Case is in progress, with input from Care Group 4
- Risk 6572 – Special School accommodation. It was reported that the problems have now been resolved and the risk will be reviewed at governance for reduction/closure.
- Risk 6886, 6755 and 7052 related to the 2023/24 financial year which has now ended. New risk entries will be inputted for 2024/25 as required.
- Risk 6602 - Change to non-surgical oncology pathways for breast and UGI services. The risk was reviewed by the risk owner and Chief Operating Officer for a reduction in rating due to the mitigations put in place.

6.2 Risk 6762 – Inpatient beds in the trolley area ASU, has been added to the Issues Register following concerns raised at Quality Committee over the inability to run SDEC.

7. Conclusion

7.1 Attention is required to maintaining the process of risk reviews within all of the Care Groups and Corporate Services; this should include all aspects of the risk including updates on the progress of action plans.

7.2 The report illustrates that the process of risk management within the trust is evolving to include further scrutiny on action plans to avoid stagnation of risks and promote a more comprehensive approach to risk management.

Alan Wolfe
Deputy Director of Corporate Affairs
July 2024

Corporate Risk Register - 15+ Risks

ID	Opened	Handler	Division	Title	Description	Risk level (initial)	Risk level (current)	Risk level (Target)	Date REVIEWED	Review date	Progress notes	Approval status	Description	Start date	Due date	Done date	Responsibility ('To')
7111	23/04/2024	Hammond-Race, Mr. Chris	Division of Therapies, Dietetics and Community Care	Current Paediatric Audiology Service not Being Accredited in Improving Quality In Physiological Services (IQIPS)	The current Paediatric Audiology Service not Being Accredited in Improving Quality In Physiological Services (IQIPS).	High 15	High 15	Moderate 10	26/06/2024	24/07/2024	[Bell, Beky Miss 27/06/24 12:35:46] Reviewed at HOS Governance Meeting 26.06.24 risk to remain at score of 15	Approved Risk	Meet with Assistant Medical director and GM of Care Group 4	02/05/2024	02/05/2024	02/05/2024	Hammond-Race, Mr. Chris
													Options appraisal for EMT submission to be drafted	02/05/2024	23/05/2024	08/05/2024	Hammond-Race, Mr. Chris
													Exceptional spend submission	23/05/2024	20/06/2024	20/06/2024	Hammond-Race, Mr. Chris
													Register with IQIPS now spend agreed	20/06/2024	19/07/2024		Burgin, Amanda
7069	14/02/2024	Storer, Cindy	Corporate Services	Band 2/3 Healthcare Support Worker job descriptions and re-banding following changes to the National job profiles in 2021	1a - There is a risk that the consultation process is not managed affectively and line with Trust policy. 2a - There is a risk that agreements with staff side on back pay go back to 2021 as stated which increases the financial risk significantly. 3a – There is a risk, new job descriptions and associated clinical skills frameworks are not followed and implemented in line with Trust policy. 4a – There is a risk that the organisation consultation is delayed resulting in increased backpay and responsibility payments. 5a – There is a risk of trade union action. 6a – There is a risk of local and National media attention if the process is not managed effectively. 7a – There is a risk of organisational unrest and indirect impact on clinical care due to ongoing consultation process affecting workforce and morale.	High 25	High 20	Moderate 10	12/06/2024	12/07/2024	[Rimmer, Claire 12/06/24 13:11:36] Risk reviewed by CS: Consultation period is about to end and interviews to start imminently. Views from consultation to be analysed.	Approved Risk	Organisational change process to be followed	27/02/2024	03/09/2024		Storer, Cindy
													Implement operational and strategic groups with key stakeholders	15/01/2024	02/12/2024		Storer, Cindy
													Additional senior nurse and HR support needed	01/01/2024	31/05/2024	12/06/2024	Storer, Cindy
													Updated paper to executive team colleagues on progress and revised financial impact	11/03/2024	03/09/2024		Dobson, Helen
6166	26/05/2020	Ramsden, Daniel	Corporate Services	Absence of a Isolated Power Supply (IPS) within All Theatres	Lack of protection to vulnerable patients in Group 2 medical locations, from the risks associated with electrical leakage currents. It is also a requirement of the standards that Group 2 Medical Locations shall have an automatic electrical supply available within 15 seconds in the event of power failure. Consequently it is usual for an IPS unit to be backed-up by an on-line UPS (uninterruptible power supply) as this will provide a 'no-break' supply source.	High 16	High 16	Low 4	24/06/2024	24/07/2024	[Ramsden, Daniel 14/06/24 12:17:00] Capital projects in the process of developing a programme of works for installing the systems within this financial year.	Approved Risk	Theatres require UPS/IPS systems installing - Possible locations	06/09/2023	26/09/2024		Ramsden, Daniel
													Theatres require UPS/IPS systems installing - develop plan of works to install	06/09/2023	01/11/2024		Ramsden, Daniel
6627	03/01/2022	Kilgariff, Mrs. Sally	Corporate Services	Patients that are Medically Fit for discharge needing Pathway 1-3 have an increased length of stay	Patients that are Medically Fit For Discharge and require Pathway 1-3 face the potential of increased length of stay after being declared Medically Fit For Discharge. There is evidence to suggest that increased length of stay in hospital can be associated with increased risk of infection, low mood and reduced motivation, which can affect a patient's health after they've been discharged and increase their chances of readmission to hospital	High 20	High 16	Moderate 8	20/06/2024	18/07/2024	[Wallett, Val 20/06/24 14:55:35] [Sally Kilgariff 20.06.24] The risk was reviewed. The action to implement discharge to assess pathways to support assessment of ongoing care in needs in patients own home has been established but needs increasing. The General Manager for the care group will continue to keep this under review. The overall risk will be reviewed as it is now more related to the criteria for Right to Reside.	Approved Risk	Daily reporting/dashboard to identify delays and ensure overnight	06/10/2022	31/03/2023	21/03/2023	Hepworth, Tracey
													Escalation meetings with place partners and senior executive level support	06/10/2022	31/03/2023	21/03/2023	Kilgariff, Mrs. Sally
													Implement discharge to assess pathways to support assessment of ongoing care in needs in patients own home - now implemented with period of embedding in place	06/10/2022	30/09/2024		Fisher, Penny

6800	05/10/2022	Kilgariff, Mrs. Sally	Corporate Services	Delays in urgent care pathway due to challenges with patient flow	Patients do not always receive timely access to urgent care due to delays due to challenges with patient flow. Caused by the absence of access to alternative urgent care pathways that avoid patients being seen in UECC and delays in discharge that result in lack of beds for patients to be admitted to. This results in delays to be seen by a clinician in UECC or by a specialty and delays in patients being admitted to a bed in a timely way.	High 20	High 16	Low 4	20/06/2024	19/07/2024	[Wallett, Val 20/06/24 15:05:39] [Sally Kilgariff 20,06.24] The risk was reviewed and the virtual ward establishment is now complete. There is a new approach to a ring-fenced environment for SDEC to be implemented, along with CHAT and frailty assessments on B6. These will be implemented by August 2024. The recovery plan for 4 hour delivery is in place. It is expected to be able to reduce the score to 12 by the end of Q2.	Approved Risk	ACT programme of transformational work	01/01/2022	01/07/2024		Kilgariff, Mrs. Sally
														Improving pathways including expansion of SDECs, implementation of the frailty pathway and introduction of virtual wards	01/01/2022	01/07/2024	20/06/2024	Kilgariff, Mrs. Sally
														Improving discharge pathways, particularly ward processes - including 100 day discharge challenge	01/01/2022	01/01/2025	20/06/2024	Storer, Cindy
														Focus on criteria for Right to Reside	20/06/2024	31/03/2025		Kilgariff, Mrs. Sally
6801	10/10/2022	Ferrie, Mr. Paul	Corporate Services	Industrial action and effect upon Trust activity	A number of trade unions have recently announced further details on their intention to proceed with statutory ballots These so far include: The Royal College of Nursing (RCN) Royal College of Midwives Junior Doctor Committee of the BMA Chartered Society of Physiotherapists NHS Staff Council trade unions: GMB UNISON Unite This would provide a risk to patient safety due to a lack of suitably qualified staff. There is also the added financial impact on the trust, the net pay costs of each industrial action varies, however we estimate the two instances of junior doctors action has resulted in a £300k cost pressure. A potential risk to patient safety has also been raised in recent months.	High 16	High 20	Low 4	27/06/2024	26/07/2024	[Paul Ferrie 27.06.24] The risk was reviewed at the June 2024 Risk Management Committee and it was agreed to keep the risk score at present whilst the on-going industrial action continues. The risk was also reviewed at the June 2024 People & Culture Committee which agreed the rating. The risk score will be reviewed again with the view to decrease the rating following the current period of industrial action and any movement taking place after the General Election.	Approved Risk	Negotiations with local staff side	10/10/2022	27/09/2024		Ferrie, Mr. Paul
														Strategic meeting to be scheduled by the EPRR Team	10/10/2022	30/12/2022	03/07/2023	Patchett, Craig
														Further central government negotiations - monitor and action as and when	10/10/2022	06/09/2024		Ferrie, Mr. Paul
6886	23/03/2023	Hackett, Steve	Corporate Services	Ability to deliver 2023/24 Financial Plan	Non delivery of the financial plan which is currently a £6.0m deficit. Caused by inability to deliver a £12.2m cost improvement programme or under recovery of elective recovery income (current target 103% of 2019/20 activity)or cost pressures exceed amounts set in reserve. Resulting in cash deficiencies limiting ability to pay suppliers and potential regulatory actions for failure to live within financial resources made available.	High 25	High 20	Low 5	27/06/2024	25/07/2024	[Wallett, Val 27/06/24 11:35:49] [Steve Hackett - 27.06.24] Accounts submitted on 27.06.24 in advance of deadline. Final financial position unchanged from draft accounts. Recommend to close.	Approved Risk	Theatre improvement programme.	23/03/2023	31/07/2024		Kilgariff, Mrs. Sally
														Outpatient utilisation programme.	23/03/2023	31/07/2024		Kilgariff, Mrs. Sally
														Cost improvement Efficiency Board.	23/03/2023	29/03/2024	20/03/2024	Hackett, Steve
														Development of robust capacity plans.	23/03/2023	31/07/2024		Kilgariff, Mrs. Sally
														Development of Winter plan.	23/03/2023	23/11/2023	03/11/2023	Hackett, Steve

6888	23/03/2023	Fletcher, Michelle	Corporate Services	Lack of clinical psychology support for risk reducing surgery patients.	Treatment delays for patients who are gene positive requiring breast surgery.	High 15	High 15	Moderate 9	28/05/2024	28/06/2024	[Short, Sally Mrs. 28/05/24 08:16:54] No Change, this risk has been escalated to the Corporate Nursing Team. 18/06/24 RMC: There are a number of psychology services not being met within the Trust. The Deputy Director of Corporate Affairs and the Deputy Chief Nurse are meeting to discuss and review the risk, to ensure it is succinct in risk description, cause and impact as it was reported in May RMC that, as there is no incoming investment, the risk is likely to remain static.	Approved Risk	Lack of Psychological support for the breast cancer patients	31/08/2023	23/12/2024		Timms, Mrs. Deborah
6969	18/08/2023	Staunton, Eamon	Division of Emergency Care	Lack of integration of IT services and lack of procedures/protocols against IT requests	Key Issue 1: When additional bloods are added on to an existing request by UECC these could be missed as these are completed on paper. Key Issue 2: Imaging, not being seen or delay to be seen by correct speciality /consultant. Significant increased work to sort imaging and redirect Imaging to correct Consultant and speciality. With subsequent SI and incidents arising from specialities not seeing own imaging. 2 PAs of EM Consultant time a week sorting this, and 2 hrs a day of secretarial time used. Key Cause 3: lack of electronic speciality referrals	High 20	High 20	Low 6	07/06/2024	05/07/2024	[Wallett, Val 07/06/24 11:56:36] [Eamon Staunton -07.06.24] Escalated to Chief Executive 15.05.24	Approved Risk	escalate to deputy medical director	05/09/2023	05/09/2023	05/09/2023	Staunton, Eamon
													Results Acknowledgement Group	02/02/2024	02/07/2024		Reynard, Jeremy
													Consultant Awareness of Issue	02/02/2024	05/07/2024		Reynard, Jeremy
7001	12/10/2023	Reynard, Jeremy	Division of Emergency Care	In ability to get patients to CT in a timely manner	Delay to CT for patients in the UECC. 30% of majors and resus patients undergo a CT from the UECC, half of which are subsequently discharged. Only 50% of patients get a CT result within 2 hours of request. At 3hours 25% of patients who are discharged are still waiting for a result.	High 20	High 15	Low 4	25/06/2024	25/07/2024	Care Group Governance, 25 June 2024: It was discussed at Governance meeting, noting that a QI project is in progress. The data shows a slight improvement however the time to CT is still measured in hours. There is a lack of portering, alongside other elements that cause delays, such as radiology, reporting, handover times. It was discussed that the portering establishment has not reflected in the influx of patients.	Approved Risk	QI Project	16/11/2023	27/09/2024		Staunton, Eamon
													Portering.	01/10/2023	31/01/2024	20/12/2023	Maton, Lynsey
													2nd CT scanner for Trust	01/11/2023	30/08/2024		Reynard, Jeremy
													Transfer team and transfer policy	01/11/2023	30/09/2024		Maton, Lynsey
													discussions across divisions.	16/11/2023	14/06/2024	27/06/2024	Stephenson, Daniel
													Safer care nursing tool	01/01/2023	31/12/2024		Maton, Lynsey
													Teletracking	17/04/2024	31/07/2024		Farrow, Lindsay

5967	27/10/2019	Hammond, Lesley	Division of Emergency Care	Insufficient provision of medical cover within the UECC and GP out of hours service	Updated 11.03.24 to link with Risk 6131 and 5238. Lack of staffing in the GP Out of Hours Service. Unable to fill the MG rota, especially at night (within UECC). Not achieving the new 4 hour target. Delay to be seen by a clinician.	High 15	High 15	Moderate 9	07/06/2024	07/07/2024	[McAuley, Heather 07/06/24 14:56:46] discussed in divisional governance and risk level agreed. June 2024 RMC: Another Deanery trainee is being provided which will help, along with some clinical fellows in August. There is also one consultant coming back from sabbatical leave in July and another consultant from maternity leave at the end of the summer.	Approved Risk	ACT programme	04/04/2022	31/03/2025		Hammond, Lesley
													Recruitment	04/04/2022	03/04/2023	18/05/2023	Hammond, Lesley
													Winter plan	01/11/2023	31/03/2024	25/04/2024	Reynard, Jeremy
													Review of rota	01/02/2023	31/08/2024		Reynard, Jeremy
													Workforce plan from ACT work	01/02/2023	30/04/2024	30/04/2024	Reynard, Jeremy
													Senior clinical fellows	04/12/2023	30/08/2024		Reynard, Jeremy
6691	28/04/2022	Reynard, Jeremy	Division of Emergency Care	Effect of un-embedded 4 hour and Acute Care Standards	The lack of ACS compliance across the trust has a detrimental effect on 1. Overcrowding in the UECC 2. Medical capacity in the UECC 3. Nursing capacity in the UECC Overcrowding in the UECC leading to the UECC not being able to function efficiently or effectively. 1. Unable to see patients. 2. Unable to offload ambulances 3. Dangerous overcrowding in the Main Waiting Room. 4. Delay to time critical treatment 5. Delay to time critical medication.	High 20	High 20	Moderate 12	27/06/2024	26/07/2024	[Roberts, Jodie 27/06/2024 16:45:23] Full capacity protocol has been completed as has bed modelling. We are planning on rerunning the bed modelling and will make some adjustments based on activity and demand over the last year. Rimmer, Claire 27/06/2024 14:54:07 It was reported at June RMC that this risk needs to be worked through as a Trust and outlined the need to hit 75% for the rest of the month. There is still a lot that needs to change in order to maintain this consistently.	Approved Risk	Work with Executive team on embedding the standards and engagement with the Trust	01/11/2023	05/02/2025		Reynard, Jeremy
													Transformational work, Task and finish group	01/02/2024	31/10/2024		Kilgariff, Mrs. Sally
													New staffing tool to be implemented	05/06/2023	15/07/2024		Maton, Lynsey
7027	29/11/2023	Reynard, Jeremy	Division of Emergency Care	Inability to provide analgesia and other time critical medications in UECC in a timely manner	Delays to pain relief, less appropriate pain relief been given. Delay to review. Delay to antibiotics. Delay to other time critical medications. Delay to ADREQ and therefore transfer and the 4 hour target.	High 15	High 15	Moderate 8	28/06/2024	27/07/2024	[Maton, Lynsey 28/06/24 12:01:28] discussed in divisional governance and current risk level agreed, Plan is for staff training on PGD's, followed by a review and re-run of the pain audit. The unit had trialled using the triage drug cupboard for codeine and dihadracodiene storage, however this was not successful with results escalated to the Medication Committee.	Approved Risk	review available PGDs	20/12/2023	24/07/2024		Maton, Lynsey
													Improve access to other services	01/02/2024	30/09/2024		Maton, Lynsey
													Improve flow	01/02/2024	30/08/2024		Hammond, Lesley
													Nursing capacity to meet demand	01/02/2024	30/08/2024		Maton, Lynsey
													explore Sepia function to show patients who require time critical medicines	22/04/2024	24/07/2024		Farrow, Lindsay

6638	07/02/2022	Smith, Mrs. Gail	Division of Integrated Medicine	The division's ability to ensure sufficient numbers of suitably qualified, competent and experienced RN	The Division of Medicines ability to recruit to all Registered Nurse vacancies and to ensure there are sufficient numbers of suitable qualified, competent and experienced Registered Nurses and HCSWs The risk assessment covers; Acute Medical Unit, Short Stay Unit, A1,A2,A3,A4,A5,A6,A7,Coronary Care Unit, Stroke and Neuro-rehabilitation The division's ability to provide safe and effective staffing with the right numbers of Registered Nurses with the right skills in the right place at the right time, which has the potential risk of; •Potential failure to protect patients and colleagues from harm •Potential increase in `care left undone / missed care` For example the ability to provide timely administration of medication, ability to provide effective pain management, ability to provide the required frequency to change a patients position to maintain safety, comfort and effective skin care, ability to undertake timely patient assessments and timely interventions for patients •Ability to provide timely patient observations in line with the assessed frequency of NEWS 2 in line with trust policy •Ability to provide the appropriate level of care for patient as assessed by the `supportive observation of care tool` •Ability of Registered Nurses to provide contemporaneous documentation as outlined in the Nursing and Midwifery Code Professional standards of practice and behaviour for nurses, midwives and nursing associates •Ability of Ward Managers to maintain their supervisory role •Ability of colleagues to have the time, space and opportunities to share learning, sustain and embed learning in clinical practice •Potential material breach of Care Quality Commission condition of registration •Potential increase in colleague's sickness and absence •Potential increase in colleagues leaving the division and or trust •Potential for the division to be non-complaint with MAST Training and Appraisals •The increase in the use of bank and agency colleagues, this has the potential to affect the financial stability of the Division and the organisation, has the ability if fill rates are low to affect the Care Hours Per Patient Day across the ward areas	High 25	High 20	Low 6	28/06/2024	26/07/2024	Benton, Jennifer 28/06/2024 09:06:47 Risk reviewed. Significant challenges to provide daily safe staffing levels, due to unfunded additional capacity beds on AMU, B5 and Stroke Unit. Proactive sickness monitoring which has reduced long term sickness however short term sickness is above 8% causing further impact on daily staffing levels. Risk reviewed at Divisional Governance and agreed the risk score to remain at 20 (L5xC4)	Approved Risk	HRBP and HON to review Long Term Sickness Cases across the Division	30/01/2023	27/03/2023	26/03/2023	Hill (No Longer with the Trust), Mark
														HRBP to work with Ward Managers and Deputy Ward Managers to provide refresher training in relation to sickness and absence management	06/02/2023	28/04/2023	17/04/2023	Hill (No Longer with the Trust), Mark
														Introduction of Roster review meetings	08/02/2023	29/05/2023	08/06/2023	Smith, Mrs. Gail
														Bespoke recruitment event for RNs across medicine	01/03/2024	30/04/2024	11/05/2024	Smith, Mrs. Gail
														review of staffing - provision of safe staffing	26/02/2024	26/08/2024		Benton, Jennifer
														Sickness absence monitoring	26/02/2024	27/05/2024	06/06/2024	Smith, Mrs. Gail
7010	26/10/2023	Lunn, Mrs. Clare	Division of Integrated Medicine	Delay in heart failure patient reviews	delay in patients being reviewed by heart failure nurse specialist Delay in patient being cared for on all wards including cardiology Longer length of stay due to none or less frequent reviews Poor clinical outcomes Higher heart failure morbidity cannot facilitate discharges resulting in patient deterioration when an in-patient High staff stress and potential for sickness and burnout.	High 15	High 15	Low 6	10/06/2024	14/07/2024	[Lunn, Clare Mrs. 11/06/24 16:52:56] costing now back on business case will be submitted to panel before the end of June 24	Approved Risk	data collection of referrals into the system	30/10/2023	11/12/2023	28/12/2023	Lunn, Mrs. Clare
														to discuss the data with SLT in division	13/11/2023	30/11/2023	14/02/2024	Lunn, Mrs. Clare
														data analysis of patient reviews	20/11/2023	29/02/2024	14/02/2024	Lunn, Mrs. Clare
														to complete a short business case	14/02/2024	13/06/2024	16/06/2024	Lunn, Mrs. Clare
														await outcome from panel and business brief	16/06/2024	16/07/2024		Mitchell, Samantha
6958	02/08/2023	Agger, Joanne	Division of Surgery	Lack of Rheumatology Consultants to meet service need	Failure to provide a consultant led Rheumatology Service	High 15	High 15	Moderate 9	17/06/2024	16/07/2024	[Ward, Sandra Mrs. 16/05/24 14:01:31] 16/05/2024 - no change from 19/03/2024 update. Risk remains static until consultants in post.	Approved Risk	consultant recruitment	02/01/2023	31/10/2024		Agger, Joanne

6809	20/10/2022	Oliver, Lauren	Division of Surgery	Lack of Local Safety Standards for Invasive Procedures (LocSSIPs)	Risk of patient safety incidents and reduced delivery of safe care during invasive procedures.	High 15	High 15	Low 6	16/05/2024	31/07/2024	[Culham, Helen 13/06/24 17:08:39] Risk reviewed and new action plan submitted.	Approved Risk	Lack of Local Safety Standards for Invasive Procedures (LocSSIPs)	13/04/2023	29/07/2024		Oliver, Lauren
													To establish Trust wide required LocSSIPs	13/06/2024	01/01/2025		Oliver, Lauren
6723	10/06/2022	Agger, Joanne	Division of Surgery	Anaesthetic Medical Staffing Availability	Unavailability of Anaesthetists due to long and short term sickness. Caused by long and short term sickness. Resulting in lack of availability of Anaesthetists results: Gaps in the on call rota Loss of operating lists in theatres potential burn out for staff picking up on call shifts.	Moderate 12	High 15	Low 6	14/06/2024	15/07/2024	18.06.24 - It was reported at June RMC that there is a challenge to allocate the responsibility to undertake the work (Phase two) and this had not yet been commissioned.	Approved Risk	SCH joint recruitment	01/08/2022	31/10/2022	22/06/2023	Howlett, Darren
													Interview 2x shortlisted consultant candidates	10/01/2023	31/01/2023	16/04/2023	Shuker, Katy
													Agree temporary alignment of additional on call rate with UECC colleagues	01/12/2022	31/01/2023	16/04/2023	Howlett, Darren
													Extend use of insourcing support	05/06/2023	29/09/2023	18/07/2023	Howlett, Darren
													External review of the Anaesthetic rotas	19/06/2023	31/12/2023	08/01/2024	Howlett, Darren
													Develop an options appraisal paper for review at ETM.	22/06/2023	31/07/2023	18/07/2023	Howlett, Darren
													Phase two - Commissioning	08/01/2024	30/09/2024		Agger, Joanne
6762	23/07/2022	Short, Mrs. Sally	Division of Surgery	Inpatient beds in the trolley area ASU	ASU trolley area not operating as surgical SDEC due to unfunded inpatient beds in both bays. Preventing flow from UECC for non ambulatory surgical patients to be managed in ASU. Caused by preventing SDEC operating due to inpatients in 10 non funded beds Medical and surgical patients in ward surgical beds. Resulting in Increased admissions to hospital due to all patients managed in waiting area sometimes for long periods. Preventing streaming/flow of non ambulatory patients from UECC. Poor patient experience and increased length of stay in department. Preventing good early flow through the unit as previously 10 trollies were available at the start of the day to ensure adequate capacity until patients were discharged from short stay beds.	Low 6	High 15	Low 6	14/06/2024	14/07/2024	[Short, Sally Mrs. 18/06/24 07:56:41] 18/6/24 Continued discussions regarding the unfunded beds and the unit not functioning as a assessment unit due to this	Approved Risk	unfunded beds to trolleys	14/06/2024	01/10/2024		Cresswell, Mr Andrew
													unfunded beds to trolleys	17/06/2024	17/09/2024	13/05/2024	Cresswell, Mr Andrew
6630	28/01/2022	Windsor, Claire	Division of Surgery	Lack of Critical Care Follow Up Clinic	Critical illness leaves patients at highly significant risk of long term physical, cognitive and psychological problems. This has the potential for considerable residual impact on patients morbidity and longevity. Caused by no Critical Care follow up service. Resulting in failure to provide vital support following discharge resulting in the inability to identify any complications relating to critical illness which require effective management and ongoing treatment or onward referral including significant mental health / psychological sequalae and physical disability. Failure to meet GPIC's V2 standards.	High 15	High 15	Low 6	27/06/2024	26/07/2024	Timms, Mrs. Deborah 27/06/2024 16:19:06 27.6.24 - Discussed at CG Governance under Risks over 15. No changes to be made to the risk at this time. Team reviewing to see where mitigations can be made. Risk to remain the same.	Approved Risk	Lack of Critical care Follow-Up	01/08/2022	30/09/2024		Timms, Mrs. Deborah

6324	23/11/2020	Petty, Sarah	Division of Family Health	Delays to 18 Week Wait and 52 week breaches	There is a potential risk to delayed treatment due to the 18ww currently our performance for RTT incomplete is 59.8% which is variable month on month against a target of 92%.	High 15	High 15	Low 6	05/06/2024	05/07/2024	[Dodd, Jamie Mr. 05/06/24 10:16:55] 05/06/2024: Reviewed by S Petty - Work continues with QI project to explore opportunities for further improvement.	Approved Risk	Weekly waiting list meetings	01/04/2021	05/07/2024	23/04/2024	Marshall, Miss Faye
													Additional theatres and reutilising theatres during leave	01/04/2021	05/07/2024	23/04/2024	Marshall, Miss Faye
													Monitor through Governance	13/06/2022	05/07/2024	23/04/2024	Marshall, Miss Faye
													Work continues with QI project to explore opportunities for further improvement.	05/06/2024	05/07/2024		Petty, Sarah
6421	31/03/2021	Wilman, Mrs. Johanna	Division of Family Health	Backlog of children waiting to be seen for assessment Child Development Centre (CDC)	Delay in assessment and formulation of a care plan for children aged 0-5yrs with additional needs. This will impact on long term outcomes including health and fulfilling educational/developmental potential	High 15	High 15	Low 6	27/06/2024	26/07/2024	Wilman, Mrs. Johanna 27/06/2024 15:25:53 Both away days were completed and all involved felt successful. 1. We are looking to get together with stakeholders to devise a robust early graduated response before a child is referred to the CDC and then ways to ensure this care continues as the child undergoes their assessment. 2.We have through trial and error been looking at a new streamlined pathway for children attending for assessment. This was approved at the teams away day on the 6th June and there is now an action plan to implement the changes. However this will not be a quick fix and we need to look at developing a SOP with the admin teams and CDC staff. 3 .We are currently looking at demand and capacity model to see if we can determine what the current capacity is given the recent demand, We are also looking at training additional staff members to do more of the autism diagnostic work. This will not only increase capacity but also provide some succession planning for any future changes 4. No news on the transfer of children to CAMHS, Vicky Whitfield is currently negotiating with them but they are insisting more of their paperwork is sent out which we do not have access to or the capacity to implement. Number currently on the list is 78.	Approved Risk	Support without referral Pathway	18/09/2023	31/09/2024		Wilkinson, Jo
													Funding for further staff	18/09/2023	30/11/2023	02/01/2024	Wilman, Mrs. Johanna
													Psychology Funding	18/09/2023	28/06/2024	03/06/2024	Wilman, Mrs. Johanna
													Joint working with RDASH	18/09/2023	30/07/2024		Wilman, Mrs. Johanna
6873	20/12/2022	Stables, Sarah	Division of Family Health	Risk of losing patient paper medical records due to the introduction of plastic wallets and the removal of stronger card folders	Maternity patient paper records are required to be safely stored for 25 years in case of any legal request from the families we care for. The risk is that CTG's and paper records may be lost leaving the Trust compromised at a later point in time.	High 16	High 16	Low 4	17/06/2024	17/07/2024	[Dodd, Jamie Mr. 18/06/24 08:05:54] 17/06/2024: A Ford update - I updated IGC on Friday, new product sourced, order placed, awaiting delivery. I will update as soon as the order is delivered.	Approved Risk	In talks with the patient records department to attempt to find a solution	23/02/2023	17/07/2024	10/01/2024	Stables, Sarah
													Meeting with Deputy Head of Midwifery, Carol O'Neill and Angela Ford to discuss ongoing issues. Records department agreed to reinstate card files until process of scanning documents is fully in place. Will be monitored through Governance.	10/01/2024	17/07/2024	20/05/2024	Stables, Sarah
													To escalate failed delivery again to Kevin Wilkinson, Laura Allwood and Angela Ford.	20/05/2024	17/07/2024		Stables, Sarah

Board of Directors' Meeting
5 July 2024

The Rotherham NHS Foundation Trust

Agenda item	P105/24
Report	**Chief Executive Report**
Executive Lead	Dr Richard Jenkins, Chief Executive
Link with the BAF	The Chief Executive's report reflects various elements of the BAF
How does this paper support Trust Values	The contents of the report have bearing on all three Trust values.
Purpose	**For decision ☐ For assurance ☐ For information ☒**
Executive Summary (including reason for the report, background, key issues and risks)	This report is intended to give a brief outline of some of the key activities undertaken as Chief Executive since the last meeting and highlight a number of items of interest. It focuses on the following key areas: • Operational Matters • Performance • Integrated Care Board (ICB), Acute Federation and Rotherham Place Development and Partnership Working • People
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	This paper reports directly to the Board of Directors.
Board powers to make this decision	No decision is required.
Who, What and When	No action is required.
Recommendations	It is recommended that the Board note the contents of the report.
Appendices	1. Chief Executive of NHS South Yorkshire update report 2. Acute Federation Annual Report

1.0 Operational Matters

1.1 The key ambition this quarter is to have no patients waiting over 65 weeks, ahead of the national September 24 target. The trajectory submitted to NHSE was 10 patients at the end of June 2024, with no patients over 65 weeks from July onwards. Work is on-going to achieve this, there are some complex cases but the Trust has managed to reduce the numbers waiting and is forecasting to achieve the trajectory of 10.

Focus also remains on reducing the number of patients waiting over 52 weeks and returning to compliance with the Referral to Treatment (RTT) standard, with each Care Group currently working on their trajectories for delivery and recovery of their RTT positions.

1.2 **Urgent and Emergency Care Activity:** The Trust continued to see high levels of attendances at UECC during May, with 8985 attendances compared to 8046 in May 2023 and this was also the highest attendance in month for the last twelve months.

In May, the Trust achieved 63.8% for 4-hour performance. Work continues in terms of the Acute Care Transformation Programme to enhance pathways of care. In addition, a recovery plan for performance has been developed to ensure delivery of the Trust ambition of 80%, with an intention of achieving over 70% performance in June 2024.

2.0 Industrial Action

2.1 Junior Doctor industrial action has been announced from 7am on Thursday 27th June to 7am on Tuesday 2nd July 2024. Plans have been developed by Care Groups for this period to ensure the Trust is able to continue to provide essential services to mitigate the impact on patient care as much as possible. As always, patient care and patient safety is our priority during the strike action.

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

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

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

3.3 The Barnsley and Rotherham partnership continues to collaborate with a number of events taking place to provide an opportunity for colleagues to make connections, focus on shared learning, support and best practice. This includes a Joint Executive Team meeting held on 19th June 2024 and a Joint Senior Leaders Team event to take place on Friday 9th August 2024.

Colleagues from each Trust continue to meet on a monthly basis via the Joint

Executive Delivery Group (JEDG) and the Joint Strategic Partnership Group. As the Partnership has been in place for over 12 months now, the JEDG will undertake an engagement exercise with the aim of gathering helpful and informative feedback from internal and external stakeholders on their perception of the partnership. The engagement plan is part of the over-arching partnership programme for 2024/25.

3.4 The Acute Federation published its Annual Report for 2023/24 (see appendix 2) which provides an overview of the progress made during the last twelve months.

4.0 People

4.1 The Trust held its annual PROUD awards ceremony on 14th June 2024. This was a fantastic night and enabled us to recognise the amazing colleagues we have across both the Trust and community. There were twelve categories and with over a recording breaking seven hundred nominations it was very difficult to choose a shortlist, finalists and then overall winners. However, I am incredibly proud to confirm that the winners were as follows:

Chairman's Award: Clinical Haematology Team
Chief Executive's Award: Laura Mumby, Deputy Director of Digital and Technology
Governors' Award for Living the Values: Danijela Preradovic, Healthcare Support Worker, Ward A1
Learner of the Year: Billy Ferguson, Procurement Graduate, Procurement
Quality Improvement Award: Andy Woods, Service Manager, Children and Young People's Services
Inspiring Leader: Chris Hammond-Race, Clinical Lead, Audiology
Diversity and Inclusion Award: Sri Kakarlapudi, Clinical Lead for Nutrition and Dietetics
Clinical Team of the Year: Virtual Ward / Urgent Community Response
Non-Clinical Team of the Year: Orthopaedic Operational Team and Schedulers
Unsung Hero Award: Billy Bell, Security, Woodside
Public Recognition Award: Dermatology and Tara Lees
Volunteer of the Year Award: – Ward B5 volunteers

As well as the above categories, we also announced the winners of our three annual Excellence Awards (chosen from the monthly award winners) and these were:

Individual:	Lucy Richardson, Healthcare Support Worker, Community Neuro-Rehabilitation
Team:	Education and Development Team
Public:	Maternity

4.2 The monthly staff Excellence Awards winners for the months of April and May 2024 are as follows:

April 2024

Individual Award –	Gary Owens, Gardener, Estates
Individual Award –	Jayne Tingle, HR Business Partner, Employee Relations
Team Award –	Contracts and Costing Team
Team Award –	Ward A1 Care Support Workers

Public Award – Julie Gent, Nurse, Early Pregnancy Advisory Unit

May 2024
Individual Award – Jeffrey Zuniga, Nurse, Short Stay Unit
Team Award – Communications Team
Public Award – Dr James Ward, Resus/Anaesthetics

4.3 The following Consultant have accepted posts and have start dates:

- Dr C Anderson, Anaesthetics (16.09.24)

We also have a number of Consultants who have accepted posts with start dates to be confirmed as follows:

- Dr A Watkin, Anaesthetics
- Dr K Khokhar, Rheumatology
- Dr H Umair, Rheumatology
- Mr H Zaki, Ophthalmology
- Dr C Fragkoulakis, Radiology
- Dr D Starostin, Radiology

4.4 I am pleased to report that two new Staff Governors have been elected and will join our existing colleagues, making five in total.

4.5 I am delighted to report that our Haematology team have achieved their Clinical Service Excellence Programme (CSEP) accreditation from Myeloma UK. The accreditation highlights our commitment to exceptional myeloma care and is a testament to the hard work and determination of the entire team involved. CSEP provides a framework for ongoing improvement and enables the team to continue to enhance services.

5.0 Pre-Election Period

5.1 The Prime Minister of the UK has announced that a General Election will be held on Thursday 4th July 2024. As a result, this means that the Trust is required to observe a pre-election period, which is designed to avoid the actions of public bodies distracting from or having influence on election campaigns and will mean that we have restrictions on what we can and cannot do until after the election.

Dr Richard Jenkins
Chief Executive
July 2024

Chief Executive Report

Integrated Care Board Meeting

1 May 2024

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

Purpose of Paper

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

Key Issues / Points to Note

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

Is your report for Approval / Consideration / Noting

To note

Recommendations / Action Required

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

Board Assurance Framework

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

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

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

Goal 1 – Inspired Colleagues: To make our organisation a great place to work where everyone belongs and makes a difference	✓
Goal 2 – Integrated Care: To relentlessly tackle health inequalities and to support people to take charge of their own health and wellbeing.	✓
Goal 3 – Involved Communities: To work with our communities so their strengths, experiences and needs are at the heart of all decision making.	✓

Are there any potential Risk Implications? (including reputational, financial etc)?
No
Are there any Resource Implications (including Financial, Staffing etc)?
No
Are there any Procurement Implications?
No
Have you carried out an Equality Impact Assessment and is it attached?
N/A
Have you involved patients, carers and the public in the preparation of the report?
N/A
Appendices
N/A

Chief Executive Report

Integrated Care Board Meeting

1 May 2024

1. Purpose

This paper provides an update from the Chief Executive of NHS South Yorkshire on the work of the ICB and system partners for March and April 2024. Part of this period is covered by the Pre-election Period ahead of the elections on Thursday 2 May 2024, and the content of the paper reflects that.

2. Integrated Care System Update

2.1 Integrated Care Partnership Board meeting.

The March 2024 Integrated Care Partnership meeting discussed the Safe Space to Sleep Programme. South Yorkshire Mayoral Combined Authority has approved £2.2m for the programme and this will be directed to trusted voluntary organisations to deliver a bed and bedding to any family with a child aged between 0-5 following a referral.

There will also be four test-and-learn pilots in Goldthorpe, Mexborough, Swinton and Gleadless, and these will help build a detailed evidence base of what works at a community level. This is a great example of a problem, which doesn't necessarily fit within the remit of a single organisation, being tackled by a wide range of organisations. NHS South Yorkshire will continue to align its work with the wider work of the ICP and organisations in South Yorkshire.

2.2 Year End performance

2.2.1 Service Delivery

NHS South Yorkshire achieved a positive year end position on key national performance standards.

The system delivered the requirement to ensure no patients were waiting longer than 78 weeks for planned treatment at the end of March with the exception of a small number of highly specialised cases for example those waiting for corneal grafts where donor tissue was not available.

Urgent and emergency care has continued to be a significant priority and we've worked hard to meet the national requirement that no one should wait more than four hours in an Emergency Department to be treated and either discharged or admitted. We achieved 74.3% against the revised target of 76% which was better than the national average. South Yorkshire was one of the most improved systems nationally. This required a 'whole system' approach with all partners in community, primary care, ambulance services, acute hospitals, mental health, social care, primary care and

beyond working together and the South Yorkshire UEC Alliance and our local partnerships in the four places have enabled this.

For those needing cancer treatment we have reduced the numbers waiting more than 62 days for initial treatment following referral to pre-pandemic levels. Again, this is a collective effort, and our South Yorkshire Cancer Alliance and wider partners will continue to work together improve the care those who need a cancer referral, diagnostic test or treatment receive.

We have also seen a reduction in the numbers of people requiring a mental health admission to hospital needing to be cared for outside of the local area. This has been achieved by reducing demand for admission through more responsive community services and improving access to local inpatient capacity when required.

Good progress has also been made in improving access to primary care in response to the national Primary Care Access Recovery Plan.

2.2.2 Finance

South Yorkshire ICB commissions and provides approximately £3bn of NHS services. However, 2023/24 has proven to be a particularly challenging year from a financial and operational perspective including the impact of frequent periods of industrial action. The budget across the NHS in South Yorkshire was exceeded by about 1.5% with a year-end deficit of £48.3m. Although disappointing this was an improvement on the mid-year forecast agreed with NHS England.

The ICB has been working with local NHS organisations, place partnerships and cross-South Yorkshire provider collaboratives and alliances, ahead of and since the publication of the NHS planning guidance released in March, to develop the 2024/25 operational and financial plan.

2.3 Industrial action

NHS consultants have accepted a new pay deal, having rejected a previous offer to avoid further industrial action. However, Junior doctors have voted in favour of extending their mandate for industrial action for another six months, meaning that they can now take industrial action up to 19 September 2024 although no new dates have been set at this point..

GPs in England are to consider their next steps, with more than 19,000 GPs and GP registrars nationally taking part in the BMA's referendum, voting ‘no’ when asked if they accepted the new contract for the service. Given the independent nature of GP practices are unlikely to take strike action but may consider working to the letter of the contract.

The NHS in South Yorkshire is continuing to maintain its plans for urgent and emergency care, as well as some planned treatment and appointments where possible, should further industrial action take place. The South Yorkshire ICB has continued to provide support through its Incident Co-ordination Centre, which has

operated at all times during industrial action in line with our Category 1 responder status.

2.4 NHS Planning Guidance

The 'Priorities and operational planning guidance 2024/25' was released just before the end of the financial year. This was a change from previous years where the guidance was traditionally released before the end of the calendar year. The overall priority within the guidance in 2024/25 remains the recovery of core services and productivity following the pandemic. This focusses on six main areas:

- Patient safety: maintain our collective focus on the overall quality and safety of our services, particularly maternity and neonatal services, and reduce inequalities in line with the Core20PLUS5 approach.
- Urgent and Emergency care: improve ambulance response and A&E waiting times by supporting admissions avoidance and hospital discharge, and maintaining the increased acute bed and ambulance service capacity that systems and individual providers committed to put in place for the final quarter of 2023/24
- Waiting times: reduce elective long waits and improve performance against the core cancer and diagnostic standards.
- Primary care access: make it easier for people to access community and primary care services, particularly general practice and dentistry.
- Mental health: improve access to mental health services so that more people of all ages receive the treatment they need.
- Staff recruitment and retention: improve staff experience, retention and attendance.

The detailed guidance focusses on 12 areas, ranging from Urgent and Emergency care and Primary and Community services, through to workforce and use of resources. Within these 12 areas there are 32 detailed objectives. The detailed objectives include:

- Improve A&E waiting times, compared to 2023/24, with a minimum of 78% of patients seen within 4 hours in March 2025
- Ensure that everyone who needs an appointment with their GP practice gets one within 2 weeks and those who contact their practice urgently are assessed the same or next day according to clinical need.
- Eliminate waits of over 65 weeks for elective care as soon as possible and by September 2024 at the latest.
- Improve performance against the headline 62-day standard to 70% by March 2025
- Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%
- Establish and develop at least one women's health hub in every ICB by December 2024, working in partnership with local authorities.
- Increase the number of adults and older adults completing a course of treatment for anxiety and depression, with at least 67% achieving reliable improvement and 48% reliable recovery.

NHS South Yorkshire has been working in anticipation of this planning guidance and plans are being developed to meet these objectives.

2.5 Alhambra Shopping centre

NHS South Yorkshire is working with Barnsley Hospital, Barnsley Council, South West Yorkshire Partnership NHS Foundation Trust and South Yorkshire Mayoral Combined Authority to transform some parts of the Alhambra Shopping Centre in Barnsley into a health and wellbeing hub for the community.

This follows the announcement in September 2023 that Barnsley Council had purchased the leasehold of the shopping centre. The new health and wellbeing hub will expand the range of services and facilities available at the Alhambra Shopping Centre.

Barnsley Hospital is planning to move some of its outpatient services out of the hospital into the new hub at the Alhambra. This will help reduce missed appointments and help improve health outcomes for people who will be more able to access vital services in a place familiar to them rather than having to go to hospital.

It's estimated more than 100,000 visits a year could be made to the Alhambra instead of Barnsley Hospital, reducing traffic and pressure on parking in the area around the hospital, while also bringing more visitors and economic benefit into our thriving town centre.

2.6 CQC ratings

Following an inspection last year, Doncaster and Bassetlaw Teaching Hospitals' Care Quality Commission (CQC) rating has been adjusted from 'Good' to 'Requires Improvement'. The CQC did recognise a number of areas of quality care and practice at the Trust and continues to be rated 'Good' for caring.

As part of the process, inspectors from the CQC visited the Trust in August and October 2023, during a period of industrial action, and assessed whether the Trust's services were safe, effective, caring, responsive and well-led across the four core services of Urgent and Emergency Care, Surgery, Medicine, Diagnostics and Maternity Services.

Since the unannounced inspection more than six months ago, the Trust has made significant progress, and the organisation's most recent Staff Survey results have shown positive changes, with 94% of responses indicating improvements in staff experiences compared to last year.

The change in rating brings the Trust into line with most other providers in South Yorkshire, and the national trend of trusts moving from Good to Requires Improvement. In South Yorkshire, Barnsley Hospital NHS Foundation Trust and Sheffield Children's NHS Foundation Trust remain Good.

3. NHS South Yorkshire

3.1 NHS England ICB Running Costs Allowance (RCA)

The ICB is close to concluding its restructuring programme in response to a nationally mandated 30% reduction of its running costs allowance. A limited voluntary redundancy scheme saw 11 staff leave and a similar number of colleagues will leave through compulsory redundancy subject to NHS England approval.

Our first estate move took place on Monday 8 April 2024 with the Sheffield location moving to Eyre Street to co-locate with South Yorkshire Fire and Rescue, which will contribute a significant financial saving. Further plans for relocating Barnsley and Rotherham offices with local authority partners are close to completion and the previous Rotherham base has now closed prior to the move into Riverside House. The Doncaster estate has already been consolidated from two buildings into one.

3.2 Joint Forward Plan

The updated Joint Forward Plan for South Yorkshire for 2024/25 has now been published. Like last year it has been shaped by the views of our communities through their involvement, as well as health and care partners. It has also been shared with each of our Health and Wellbeing Boards and our South Yorkshire Integrated Care Partnership. Given the initial plan was only published last year, there are no major changes to the refreshed plan. However, there has been:

- A refreshed summary of our Joint Strategic Needs Assessment (JSNA) including updated data and information on women's health, men's health and end of life care.
- The inclusion of developing plans to address women's health issues
- Strengthened plans to further develop collaborative tobacco control work across South Yorkshire, including an expanded communication campaign
- Updated case studies, a stroke campaign in Barnsley and confirmation of the opening date for Sheffield Elective Orthopaedic Centre and the Montagu Elective Orthopaedic Centre.
- Strengthened plans to improve palliative and end of life care through delivery of our Palliative and End of Life Care Strategy and underpinning action plans.

The full plan can be accessed here.

3.3 NHS booking system open for spring Covid-19 vaccinations

People in South Yorkshire aged 75 or over, and children and adults with a weakened immune system, can now book their spring Covid-19 vaccine to get protection from the risk of serious illness.

The Joint Committee on Vaccination and Immunisation (JCVI) have advised that the eligible cohorts include adults aged 75 years and over, residents in care homes for older adults and individuals aged six months and over who are immunosuppressed. The vaccinations started in late April 2024 and will be available until 30 June 2024.

3.4 Start with People Strategy

NHS South Yorkshire has worked with partners and our wider communities to help refresh our 'Start with People: South Yorkshire' strategy, which was initially launched in July 2022 when NHS South Yorkshire was created. The strategy outlines how we listen to our communities, especially those who are often underserved, and involve them in the way we provide NHS and care services. The strategy is also informed by the Integrated Care Partnership strategy and the Five-Year Joint Forward Plan, both of which were created with involvement from our communities. The final strategy will be published this summer.

4. NHS South Yorkshire Place Updates

4.1 Sheffield

The NHS has opened a new gambling clinic in Sheffield. The clinic will meet the growing demand for services and means that the NHS has now almost doubled the number of specialist clinics available. The Sheffield clinic, which joins existing problem gambling services in 14 other national locations, will treat patients over the age of 13, with each centre treating an average of 200 people a year. Patients who are referred can get support from specialist teams, which include clinical psychologists, therapists, mental health practitioners, psychiatrists, and peer support.

4.2 Doncaster

Medical students at Doncaster and Bassetlaw Teaching Hospitals are involved in an innovative pilot scheme to test virtual reality medical training simulations. Using a virtual reality headset as well as Oxford Medical Simulation software, the students were able to see and interact with a computer-generated bedside hospital scenario of a patient, as part of a training simulation. During the scenario, the headsets tracked participant's physical movements, allowing them to interact with the medical equipment and patient within the scenario. By doing so, they were able to administer tests, ask the patients questions, give medicines based on their results and diagnose.

4.3 Rotherham

Rotherham Council has been successful in securing an additional £1m of funding to expand the Short Breaks Innovation Fund programme for 2024/25. This funding will support children with some of the most complex needs. Last year, the Council secured almost £560,000 to deliver the first year of the project. The project has created a Short Breaks Hub linked to Liberty House. This additional funding will supplement existing Short Breaks provision and will mean that more children aged ten and above with complex Special Educational Needs and Disabilities (SEND) needs can access additional care and support. Specialist Residential Practitioners and a network of education and health professionals provide support at the Short Breaks Hub.

4.4 Barnsley

Barnsley Hospital's Occupational Health Service is introducing access to a Professional Nurse Advocate (PNA), who can help support NHS colleagues. The PNA

role was launched nationally in 2021 by NHS England's Chief Nursing Officer. The innovative role is aimed at improving the health and wellbeing of the nursing workforce and supporting nursing retention. PNAs are registered nurses who support the wellbeing of their colleagues. They use a model called 'restorative clinical supervision' (RCS), which provides a safe space for staff to discuss challenges they face. RCS has been effective in reducing burnout and stress for a range of health professionals.

5. General Updates

5.1 Smoking consultation

The Tobacco and Vapes Bill passed its first vote and at the time of writing was in the committee stage of its progress through the House of Commons. There are a number of stages for it to go through before receiving Royal Assent, including scrutiny in the House of Lords, but the initial vote with cross party support is very encouraging.

NHS South Yorkshire has previously indicated its support for the change in the law since its initial announcement last year. This is because in South Yorkshire there are at least 16,000 hospital admissions due to smoking each year, and smoking takes the lives of 5,900 people every year from our communities. In addition, Smokers are 2.5 times more likely to need social care and on average will need care 10 years earlier than non-smokers. There are also estimates that suggest there are around 11,000 people out of work due to smoking in South Yorkshire.

NHS SY has previously written to elected representatives to ask them to support the measures and, following the current pre-election period, will continue to demonstrate our support for this important legislation.

5.2 Nuclear medicine at Weston Park

A new £4m state-of-the-art nuclear medicine and molecular radiotherapy suite has opened at Weston Park Cancer Centre. The new facility uses high-precision technologies which can detect, image and treat tumours and visualise organ systems in real time. This will play a key role in enabling the specialist cancer hospital to deliver a wave of newly targeted treatments that are set to come on board in the next few years. It will also provide opportunities for patients across the region to take part in leading national and international cancer research trials.

The new Centre will build on Sheffield Teaching Hospitals NHS Foundation Trust's reputation as a European Neuroendocrine Tumour Society Centre of Excellence for the treatment and diagnosis of rare neuroendocrine tumours. In addition, it will increase the capacity of the Trust's nuclear medicine department to provide treatment for these tumours across a wide geographical area. The purpose-built unit will be staffed by nuclear medicine technologists, clinical scientists, oncologists and radiologists.

5.3 Awards

A joint project between South Yorkshire ICB, Doncaster and Bassetlaw Teaching Hospitals and local schools, has been shortlisted for an award at the HSJ Partnership

Awards. The project, which is making local schools ‘asthma friendly’, was nominated for the Most Impactful Partnership in Preventative Healthcare award, which recognises outstanding dedication to improving healthcare and effective collaboration with partner organisations.

NHS South Yorkshire have been shortlisted for the Employee Benefits Awards. The award nomination was for support through the ICBs mental health hub and Health and Wellbeing hub over the last 12 months, which has been a difficult time for our staff due to the running costs reduction programme. In addition, Sheffield Teaching Hospitals has been nominated for the Best Financial Wellbeing strategy Award

Two Nurse Consultants at Sheffield Teaching Hospitals have recently been commended at the prestigious national 2024 British Journal of Nursing Awards. Dr Iain Armstrong, Consultant Vascular Nurse at the Royal Hallamshire Hospital’s Pulmonary Vascular Disease Unit, was named winner in the ‘Cardiovascular Nurse of the Year’ as well as runner-up for ‘Nurse of the Year’, while Weston Park Hospital’s Dr Jo Bird, Nurse Consultant (Melanoma & Immunotherapy Late Effects), was a finalist in the ‘Oncology Nurse of the Year’ category.

Gavin Boyle
Chief Executive NHS South Yorkshire Integrated Care Board
Date: 1 May 2024

NHS
South Yorkshire & Bassetlaw
Acute Federation

Annual Report
2023/2024

Contents

Lead Chair and Lead Chief Executive's Statement

Welcome to the South Yorkshire and Bassetlaw Acute Federation's Annual Report for 2023/24 which provides an overview of the progress made during the last 12 months.

Progress on our collective ambition to work at scale to reduce unwarranted variation in services, outcomes and patient experience and strengthen sustainability continues to gather pace. Reflecting on the past year, there are some notable achievements made possible by a shared vision and goals, effective governance arrangements and system support for our priority programmes.

The single South Yorkshire and Bassetlaw Pathology Network went live on 1 April 2024 following strong commitment and much hard work from our teams. It brings together the best in healthcare science and clinical expertise from some of the UK's leading specialist laboratories for the people of South Yorkshire and Bassetlaw and beyond. We will continue to build on this to release the quality and efficiency benefits we expect to achieve from collaboration.

This year we also launched our Elective Orthopaedic Centres at Sheffield and Mexborough which provide additional service capacity to ensure patients are seen and treated as quickly as possible. As a result, we are starting to see waiting times decrease and have received excellent early patient feedback. We have also seen positive mutual aid in action with Trusts in neighbouring systems, for patients requiring treatment for urological conditions and corneal transplants, amongst other things. We have made significant productivity improvements in measures like theatre utilisation and day case rates which will mean patients can be seen and treated more quickly.

Our new Community Diagnostics Centres have exceeded their targets and delivered an additional 90,000 tests for the people of South Yorkshire & Bassetlaw. We are taking innovative approaches to training with the opening of the new Yorkshire Endoscopy Training Academy, based at Sheffield Teaching Hospitals NHS Foundation Trust. And we have optimised digital technology to support waiting list management through systems like iRefer for Imaging and Patient Engagement Portals.

The Acute Trust Paediatric Innovator gathers momentum with agreement on a shared goal to deliver Healthcare That Works for Young People, to ensure the care that young people with complex or chronic conditions receive, when moving from paediatric to acute trust settings, is appropriate for them. We have secured funding to rollout remote monitoring technology for Virtual Ward for children which will deliver care closer to home and reduce the need for children and their families to spend time in hospital. And we have been working in partnership with children and young people to explore ways to improve access to elective paediatric Dental and Ear, Nose & Throat services through things like high intensity theatre operating lists, an approach being pioneered by Sheffield Children's Foundation Trust.

Because of our QUIT smoking programme, South Yorkshire and Bassetlaw is one of the first integrated care

systems to have all mental health and acute trusts reaching their target on Tobacco Dependency, helping thousands of people to give up smoking.

The Integrated Stroke Delivery Network has built on the South Yorkshire and Bassetlaw partnership to deliver improvements across the whole of the Stroke pathway including diagnosis, treatment and rehabilitation.

Although 2023/24 has been a difficult year due to the impact of industrial action and workforce shortages, all of our providers within the Cancer Alliance programme demonstrated progress against the national targets with the system backlog trajectory being delivered. Focused work on challenged pathways has led to consistent improvement against the Faster Diagnosis Standard.

At a time of huge challenge, with growing demand for services and pressure on resources, the Acute Federation has much to be proud of, and we wholeheartedly thank our colleagues for their efforts, but as ever there is still more to do.

Annette Laban, Lead Chair for the South Yorkshire and Bassetlaw Acute Federation and Chair of Sheffield Teaching Hospitals NHS Foundation Trust

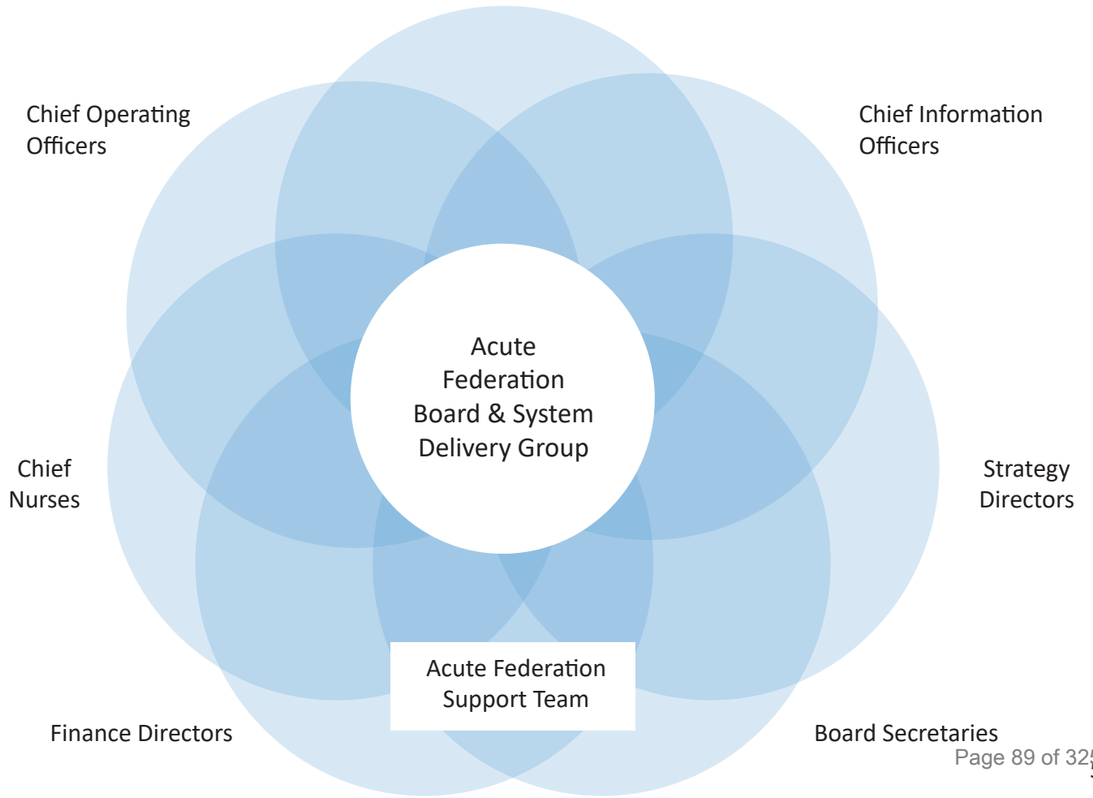
Ruth Brown, Lead Chief Executive for the South Yorkshire and Bassetlaw Acute Federation and Chief Executive of Sheffield Children's NHS Foundation Trust

Who we are and what we do

The South Yorkshire and Bassetlaw (SYB) Acute Federation is made up of five acute NHS Trusts: Barnsley Hospital NHS Foundation Trust (BHFT), Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTHFT), The Rotherham NHS Foundation Trust (TRFT), Sheffield Children's NHS Foundation Trust (SCFT) and Sheffield Teaching Hospitals NHS Foundation Trust (STHFT).

Together we have committed to using our collective expertise and resources to ensure the people of SYB have prompt access to excellent healthcare through:

Quality care	Health equality	Happy staff	Great partner	Waiting times	Effective spending
Working together to drive the quality of care to be amongst the best in the country	Taking a proactive approach to reduce health inequalities for the populations we serve	Collaboratively developing our colleagues and teams so that there are happy staff across all partners	Being a great partner to the rest of the health and care system in South Yorkshire and Bassetlaw	Supporting each other to achieve all the NHS waiting time standards for local people	Seeking innovative ways to more effectively use the NHS pound so there is enough resource for the whole system



Our Chief Executives and Chairs

At the South Yorkshire and Bassetlaw Acute Federation we are supported by the Chairs and Chief Executives of our Hospital Trusts.

Dr Richard Jenkins, Chief Executive

Sheena McDonnell, Chair

NHS
Barnsley Hospital
NHS Foundation Trust

Dr Richard Jenkins, Chief Executive

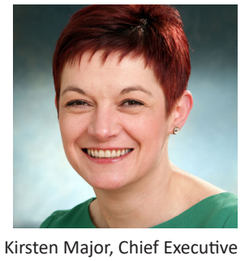
Mike Richmond, Chair

NHS
The Rotherham
NHS Foundation Trust

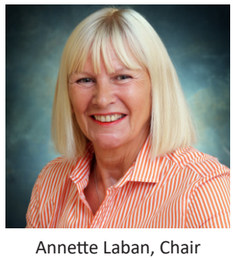
Richard Parker OBE, Chief Executive

Suzy Brain England OBE, Chair

NHS
Doncaster and Bassetlaw
Teaching Hospitals
NHS Foundation Trust

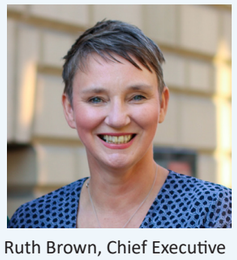


Kirsten Major, Chief Executive

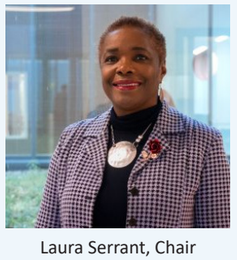


Annette Laban, Chair

NHS
Sheffield Teaching Hospitals
NHS Foundation Trust



Ruth Brown, Chief Executive



Laura Serrant, Chair

NHS
Sheffield Children's
NHS Foundation Trust

Our year at a glance

- The single South Yorkshire & Bassetlaw Pathology Network went live on 1 April and is now set to deliver quality and efficiency benefits for patients and staff.
- We published our Clinical Strategy: a five-year framework for clinical collaboration across the Acute Federation.
- The Sheffield Elective Orthopaedic Centre (SEOC) opened on 3 April 2023 with a phased introduction of the Enhanced Care Unit. This has increased day case rates for primary arthroplasty and significantly reduced the number of long waiters. The number of patients waiting over 52 weeks for orthopaedic surgery at SEOC reduced from 462 in April 2023 to 173 by December 2023 with no patients waiting over 78 weeks.
- The Mexborough Elective Orthopaedic Centre, a collaboration between Barnsley Hospital NHS Foundation Trust, Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust and The Rotherham Foundation Trust, opened on 15 January 2024 and was delivered to time and to budget.
- Patient Initiated Follow Up in elective care increased from 2.45% in April 2023 to 3.67% in Feb. 2024 which is above the national average and use of specialist advice at rate of 56.1 per 100 referrals in February 2024.
- Three Community Diagnostic Centres are currently open, delivering additional capacity for Imaging, Endoscopy and Physiological Sciences, exceeding the original target number of additional tests of 84,317 with actual activity numbers of 89,742.
- The Yorkshire Endoscopy Training Academy (YETA) formed in June 2023, hosted by Sheffield Teaching Hospitals. The first trainee to complete immersion training was able to perform independent lists 20 weeks earlier than would have been feasible with standard training.
- The Acute Paediatrics Innovator Programme was launched in 2023 and has secured funding for Paediatric Virtual Ward remote monitoring technology, established clinical networks to improve access to Paediatric Dental elective and Ear, Nose & Throat elective services.
- Sheffield Children's NHS Foundation Trust's has pioneered a High Intensity Theatres Operating List enabling the clinical team to increase Ear, Nose and Throat surgery for children from 10 to 20 procedures a day.
- The SYB Stroke Health Inequalities Report was published in July 2023 to support service development and identify areas of high impact.
- The SYB Integrated Stroke Delivery Network (ISDN) successfully implemented multiple projects with third sector partners responding to gaps in access to services supporting life After Stroke through the Stroke Quality Improvement for Rehabilitation Scheme including dedicated Social Prescribing Link workers to support people post-stroke and piloting a new six-week clinic in Sheffield for stroke patients who are able to be discharged promptly from Hyper Acute Stroke Units. The ISDN also delivered pre-hospital video triage pilot which is now business as usual within Sheffield and Doncaster Hyper Acute Stroke Units.
- We have used our insight to inform Barnsley Metropolitan Borough Council's Stroke Prevention Campaign to address higher stroke mortality rates in Barnsley.
- 16,000 tobacco specialist assessments have been completed with inpatients across Acute, Mental Health and Children's Trusts.
- There have been 2,237 four-week quits achieved as a result of the QUIT programme which, following national statistics, equates to over 1,000 smoking-related deaths avoided.
- SYB successfully met the 62-day backlog trajectory for Cancer treatment at the end of March 2024.
- SYB providers delivered £1.6 million of savings through collaborative procurement – which is 328% of the original target of £480,000.

Progress against our 2023/24 priorities

2.1 Elective Recovery

Aim	Progress summary
Supporting each other to achieve the NHS elective recovery waiting time standards for local people.	Although 2023/24 has been a difficult year due to the challenges of industrial action and workforce shortages, the elective programme has made huge improvements against national targets. The year has seen the opening of both its planned surgical hubs increasing theatre capacity across the system. New collaborations between primary and secondary care have improved relationships and enabled a reduction in unnecessary activity which will reduce waiting times for patients. Digital transformation has played a key role in supporting waiting list management and patient engagement and will continue to support transformation into 2024/25.

Elective recovery action plan

Expand capacity

- Implementation of two surgical hubs.
- Identified opportunities from GIRFT. Sharing of protocols and best practice and implementation of digital tools to increase utilisation and missed appointments.
- Trusts using and benchmarking themselves against Further Faster and Right Procedure Right Place.
- The establishment of collaborative secondary, primary, contracting and commissioning Ophthalmology meetings.
- Improved mutual aid across SYB and the wider regional footprint.

Prioritise treatment

- Benchmarking from Model Health System and sharing of best practice to deliver 'excellence in basics' using information from Model Health System has been shared at specialty meetings to improve performance and patient pathways.
- Standardisation of clinical prioritisation and ap- plication of 'Evidence Based Interventions'.

Manage demand

- Offering choice at point of referral. Developing communications and engagement with primary and secondary care clinicians.

Transform care

- Sharing of Patient Initiated Follow Up protocols to drive ongoing roll-out across specialities.
- Benchmarking of first and follow up appointments and procedures.
- Alignment of clinic templates with Royal College guidelines.
- Action planning following Anaesthesia and Perioperative Medicine Gateway review meeting.

Empower Patients

- Patient Engagement Portals (PEPs) have been implemented with and patient access to records with the ability to manage appointments and inform treatment.

Enable connectivity

- Supported collaborative approach to funding bids and procurement to work towards common solutions across SYB. Robotic Process Automation and Artificial Intelligence business case development to increase efficiency.

Achievements in 2023/24

The Sheffield Elective Orthopaedic Centre (SEOC) opened on 3 April 2023 with a phased introduction of the Enhanced Care Unit. This has resulted in 2.5 operating lists being delivered per day, 6 days a week achieved by January 2024. This has increased day case rates for primary arthroplasty and significantly reduced the number of long waiters. The number of patients waiting over 52 weeks for orthopaedic surgery at SEOC reduced from 462 in April 2023 to 173 by December 2023 with no patients waiting over 78 weeks.

The Mexborough Elective Orthopaedic Centre (MEOC) opened on 15 January 2024 and is a collaboration between Barnsley Hospital NHS Foundation Trust (BHFT), Doncaster & Bassetlaw Teaching Hospitals NHS Trust (DBTHFT), The Rotherham NHS Foundation Trust (TRFT). Recruitment and improvement work will continue into 2024/25 to optimise efficiency and productivity in line with GIRFT principles. The MEOC was delivered to time and to budget.

The SYB Day case rate (for BADS procedures) increased through 2023/24 to 81.3% and the capped theatre utilisation rate also increased through the year (latest value 78.3%).

The establishment of collaborative secondary, primary, contracting and commissioning Ophthalmology meetings has resulted in improved relationships with the agreement of training placements in Trusts, which will lead to an increased numbers of Optometrist prescribers.

Nurse injectors have been introduced at TRFT in Ophthalmology which will release five consultant-led clinics per week with a further release of 10 once the third nurse completes training.

Collaboration between secondary, primary and commissioning Ophthalmology teams means information is being shared with Local Optical Committees to ensure patients are offered an informed choice at referral.

Optometry First models of care will enable stable glaucoma and paediatric refraction patients to be seen in primary care.

The clinically-led SYB Perioperative network is working to apply digital solutions to support assessment of needs on an individual basis and to develop a consistent approach to the risk assessment of patients waiting, in order to offer health optimisation and improve outcomes for patients. The Perioperative network has agreed consistent thresholds for pre-assessment to reduce unnecessary diagnostic tests and prevent on the day patient cancellations.

A digital platform has been implemented in Sheffield and Doncaster to give Optometrists the ability to make referrals and attach high resolution images and recordings.

Patients can now access the Trusts' Patient Engagement Portal (PEP) via the NHS APP (BHNFT, DBTHFT and TRFT), allowing them to view appointments supporting waiting list validation and in some cases, view letters and complete questionnaires. Further developments will enable patients to amend appointments and will support two-way communication.

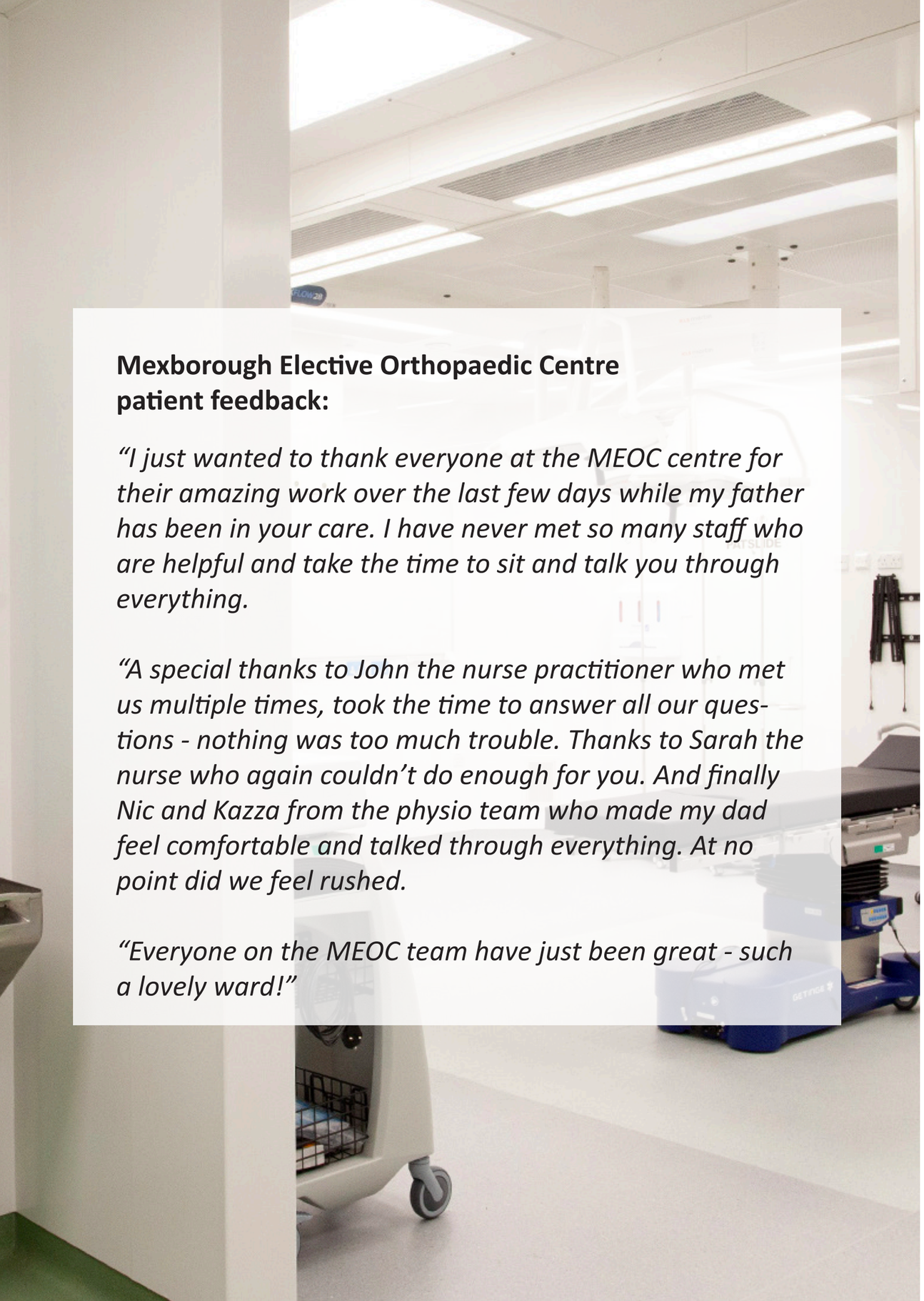
All SYB providers are applying and expanding digital solutions to support elective recovery and management of long waiting patients. TRFT is part of an 'e-meet and greet' pilot that digitally informs patients when their referral has been received.

Trusts are investing in additional validation resource and Referral to Treatment (RTT) training where this is appropriate; together with the digital solutions these steps will ensure patients that require and want treatment are accurately recorded on patient treatment lists and support management of long waiting patients. Providers are also using a range of digital tools and dashboards to support the optimal scheduling of patients and maximise use of available capacity.

The year ahead

Our Elective Recovery Plan will continue into 2024/25.

Collaborative action will be focused on and informed by a clinically-led review of service sustainability, those specialties with the highest volume of long waiters or most rapidly growing waiting lists, and where benchmarking indicates significant variation and improvement opportunities.



Mexborough Elective Orthopaedic Centre patient feedback:

"I just wanted to thank everyone at the MEOC centre for their amazing work over the last few days while my father has been in your care. I have never met so many staff who are helpful and take the time to sit and talk you through everything.

"A special thanks to John the nurse practitioner who met us multiple times, took the time to answer all our questions - nothing was too much trouble. Thanks to Sarah the nurse who again couldn't do enough for you. And finally Nic and Kazza from the physio team who made my dad feel comfortable and talked through everything. At no point did we feel rushed.

"Everyone on the MEOC team have just been great - such a lovely ward!"

2.2 Diagnostic Recovery

Aim	Progress summary
Supporting each other to achieve the NHS diagnostic recovery waiting time standards for local people	Throughout 23/24 the Diagnostic Programme has continued to make positive strides forward. Although pressures in recovery remain, the overall trend has been one of improvement. A key priority has been the agreement on a joint system ambition to progress the collaborative procurement of a common Picture Archiving Communication System (PACS) and Radiology Information System (RIS), which sets the foundations for system working. Physiological Science Networks continue to grow, with the Cardiac Diagnostic Group now established and two further working groups, Audiology and Sleep Studies, introduced.

Diagnostic recovery action plan

The Diagnostic Recovery Plan covers six priority areas: Expand capacity, prioritise treatment, manage demand, transform care, empower patients and enable connectivity.

Achievements in 2023/24

Expand Capacity

- Three Community Diagnostic Centres (CDC) are currently open, delivering additional capacity for Imaging, Endoscopy and Physiological Sciences, exceeding the original target with actual activity numbers of 89,742.
- The Yorkshire Endoscopy Training Academy (YETA) formed in June 2023, hosted by Sheffield Teaching Hospitals. The first trainee to complete immersion training was safely able to perform independent lists 20 weeks earlier than would have been feasible with standard training.
- Secured funding to support practice educator posts for the system. This allows a dedicated training post to support the improvement in training experiences.
- Funding also secured for research modules to enable Sonographers to work towards the top of their skillset.

Manage Demand

- The iRefer system has been implemented and is live at both DBTHFT and TRFT. BHFT is due to go live in April 24 and there is ongoing work with STHFT to understand options to implement.
- Feedback from providers suggests CT demand has increased by 9% from previous year; without iRefer this was predicted to be 12.5%.
- The Faecal Immunochemical Test (FIT) has been introduced to detect bowel cancer which also reduces the need for Colonoscopy.

Enable Connectivity

- The SYB Imaging Network has successfully procured and implemented a shared imaging system, enabling users to view medical images across SYB without time-consuming manual transfer.
- We are now working collaboratively with the aim of procuring a common PACS and RIS solution; this will support shared reporting in the future.
- DBTHFT were successful in securing funding under the CDC digital enablers to improve automated referral pathways between DBTHFT, TRFT and BHFT for Endoscopy delivered at Montagu CDC.

Transform Care

- Imaging AI Pilot of fracture detection software at TRFT and work ongoing for multi-vendor testing of chest x-ray lung nodule detection.
- We have been lucky enough to have a brand-new Olympus AI-assisted technology stack introduced within Endoscopy rooms at SYB trusts. So far, at BHFT this cutting-edge technology has proven to be immensely helpful to the department in key ways, ranging from enhancing efficiency and accuracy to facilitating training opportunities for trainee endoscopists. Traditionally, the detection of polyps relied heavily on the expertise and visual acumen of the endoscopist, leaving room for human error and oversight, particularly towards the end of a long day. However, with the integration of artificial intelligence algorithms into the Endoscopy system, subtle lesions and abnormalities that might have otherwise been

missed can now be rapidly highlighted and brought to the attention of the endoscopist in real-time. This additional layer of scrutiny not only enhances the endoscopist's confidence in their findings but also instils trust and peace of mind in both patients and healthcare providers alike, knowing that the procedure has been thoroughly and comprehensively conducted. In conclusion, the introduction of the new Olympus AI-assisted endoscopy stack has been a great addition, offering a myriad of benefits that extend beyond technological innovation. From expediting the detection of potential polyps to providing reassurance to endoscopists and augmenting training opportunities for trainees, this technology paves the way for more efficient, accurate, and comprehensive patient care. I am sure it will become a mainstream addition to all endoscopy departments.

The year ahead

Our Diagnostic Recovery Plan will continue into 2024/25.

Collaborative action will be focused on and informed by a clinically-led review of service sustainability, those test modalities with the highest volume of long waiters or most rapidly growing waiting lists, and where benchmarking indicates significant variation and improvement opportunities.

Support will also be given to the SYB PACS and RIS procurement to enable the benefits of shared image reporting and efficiencies of working at scale to be realised.

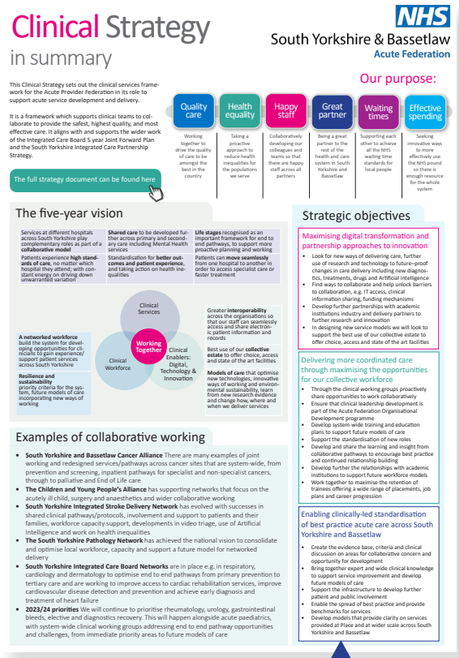
Ryan Jennings, has recently completed an intensive block of procedures through the Endoscopy Training academy and has qualified as an independent endoscopist, 20 weeks ahead of his original schedule. He said:

"My experience with the Yorkshire Endoscopy Training Academy has been fantastic. I was able to assist with a large number of procedures in one intensive training block which not only meant that I could qualify earlier, but that the training felt more effective as I was able to focus in, keep up the practice without gaps and really cement the learning."

"During immersive training there is opportunity to work with several different endoscopists and consultants who have different specialities and interests and as such can cover a large range of learning points for different diseases and pathology opportunities that may not be available without the immersive programme."

2.3 Implement Clinical Strategy

Aim	Progress summary
Working together to drive the quality of care to be amongst the best in the country. Supporting each other to strengthen service resilience and achieve NHS waiting time standards for local people	Progress has been made with the implementation of the Clinical Strategy. SYB AF priorities have been well socialised and clinical engagement in delivery has been strong. As we move into 2024/25 the impact of the work should begin to be reflected in patient outcomes and experience. Agreement has also been reached to conduct a clinically-led review of service sustainability and pursue digital convergence to benefit patients and staff.



Click here to see the strategy in summary

Clinical strategy

Our Clinical Strategy was published in early 2023 and sets out our five-year vision and framework for clinical collaboration.

Urology

The Urology Area Network (UAN), established following GIRFT best practice guidance, has made strides towards integrated working to ensure patients have access to a range of treatments and are treated as quickly as possible.

Our collaborative work with Chesterfield Royal Hospital NHS Foundation Trust, in a neighbouring integrated care system, has included a workforce stocktake, mapping of on-call services, development of a Benign Prostatic Hyperplasia (BPH) pilot to increase access to a range of treatments, developing a shared Patient Treatment List for BPH, developing options for sustainable on call and establishing a mutual aid pathway. The UAN is viewed as an exemplar network.

Rheumatology

The programme plan has been implemented and focused on workforce planning, testing of a shared recruitment approach for consultants and development of a more standardised referral approach.

Work has included a stocktake of demand, capacity and workforce, a workforce survey, joint recruitment, developing an agreed set of SYB referral criteria and information. Lessons learnt have been captured.

Achievements in 2023/24

Urology

An effective and collaborative UAN has been established which is viewed as an exemplar.

Mutual Aid for Nephrectomies at Chesterfield Royal Hospital / Sheffield Teaching Hospitals has been implemented. Patients are now being offered surgery at Chesterfield.

A BPH Pilot has been designed and will be implemented in May 2024. This aims to offer patients more treatment choice and lead to improved outcomes.

Options for sustainable Urology on-call services have been developed and will be progressed through 2024/25. This will ensure that all patients across the UAN have access to emergency treatment 24 hours a day.

Rheumatology

An agreed set of referral criteria and standardised referral information has been agreed and will be implemented in early 2024/25.

Insights from the workforce have been gathered and a Joint recruitment approach tested. Both Sheffield Teaching Hospitals and The Rotherham Foundation Trust have now appointed additional consultants.

The year ahead

Heading into 2024/25, the urology BPH pilot will be implemented early in May 2024 and evaluated at 12 months. Urology on-call options will be further progressed as sustaining on-call rotas will continue to be a key challenge. There will be opportunities to build on the UAN approach across the partnership.

2.4 Financial Improvement and commissioning

Aim	Progress summary
Seek innovative ways to more effectively use the NHS pound so there is enough resource for the whole system.	We have delivered significant savings through collaborative procurement, facilitated by the introduction of a new Procurement Board to strengthen oversight of collaborative procurements.

Financial improvement action plan

- Implement inter-hospital transfer process to improve operational efficiency by reducing delays for system wide transfers.
- Collaborative procurement- Reduce the cost of service provision through a set of targeted interventions which standardise goods and services and produce efficiencies.
- Medical agency – Reduce the numbers of vacancies which require premium cost medical / clinical / nursing cover and reduce variation in extra contractual medical pay.
- Explore the development of a shared Acute Federation financial improvement plan and identify opportunities for integrated commissioning.

Achievements in 2023/24

Acute Federation Chief Finance Officers have agreed to support the formation of a new Procurement Board tasked with more oversight of collaborative procurements.

An inter-hospital transfer escalation process has been implemented with 319 patients being dealt with quicker between September 2023 and February 2024 as a result.

We delivered £1.6 million of savings through collaborative procurement – which is 328% of the original target of £480,000. There are more projects in the pipeline that are expected to deliver a further £1.4 million in 24/25. The SYB collaborative procurement has been recognised with a Healthcare Supply Association (HCSA) award.

We have also reached agreement to standardise extra contractual medical pay over a number of years. Acute Federation Trust financial planning for 2024/25 has now been aligned through the efforts of the Acute Federation Chief Finance Officers and a system efficiency plan for next year and beyond has been agreed.

The year ahead

The focus for financial improvement in 2024/25 will be on delivering on system efficiency actions to reduce the South Yorkshire deficit.

We will be agreeing a single bundle of productivity metrics, conducting a clinical services sustainability review and a corporate services efficiency review.

2.5 Engagement to Drive Collaboration

Aim	Progress summary
Working together to drive the quality of care to be amongst the best in the country. Collaboratively developing our colleagues and teams so that we have happy and engaged colleagues across all partners. Being a great partner to the rest of the health and care system in SYB.	Key documents have been published to enable collaboration like the Clinical Strategy and the profile of the Acute Federation is gradually being raised locally and nationally through projects like the Paediatric Innovator and collaborative procurement, which was recognised with an HCSA award.

Engagement to Drive Collaboration action plan

- Develop and implement a clinical engagement Plan.
- Produce an organisational development plan and framework.
- Refresh communications plan.

Achievements in 2023/24

- Wide clinical engagement has been conducted as part of Clinical Strategy engagement.
- An organisational development approach has been used for the Healthcare That Works for Young People workstream of the Paediatrics Innovator. This approach will be developed for other collaborative projects.
- The communications plan has been refreshed with the Clinical Strategy publication, quarterly newsletter and active Acute Federation social media approach.
- The Paediatrics Innovator scheme attracted national attention and has resulted in wide engagement across the Acute Federation workforce.
- We won the HCSA award for collaborative procurement and have presented at the national NHS Providers conference to share the learning with others.
- We established the SYB Provider Collaborative and Alliance network to connect with system partners.

The year ahead

The focus for engagement in 2024/25 will be on developing a communications and stakeholder engagement approach which helps us to strengthen communication and relationships across Acute Federation Professional Partnership Groups and with external partners like the ICB and SYB Alliances and Provider Collaboratives.

2.6 Acute Paediatrics Innovator Programme

Aim	Progress summary
Working together to drive the quality of care to be amongst the best in the country/Taking a proactive approach to reduce health inequalities for the populations we serve/ Collaboratively developing our colleagues and teams so that we have happy staff. Accelerate the design and implementation of the South Yorkshire & Bassetlaw collaborative model for acute paediatric services as part of NHS England's national innovator scheme.	The Acute Paediatric Innovator Programme was successfully launched this year. Trust and clinical engagement have been high with strong evidence of collaboration. Funding for Paediatric Virtual Ward has been successfully awarded and progress is being made in all workstreams. Options for improving patient access have been appraised and 2024/25 will focus on the delivery of innovative, collaborative approaches to paediatric care and the realisation of benefits. Engagement with children and young people will inform and support delivery.

Acute Paediatrics Innovator action plan

To establish programme infrastructure and governance, gain strong clinical engagement and leadership and ensure the programme is data driven and informed by the voices of children and young people. To contribute to gathering and sharing lessons learn across the national innovator programme.

Virtual ward

To deliver care closer to home through Virtual Wards for children and young people.

Ear, Nose and Throat Paediatric Elective Services

To improve access to elective Ear, Nose and Throat services for children.

Dental

To improve access to elective Dental services for children.

Healthcare That Works for Young People

To develop core datasets and processes that enable developmentally appropriate healthcare for young people with long term conditions needing acute trust care.

Delegated commissioning

To explore and develop options for delegated commissioning of acute trust Paediatric services for greater equity of outcomes, access and experience.

Achievements in 2023/24

Whole programme

Programme infrastructure and governance are now well established which means we are able to engage clinicians and deliver and track progress. We have partnered with Chilypep, a children and young people's voice charity, to enable robust engagement with patients and the public.

Virtual Ward

£295,000 of Health Technology Adoption and Acceleration funding has been secured with a technology partner in place. Options have been developed and appraised. A model has been agreed which will allow early adopters to test Virtual Ward with the intention of rolling out across SYB.

Ear, Nose and Throat Paediatric Elective Services

Options have been developed and appraised. Capacity and demand have been mapped and the next step will be to explore the benefits of a surgical hub. A video has been produced which shares learning from Sheffield Children's NHS Foundation Trust's experience of implementing a High Intensity Theatres Operating List.

Dental

We have gathered information about elective Paediatric Dental services across SYB which will inform work to improve access to care for children. A collaborative plan is being developed in partnership with the South Yorkshire Integrated Care Board to implement innovative approaches to waiting time management and pathways.

Healthcare That Works for Young People

A core data set has been developed to enable us to identify and track the volumes of young people with long term conditions who will require developmentally appropriate healthcare. A strategy is being co-developed with experts from across the system.

Delegated Commissioning

We are reviewing evidence of the benefits of delegated commissioning to assess the degree to which it will enable improvement in outcomes and experience.

The year ahead

The Acute Paediatric Innovator Programme will continue throughout 2024/25 with a number of key milestones to be achieved.

An innovator lessons learnt case study will be shared for the benefit of others within the NHS.

Formal evaluations will be undertaken, in partnership with Higher Education and Research and Development partners where appropriate.

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2.7 Pathology Transformation Programme

Aim	Progress summary
Working together to drive the quality of care to be amongst the best in the country.	A single unified SYB Pathology Service was formed on 1 April 2024, hosted by Sheffield Teaching Hospitals NHS Foundation Trust on behalf of the five Acute Federation Trusts. This paves the way to a future target operating model which will deliver quality and efficiency benefits for patients, staff and wider stakeholders, whilst creating opportunities for career progression across the entire workforce. These benefits could not be achieved by each Trust working in isolation.

Achievements in 2023/24

- Working constructively with the SYB Pathology Partnership Board and Acute Federation. representatives across all partner organisations.
- Agreement reached by five Trust Boards to transition to a new Target Operating Model (TOM) in line with the national direction of travel for pathology networks.
- Establishment of a single South Yorkshire and Bassetlaw Pathology service from 1 April 2024 consisting of over 1,300 staff.
- Design and collaborative configuration of a new Laboratory Information Management System for use across all our laboratories.
- Preparations for a collaborative Managed Service Contract procurement standardising equipment and technology across our laboratories and delivering economies of scale.
- Agreed plans to expand the use of digital pathology to support histopathology reporting across the region.

Priorities for 2024/25

- Embedding new operational management and clinical governance systems and processes for the single SYB Pathology Service.
- Performance monitoring of key performance indicators across all laboratories.
- Continued measures to improve histopathology performance.
- Shaping longer term plans to consolidate histopathology services across SYB
- Delivery of financial plans for 2024/25 and efficiency targets.
- Continued development of the new LIMS system
- Managed Service Contract procurement and engagement with suppliers.
- Digital pathology expansion to enable remote reporting of slides on all sites.
- Transport logistics planning to consider how samples can be fast-tracked improving pathology workflow.
- Plans to introduce a new Quality Management System for use in all laboratories and to facilitate harmonisation of future standard operating procedures.
- Harmonisation of working arrangements.

The Acute Federation Trusts have also worked collaboratively with partners across South Yorkshire & Bassetlaw to make progress in other areas

3.1 Integrated Children & Young People's Alliance

Aim	Progress summary
Working in wide partnership to ensure innovate approaches to the delivery of services for Children & Young People are taking place in the right place, with the right people at the right time	The Children & Young People's (CYP) Alliance aims to support a complex system to deliver sustainable transformation and improve access for the most vulnerable. The Alliance works in partnership with children and young people to co-create change. Many of the work programme priorities are driven by the NHS England CYP Transformation Programme, and support the CYP elements of South Yorkshires Joint Forward Plan and the Integrated Care Strategy bold ambition: best start in life. The CYP Alliance was established in 2021. Its growth stemmed from the acute system focus on CYP through the CYP clinical networks, working towards building connections with a wide range of partners to address health inequalities and improve outcomes for all South Yorkshire's CYP.

Achievements in 2023/24

NHS South Yorkshire ICB has now commissioned Barnardo's to lead the new Early Years Neighbourhood Pilot, named Bump, Birth and Beyond. Barnardo's brings expertise in delivering early years services at both a community and system level, whilst keeping the voices of individuals and communities that they support at the centre of decision making.

The CYP Alliance has been working as a collaborative partner across the system to support access to services, tackle barriers, reach communities and reduce health inequalities. The model is being co-produced with families, communities and services within the four districts to deliver a holistic family intervention model connecting families, communities and support services.

Core groups have been established to address variation in care between Epilepsy services, supporting mental health and wellbeing of children and young people with epilepsy, improving referrals into tertiary services and the Children's Epilepsy Surgery Service (CESS) and improving the transition from paediatric to adult epilepsy services.

The CYP Alliance has a strong focus on ensuring the voice of children and young people are front and centre of all they do. Supported by Chilypep, there is now an established community of practice for South Yorkshire where any organisation from any sector involved in CYP voice and engagement can come together with others to amplify the voice of CYP.

The year ahead

The focus for the CYP Alliance in 2024/25 for the acute sector will remain on Asthma and Epilepsy care improvements for CYP with an additional focus on Diabetes care and Complications from Excess Weight services, to ensure that there is a clinic available in South Yorkshire and Bassetlaw.

There will also be a focus on mental health champions within acute trusts to focus on the needs of CYP.

In addition, the Alliance will continue to work alongside the Acute Paediatric Innovator Programme to support improvements in the transition of care from Paediatric to Adult services.

3.2 Integrated Stroke Delivery Network

Aim	Progress summary
Ensuring equitable access across South Yorkshire to effective, efficient, evidence-based stroke care through an active resilient regional network.	Progress has been made in 2023/24 despite challenges with staff turnover. A network manager and clinical lead are in place with recurrent Integrated Stroke Delivery Network and national Service Development Funding in place. The work plan and partner commitment to participation is in place.

Achievements in 2023/24

The SYB ISDN Health Inequalities Report was published in July 2023 to support service development and identify areas of high impact.

We successfully implemented multiple projects with third sector partners responding to gaps in access and availability of provision using the Stroke Quality Improvement for Rehabilitation (SQUIRE) funding. This included:

- Dedicated Stroke Social Prescribing Link workers across SYB offering additional support to patients following a stroke such as referrals to walking groups, gardening groups and be- friending services, or offering practical support, navigating food banks, benefits, and applications for personal assistants.
- Working with Aphasia Support to support people with aphasia and apraxia of speech to transition away from NHS services by providing long term speech and language therapy support and psychological support.
- Working with the Stroke Association to provide a Stroke Recovery Service including 6-month reviews with a specific focus on level 1 emotional support in Doncaster.
- Piloting a new six-week clinic in Sheffield for stroke patients who are discharged very promptly from the Hyper Acute Stroke Unit, and therefore do not have the opportunity to see the multidisciplinary team.

The pre-hospital video triage pilot was successfully implemented and is now business as usual within Rotherham and Doncaster Hyper Acute Stroke Units.

The ISDN has worked with public health partners to compile data demonstrating late presentations of residents with stroke symptoms and higher mortality in Barnsley. This was presented to Barnsley Metropolitan Borough Council, resulting in a Barnsley specific Stroke Prevention Campaign.

We published a South Yorkshire Integrated Stroke Delivery Network (SY ISDN) Workforce Plan in November 2023 to support the identification of gaps and service improvement opportunities to address these.

We have established a Yorkshire and Humber wide stroke community of practice in collaboration with neighbouring ISDNs to maximise the opportunities for staff to come together, share and learn.

During 2023/24, we undertook a TIA service gap analysis to inform required service development against national guidelines including 7-day access.

The year ahead

We will agree ISDN 2024/25 work plan at next oversight group and establish/refresh four regional expert groups:

- acute care
- community and rehab
- stroke survivors
- data

SSNAP to agree and implement work in relation to each priority.

3.3 QUIT smoking programme

Aim	Progress summary
To reduce smoking prevalence across South Yorkshire by offering support to patients at a 'teachable moment'. To implement and embed Tobacco Treatment across Acute and Mental Health Trusts, including inpatient, outpatient and staff. Shifting culture around tobacco dependency from a lifestyle choice to a treatable addiction.	The QUIT programme has seen some significant performance improvements during 23/24 which suggest tobacco treatment is becoming business as usual to ward staff. However, there remains opportunity for improvement across each setting, specifically around ensuring patients are given Nicotine Replacement Therapy early in the admission journey and are seen by a tobacco treatment advisor before discharge.

Achievements in 2023/24

All NHS Trusts in South Yorkshire and Bassetlaw have delivered against the NHS Long Term Plan Tobacco Dependency delivery model ahead of the March 2024 target and are now working towards increasing performance across the whole pathway to achieve the overall return on investment figure for the QUIT programme. Continuous quality improvement approaches are in place at all Trusts to fully embed tobacco treatment.

During 23/24 improvement against individual Trust-level performance measures was evident in the majority of Trusts. Planning for 24/25 will include performance measures and analysis of Trust progress against modelled trajectories to reach the targeted return on investment.

South Yorkshire one of the first ICBs to have all Mental Health and Acute Trusts reaching delivered status against target on Tobacco Dependency.

16,000 tobacco specialist assessments have been completed with inpatients across Acute, Mental Health and Children's.

There have been 2,237 four-week quits achieved as a result of the QUIT programme which, following national statistics, equates to over 1,000 smoking-related deaths avoided.

An effective, system-wide, oversight group and Steering group has been established to share best practice and lessons learnt across South Yorkshire.

The year ahead

In 2024/25, we will maintain Executive level focus on the programme via the QUIT Oversight Board.

Specific focus will be placed on socialising and amplifying the impact of the QUIT programme with audiences across the system including Trust Boards.

QUIT service feedback:

"I have just reached 12 weeks on my QUIT journey. My health was deteriorating, and I was struggling to breath, bringing phlegm up every morning.

I had tried to stop smoking before but obviously failed twice before but this time QUIT really helped me out, giving me the boost I needed. Now I'm able to not worry about meeting up with friend as they all smoke E pens now.

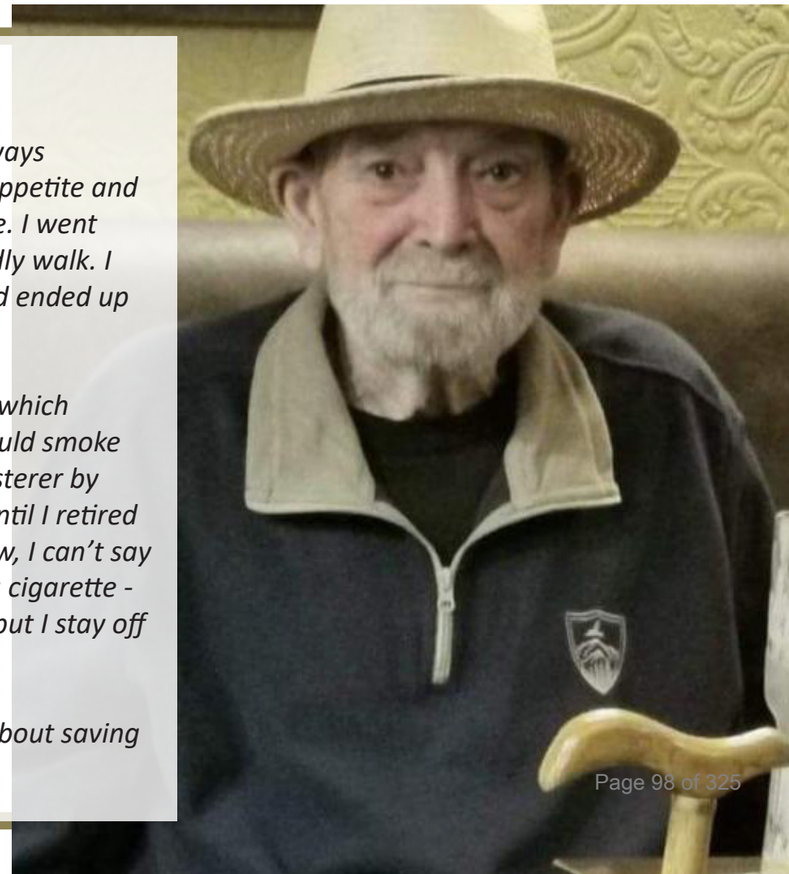
"My advisor is very positive and gives me all the help that I need. I enjoy meals now I have my taste buds back I feel much healthier - not out of breath anymore. I've joined the Gym and I'm off there tonight."

QUIT service feedback:

"I suffer from COPD but have always controlled it. But then I lost my appetite and the weight was just falling off me. I went from 11st to just 8st. I could hardly walk. I had no idea what was wrong and ended up in hospital.

I've smoked since the age of ten which people did in those days and I could smoke as many as 60 a day. I was a plasterer by trade and always worked hard until I retired at 60 through ill-health. Even now, I can't say in all honesty that I don't fancy a cigarette - sometimes I could murder one - but I stay off them.

"Cigs are expensive but it's not about saving money, it's about my health."



3.4 Cancer Alliance

Aim	Progress summary
Improving pathways and supporting each other to achieve the NHS Cancer recovery waiting time standards for local people.	Although 2023/24 has been a difficult year due to the challenges of industrial action and workforce shortages, all SYB providers within the Cancer Alliance programme demonstrated progress against the national targets with the system backlog trajectory being delivered. Focused work on challenged pathways has led to consistent improvement against the Faster Diagnosis Standard. The Cancer Alliance has supported mutual aid for pressured pathways, for example in Urology; strengthened business intelligence with a consistent approach to demand and capacity modelling; maximising the use of Community Diagnostic Centres, GP Direct Access and digital capabilities to support timely cancer diagnosis and treatment for patients.

Achievements in 2023/24

- SYB successfully met the 62-day backlog trajectory at the end of March with BHFT, DBTHFT and TRFT consistently achieving throughout the year. STHFT ensured funding was targeted at the services with the longest waits and secured additional activity to ensure that the system trajectory was achieved.
- Throughout 2023/24 SYB achieved or was very close to achieving the Faster Diagnosis Standard. All providers continued focused work on improving the Lower Gastrointestinal pathway through ensuring the utilisation of Faecal Immunochemical Test (FIT) in primary care to reduce the number of referrals into secondary care and enabling triage to be undertaken in secondary care facilitating improved utilisation of straight to test pathways. This led to better utilisation of Endoscopy capacity and a marked improvement in Faster Diagnosis Standard. The use of patient facing navigators ensured that patients were aware of the next step in their pathway and reduced unnecessary tests and non-attendance for appointments.
- All providers accessed Service Development Funding to implement LATP which releases the requirement for theatre capacity and a faster pathway. DBTHFT introduced a same day service for assessment, MRI and biopsy, if required, which has been shared with other providers.
- The Clinical Delivery group for gynaecological cancers developed a new pathway for women with unexpected bleeding on Hormone Replacement Therapy following a large increase in the number of referrals on a suspected cancer pathway which did not translate into a cancer diagnosis.
- The Cancer Alliance has worked collaboratively with Place leads to develop and agree a single Teledermatology Service Specification which will allow better triage and management of low risk lesions allowing secondary care to focus on the higher risk and 'suspicious of cancer' lesions.
- Cancer Alliance funding was utilised to support an extended contract for C the Signs supporting primary care colleagues to access all the relevant clinical information to inform decisions about urgent suspected cancer referrals.
- The ICB approved the recommendation to commission a stabilisation phase model for NSO outpatient appointments to facilitate timely access across all Places with the transformation programmes focusing on improving the virtual offer and delivery of systemic anti-cancer treatments closer to home. Cancer Alliance funding also supported additional clinical nurse specialist appointments to ensure continuity of care for patients which was a key suggestion from our engagement work.
- Digital capability to connect pathways and share information between providers was progressed through the Single Cancer Management System.

The year ahead

Our Cancer Recovery plan in 2024/25 will continue to focus on ensuring sufficient diagnostic and treatment capacity to improve the 62-day performance standard and the adoption of new pathways for primary care to support earlier and faster diagnosis. The Alliance will also continue to work closely with the Acute Federation to align work on clinically-led service sustainability. There will also be an increased focus on ensuring people are supported throughout their pathway with emphasis on advocacy and improved personalised care.

NHS
South Yorkshire & Bassetlaw
Acute Federation

Board of Directors
5 July 2024

Agenda item	P107/24
Report	**Patient Experience Annual Report**
Executive Lead	Helen Dobson – Chief Nurse
Link with the BAF	B1 Standards and quality of care do not deliver the required patient safety, clinical effectiveness and patient experience that meets regulatory standards
How does this paper support Trust Values	Ambitious – aiming to achieve full compliance against national standards for safe staffing Caring - supporting health and wellbeing of staff to improve retention and providing a set of metrics to ensure patients are safe and have a positive experience Together – the actions and recommendations are Trust wide to support all areas employing clinical staff
Purpose	Decision ☐ To note ☒ Approval ☐ For information ☐
Executive Summary (including reason for the report, background, key issues and risks)	The Patient Experience Annual Report provides an overview of activity, key achievements and challenges during 2024/25. Key points include: During 2023/4 4,629 Compliments were received. 277 Formal Complaints were received. 2273 Concerns were received Of the complaints closed: 61 of the complaints were upheld. 153 partly upheld. 49 were not upheld. 10 Divisional presentations were heard through the Patient Experience Group (PEG). Total number of re-opened complaints was 29 (11.03%) 100% of Complaints were acknowledged in 3 working days. Complaint responded to in the agreed timescale was 100%. The Trust took part in all the CQC patient experience surveys this year and Quality improvement plans have been developed as a result of this work. Division presentations have been received at the Patient Experience Group throughout the year and improvement work shared in the report.
Due Diligence (include the process the paper has gone through	This report was presented to the Patient Experience Committee on 29 April 2024 and Quality Committee on 29 May 2024.

prior to presentation at Board of Directors' meeting)	
Board powers to make this decision	N/A
Who, What and When (what action is required, who is the lead and when should it be completed?)	N/A
Recommendations	The Trust Board is asked note the annual Patient Experience Report
Appendices	None


NHS
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The Rotherham NHS Foundation Trust
Patient Experience
Annual Report
2023/24
Ambitious
Caring
Together

1. Introduction

1.1 Good experience of care, treatment and support is increasingly seen as an essential part of excellent health and social care service, alongside clinical effectiveness' and safety. A person's experience starts from their very first contact with the health and social care system, right through to their last and includes end-of-life care.

1.2 The Local Authority Social Services and National health Service Complaints (England) Regulations (2009), Section 18 confirms the requirements for an annual report, specifying the number of complaints received, the subject matter of complaints and the way in which the complaint was handled. There is, however, no stipulation in the legislation that the annual report should only include complaints.

1.3 This report provides a summary of patient complaints received between 1 April 2023 and 31 March 2024 and includes details of the numbers of concerns received during the year, performance in responding to complaints, Parliamentary and Health Service Ombudsman (PHSO) investigations and action taken by the Trust in response.

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

1.5 The Trust continues to focus strongly on improving patient experience and this continues to develop and evolve. The Trust is committed to resolving any concerns at the earliest opportunity and all colleagues are encouraged to manage concerns raised in an effective and timely manner rather than letting them escalate to a formal complaint. This is often achieved through the patient, relative or carer discussing their concerns directly with the service. Patient care is at the heart of what we do, and we are committed to improving the experience

of our patients, but we know that we do not always get it right. This is why it is important to us that people find it easy to raise their concerns and complaints with us and that they feel their feedback is welcomed and dealt with in a timely manner.

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

2. Purpose

2.1 The Patient Experience quarterly reports provide the Patient Experience Group/ Patient Experience and Inclusion Committee and then the Quality Committee with information relating to all the patient experience feedback received, leading to this annual report, presented to the Board of Directors. This includes:

- Headlines for the year
- Complaints; numbers and top ten themes
- Concerns; numbers and top ten themes
- Compliments; numbers and top themes
- Friends and Family Test
- Social media patient feedback
- Headlines and analysis from the monthly patient experience audits
- CQC surveys
- Improvement work and feedback

2.2 This insight helps identify key priorities and outcomes that are measures through patient experience feedback and will outline our intention to implement and monitor performance, while demonstrating learning that has taken place across the Trust.

3. Context

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

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

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

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

4. Data Collection, Analysis and Reporting

4.1 Data is recorded on the 'Complaints' module within Datix which allows for analysis against a defined set of categories. As part of the Trusts reporting mechanisms a quarterly Patient Experience Report is provided to the Quality Committee and South Yorkshire Integrated Care Board (ICB). Complaints and Patient Experience are also a monthly standing agenda item on the Divisional Performance dashboard, Patient Experience Group[1] (PEG) and Organisational Learning Actions Forum (OLAF). A sample of complaint files are also reviewed on a quarterly basis by a Non-Executive Director which also forms part of this annual report.

[1] PEG is accountable to the Patient Experience and Inclusion Committee which reports directly to the Quality Committee.

5. Headlines in 2023-2024

Welcoming complaints in a positive way  An effective complaint system goes out of its way to create a positive environment in which complaints are welcomed and resolved at the earliest opportunity.	4,629 Compliments were received. 277 Formal Complaints were received. 2273 Concerns were received.
Promoting a just and learning culture  An effective complaint handling system promotes a culture that is open and accountable when things do not go as they should. It puts in place clear ways to demonstrate how the organisation uses learning to improve.	Of the complaints closed: 61 of the complaints were upheld. 153 partly upheld. 49 were not upheld. 10 Divisional presentations were heard through the Patient Experience Group (PEG).
Being thorough and fair  An effective complaints system makes sure staff take a thorough, proportionate and balanced look into the issues raised by a complaint. It makes sure people receive a fair and open answer to their questions based on the facts and takes full accountability for mistakes identified.	Total number of re-opened complaints was 29 (11.03%) 100% of Complaints were acknowledged in 3 working days. Complaint responded to in the agreed timescale was 100%.
Giving fair and accountable responses  An effective complaints handling system enables staff to give a fair and balanced account of what happened and what conclusions they have reached.	We continue to work on triangulating data on complaints that also resulted in moderate or severe harm. There have been 45 disclosure requests relating to complaints this year. 4 complaints have been accepted for investigation by the PHSO.

6. Complaints and Concerns

6.1 In 2023-4, the Trust received 277 formal complaints and 2,273 concerns. The table below compares the number of complaints and concerns received in the last three financial years. There was an increase of 3% in the total number of complaints and concerns received in 2023-24 to 2022-23.

	2021/22	2022/23	2023/24
Formal complaints	266	282	277
Concerns	2,171	2,192	2,273
Total	2,437	2,474	2,550

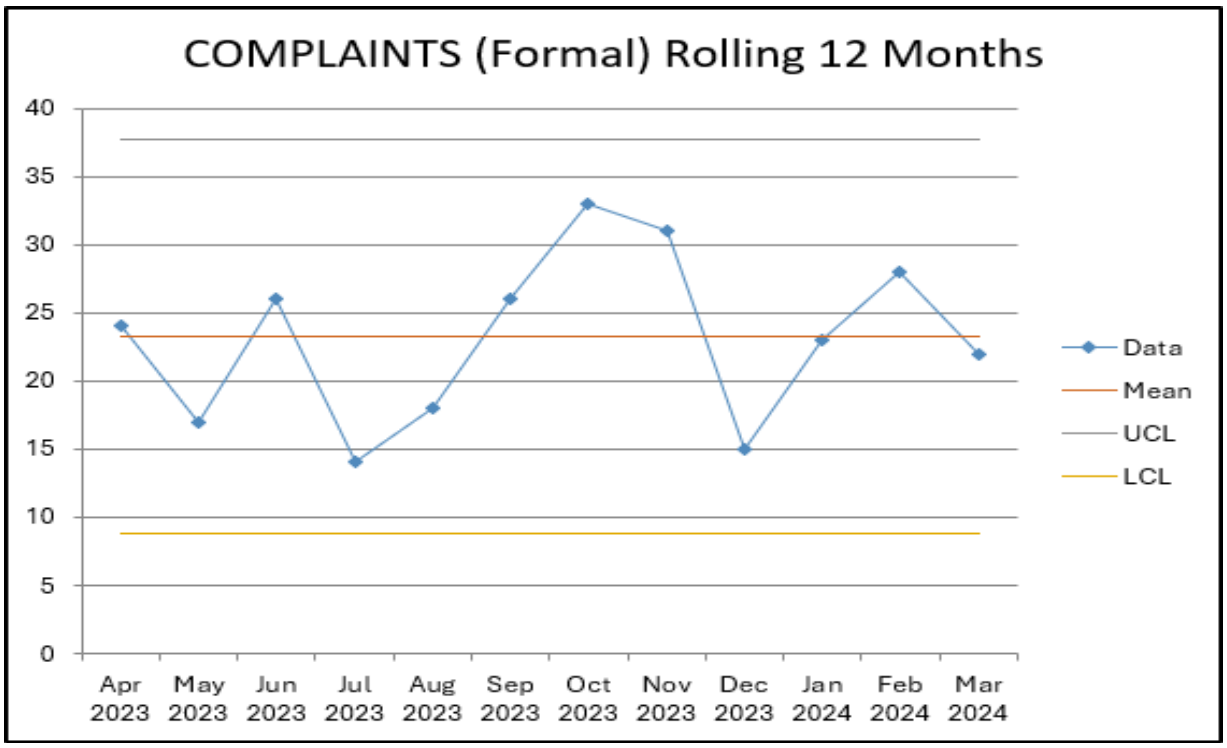
6.2 To compare the number of complaints and concerns to the patient attendances, the figure below breaks down the increase in attendances and ratio of complaints and concerns.

	2021/22	2022/23	2023/24
Inpatient Episodes			
Number of inpatient complaints	133	138	131
Inpatient Episodes	69,128	73,131	77,970
Complaints per 1000 episodes	1.92	1.89	1.68
Outpatient Attendances			
Number of outpatient complaints	48	50	79
Outpatient Attendances	272,257	250,232	258,562
Complaints per 1000 attendances	0.18	0.20	0.31
ED Patient Attendances			
Number of ED complaints	67	75	31
ED Attendances	95,438	92,333	97,039
Complaints per 1000 attendances	0.70	0.81	0.32

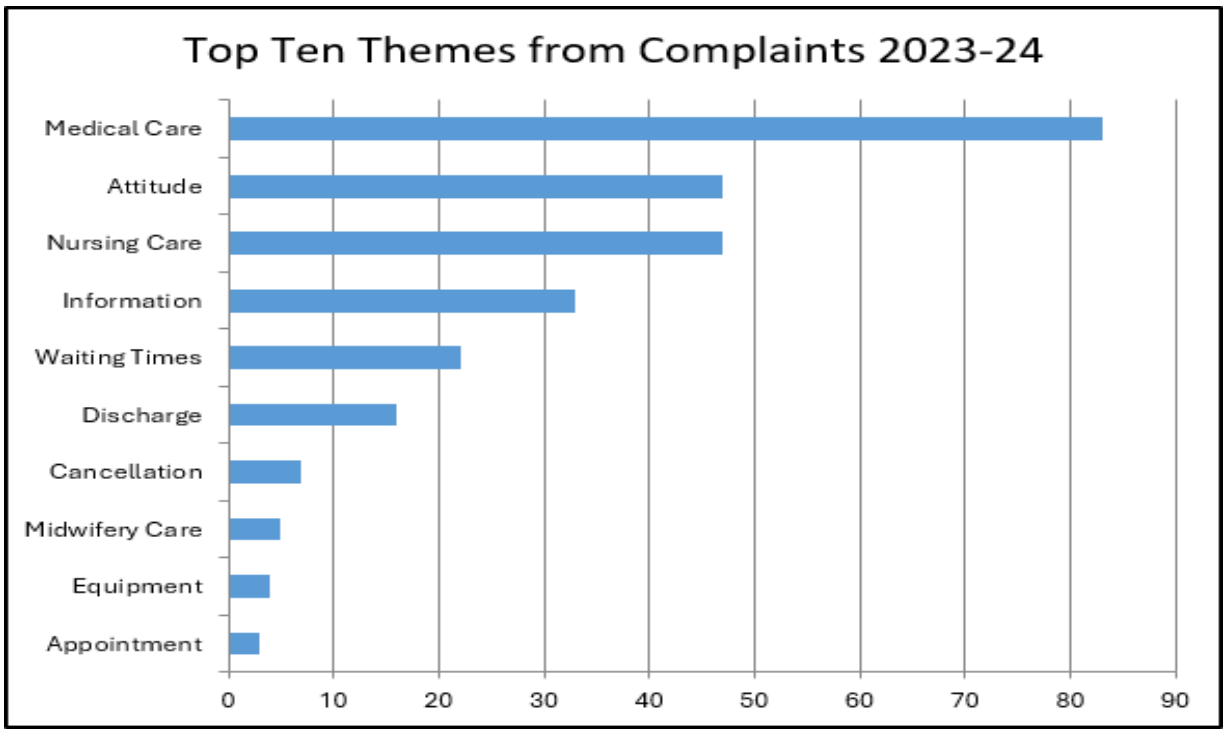
- Inpatient episodes have increased over the past three years, but the number of complaints has decreased slightly per 1000 episodes.
- Outpatient attendances and complaints has increased per 1000 episodes.
- UECC attendances have risen but the number of complaints has significantly reduced.
- The remaining 36 complaints this year did not fit specifically into these categories for example corporate functions or Community Care.

6.3 Formal Complaints

There were 277 formal complaints received in 2023-24. This gives a rolling average of 23.25 complaints a month using Statistical Process Control (SPC). There is a pattern of decreased complaints in December each year which can be associated with the Christmas period.



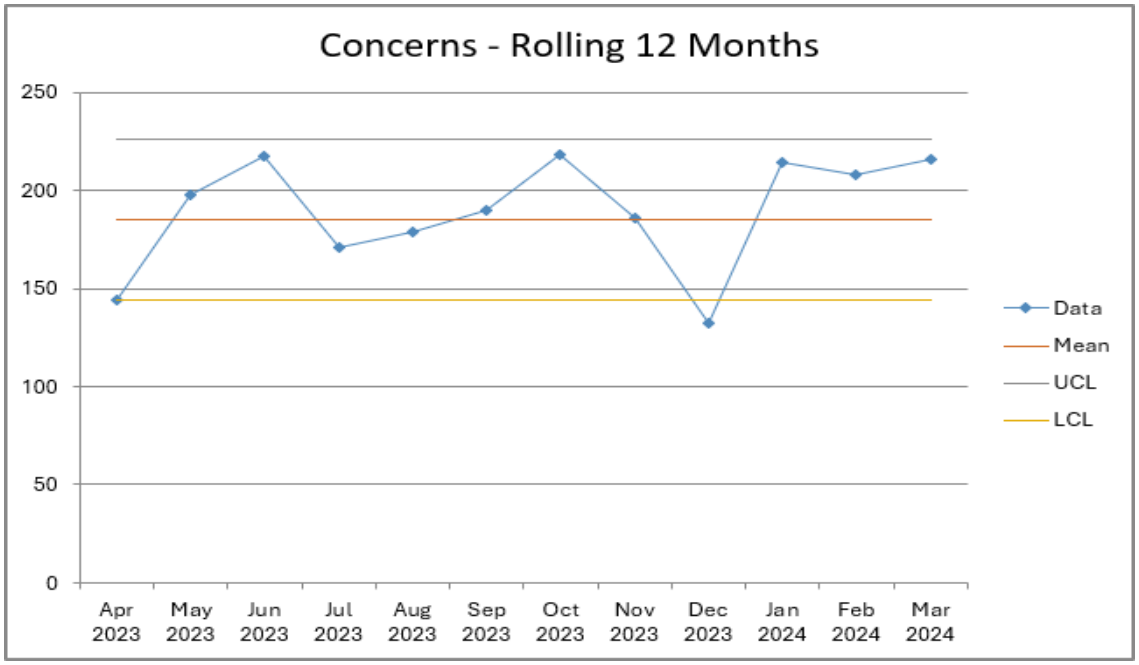
6.4 Themes from formal complaints



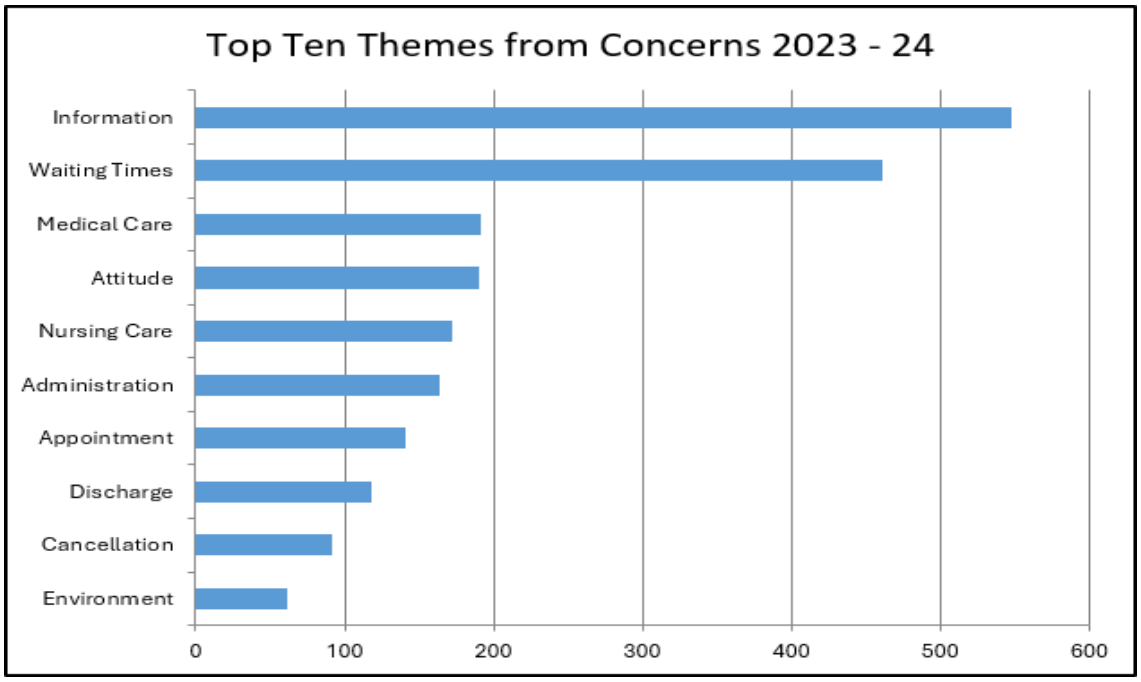
Data shows that the top five themes of formal complaints are primarily linked to medical care, attitude, nursing care, and information/communication and waiting times. Other factors also influenced the number of complaints received, such as Discharge, environment, and cancellation of scheduled appointments.

6.5 Concerns

There were 2273 concerns being received during 2023-24, giving a rolling average of 185.25 concerns a month using SPC. A similar pattern of decreased concerns is also noted for the month of December.



6.6 Themes from Concerns



Concerns are primarily linked to the lack of information/communication, followed by waiting times, Medical Care, Attitude and Nursing Care. Other factors also

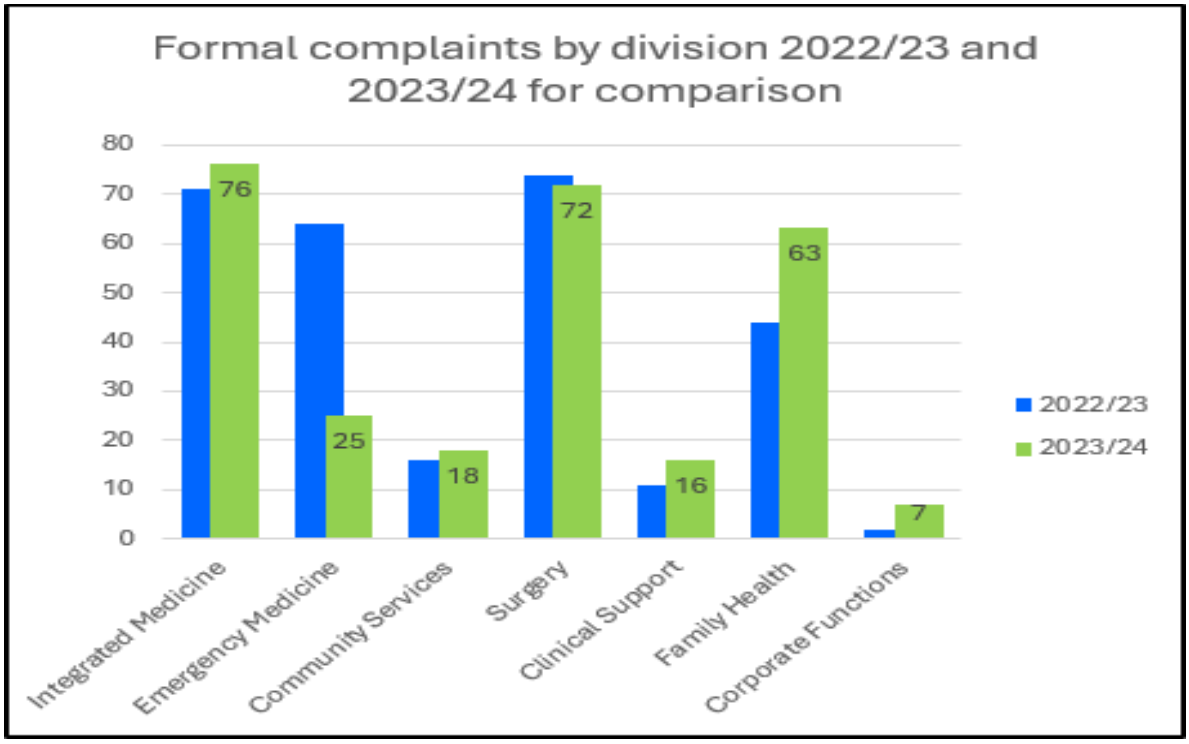
influenced the number received, such as discharge process, appointment waits, cancellation and environment.

It should be noted that staff attitude now appears in the top 5 themes of both formal complaints and concerns.

7. Complaints by Division and Speciality

7.1 Complaints by Division

The Division of Medicine received the most formal complaints during 2023-24 (76) followed by Surgery (72) and Family Health (63).



7.2 Complaints by speciality

Medicine received the greatest number of formal complaints, in comparison and similar in numbers to that of 2022-23. Surgery also received comparable data.

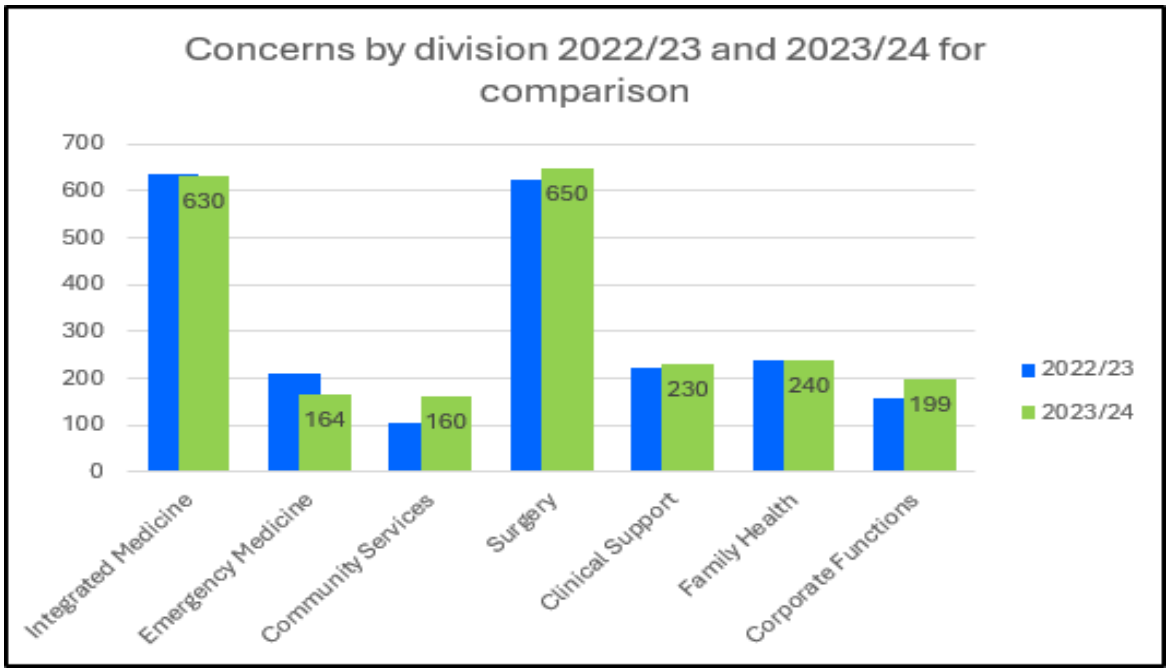
It should be noted that Obstetrics and Gynaecology saw a significant increase in complaints. However, it should be recognised that the service are encouraging open conversations and ensuring patients can feel comfortable to provide feedback regarding their experience.

Community Adult Therapy Services, Children and Younger Peoples Services (CYPS) and Clinical Radiology and Laboratory Medicine and Specialist Medicine experienced a slight increase.

However, it should be noted that Orthopaedics, Anaesthetics and Theatres, General Surgery and Nutrition and Dietetics and experienced a decrease in the number received.

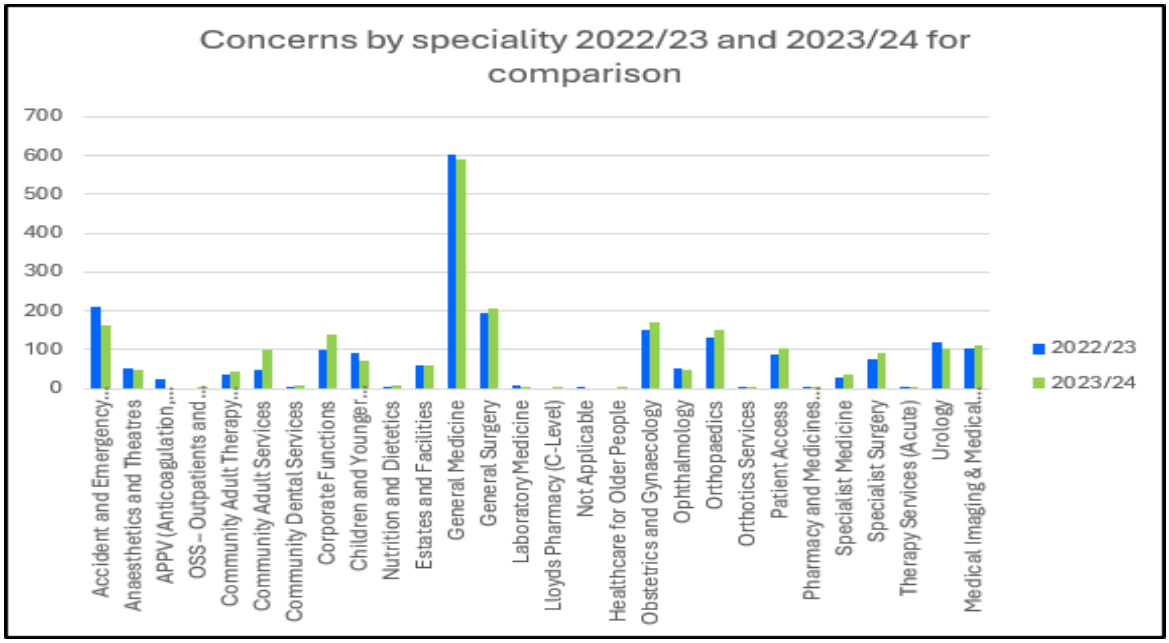
7.2.1 Concerns by Division

Surgery received the highest number of concerns closely followed by Medicine. As with formal complaints the divisions of Clinical Support, Community Services and Corporate Services all experienced an increase in 2022-23.



7.4 Concerns by Speciality

There has been no significant increase in the number of concerns received by any speciality. However, it is evident that there has been a decrease in the number received by UECC.



8. Grading and risk rating

8.1 Complaints are triaged on receipt using the National Patient Safety Agency (NPSA) risk rating matrix guidance. This is a systematic and effective method of identifying risks. It also encompasses the processes of risk analysis and risk evaluation with colour rated scoring, green being minor through to red being major.

8.2 The initial grading is determined by the Patient Experience Team based on the content of the complaint and is reviewed by the division for appropriateness. As part of this triage, complaints that highlight potentially Patient Safety Incident Investigations (PSII) or have Care Quality Commission (CQC) involvement are discussed with the Deputy Chief Nurse upon receipt and are routinely reviewed by colleagues they may also be linked to a PSII under the Duty of Candour (DoC).

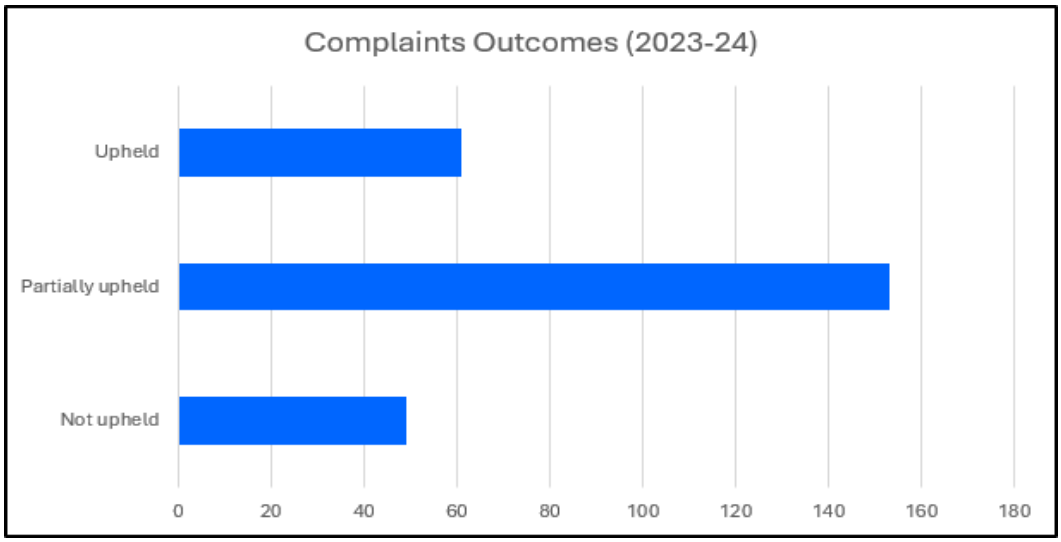
8.3 There was no red complaints in 2023-24. It should be noted that if a complaint was to be investigated as PSII, which would include a formal Duty of Candour letter being sent to the patient and or family. An explanatory letter is sent to all complainants in these circumstances to explain that their complaint is being investigated through a different process. However, they do have the option to return to the complaints process once the PSII investigation is complete should they remain dissatisfied.

Year	Green	Yellow	Amber	Red
2021/22	0.8%	69.9%	29.3%	0.0%
2022/23	0.0%	62.0%	37.6%	0.4%
2023/24	0.3%	63.2%	36.5%	0.0%

9. Complaint outcomes

9.1 Once the local resolution stage has been completed, then the appropriate or lead Division will determine if the complaint was upheld, partially upheld or was not upheld. This is in line with the Parliamentary Health Service Ombudsman (PHSO) and Care Quality Commission (CQC) standards.

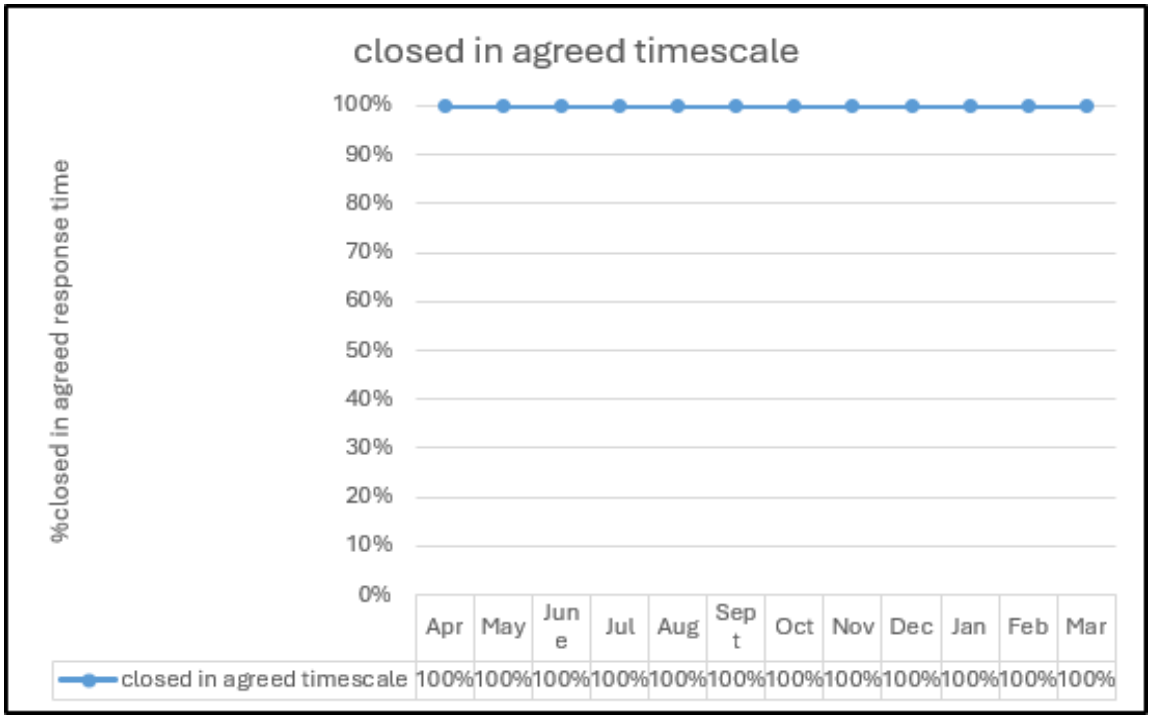
9.2 Of the 264 formal complaints closed in 2023-24, 23.19% (61) were upheld, 58.17% (153) partially upheld and 18.64% (49) not upheld.



10. Responding to Complaints within the agreed timescale

10.1 The Trust complaints policy aims to respond to all formal complaints within 30 working days and the responsibility for ensuring timely responses is shared between the patient experience team and divisions. If the complaint is complex multi-faceted or involves several organisations a timescale of 40 or 60 working days can be allocated.

10.2 In 2023-24 the Trusts target remained unchanged to respond to 95% of complaints within the agreed timeframe. It should be noted that for the year the Trust again exceeded this target by reaching 100% for the second consecutive year.



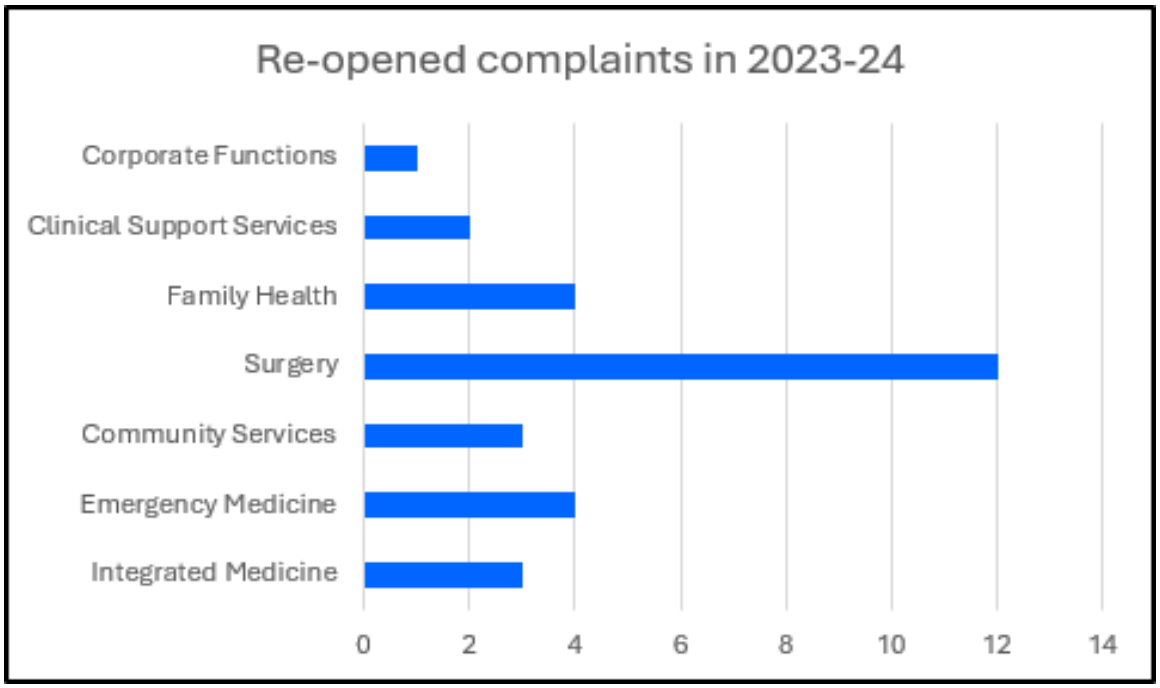
11. Complaints returned for further local resolution.

11.1 Complaints returned for further local resolution can be an indicator of how well a response is explained, how comprehensive the complaint investigation and response has been, or how satisfied complainants are.

11.2 Re-opened complaints need additional time and focus, and where possible and if not already provided, these discussions need to take place through the conciliation process. Complaints can be re-opened many months after the response has been closed, which can sometime be in the new financial year.

11.3 Out of the 264 formal complaints closed in 2023-24, 10.5% (29) were re-opened. This was a significant decrease compared to the financial year of 2022-23 when 40 were re-opened.

11.4 The Division of Surgery received the greatest number of re-opened complaints.



12. Parliamentary Health Service Ombudsman (PHSO)

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

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

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

12.4 Below shows that four cases were received for investigation in 2023-24 which remain open, and one case was closed and one case from 2022-23.

Speciality	Primary subject matter	Outcome	Recommendations
10933 UECC	Complaint made regarding the care and treatment received by the child. Patient passed away.	Closed	Upheld Apology including confirmation of an explanation of cause of death and

			offer of financial redress
12352 Specialist Surgery	Concerns regarding management of throat cancer.	Ongoing	
12668 Medicine	Concerns raised about patient remaining in hospital than necessary and patient contracted Covid. Patient passed away.	Ongoing	
12997 Surgery	Concerns raised following cataract surgery and subsequent treatment.	Ongoing	
14572 Surgery	Concerns raised regarding potential delay in diagnosis of cancer. Patient passed away.	Ongoing	
15783 UECC	Concerns regarding treatment and care following head injury.	Ongoing	

13. Review of Closed Complaints

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

13.2 For each quarterly review the main areas of complaint were identified; although it should be noted that clearly some of the complaints had multiple areas of concern.

13.3 From the reviews undertaken it was evident the structure, timeliness of handling and responding to the complaints was compliant with the Trust complaints policy. The files managed by the PET were well organised and contained copies of all correspondence and the letters of response were generally of good quality. Concerns were raised around the action plans and evidence of agreed actions being closed.

14. Demographics

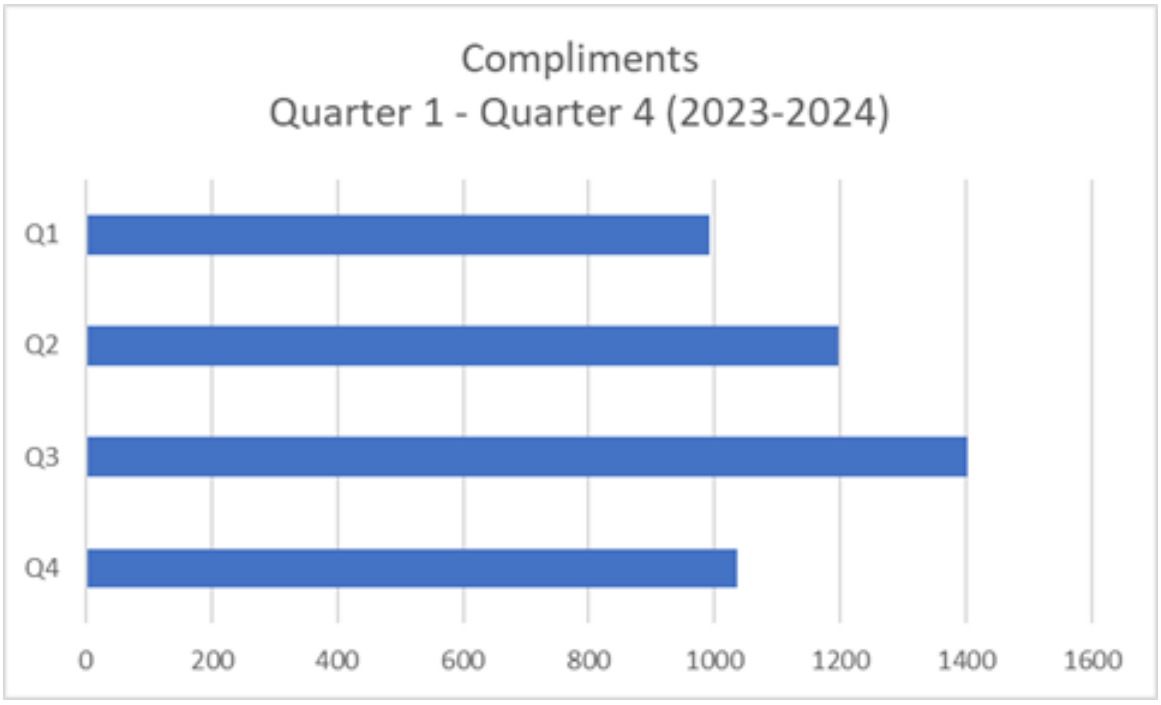
14.1 The main age range of people making formal complaints is between age 26 – 55 (36%) followed by over 75's (23%)

14.2 The main ethnicity of people making formal complaints is white British (66%) with 32% not stated.

15. Compliments

15.1 Our staff strive to deliver exceptional care and a positive experience for all of our patients. When this is recognised by patients and families in the form of a compliment, this valuable insight also helps us understand what is important to patients and how we can share learning in a positive way.

15.2 The Trust received 4,629 compliments in 2023-24. These were generated by various expressions of gratitude including thank you cards, letters, or positive reviews posted on the NHS website and token gifts such as Chocolates or biscuits. Feedback received via the Patient Experience Team is shared with staff/team(s) involved and recorded.

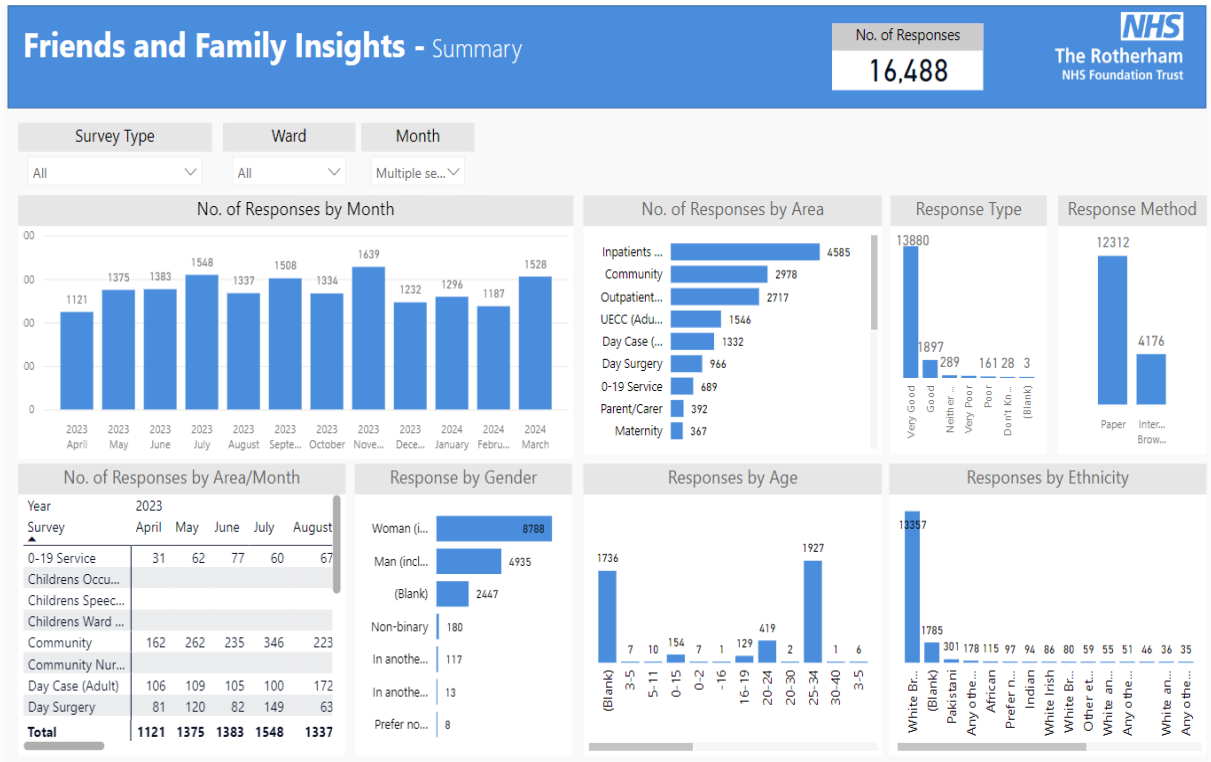


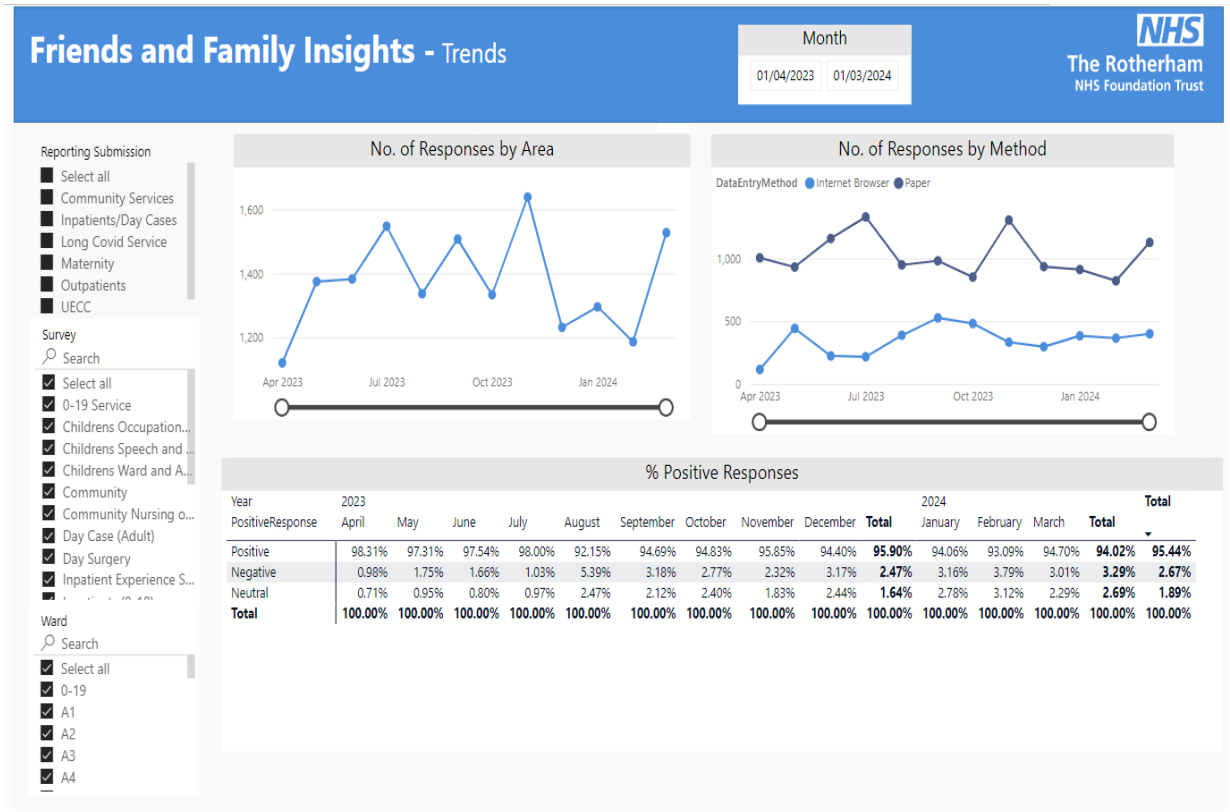
15.3 Work on ongoing to record all compliments to Datix so the data can be captured and recorded in the same format as complaints and concerns. When patients tell us care has gone well, this always reflects the individuals the patient has come into contact with. Porters, hostesses, cleaners, nurses, therapists, doctors, receptionists and volunteers are named as helping to put patients at ease, provide the right information, being kind, supportive and caring for people.

We know that kind, friendly, responsive colleagues, working to put patients first, helps to make the patient experience a positive one, even when the patients' outcomes aren't always what they would have wanted.

16. Friends and Family Test

16.1 There were 16,488 responses for the Friends and Family Test (FFT) in the year. Of these responses, 95.44% were positive, 2.67% negative and 1.89% neutral. A detailed report of the FFT data is shared at the Patient Experience Group, with a summary below:





17. External Feedback narrative for the year

17.1 We received 34 comments via Care Opinion and NHS UK, using the star classification as a type of rating system of one to five, with five being the highest rating.

Department	Number of Stars	Theme
UECC	*****	For all the negativity and bad press that national A&E departments have received over last few years regarding waiting times and overcrowded waiting rooms, I think Rotherham UECC has forged through the troubles and come out the other side, shining. From being greeted professionally at the front door by the Primary care team, with a caring, efficient attitude to the consultation with an A&E consultant who was just marvellous and sorted my health problems with compassion, empathy, professionalism and a smile, I am in awe of the work everyone does here. Thankyou Rotherham UECC you are all superstars!
Oncology	*****	Service from the Oncology department first class could not fault any aspect, treated with respect at all times. Appointments on time all staff giving more than 100 %
Children's Ward	*****	Our young son came to the children's ward for a small operation, everyone was lovely with him making the experience so much better. From the ward staff, nurses, the anaesthetist, consultant, porters, theatre

		staff and especially a brilliant student nurse. Thank you
Car Parking	****	This needs seriously reviewing. Cars are parking anywhere (not in parking bays) and blocking cars in that have parked correctly. I have just witnessed this and went to help a stressed lady who was unable to get out due to inconsiderate people parking their cars.
Endoscopy	*	Had a gastroscopy booked for 3.15 pm. Arrived in plenty of time. Was not told they were running two to three hours late. Had to leave and have asked to be rebooked. Very poor service and communication.
Out-Patients	*	I am an 84-year-old pensioner. I had an appointment for 8.30am 12th October and arrived ahead of the time required and waited nearly 2 hours to the be told that I could not be seen today and will have to arrange for another appointment in a months' time, no explanation given! I have been in tears all day about this experience and totally dissatisfied with the lack of due care and respect shown.

18. The National CQC Patient Experience Surveys for Acute Trusts

18.1 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.

18.2 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.

To prepare for the adult inpatient survey 2023, a series of workshops were held to share learning on patient experience and a business card was developed to give to patients discharged in November 2023 to try and increase response rates.

18.3 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.

18.4 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.

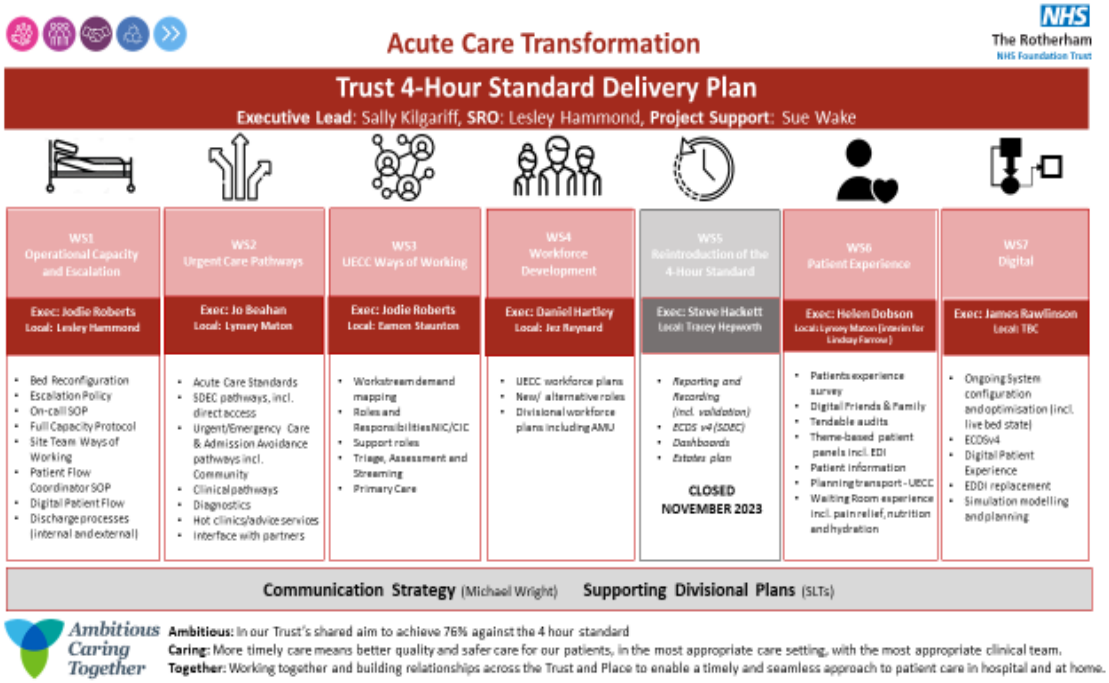
19. Thematic analysis from patient experience data

19.1 The thousands of pieces of patient experience data (compliments, complaints, concerns, audits, FFT and CQC surveys) we collect by month, quarter and year are all things that are important to patients and they want us to know about. Patient experience improvement needing systems thinking on the main themes to focus on and a quality improvement approach on those themes. The main themes for 2023-4 are overleaf:

Too long waiting times in UECC at the start of the IP journey	Having the right staff, with the right skills, in the right place, at the right time	Prevention of deconditioning, timely, safe, effective discharge

Management of pain, consistently and proactively	Meeting all patients nutritional and hydration needs	Involving people in decisions about their care

19.2 Acute Care Transformation



The Acute Care Transformation has resulted in a 78% reduction in formal complaints and an increase in FFT response rate to over 80% with the introduction of digital text messaging. This work stream will now move into business as usual.

19.3 Safe Staffing on Inpatient wards, Assessment Areas, UECC and Children and Young People areas – Milestones achieved in 2023-4

19.3.1 Establishment Setting

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.

19.3.2 Daily Deployment of Staff

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.

19.3.3 Retention

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

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

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

19.3.6 Health and Wellbeing needs of staff were supported with the successful business case for staff changing rooms and in April 2024, the new Rooftop Changing Rooms were 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

19.3.7 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.

19.3.8 The first Cultural Celebration event to celebrate our diverse workforce was help all supporting improvements in this work was held in October 2024.

19.4 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 You're Up and Dressed' regular IP 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 provide a familiar destination for 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.

19.5 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 apain 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.

19.6 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 – TPN) 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. A4 Menu posters have also been provided to each in-patient bedside. The menu has a QR code so that patients can scan the QR code with the telephones and view the menu options each day.

19.7 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.

19.8 Patient Advice and Liaison Service (PALS)

A business case to develop a new PALS was approved during this financial year to support front line resolution for patients and families in real time. Recruitment of staff to the new area is in progress.

To further compliment first impressions of the main entrance, the Patient Experience Team will be taking over line management of the welcome desk and a planned refurbishment of that area is underway.

In direct response to patient feedback, new wheelchairs with a £1 return function have now been purchased and are waiting for installation in the main entrance.

20. Shared learning from Patient Experience

21.1 To move away from individual action plans in response to one incident, Divisions are encouraged to triangulate all patient experience data and use a Quality Improvement approach to evidence their response the themes from their feedback. The method to triangulate patient experience is the (evidenced based) Yorkshire Patient Experience Toolkit. Divisions present their work back to the patient experience group once a year.

During 2023/4 the following Division presentations were heard on the following dates:

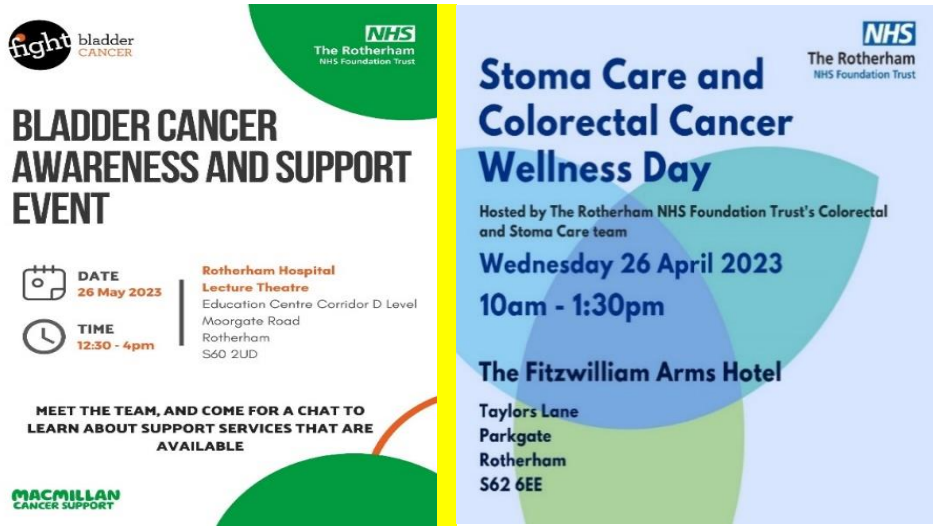
- April 2023 – Urgent & Emergency Care and Surgery
- May 2023 – Community
- June 2023 – Family Health, Children & Young Peoples Services
- September 2023 – Clinical Support Services and Medicine
- February 2024 – Urgent & Emergency Care and Surgery
- March 2024 – Community and Family Health, Obstetrics & Gynaecology

21. Additional improvement work achieved during 2023-24

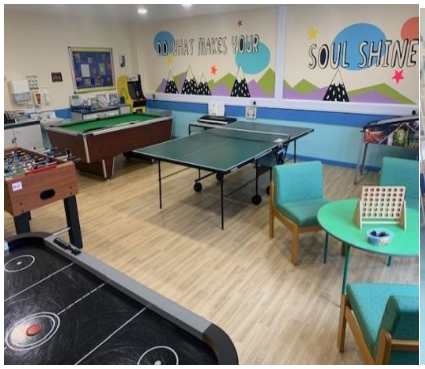
21.1 In April 2023, the Matron for UECC presented the department's patient experience feedback via a number of routes. Public events have taken place in October 2022 and March 2023. Feedback included poor signage in the department and dissatisfaction where there have been long waits to be seen.

21.2 To improve the experience of patients living with Dementia or experiencing delirium in UECC, the division have designed and bought the "UECC bus stop." With the additions of (single use) Twiddle muffs and Dementia dolls, this has provided some much needed distraction therapy for patients while in the department.


21.3 The Surgical Matron for Endoscopy and Head and Neck Cancer Nurse Specialist presented their Patient Engagement work. There was a focus group undertaken with all head and neck cancer patients diagnosed in 2020/2021. The group was to discuss patient experiences throughout their cancer treatment with a view to what went well and what areas could be improved. There was also a stoma care and colorectal cancer wellness day and a bladder cancer awareness and support event.

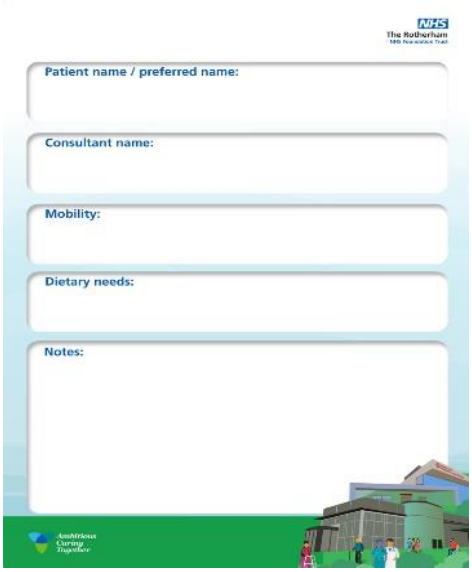


21.4 In June the Division of Family Health, presented an excellent presentation which focused on all the Quality improvement taking place in Children's services. Examples of this included the re-opening of the Children's play area on the children's ward, purchasing of a new safety bed, new artist work on the walls, development of an adolescent room, colourful bedside lockers, weighted blankets, sensory room, sensory tent and Katie's calm kit.


21.5 Following the Rapid Improvement Event for Discharge in April 2023, work has continued on the theme of Discharge. This centred around the new Person Centred Care (PCC) study day, which focused on deconditioning,reconditioning and fundamentals of care. From the PCC day, the faculty meet monthly to discuss feedback and pick up improvement actions. We are calling this work **Recondition Rotherham – You Look Your Best When You're Up and Dressed.** Initiatives in quarter two included;

21.6 Encouraging the use of the new Behind the Bed Board to communicate the Patients preferred name, Consultant, Mobility, Dietary needs and any other notes. The Dieticians have verbally feedback an improvement in dietary needs being completed, with colleagues in the catering department finding the ordering of meals much easier when the board has been updated.



21.7 For patients living with Dementia or experiencing Delirium, the twiddlemuff campaign was re-launched. These single use, knitted sleeves can be worn by patients as distraction therapy, while also engaging with our wider Rotherham Community for their kind support and donations.

21.8 Tea for Two was also launched as a simple initiative for any member of staff to sit with a patient who does not have a visitor and or is reluctant to drink enough fluids. Trying to mirror the social environment most of us would be used to when having a drink with a friend or family member. This initiative has been supported by executive colleagues for the benefit of patients.

21.9 Also in October we introduced Pet Therapy to the Trust through Therapy dogs Nationwide. This has had such a positive impact for both patients and staff and requests for visits continues to grow. Evidence shows that positive interactions with an animal may lead to benefits such as reduced stress levels and have a calming effect especially for patients that suffer from dementia or anxiety. Chester visits twice a week.

21.10 A patient clothes store has opened where clean, donated clothes can be stored for patients who do not have anything. The stock shop on site made a healthy donation of unused stock to get this started.

21.11 The Discharge to Assess Model has also launched with patients, wherever possible being assessed for discharge in their own home do the Therapy team can gain an understanding of how people function in their own homes. The NHS England Discharge team have asked for a written case study on this work as many other Trusts have struggled to get this off the ground.

21.12 Other work on the Virtual Ward and in reach for the District Nursing team have resulted in admission avoidance and earlier discharge for patients with long term conditions known to the District nursing Team.

21.13 Continuing our focus on patient-centred care we also introduced a hospital hairdresser as many patients miss their regular trips to the salon when they have an extended stay. Our 'look your best when you're up and dressed shines a spotlight on the benefits of patients looking and feeling more like themselves. Our hairdresser visits every Tuesday afternoon.

21.14 The Improving Reliable Care project with the Improvement Academy achieved additional funding from the Health Foundation and a Trust project manager is supporting the implementation at ward level. Ward A5 have now completed their testing and are running with the system. Further analysis when this is embedded will be shared.

21.15 The discharge lounge had been rebranded to the Community Ready Unit (CRU) to re-phrase the language used. Increased use of the unit will ensure improved flow through the organisation and therefore less people waiting in the UECC for an acute bed.

21.16 On the 10 November the Trust's the Remembrance tea party. The theme was around promoting good nutrition and hydration for patients as well as embedding the concept of reconditioning remained the focus. Ward A3 won the Tea-Pot hamper prize for their war themed efforts and person centred care.
The runners up were UECC who took part for the first time with their patients. A personalised Tea-Pot was awarded to the team for demonstrating the 'UECC Dunkirk Spirit'

21.15 To continue the theme of Joy in Work, a Christmas Santa visit was arranged in the last working week before Christmas. One of the Trust volunteers who regularly dresses as Santa for the Children's wards agreed to come in to visit the adult wards. Thanks to the Charity and Dunelm, over 300 presents were donated from people in the Rotherham community for the benefit of our patients.

21.16 The Trust started work on patients prefered names on wrist bands in 2022 and this has been re-launched with TRFT Consultant support as a campaign called #CallMe or Call Me Because Names Matter.
This is a campaign to ensure that people are addressed by the name they prefer every time, everywhere in healthcare. Creating cultural awareness and making sure preferred terms of address are accessible to be used every time, everywhere in healthcare. We have publicaly expressed support for this campaign with the team at www.callmebecausenamesmatter.org.

21.17 As part of Nutrition and Hydration week staff members across the Trust got involved to highlight and educate people in the value of food and drink in maintaining health and wellbeing in health and social care and 13 March the Trust held its global tea party as part of Nutrition and Hydration week.

21.18 Following analysis of the Eyes, Ears Teeth bags, some patients are reluctant to use them as they fear things could break. A successful bid to the Charitable Funds committee has resulted in a new pilot for Eyes, Ears, and Teeth boxes to see if these are used more effectively.

21.19 Finally at the end of March we received hundreds of Easter eggs kindly donated by Wath-Upon Dearne's Tesco in the Community and the generous donations of the local Community. For patients spending their Easter holiday in hospital and on their own in the Community. To help distribute the Easter Bunny took time in his busy schedule to visit.



23. Internal Audit

The Internal Audit report into Patient Experience, published January 2024 found significant assurance – relating to establishment of themes, and implementation of actions relating to the tracer theme. A generally sound framework of governance, risk management and control designed to meet the objectives of the system under review, and controls were generally being applied consistently.

Limited assurance was found in the design and/or inconsistent application of the framework of governance, risk management and control that could result in failure to achieve the objectives of the system under review.

The actions from this review link to the new action planning module being available on Datix for complaints and concerns. The improvement themes identified (apart from the ACT programme) were all registered on the Trust audit system AMAT with actions assigned to individual owners.

24. Conclusion

24.1 Patient experience can be described as ‘what the process of receiving care feels like for patients. Complaint handling has performed strongly with 100% of complaints acknowledged within 3 working days. 100 % of complaints were graded upon receipt and the response rate to formal complaints responded to in the agreed timescale was 100%.

24.2 This report has aimed to describe the direct feedback from patients, through complaints, concerns, compliments, FFT, CQC surveys, Care Opinion and NHS UK. From this feedback, an evidenced based process has been introduced to help make sense of the data and learn thematically to prioritise Quality Improvement.

24.3 For the CQC patient experience surveys, divisions were invited to facilitated feedback, provided through Picker. These have been well attended with clinical teams increasing understanding of what is important to patients and what needs to improve.

24.4 A full year of Quality improvement initiatives have taken place, with something new launching every single month for the benefit of our patients and in co-production with the clinical teams in divisions.

24.5 To better understand if the improvements have made a difference, patient experience is no longer collected by the Tendable app. Instead an In-patient survey, using a several of the CQC questions has been developed and a selection of patients will be randomly selected following discharge on a quarterly basis.

24.6 Although the numbers of formal complaints has remained the same, there has been an increase on the number of out-patient complaints with a decrease in UECC. This is also in line with the increased numbers of patients being seen. Work planned for next year include adding compliments into the Datix system to further learn from what is important to patients and where care has excelled to be able to share that learning.

Agenda item	P108/24
Report	**End of Life Care Annual Report 2023/4**
Executive Lead	Helen Dobson – Chief Nurse
Link with the BAF	B1 Standards and quality of care do not deliver the required patient safety, clinical effectiveness and patient experience that meets regulatory standards
Purpose	Decision ☐ To note ☒ Approval ☐ For information ☐
Executive Summary (including reason for the report, background, key issues and risks)	The End of Life Care Annual Report provides an overview of activity, key achievements and challenges during 2024/25. Key points include: The Trust Strategy for Palliative and End of life Care was launched during a series of promotions during Dying Matters Week 2023. Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) went live in October 2023 across Rotherham Place and the post implementation work continues. A new Lead Nurse for the Supportive Care Team was recruited and started post in January 2024 and the Team were transferred to Corporate Nursing for quarter one 2024/5. A full establishment review was conducted resulting in recruitment of vacant posts. 950 adult inpatients died during this time period and 559 of these were given tailored care through the individualised plan of care in the last days of life. This was a total of 58.8% of patients which is an improvement from the first year of implementation but not reaching the quality priority aim of 75% (national average). Education has been provided throughout the year with over 400 colleagues attending the person centred care day, grand rounds and medical induction has also included teaching in palliative and end of life care. The National Audit of Care at the End of Life (NACEL) was revised and re-launched in January 2024 and the family feedback survey was available by the end of this financial year. Findings have been included in the report and an action plan will be developed when the case note audit data and staff feedback data has been published.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	This paper was presented to the Patient Experience Committee on 29 April 2024 and to Quality Committee on 29 May 2024.
Board powers to make this decision	N/A

Who, What and When (what action is required, who is the lead and when should it be completed?)	The Board is asked to review the activity undertaken to support patients at the end of their life and note the planned improvements.
Recommendations	The Trust Board is asked to note the content of the paper.
Appendices	Appendix one – the PowerBi report for patient deaths and numbers of care plans Appendix 2 the NACEL family feedback data from Q4 2024

End of Life Care
Annual Report

April 2023 – March 2024

purple butterfly
In Memory Giving

1. Introduction

This report relates to the period April 2023–March 2024 and aims to share work and progress with the ongoing improvement of End of Life Care (EoLc) within the Trust

2. Key Achievements

- Recruitment of new Lead Nurse - Jan 2024
- Development and co-production of a Trust Strategy
- Engagement with Dying Matters Week 2023
- National Audit of Care at the End of Life (NACEL) audit submission Q4 2024
- Maintenance and development of staff education and training
- Day to day support to wards for patients in last days of life

3. Workforce – The Team

3.1 The Rotherham NHS Foundation NHS Trust Supportive Care Team is supported by a Consultant in Palliative Medicine working 4 sessions each week funded by the Trust, the Consultant also provides support to Rotherham Hospice and Community Nursing as well as providing On-call support. This year saw a change in management with a new, experienced, Lead Nurse for the Supportive Care Team, starting in Q4 2024. The team consists of:

Lead Nurse
1 WTE 8A Lead Nurse

Palliative Care / End of life CNS
3.69 WTE Band 7 Palliative Care Clinical Nurse Specialist (CNS)
1WTE Band 6 Palliative Care CNS

Acute Oncology
0.91 WTE Acute Oncology Service Lead (AOS) Lead Nurse
1 WTE Band 6 AOS development post- currently a secondment post funded by Macmillan.
0.68 WTE Band 6 AOS CNS

Cancer of Unknown Primary
0.80 WTE Cancer of Unknown Primary (CUP) Lead Nurse
0.76 WTE Band 6 CUP CNS

Supportive Care Support Worker
1 WTE Supportive Care Support Worker

3.2 Since the new lead nurse has commenced post, an additional 15 hours of CNS has been advertised to support the growing demand in the Acute Oncology service and existing budget for a B3 coordinator has been converted to a B4 to align with the Macmillan support worker role.

3.3 There remains a vacant Palliative Care Consultant Post, vacant Clinical Lead for Acute Oncology and some work to plan for resilience with the Cancer of Unknown Primary Clinical Lead cover. The admin for the Consultants was recruited to by the Hospice.

4. ACTIVITY – SUPPORTING PATIENTS IDENTIFIED AS BEING IN THEIR LAST DAYS OF LIFE

The Supportive Care Team pick up referrals through Meditech/System One Monday – Friday between 08.00 –18:00

The team review patients presenting with an Acute Oncological Emergency, any patients who have a Cancer of Unknown Primary, patients who require palliative care support/symptom management or those approaching end of life (EOL.)
AOS/CUP report separately

Between 1 April 2023 and 31 March 2024, the Palliative or End of life care team reviewed 1,088 patients who were in the criteria discussed above.

The Palliative/EOL care team receive a number of referrals each month, the themes of the referrals are to support with, Pain, symptom management, distress (physical, psychological, emotional, social or spiritual as well as complex discharges. Going into the next financial year we will provide a breakdown of analysis of the themes.

4.1 Referrals

Month	Patients
April 2023	101
May 2023	85
June 2023	73
July	73
August	97
September	68
October	100
November 2023	108
December	97
January 2024	104
February 2024	78
March 2024	104
Total	**1,088**

5. LAST DAYS OF LIFE CARE PLAN

5.1 The Last Days of Life Care Plan was implemented at Rotherham in March 2022. The plan itself is a comprehensive document which not only records care delivery and decisions taken but also notes conversations with patients and their families so that their needs are taken into account. The plan must be agreed, co-ordinated and delivered with compassion and every plan is based on five key principles, including commitments to:

- communicate sensitively with patients and those identified as important to them.
- involve the patients, and those identified as import to them, in decisions about treatment and care.
- support, by ensuring that the needs of families and others identified as important to the patient are actively explored, respected and met as far as possible.
- plan and do, by implementing an individual plan of care which includes food and drink, symptom control and psychological, social and spiritual support.

5.2 The number of adult inpatient deaths in the Trust is below and this includes the numbers of patients given tailored care through the individualised plan of care for the last days of life;

Month	Deaths	Patients on individualised plan of care last days of life	Percentage
April 2023	78	42	(53.8%)
May 2023	71	42	(59.2%)
June 2023	73	41	(56.2%)
July 2023	44	28	(64%)
August 2023	70	40	(57%)
September 2023	73	34	(47%)
October 2023	80	57	(71%)
November 2023	80	52	(65%)
December 2023	97	55	(67%)
January 2024	104	57	(54.8%)
February 2024	80	50	(62.5%)
March 2024	101	61	(60.4%)
TOTAL	**950**	**559**	**58.8%**

Areas of concern

- Still not achieving 75% of patient approaching end of life on the care plan, acknowledging there will always be some patients experiencing a sudden or unexpected death.
- Inconsistency in record keeping- Clinicians continue to document under 'ward round review' when the care plan has been commenced.
- Late recognition of diagnosing dying and commencement of care plan.

Plans moving forward

- Share findings from the revised National Audit of Care at the End of Life (NACEL) for family experience with all colleagues across the Trust.
- Share findings from the staff awareness audit (once complete) in 2024 to develop gap analysis on education and development of clinical teams.
- Continue to teach on the preceptorship/HCSW and patient centred study days.
- Now teaching on the FY1 rotation teaching.

6. AUDIT

6.1 The National Audit of Care at the End of Life (NACEL) was commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England in October 2017 and the first round of the audit took place in 2018. The audit was not undertaken in 2020, due to the Covid-19 pandemic. NACEL is a national comparative audit of the quality and outcomes of care experienced by the dying person (18+) and those important to them during the last admission leading to death.

6.2 The overarching aim of NACEL is to improve the quality of care of people at the end of life in acute, mental health and community hospitals. The audit monitors progress against the five priorities for care set out in One Chance to Get It Right, 2014 and NICE Guideline (NG31) and Quality Standards (QS13 and QS144).

Components of NACEL

- An Organisational level Audit

- Trust Board level audit
- A Case Note Review
- A Quality survey (From Relatives)
- Staff Report Measures (Staff Survey)

The Quality Survey is based around the 5 priorities of care:

Recognise	Recognition of dying
Plan and Do	Individualised management of symptoms
	Actions to meet the holistic needs of the dying person
	Actions to meet the needs of those important to the dying person
	Timely review of the dying and deceased patient
Communicate	Communication about dying
Involve	Personalised care and support planning
Support	Equitable care
	Workforce supported, equipped and engaged to provide end of life care

NACEL was redesigned for 2024 with key changes being:

- More frequent data collection and reporting
- Focus on Quality Improvement activities
- Revised data points
- New reporting system
- Data and Improvement Tool

NACEL was commenced in January 2024 and by the end of March 2024, the family or those important to the dying person survey data was made available for Trusts to review. This is the first time the Trust has received family feedback. 19 surveys were received in Q4 and the full data is available in **Appendix 2.** It should be noted that this is a very small survey and this should be taken into account when considering responses but even so, there are clear opportunities for improvement that will be addressed over the coming year.

Recognition:

A member of staff explained to the person that they were likely to die in the next few days

As an organisation we are the worst nationally with only 4.76% of our relatives stating that the person was told they were likely to die in the next few days.

14.29% stated that they could have been told but weren't

19.05% stated no they weren't told

52.38% were not told as they were too unwell, unconscious or unable to understand

9.5% responded that they didn't know

This is a clear indication that 85% of our patients were not informed that they were likely to die in the next few days. Showing our lack of recognition for the dying patient and leaving the decision too late.

Plan & Do:

The Person was given enough pain relief

Feedback from our relatives is that 65% of our patients were given enough pain relief.
5% of our patients did not require any pain relief, and 15% felt that they did not receive enough.

This is slightly below the national average which is 70% and will be a focus for improvement work.

The person had enough relief of symptoms other than pain (such as nausea, breathlessness or restlessness)

50% agreed that symptoms were addressed
15% disagreed
5% of our patients had no symptoms

This shows a need for further education and training in relation to symptom management

The person had support to eat or receive Nutrition if they wished

45% of relatives agreed that the patient was supported to eat if they wished
30% of relatives disagreed
20% felt that is wasn't appropriate
Further work on taste for pleasure and communication is needed in relation to hydration and nutrition

The person had support to drink or receive fluid if they wished

45% of relatives agreed that the patient received hydration
25% disagreed
20% of relatives felt that it wasn't applicable

As above

Overall rating of the care and support given by the hospital to the dying person

80% of our relatives felt that the care and support given by our hospital was fair to excellent
20% felt that care was poor

Communication and involve

A member of staff at the hospital explained to families and others that the person was likely to die in the next few days

60% of our relatives felt that this was explained to them
5% felt that this was not done appropriately
Sadly 30% stated that they wasn't told but could have been

30% not informed shows that work needs to be done in the way in which we communicate with families and those important to the dying person.

If families and others wanted to be with the person when they died, they received timely communication to be there

80% of our families wanted to be with the patient when they died and felt that they were given timely communication to be there.
20% of families stated that they wasn't given timely communication

This is a good result but equally shows there can be improvement in this area.

The person had an advance care plan in place before they died

Only 10% of our patients came into the hospital with an advanced care plan
10% were started during their final admission
60% of our patients didn't have an advanced care plan in place
20% didn't know

This result shows that we need to work collaboratively in relation to having advance care planning with our patients

Support

The person was offered an interpreter or other language support so they could communicate with staff

95% of our patients did not need an interpreter however of the 5% that did, this did not happen

Families and others were offered an interpreter or other language support so I could communicate with staff

95% of our patients did not need an interpreter however of the 5% that did, this did not happen

Staff looking after the person had the skills to care for someone at the end of their life

60% of relatives felt that staff had the skills to care for patients at the end of their life
25% neither agreed nor disagree
15% of relatives feel that staff were not skilled to care for patients at end of life

It is concerning that 15% felt that that staff were not skilled,
The staff survey will equally show where education & development is needed

Staff behaved with compassion and care

Feedback is that 80% of relatives felt that staff at TRFT behaved with compassion and care.

20% neither agreed nor disagreed

This is a good result and shows that we are compassionate and caring organisation

7. EDUCATION PROGRAMME

7. End of life care is delivered in a variety of ways across the Trust

Course Title	Staff Group	Number	Comments
HCSW	Health Care Support workers	46	
Syringe Driver Training	Registered Nurses	24	Point of Care (Day 3) annually.
PCC Days	All staff	347	Monthly Dates
Preceptorship	Registered Nurses	54	
End of Life Care Plan	Registered Nurses/Health Care Support workers.	33	Now part of the SET offer for all staff.
Urgent and Emergency Care (UECC) training day	Consultant/Dr'S/ACP's and registered Nurses		Teaching on Palliative Care UECC Day Dr Hendry and Dr Flint
Recognising Dying	FYI		Dr Flint
Recognising Dying	HCOP Doctors		Dr Hendry
TRFT Schwartz Round			Dr Hendry
Palliative Care	FYI Induction		Dr Hendry
Rapid Deterioration since Diagnosis in Advanced Cancer	Grand Round Medicine		Dr Keegan
Medication at the end of life	Pharmacists	12	Dr Hendry
Communication Skills	Advanced Care Practitioners Acute Response Team	6	
Muslim Deaths in Hospital	All staff	19	Dr Evans

8. RECOMMENDED SUMMARY PLAN FOR EMERGENCY CARE AND TREATMENT (ReSPECT)

8.1 The South Yorkshire Integrated Care System (ICS) runs a quarterly ReSPECT group, chaired by Dr Rod Kersh, TRFT Lead for ReSPECT. The meeting enables colleagues from across the ICB (acute, community, mental health, social and primary care) to share learning from the ReSPECT process, including implementation.

8.2 Most recently, Nottinghamshire have joined the group given their association with Bassetlaw Hospital and their intention to implement ReSPECT in the city.

8.3 The Rotherham ReSPECT partnership last met in April 2024 and following implementation has stepped meeting frequency from bi-monthly to quarterly.

8.4 ReSPECT was formally adopted in Rotherham on the 1st of October 2023 and a Trust policy published.

8.5 Dr Kersh also chairs the Yorkshire and North East ReSPECT Group, which is well attended with good representation from different sectors.

8.6 The next phase of implementation in Rotherham will involve more detailed data collection and audit of quality of documentation.

9. QUALITY IMPROVEMENT

9.1 END OF LIFE CARE BUTTERFLY VOLUNTEERS

9.1.1 The Butterfly Volunteer service has continued to enhance the experience of patients identified as being in the last days of life. The volunteers may sit with dying patients as requested to allow relatives or those important to the patient a break. Sometimes patients have no one to sit with them to the purple butterfly volunteers can sit with people to ensure they do not die alone.

9.1.2 The Volunteers will talk to patients and/or read to them, and sometimes just sit with them to provide company. The EoLC Butterfly Volunteers also work as part of the ward team, and help to undertake non-clinical activities in relation to end of life care, such as re-stocking end of life care related resources for the ward.

9.1.3 The fixed term funding from NHS England for the Purple Butterfly Volunteer Lead ended in October 2023 and this had an impact on retention of the existing volunteers.

9.1.4 Following approval from the Executive Team, the Supportive Care Team formally transferred to Corporate Nursing on 1 April 2024. A full review of available budgets took place prior to the transfer and a new substantive band 4 post was created. This job description will align with the Macmillan Cancer Support workers but will be based in the Supportive Care Team and will incorporate the Purple Butterfly Volunteer programme.

2023-2024	The Rotherham NHS Foundation Trust					
	Number of Active Volunteers	Hours by the Bedside	Number of Patients Visited (First Visit)	Return Visits	Number of Visitors Supported	Total Visits
Apr-23	11	15	7	4	13	11
May-23	11	27	39	15	33	54
Jun-23	11	40	23	25	40	48
Jul-23	11	35	21	17	24	38
Aug-23	19	33.5	31	18	25	49
Sep-23	7	7.5	13	3	22	14
Oct-23	4	9	9	2	15	11
Nov-23	4	11	9	3	12	12
Dec-23	3	9	4	1	12	5
Jan-24	2	9.8	8	2	10	10
Feb-24	2	8.25	8	2	10	10
Mar-24	2	6.08	8	2	10	10
Total	N/A	**129.13**	**111**	**50**	**140**	**159**

9.2 BUTTERFLY ROOMS

9.2.1 Butterfly rooms are specially designed areas for patients and families to be together, in privacy and with dignity while experiencing end of life care. There are currently three Butterfly rooms in use across the Trust. Two are for adult patients and one is for bereaved mothers.

9.2.2 It has been identified at the end of Q4 that a named lead within the teams needed to regularly audit and inspect the maintenance of the rooms as the 'Purple Butterfly In Memory Giving' charitable fund supports the ongoing maintenance and good repair of these rooms. This will be included in team objectives from Q1 2024.

10. DYING MATTERS WEEK

10.1 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. For Dying Matters Awareness Week 2023, the theme focused on Dying Matters at work. 57% of employees will have experienced a bereavement in the last five years and every day, more than 600 people quit work to look after older and disabled relatives. And yet, fewer than one in five managers feel very confident supporting someone they manage with a bereavement.

10.2 The main event of Dying Matters Awareness Week 2023 was the launch of the new Trust Strategy for Palliative and End of Life Care. This was based around the national ambitions for Palliative and End of Life Care. The Strategy launch was complimented by a series of posters and pull up banners for clinical colleagues to use in their areas, with one for each ambition.

10.3 On Tuesday 9 May a Lunchtime lecture was held with stalls from the chaplaincy, health and wellbeing teams offering hand massage. Colleagues who attended dying matters week events received a goody bag with leaflets, reading lists, pens and resources included.

10.4 On Wednesday 10 May, there was an event in the rooftop restaurant and main entrance with a webinar led by Dr Kersh on a 'Good Death and Bad Death' held for all to join.

10.5 Dying Matters Week 2024 will take place from 6 – 12th May. During the last quarter of 2023/4 work started to plan this year's theme 'The way we talk about Dying Matters.' This will focuses on the language that we use, and conversations we have, around death and dying – specifically between healthcare professionals and patients, and those important to them.

11. TRUST STRATEGY

11.1 The national ambitions for palliative and End of Life Care (https://www.england.nhs.uk/wp-content/uploads/2022/02/ambitions-for-palliative-and-end-of-life-care-2nd-edition.pdf)
Describe how death and dying is inevitable, therefore good palliative and end of life care must be a priority. The ambitions confirm that the quality and accessibility of this care will affect us all and it must be made consistently better for all of us. The needs of people of all ages who are living with dying, death and bereavement, their families, carers and communities must be addressed, taking into account their priorities, preferences and wishes.

11.2 The strategy was developed and written during 2022/3 and was approved at the Patient Experience Committee in April 2023. The new strategy has required colleagues across The Rotherham Foundation Trust (TRFT) to lead and exemplify new ways of organising care and support for people.

One Chance to Get It Right...

"When it comes to death the statistics are stark. 100% of us will die. The question is what are we all going to do about that? How are we going to create confidence in the care that we may need? And how do we promote the wellbeing of those living with loss? We cannot defeat death. However, we can change the way we talk about dying, death and bereavement and prepare, plan, care and support those who are dying and the people who are close to them. We must strengthen and improve our ability to provide care whatever the circumstances of our dying."

Ambitions for Palliative and End of Life Care: A National Framework for Local Action 2021-26

End of Life Care Plans
(RU numbers Removed)

End of Life Care Plans

Commenced Care Plan

Number of Care Pla...
667

NHS
The Rotherham
NHS Foundation Trust

Doc Created Date

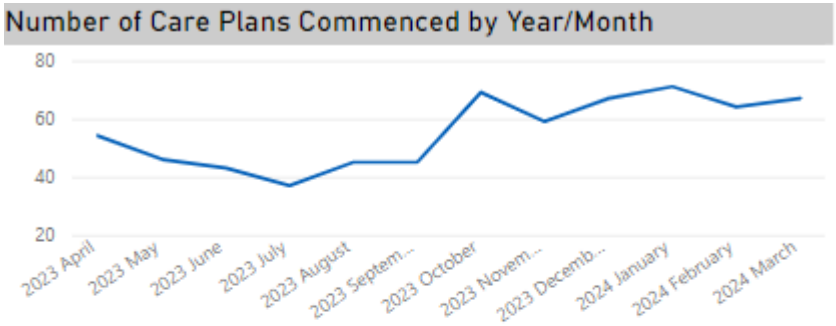
01/04/2023 31/03/2024

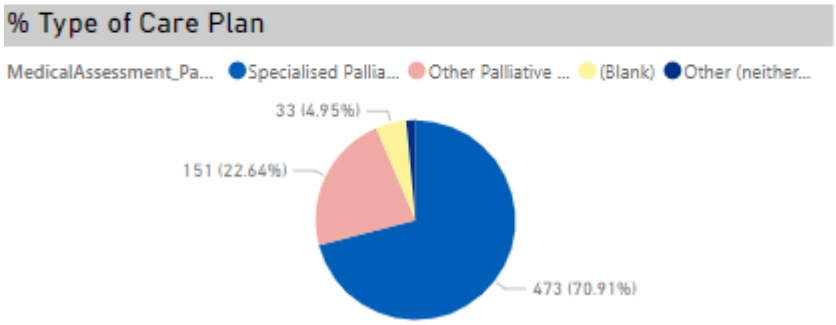
Care Plan Type

- (Blank)
- Other (neither of the other giv...
- Other Palliative Care/ EOL Plan...
- Specialised Palliative Care/ EO...

Number of Care Plans Commenced by Year/Month (Count based on Acc Number)

Year	2023									2024		
MedicalAssessment_PalliativeCareType	April	May	June	July	August	September	October	November	December	January	February	March
Specialised Palliative Care/ EOL Care Plan - Specialised	44	37	32	33	42	35	54	48	39	51	32	26
Other Palliative Care/ EOL Plan - NOT Specialised	10	8	11	4	3	10	13	8	26	17	32	9
Other (neither of the other given options)		1					2	2	2	3		
								1				32
Total	**54**	**46**	**43**	**37**	**45**	**45**	**69**	**59**	**67**	**71**	**64**	**67**

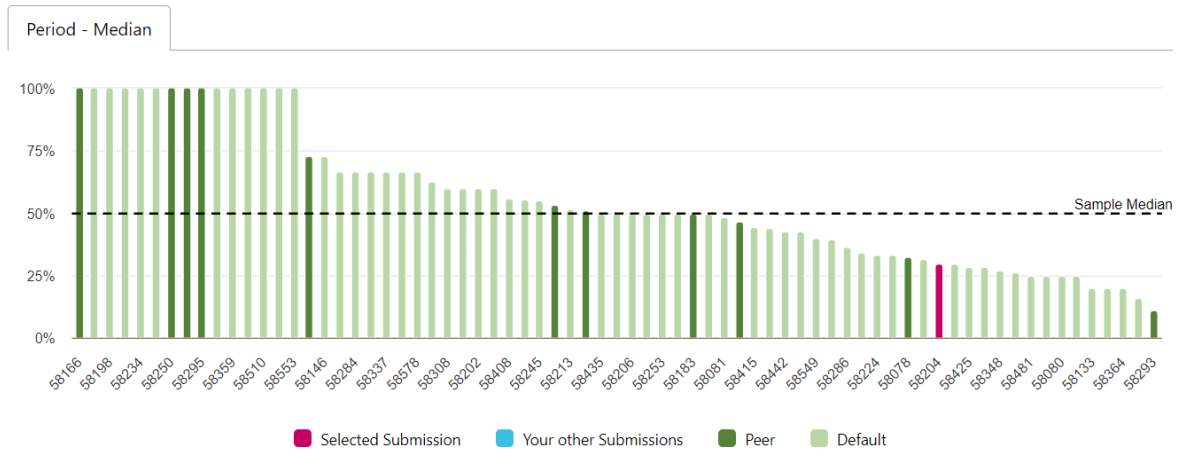


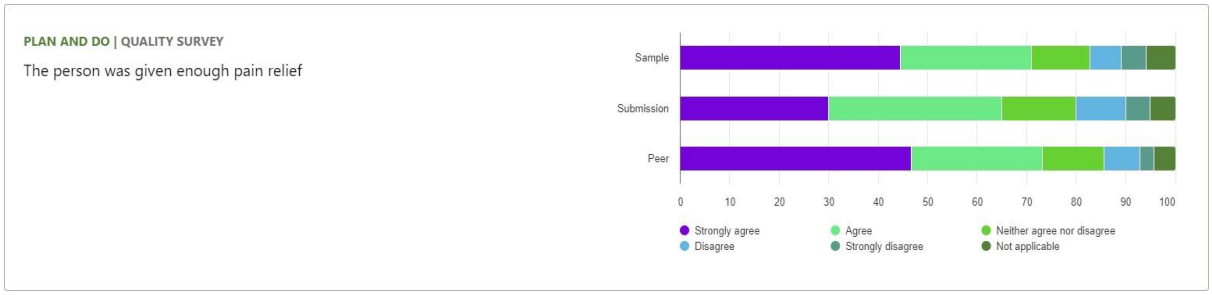


National End of life care Relatives audit

Plan and Do

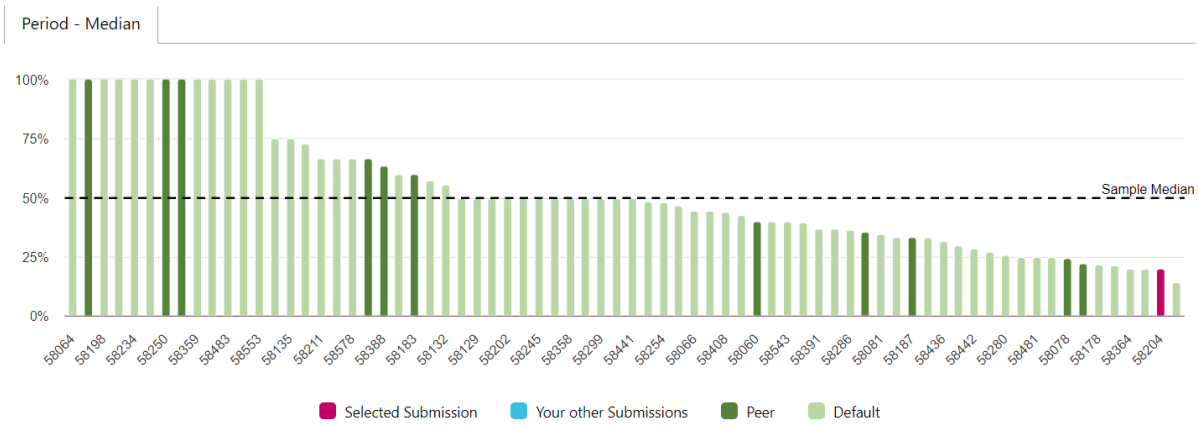
The person was given enough pain relief





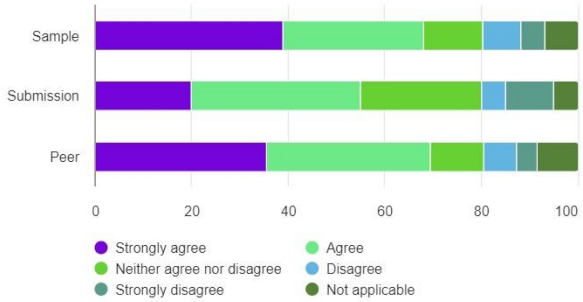
Site	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	N/A
National	44.2%	26.4%	11.9%	6.3%	5.2%	5.9%
Rotherham	30%	35%	15%	10%	5%	5%
Peers	46.8%	26.5%	12.2%	7.1%	2.9%	4.2%

The person had enough relief of symptoms other than pain (such as nausea, breathlessness or restlessness)



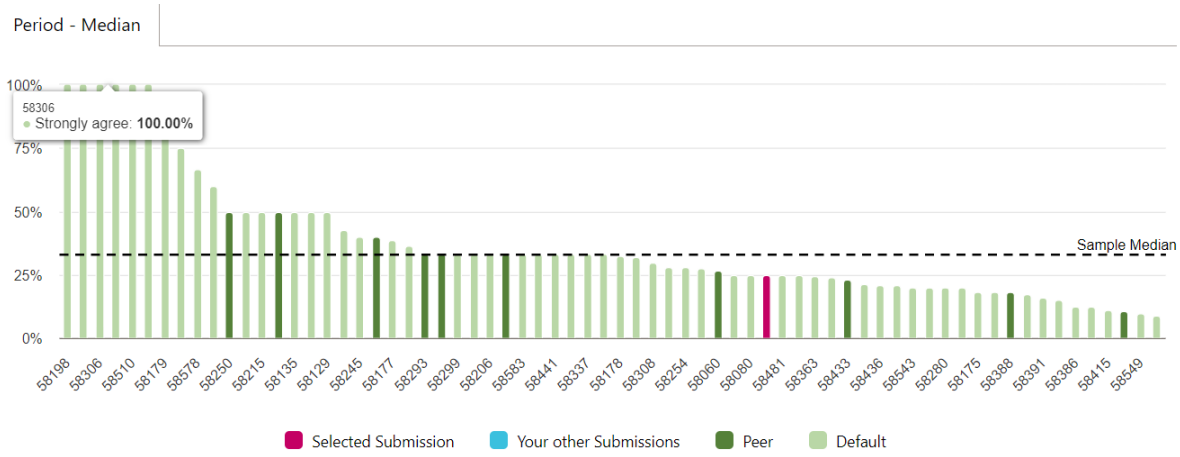
PLAN AND DO | QUALITY SURVEY

The person had enough relief of symptoms other than pain (such as nausea, breathlessness or restlessness)



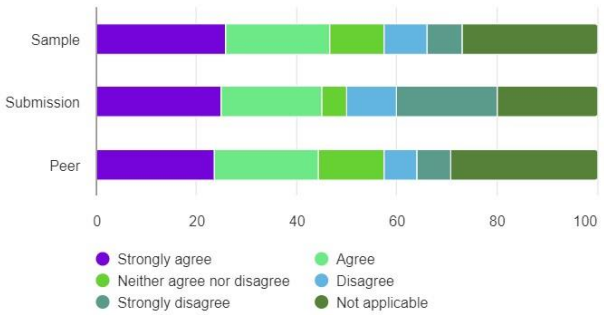
Site	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	N/A
National	38.9%	29.2%	12%	7.8%	5.6%	6.7%
Rotherham	20%	35%	25%	5%	10%	5%
Peers	35.5%	33.9%	11%	6.7%	4.2%	8.4%

The person had support to eat or receive nutrition if they wished



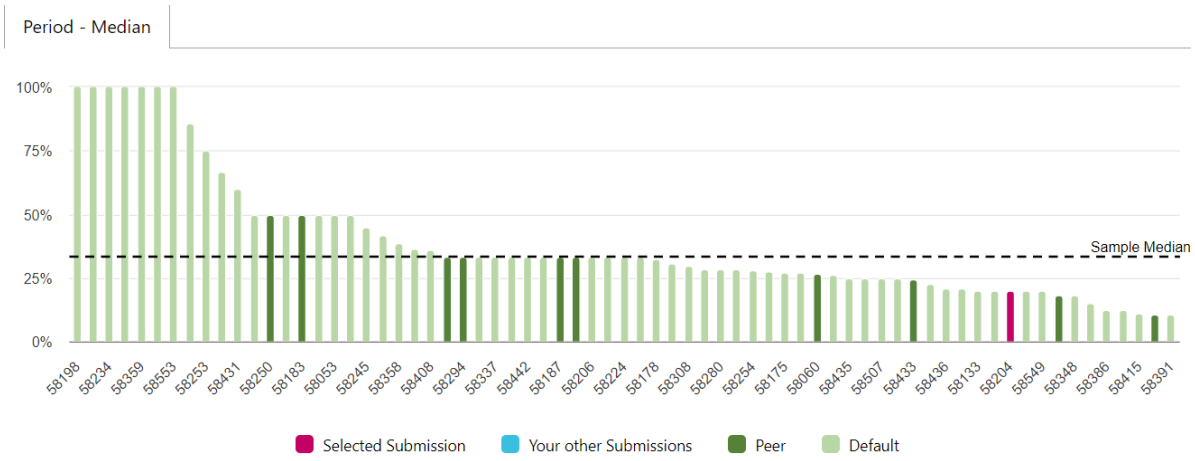
PLAN AND DO | QUALITY SURVEY

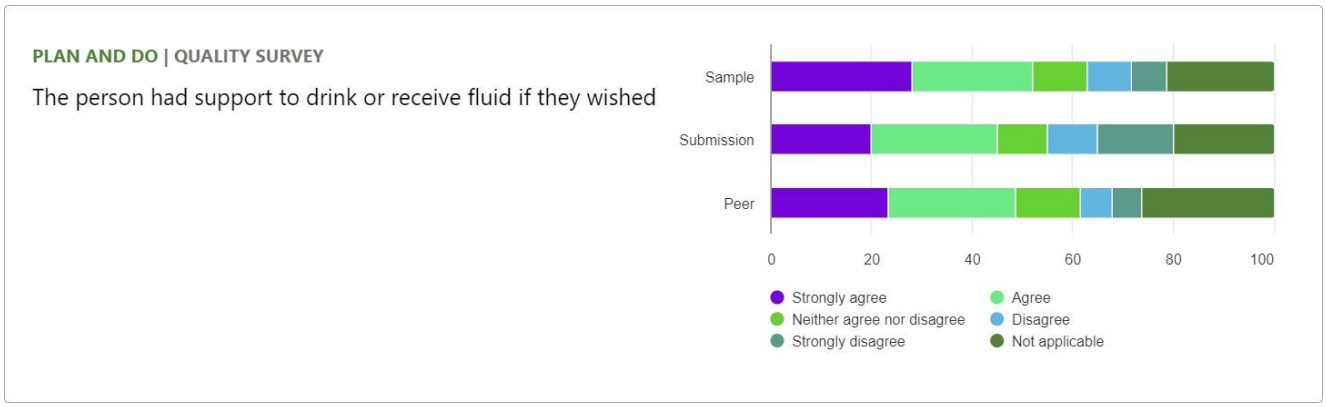
The person had support to eat or receive nutrition if they wished



Site	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	N/A
National	25.7%	21.1%	10.6%	8.7%	7.2%	26.7%
Rotherham	25%	20%	5%	10%	20%	20%
Peers	23.6%	20.6%	13%	6.7%	6.7%	29.1%

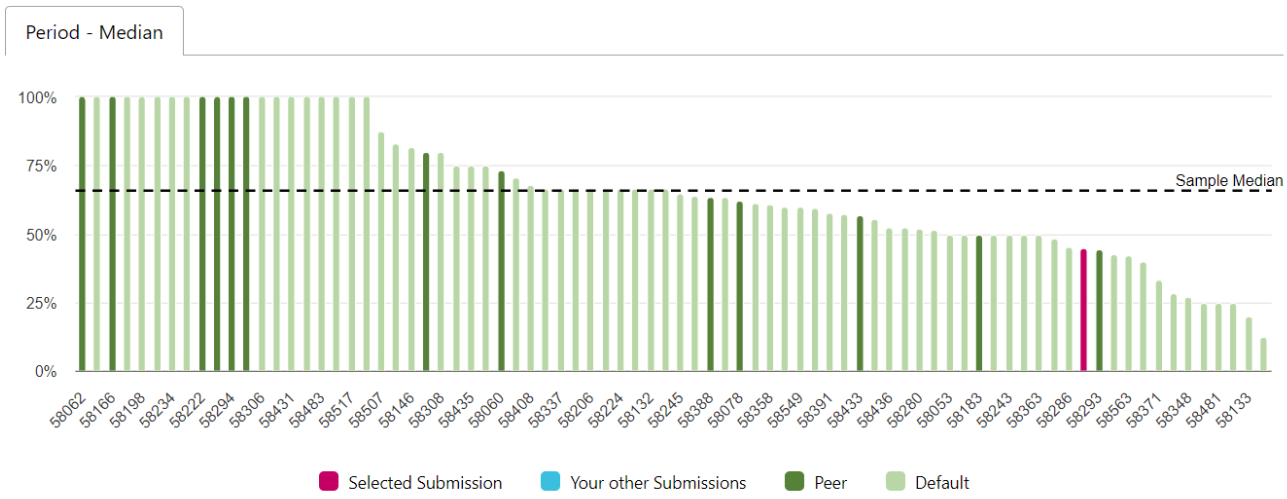
The person had support to drink or receive fluid if they wished





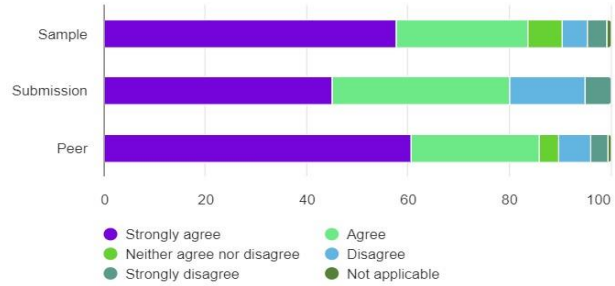
Site	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	N/A
National	27.9%	24.1%	10.7%	8.7%	7%	21.1%
Rotherham	20%	25%	10%	10%	15%	20%
Peers	23.3%	25.4%	12.7%	6.3%	5.9%	26.2%

Staff looking after person treated them with dignity



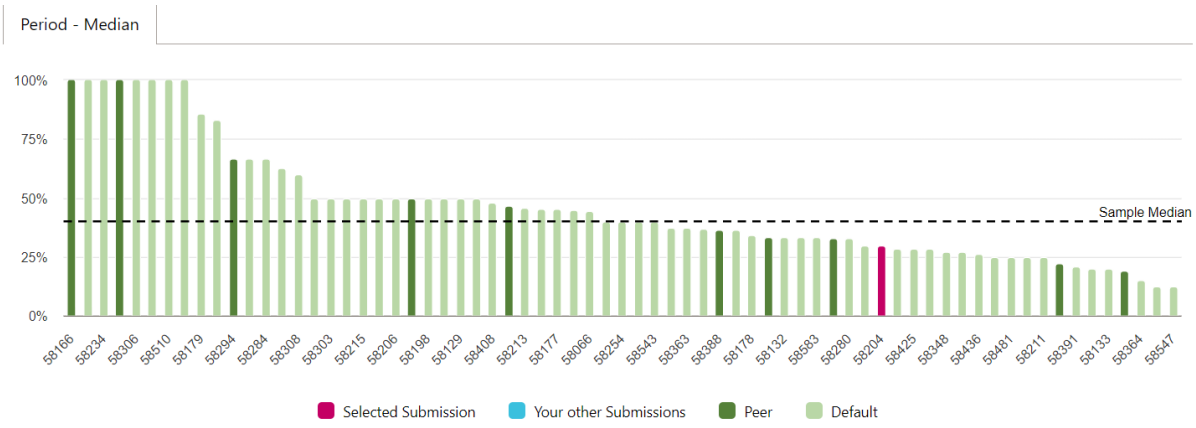
PLAN AND DO | QUALITY SURVEY

Staff looking after the person treated them with dignity



Site	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	N/A
National	57.6%	25.8%	6.8%	5.1%	3.9%	0.6%
Rotherham	45%	35%	-	15%	5%	-
Peers	60.5%	25.4%	3.8%	6.3%	3.3%	0.4%

Staff at the hospital made a plan for the person's care which considered the person's needs and wishes



PLAN AND DO | QUALITY SURVEY

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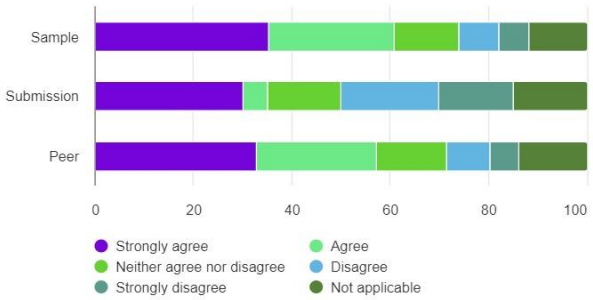
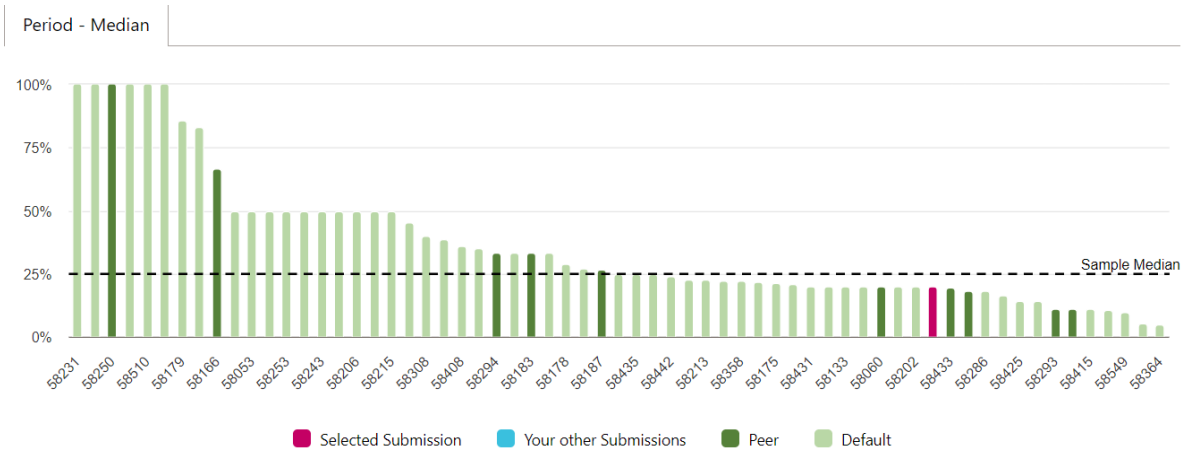
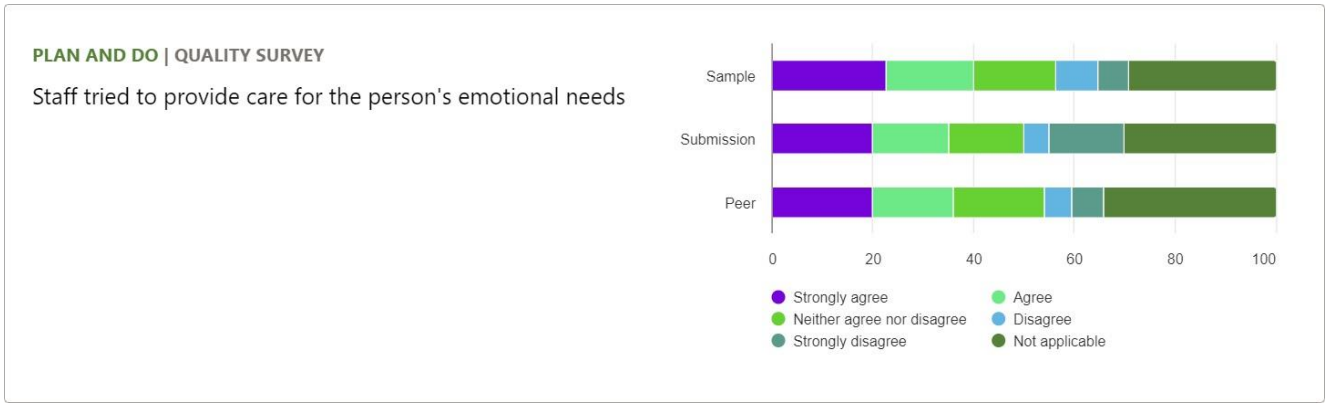


Site	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	N/A
National	35.4%	25.4%	13.1%	8.1%	5.9%	11.7%
Rotherham	30%	5%	15%	20%	15%	15%
Peers	32.7%	24.3%	14.2%	8.8%	5.8%	13.8%

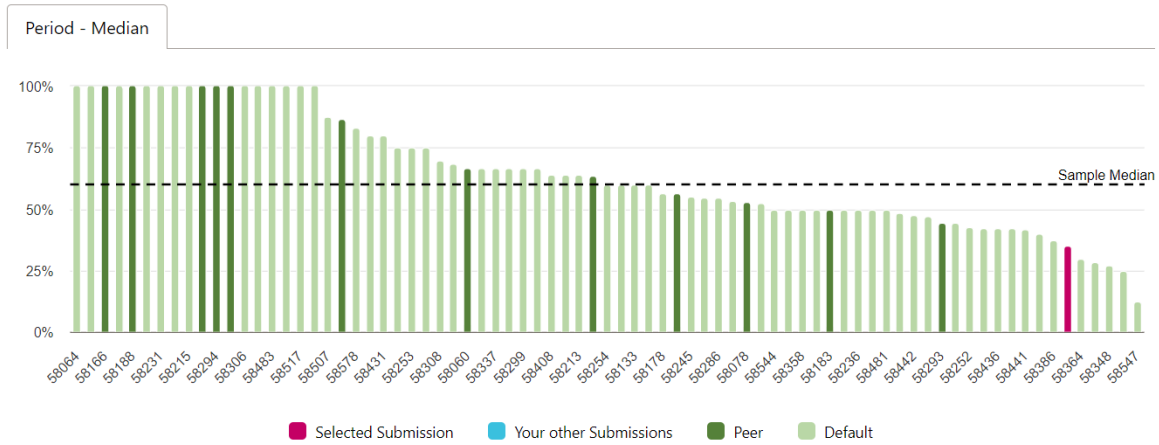
Staff tried to provide care for the person's emotional needs





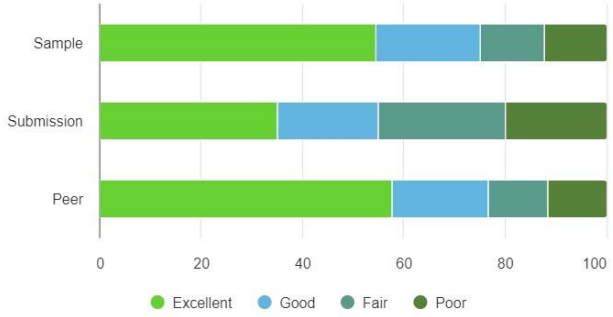
Site	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	N/A
National	22.6%	17.3%	16.1%	8.4%	6.2%	28.9%
Rotherham	20%	15%	15%	5%	15%	30%
Peers	19.8%	16%	18.1%	5.4%	6.3%	34.1%

Overall rating of the care and support given by the hospital to the dying person



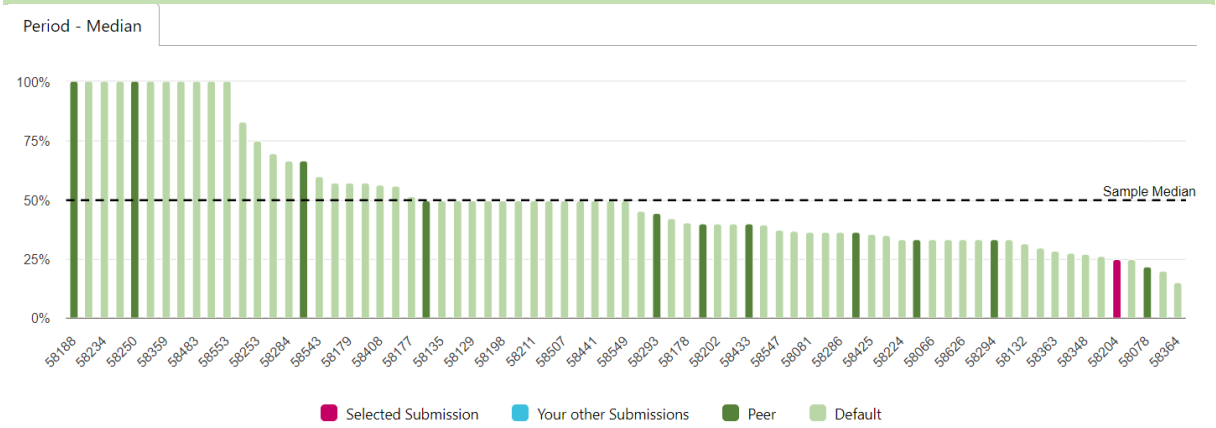
PLAN AND DO | QUALITY SURVEY

Overall rating of the care and support given by the hospital to the dying person



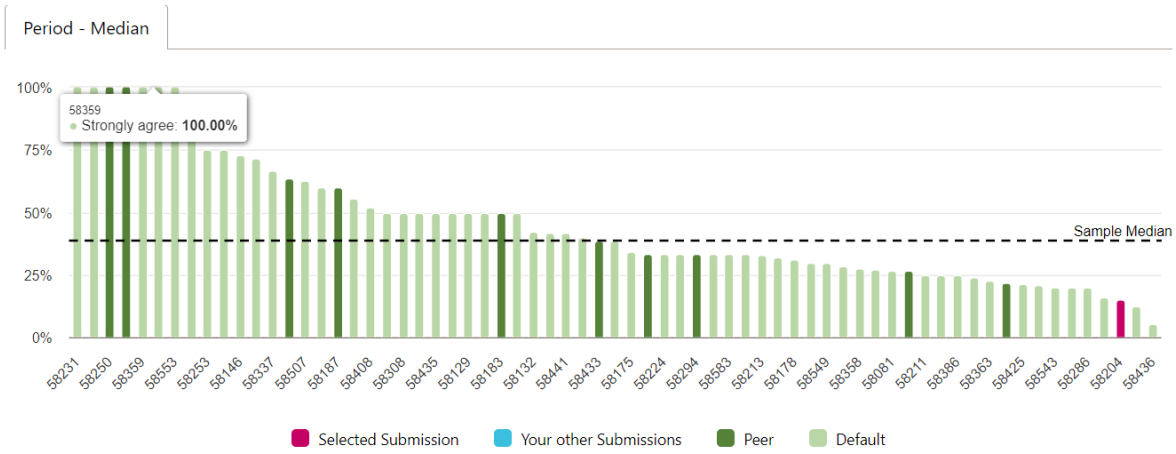
Site	Excellent	Good	Fair	Poor
National	54.7%	20.3%	12.6%	12.3%
Rotherham	35%	20%	25%	20%
Peers	57.6%	19%	11.8%	11.4%

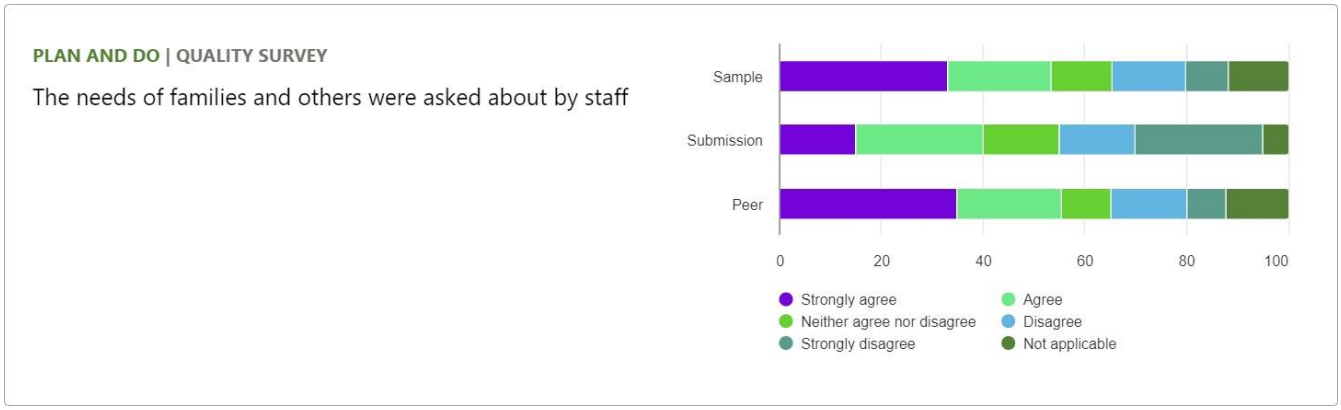
Staff at the hospital involved the person in decisions about care and treatment as much as they would have wanted in the last 2 to 3 days of life



Site	Involved as much as wanted to be	Would have liked to be more involved	Not able to be involved	Not sure
National	38.5%	6.3%	43.2%	11.7%
Rotherham	25%	10%	55%	10%
Peers	36.2%	5.4%	45.8%	12.5%

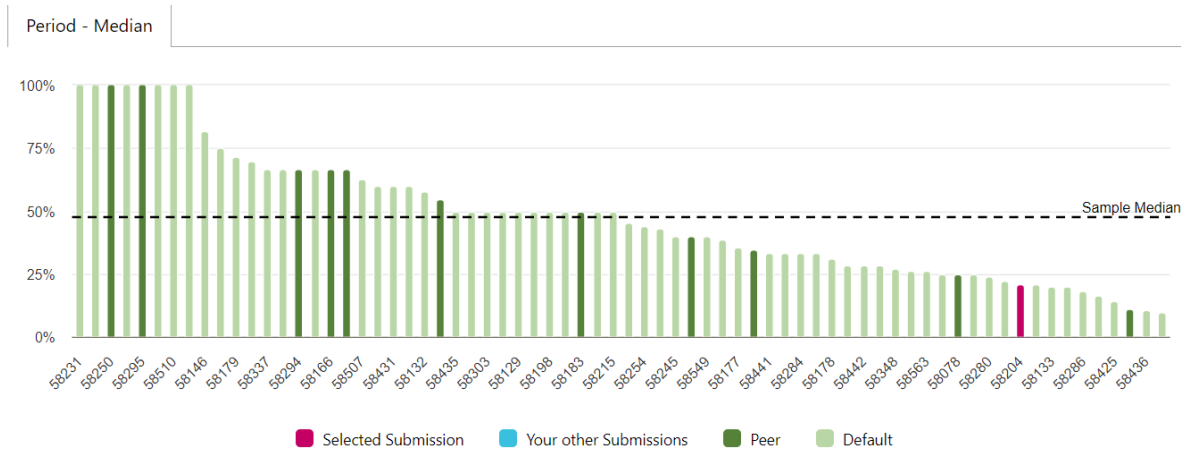
The needs of families and others were asked about by staff





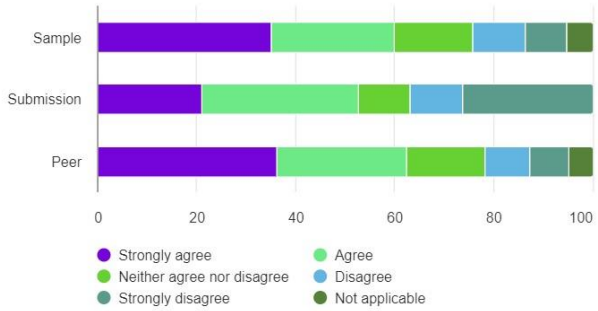
Site	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	N/A
National	33%	20.2%	12%	14.5%	8.5%	11.7%
Rotherham	15%	25%	15%	15%	25%	5%
Peers	34.7%	20.7%	9.7%	14.8%	7.6%	12.2%

Families and others were given enough emotional support



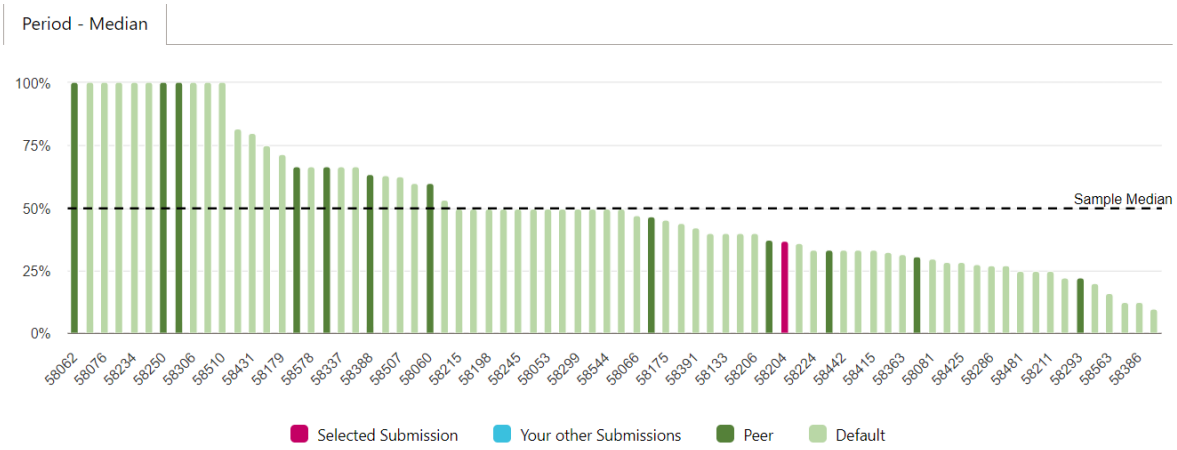
PLAN AND DO | QUALITY SURVEY

Families and others were given enough emotional support



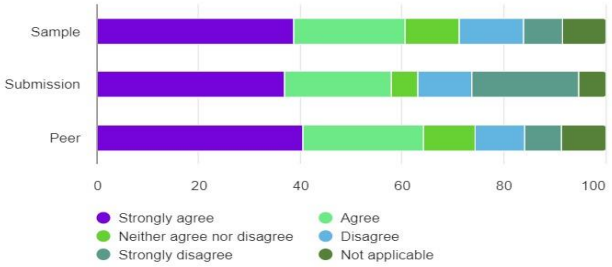
Site	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	N/A
National	35%	24.9%	15.7%	10.6%	8.4%	5.2%
Rotherham	21%	31.5%	10.5%	10.5%	26.3%	-
Peers	36.1%	26.3%	15.7%	8.9%	8%	4.6%

Families and others were given enough practical support



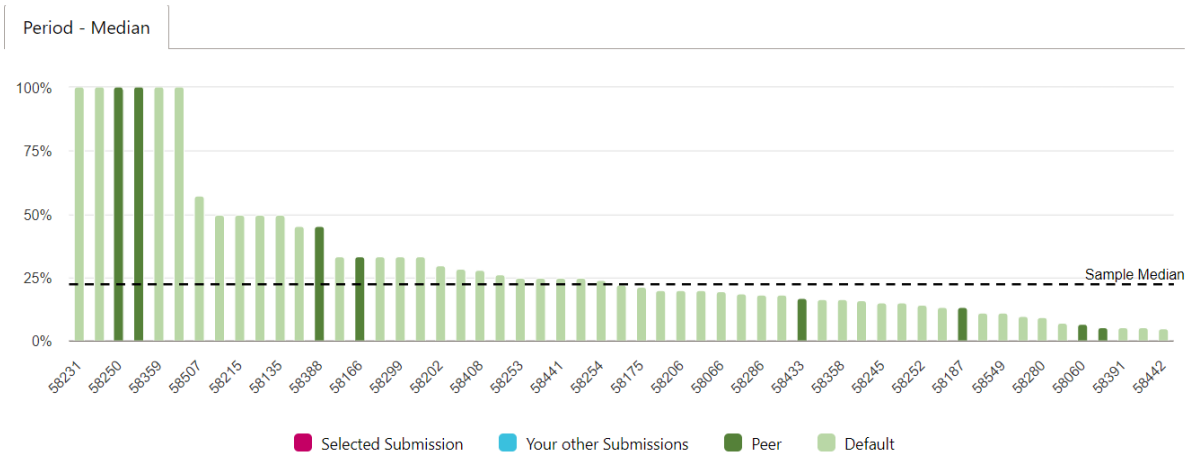
PLAN AND DO | QUALITY SURVEY

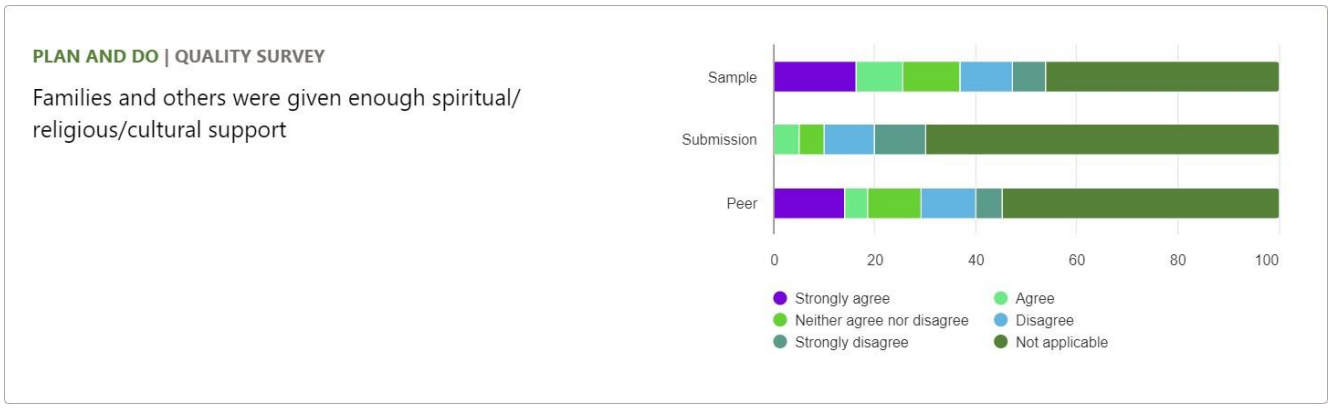
Families and others were given enough practical support



Site	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	N/A
National	38.8%	22%	10.4%	12.7%	7.7%	8.4%
Rotherham	36.8%	21%	5.2%	10.5%	21%	5.2%
Peers	40.4%	23.8%	10.2%	9.7%	7.2%	8.5%

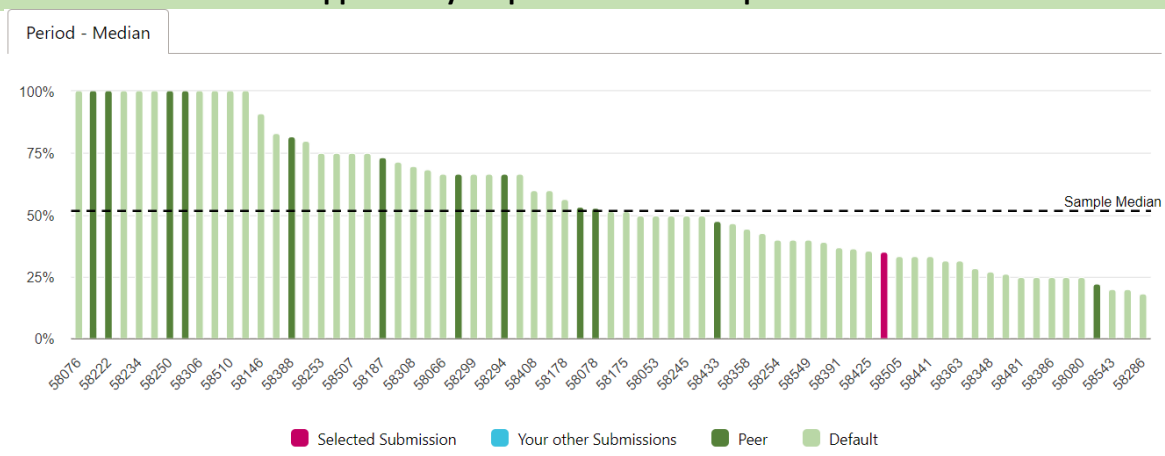
Families and others were given enough spiritual/religious/cultural support





Site	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	N/A
National	16.4%	9.1%	11.4%	10.5%	6.6%	46%
Rotherham	-	5%	5%	10%	10%	70%
Peers	13.9%	4.6%	10.5%	10.9%	5%	54.8%

Families and others felt supported by hospital staff after the person had died



PLAN AND DO | QUALITY SURVEY

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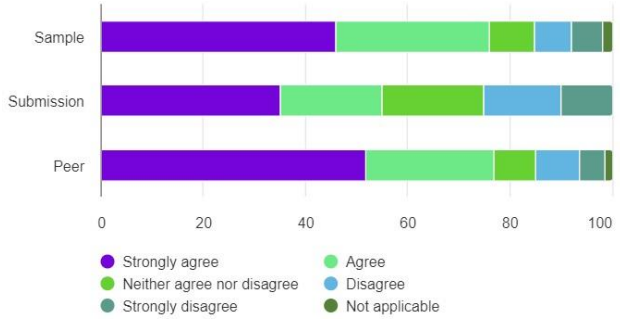
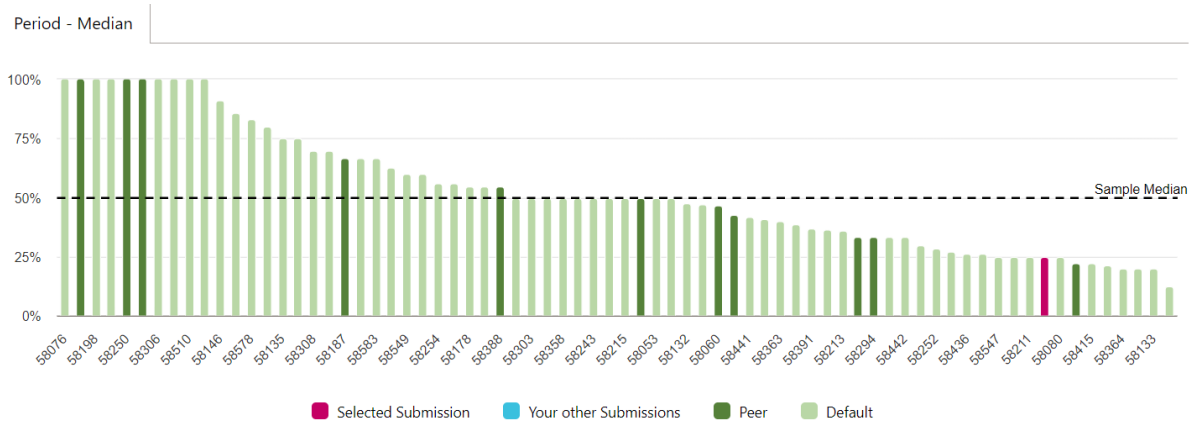


Site	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	N/A
National	46.1%	29.8%	8.8%	7.2%	6.1%	1.8%
Rotherham	35%	20%	20%	15%	10%	-
Peers	51.9%	25.1%	8%	8.5%	5.1%	1.2%

Families and others were kept updated and had enough opportunity to discuss the person's condition and treatment with staff



PLAN AND DO | QUALITY SURVEY

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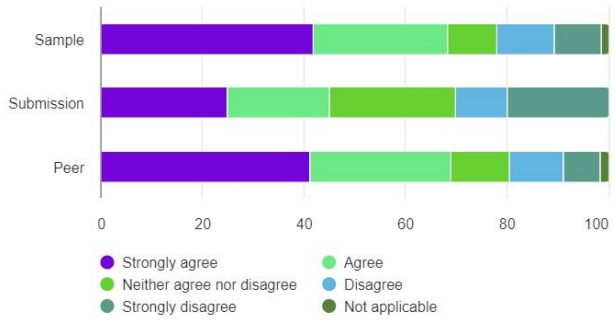
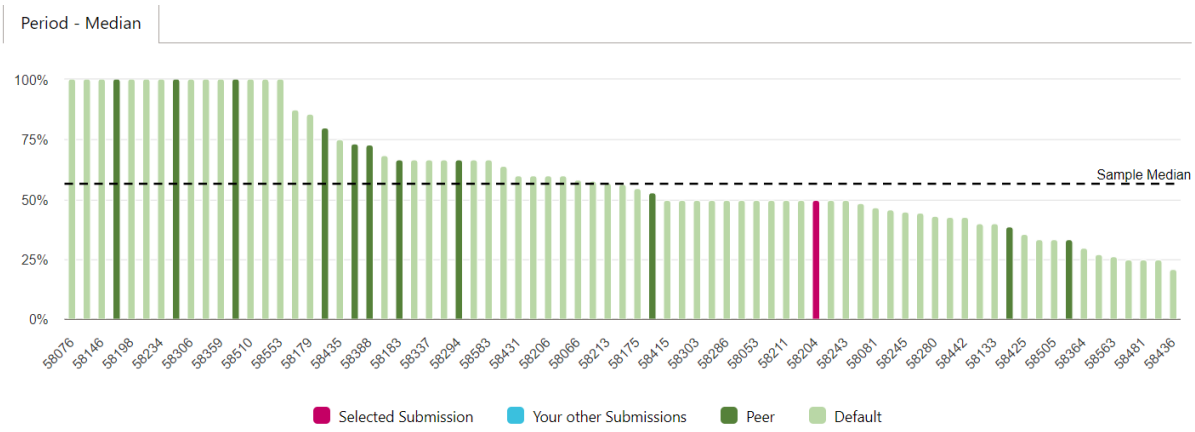
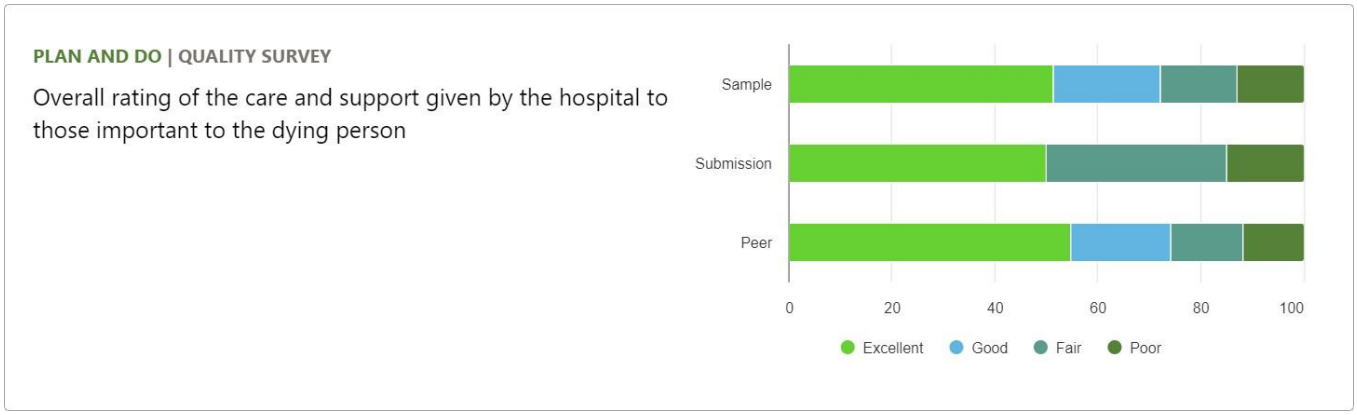


Site	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	N/A
National	41.9%	26.4%	9.8%	11.1%	9.4%	1.4%
Rotherham	25%	20%	25%	10%	20%	-
Peers	41.1%	27.9%	11.4%	10.5%	7.2%	1.6%

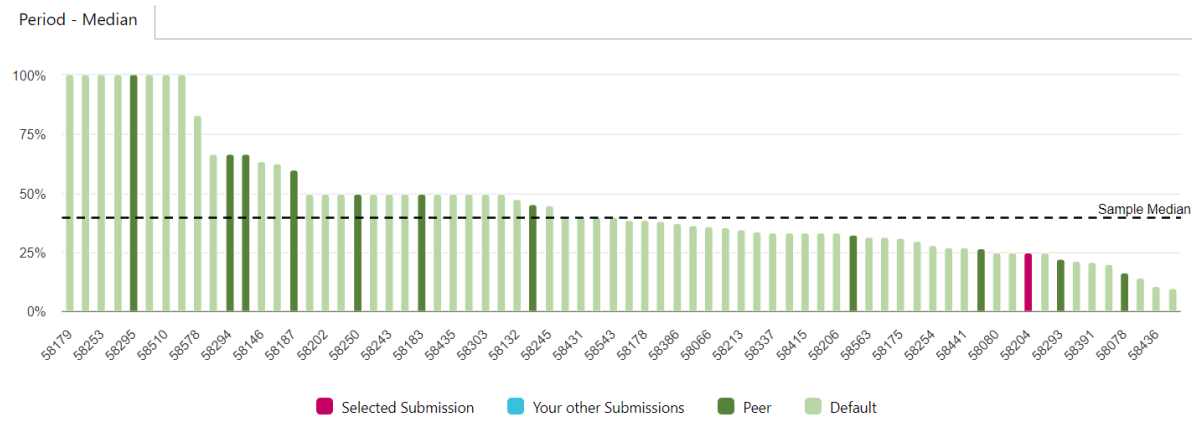
Overall rating of the care and support given by the hospital to those important to the dying person





Site	Excellent	Good	Fair	Poor
National	51.3%	20.7%	14.9%	12.9%
Rotherham	50%	-	35%	15%
Peers	54.6%	19.4%	13.9%	11.6%

There was a co-ordinated care approach by hospital staff during the final admission, including with health and care providers outside the hospital where appropriate



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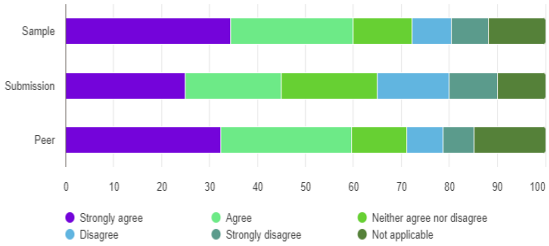
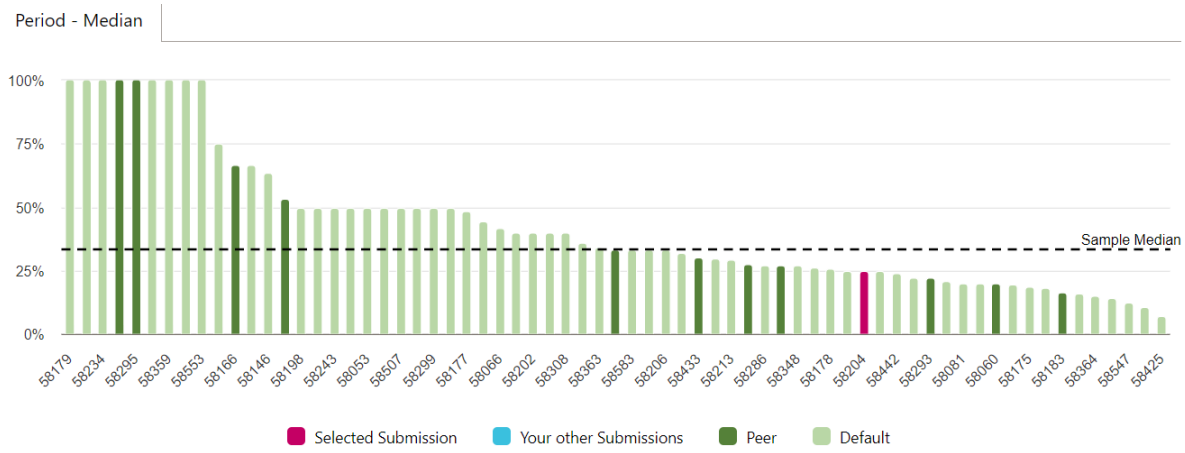


Site	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	N/A
National	34.4%	25.6%	12.3%	8.2%	7.7%	11.8%
Rotherham	25%	20%	20%	15%	10%	10%
Peers	32.3%	27.2%	11.4%	7.6%	6.3%	14.8%

The hospital staff regularly checked and addressed the person's needs



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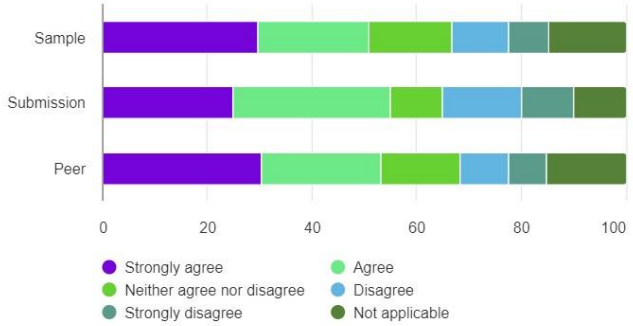
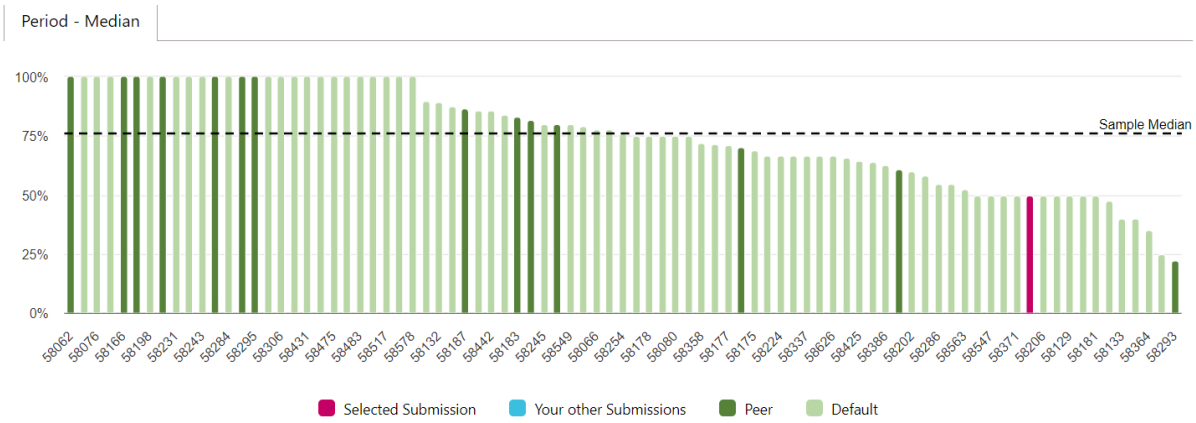


Site	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	N/A
National	29.7%	21.1%	15.7%	10.9%	7.6%	14.7%
Rotherham	25%	30%	10%	15%	10%	10%
Peers	30.3%	22.7%	15.1%	9.2%	7.1%	15.1%

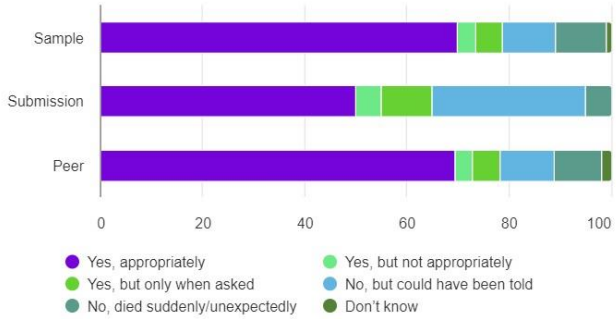
Communicate and Involve

A member of staff at the hospital explained to families and others that the person was likely to die in the next few days



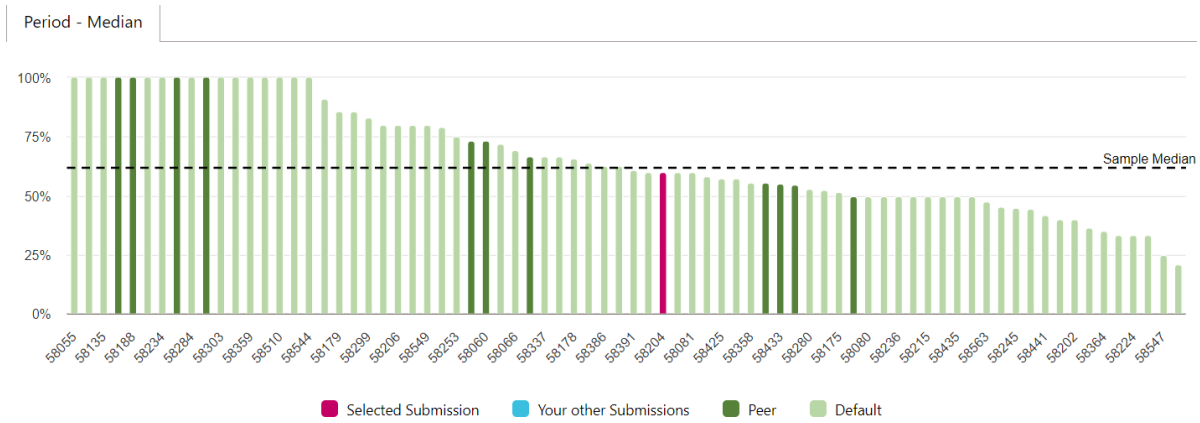
COMMUNICATE AND INVOLVE | QUALITY SURVEY

A member of staff at the hospital explained to families and others that the person was likely to die in the next few days



Site	Yes, appropriately	Yes, but only when asked	No, died suddenly/unexpectedly	Yes, but not appropriately	No, but could have been told	Don't know
National	69.8%	5.2%	10.4%	3.6%	10.3%	0.9%
Rotherham	50%	10%	5%	5%	30%	-
Peers	69.3%	5.5%	9.3%	3.4%	10.6%	1.7%

If families and others wanted to be with the person when they died, they received timely communication to be there



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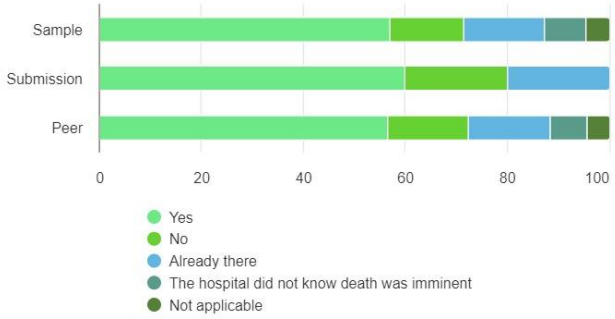
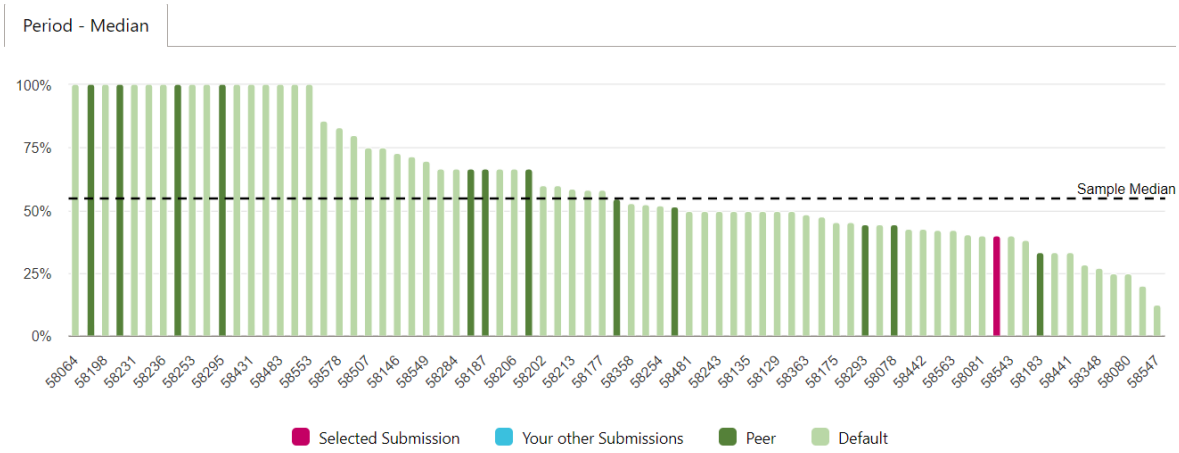


Site	Yes	No	Already there	The hospital did not know death was imminent	NA
National	57%	14.2%	15.9%	8.3%	4.4%
Rotherham	60%	20%	20%	-	-
Peers	56.6%	15.7%	16.1%	7.2%	4.2%

Staff looking after the person communicated sensitively with them



COMMUNICATE AND INVOLVE | QUALITY SURVEY

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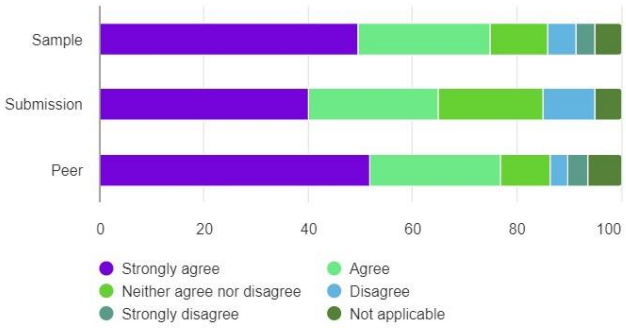
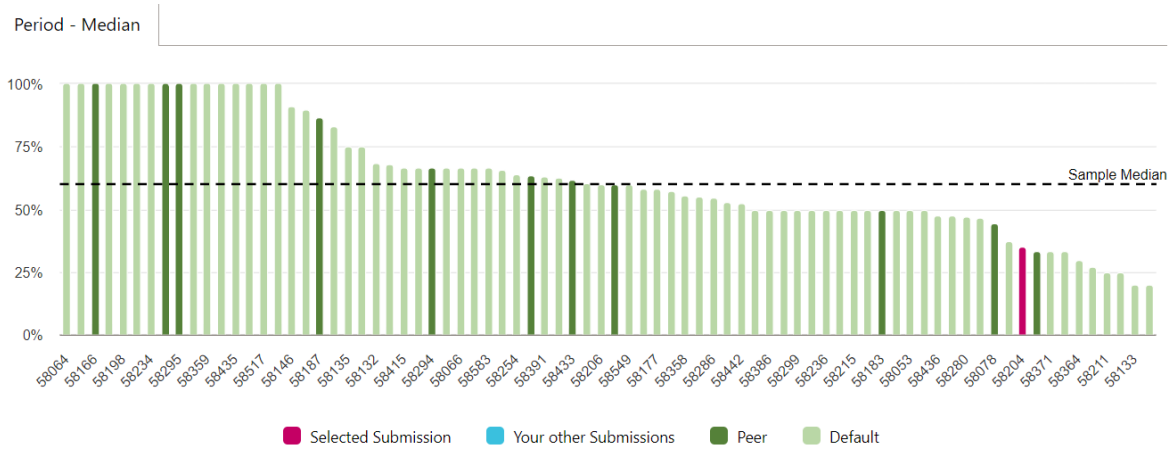
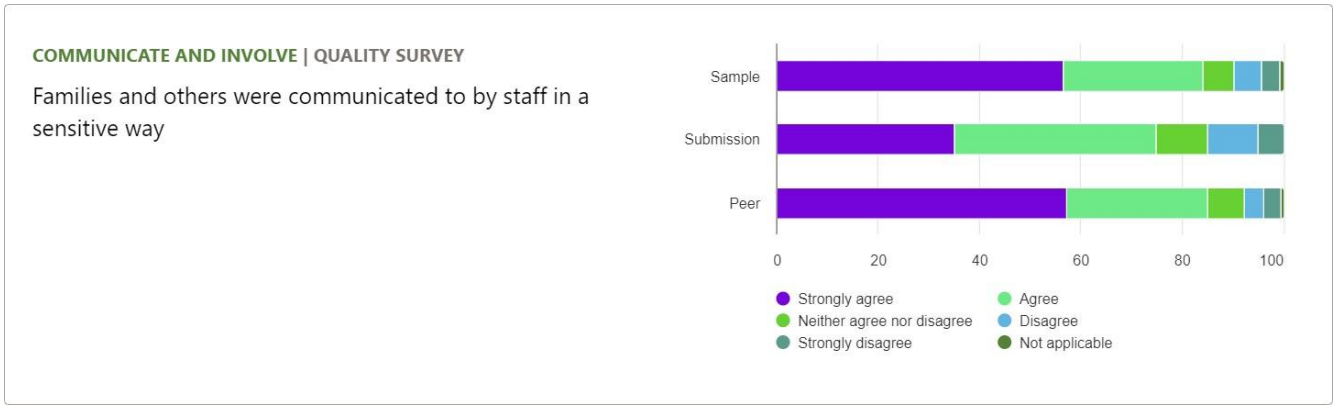


Site	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	N/A
National	49.6%	25.3%	10.9%	5.4%	3.8%	4.9%

Rotherham	40%	25%	20%	10%	-	5%
Peers	51.9%	25.1%	9.3%	3.4%	3.8%	6.3%

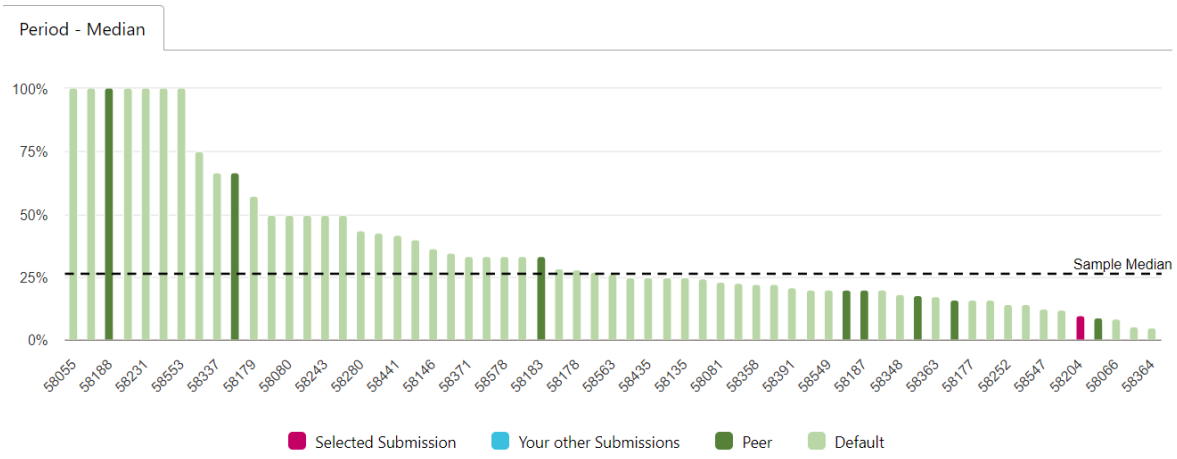
Families and others were communicated to by staff in a sensitive way

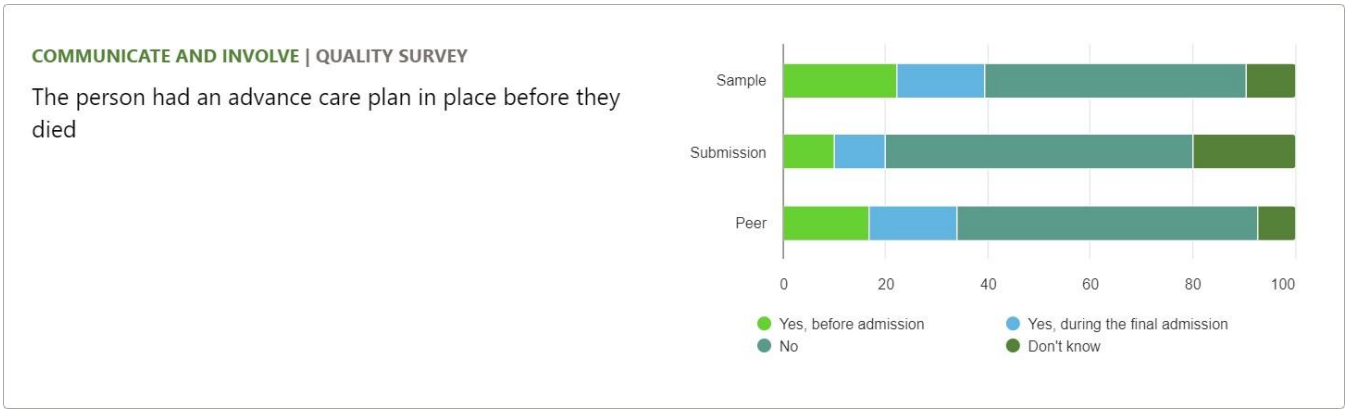




Site	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	N/A
National	56.3%	27.7%	6.3%	5.3%	3.7%	0.6%
Rotherham	35%	40%	10%	10%	5%	-
Peers	57.2%	27.7%	7.2%	3.8%	3.4%	0.4%

The person had an advance care plan in place before they died

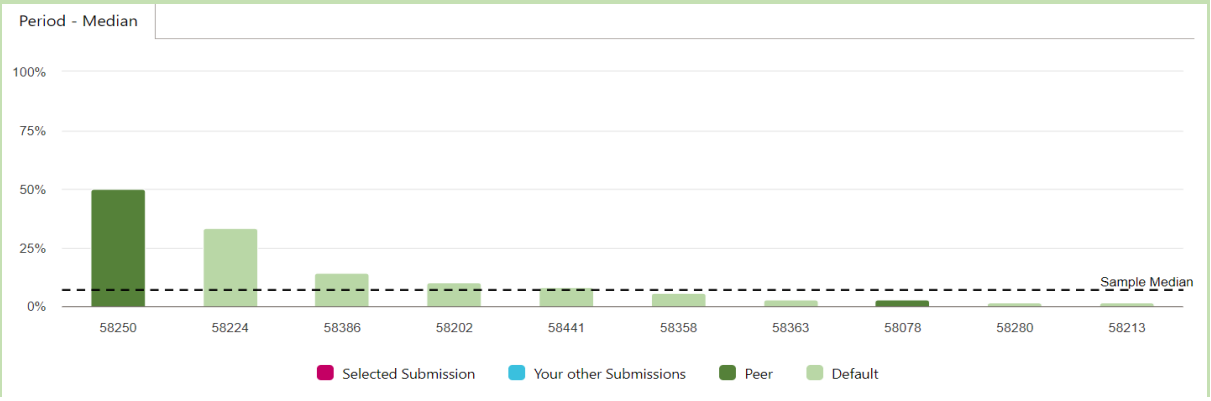


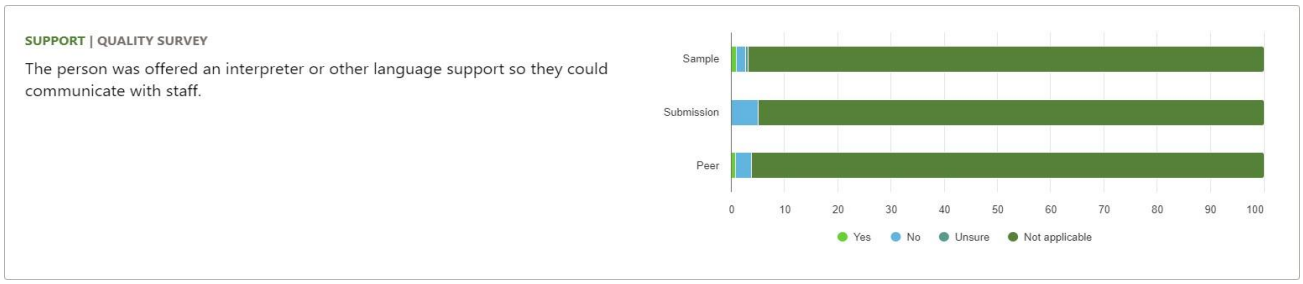


Site	Yes, before admission	No	Yes, during the final admission	Don't know
National	22.1%	51.1%	17.1%	9.5%
Rotherham	10%	60%	10%	20%
Peers	16.8%	58.5%	17.2%	7.1%

Support

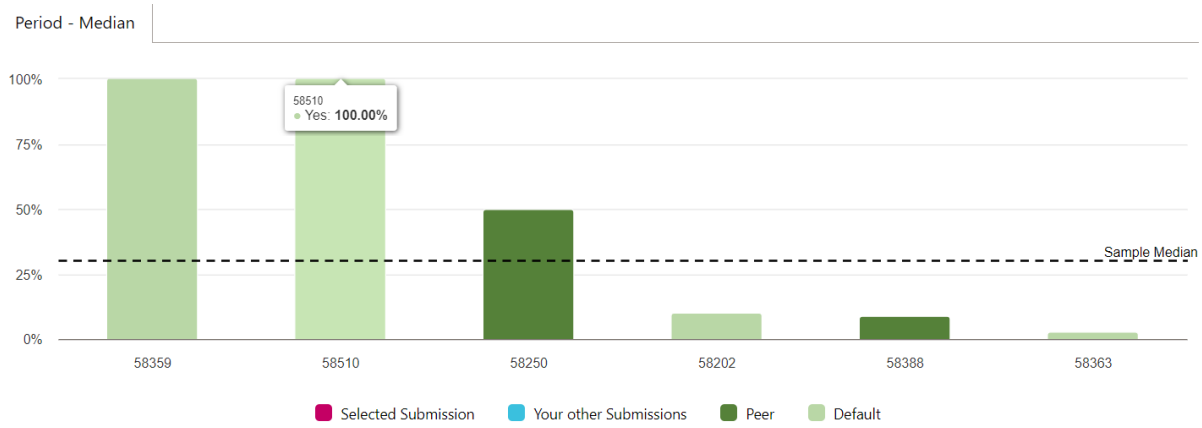
The person was offered an interpreter or other language support so they could communicate with staff

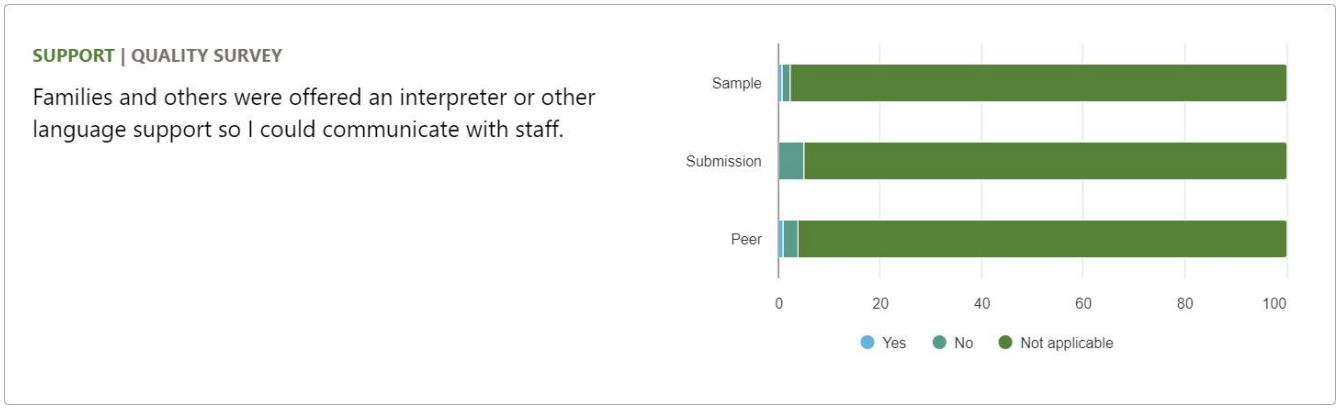




Site	Yes	No	Unsure	NA
National	1%	1.6%	0.4%	96.9%
Rotherham	-	5%	-	95%
Peers	0.8%	2.9%	-	96.2%

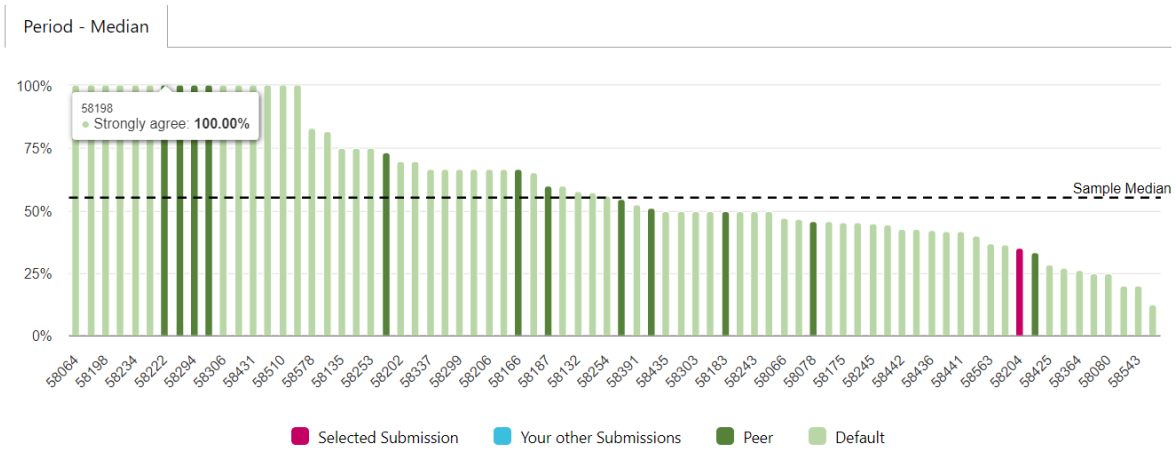
Families and others were offered an interpreter or other language support so I could communicate with staff

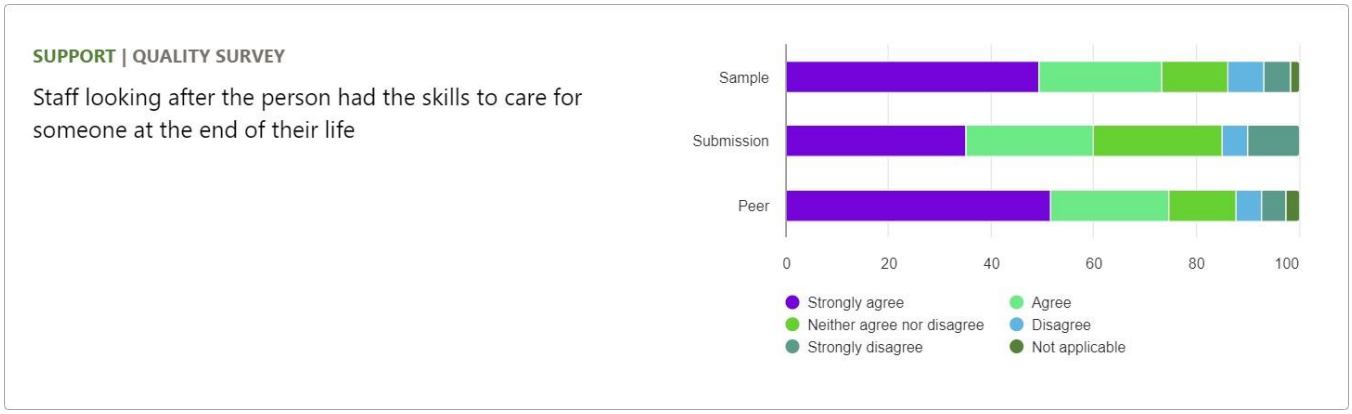




Site	Yes	No	NA
National	0.6%	1.7%	97.6%
Rotherham	-	5%	95%
Peers	0.8%	2.9%	96.1%

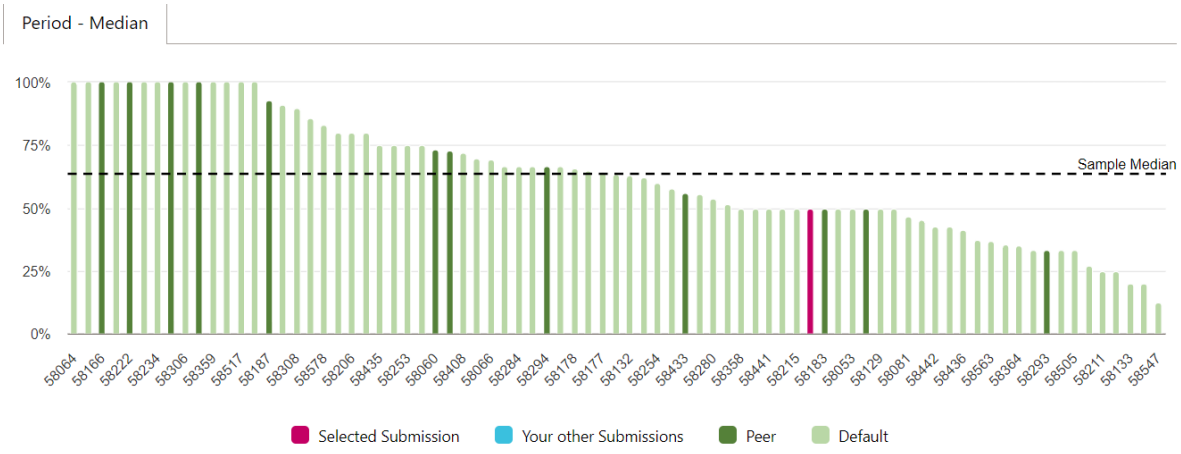
Staff looking after the person had the skills to care for someone at the end of their life

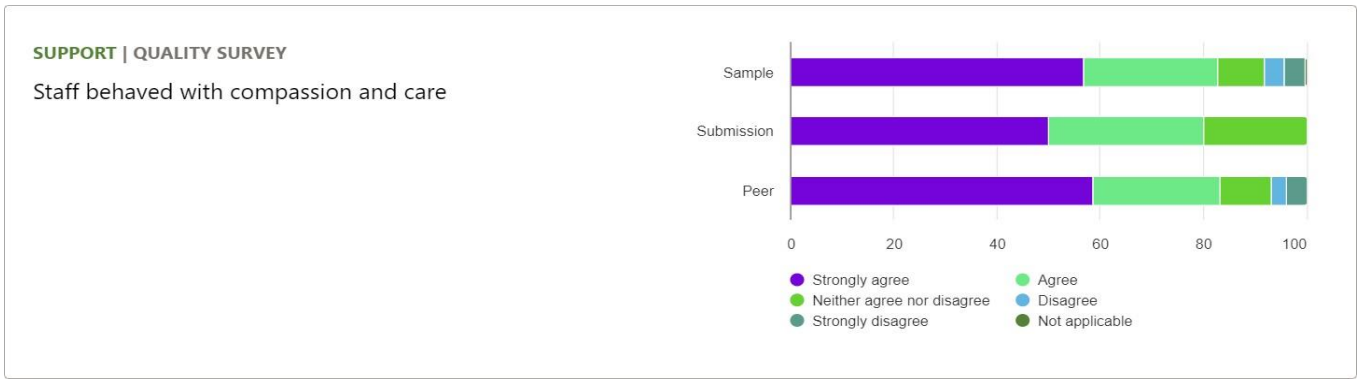




Site	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	N/A
National	49.3%	23.9%	12.8%	7%	5%	1.6%
Rotherham	35%	25%	25%	5%	10%	-
Peers	51.4%	23.2%	13%	5%	4.6%	2.5%

Staff behaved with compassion and care

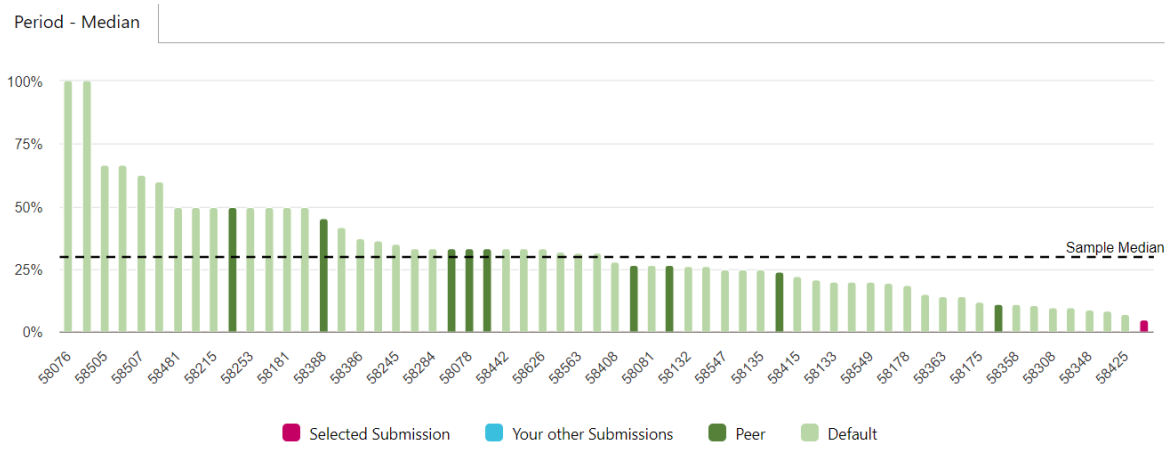


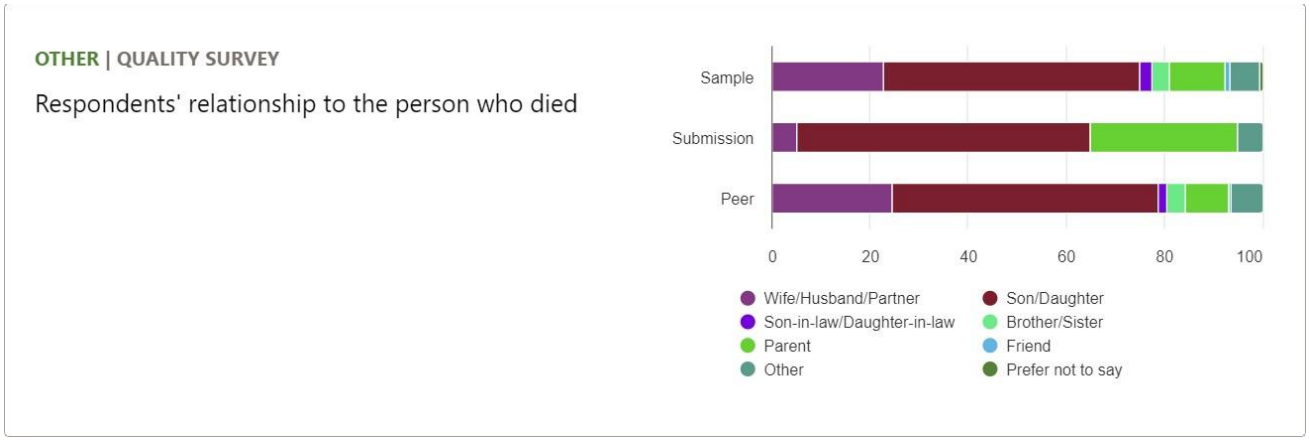


Site	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	N/A
National	56.8%	25.8%	9%	3.9%	4%	0.3%
Rotherham	50%	30%	20%	-	-	-
Peers	58.5%	24.7%	9.8%	2.9%	3.8%	-

Other

Respondents' relationship to the person who died

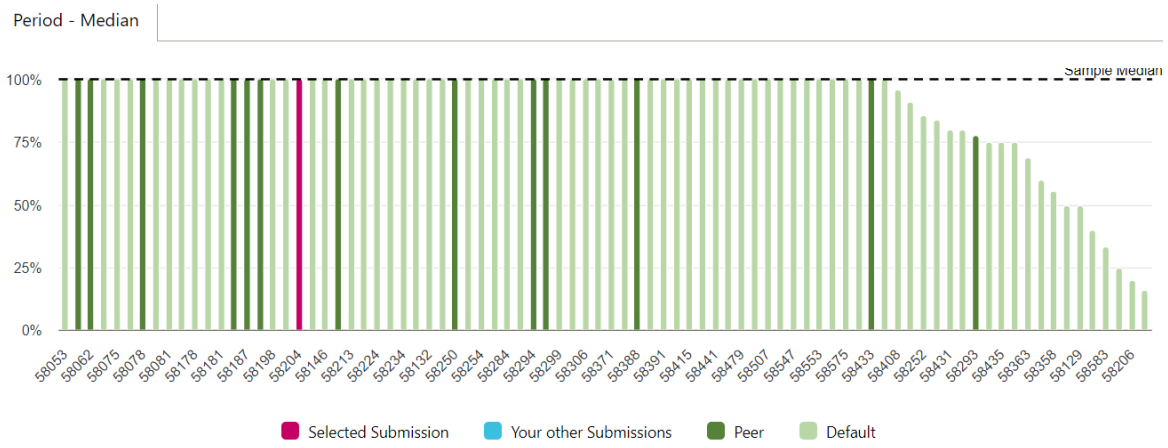


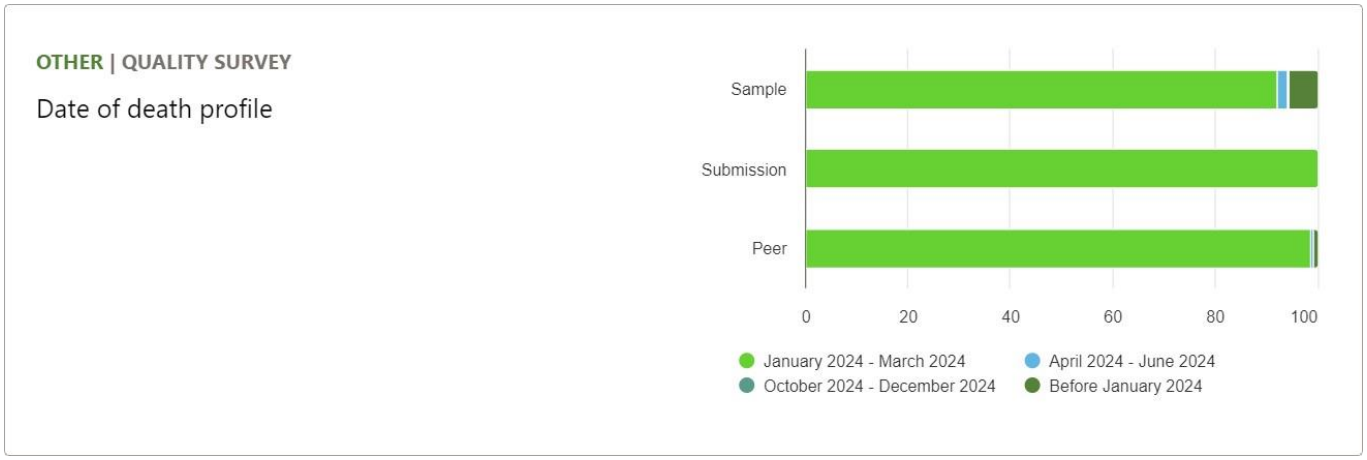


Site	Wife/Husband/Partner	Son/Daughter	Son-in-law/Daughter-in-law	Brother/Sister	Parent	Friend	Other	Prefer not to say

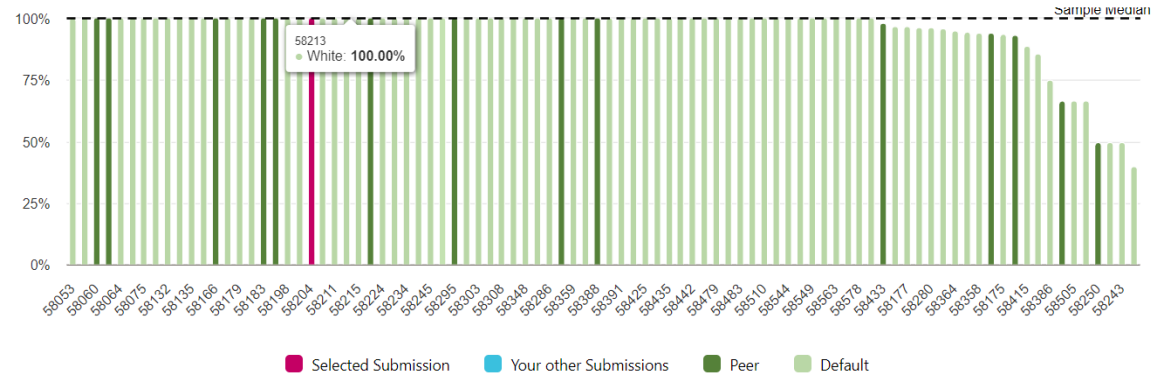
National	22.7-6%	52.3%	2.5%	3.5%	11.2-3%	1.1%	6.1%	0.5%
Rotherham	5%	60%	-	-	30%	-	5%	-
Peers	24.4%	54.4%	1.6%	3.8%	8.8%	0.4%	6.3%	-

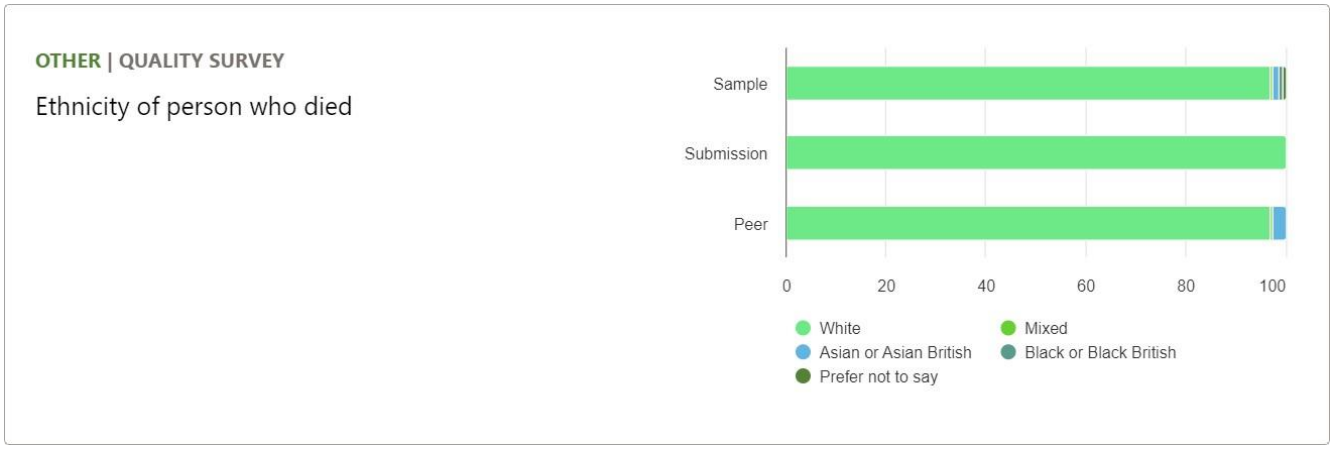
Date of death profile





Ethnicity of person who died





Site	White	Asian or Asian British	Mixed	Black or black British	Prefer not to say
National	96.8%	1.3%	0.4%	0.8%	0.6%
Rotherham	100%				
Peers	97%	2.5%	0.3%		

Board of Directors' Meeting
5 July 2024

The Rotherham NHS Foundation Trust

Agenda item	P109/24
Report	**National, Integrated Care Board and Rotherham Place Update**
Executive Lead	Michael Wright, Managing Director
Link with the BAF	R2: There is a risk we will not establish ourselves as leaders in improving the lives of the population we serve because of insufficient influence at PLACE leading to increased ill health and increased health inequalities OP3: There is a risk robust service configuration across the system will not progress and deliver seamless end to end patient care across the system because of a of lack of appetite for developing strong working relationships and mature governance processes leading to poor patient outcomes
How does this paper support Trust Values	Together: this paper demonstrates how the Trust and partners across both Rotherham Place and the wider system work together in providing patient care and providing mutual support.
Purpose	**For decision** ☐ **For assurance** ☐ **For information** ☒
Executive Summary (including reason for the report, background, key issues and risks)	The purpose of this report is to provide the Board of Directors with an update on national developments, developments across the South Yorkshire Integrated Care Board (SYB ICB) and Rotherham Place. Key points to note from the report are: Junior Doctors commenced another period of Industrial Action from 7am on the 27th June through to 7am on the 2nd July. As at the 11th May 2024, more than half of England's care home residents had received their spring covid-19 vaccine from the NHS. Overall, 2.5million people across England had received their spring vaccine and those eligible to book an appointment were being encouraged to come forward as soon as possible The Rotherham Place Digital Enabling Group's work across the Place has led to the following: • All users and practices migrated from the Rotherham Health App to the NHS App by the deadline of 31st March 2024. • Migration activities included enabling access to booking for extended access services, self-referral to community services, and enhanced practice communications via the NHS App • 55% of the Rotherham GP patients over the age of 13 are now registered for the NHS APP (ICB average is 53%)

	GP Connect, the first of its type in the UK is now live and operational. It plays a crucial role in clinical processes such as medicines reconciliation, enabling clinical teams in near real-time to pull in accurate medication lists and allowing Pharmacists or other clinicians within the Trust to directly transfer parts of a patient's primary care record, such as their medications and allergies, directly into the hospital's Electronic Patient Record.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	The Executive Team receives a weekly verbal update covering key Place and South Yorkshire Integrated Care Board (SYICB) level activities in addition to specific papers periodically, as and when required.
Board powers to make this decision	N/A
Who, What and When (what action is required, who is the lead and when should it be completed?)	N/A
Recommendations	It is recommended that the Board note the content of this paper.
Appendices	1. Rotherham Place Partnership Update May and June 2024.

1.0 Introduction

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

2.0 National Update

2.1 NHS patients in England will benefit from faster access to the most innovative and cutting-edge medical technologies under new plans. Proposals set out in a joint NHS England and NICE consultation outline a new route for MedTech developers to access NHS funding to fast-track clinically and cost-effective products for use by the healthcare system. The plans will ensure the growing number of products recommended by NICE can be introduced to the NHS on a large-scale to improve patient outcomes.

The proposals in the consultation document have been developed by NHS England and NICE with input from the Department of Health and Social Care and other partners, including the Office for Life Science (OLS) and the Medicines and Healthcare products Regulatory Agency (MHRA).

2.2 As at the 11th May 2024, more than half of England's care home residents had received their spring covid-19 vaccine from the NHS in the previous four weeks. Overall, 2.5 million people across England have had their spring vaccine and those eligible to book an appointment are being encouraged to come forward as soon as possible.

2.3 Thousands of people with sight loss in England will find it easier to participate in life-saving bowel cancer screening because of a new specially designed NHS tool. People who are blind or partially sighted will be offered a specially designed tool to support them complete a faecal immunochemical test (FIT) kit, which can detect signs of bowel cancer. The FIT aid tool is an adaptation of the standard FIT test making it more accessible with a channel that enables the sample to be guided into the bottle, as well as a stand that holds the FIT tube steady to help those with manual dexterity issues. It includes options for braille instructions, an audio CD or a link to audio and video instructions.

During the six-month pilot, around 500 people with sight loss will be sent the FIT aid tool to help them complete the test. If successful, it may be rolled out initially to thousands more people to help improve the accessibility and uptake of bowel cancer screening, whilst reducing healthcare inequalities.

2.4 Junior Doctors commenced another period of Industrial Action from 7am on the 27th June through to 7am on the 2nd July.

3.0 South Yorkshire Integrated Care Board (SYCIB)

3.1 The SYICB recently received an update on Tobacco control, cardiovascular disease prevention and Stroke. Whilst adult smoking rates are decreasing in South Yorkshire, there is still a way to go to reach the target of 5% by 2030. Supporting someone to stop smoking is the single most-cost effective intervention that the NHS can provide and one of the quickest ways to reduce health inequalities. The QUIT Programme is now embedded in all Trusts and there has been a substantial improvement in delivery and outcomes in 2024/25. 85% of admissions are now having their smoking status recorded and in total over 16,000 specialist assessments have been undertaken. 4,500 patients have accepted

ongoing support to quit post discharge and over 2,200 people directly supported by QUIT have achieved a 4-week quit target.

Furthermore, each maternity service in South Yorkshire is implementing the NHS Tobacco Dependence Treatment Services Delivery Model in line with the NHS Long Term Plan. Barnsley, Doncaster and Rotherham have all seen smoking at time of delivery rates reduce by more than the national average between 2021 and quarter 2 of 2023/24. South Yorkshire Integrated Partnership Board gave support in October 2023 for the development of a proposal for a South Yorkshire wide tobacco control initiative. This will complement the Smoke Free Generation work being undertaken at a national level. SYICB is the 4th highest (best) performing ICB for hypertension management, 2nd highest for lipid lowering drug prescribing and 7th for lipid optimisation. However, despite progress on cardiovascular disease risk factor management, the under 75 mortality rates from all circulatory diseases is increasing in all four of our places. As well as being a priority for the NHS in the operational planning guidance, the ICB will continue its focus on inequalities by standardising care across places and supporting self-management.

The Integrated Stroke Delivery Networks (ISDN) is undertaking a comprehensive programme to address inequalities in stroke awareness, prevention and management. Together with Barnsley partners, a campaign to increase stroke awareness in Barnsley and encourage people to present at hospital earlier had been launched. Pre-hospital stroke video triage has enabled people to be diagnosed and treated faster and CT perfusion scanning has improved the identification of patients who will benefit from thrombolysis and thrombectomy, leading to better patient outcomes.

4.0 Rotherham Place

4.1 The Rotherham Place Board received an update from the Chief Executive of the Rotherham Hospice for the last twelve months up to May 2024. The Hospice continues to experience high demand for services. So far this year, the Hospice has cared for 117 patients, with occupancy consistently at 90% or above. It has also conducted 3,778 face to face visits and 3,898 telephone support contacts and supported 97 children. It has also raised £2.2m for vital services.

To plan for the future, the Hospice has undertaken a four-month stakeholder research project. This identified its key priorities, which closely aligned with the national priorities and are set out below:

- More personalised care: working to ensure care at end-of-life can be delivered based on what matters most to the patient. Not following a one-size fits all mentality
- Improving and expanding community services for people to die at home or in their preferred place in the community
- Starting support earlier, at the point a terminal diagnosis is received. The phasing out of curative care and the phasing in of palliative.
- Providing good care irrespective of who the patient is, their circumstances or where they live
- Working more closely with local organisations and communities to ensure better co-ordinated care and to help conversations about living and dying well
- Improving and expanding Hospice facilities.

Some of the barriers to be overcome were also highlighted including financial sustainability, raising public awareness of the Hospice's services, charitable support, the physical aspects and constraints for expansion and workforce growth.

The Hospice will launch its full strategy in July/August this year and is looking forward to celebrating 30th Anniversary year in 2026. Work is underway to reshape the workforce to meet its needs and it is investing further in fundraising and retail/community presence. Services and solutions are being sought to help patients throughout their journey, which will include outreach facilities. To meet increasing demand the best long-term options are being assessed to resolve current challenges, particularly around the estate.

4.2 The Rotherham Place Digital Enabling Group provided an update to Place Board on their activities across Rotherham Place. This work has led to the following deliverables across the Place:

- All users and practices migrated from the Rotherham Health App to the NHS App by the deadline of 31st March 2024
- Migration activities included enabling access to booking for extended access services, self-referral to community services, and enhanced practice communications via the NHS App
- 55% of the Rotherham GP patients over the age of 13 are now registered for the NHS APP (ICB average is 53%)

4.3 GP Connect, the first of its type in the UK is now live and operational. It plays a crucial role in clinical processes such as medicines reconciliation, enabling clinical teams in near real-time to pull in accurate medication lists and allowing Pharmacists or other clinicians within the Trust to directly transfer parts of a patient's primary care record, such as their medications and allergies, directly into the hospital's Electronic Patient Record. This means a much faster and higher quality medicines reconciliation process, along with high levels of data quality. It was not that long ago, medicines reconciliation relied on sending faxes to GP surgeries and manually updating paper records.

4.4 The Voluntary Action Rotherham (VAR) Cancer Timely Presentation Project are providing education sessions to Black and Minority Ethnic (BAME) and seldom groups across Rotherham. The sessions are providing insights into how we may want to adapt services and target education messages for campaigns and improve the uptake of cancer screening.

Sessions have shed light on the cultural stigma surrounding breast cancer in BAME households and provided information on the options available and how women can access culturally sensitive screening services. They have also included information about cervical screening, menopause and lung health checks.

4.5 Further updates in relation to activities across Rotherham Place can be seen in the newsletter (appendix 1).

4.6 As previously discussed at Trust Board, the Skills Street development at Gulliver's Kingdom is a registered Community Interest Company. Skills Street is due to open in September 2024. The Trust, in partnership with Rotherham Metropolitan Borough Council has now signed an agreement to secure an area within Skills Street to promote health and social care to visiting school pupils and students.

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

- Progressing the missed appointments analysis, exploring the data and reasons behind the cancer missed appointments, using health inequalities tools
- In July, there are two lunchtime lectures to build on the making every contact count and prevention agendas: one to focus on developing healthy conversation skills in our workforce, led by the healthy hospitals team, and another to develop our thinking around exercise and physical movement, led by Sports Yorkshire. It is expected that these will offer a platform for further training and development to upskill our staff in supporting patients to make healthy decisions
- A future Trust Board development session on health inequalities, including an organisational self-assessment and some critical thinking around inequalities and performance reporting. This is likely to take place in October 2024
- There is continuing work to improve our system response to chronic pain management. A multidisciplinary workshop will take place on 2 July 2024 to explore ways to integrate pharmacy, mental health and physiotherapy provision in a more holistic way

4.8 The Trust continues to work with South Yorkshire Police (SYP) to tackle violent and aggressive behaviour against colleagues working on the front line at the Trust. SYP continue to attend the Trust on a weekly basis offering advice and guidance in addition to taking forward cases of violent and aggressive behaviour. Colleagues across the Trust have valued the support provided.

Michael Wright
Managing Director
July 2024

Rotherham Place Partnership Update: May and June 2024

Rotherham Family Hubs and Best Start in Life programme – A spotlight on the Parent and Carer Panel

- The Family Hubs and Best Start in Life programme brings services together, to work with families from pregnancy and through childhood to 19 years old and up to 25 with special educational needs and disabilities.

Work is being delivered by a range of organisations including the Council, Voluntary Action Rotherham and NHS.

A key focus of the programme is to put the needs of local babies and families at the centre of service design and delivery. A Parent and Carer Panel has been established to achieve this and enable continuous improvement across services. The Parent and Carer Panel meets every 8 weeks across the Borough and online. The meetings are family-focused and designed to gain feedback on experiences in the Start for Life period from conception to age two.

The Parent and Carer Panel has been developed to ensure that everyone's views are heard. Feedback from different communities and with different needs is essential. Focus groups take place monthly at various Voluntary and Community Sector (VCS) sites that are part of the Family Hubs network. An online survey is published monthly providing parents and carers with the opportunity to feedback and help shape the services and support that is available for families in Rotherham.

A number of achievements have been delivered so far. The Panel is fully established with 14 active members and will soon celebrate its one-year anniversary. The Rotherham Start for Life Offer has been developed through co-production with the Panel. A weekly parent and toddler group takes place at Rotherham Ethnic Minority Alliance (REMA) following feedback from focus groups. A progression pathway is available for Panel members who wish to volunteer across the wider Family Hub network, and this has been taken up by 7 parents so far, who have moved into roles including Family Hub Group Support volunteer, Family Hub Champion and Breastfeeding Peer Support volunteer.

Lucy, mum to Orson 6 months, Clementine and Camilla (both 3 years) shared: *"Joining the Parent and Carer Panel has allowed me to get my voice heard in order to try and make change to improve services for all families in Rotherham. As an added bonus it's allowed me to feel involved in my community and meet likeminded parents and carers."*

You can learn more about the Family Hubs and Best Start in Life programme at: https://www.rotherham.gov.uk/family-hubs

Voluntary Action Rotherham

FAMILY HUBS Rotherham

Rotherham Metropolitan Borough Council

Action on Prevention and Health Inequalities - Holding diabetes swap shops

In April 2023, NHS England published new commissioning recommendations for patients using blood glucose and ketone meters, testing strips and lancets. This followed a national assessment which aimed to support the delivery of the NHS Long-Term Plan for diabetes management through the following key objectives:

- Equitable access to the same products for all eligible people, no matter where they live
- Minimum quality standards established in a fair and transparent way to better address the needs of all people living with diabetes
- Prescribing practices aligned across primary and secondary care; and
- Making best use of NHS Resources, whilst ensuring that the price paid is commensurate to the quality offered.

To aid with the adoption of these new commissioning recommendations and align with both the Rotherham Place High Impact Transformation project in Diabetes and the Medicines Optimisation (MO) agenda, the Rotherham Place Medicines Optimisation (MO) team have undertaken several 'Swap Shops'.

At a Swap Shop, diabetic patients from a particular practice whose blood glucose meter no longer meet the standards set out in the new NHS England recommendations are invited to a local venue. Here they meet the MO team and have their current outdated blood glucose meter swapped to one of a range of new NHS England compliant blood glucose meters with the corresponding test strips and lancets. During their visit, the patients can choose and ask any questions about their new meter, ask questions about their diabetic medications, and receive dietary advice from a secondary care Dietician specialising in diabetes. The patients GP record is updated during their visit to reflect any changes and reduce any additional workload to the GP practice.

Diabetic patients from five GP practices have been invited to a Swap Shop so far with 192 patients attending. Patient feedback has been positive and further Swap Shops are planned throughout the year. There has also been strong interest to replicate this model across the wider South Yorkshire footprint.

Continued funding of the Paediatric Diabetes Family Support Worker and Dietician who are supporting **Equitable Provision of Diabetes Treatment Technology.**

The project is supporting some of our most vulnerable families to access technology to support the management of their child's diabetes.

This has shown to have a significant impact on diabetes management and health and wellbeing outcomes.

Feedback on Quality of Life/Reduction in Diabetes Burden

'It's amazing – it really is. Just to have my little girl back'

'It's a bit scary as your not as in control – but the difference/change in her is lovely'

'I feel lighter – I used to be sluggish and droopy'

Double thumbs up from one of the children with neurodiversity

'A game changer – it's made life'

'It's great – I love it. It's just easier'

'The difference in her is just amazing'

RDASH statutory annual members meeting with a difference

- The Trust are holding their statutory annual members meeting, but with a change to make it a community event for staff, partners, and the public.
- There's no need to book, unless colleagues want to compete in the 'It's a Knockout' or the 'rounders' contests.
- RDASH would love to see partners join them for ice cream, games and a bit of a laugh

In addition:

- The Older Adult Hospital Liaison Team have worked with The Rotherham Foundation Trust (TRFT) and are providing a dementia advice and carers support table in TRFT reception area on a monthly basis
- The Psychiatric Intensive Care Unit Team (PICU) have been shortlisted for the HSJ Patient Safety Pilot Project of the Year Award with Improving patient safety through an organisational culture intervention on a PICU: A controlled pilot project
- The older adult wards have introduced a new carers care plan to improve engagement techniques for families and to enhance the communication they receive
- RDaSH colleagues supported carers week by attending various events in liaison with RMBC and Rotherham the Borough that Cares network. This included attendance and stalls at TRFT, Riverside café and Crossroads. It was a great opportunity to network with other carer support charities and initiatives.

Special Educational Needs and Disabilities (SEND) Education Health and Care Plans

- Massive shout out to our Designated Clinical Officer Vicky and all our colleagues across The Rotherham Foundation NHS Trust and Rotherham, Doncaster and South Humber NHS Trust for their hard work, commitment, and determination to improve the timeliness of advice for Education, Health and Care Plans (EHCP). This quarter there were 1523 EHCP requests for general health advice and 78.4% were returned within 6 weeks, only 5% remain outstanding. In addition, there were 199 EHCP requests for CAMHs advice and 88.4%were returned within 6 weeks, only 6% remain outstanding.

This is a phenomenal achievement, and has really made a difference to Rotherham children, the overall timeliness of EHCPs has significantly improved which is now ensuring that children are getting the right educational provision much earlier.

For more information about Special Educational Needs and/ or Disabilities please look on the local offer. Rotherham SEND Local Offer – Here you will find help, advice and information about the services available for your child or young person from birth to 25 years with a Special Educational Need or Disability (SEND).

SEND LOCAL OFFER ROTHERHAM

The Waverley build is progressing well, as you can see from the photo. The new health centre is the two-storey roofed structure at the back of the site and is expected to be completed by the end of 2024, providing primary health services for the people of the new Waverley estate on the border with Sheffield.

The Rotherham VAR Cancer Timely Presentation Project are providing education sessions to Black and Minority Ethnic (BAME) and seldom heard groups across Rotherham. The sessions are providing some great insights into how we may want to adapt services and target education messages for campaigns and improve uptake of cancer screening.

Sessions have shed light on the cultural stigma surrounding breast cancer in BAME households and provided information on the options available and how women can access culturally sensitive screening services.

Sessions have also included information about cervical screening, menopause and lung health checks.

After attending one lady commented:
"I felt much more relaxed after the session on Breast Awareness, I immediately booked my mammogram which I had been putting off for several months"

Sharon Kemp, Chief Executive of Rotherham Council has been **awarded an OBE** in the King's Birthday Honours list, for her services to business and to the community in Rotherham and South Yorkshire.

The honour comes following 30 years of public service across community safety, neighbourhood management, community cohesion, performance management, and partnerships.

Joining the council in 2016, she has been central to their improvement journey which saw Children and Young People's Services rated as 'Good' by Ofsted in 2017 and the organisation come out of special measures and intervention in 2018.

The Council was recognised as the 'Most Improved Council' in the country at the Local Government Chronicle (LGC) Awards in 2022, followed by an LGA peer review which described the Council as 'an impressive organisation which serves the town well' in 2023.

Sharon said: *"This is an incredible honour, and I will be accepting in recognition of the Council, the borough, and all councillors, colleagues, partners and communities that work together to make Rotherham the amazing place it is".*

Board of Directors' Meeting
5 July 2024

Agenda item	P110/24
Report	**Finance Report**
Executive Lead	Steve Hackett, Director of Finance
Link with the BAF	D6: We will not be able to deliver our services because we have not delivered on our Financial Plans for 2024/25 in line with national and system requirements leading to financial instability and the need to seek additional support.
How does this paper support Trust Values	This report supports the Trust's vision to always ACT the right way and be PROUD to provide exceptional healthcare to the communities of Rotherham by adhering to the core values – (A)mbitious, (C)aring and (T)ogether and focussing on our strategic ambitions: (a) (P)atients - We will be proud that the quality of care we provide is exceptional, tailored to people's needs and delivered in the most appropriate setting for them; (b) (R)otherham - We will be proud to act as a leader within Rotherham, building healthier communities and improving the life chances of the population we serve; (c) (O)ur partners - We will be proud to collaborate with local organisations to build strong and resilient partnerships that deliver exceptional, seamless patient care; (d) (U)s - We will be proud to be colleagues in an inclusive, diverse and welcoming organisation that is simply a great place to work; (e) (D)elivery - We will be proud to deliver our best every day, providing high quality, timely and equitable access to care in an efficient and sustainable organisation. Exercising strong financial management, control and governance is a key component element in the Trust achieving these ambitions.
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐

Executive Summary (including reason for the report, background, key issues and risks)	This detailed report provides the Board of Directors with an update on:
	
	• Section 1 – Financial Summary for May 2024 (Month 2 2024/25):
	
	  ○ A summary of the key performance metrics linked to income and expenditure, capital expenditure and cash management.
	
	• Section 2 – Income & Expenditure Account for May 2024 (Month 2 2024/25:
	
	  ○ Financial results for May 2024.

	- A deficit to plan of £338K in month and £620K year to date; - The same deficits to the planned (external) control totals. NHS England measures the Trust's I&E performance against its control total having adjusted for depreciation on donated assets, impairments and accounting for Private Finance Initiatives under IFRS 16 – Leases (total of £123K). • Section 3 – Capital Expenditure for May 2024 (Month 2 2024/25) o Results for May 2024 show expenditure of £169K in month and £309K year to date, which is on plan. o Final capital expenditure plans for 2024/25 were agreed at the Capital Monitoring Group, chaired on behalf of the Director of Finance, on 20th May 2024. Financial plans and monthly profiles will be revised and updated in line with budget holder expectations. • Section 4 – Cash Flow 2024/25 o A cash flow graph showing actual cash movements between April 2023 and May 2024. A month-end cash value as at 31st May 2024 of £10,653K, which is £400K better than plan.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	This report to the Board of Directors has been prepared directly from information contained in the Trust's ledgers and is consistent with information reported externally to NHS England. o The overall financial position for I&E has been reviewed collectively by and agreed with the senior Finance Team together with the Director of Finance. o CIP performance has been discussed with the Efficiency Board chaired by the Deputy Chief Executive. o The capital expenditure position has been discussed and reviewed by the Capital Planning & Monitoring Group, chaired by the Director of Finance. o More comprehensive and detailed reports of the financial results have been presented to Finance & Performance Committee and the Executive Team.
Board powers to make this decision	Within Section 4.5 of Standing Financial Instructions – Budgetary Control and Reporting – paragraph 4.5.1 states that *"The Director of Finance will devise and maintain systems of budgetary control. These will include:* *(a) Financial reports to the Board, in a form approved by Finance & Performance Committee on behalf of the Board."*

Who, What and When (What action is required, who is the lead and when should it be completed?)	• Overall financial performance was discussed at the monthly performance meetings held on 25 June 2024. • CIP performance was discussed at the Efficiency Board meeting held on 12 June 2024. • Capital expenditure was reviewed at the Capital Monitoring Group held on 17 June 2024. • Detailed discussions have also taken place at the meeting of Finance & Performance Committee on 26 June 2024, including feedback from all of the above. Any issues for escalation from the Committee will be reported at the meeting of the Board.
Recommendations	It is recommended that the Board of Directors note the content of the report.
Appendices	None.

1. Key Financial Headlines

1.1 The key financial metrics for the Trust are shown in the table below. These are:

- Performance against the monthly income and expenditure plan;
- Capital expenditure;
- Cash management.

Key Headlines	Month			Year to date		
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
I&E Performance (Actual)	(851)	(1,189)	(338)	(1,701)	(2,321)	(620)
I&E Performance (Control Total)	(789)	(1,127)	(338)	(1,578)	(2,198)	(620)
Capital Expenditure	169	169	0	309	309	0
Cash Balance	(3,715)	(1,200)	2,515	10,253	10,653	400

1.2 The Trust has over-spent against its I&E plan and control total in May 2024 by £338K and year to date by £620K. NHS England measures the Trust's I&E performance against its control total having adjusted for depreciation on donated assets, impairments and accounting for Private Finance Initiatives under IFRS 16 - Leases. These figures do not include any adjustment for under or over-performance on elective recovery activity, which by default is assumed to be covered within the current level of reserves.

1.4 Capital expenditure is on plan having spent £309K year to date. The capital programme is continuing to be monitored by the Capital Monitoring Group chaired by the Director of Finance.

1.5 The cash position at the end of May 2024 remains strong at £10,653K and is above plan by £400K.

2. Income & Expenditure Account for May 2024 (Month 2 2024/25)

2.1 The table below shows the financial results subjectively (by type of expenditure). The Trust has delivered deficits to plan in May 2024 of £338K and year to date of £620K.

Summary Income and Expenditure Position	Annual plan £000s	Month			Year to date			2024/2025 Monthly Trend / Variance
		Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	
Clinical Income	333,440	27,796	27,878	82	55,592	55,682	90	
Other Operating Income	22,881	2,116	2,221	105	4,131	4,481	349	
Pay	(227,397)	(19,597)	(20,667)	(1,070)	(38,929)	(40,881)	(1,953)	
Non Pay	(95,348)	(9,138)	(9,747)	(609)	(18,788)	(19,632)	(844)	
Non Operating Costs	(5,131)	(375)	(313)	63	(751)	(623)	127	
Reserves	(36,118)	(1,652)	(562)	1,090	(2,957)	(1,347)	1,610	
Retained Surplus/ (Deficit)	(7,673)	(851)	(1,189)	(338)	(1,701)	(2,321)	(620)	
Adjustments	1,365	62	62	(0)	123	123	(0)	
Control Total Surplus/ (Deficit)	(6,308)	(789)	(1,127)	(338)	(1,578)	(2,198)	(620)	

2.2 Clinical Income is on plan in month, however, these figures do not include any adjustment for under or over-performance on elective recovery activity, which by default is assumed to be covered within the current level of reserves. At Month 2, the detailed elective recovery targets had not been received from NHSE. The overall target for South Yorkshire ICB and the Trust is 103% of 19/20's activity (priced at current tariff).

2.3 Other Operating Income is ahead of plan in month and year to date with increased income from staff recharges (£282K), which will be an offset to the pay over-spend, and increased research, education and training income (£96K).

2.4 Pay costs are over-spending by £1,953K year to date. Bank and agency expenditure is not currently being maintained within the gross establishment budget, and contributing to this is £624K under-delivery against the planned cost improvements.

2.5 Non Pay costs are over-spending by £844K year to date. The overspend is largely related to Drugs and Clinical Supplies, Energy & Utilities £96K, and under-delivery against cost improvement plans of £252K.

2.6 The positive performance in Non Operating Costs is due to interest receivable on cash balances being better than planned.

2.7 £1,610K has already been released from Reserves in month, this is to cover the under-delivery of CIP and additional capacity over and above the winter plan.

3. Capital Programme

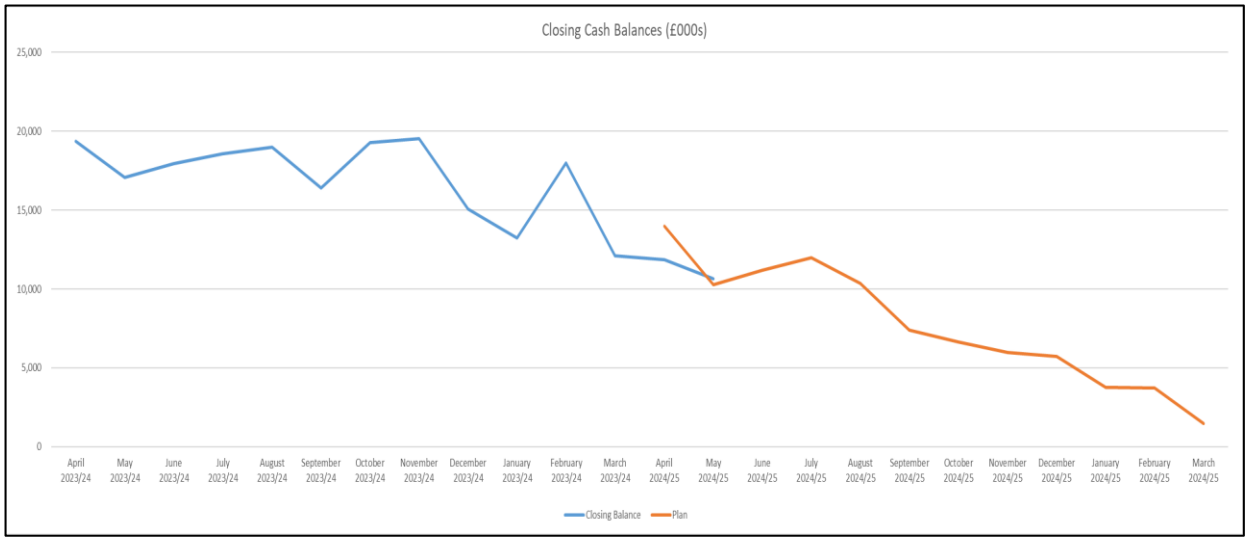
3.1 During May 2024 the Trust incurred capital expenditure of £169K and £309K year to date, which is currently on plan. The planned capital spend for the year is £11,150K.

Capital Expenditure	Month			YTD		
	P £000s	A £000s	V £000s	P £000s	A £000s	V £000s
Estates Strategy	(72)	58	(129)	17	46	(29)
Estates Maintenance	(64)	38	(102)	36	(4)	40
Information Technology	154	86	68	158	274	(116)
Medical & Other Equipment	(100)	4	(104)	0	28	(28)
Other	965	0	965	1,335	0	1,335
TOTAL	883	186	697	1,546	344	1,202

3.2 Final plans for 2024/25 were considered at the Capital Monitoring Group, chaired on behalf of the Director of Finance, on 20th May 2024. Financial plans and monthly profiles will be revised and updated in line with budget holder expectations

5. Cash Management

5.1 Compared to plan, there is an in-month favourable variance of £2,515K. Cash remains strong with a closing cash balance of £10,653K as at 31st May 2024. This has allowed the Trust to earn interest on its daily cash balances of £159K year to date.



Steve Hackett
Director of Finance
17 June 2024

Board of Directors Meeting
July 2024

Agenda item	P111/24
Report	**Integrated Performance Report**
Executive Lead	Michael Wright, Deputy Chief Executive
Link with the BAF	D5, D6, P1, R2
How does this paper support Trust Values	The Integrated Performance Report supports the Trust's *Ambitious* value in ensuring we are constantly striving to deliver stronger performance across all of the core domains.
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	The Integrated Performance Report (IPR) is the monthly summary of Trust performance across the four domains of Operational Delivery, Quality, Finance and Workforce. This month's report relates to May 2024 data wherever it is available. It highlights performance against agreed national, local or benchmarked targets. It should be noted that the IPR has recently been developed and the report presented today is in the new reporting format. There are a number of Statistical Process Control (SPC) charts included at the end of this report. A brief explanation of the key elements of the SPC charts is included at the back for reference.
Due Diligence	The Finance and Performance, Quality Committee Committees and People Committee have received the relevant elements of the Integrated Performance Report or identical information, with the Executive Directors approving the content for their domain.
Board powers to make this decision	In order to be assured of the performance of the organisation, the Board needs to have visibility of the Trust's performance against core metrics.
Who, What and When	The Managing Director is the Lead Executive for reporting on the performance of the organisation through the Integrated Performance Report on a monthly basis.
Recommendations	It is recommended that the Board of Directors note the Trust's performance against the metrics presented in the Integrated Performance Report and receive assurance on the basis of this report.
Appendices	Integrated Performance Report – May 2024

Board of Directors

Integrated Performance Report - May 2024

Performance Matrix Summary

The Rotherham NHS Foundation Trust

Variation	Assurance: Pass	Assurance: Hit or Miss	Assurance: Fail
Special Cause: Improvement	**EXCELLENT: LEARN AND CELEBRATE**	**GOOD: CELEBRATE AND UNDERSTAND** • Readmissions • Vacancy Rate (total)	**CONCERNING: CELEBRATE BUT TAKE ACTION** • Avg time to see clinician • 4 hour performance, • Ambulance Handover < 15mins • Patients Spending > 12 hrs in A&E
Common Cause	**GOOD: CELEBRATE AND UNDERSTAND** • Urgent 2 Hour Community Response • LoS > 21 Days • Outpatient moved or referred to PIFU • 62 Day Standard • Combined Positivity Score • 1:1 Care in Labour • Stillbirth rate • MAST - Core	**STATIC: INVESTIGATE AND UNDERSTAND** • Number of 65+ Weeks, Number of 52+ Weeks • FDS, 31 Day Standard • Discharge Date = Discharge Ready Date, A&E Attendances, & admissions from Care Homes, Pts on Virtual Ward • Ambulance Handover Times >60min,, 12 hr trolley waits, Bed Occupancy, Waiting List Size, Overdue Follow-ups, DM01 • Activity rates against 19/20, Daycase Rates • VTE Risk Assessments, Care Hours per Patient Day, Complaints, Pressure Ulcers Cat 3 and above per 1000 days, Patient Harm Falls per 1000 bed days, Patient Safety Incident Reports, Medication Incidents • Turnover (12 month rolling)	**CONCERNING: INVESTIGATE & TAKE ACTION** • Criteria to Reside is No • Clinic Utilisation • Capped Theatre Utilisation • Discharges before 5pm • Breast milk first feed • Sickness Rates (12 month rolling) • Sickness Rates
Special Cause: Concern	**CONCERNING: INVESTIGATE AND UNDERSTAND** • MAST – Job Specific	**CONCERNING:INVESTIGATE & TAKE ACTION** • Referral To Treatment % • C. diff infections	**VERY CONCERNING: INVESTIGATE & TAKE ACTION** • Appraisal Rates (12 month rolling)

How to read the ICONs in this report:

Have we achieved in month?

Are we consistently passing(P)/failing (F) or is it hit and miss (?)

Are we significantly Improving /deteriorating or is there no significant change?

Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
Waiting List Size	-	30,402	Feb-24	-	-	H		C
Number of 52+ Weeks	200	678	Feb-24	✗	F	H		VC
Number of 65+ Weeks	37	74	Feb-24	✗	?			S

Quality

Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
SHMI	"As expected"	102	Jan-24	N/A	N/A	N/A	N/A	N/A
Readmissions (%)	-	9.1	Apr-24	-	-	L		GI
VTE Risk Assessments (%)	95.0	96.6	May-24	☑	?		-	S
Care Hours per Patient Day	7.3	7.0	Apr-24	☒	?			S
Combined Positivity Score (%)	95.0	96.7	Apr-24	☑	P		-	G
Complaints	-	36	May-24	-	-		-	S
Patient Safety Incident Investigations	0	2	Apr-24	☒	?		-	S
Medication Incidents	-	102	May-24	-	?		-	S
Pressure Ulcers (Cat 3/4/STDI and Unstageable) per 1000 bed days	-	3.0	Apr-24	-	-		-	S
Patients Falls (Moderate and Above) per 1000 bed days	0.19	0.2	May-24	☒	?			S
C. difficile Infections	2	10	May-24	☒	?	H		C

*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

SHMI: Summary Hospital-Level Mortality Indicator

Data, Context and Explanation

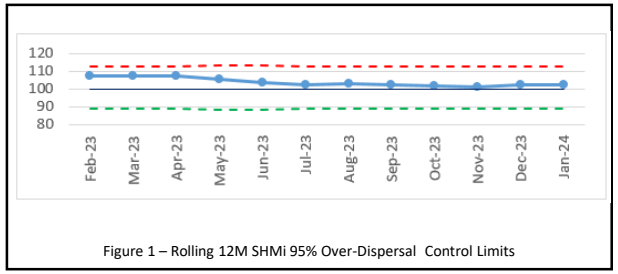


Figure 1 – Rolling 12M SHMi 95% Over-Dispersal Control Limits

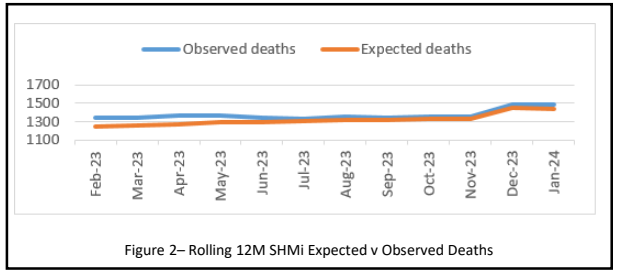


Figure 2– Rolling 12M SHMi Expected v Observed Deaths

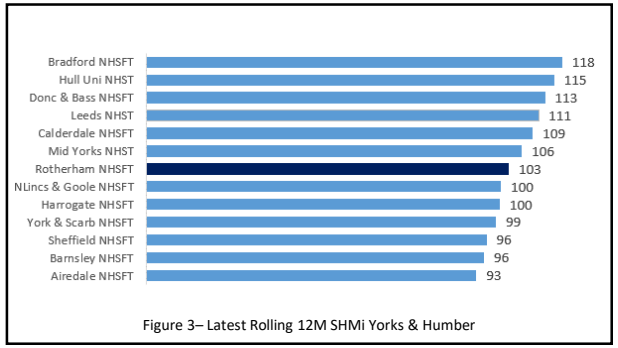


Figure 3– Latest Rolling 12M SHMi Yorks & Humber

Covid activity was added back into the SHMI data Dec 2023

- The SHMI reports on mortality at trust level across the NHS in England using a standard methodology. It is produced and published monthly as a National Statistic by NHS Digital
- The SHMI is the ratio between the observed 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
- The SHMI acts as a 'smoke alarm' to prompt Trusts to consider investigating areas of potential area of concern where more deaths are observed than expected
- There are 3 SHMI banding, As Expected, Higher or Lower. **TRFT's SHMI has consistently been As Expected, since July 2021**
- SHMI Bandings are calculated for the Trust overall and 10 diagnostic groups

Metric	Current	Target	Exec Owner	Organisational Lead
Latest Rolling 12 Month SHMI -Jan 24	102.6	-	Jo Beahan	John Taylor
Expected Deaths	1445	-		
Observed Deaths	1485	-		
Trust Banding	Expected	-		

What actions are planned?

- To monitor and report the monthly published SHMI values
- The Trust Mortality Group inform required investigations/reviews based on learnings from reviews

What is the expected impact?

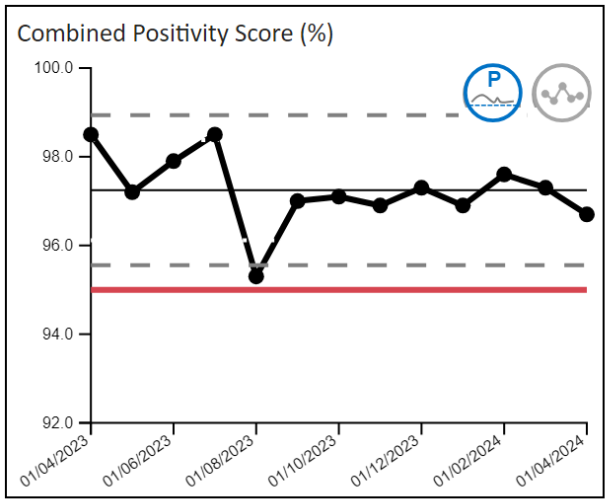
- Intelligence from SHMi investigations/reviews may lead to changes/improvements in practice

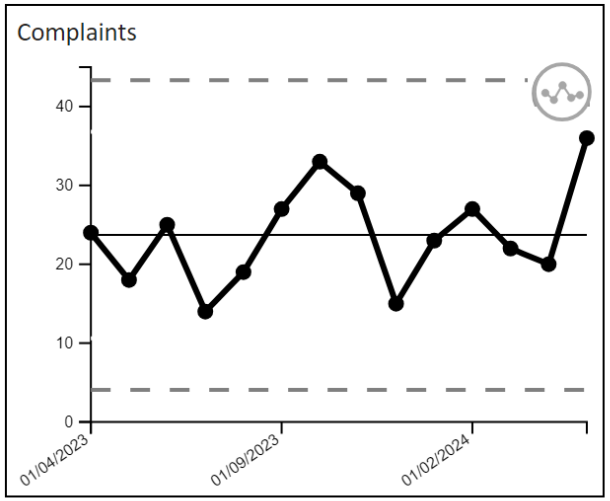
Potential risks to improvement?

- The SHMI isn't monitored and reported on routinely
- Intelligence from any investigations/reviews isn't acted upon

Subtheme: Patient Experience

Data, Context and Explanation





Listening to the views of patients and staff helps identify what is working well, what can be improved and how.

•The Friends and Family Test (FFT) is a feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.

•The FFT asks people if they would recommend the services they have used and offers a range of responses.

•Patients can complain about any aspect of NHS care, treatment or service and this is written into the NHS Constitution.

•Some people find it helpful to talk to someone who understands the complaints process first and get some guidance and support. The Patient Advice and Liaison Service (PALS) will open in 2024 to provide a free, confidential and independent service for the Trust

The Trust continues to have above target performance with an average positivity score of 96.7

The number of complaints continues with an average of 22 per month.

Metric	Value	Target	Exec Lead	Ops Lead
Combined Positivity Score (%)	96.7	95.0	Helen Dobson	Cindy Storer
Complaints	36	-	Helen Dobson	Cindy Storer

What actions are planned?

- The 5 point Patient Experience Improvement Plan has been shared at the Patient Experience Group in June 24, actions will focus on Communication, PALs Support, EoLC, Carers and Improved Facilitates.
- The Patient Advice and Liaison Service (PALS) is anticipated to open in Q2 and will provide a free, confidential and independent service for the Trust.

What is the expected impact?

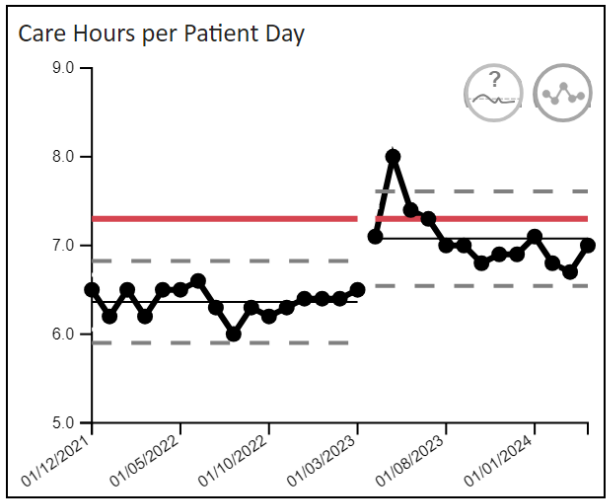
- FFT Continued Positivity score above 95
- The PALS service aims to promote local resolutions to concerns earlier in the process leading to a reduction in formal complaints as experience improves.
- .

Potential risks to improvement?

- Ongoing delays in recruitment of PALS officers
- Changes in digital infrastructure in support of FFT collection resulting in new ways of working, via text messages and/or more granular online surveys

Subtheme: Care hours per patient day

Data, Context and Explanation



Care Hours Per Patient Day (CHPPD) is the formal, principal measure of workforce deployment in ward-based settings.

CHPPD forms an integral part of a ward/unit/trust review and oversight of quality and performance indicators to inform quality of care, patient outcomes, people productivity and financial sustainably.

CHPPD should be used alongside clinical quality and safety outcome measures to understand and reduce unwarranted variation, and support delivery of high quality, efficient patient care

Significant improvement noted in March 2023, coming out of the winter pressures of FY22/23. We have seen consistent performance ever since with winter FY 23/24 achieving a higher CHPPD due to increased recruitment and retention. We are consistently just above 7, against a target of 7.3 (NB – Target can move month on month)

Metric	Value	Target	Exec Lead	Ops Lead
Care Hours per Patient Day	7.0	7.3	Helen Dobson	Cindy Storer

What actions are planned?

- Roll out of the Exemplar Accreditation programme. This programme is underpinned by Quality dashboards, containing the CHPPD measure alongside health roster KPI, patient safety, patient experience & healthcare infections
- Ward establishments to be reviewed, and set, every 6 months using evidenced based methodology and professional judgement

What is the expected impact?

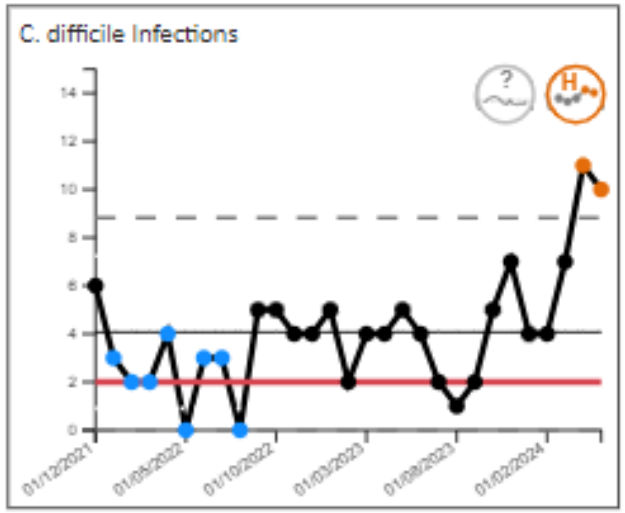
- Improved CHPPD rate
- Clinical quality and safety outcomes are maintained and unwarranted variation reduced across ward areas.

Potential risks to improvement?

- Needing to open additional beds using existing establishments
- Roster KPI not being met
- Turnover of Nurses, Midwives and HCSW

Subtheme: Infection Prevention & Control

Data, Context and Explanation



- Clostridium difficile (C. diff) is a type of bacteria that can cause diarrhoea. It often affects people who have been taking antibiotics. It can usually be treated with a different type of antibiotic.
- The last two months have shown significantly higher than expected rates. This is reviewed monthly at Harm Free Care panels and the emerging themes link to antimicrobial stewardship and prescribing practices.
- Results for Q4 have just been published and indicate that TRFT is not an adverse outlier within the region although the Q1 position for 25/25 is likely to show a deterioration.

Metric	Value	Target	Exec Lead	Ops Lead
C. difficile Infections	10	2	Helen Dobson	Jen Hilton

What actions are planned?

- Identify themes and learning from the monthly Trust harm free panel (antibiotic - prescribing, infection prevention and control practice)
- Re-launch of the National Standards of Healthcare Cleanliness (2021) has commenced Virtual Cdiff ward rounds through microbiology (already happening on ITU) Regional antimicrobial stewardship support accepted
- Review meeting with Public Health and UKHSA colleagues to identify further opportunities for improvement

What is the expected impact?

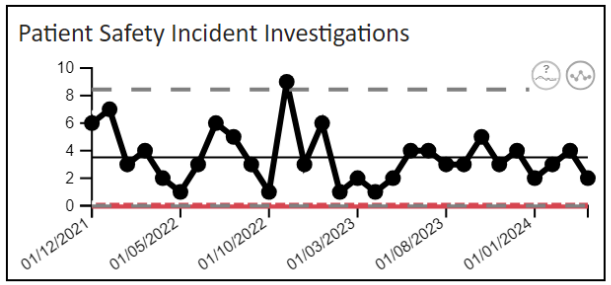
- A Reduction in case of C.Diff and associated per 100,000 bed day rate

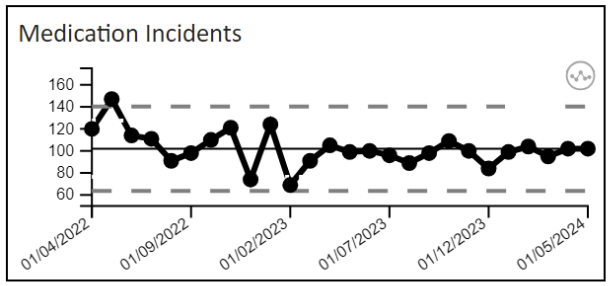
Potential risks to improvement?

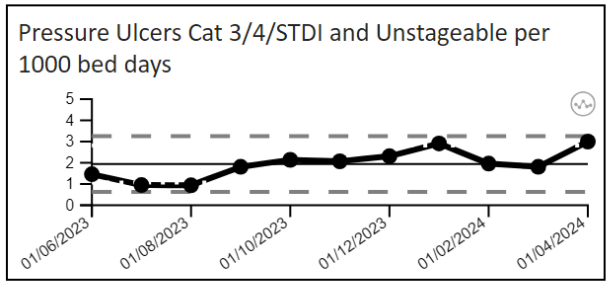
- Lack of Antimicrobial Pharmacist to lead strategically across the Trust, advise clinicians and input into Trust Harm Free Care Panel.
- Intermittent microbiology support to lead strategically across the Trust, support proactive ward rounds and input into Trust Harm Free Care Panel.

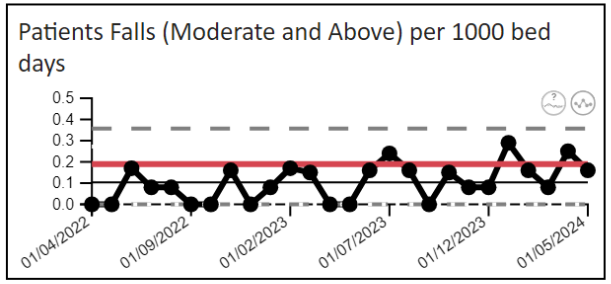
Subtheme: Care Incidents

Data, Context and Explanation









•Patient Safety Incident Investigations are completed when a patient has been involved in a moderate harm incident and there has been significant learning identified.

•Medication incidents that are reported through the Datix system can occur for a number of reasons. We encourage staff to be open and transparent in their reporting of incidents.

•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.

•Pressure Ulcers that are classified as category 3, 4, SDT or Unstageable would class at moderate or above harms to patients.

•The number of patient falls at moderate harm and above should be less than 0.19 per 1000 bed days

Metric	Value	Target	Exec Lead	Ops Lead
Patient Safety Incident Investigations	2	0	Helen Dobson	Victoria Hazeldine
Medication Incidents	102	-	Jo Beahan	Victoria Hazeldine
Pressure Ulcers Cat 3/4/STDI and Unstageable per 1000 bed days	3.0	-	Helen Dobson	Victoria Hazeldine
Patients Falls (Moderate and Above) per 1000 bed days	0.2	0.19	Helen Dobson	Victoria Hazeldine

What actions are planned?

To ensure that the total number of PSII's are reduced where possible and does not exceed 10 per month
• To establish an acceptable rate of medication incidents per 1000 bed days
•To establish an acceptable rate of pressure ulcers at CAT 3/4/unstageable and SDTI per 1000 bed days in the acute Trust and per 1000 contacts in the community
•To reduce the total number of all falls and moderate harm falls there will some key Qi projects that will commence

What is the expected impact?

•Stabilisation of PSII's with adequate evidence of shared learning

•Reduction in the total number of falls

•Reduction in the number of CAT 3/4/SDTI and unstageable pressure ulcers

Potential risks to improvement?

•Increase in the number of patients admitted to acute Trust with complex health problems and additional bed capacity, resulting in reduced nursing and medical ratio's

•The lack of a falls lead practitioner to complete work across acute and community to ensure the Trust is compliant with NAIF and Qi initiatives

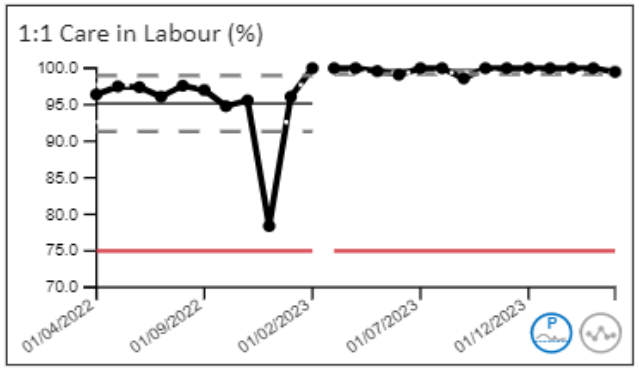
Maternity

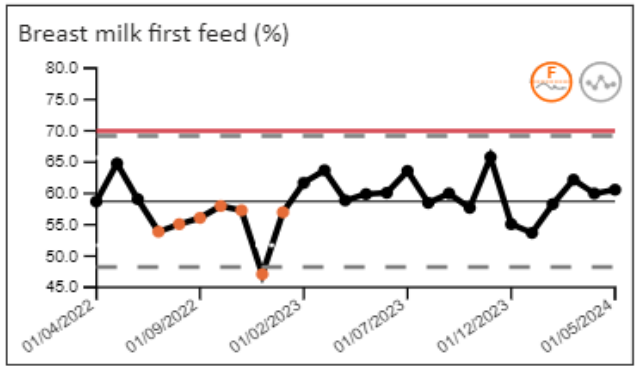
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
1:1 Care in Labour (%)	75.0	99.5	Apr-24	☑	P	H	-	VG
Breast milk first feed (%)	70.0	60.6	May-24	☒	F			C
Stillbirth rate (per 1000 births)	4.66	2.0	May-24	☑	P	L	-	VG

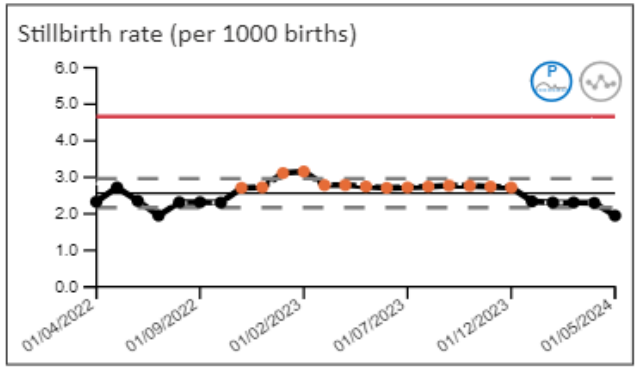
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

Subtheme: Maternity

Data, Context and Explanation







- 1:1 care in labour consistently meets the 75% target, Birth Rate Plus data demonstrates 100% for 1:1 care in labour. January 23 report included BBA'S. Validated Birth Rate Plus =100%
- Brest Milk First Feed % continues to be below standard, with an average of 59% against a Trust target of 66%. The national target is 75%. . Work is ongoing to educate and support families regarding the benefits of breast milk. TRFT Maternity services are working with partners to support this.
- Still Birth Rates consistently lower that the NHS England ambition, with a rate of 2 per 1000 births at TRFT. We are currently seeing a downward improving trend.

Metric	Value	Target	Exec Lead	Ops Lead
1:1 Care in Labour (%)	99.5	75.0	Helen Dobson	Sarah Petty
Breast milk first feed (%)	60.6	70.0	Helen Dobson	Sarah Petty
Stillbirth rate (per 1000 births)	2.0	4.7	Helen Dobson	Sarah Petty

What actions are planned?

- Unicef Baby Friendly action plan to achieve standards for BFI, working in collaboration with RMBC and 0-19. Actions have included High standards of parent information and education on breast feeding, working with partners in Family hubs to improve infant feeding support.
- Continuous improvement with the Saving Babies Lives care bundle version 3 implementation – Trft currently at 89% compliance.

What is the expected impact?

- Performance to be maintained following safe staffing /escalation policy for TRFT.
- Achieving BFI accreditation ensures that TRFT meet the required standards to support infant feeding standards across the service. The Three year delivery plan recommends that this is achieved by March 27
- The LMNS assurance visit IN March 2024 highlighted compliance at 89% for TRFT

Potential risks to improvement?

- Maintain birth rate plus establishment setting requirements and backfilling maternity leave and gaps above headroom supports safe staffing on every shift. Infrastructure and support to gain BFI including training. To maintain partnership working with RMBC.
- The recent withdrawal of public health funding for smoking in pregnancy service could impact service delivery.

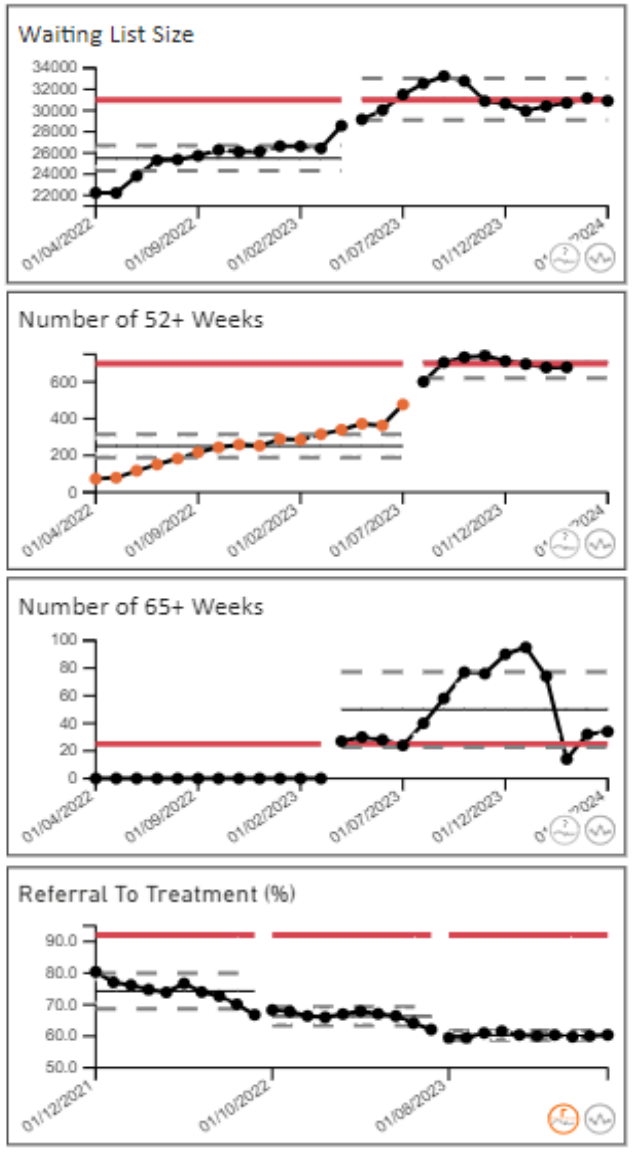
Elective Care and Cancer

Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
Waiting List Size	31,000	30,906	May-24	☑	?			S
Number of 52+ Weeks	700	764	May-24	☒	?			S
Number of 65+ Weeks	25	34	May-24	☒	?			S
Referral To Treatment (%)	92.0	60.4	May-24	☒	F			C
OP Activity moved or Discharged to PIFU (%)	1.5	2.9	May-24	☑	P			G
Overdue Follow-ups	-	16,489	May-24	-	-		-	S
DM01 (%)	1.0	0.3	May-24	☑	?			S
Faster Diagnosis Standard (%)	77	75.4	Apr-24	☒	?			S
31 Day Treatment Standard (%)	96.0	94.5	Apr-24	☒	?			S
62 Day Treatment Standard (%)	70	72.1	Apr-24	☑	P			G

*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

Subtheme: Long Waiters

Data, Context and Explanation



- For 2024/25, the national planning guidance has set an objective for no patients to be waiting over 65 weeks for their treatment by the end of September 2024.
- The Trust has committed to delivering this target by June 2024 and remains on track to deliver the trajectory by the end of June, subject to no further industrial action.
- The Trust has also committed to reducing the number of patients waiting over 52 weeks by 50% by March 2025.
- The waiting list continues to grow impacting on the ability to reduce the number of patients waiting over 52 weeks.
- A robust transformation programme which will focus on increasing theatre and outpatient productivity, underpinned by GIRFT Further Faster, will support delivery of our objectives.
- This work will also see us reach our Trust ambition to achieve RTT performance of 92% in a minimum of 5 specialties.

Metric	Value	Target	Exec Lead	Ops Lead
Waiting List Size	30,906	31,000	Sally Kilgariff	Andrea Squires
Number of 52+ Weeks	764	700	Sally Kilgariff	Andrea Squires
Number of 65+ Weeks	34	25	Sally Kilgariff	Andrea Squires
Referral To Treatment (%)	60.4	92.0	Sally Kilgariff	Andrea Squires

What actions are planned?

•Approval of an additional 136 outpatient clinics in gynaecology (11 per month) which will support 1,317 first outpatient appointments for our patients
•Approval of an additional 3 all day weekend theatre lists for orthopaedics in June which will support 12 of our longest waiting patients to receive their surgery
•Approval of 3 all day theatre lists for ophthalmology via insourcing which will support all 5 patients currently waiting for corneal graft surgery to receive their treatment

What is the expected impact?

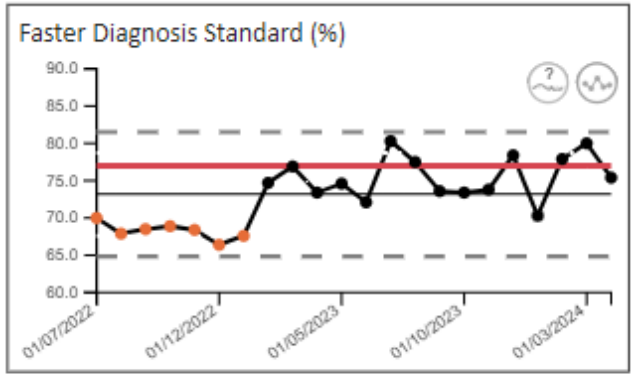
•Reduction in the gynaecology waiting list to ensure all patients receive a first outpatient appointment within 6 weeks by March 2025
•Orthopaedics will achieve the standard of having zero patients waiting more than 65 weeks for their treatment by the end of June 2024
•Ophthalmology will achieve the standard of having zero patients waiting more than 65 weeks for their corneal graft surgery by the end of June 2024

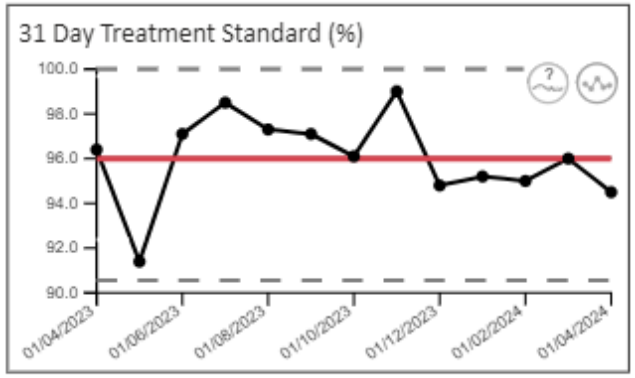
Potential risks to improvement?

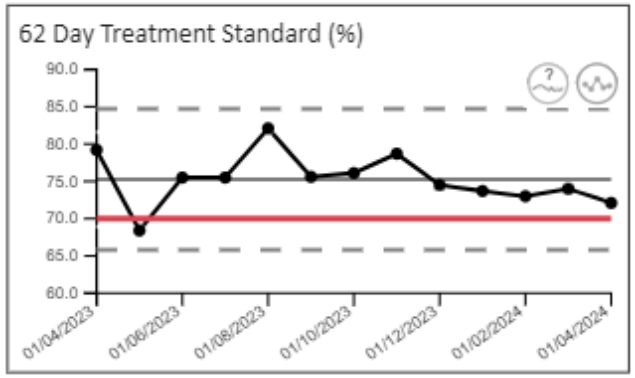
••Clinician agreement and availability to undertake additional sessions as required to support the outpatient and theatre activity approved
••Tissue availability to support completion of our 2 longest waiting patients in ophthalmology (currently 77 weeks) due to national shortage
••Potential loss of activity due to junior doctor industrial action planned for 27 June to 2 July 2024

Subtheme: Cancer

Data, Context and Explanation







•In 2024/25, the national planning guidance set an objective to improve performance against the 28-day Faster Diagnosis Standard to 77% by March 2025.

•The Trust has committed to achieving this standard and has set a further ambition to improve performance to 80% by March 2025.

•The national planning guidance sets the objective to improve performance against the 62-day Referral-to-Treatment Standard to 70% by March 2025.

•As the Trust is consistently achieving this standard, we have set a further ambition to improve performance to 77% by March 2025.

• A Cancer transformation programme will be developed which will focus on delivery of these objectives and improving personalised care and support for our patients.

Metric	Value	Target	Exec Lead	Ops Lead
Faster Diagnosis Standard (%)	75.4	77	Sally Kilgariff	Andrea Squires
31 Day Treatment Standard (%)	94.5	96.0	Sally Kilgariff	Andrea Squires
62 Day Treatment Standard (%)	72.1	70	Sally Kilgariff	Andrea Squires

What actions are planned?

•Pilot of good news clinics in Gynaecology, Lower GI and Upper GI to ensure patients receive timely communication of diagnosis
•Development of 'one stop pathways' in Skin and Head & Neck to ensure timely access to diagnostics and diagnosis
•Full pathway analysis for Urology and Lower GI to support whole pathway improvement projects
•Development of Endoscopy and Cancer Transformation programmes for 2024/25

What is the expected impact?

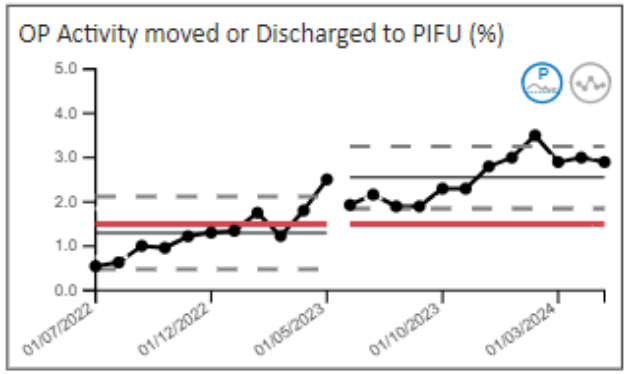
•The Faster Diagnosis Standard (80%) has been achieved in 7 of the 12 cancer tumour sites. The ongoing improvement work will support achievement in the remaining 5 tumour sites (LGI, UGI, Urology, Haematology and Sarcoma) by March 2025
•Full pathway analysis and improvement work will reduce the number of patients waiting more than 62 days for treatment by half in Lower GI and Urology by the end of Q2, and will meet the 62 day standard of 80% by March 2025

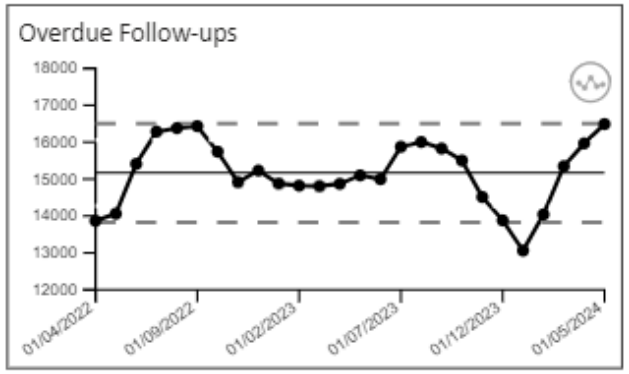
Potential risks to improvement?

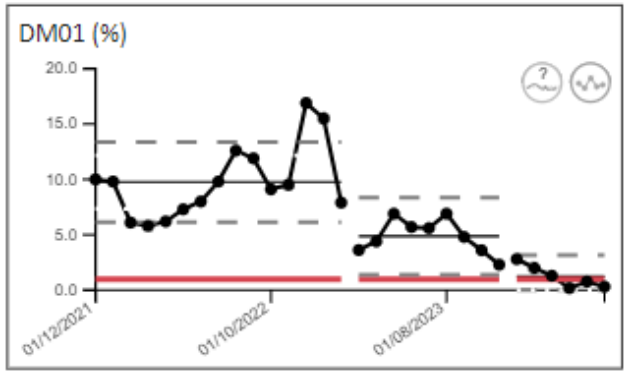
•Reliance on insourcing to support endoscopy capacity continues which may impact the ability to achieve the FDS and 62 day standard in Lower GI
•Workforce challenges in both Lower GI and Urology continue to impact cancer pathway progression and improvement work
•The new cancer improvement team are supported by fixed term funding and sustainability of these roles is therefore a concern

Subtheme: Diagnostics & Follow-ups

Data, Context and Explanation







•In 2024/25, the national planning guidance set an objective to increase the percentage of patients that receive a diagnostic test within 6 weeks in line with the March 2025 ambition of 95%.

As the Trust is consistently achieving this standard, we have set a further ambition to maintain performance at 99% for the full year to March 2025

Metric	Value	Target	Exec Lead	Ops Lead
OP Activity moved or Discharged to PIFU (%)	2.9	1.5	Sally Kilgariff	Andrea Squires
Overdue Follow-ups	16,489	-	Sally Kilgariff	Andrea Squires
DM01 (%)	0.3	1.0	Sally Kilgariff	Andrea Squires

What actions are planned?

•Approval of additional theatre session which will support 7 patients to receive their Urodynamic procedure in June 24
•Approval of additional endoscopy sessions via insourcing which will support 211 patients to receive their Endoscopy procedure in June 24
•Deep dive to be completed in Audiology to understand impact of proposed changes to Diagnostic Waiting Times Guidance for Surveillance patients

What is the expected impact?

•Urodynamics will achieve the DM01 standard of having zero patients waiting more than 6 weeks for their diagnostic procedure by the end of June 2024
•Endoscopy will achieve the DM01 standard of having zero patients waiting more than 6 weeks for their diagnostic procedure by the end of June 2024
•Audiology will fully understand the impact of proposed changes to DM01 guidance and develop a mitigation plan to mitigate against such changes

Potential risks to improvement?

•Clinician agreement and availability to undertake additional sessions as required to support the urodynamic theatre activity approved
•Reliance on insourcing to support endoscopy capacity continues which may impact the ability to achieve the DM01 standard
•Changes to DM01 guidance for endoscopy commences in September 2024 which could result in a further 600 patients being added to the endoscopy DM01 waiting list

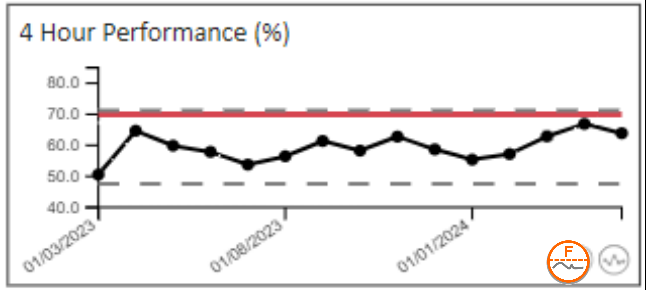
Non-elective and Flow

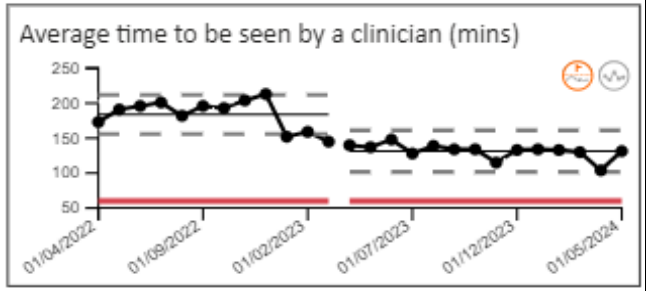
Metric	Trust Target	Latest Data	Period	Achieved in Month)	Assurance	Variation	Quartile	Grid*
4 Hour Performance (%)	70.0	63.9	May-24	☒	F			C
Ambulance Handover Times <15 mins (%)	65	50	May-24	☒	F			C
Ambulance Handover Times >60 mins (%)	0.0	4.6	May-24	☒	?		-	S
Average time to be seen by a clinician (mins)	60	131.4	May-24	☒	F		-	C
Patients spending >12 hours in A&E from time of arrival (%)	2.0	4.9	May-24	☒	F			C
12hr Trolley Waits	0	1	May-24	☒	?		-	S
Bed Occupancy (%)	91.6	90.1	May-24	☑	?			S
Criteria to Reside is No (%)	9.9	17.1	May-24	☒	F		-	C
Length of Stay over 21 Days	70	45	May-24	☑	P		-	G
Patients where Date of Discharge = Discharge Ready Date (%)	85.0	82.1	Apr-24	☒	F		-	S

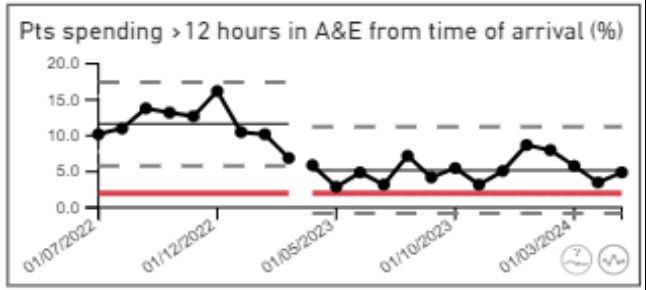
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

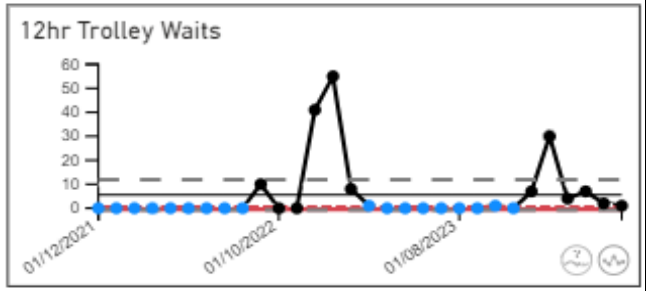
Subtheme: Emergency Care - Waiting Times

Data, Context and Explanation









••In 2024/25, the national planning guidance set an objective for all trusts to achieve target of 78% by March 2025.

•There are numerous factors contributing to 4 hour performance. The focus on time to seen a clinician is concerning but improvements have been made and it is on a downward trajectory.

•National focus on reducing 12 hours in the department

•There is a correlation between handover times and >12 hour waits. However, neither appear to have an impact on 4 hour performance.

•The trust have set a target of zero trolley waits in line with national guidance

Metric	Value	Target	Exec Lead	Ops Lead
4 Hour Performance (%)	63.9	70.0	Sally Kilgariff	Lesley Hammond
Average time to be seen by a clinician (mins)	131.4	60.0	Sally Kilgariff	Lesley Hammond
Pts spending >12 hours in A&E from time of arrival (%)	4.9	2.0	Sally Kilgariff	Lesley Hammond
12hr Trolley Waits	1	0	Sally Kilgariff	Lesley Hammond

What actions are planned?

•A recovery plan has been developed, identifying detailed actions to reduce the number of breaches through the department daily
•Acute Care Transformation for 4 hours – Care Groups meeting to discuss the option of relocating patients needing additional investigations/assessments that will take over 4hr
•8 new clinical fellows will start in August this will increase doctor capacity in UECC and the rota will be realigned to meet demand
•ETM agreed ongoing use of fracture clinic to provide additional capacity

What is the expected impact?

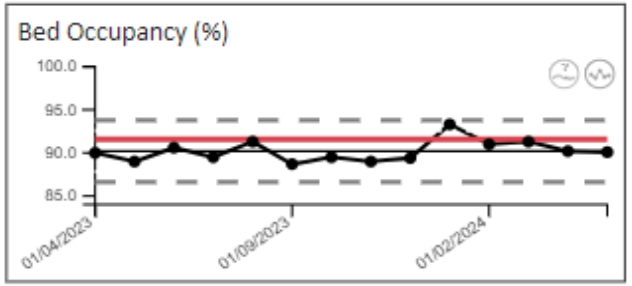
•Visibility of the plans and actions to specialty lead to reduces breach within their service this will reduce the number of breaches to support achievement of 80% at end of Aug 24
•Care Groups to agree to a pilot to support reducing the breaches by the end of Jul24.
•The clinical fellows will increase productivity across the day and reduce the time to be seen by a clinician and also reduce locum spend by September 2024
•Primary care and minor injuries to achieve performance of 100% within 4 hours by the end of August 2024.

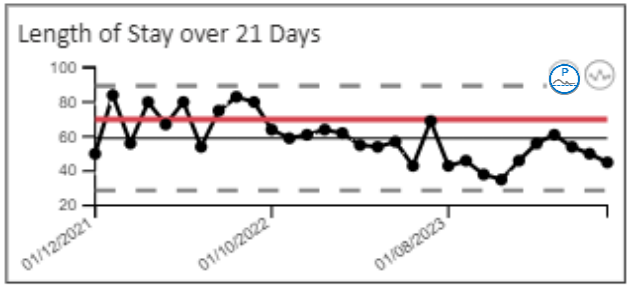
Potential risks to improvement?

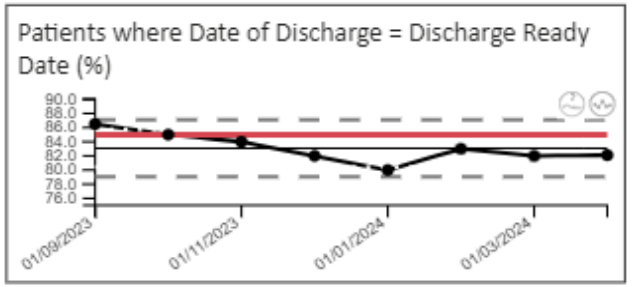
• Potential loss of capacity to support improvement plans due to junior doctor industrial action planned for 27 June to 2 July 2024.
• Attendances to UECC continue to increase beyond 24/25 plan and 23/24 levels.

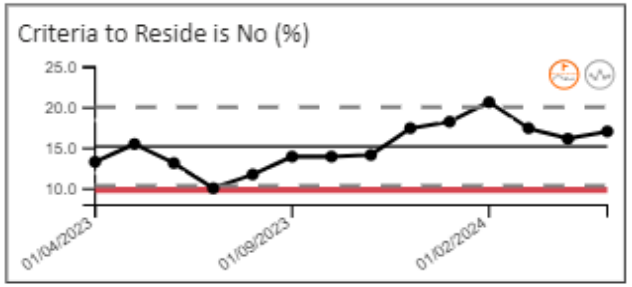
Subtheme: Inpatient Flow

Data, Context and Explanation









•Bed occupancy has decreased due to additional capacity being opened across the trust in winter

•

•The criteria to reside has seen an in increase over winter, Challenges experience with discharge on all pathways

•

•Significant work completed in over 21 days delays however additional work needed in the 14 and 7 day Length of stay

Metric	Value	Target	Exec Lead	Ops Lead
Bed Occupancy (%)	90.1	91.6	Sally Kilgariff	Lesley Hammond
Length of Stay over 21 Days	45	70	Sally Kilgariff	Lesley Hammond
Patients where Date of Discharge = Discharge Ready Date (%)	82.0	85.0	Sally Kilgariff	Lesley Hammond
Criteria to Reside is No (%)	17.1	9.9	Sally Kilgariff	Lesley Hammond

What actions are planned?

•Clinical Director Care Group 1 taking lead on MDT approach and LOS ward rounds to maximise discharges by end of June 2024.
•C2R – additional training taking place at daily huddles within the medical bed base. Ensuring everyone understands data recording requirements, To expand to the rest of the bed base. Informatics involved to ensure the correct elements of the C2R document is pulling through. Assurance to be given by July 2024.
•Bed reconfiguration – will look at a more flexible approve to opening escalation capacity and closing escalation capacity. Ensuring specialities are in the right place by the end of August 2024.

What is the expected impact?

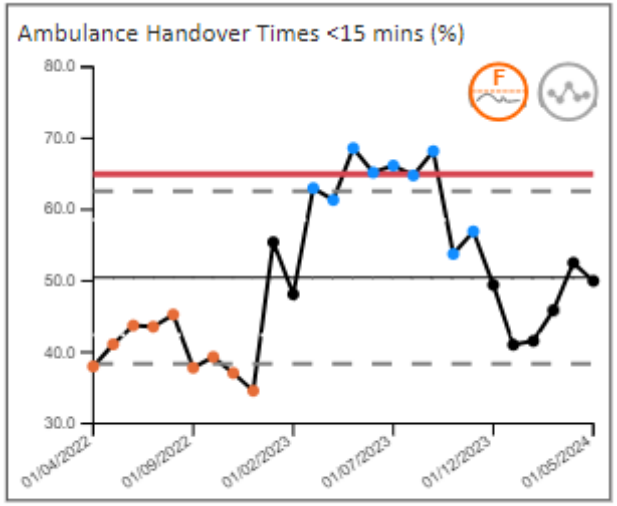
•Reduction in LOS and patients over 21 days
•Reduction in the C2R and an accurate recording position.
•Improved flow through the organisation support the trajectory plan to get to 80% at the end of August and getting ready for winter

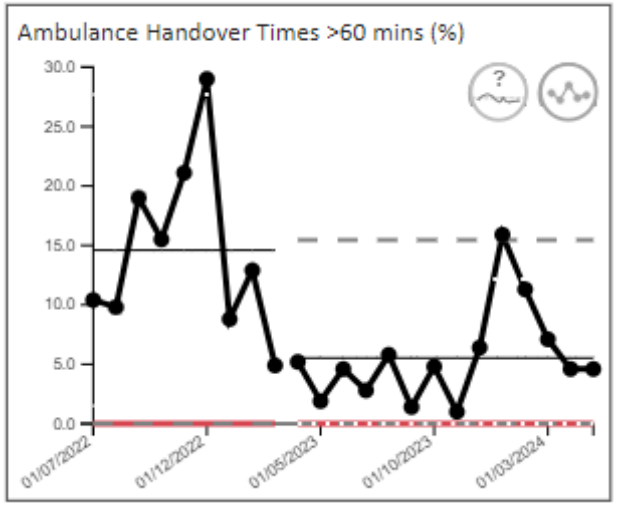
Potential risks to improvement?

•Potential loss of capacity to support improvement plans due to junior doctor industrial action planned for 27 June to 2 July 2024.

Subtheme: Emergency Care - Ambulance

Data, Context and Explanation





•The Operational Planning Guidance set an objective to achieve an average of 30 minutes average handover time across 2024/24

•The two metrics that support achievement of this objective. Patients waiting less than 15 mins for handover and patients not waiting over 1 hour for handover

•There is a correlation in performance when patients over waiting 15 mins for handover and a further deterioration in performance when patients waiting over 60 mins

•The performance of ambulance handover is impacted when there is challenge with patient flow through the Trust

•Pressure around both matrix have been linked to winter increases

Metric	Value	Target	Exec Lead	Ops Lead
Ambulance Handover Times <15 mins (%)	50.0	65	Sally Kilgariff	Lesley Hammond
Ambulance Handover Times >60 mins (%)	4.6	0.0	Sally Kilgariff	Lesley Hammond

What actions are planned?

•Utilising capacity in UECC and support from AMU to get to a position that no ambulances wait over 60 mins.
•Launch of digital visibility of ambulances over 30 mins direct to mobile device to site team and operational team in ED to ensure a robust and handover process. Starts with the site team 20th June. Operational team in ED have been trialling this.
•ACT – workstream around handover with YAS an TFRT working in collaboration to reduce conveyance and deflection to community pathways

What is the expected impact?

•No ambulances over 60 mins and an improvement in handovers <15 mins by end of August 2024.
•Reduction in conveyance rates to TRFT by September 2024

Potential risks to improvement?

•Potential loss of capacity to support improvement plans due to junior doctor industrial action planned for 27 June to 2 July 2024.
•Increase in demand of ambulances and batching of ambulances that impact on flow

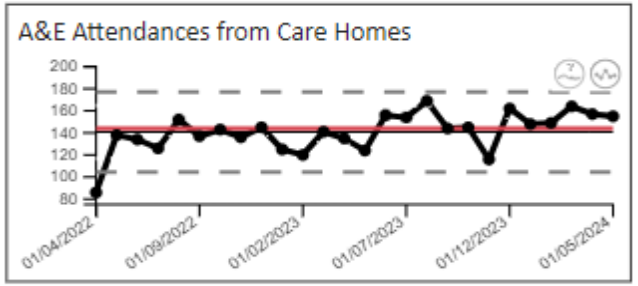
Community

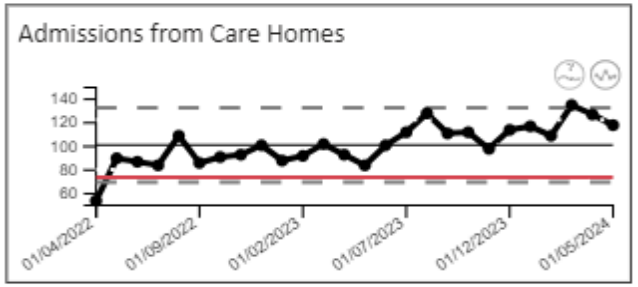
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
A&E Attendances from Care Homes	144	155	May-24	✗	?		-	S
Admissions from Care Homes	74	118	May-24	✗	?		-	S
Number of Patients on Virtual Ward	80	76	May-24	✗	?		-	S
Urgent 2 Hour Community Response (%)	70.0	75.0	Apr-24	✓	P		-	G

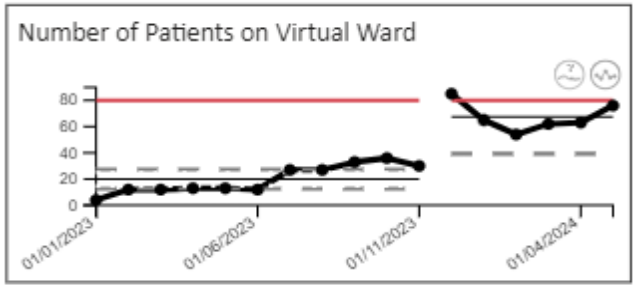
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

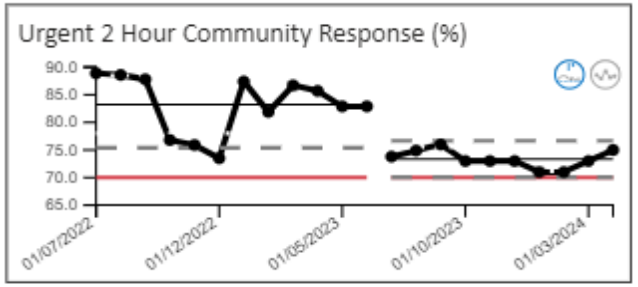
Subtheme: Community

Data, Context and Explanation









•**Care Homes:** Care Group 4 have limited influence over attendances from care homes. However, we do promote the use of TOCH to avoid conveyance. We also work closely with YAS through the push model.

•The community unplanned team in reach into UECC to prevent any unnecessary admissions. The Care Home Liaison team also monitor acute inpatient stays from Care Homes and will expedite discharge when appropriate

•**VW:** Our current capacity is 100 VW beds including both frailty and respiratory.
•Occupancy trajectory is 80 beds capacity.
•The agreed national target is 80% bed occupancy each month.

•The number of patients on the ward is captured on the final day of the month, 57. The average occupancy throughout May was 76 reaching a peak of 91 on the 15 May.

•**UCR:** The National target is 70% of appropriate referrals which meet the 2 hour criteria are to be seen within 2 hours.

•The submission process includes two phases a validation phase and a refresh phase, this allows providers to clinically validate 2 hour referrals to ensure the criteria is correctly applied.
•Work continues on data collection and validation. The service anticipate the 70% target will be met on a monthly basis.

Metric	Value	Target	Exec Lead	Ops Lead
A&E Attendances from Care Homes	155	144	Sally Kilgariff	Penny Fisher
Admissions from Care Homes	118	74	Sally Kilgariff	Penny Fisher
Number of Patients on Virtual Ward	76	80	Sally Kilgariff	Penny Fisher
Urgent 2 Hour Community Response (%)	75.0	70.0	Sally Kilgariff	Penny Fisher

What actions are planned?

•VW Technology: Pathway work completed on the contract, SOP and Information Governance. Work remains on-going on the risk assessment and hazard log with the Trust CSO. Review Dashboard options to provide visibility of capacity.
•Development of a Heart Failure pathway to be in place by end of June
•Rotherham VW Acuity Tool: Introduction of an assessment tool to assess the intensity of care required based on patient acuity.
••UCR: Standardise triage process, strengthen workforce through strategic recruitment, support staff well-being and professional development. Undertake a review of the Directory of Service

What is the expected impact?

•VW Technology: Increased offer to patients and increased referrals, thereby increasing our VW bed numbers
•Heart Failure Pathway: Improved pathway to include more diagnoses & improve VW offer by Aug 24
•Rotherham Virtual Ward Acuity Tool: Categorise patients into three general acuity levels, each assigned a specific weight to inform occupancy ratios beyond patient numbers by August 2024
•UCR: Increase offer to increase patient volume and improved systems & processes, along with staff well-being by end of July 24.

Potential risks to improvement?

- There is significant transformation work being undertaken in the VW and UCR team, whilst continuing to provide a quality service. Retention and wellbeing of the workforce is a significant risk

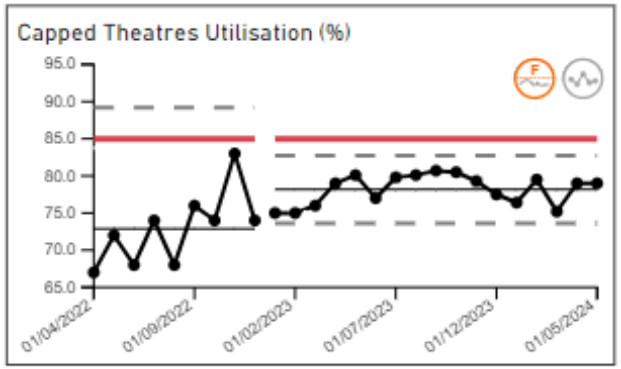
Productivity Priorities

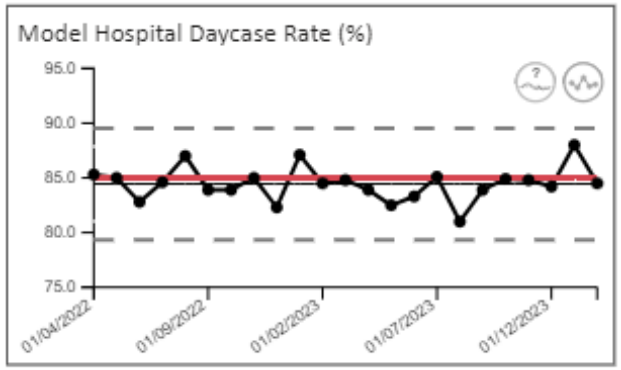
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
Clinic Utilisation (%)	85.0	75.8	May-24	☒	F		-	C
Capped Theatres Utilisation (%)	85.0	79.0	May-24	☒	F			C
Model Hospital Daycase Rate (%)	85.0	84.5	Feb-24	☒	?			S
Did Not Attend (%)	7.0	7.7	May-24	☒	F			C
Outpatients (% of 19/20)	103.0	110.0	May-24	☑	?		-	S
Inpatients (% of 19/20)	103.0	92.0	May-24	☒	?		-	S
Daycases (% of 19/20)	103.0	104.0	May-24	☑	?		-	S
Length of Stay over 7 days	-	168	May-24	-	-		-	S
Mean Length of Stay (Non-elective)	-	5.2	May-24	-	-			S
Mean Length of Stay (Elective excluding Daycases)	-	2.5	May-24	-	-			S
Discharged before 5pm (%)	70.0	63.5	May-24	☒	F		-	C

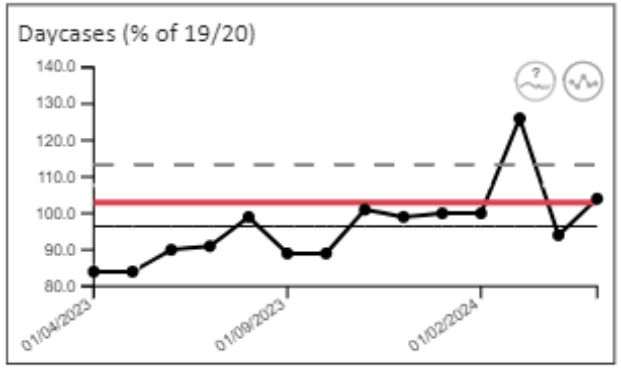
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

Subtheme: Theatres

Data, Context and Explanation







•National planning guidance has set a trajectory of 85% capped theatre utilisation (operating time of planned theatre sessions)

•Consistent issues with capped utilisation

•Day case rate has steadily increased with more cases being seen as day cases. This has a positive impact on the organisation as there is less reliance on bed base. Recovery is quicker and safer for patents.

•Significant increase in month for day case rates, this has however increased in conversion rates at times.

Metric	Value	Target	Exec Lead	Ops Lead
Capped Theatres Utilisation (%)	79.0	85.0	Sally Kilgariff	Jodie Roberts
Model Hospital Daycase Rate (%)	84.5	85.0	Sally Kilgariff	Jodie Roberts
Daycases (% of 19/20)	104.0	103.0	Sally Kilgariff	Jodie Roberts

What actions are planned?

•New schedulers starting in role will be trained and developed to ensure theatres are booked in advance by the end of June 2024.
•Theatre booking tool will be further developed in Q2 and utilised in some specialities.
•Increased pre-op assessment sessions to support scheduling and utilisation following 6-4-2 principles and ensuring we are booking out to 6 week

What is the expected impact?

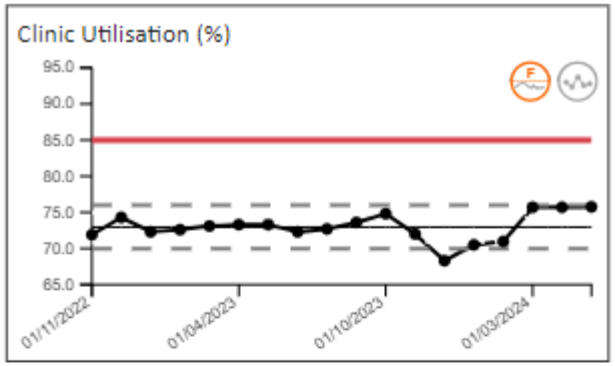
- Improved capped theatre utilisation
- Improved overall usage of theatres
- Increase in use of day cases theatres
- Increased activity levels

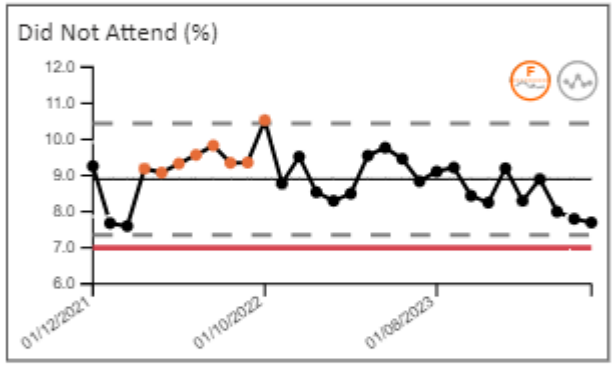
Potential risks to improvement?

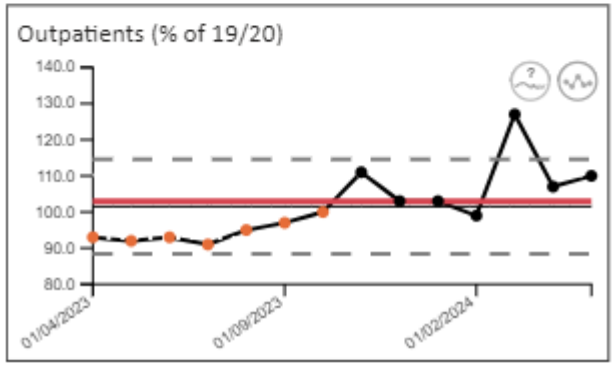
- Aesthetic gaps
- Industrial Action
- Capacity to deliver pre-op assessment
- Capacity in day case theatres as utilisation already high

Subtheme: Outpatients

Data, Context and Explanation







•Outpatient productivity provides the organisation with the greatest opportunity to increase activity levels and improve outcomes for patients

•DNA rates are set nationally and as a trust need to focus on reducing the variability and meeting the needs of our local population when attending for OP appointments

•Activity delivery is key to ensuring patients are seen and treatment/discharge decisions are made in a timely manner, increasing activity levels supports the reduction in our waiting lists and RTT

•Utilisation is key to productivity and under utilised clinics is a key focus for the trust this year

•The Further Faster programme (GIRFT) supports each speciality in a addressing their own specific productivity challenges in relation to outpatients

Metric	Value	Target	Exec Lead	Ops Lead
Clinic Utilisation (%)	75.8	85.0	Sally Kilgariff	Jodie Roberts
Did Not Attend (%)	7.7	7.0	Sally Kilgariff	Jodie Roberts
Outpatients (% of 19/20)	110.0	103.0	Sally Kilgariff	Jodie Roberts

What actions are planned?

••Increased capacity to deliver first outpatient appointments across numerous specialities to support activity levels
••Dedicated meetings between specialities and the contact centre weekly to ensure clinics are fully booked
••Contact centre working with specialities to ensure cancellations are backfilled

What is the expected impact?

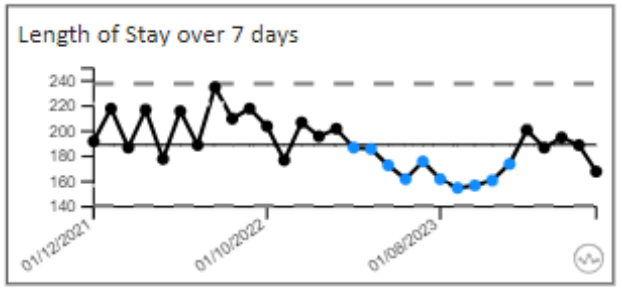
•Increase in clinic utilisation by 5% in month by Q2
•Reduction in patients that DNA by Q2

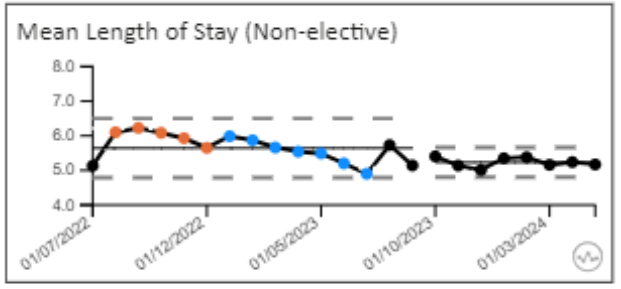
Potential risks to improvement?

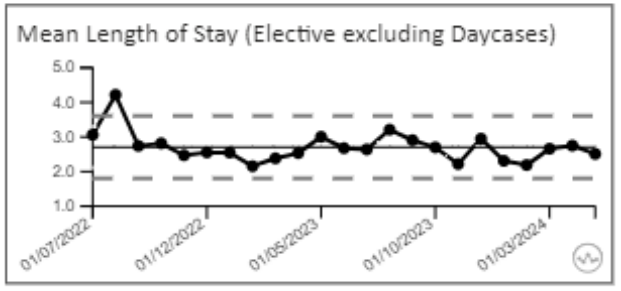
•Capacity in the contact centre to ensure that clinics are filled and any cancellations are back filled
•Consultants' workforce absence
•Patient availability
•Industrial Action

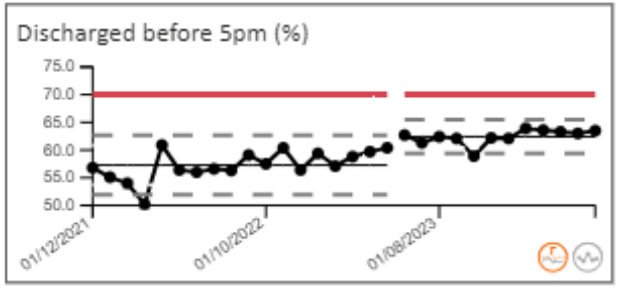
Subtheme: Inpatients

Data, Context and Explanation









- Long length of stay is often associated with deconditioning and poorer outcomes for patients. A focus on length of stay at 7 days is an opportunity to get patients to the right place and follow the home first approach.
- Length of stay at 7 days + has risen over the winter months
- A focus on medical length of stay is imperative to support the gaining population and identifying any challenges with onwards care needs
- Average length of stay for NEL patients has remained pretty stable
- Discharging people home at an appropriate time of day support people in their recovering and in providing a positive patients experience
- Support in the trust ambition of back to balance in 2 years
- Support flow though the system and care in the right place at the right time
- Support delivery of urgent care metrics

Metric	Value	Target	Exec Lead	Ops Lead
Length of Stay over 7 days	168	-	Sally Kilgariff	Jodie Roberts
Mean Length of Stay (Non-elective)	5.2	-	Sally Kilgariff	Jodie Roberts
Mean Length of Stay (Elective excluding Daycases)	2.5	-	Sally Kilgariff	Jodie Roberts
Discharged before 5pm (%)	63.5	70.0	Sally Kilgariff	Jodie Roberts

What actions are planned?

- Increase daily numbers through the discharge lounge by 10% to support discharge before 5pm
- Review patients on LOS reviews that are 5 days+
- Increase medical support to LOS reviews

What is the expected impact?

- Increase number of patients discharged before 5pm- improving flow throughout the trust and supporting 4 hour performance by Q2
- Decrease number of patients that have been in the trust with a LOS over 7 days by Q2
- Reduction in overall LOS in NEL and Elective care by Q2

Potential risks to improvement?

- Increased complexity of patients and a reliance on care in the community
- Increased number of beds open to deal with demand and thorough discharge planning
- Ability for the discharge lounge to manage significant increase in numbers and transport to support earlier discharge (peaks and toughs in demand)

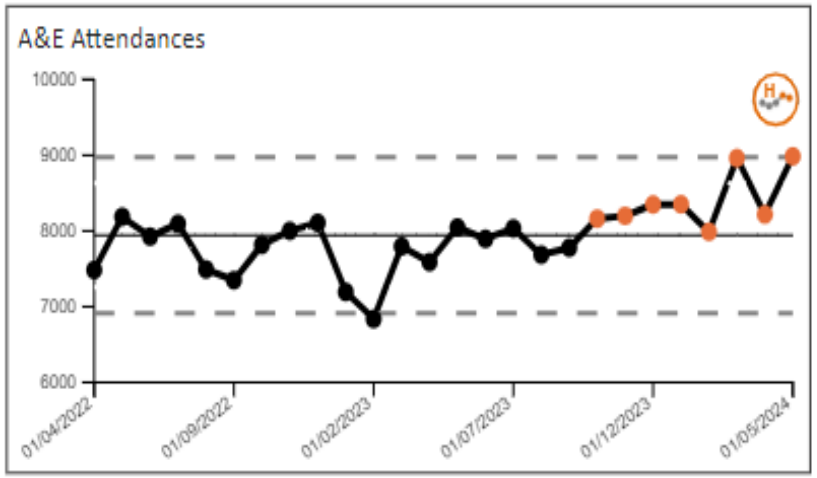
Activity

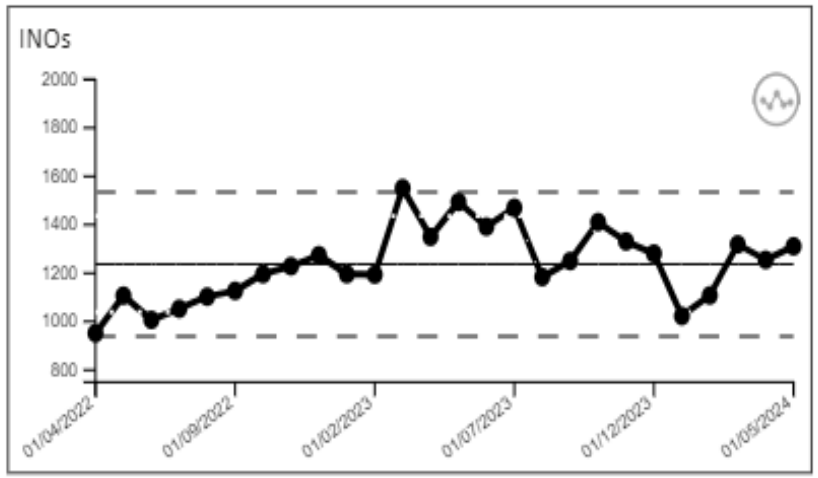
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
A&E Attendances	-	8,985	May-24	-	-		-	C
INOs	-	1,311	May-24	-	-		-	S
NE Inpatients (exc obs)	-	3,775	May-24	-	-		-	S
New Outpatients	-	7,068	May-24	-	-		-	S
Follow Up Outpatients	-	16,541	May-24	-	-		-	S
Daycases	-	2,234	May-24	-	-		-	S
Inpatients - Electives	-	388	May-24	-	-		-	S
Referrals	-	8,547	May-24	-	-		-	S
2ww Referrals	-	1,179	May-24	-	-		-	S

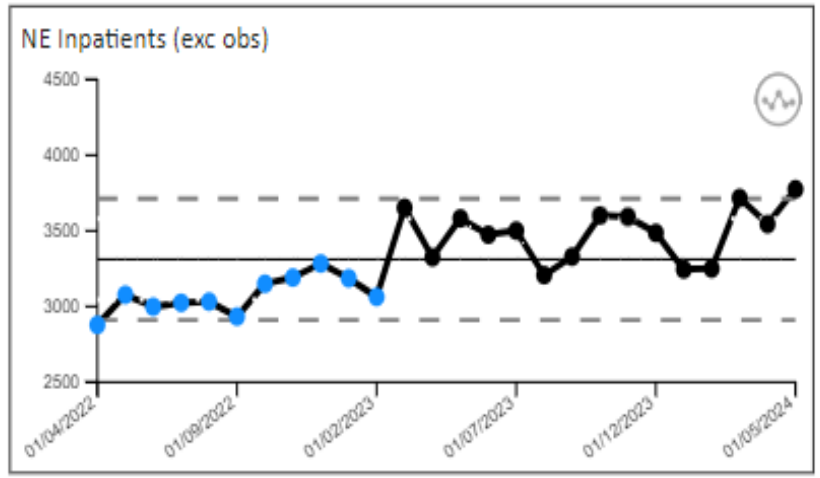
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

Subtheme: Non-Elective Activity

Metric	Value	Target	Exec Lead	Ops Lead
A&E Attendances	8,985	-	Sally Kilgariff	Sally Kilgariff
INOs	1,311	-	Sally Kilgariff	Sally Kilgariff
NE Inpatients (exc obs)	3,775	-	Sally Kilgariff	Sally Kilgariff

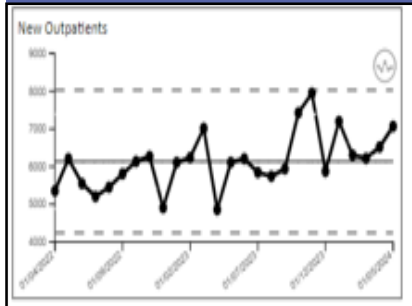


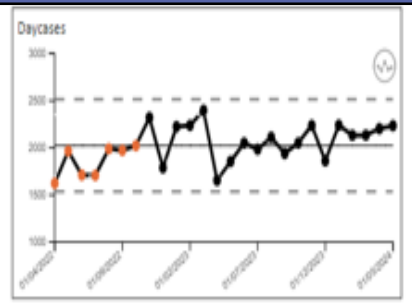


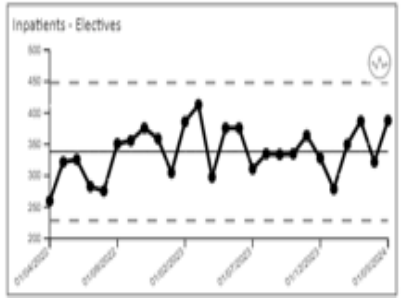


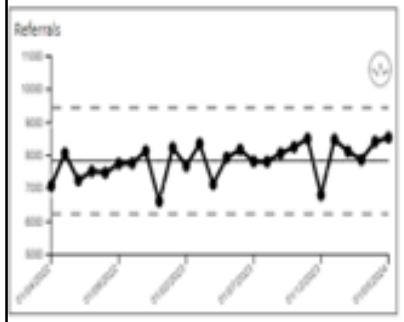
Subtheme: Elective Activity & Demand

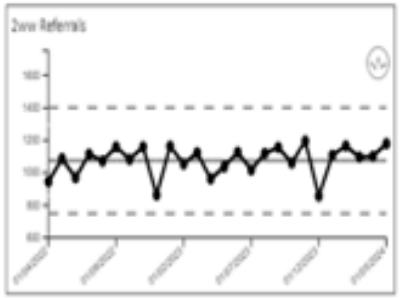
Data, Context and Explanation











- National Planning guidance sets the ERF target at 103% of 19/20 levels (based on month 12 freeze position)
- ERF operates on a cost and volume basis for Daycases, Elective, New Outpatients and Outpatient Procedures
- Outpatient follow Ups are excluded from ERF
- Providers will be paid in line with performance against the ERF metrics (as stated above) – financial under performance against targets will be recovered by Commissioners, over performance will be paid to Providers
- NHSE have shared ERF high level profiles by Provider and internal 24/25 plans have been aligned to the national expectation
- National ERF guidance excludes some Treatment Function Codes (TFC) and Healthcare Resource Groups (HRG) – these have been applied to the internal ERF targets
- The plan has been fully validated and shared with Care Groups
- Activity performance is reviewed in detail at monthly Contract Compliance meetings with recovery plans agreed at Elective Recovery meetings (chaired by the Chief Operating Officer)

Metric	Value	Target	Exec Lead	Ops Lead
New Outpatients	7,068	-	Sally Kilgariff	Sally Kilgariff
Follow Up Outpatients	16,541	-	Sally Kilgariff	Sally Kilgariff
Daycases	2,234	-	Sally Kilgariff	Sally Kilgariff
Inpatients - Electives	388	-	Sally Kilgariff	Sally Kilgariff
Referrals	8,547	-	Sally Kilgariff	Sally Kilgariff
2ww Referrals	1,179	-	Sally Kilgariff	Sally Kilgariff

What actions are planned?

- Additional internal sessions to increase OPFA and Elective/Daycase activity
- Continuation of existing insourcing schemes (Dermatology, Ophthalmology, OMFS) and exploring further insourcing /outsourcing opportunities
- Identified activity recording issues being addressed to ensure correct activity mapping and appropriate income is being recognised in ERF

What is the expected impact?

- Internal additional sessions and insourcing/outsourcing schemes will support delivery of 103% ERF target and contribute to improving the income position
- Correction of activity recording issues will ensure activity is correctly aligned and the appropriate income is received

Potential risks to improvement?

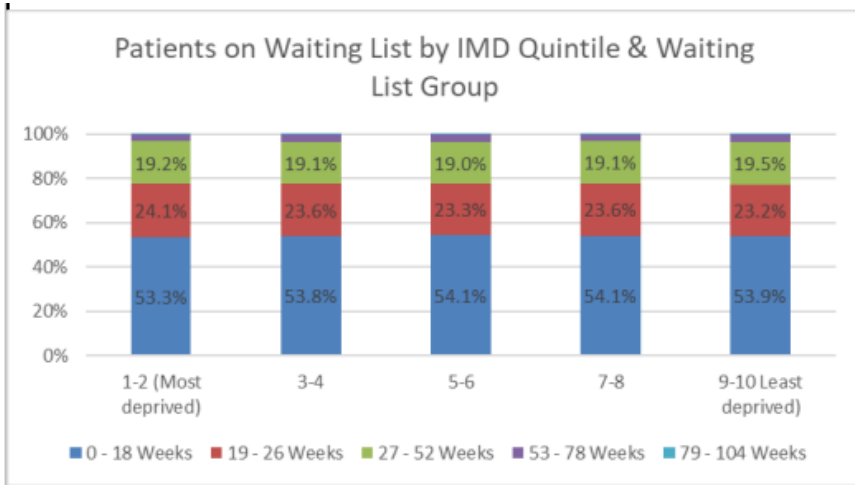
- Internal workforce availability (consultant and wider) to support additional sessions
- Efficient utilisation of core capacity (e.g. if core lists are stood-down or consistently under utilised, any additional sessions/insourcing will be replacing that loss of activity as opposed to delivering additional capacity)
- Admin/coding capacity to support correction/backdating of recording errors

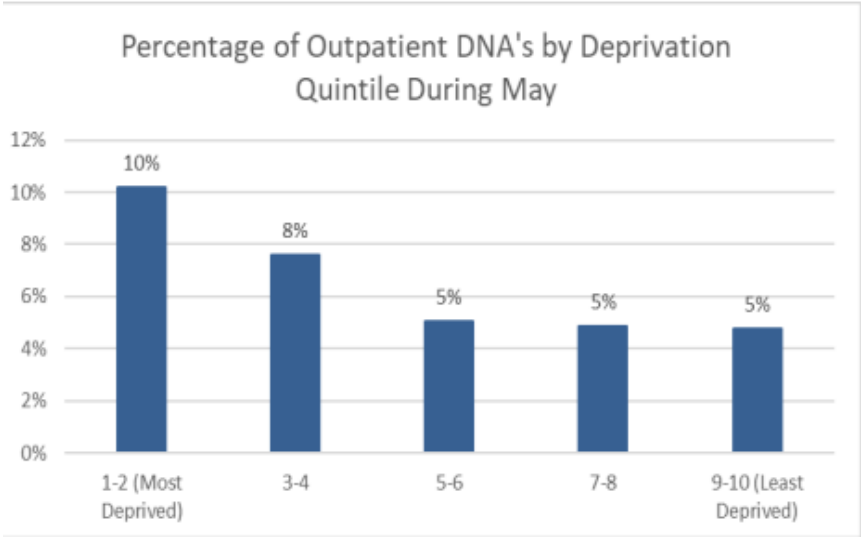
Finance

Executive Team and Senior Leaders Team - April 24 to May 24

Key Headlines	Month P £000s	Month A £000s	Month V £000s	YTD P £000s	YTD A £000s	YTD V £000s
I&E Performance (Actual)	(851)	(1,189)	(338)	(1,701)	(2,321)	(620)
I&E Performance (Control Total)	(789)	(1,127)	(338)	(1,578)	(2,198)	(620)
Efficiency Programme (CIP)	407	15	(392)	1,349	17	(1,332)
Capital Expenditure	169	169	0	309	309	0
Cash Balance	(3,715)	(1,200)	2,515	10,253	10,653	400

Health Inequalities





RTT Snapshot 26/05/24					
IMD Quintile	Patients on Waiting List	Median Wait (Wks)	% of All RTT Patients	% of Rotherham Population	% Proportion Difference to Rotherham Population
1-2	10,610	14	38.1%	36.0%	2.1%
3-4	6,642	13	23.9%	23.2%	0.6%
5-6	4,158	13	14.9%	15.2%	-0.3%
7-8	4,976	13	17.9%	19.5%	-1.6%
9-10	1,469	13	5.3%	6.0%	-0.7%
Total	**27,834**	**13**	**100.0%**	**100.0%**	**0.0%**

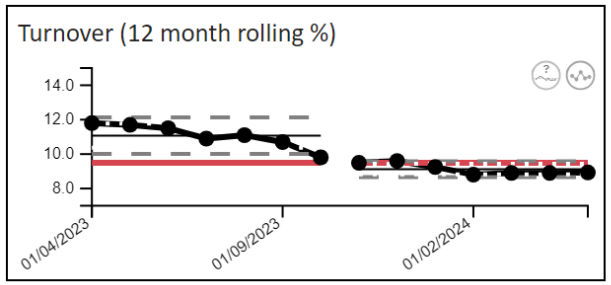
People and Culture

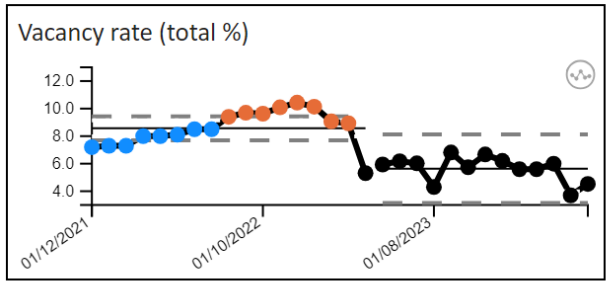
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
Turnover (12 month rolling %)	8.0-9.5	8.9	May-24	☑	?			S
Vacancy Rate (total %)	-	4.5	May-24	-	-		-	S
Sickness Rates (12 month rolling %)	4.8	5.9	May-24	☒	F		-	C
Sickness Rates (%)	4.8	5.7	May-24	☒	F			C
Appraisal Rates (12 month rolling %)	90.0	68.3	May-24	☒	F	L	-	VC
MAST – Core (%)	85.0	92.4	May-24	☑	P		-	G
MAST – Job Specific (%)	85.0	88.6	May-24	☑	P	L	-	C

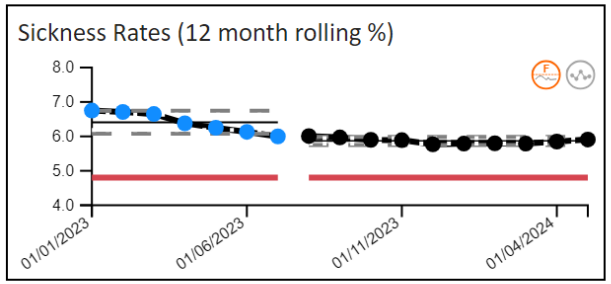
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

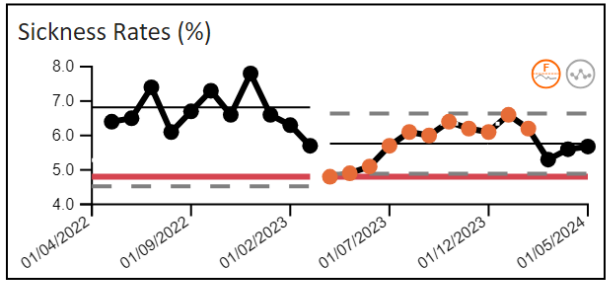
Subtheme: People

Data, Context and Explanation









Retention performance continues to be strong and in within our target range for 2024/25 of 8-9.5%. Care Groups are all within a healthy range with more detailed breakdowns provided as part of operational management information for action where appropriate.

Vacancy rate performance is a function of the relationship between retention, recruitment and establishment size, and is in a strong position.

Sickness absence rate performance is now static following improvement during 2023/24 and as a result a cause for concern. The rate of sickness absence is been driven primarily by long term sickness absence. Links between deprivation, population health and the health and wellbeing of our people are also relevant here.

Metric	Value	Target	Exec Lead	Ops Lead
Turnover (12 month rolling %)	8.9	9.5	Daniel Hartley	Paul Ferrie
Vacancy rate (total %)	4.5	-	Daniel Hartley	Paul Ferrie
Sickness Rates (12 month rolling %)	5.9	4.8	Daniel Hartley	Paul Ferrie
Sickness Rates (%)	5.7	4.8	Daniel Hartley	Paul Ferrie

What actions are planned?

- Continued emphasis on delivering our People and Culture strategy – 'We said, we did' action plans to drive engagement and improvement to maintain and strengthen retention and vacancy rate performance
- Comprehensive work on Health Wellbeing and Attendance including a full review of the Trust's approaches to this informed by; evidence based tools; best practice and audit work as per People and Culture Strategy

What is the expected impact?

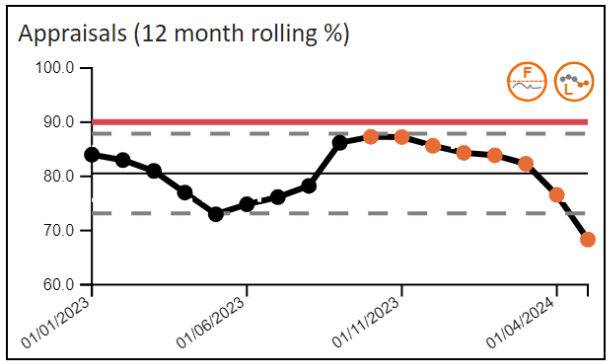
- Continued strong performance on retention and vacancy rates
- Improvement in sickness absence rates

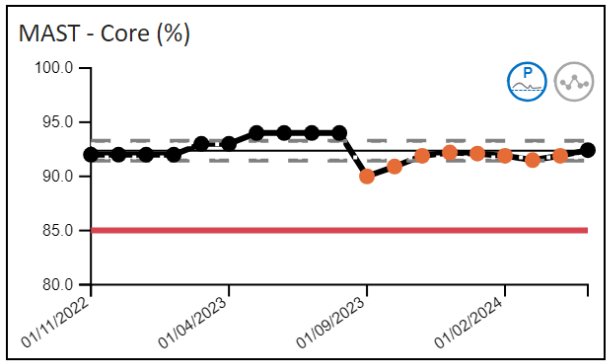
Potential risks to improvement?

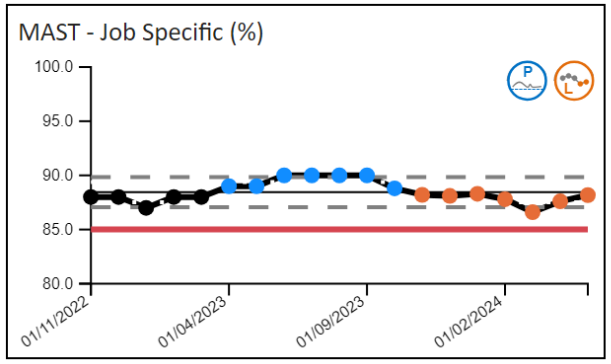
- Lack of pay award for 2024/25 to implement
- Continued dispute between junior doctors and HM government
- Increases to rate of national living wage relative to Agenda for Change Band 2 pay
- Continued impact of ill-health of staff on attendance

Subtheme: MAST & Appraisals

Data, Context and Explanation







Rolling 12 month appraisal performance has reduced markedly at the start of the new appraisal season and is 5% below this point last year. This is a function of appraisal completion rates not reaching the target in 2023/24 and a relatively slow start to the appraisal season this year.

New seasons appraisal completion rate performance is 15% with the Care Group ranges from 10% - 30%. This is a big focus for senior leaders and part of internal performance mechanisms.

MAST performance is on track with more detailed breakdowns provided as part of operational management information for action where appropriate.

Metric	Value	Target	Exec Lead	Ops Lead
Appraisals (12 month rolling %)	68.3	90.0	Daniel Hartley	Paul Ferrie
MAST - Core (%)	92.4	85.0	Daniel Hartley	Paul Ferrie
MAST - Job Specific (%)	88.2	85.0	Daniel Hartley	Paul Ferrie

What actions are planned?

Focus on continued roll out and cascade of appraisals for this year using new suite of appraisal documentation which was improved based on feedback.
Emphasis on senior leader accountability for Appraisal and MAST compliance

What is the expected impact?

Improvement in appraisal completion rates both in month and rolling 12 months
Improvement in MAST Core and Job Specific completion rates

Potential risks to improvement?

Operational pressures resulting in reduced time for proactive people management and time for Appraisals and MAST completion
Industrial action pressures resulting in reduced time for proactive people management and time for Appraisals and MAST completion

APPENDIX

Assurance

Variation/Performance

	PASS	HIT OR MISS	FAIL
H	**VERY GOOD: CELEBRATE AND LEARN** • This metric is improving. • Your aim is high numbers and you have some. • You are consistently achieving the target because the current range of performance is above the target.	**GOOD: CELEBRATE AND UNDERSTAND** • This metric is improving. • Your aim is high numbers and you have some. • Your target lies within the process limits so we know that the target may or may not be achieved.	**CONCERNING: CELEBRATE BUT TAKE ACTION** • This metric is improving. • Your aim is high numbers and you have some. • HOWEVER your target lies above the current process limits so we know that the target will not be achieved without change.
L	This metric is improving. • Your aim is low numbers and you have some. • You are consistently achieving the target because the current range of performance is below the target.	• This metric is improving. • Your aim is low numbers and you have some. • Your target lies within the process limits so we know that the target may or may not be achieved.	• This metric is improving. • Your aim is low numbers and you have some. • HOWEVER your target lies below the current process limits so we know that the target will not be achieved without change.
	GOOD: CELEBRATE AND UNDERSTAND • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • HOWEVER you are consistently achieving the target because the current range of performance exceeds the target.	**STATIC: INVESTIGATE AND UNDERSTAND** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • Your target lies within the process limits so we know that the target may or may not be achieved.	**CONCERNING: INVESTIGATE AND TAKE ACTION** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • HOWEVER your target lies outside the current process limits and the target will not be achieved without change.
H	**CONCERNING: INVESTIGATE AND UNDERSTAND** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • HOWEVER you are consistently achieving the target because the current range of performance is below the target.	**CONCERNING: INVESTIGATE AND TAKE ACTION** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • Your target lies within the process limits so we know that the target may or may not be missed.	**VERY CONCERNING: INVESTIGATE AND TAKE ACTION** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • Your target lies below the current process limits so we know that the target will not be achieved without change
L	• This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • HOWEVER you are consistently achieving the target because the current range of performance is above the target.	• This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • Your target lies within the process limits so we know that the target may or may not be missed.	• This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • Your target lies above the current process limits so we know that the target will not be achieved without change

APPENDIX: SPC Summary Icons Key

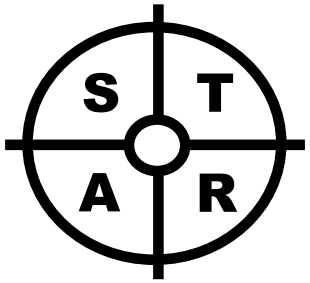
Assurance Icons

Icon	Technical Description	What does this mean?	What should we do?
	This process will consistently HIT AND MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **within** those limits then we know that the target will not be consistently achieved.	**Consider** whether this is acceptable and if not, you will need to change something in the system or process.
	This process is not capable and will consistently FAIL to meet the target if nothing changes.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the wrong direction** then you know that the target cannot be achieved.	**You need to change something in the system or process** if you want to meet the target.
	This process is capable and will consistently PASS the target if nothing changes.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the right direction** then you know that the target can be consistently achieved.	**Celebrate** the achievement. **Understand** whether this is by design and **consider** if the target is still appropriate.

Variation Icons

Icon	Technical Description	What does this mean?	What should we do?
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.	**Consider if the level/range of variation is acceptable.** If the process limits are far apart you may want to change something to reduce the variation in performance
	Special cause variation of a **CONCERNING** nature where the measure is significantly HIGHER.	**Something is going on!** Your aim is to have LOW numbers but you have some high numbers – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what is going on. Is it a one-off event that can be explained or do you need to change something?
	Special cause variation of a **CONCERNING** nature where the measure is significantly LOWER.	**Something is going on!** Your aim is to have HIGH numbers but you have some low numbers – something one-off, or a continued trend or shift of low numbers.	**Investigate** to find out what is going on. Is it a one-off event that can be explained or do you need to change something?
	Special cause variation of a **IMPROVING** nature where the measure is significantly HIGHER.	**Something good is happening!** Your aim is to have HIGH numbers and you have some – either something one-off, or a continued trend or shift of high numbers.	Find out what is going on. **Celebrate** the improvement and **share learning** with other areas.
	Special cause variation of a **IMPROVING** nature where the measure is significantly LOWER.	**Something good is happening!** Your aim is to have LOW numbers and you have some – either something one-off, or a continued trend or shift of low numbers.	Find out what is going on. **Celebrate** the improvement and **share learning** with other areas.

Data Quality STAR Key



Domain	Definition
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?
Timely and Complete	Is the data available and up to date at the time someone is attempting to use it to understand the data? Are all elements of information need present in the designated data source and no elements of need information are missing?
Audit and Accuracy	Are there processes in place for either external or internal audits of the data and how often do these occur?
Robust Systems and 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?

Metric Log

Metric	Definition	Target Type	Target Value	DQ STAR
SHMI	Ratio between the actual number of patients who die following hospitalisation and the number expected to die based on population average.	Benchmark	As Expected	
Readmissions (%)	Proportion of readmissions within 30 days from the same Treatment Function specialty back to same Treatment Function specialty.	-	-	
VTE Risk Assessments (%)	Proportion of patients eligible for VTE Screening who have had a VTE screen completed electronically as per DH and NICE guidance.	National	95.0	
Care Hours per Patient Day	The Number of Care Hours per patient day.	National	7.3	
Combined Positivity Score (%)	The Positivity Rate of all the Friends and Family tests done combined - includes IP/DC/OP/UECC/Community/Maternity/Paeds/Long Covid	National	95.0	
Complaints	The number of formal complaints received.	Local	-	
Patient Safety Incident Investigations	The number of Patient Safety Incident Investigations that take place.	Local	0	

Metric Log

Metric	Definition	Target Type	Target Value	DQ STAR
Medication Incidents	The number of recorded medication incidents	Local	-	
Pressure Ulcers (Cat 3/4/STDI and Unstageable) per 1000 bed days	The number of Pressure Ulcers (Cat 3/4/STDI and Unstageable) per 1000 bed days	Local	-	
Patient Falls	The number of Patients Falls (Moderate and Above) per 1000 bed days	Local	0	
C. difficile Infections	The number of recorded C. difficile infections	Local	0	
1:1 Care in Labour (%)	Proportion of women in established labour who receive one-to-one care from an assigned midwife.	Local	75.0	
Breast milk first feed (%)	The percentage of babies born that receive maternal or donor breast milk as their first feed	National	70.0	
Stillbirth rate (per 1000 births)	The number of still births per 1000 live births	Local	4.66	

Metric Log

Metric	Definition	Target Type	Target Value	DQ STAR
Waiting List Size	Number of patients waiting to receive a consultative, assessment, diagnosis, care or treatment activity	Local	-	
Number of 52+ Weeks	Number of patients on the incompletes waiting list for more than 65 weeks	Local	200	
Number of 65+ Weeks	Number of patients on the incompletes waiting list for more than 65 weeks	Local	37	
Referral To Treatment (%)	Proportion of patients that receive treatment in less than 18 weeks from referral	National	92.0	
OP Activity moved or Discharged to PIFU (%)	Proportion of patients moved to a Patient Initiated Follow-up Pathway following an outpatient appointment	National	3.0	
Overdue Follow-ups	Number of patients who are overdue their follow-up appointment, based on the requested time-period for the appointment made by the clinician	Local	-	
DM01 (%)	Proportion of diagnostics completed within 6 weeks of referral for 15 Key Tests	National	1.0	

Metric Log

Metric	Definition	Target Type	Target Value	DQ STAR
Faster Diagnosis Standard (%)	Proportion of patients diagnosed with cancer or informed cancer is excluded within 28 days from receipt of urgent GP referral for suspected cancer, breast symptomatic referral or urgent screening referral	National	75.0	
31 Day Treatment Standard (%)	Proportion of Patients receiving first definitive treatment for cancer within 31 days following an urgent referral for suspected cancer	National	96.0	
62 Day Treatment Standard (%)	Proportion of Patients receiving first definitive treatment for cancer within 62 days following an urgent referral for suspected cancer	National	85.0	
4 Hour Performance (%)	Proportion of Patients that have been seen and treated and left dept within 4hrs (admitted or discharged) based on Dept date.	Local	70.0	
Ambulance Handover Times <15 mins (%)	Proportion of Ambulance Handovers where the time recorded was as waiting less than 15 mins for handover.	-	-	
Ambulance Handover Times >60 mins (%)	Proportion of Ambulance Handovers where the time recorded was as waiting over 60 mins for handover.	National	0.0	
Average time to be seen by a clinician (mins)	The average time a patient waits from Arrival to being seen by a clinician in ED.	Local	60	

Metric Log

Metric	Definition	Target Type	Target Value	DQ STAR
Patients spending >12 hours in A&E from time of arrival (%)	Proportion of Patients who are in ED for longer than 12hrs from Arrival to Departure/Admission	Local	2.0	
12hr Trolley Waits	Number of patients waiting more than 12 hours after a decision to admit	National	0	
Bed Occupancy (%)	Proportion of Adult G&A beds occupied as at midnight snapshots daily as per KH03 guidance.	Local	91.6	
Criteria to Reside is No (%)	Proportion of inpatients where Criteria to Reside is no	Local	9.9	
Length of Stay over 21 Days	Snapshot of number of Inpatients with a current LOS of 21 days or more as at month end.	Local	70	
Patients where Date of Discharge = Discharge Ready Date (%)	Proportion of patients where date of discharge is same as the recorded Discharge Ready Date	Local	85.0	
A&E Attendances from Care Homes	Number of care home residents attending A&E (based on postcode)	Local	144	

Metric Log

Metric	Definition	Target Type	Target Value	DQ STAR
Admissions from Care Homes	Number of care home residents admitted (based on postcode)	Local	74	
Number of Patients on Virtual Ward	Number of patients on a virtual ward in the month	Local	80	
Urgent 2 Hour Community Response (%)	Proportion of standard Urgent 2 Hour Community Response (UCR) referrals seen within 2hrs.	Local	70.0	
Clinic Utilisation (%)	Proportion of Outpatient clinic slots that are utilised	Local	85.0	
Capped Theatres Utilisation (%)	Proportion of time spent operating in theatres, within the planned session time only.	National	85.0	
Model Hospital Daycase Rate (%)	The total number of Day Cases done on patients over 17 where the admission method is elective and the episode is "pre-planned with day surgery intent"	Local	85.0	
Did Not Attend (%)	Proportion of Outpatient clinic slots where the outcome was Did Not Attend	Local	7.0	

Metric Log

Metric	Definition	Target Type	Target Value	DQ STAR
Outpatients (% of 19/20)	In month activity compared to same month 19/20 based on number of working days.	National	103.0	
Inpatients (% of 19/20)	In month activity compared to same month 19/20 based on number of working days.	National	103.0	
Daycases (% of 19/20)	In month activity compared to same month 19/20 based on number of working days.	National	103.0	
Length of Stay over 7 days	Snapshot of number of Inpatients with a current LOS of 7 days or more as at month end.	Local	-	
Mean Length of Stay (Non-elective)	Average LOS for all discharged patients where the admission method is non-elective, 0 LOS are excluded and Observations are excluded.	Local	-	
Mean Length of Stay (Elective excluding Daycases)	Average LOS for all discharged patients where the admission method is elective, 0 LOS are excluded and Daycases are excluded.	Local	-	
Discharged before 5pm (%)	Proportion of patients discharged before 5pm - includes transfers to discharge lounge.	Local	70.0	

Integrated Performance Report Commentary

OVERVIEW

- The Integrated Performance Report now includes significant data and trend analysis. Where available, national benchmarking is provided, which in the main illustrates a number of positives that can be taken in relation to delivery and progress and also a number of areas where actions are in progress to improve the position.

- This executive summary identifies areas where action is required and is taking place. There are also a number of areas referenced where the Trust is performing well.

QUALITY SUMMARY

- Care Hours Per Patient Day (CHPPD) – Still a challenging area, although significant improvement noted in March 2023, as the Trust exited the winter pressures in 2022/23. There has been consistent performance ever since with the winter of 2023/24 achieving a higher CHPPD due to increased recruitment and retention. The Trust consistently just above 7, against a target of 7.3

- Mortality - There are 3 SHMI bandings, As Expected, Higher or Lower. The Trust's SHMI has consistently been As Expected, since July 2021. It should be noted that the Trust has recently moved away from using HSMR, which as an indicator showed vast improvement over the last three years.

- Clostridium difficile (C. diff) is a type of bacteria that can cause diarrhoea. It often affects people who have been taking antibiotics. It can usually be treated with a different type of antibiotic. The last two months have shown significantly higher than expected rates. This is reviewed monthly at Harm Free Care panels and the emerging themes link to antimicrobial stewardship and prescribing practices. Results for quarter 4 last year have just been published and indicate that the Trust is not an adverse outlier within the region, although the quarter 1 position for 2024/25 is likely to show a deterioration

- The Trust continues to have above target performance for the Friends and Family Test, with an average positivity score of 96.7

OPERATIONAL PERFORMANCE

- Elective and Cancer – There are a number of areas where there is common cause variation (no significant change). These include:
  - 52 week waits
  - 65 week waits
  - Referral to Treatment

- It should however be noted that the Trust benchmarks well for both 52 and 65 week wait patients, being in the upper quartile for both. The Trust has committed to reducing the number of patients waiting over 52 weeks by 50% by March 2025.

- With regards to positive performance, DMO1 and 62 day cancer treatment perform well, benchmarking in the upper quartile for DMO1 and the second quartile for 62 day cancer performance. As the Trust is consistently achieving the DM01standard, the ambition is to maintain performance at 99% for the full year to March 2025

- Non-elective and flow – continues to show common cause variation. A key target being for 4 hour performance with 63.9% achieved against the plan of 70% for May. It should be noted that the last three points have been above the mean which may be the start of a shift, however further data points are required There are numerous factors contributing to 4 hour performance including the time to be seen by a clinician which is currently in common cause and missing the target, however there have been improvements against this metric and efforts continue to improve in this area.

- The number of patients with a length of Stay over 21 days is in line with plan as is bed occupancy, although additional capacity is still open across the Trust.

- For May, Community metrics show that the 2hr Urgent Community Response standard is being achieved and should consistently do so. Whilst the Virtual Ward is off plan, with an average of 76 patients against a target of 80, positives can be taken from this for example there were several days where the total number of patients were in excess of this.

PEOPLE AND CULTURE SUMMARY

- Retention performance continues to be strong and in within our target range for 2024/25 of 8-9.5%.

- Vacancy rate performance is a function of the relationship between retention, recruitment and establishment size, and is in a strong position.

- Sickness absence rate performance is now static following improvement during 2023/24 and as a result a cause for concern. The rate of sickness absence is been driven primarily by long term sickness absence. Links between deprivation, population health and the health and wellbeing of our people are also relevant here.

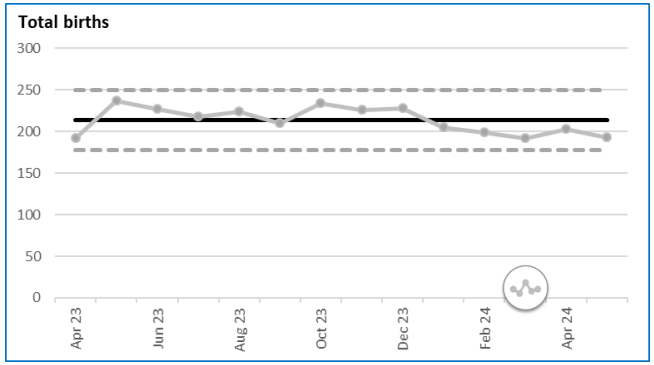
Board of Directors' Meeting
5 July 2024

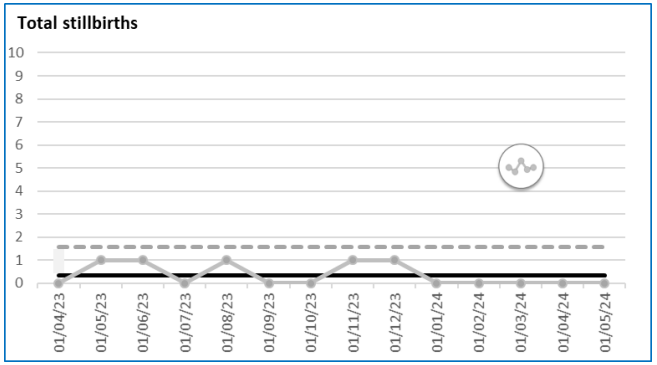
The Rotherham NHS Foundation Trust

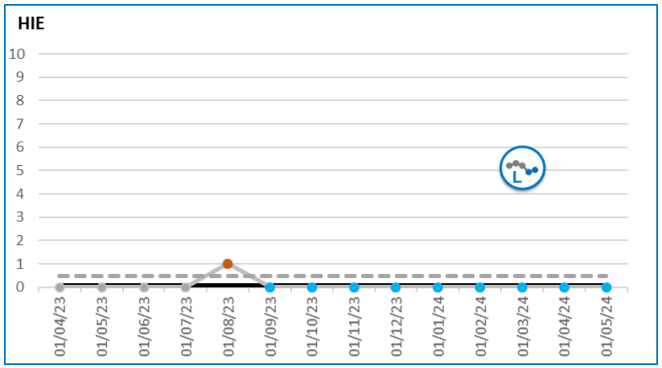
Agenda item	P112/24
Report	**Maternity and Neonatal Safety**
Executive Lead	Helen Dobson, Chief Nurse
Link with the BAF	P1: There is a risk that we will not embed quality care within the 5-year plan because of lack of resource, capacity and capability leading to poor clinical outcomes and patient experience for our patients.
How does this paper support Trust Values	High Standards for the services we deliver, aim to be outstanding, delivering excellent and safe healthcare.
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	It is a national requirement for The Board of Directors to receive a monthly update on Maternity and neonatal Safety, which goes through Quality Committee. • The Perinatal oversight maternity dashboard data is represented below in the Safety Statistical Process Control charts (SPC). There are no themes to highlight as performance remains consistent. • The Smoking data from April 2021- 2024 is highlighted in the tables below for numbers and percentages of booking and smoking for the time of delivery (SATOD). Quarter 4 data has demonstrated significant improvement in smoking rates. Quality improvements in Smoking in pregnancy (SIP) in line with the Saving Babies Lives care bundle version 3 have supported a reduction in SIP overall. The SIP service aims to build on these improvements with government funded incentives for stopping smoking which should be implemented by the end of Quarter 1. • The perinatal summary for May 2024 is highlighted in the SPC charts. There were no stillbirths to report however, there was 1 neonatal death of a 28/40 baby who was transferred to Sheffield. The total perinatal deaths including Medical Termination of Pregnancy (MTOP) and congenital abnormalities is 4.29/1000. The adjusted perinatal rate (excluding MTOP and congenital abnormalities) remains stable at 2.34/1000. With a stillbirth rate of 1.56/1000. • Multidisciplinary training data for May 2024 highlights that 90% compliance is maintained for all disciplines except for the junior doctors due to the new rotation in February 2024. There is a plan in place for all trainee doctors to have attended training by July 2024. Requirements have changed for obstetric Anaesthetists for year 6 of the Maternity incentive scheme and they are now required to complete a full day MDT training, therefore compliance is low because the full day commenced in April 24. • The All-Party Parliamentary Group on Birth Trauma (appg) report has been reviewed and benchmarked across South Yorkshire against the

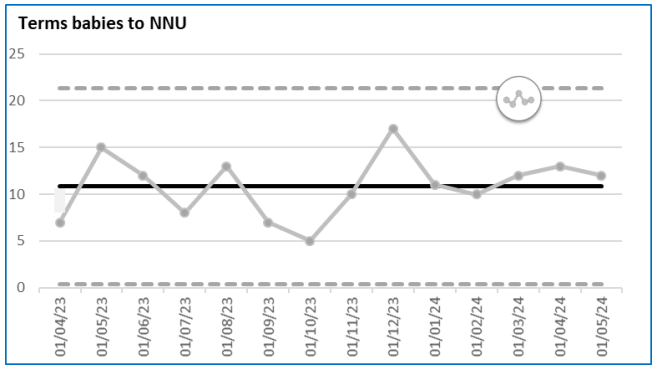
	recommendations (appendix 3), including the four commitments outlined in the letter from NHS England (appendix 2). • The action plan has been completed for the Perinatal Quadrumvirate Culture and Leadership Development Programme following the listening events and feedback sessions with staff groups (appendix 4) • The biannual staffing review is shared in appendix 5, the review highlights that maternity services meet Birth Rate Plus recommendations following the establishment review in August 2023. The Division has a challenge with Maternity leave and an over recruitment has been agreed by the Executive team of 6 WTE to support the workforce gaps. The medical and Neonatal staffing has been reviewed and the report highlights compliance with CNST year 5 for Obstetric medical and anaesthetic staffing and qualified in speciality (QIS) for neonatal nursing.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	This paper has been prepared by the Head of Midwifery and shared through Maternity and Care Group 3 Business and Governance, the Maternity and Neonatal Safety Champions and Quality Committee
Board powers to make this decision	The Trust Board are required to have oversight on the maternity safety work streams.
Who, What and When (what action is required, who is the lead and when should it be completed?)	Helen Dobson, Chief Nurse, is the Board Executive Lead. The Head of Midwifery attends Quality Committee and Trust Board bi-monthly to discuss the Maternity and Neonatal Safety agenda.
Recommendations	It is recommended that Quality Committee are assured by the perinatal Quality report for June 2024.
Appendices	The following appendices are located in the Convene Review Room: 1. MNVP Workplan 2. NHS E letter 3. Birth Trauma Report South Yorkshire benchmarking 4. Perinatal Culture and leadership action plan 5. Biannual safe staffing review

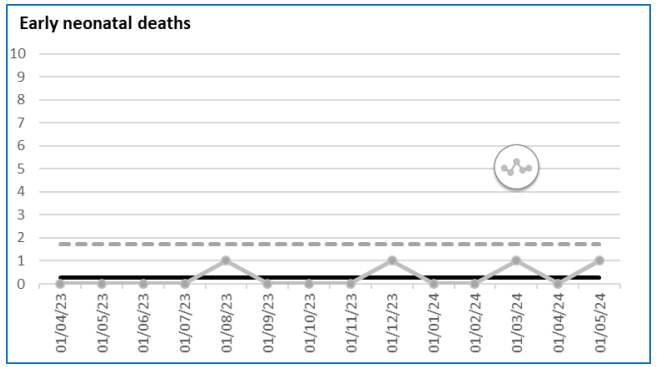
Maternity Safety Statistical Process Control charts (SPC)

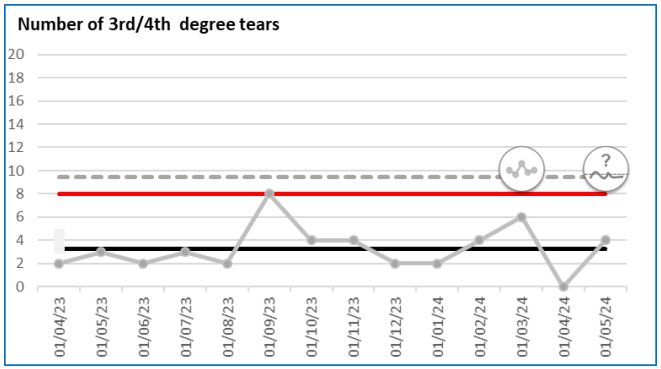


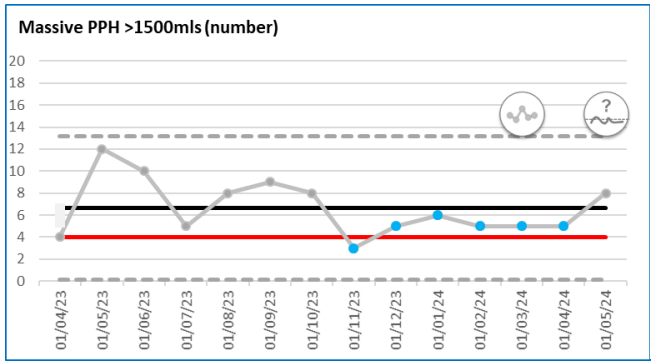


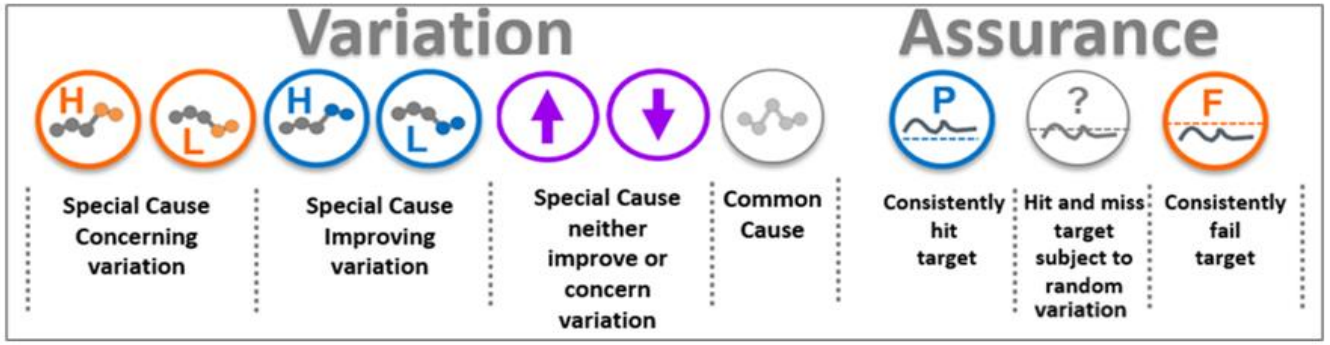






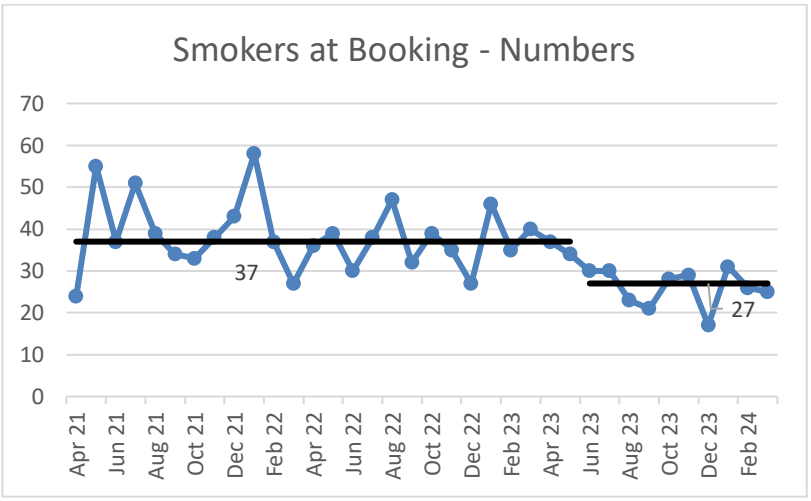


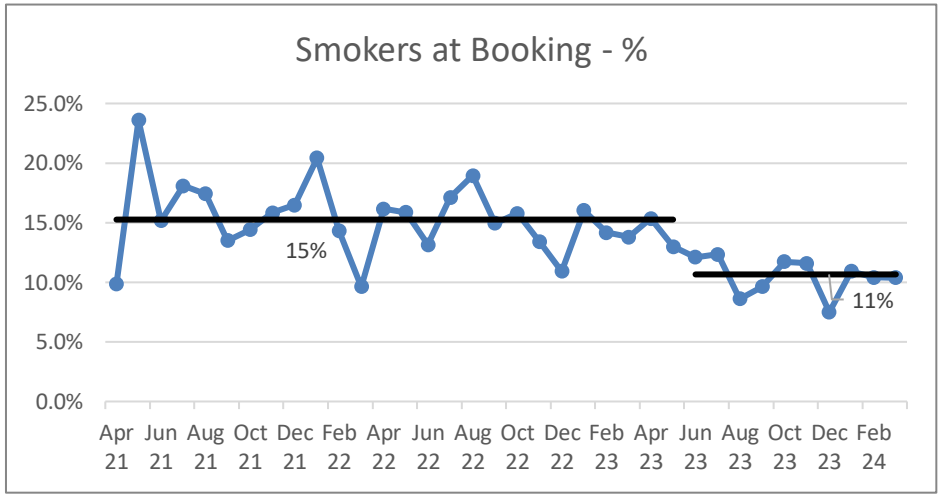




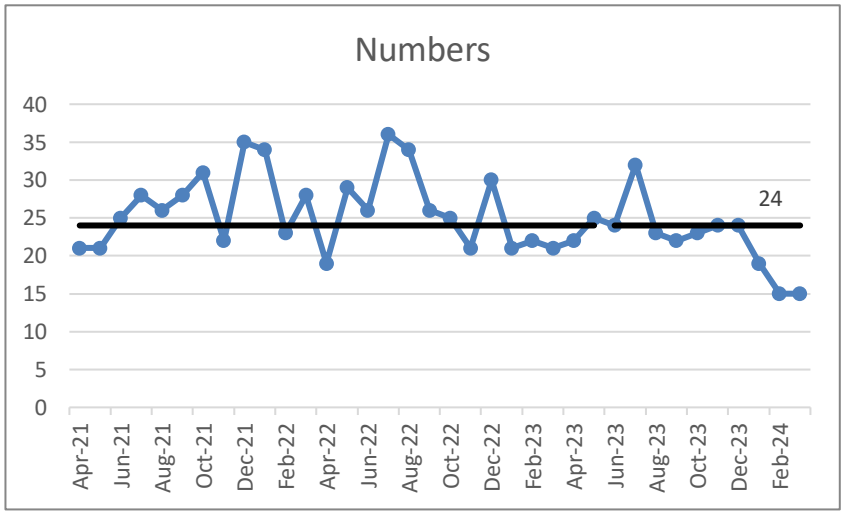
Key

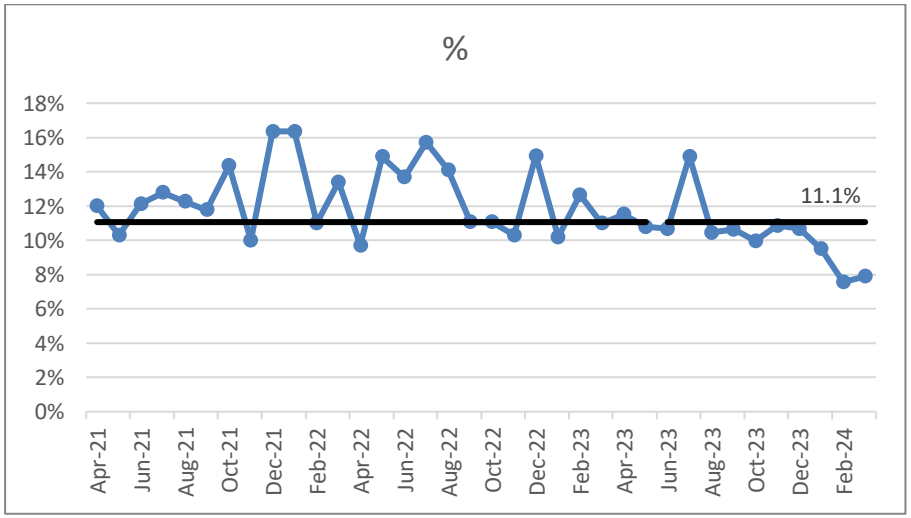
Smoking at Booking 2021-2024





Smoking at time of Delivery (SATOD 2021- 2024)





TRFT Maternity Dashboard: General

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Smoking at booking %	Apr 24	6.4%	6.0%			10.8%	5.3%	16.4%
Smoking at birth %	Apr 24	7.3%	6.0%			10.8%	6.4%	15.3%
Number of bookings	May 24	249	-			249	185	312
Booking < 13 weeks	May 24	93.2%	90.0%			90.0%	85.0%	95.0%
Booking < 10 weeks	May 24	76.3%	90.0%			71.9%	61.3%	82.5%
Personalised Care Plan	May 24	97.2%	95.0%			97.8%	94.4%	101.1%
Total Induction rate	May 24	40.8%	32.8%			34.1%	25.9%	42.3%
Augmentation IOL	May 24	49	-			42	22	62
Augmentation 1st Stage	May 24	10	-			14	-2	30
Augmentation 2nd stage	May 24	1	-			3	-2	7
Shoulder dystocia	May 24	0	2			2	-4	9
Massive PPH >1500mls (number)	May 24	8	4			7	0	13
Massive PPH >1500mls (%)	May 24	4.1%	2.0%			3.1%	0.0%	6.2%
Number of 3rd/4th degree tears	May 24	4	8			3	-3	9
3rd/4th degree tears in normal birth	May 24	2	-			2	-3	8
3rd/4th degree tears in normal birth (%)	May 24	2.1%	2.8%			2.0%	-3.3%	7.2%
3rd/4th degree tears assisted birth	May 24	2	-			1	-2	4
3rd/4th degree tears assisted birth (%)	May 24	16.6%	6.0%			5.9%	-15.6%	27.4%
Number of eclamptic fits	May 24	0	-			0	0	0
Pressure ulcers	May 24	0	-			0	-1	1
Optimal Cord Clamping	May 24	91.0%	-			90.1%	83.3%	96.9%
APGARS 0-6 @ 1 minute	May 24	12	-			11	-3	25
APGARS 7-10 @ 1 minute	May 24	181	-			201	169	234
Skin to skin	May 24	82.9%	80.0%			81.7%	70.8%	92.5%
Breastfeeding	May 24	61.0%	72.7%			59.8%	51.2%	68.4%

DATA MEASURES – REVISED PERINATAL QUALITY SURVEILLANCE TOOL

Trust:

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

Maternity Safety Support Programme	Select	No

	2024											
	Jan	**Feb**	**March**	**April**	**May**	**June**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
1.Findings of review of all perinatal deaths using the real time data monitoring tool	No immediate learning identified at the January 2024 perinatal Meeting. Cases to be closed still.	Questions raised at the review meeting, the cases are to be presented again for further discussion and review.	No perinatal mortality meeting held March 2024	Issues raised with 1 case. Thematic review of processes in triage to be undertaken	No immediate learning identified for cases presented at May perinatal mortality meeting. Some learning to be disseminated to staff via learning points.							
2. Findings of review of all cases eligible for referral to HSIB	1 case in progress. Draft report received with no safety recommendations	1 case completed. Final report shared with staff involved. Tripartite meeting to be held with family in April. No safety recommendations	No cases reported to MNSI in March	1 case referred to MNSI in April. Cat 1 section for pathological CTG. Baby has HIE.	1 case ongoing with MNSI. No new referrals in May.							
Report on: 2a. The number of incidents logged graded as moderate or above and what actions are being taken	16 recorded as moderate harm. Following MDT review 0 remained moderate harm	15 recorded as moderate harm. Following MDT review 0 remained at moderate harm	20 recorded as moderate harm. Following MDT review 0 remained at moderate harm	14 recorded as moderate harm. Following MDT review 1 remained at moderate harm	15 recorded as moderate harm. Following MDT review all were graded as low or no harm.							
2b. Training compliance for all staff groups in maternity related to the core competency framework and	All staff groups are over the required 90%	Training compliance of Obstetric	See section 12.2	90% for all disciplines with the	90% for all disciplines with the exception of junior Doctors. The new							

wider job essential training	compliance range. See point 7.0 in report.	trainees has declined to below 90% due to new rotation of trainees. Training for all other disciplines is >90%		exception of junior Doctors.	programme for obstetric Anaesthetists requires a full day MDT training from April 24							
2c. Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively	See point 12 within this report for a full break down.	No issues for escalation	See section 19	No staffing issues for escalation see Appendix 2 for Bi annual staffing report	No staffing issues for escalation see Appendix 2 for Bi annual staffing report							
3.Service User Voice Feedback	NHS CQC Maternity Survey 2024 Result, see point 5.1 within this report.	MNVP role to change over to the MNVP engagement officer from April 2024.	MNVP 15 Steps NNU	Feedback shared from MNVP facebook page for TRFT	Interim MNVP lead supporting TRFT, chairing local MNVP meeting and sharing user feedback.							
4. Staff feedback from frontline champion and walk-abouts. Executive / NED meeting with the perinatal leadership team	Walk-about and meeting feedback, see point 13 within this report.	Visit to NNU to support the team. No escalations.	No walk around meeting in March 2024	No walk around meeting in April 2024	Visit to NNU							
5.HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	Nil	Nil	Nil	Nil	Nil							
6.Coroner Reg 28 made directly to Trust	0	0	0	0	0							
7.Progress in achievement of CNST 10	Achieved	Achieved	Achieved	Achieved	Achieved							

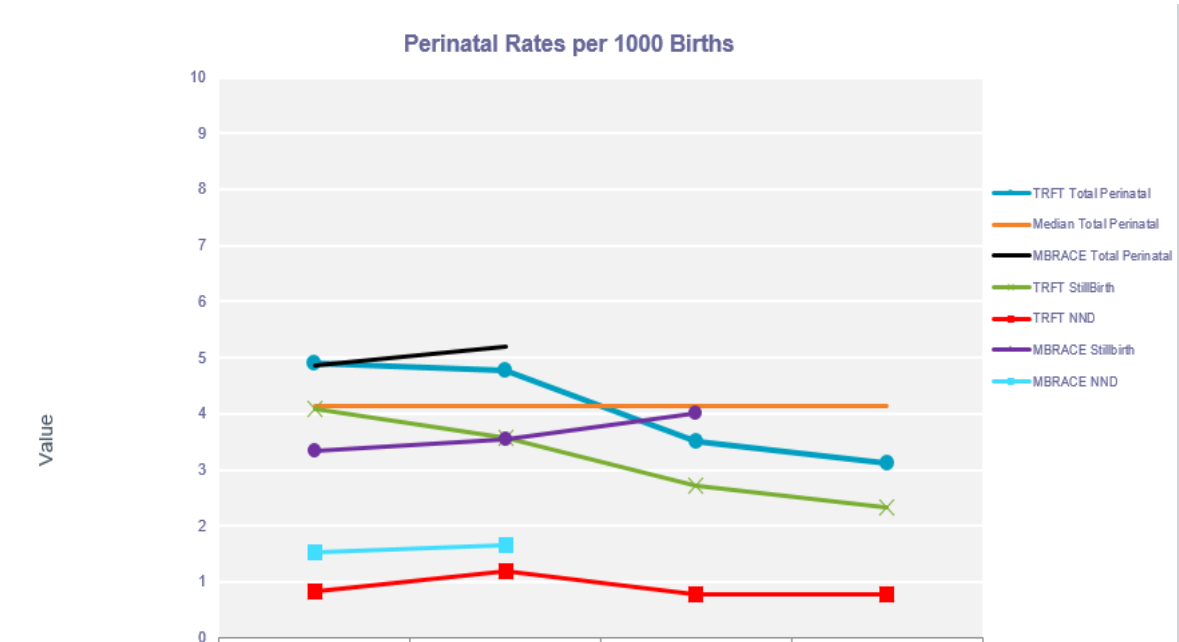
8.Proportion of midwives responding with 'Agree' or 'Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (Reported annually)	2023 results 77%
9.Proportion of speciality trainees in Obstetrics & Gynaecology responding with 'excellent' or 'good' on how they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

1 Report Overview

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

2 Perinatal Mortality Rate

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



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

Table 2.2 Total perinatal deaths

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

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

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

3 Perinatal Mortality Summary for month of May 2024

3.1 One woman chose to have a termination of pregnancy due to fetal abnormalities in May 2024 at TRFT. This case was below 22 weeks gestation therefore did not meet the criteria for PMRT. Following an in utero transfer from Bassetlaw to Rotherham, there was a neonatal death reported at day 5. Baby was born at Rotherham @ 28 weeks gestation and then transferred to Sheffield for ongoing care due to baby's condition deteriorating following extubation, this case is reportable to PMRT by Sheffield.
Table 3.1 reports perinatal data from May 2024 in comparison to the last two years data as a rolling tracker.

	2022 Total:	2023 Total:	01/01/2024 – 30/04/2024	In Month: May 2024	Information
Total Stillbirths (All)	7	6	-	-	
Stillbirths >37 weeks	1	1	-	-	
Stillbirths 24 - 36+6 weeks	6	5	-	-	
Intrapartum Stillbirths	1	-	-	-	
MTOP Anomaly >24 weeks	0	2	-	-	
Adjusted Stillbirths	7	6	0	0	
Total Neo-Natal Deaths (NND)	8	4	2	0	

ENND >24 weeks up to 7 days of life	**7**	**2**	**-**	**-**	
LNND 7-28 days	**1**	**1**	**-**	**-**	
Adjusted Neonatal Deaths – All gestation (EXCL MTOP)	**2**	**2**	**0**	**0**	
Total Adjusted Perinatal (24 wk – 28 days)	**9**	**8**	**0**	**0**	
MTOP ENND	**1**	**-**	**-**	**-**	
Stillbirth Elsewhere	**0**	**-**	**-**	**-**	
Neo-Natal Deaths Elsewhere (outside of TRFT)	**2**	**2**	**-**	**1**	**See 1 below**
Maternal Deaths	**0**	**1**	**-**	**-**	
NVF <24 weeks	**12**	**10**	**6**	**1**	**See 2 below**
NPMRT entered	**12**	**10**	**2**	**0**	
NPMRT Closed	**14**	**10**	**2**	**3**	

Table 3.1

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

Perinatal mortality All deaths (including congenital anomalies) Total perinatal **4.29/1000 births**		
Type of death	Number	Rate per 1000 births
Stillbirth	5 (incl MTOP)	1.95
Neonatal death	6	2.34

Adjusted Perinatal Mortality (excludes deaths due to congenital anomalies and MTOP) Adjusted Total Perinatal **2.34/1000 births**		
Type of death	Number	Rate per 1000 births
Stillbirth	4	1.56
Neonatal Death	2	0.78

4 PMRT real time data monitoring tool

4.1 In Jan 2024 –May 2024, 7 new PMRT cases were closed and the reports published.

4.2 Other summary findings of note were;

- All pregnancies identified as being intrauterine growth restricted (IUGR) in this period were managed appropriately prenatally.
- Parental perspective of care were sought and considered in the review process in 100% of cases.
- Communication issues – different providers and family, management of expectations. Case to be presented at ODN meeting.

5 Learning from PMRT reviews

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

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

6.1 Since the commencement of HSIB maternity investigations in 2018, TRFT have reported 21 cases for external review. Of the 21 cases, 8 were rejected, leaving 12 cases progressing to a full external investigation. 12 cases have been completed to date. One case is ongoing for a baby having seizures at 36 hours of age and abnormal head CT and MRI.

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

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

Table 6.1

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

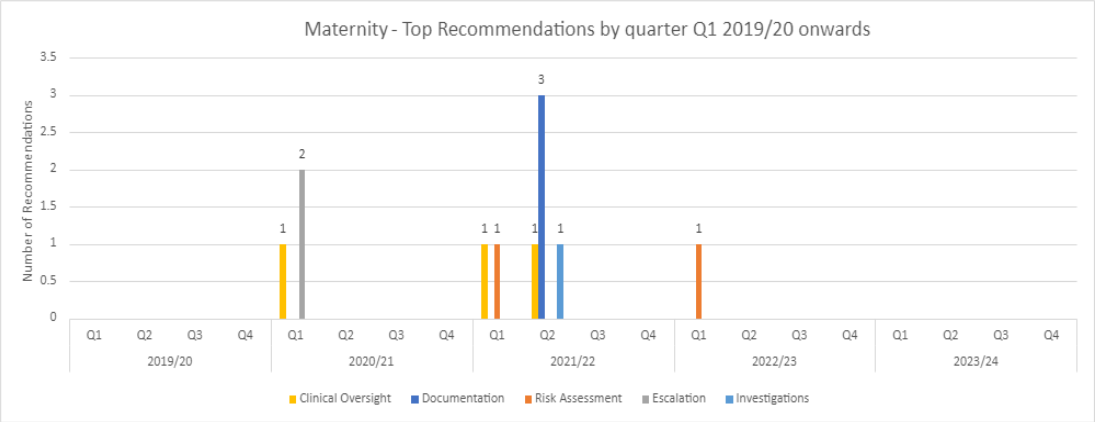


Table 6.3

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

Ref	MNSI Reference	Confirmed level of investigation	Date confirmed Investigation	Incident overview	Progress
2023/16751	N/A	PSII	04/09/2023	Missed third degree tear following instrumental birth	Presented to sign off panel 10/04/2024
164265	N/A	PSII	08/01/2024	28+5 day neonatal death.	Draft shared with staff and family.
167978	MI-037282	MNSI investigation	22/04/2024	Pathological CTG. Seizures at 36 hours old with abnormal head CT and MRI.	Interviews currently being conducted with staff
168816	N/A	PSII	17/04/2024	29 day old baby bought into UECC in cardiac arrest.	PSII in progress. Draft due 01/07/2024

Table 7.1.

8 Coroner Reg 28 made directly to Trust

TRFT Maternity have no Coroner Regulation 28 orders.

9 Maternity Patient Safety Investigations and After Action Reviews

9.1 During the month of April there were two maternity patient safety investigations declared. One has now progressed to an MNSI investigation, and one is a joint PSII with CYPS for a 29 day old infant death.

9.2 There has been one After Action Review declared in the month of May 2024. This was for a patient who had an elective LSCS and required a return to theatre the following day with an intra-abdominal bleeding resulting in a Massive Obstetric Haemorrhage of 2 litres. This harm was not graded as a moderate as there was no harm to the mother however, it was felt that a review was needed to highlight learning and good practice.

10 Midwifery Continuity of Care (MCOC)

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

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

11 Three-year delivery plan for maternity and neonatal services

11.1 Below is an update on the 3 Year Delivery plan for Maternity and Neonatal services for May 2024.
Listening to women

- The MNVP engagement lead has been appointed for TRFT. This is an employed role supported by the LMNS.
- In May 2024 there were 2 complaints for Maternity services, one regarding a data breach and the patient's handheld maternity record and the other regarding care in labour and a wound infection. There was one complaint for Neonates regarding missed opportunities to diagnose hip dysplasia. This has been reported through harm free panel recommending further investigation following the complaint meeting and investigation.
-
- The Rotherham MNVP continues to run Bright Stars group in Rotherham supporting women and people postnatally, providing feedback to Maternity services on availability of tongue tie clinics for women and families in Rotherham. This is currently an area of focus for the infant Feeding Team.
- The South Yorkshire MNVP group are working on a project informing

women on choices around place of birth. The format for this is a story board which will be available digitally around best place of birth for their baby at various gestations. This will be available in the top 5 languages across South Yorkshire.

- The MNVP workplan priorities have been developed which include the actions for TRFT following the 2023 CQC Maternity survey results (Appendix1). Actions include improvements to discharge process and induction of labour. Workshops have commenced to improve women's experience and to ensure that they are informed on the options available.

11.2 On 9th January 2024, the All-Party Parliamentary Group (appg) on Birth Trauma established the first national inquiry in the UK Parliament to investigate the reasons for birth trauma and to develop policy recommendations to reduce the rate of birth trauma. The Inquiry received 1,300 submissions from people who experienced traumatic birth, as well as nearly 100 submissions from maternity professionals. It also held seven evidence sessions, in which testimony from both parents and experts, including maternity professionals and academics, was heard. The findings were published in May 2024.

11.3 NHS England wrote to all trusts (Appendix 2) on the 17th May following publication of the appg's report on Birth Trauma highlighting that the implementation of the Three-Year Delivery Plan for Maternity and Neonatal Services was a requirement of the operational planning guidance for 2024/25. In addition, they requested that Trust boards review the commissioning and implementation of existing commitments for which they have received funding for implementation in 23/24, and which will help address recommendations in the appg Birth Trauma report.

These commitments are:

- **Perinatal pelvic health services, in line with the national service specification**
- **Maternal mental health services, in line with national guidance**
- **Availability of bereavement services 7 days a week**
- **LMNS equity and equality action plans, working across organisational boundaries**

11.4 Appendix 3 provides the South Yorkshire response to the existing commitments and the benchmarking against the twelve recommendations from the Birth Trauma report.

12 Developing our workforce

The Maternity service has recruited 6 WTE Early career midwives to support maternity leave and predicted gaps based on the last 6 months turnover. It is anticipated that this will reduce NHSP spend once the new starters commence in post. The leadership team continue to hold monthly roster meetings to ensure that there is a grip on absence, NHSP usage and unfilled shift rates in the Care Group.

13 Developing a Safety Culture

The action plan has been completed for the Perinatal Quadrumvirate Culture and Leadership Development Programme following the listening events and feedback sessions with staff groups. The action plan has been produced in consultation with anaesthetic colleagues and Director of Health informatics (Appendix 4).

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

14.1 The Division continues to work towards the three-year core curriculum local training plan, which has had input from service users (MNVP), and has been informed through learning from themes and trends from incidents and investigations. Year Six Maternity incentive scheme (MIS 6) guidance published on 2nd April 2024 requires 90% attendance of the relevant staff groups at:

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

14.2 Table 14.2 represents the current training compliance for May 2024, the reason for compliance been low for trainees has been due to the new rotation. MIS 6- launched April 24, Anaesthetists are now separated into non-Obstetric roster and Obstetric roster contributing staff. Anaesthetists contributing to Obstetric roster must attend all day of PROMPT. The non obstetric rostered staff who only do occasional on call are required for this MIS 6 year to attend the half day simulation day and the accepted target is 70%.

	Obstetric Consultants	Obstetric Registrars (ST3-7)	Obstetric Trainees (ST1-2)	Midwives (All bands)	NHSP Midwives	Clinical Support staff	Obs Anaes	Non Obs Anaes
PROMT	92%	100%	56%	93%	100%	89%	8%	79%
Core Competency Day (Modules 1/4/5/6)	92%	100%	56%	94%	100%	92%	N/A	N/A
Fetal Monitoring	92%	90%	100% - (Career SHO only)	96%	96%	N/A	N/A	N/A
Newborn life support Ob's and Maternity	92%	100%	56%	93%	100%	92%	N/A	N/A
Newborn life support Paeds and nurses.	Paediatric consultants 91%	N/A	N/A	Neonatal Nurses 97.5%	N/A	N/A	N/A	N/A

Table 14.2

15 Safety Champions meetings

15.1 In May 2024 there was a Safety champion walk around visiting the neonatal unit (NNU). The Executive Safety Champion thanked the teams for their continued challenging work and the teams had an opportunity to share what worked well in the unit as the new environment has improved both patient and staff experience.

15.2 An escalation to the Safety Champions has been the issues highlighted by the sampling of the water supply on the NNU. The unit was sampled for Pseudomonas A, legionella and TVC's just prior to opening, so precautionary water filters were installed while the patients and staff moved back, and results were pending. When the results were made available, they showed high Total Viable Count (TVC) across the unit and three positive Pseudomonas. Regular meetings are in place to track process in possible sources of the contamination. Taps and pipework have been sent to a Laboratory in Hertfordshire for analysis. These have come back indicating high counts of both TVC's and Pseudomonas type (nonspecific). An external Consultant has been commissioned to collaborate with the team at TRFT as at present the current actions have not produced the results required. Staff in NNU are required to run all taps 6 times a day to flush the system.

16 Concerns raised by service users

The interim Chair for the MNVP Hayley McGovern is attending the Safety Champion meetings and no service user concerns have been shared.

17 Culture/SCORE survey findings

Please refer to section 13.

18 Saving Babies Lives V3

18.1 In March 2024, the LMNS undertook an assurance review of Rotherham maternity services to assess our progression towards fully implanting the Saving Babies Lives Version 3 care bundle. The previous score awarded to TRFT's implementation was 89% compliant (see table 18.1). The next assurance review visit is on the 27th of June 2024 where further progress will be discussed with the LMNS team. Year 6 CNST requirements now stipulates that Trusts must clearly show progression at each LMNS visit.

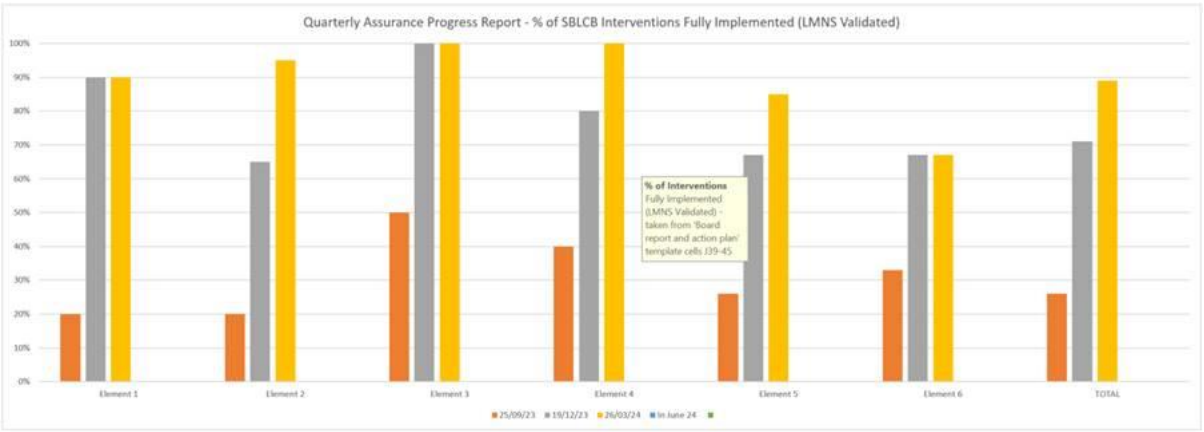


Table 18.1

18.2 Work still to be completed to demonstrate 100% compliance includes.

- **Smoking element 1**: Training for all staff undertaking the VBA e-learning. Progression has been made from the previous assessment by the LMNS.
- **Pre-term birth, Element 5**: Work is progressing to ensure that the medical team have job plans that reflect the work that is currently taking place. As a team we are considering if the Ockenden funding will allow for job plans to be put in place.
- Pre-term interventions and pre-term birth rate: Both aspects demonstrate improvement, we will seek to be made fully compliant at the next review meeting, see table 18.2.
- **Management of Diabetes, Element 6**: The requirement is to have a diabetic nurse specialist available at antenatal clinics. Whilst this role has been advertised, the community nursing services have been unable to recruit into the role.

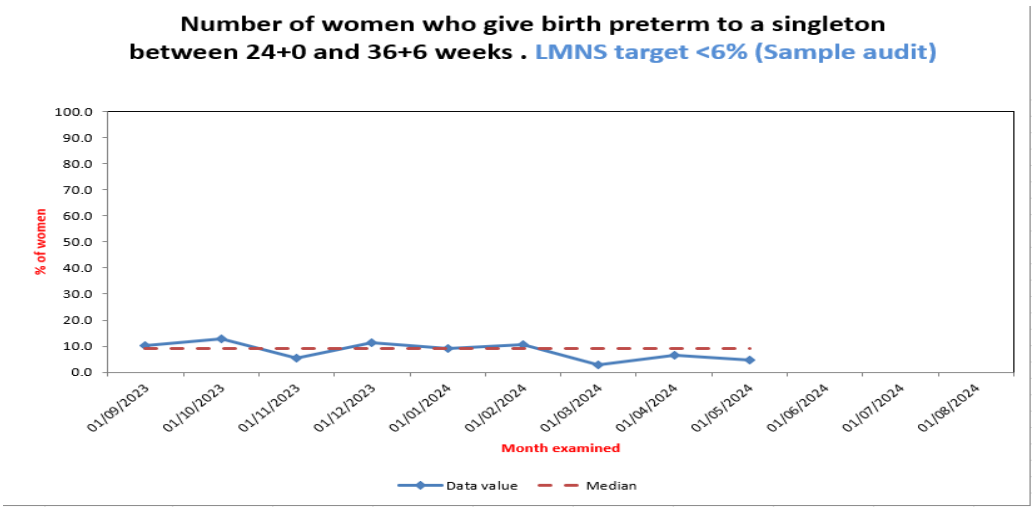


Table 18.2

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

19.1 TRFT have received confirmation regarding the payment received for achieving the MIS year 5 a total of £440254.01, including a share of the payment for Trusts that did not achieve the standards. Work continues with

year 6 MIS and progress continues with the ten safety actions. The service is awaiting confirmation of the Non-Executive Safety Champion for Safety Action 9.

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

20.1 The tables below highlight the number of women who suffered a moderate harm in the month of May 2024. Table 20.1 shows that in May there were fifteen incidents that were recorded as a moderate harm and the categories. All cases have been examined at the Maternity Weekly Datix meeting by a senior MDT. Following MDT review all 15 were downgraded as care was found to have been appropriate and harm rating reduced to low or no harm. Regardless of the outcomes from the MDT reviews, deprivation scores have been collected for this group (Table 20.2) and show that for May, poorer outcomes were sustained by the women who live in the poorest areas of Rotherham. In Table 20.3, the cumulative data collected since November 2023, the theme of high deprivation and an increased level of harm can be identified. This correlates with the most recent IMD data which highlights that 19.5% of residents in Rotherham are living within the most deprived 10% of England. This data supports the work that is ongoing in the LMNS and locally at Rotherham to reduce health inequalities for the most deprived. The work to reduce smoking in pregnancy is an example of the improvements made. However, there remains more work and improvement to support public health priorities.

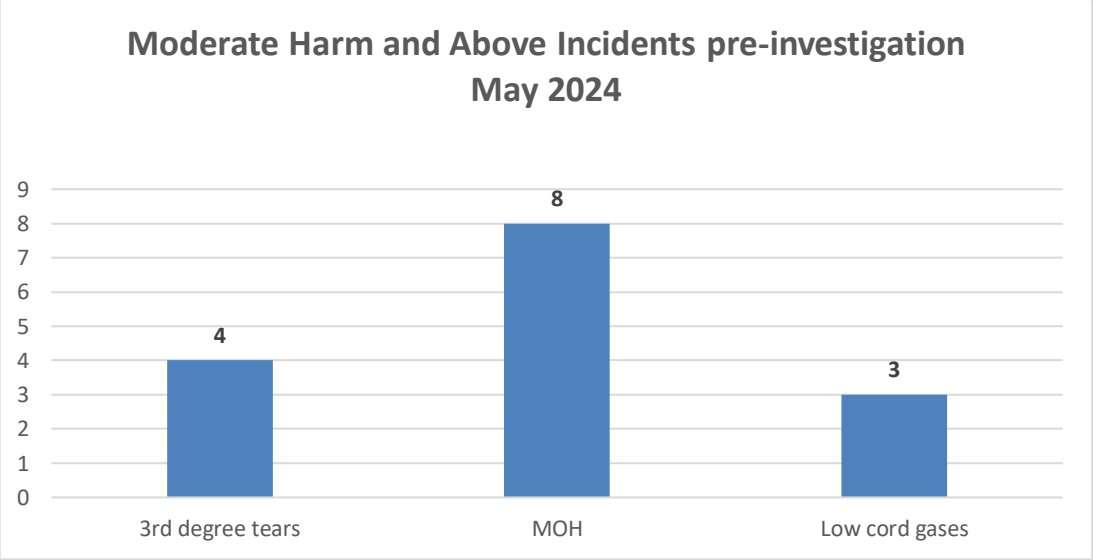


Table 20.1

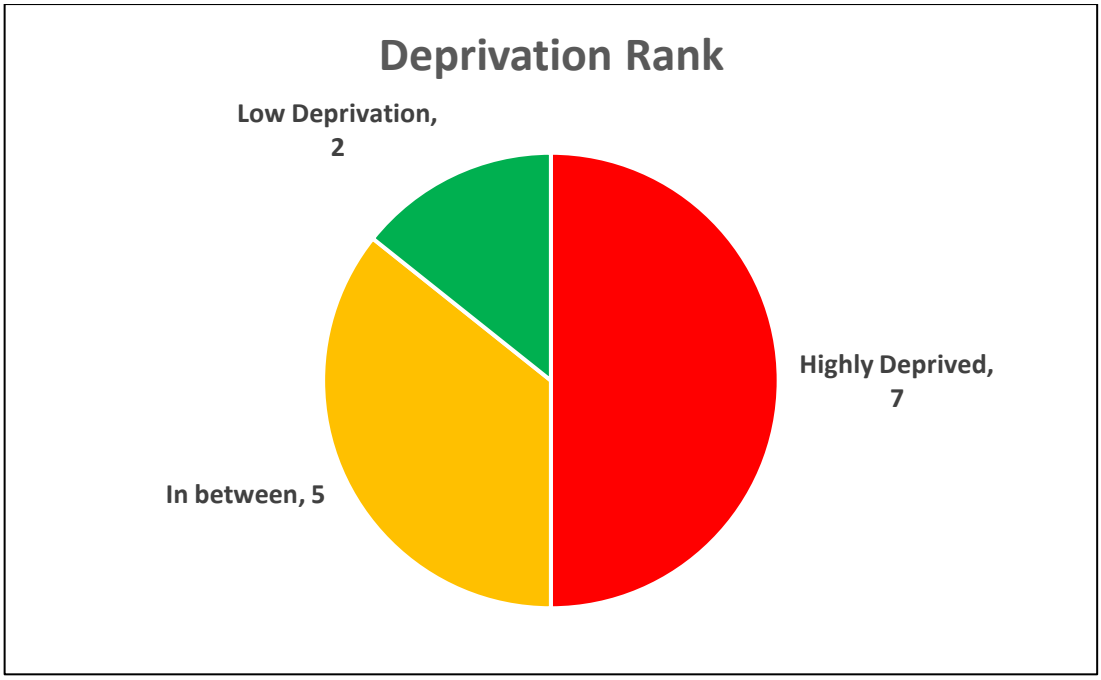


Table 20.2

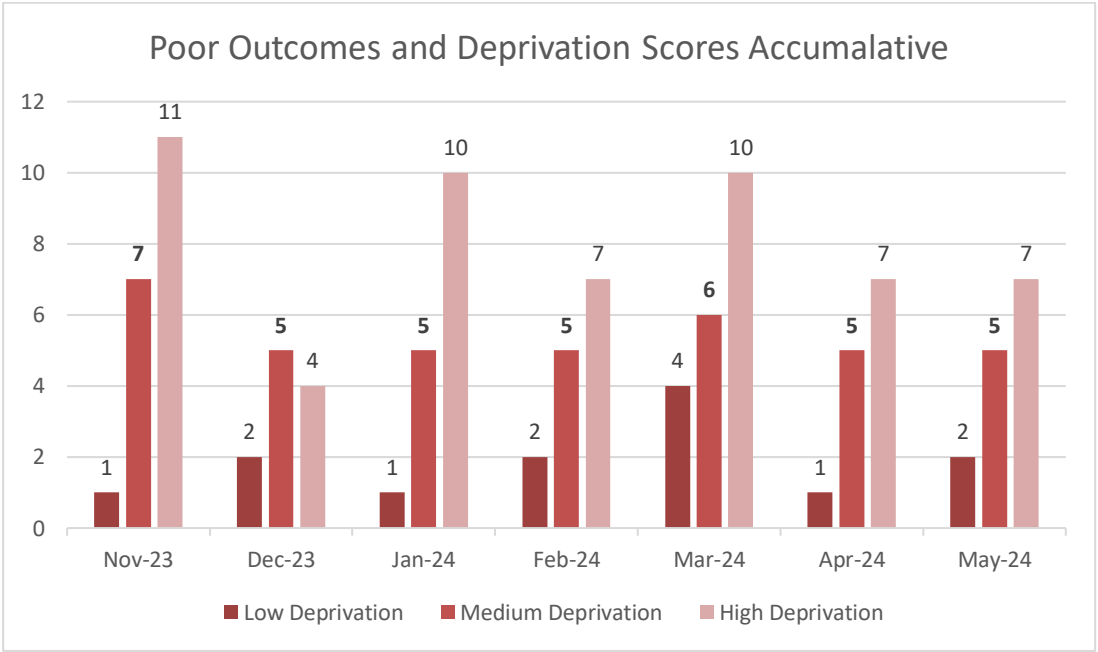


Table 20.3

21 Safe Maternity Staffing

21.1 Organisational requirements for safe midwifery staffing for maternity settings (NICE 2017) states that midwifery staffing establishments develop procedures to ensure that a systematic process is used to set the midwifery staffing establishment to maintain continuity of maternity services and to always provide safe care to women and babies in all settings. Maternity and midwifery staffing is reported separately to the Care Group 3 and Trust Board biannually to meet the requirements for the maternity incentive scheme (Appendix 5). The review highlights that maternity services meet Birth Rate Plus recommendations following the establishment review in August 2023. The

CSU has a challenge with maternity leave and an over recruitment has been agreed by the Executive team of 6 WTE to support the workforce gaps. The medical and Neonatal staffing has been reviewed and the report highlights compliance with CNST year 5 for Obstetric medical and anaesthetic staffing and qualified in speciality (QIS) for neonatal nursing.

22 Midwifery Staffing

22.1 Table 22.1 highlights the current nominal role for midwifery staffing highlighting a marginal over establishment which has supported maternity leave. The current position and predictions for midwifery workforce and gaps can be seen in Table 22.1 and shows that there has been an increase due to a reduction in the previously agreed over recruitment margin.

	2024/25											
Trajectory	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Contracted Vacancies	**-3.24**	**-1.64**	**-1.64**	**-1.64**	**-1.64**	**-1.64**	**-1.64**	**-1.64**	**-1.64**	**-1.64**	**-1.64**	**-1.64**
Maternity leave	7.28	7.28	8.08	6.12	5.12	4.48	6.48	7.52	10.16	9.52	8.88	8.24
Long term sickness	2.64	2.24	1.60	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Upcoming Leavers	0.00	0.20	1.44	1.44	2.77	2.77	3.09	3.09	3.09	3.09	3.09	3.09
Other - see detail	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20
Total Gaps	**6.88**	**8.28**	**9.68**	**7.12**	**6.45**	**5.81**	**8.13**	**9.17**	**11.81**	**11.17**	**10.53**	**9.89**
New Starters (reducing gaps)	0.00	-0.09	-1.53	-1.53	-1.53	-1.53	-1.53	-1.53	-1.53	-1.53	-1.53	-1.53
New Starters - students/NQM's	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-6.08	-6.08	-6.08	-6.08	-6.08
Trajectory - for planning	**6.88**	**8.19**	**8.15**	**5.59**	**4.92**	**4.28**	**6.60**	**1.56**	**4.20**	**3.56**	**2.92**	**2.28**
% Workforce Gaps	**7.0%**	**8.3%**	**8.2%**	**5.7%**	**5.0%**	**4.3%**	**6.7%**	**1.6%**	**4.2%**	**3.6%**	**3.0%**	**2.3%**

Table 22.1

22.2 Table 22.2 highlights the acuity data for labour ward for May 2024 and demonstrates that midwifery staffing met acuity 97% of the time, with 3% showing that the unit was short by up to 2 Midwives, actions taken to reduce the acuity gaps included, lead midwives and specialist midwives being re-deployed to assist and maintain safety and one to one care for the mothers in labour. Compliance in data entry improved in May to >85%.

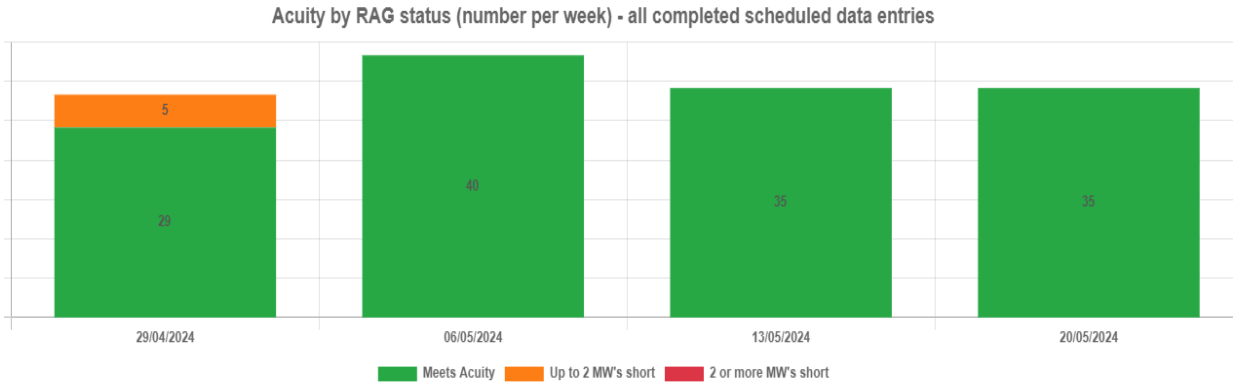


Table 22.2

22.3 Table 22.3 below represents May 2024 workforce data. Sickness rates have remained very similar to last month. No themes or trends have been identified.

Maternity unit closures	0	Datix / Birth-rate Plus®
Utilisation of on call midwife to staff labour ward (Night Duty)	0	Birth-rate Plus® data/ Datix
1-1 care in labour	100%	Data from Birth-rate Plus® acuity tool / Maternity Dashboard
Redeploy staff internally	12	Birth rate plus Acuity (Occasions)
Redeploy staff from Community	1	Birth rate plus Acuity (Occasions)
Matron Working Clinically	0	Birth rate plus Acuity
Delay in Induction of Labour	5	Birth rate plus Data and Datix
Supernumerary labour ward co-ordinator	100%	Data from Birth-rate Plus® acuity tool/Maternity Dashboard/Datix
Staff absence 1	5.68%	May 24 data, 1.88% short term 3.80% long term
Obstetric compliance at mandatory consultant escalation	100%	No Datix incidents reported
Compliance with twice daily face to face ward round	100%	Datix

Table 22.3

23 Obstetric staffing

The following outlines Obstetric cover on Labour Ward and gaps in the rota.

Grade	No of Shifts	Reason	Internal/External
ST1/2	4	4 x reduced duties	1 x internal 3 x external
ST3/7	20	14 x Vacancy 5 x Additional Theatres 1 x Reduced Duties	15 x Internal 5 x External
CONSULTANT	43	3 x Additional section list 12 x Annual/Study/Carer Leave 15 x Additional clinics 13 X Additional Theatres	43 x Internal

24 Quality Improvement projects / progress

Below is a sample of quality improvement projects that are currently being undertaken within maternity service.

- Reducing smoking in pregnancy (SBLV3, Element 1). See graphs 2.1 which demonstrates the reduction in smoking rates both at booking and at birth.
- Reduction in preterm births (SBLV3, Element 5) See graph 18.2.
- Triage thematic review has begun following a number of incidents and complaints around the triage service.
- Pre-term pathway improvements including patient information and Meditech pop up for women on this pathway.
- Theatre optimisation working party to review how maternity theatres are used and to see if there is further capacity within main theatres to support the growing elective caesarean birth lists.

25 Implementation of the A EQUIP model

The Professional Midwifery Advocate (PMA) team are responsible for implementing and deploying the A-EQUIP model (Advocating for Education and Quality Improvement) which supports a continuous improvement process that aims to build personal and professional resilience, enhance quality of care and support preparedness for appraisal and professional revalidation. The PMAs have supported colleagues following two clinical incidents that required After Action Reviews which was valued by those colleagues involved. PMA activity for the month is detailed below in Table 25.1.

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

Table 25.1

26 Avoidable Admission into the Neonatal Unit (ATAIN)

26.1 The National Ambition

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

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

- Reducing harm through learning from serious incidents and litigation claims

- Improving culture, teamwork and improvement capability within maternity units.

26.2 Why is it important?

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

26.2.2 The number of term babies admitted to the Neonatal Unit (NNU) in May 2024 was 12. This as a percentage of all live births is 6.2% see table 26.3, (local ambition is below 5%, national ambition is below 6%). Weekly multidisciplinary reviews of all term admissions to NNU are undertaken using a LMNS standardised approach, this now requires us to include congenital abnormalities whereas previously they were excluded from the ATAIN process. This month we had two congenital abnormalities and without these being included our percentage would have been 5.1%. There were no avoidable admissions in May 2024. The ATAIN figures for Q4 were submitted to the LMNS in April along with the completed rolling action plan for Avoidable Term Admissions to NNU for the year 2023-24. An LMNS working group has commenced focused work on reducing overall term admissions across the region as there has been a sustained increase across South Yorkshire. term. As part of this year's CNST Safety Action 3 work, a QI project is required for ATAIN or Transitional Care and work has begun on this with the multidisciplinary team.

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

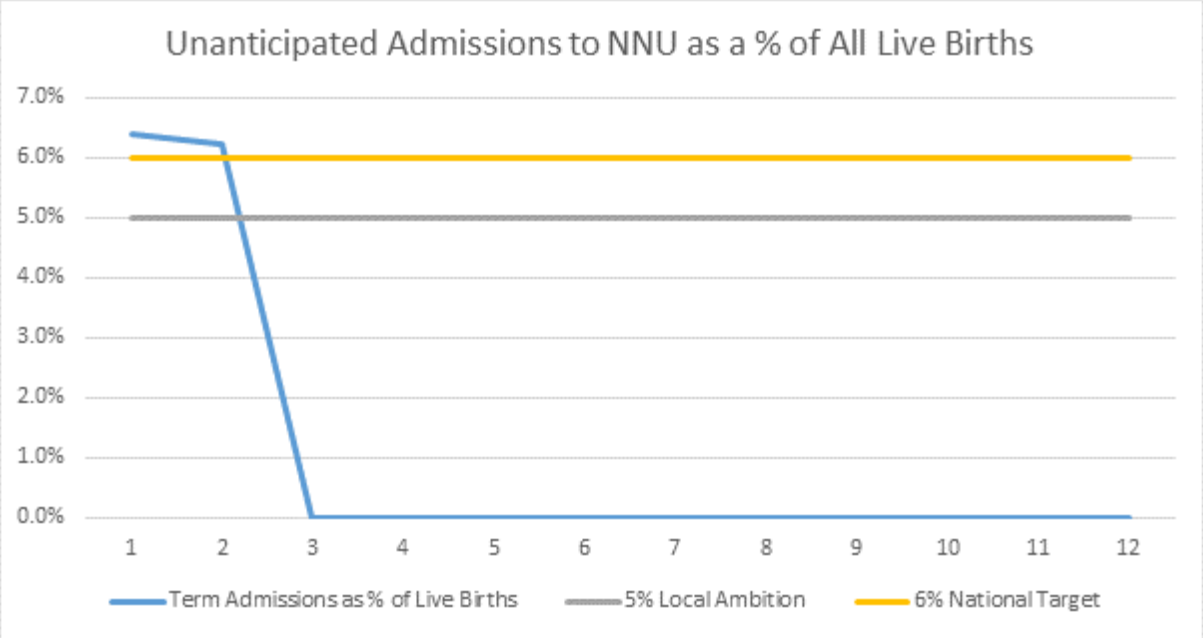


Table 26.3

28 Staff Survey

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

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

29 Red Risks/Risk register highlights

The highest risk currently on the Obstetric dashboard is the use of poor-quality plastic wallets to store CTG recordings in labour, the new wallets have been ordered and we are awaiting delivery of these, it is anticipated that this action will reduce if not remove this risk.

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

30 Recommendation

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

Board of Directors' Meeting
5 July 2024

Agenda item	P113/24
Report	**Safe Staffing and Establishment**
Executive Lead	Helen Dobson – Chief Nurse
Link with the BAF	P1: There is a risk that we will not embed quality care within the 5 year plan because of lack of resource, capacity and capability leading to poor clinical outcomes and patient experience for our patients.
How does this paper support Trust Values	Ambitious – aiming to achieve full compliance against national standards for safe staffing Caring - supporting health and wellbeing of staff to improve retention and providing a set of metrics to ensure patients are safe and have a positive experience Together – the actions and recommendations are Trust wide to support all areas employing clinical staff
Purpose	**For decision** ☒ **For assurance** ☐ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	The National Quality Board (NQB) publication: Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: Safe, Sustainable and Productive Staffing (2016) outlines expectations and the framework. In addition improvement resources have been published to support and underpin this approach in 2018 for adult inpatient wards in an acute hospital, community nursing services, children and young people, neonatal units and maternity services. This paper has used the SNCT tool to thoroughly review the acuity and dependency of adult inpatients, adult assessment areas, children's wards and emergency departments. This paper has also used the Community Nursing Safe Staffing Tool (CNSST) to review the acuity and dependency of community nursing services. There has been some historical management of establishment changes in divisions, without understanding of the risks to RN skill mix. The risks of this are reiterated at the establishment reviews. All the ward managers applied professional judgement to their establishments and confirmed when planned staffing met actual staffing the areas were safe. The Surgical and Medical Assessment units had SNCT data with a positive variance of 17.96. Both Assessment Unit establishments including the SDEC teams whose patients aren't inpatients so aren't included in the data sets for these areas.

	The Medical Wards (excluding the assessment unit) have the largest amount of inpatient beds and had SNCT data with a variance of –12.6 WTE. The Surgical Wards (excluding the assessment unit) had the biggest difference between funded establishments and SNCT average data with a variance of +17.41 WTE but after adding professional judgement, there are no recommended changes. These wards have smaller bed bases and therefore more expensive to run. For Children's ward and Children's UECC, there is opportunity to consider dropping the funded establishment on Children's ward and increasing the funded establishment on Paediatric UECC. Children's Wards has a SNCT positive variance of 6.9 WTE and Paediatrics UECC had a SNCT negative variance of -1.51WTE (22% headroom) and -2.04WTE (25% headroom) Adult UECC has a SNCT positive variance of 4.3 WTE (22% headroom) and 3.25 WTE (25% headroom) but after adding professional judgement and considering the layout of the department in particular there are no recommended changes Community Nursing Safe Staffing Tool (CNSST), has been used by both the planned and unplanned community nursing teams. NHS England have asked all trusts to pause use of this tool as they review some inconsistencies. The planned community nursing teams have a CNSST positive variance of 1.22 WTE. The unplanned teams are showing a positive variance but as there are some inconsistencies in the data this is not felt to be accurate after only two data collections, further planned data collections are postponed. The Chief Nurse has reviewed the Ward Manager Role which is currently fully supervisory. Consideration is being given to reducing this to 80% of their working time as supervisory and 20% working clinically as part of the ward numbers. The Trust Board are asked to support the recommendation of the establishment review as led by the Deputy Chief Nurse (nursing workforce) and agreed with the Chief Nurse to maintain existing establishments unchanged. Current establishments are assessed to be safe and daily professional judgement is used to redeploy as needed to maintain this.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	The Chief Nurse has reviewed the proposed establishments and supports the recommendations in the paper. This paper was presented to People Committee in June 2024.
Board powers to make this decision	The Board of Directors are authorised to approve any changes to nursing establishments in line with national guidance.

Who, What and When (what action is required, who is the lead and when should it be completed?)	If reductions to establishments are proposed the Board are required to ensure a Quality Impact Assessment has been undertaken. This is not currently required as no change is proposed.
Recommendations	The Board of Directors are assured by the process of collecting the SNCT data and using professional judgement to collate proposed establishments The Board of Directors are asked to agree to maintain existing establishments whilst further data is collected, particularly in Community where sufficient data is not yet available and in relation to proposed bed reconfiguration changes this year.
Appendices	**All appendices are located in the Convene Review Room** Appendix 1 – SNCT for assessment areas Appendix 2 – SNCT for Surgical Wards (excluding ASU) Appendix 3 – SNCT for Medical Wards (excluding AMU) Appendix 4 – SNCT for Paediatrics Appendix 5 – SNCT for UECC Appendix 6 – CNSST for community nursing teams Appendix 7 – SNCT Forward Plan

1. Introduction

1.1 The National Quality Board (NQB) publication: Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: Safe, Sustainable and Productive Staffing (2016) outlines expectations and the framework. In addition improvement resources have been published to support and underpin this approach in 2018 for adult inpatient wards in an acute hospital, children and young people, neonatal units and maternity services.

1.2 These resources have been used to support establishment setting, approval and deployment from the ward sisters and charge nurses through to the Chief Nurse.

1.3 There has been a refreshed approach to setting the Nursing establishments in the Trust since November 2022, to ensure compliance with the National Quality Board Standards and Developing Workforce Safeguards. This included the implementation of the Safer Nursing Care Tool (SNCT), an evidence based tool which will support and inform the establishment setting process. SNCT is an objective tool which utilises acuity and dependency scoring to support workforce planning. The tool had been recognised for supporting safe staffing on in-patient wards, and received NICE endorsement in 2014.

Figure 1: Principles of safe staffing

1.4 Four cycles of acuity and dependency data collection using SNCT were completed in 2023, and two cycles are planned for 2024, the first being completed across February and March and these results are included in this report.

1.5 Intensive care and high dependency were excluded as staffing is in line with the Guidelines for the Provision of Intensive Care Services (GPICS, 2019).

1.6 Hard Truths commitments regarding the publishing of staffing data (Care Quality Commission, March 2014) states 'data alone cannot assure anyone that safe care is being delivered'. However research demonstrates that staffing levels are linked to the safety of care and that fewer staff increase the risk of patient safety incidents occurring'.

1.7 In order to assure the People Committee of safe staffing on our wards, this paper sets out the outcome of the strategic staffing review which has been undertaken in line with national guidance. The review has been a comprehensive assessment of each ward, with the ward manager, matron, head of nursing and management accountant, to take into account the following;

- Ensuring professional judgement is applied to staffing and is representative of activity requirements whilst ensuring the appropriate skill mix of staff.

- Benchmarking ward level CHPPD data from peer organisations is incorporated into each review.
- Nurse/midwifery sensitive indicators are aligned to each review such as pressure ulcers, falls, medication incidents and complaints relating to nursing care.
- The financial impact to setting of budgets is considered.

1.8 With each staffing review our compliance against the SNCT guidelines is reviewed to ensure validity of the data. The assessment can be found in appendix 1 (adult assessment areas, appendix 2 and 3 (surgical and medical adult wards), appendix 4 (Children's ward), appendix 5 (UECC) and appendix 6 (Community)

2. Compliance against national standards

2.1 A gap analysis on the Trust compliance with the workforce safeguards was presented to the Board of Directors in January 2023. There were recommendations within the paper to further improve full compliance with NQB guidance and workforce safeguards.

2.2 To support full compliance with the workforce safeguards, work has been completed in the following areas;

- Training 70 staff on the use of the SNCT to ensure inter-rater reliability. All have received further training for the updated SNCT tool which was released December 2023 and we have used in this years data collection
- The roll out of the community nursing safe staffing tool (CNSST), which has included training all Registered Nurses and HCSWs
- Formal reporting of safe staffing and quality to the Quality Committee from April 2023.
- Progression of a Trust wide safety and quality dashboard.
- Implementation of a clear Retention of Nurses plan across TRFT

2.3 The Safe Staffing and Quality Paper, reported every other month to the Quality Committee, includes a detailed analysis of the Care Hours Per Patient Day (CHPPD), triangulated with patient outcomes, reported incidents and the progress on the plan to retain the whole nursing workforce.

2.4 The report is grounded in the need to ensure safe nurse and midwifery staffing levels and has been underpinned by the following publications/resources:

- NHS improvement – developing workforce safeguards, supporting providers to deliver high quality care through safe and effective staffing, October 2018.
- National Quality Board – Safe, sustainable and productive staffing - An improvement resource for Urgent and Emergency Care, 2018
- National Quality Board – Safe, sustainable and productive staffing - An improvement resource for adult inpatient wards in acute hospitals Edition 1, January 2018.
- National Quality Board – Safe, sustainable and productive staffing - An improvement resource for neonatal care, Edition 1, June 2018.
- National Quality Board – Safe, sustainable and productive staffing - An improvement resource for children and young people's inpatient wards in acute hospitals, Edition 1, January 2018.
- National Quality Board – Safe, sustainable and productive staffing - An improvement resource for Maternity, Edition 1, January 2018.
- National Quality Board – Safe, sustainable and productive staffing (SSPS). An improvement resource for adult inpatient wards in acute hospitals 2016 (2017 approved).
- Hard Truths – The Journey to Putting Patients First 'Hear the patient, speak the truth and act with compassion'. Published by the Department of Health 2014.

- National Quality Board report – How to ensure the right people, with the right skills, are in the right place at the right time. Published by NHS England 2013.
- The Model Hospital Portal - a new digital information service provided by NHS Improvement to support the NHS to identify and realise productivity opportunities; key nursing information is contained within the portal. https://improvement.nhs.uk/news-alerts/updates-model-hospital/

3. Feedback to Care Groups

3.1 The Heads of Nursing and Midwifery received their SNCT data, once collected and verified. A detailed feedback session was then arranged with every ward manager, matron, head of nursing/ midwifery and management accountant in April 2024.

3.2 The Deputy Chief Nurse (Nursing Workforce) and Matron for Safe Staffing led the feedback. During the session, the funded establishment was confirmed, the current funded skill mix, the average of the latest four SNCT data collections and ward manager supervisory time of 1.0 wte per inpatient ward also confirmed.

3.3 Adding in the professional judgement of each ward manager, matron and head of nursing a proposed establishment was then agreed.

4. Analysis

4.1 Following the addition of professional judgement to the SNCT average data results, the explanation was given to divisions that establishments shouldn't stay static and should be amended and updated, subject to the rigour of the SNCT process.

4.2 The purpose of the feedback sessions in some instances, this meant an increase in the funded establishment and in some instances this meant a decrease in funded establishments.

4.3 The full data collections are in the appendices 1 – 4 and the UECC data in appendix 5 and the headlines by division are below:

4.4 Assessment Units

	Funded Bed Number	Funded Establishment updated April 2024	SNCT Average	Establishment Variance	RN skill mix (planned actual)
AMU	29	64.42 (inc SDEC)	52.7	11.7	55%
ASU	23+10	48.93(inc SDEC)	42.69	6.24	55%
Totals	52 +10	113.35	95.39	17.96	55%

4.4.1 The current funded establishment for medical and surgical assessment units including the ward managers is 113.35 WTE this includes SDEC. The recommended establishments from the last four SNCT data collections is 95.39 WTE. This includes a 22% headroom on average across all the areas as the SNCT tool will not allow a recommended establishment below this head room. This is a variable of 17.96 WTE nursing staff.

4.4.2 The recommended WTE doesn't include SDEC as it is not an inpatient area, therefore the SNCT data collection does not cover this area. But because the establishments for SDEC and the assessment units are currently combined in both Medicine and Surgery the SDEC establishment cannot be fully separated from the AMU establishment.

4.4.3 Work is currently ongoing to separate SDEC and AMU establishments in Medicine. A review of SDEC provision is proposed during the next 6 months and it is therefore recommended that we do not make any adjustments to these budgets at this stage.

4.4.4 ASU does not have a separate budget for the SDEC area, so this is staffed and included in this funded establishment.

4.4.5 The current funded Registered Nurse (RN) and Registered Nursing Associate (RNA) skill mix (column 6 above) is variable with an average of 55% across the assessment areas. The evidence base for assessment areas is 70% RN skill mix.
Current establishments won't allow the changes needed to work towards the 70% skill mix, but as the Trust have agreed to an over-establishment of Newly Registered Nurses from September 2024 this will allow some establishment restructuring to take place and enable a change to increase the skill mix

4.4.6 At the establishment reviews with ward managers, matrons and heads of nursing, medicine confirmed their funded establishments (where the planned staffing matches the actual) is safe.

4.5 <u>Medical wards</u>

Medicine	Funded Bed Number	Funded Establishment updated April 2024	SNCT Average	Establishment Variance	RN skill mix (planned actual)
A1	33	39.68	39.2	0.48	50%
A2	24	35.07	37.07	-2	52%
A3	33	39.52	45.6	-6.08	49%
A4	33	40.36	45	-4.64	49%
A5	33	39.48	40.32	-0.84	49%
A7	12	20.87	15.7	5.17	63%
CCU	8	20.91	14.6	6.31	80%
Stroke Unit	24	33.83	38.9	-5.07	55%
Short Stay	27	38.4	35.7	2.7	54%
B5	24	33.22	41.31	-8.09	50%
Totals	251	341.34	353.4	-12.06	55.1%

4.5.1 The current funded establishment for medicine including the ward managers is 341.34 WTE for the inpatient wards. The recommended establishments from the last four SNCT data collections is 353.4 WTE. This includes a 22% headroom on average across all the areas as the SNCT tool will not allow a recommended establishment below this head room. This is a variable of -12.06 WTE nursing staff.

4.4.3 The current funded Registered Nurse (RN) and Registered Nursing Associate (RNA) skill mix (column 6 above) is variable with an average of 55.1% across all areas. The evidence base for Inpatient wards should be a 65% RN skill mix
Current establishments won't allow the changes needed to work towards the 65% skill mix, but as the trust have agreed to an over-establishment of Newly Registered Nurses from September 2024 this will allow some establishment restructuring to take place and enable a change to increase the skill mix.

4.4.4 At the establishment reviews with ward managers, matrons and heads of nursing, medicine confirmed their funded establishments (where the planned staffing matches the actual) are safe.

4.5 Surgical wards

Surgery (Excluding ASU)	Funded Bed Number	Funded Establishment updated April 2024 Excluding 2.75 quality roles	SNCT Average	Establishment Variance	RN skill mix
Sitwell	14	20.94	19.04	1.9	55%
B10	22	29.73	25.54	4.19	56%
Rockingham	22+6flex	31.61	25.8	5.81	53%
Fitzwilliam	27+PBR	39.68	39.6	0.08	50%
B11	14	18.63	13.2	5.43	63%
Totals	99+7	140.59	123.18	17.41	55.4%

4.5.1 The current funded establishment for Surgery is 140.59 for the inpatient wards and the recommended establishments from the last four SNCT data collections is 123.18 WTE. This would give a 22% headroom on average across all the areas but is only an average. This is a variance of + 17.41 WTE nursing staff.

4.5.2 Professional judgement was applied in addition to the data. As the surgical wards are smaller than the medical wards but safety still needs to be maintained and as such some wards with smaller bed base have an SNCT average which would not give the minimum of 2 Registered Nurses per shift as is needed to maintain patient safety. No changes to the establishments were proposed when professional judgement applied.

4.5.2 The current funded Registered Nurse (RN) skill mix is variable with an average of 55.4% across all areas. The evidence base for Inpatient wards should be a 65% RN skill mix.
Current establishments won't allow the changes needed to work towards the 65% skill mix, but as the trust have agreed to an over-establishment of Newly Registered Nurses from September 2024 this will allow some establishment restructuring to take place and enable a change to increase the skill mix

4.5.3 At the establishment reviews with ward managers, matrons and heads of nursing, surgery confirmed their funded establishments (where the planned staffing matches the actual) is safe

4.6 Paediatrics

	Funded Bed Number	Funded Establishment	SNCT Average	Establishment Variance	RN skill mix
Childrens ward	22-25	39.4	32.5	6.9	71%

4.6.1 The current funded establishment for Children's wards is 39.4 WTE, the recommended establishment from the last four SNCT data collections is 32.5 WTE. This would give a 22% headroom. This is a variance of + 6.9 WTE nursing staff Professional judgement was applied in addition to the data and it was agreed due to the flexible number of beds and variable acuity, including assessment beds no changes to establishment is proposed

4.6.2 The current funded Registered Nurse (RN) skill mix is 71% for Children's ward. The evidence base for Children's wards should be a 67% RN skill mix but this area is also an assessment area so the 71% funded skill mix is appropriate.
The Head of Nursing also covers Paediatric UECC and Neonatal Unit so daily redeployment takes place across these areas dependant on acuity in each area

4.6.3 At the establishment reviews with ward manager, matron and head of nursing, children's ward confirmed their funded establishments (where the planned staffing matches the actual) is safe.

4.6.4 When using professional judgement with the Childrens Wards, there are no proposed changes to the funded establishments.

4.7 <u>UECC</u>

UECC Acuity and Dependence data ADULTS	Average attendees 2023-2024	Funded Establishment updated April 2024 Excluding 2.75 quality roles	SNCT Average	Establishment Variance	RN skill mix
UECC Adults 22% headroom	75951	84.05	79.7	4.3	68%
UECC Adults 25% headroom	75951	84.05	80.8	3.25	68%

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UECC Acuity and Dependence data Paediatrics	Average attendees 2023-2024	Funded Establishment updated April 2024	SNCT average	Establishment variance	RN skill mix
UECC Paediatrics 22% headroom	21088	19.49	21	-1.51	73%
UECC Paediatrics 25% headroom	21088	19.49	21.5	-2.04	73%

4.7.2 A headroom of 25% is recommended in the NQB 2018 guidance (safe, sustainable and productive staffing: An improvement resource for urgent and emergency care). This supports the amount of regulatory training for Registered Nurses within the UECC. The trust headroom is currently 21% but the SNCT tool does not allow for below 22% headroom therefore the establishment review included 22% and 25% headroom percentages.
As the Trust have agreed to an over-establishment of Newly Registered Nurses from September 2024 no current changes to establishment are being requested as this over recruitment will enable the increased amount of regulatory training to be completed.

4.7.3 For adult UECC, adding professional judgement – there was still concern that staffing numbers are not meeting patient needs. The planned establishment is higher than the recommended establishment by either 4.3 WTE or 3.25 WTE, but the layout of the department means that these staffing numbers are required to maintain patient safety.

4.7.4 Paediatric UECC has demonstrated a gap in funded establishment and SNCT recommended data of 1.51 WTE or 2.04 WTE when considering the headroom's of 22% and 25%. Adding in Professional Judgement there are no proposed changes to the funded establishment, although discussion has taken place around the possibility of moving resource between Children's wards and Paediatric UECC as Children's wards have a variance of + 5.9 WTE nursing staff. Currently deployment takes place across these areas dependant on acuity in each area which was felt a more appropriate way of managing daily staffing.

4.7.5 Previous reports have used national average data based in the Trust's annual attendance only and uses the national average percentage distribution of patients at each level of acuity and dependency.

4.7.6 To assess the local distribution of patient acuity and dependency, alongside the annual attendances is a more precise method of identifying the nurse staffing resource for the Trust's ED. This is the way that has been used to inform this report

5. <u>Community Nursing</u>

Community Nursing	Funded Establishment Updated April 2024	SNCT Average	Establishment Variance	RN skill mix
Unplanned				
Urgent Response and Virtual Ward	65.71	56.24	9.47	79%

Out of Hours	30.75	13	17.75	42%
Totals	96.46	69.24	27.22	60.5%
Planned				
South	30.92	29	1.92	80%
Central North	29.84	28.8	1.04	76%
Central South	28.61	31.3	-2.69	78%
North	30.25	29.3	0.95	88%
Totals	119.62	118.4	1.22	80.5%

5.1 The community nursing safe staffing tool (CNSST) was used for the first time in July 2023 year. Since then most of the planned community Nursing teams have undertaken a further 3 data collections. The Unplanned Teams have only undertaken 2 data collections and there is some inconsistencies in the results which need to be explored further by the Matron for Safe Staffing and the Senior Nursing team

5.2 The current funded establishment for the Unplanned Community Nursing Teams is 96.46 WTE, the recommended establishment from the two CNSST data collections completed is 69.24 WTE. This would give a 22% headroom. This is a variance of + 27.22 WTE nursing staff, it is not clear why the difference is so much and more data is needed before any establishment changes would be suggested

5.3 The current funded establishment for the four Planned Community Nursing Teams is 119.62 WTE, the recommended establishment from the last four CNSST data collections completed is 118.4 WTE. This would give a 22% headroom. This is a variance of + 1.22 WTE nursing staff, No changes are advised to current Nursing establishments

5.4 The current funded Registered Nurse (RN) skill mix is 60.5% for the Unplanned Community Nursing Teams and 80.5% for the Planned Community Nursing Teams.

5.5 Planned data collections have been postponed as advised by NHS England who are looking further into some concerns raised about the efficacy of the tool

6. <u>Conclusion</u>

6.1 The Board are asked to note the process undertaken in the establishment review, in conjunction with the wards in line with the national recommendations.

6.2 There has been some historical management of establishment changes in divisions, without understanding of the risks to RN skill mix. The risks of this are reiterated at the establishment reviews. All the ward managers applied professional judgement to their establishments and confirmed when planned staffing met actual staffing the areas were safe.

6.3 The Assessment Units for Medical and Surgical Wards had SNCT data with a variance of +17.96. These establishments include the SDEC units which aren't part of the data collection so it isn't possible to make suggested changes until these establishments are separated.

6.4 The Medical Wards, who carry the largest amount of inpatient beds had SNCT data with a variance of -12.6 WTE.

6.5 The Surgical Wards had the biggest difference between funded establishments and SNCT average data with +17.41 WTE but after adding professional judgement, there are no

recommended changes. These wards are smaller areas and therefore more expensive to run.

6.6 For Children's ward and Children's UECC, there is opportunity to consider dropping the funded establishment on Children's ward and increasing the funded establishment on Paediatric UECC. When applying professional judgement, there was a concern that reducing Children's ward establishment would not be safe but an acknowledgement that Paediatric UECC needed a bigger establishment. This is currently reviewed daily dependant on acuity within each area and deployments take place.

6.7 Data is provided in this paper for Community following 4 data collections from the planned nursing teams (except the South team who have provided 3 data collections). The unplanned nursing teams have provided 2 data collections. No changes are recommended currently to the community nursing establishments and the Matron for safe staffing will be working closely with the community teams once updates are received from NHS England to enable restarting data collections.

6.8 Licences for the SNCT have been updated to include where patients are receiving 1:1 supervision and 2:1 supervision. The new licences have now been received for all SNCT tools and have been used for this year's data collections

6.9 CNSST renewed licences have not yet been released and the national team have asked all trusts to stop using the tool for 3 months as they review some inconsistencies in the tools use.

6.10 The Chief Nurse has reviewed the Ward Manager Role which is currently fully supervisory. This role is not fully supervisory in other Trusts and therefore consideration is being given to reducing this to 80% of their working time as supervisory and 20% working clinically as part of the ward numbers.
This will ensure clinical credibility and also ensure they are visible amongst the clinical teams, this in turn will support an increase in CHPPD and improve quality of care

6.11 The Board of Directors are asked to note that work is continuing to develop the HCSW workforce. This started in August 2023 and has involved review of Band 2 and 3 roles to align with national job profiles. Care Groups have worked with the project manager to agree requirements and trade union representatives have been involved. There is a plan being built up for potentially 40% of HCSW needing to move to the B3 CSW role.

6.12 The Board of Directors are asked to support the recommendation of the establishment review as led by the Deputy Chief Nurse (nursing workforce) and agreed with the Chief Nurse.

Board of Directors
05 July 2024

The Rotherham NHS Foundation Trust

Agenda item	P114/24
Report	**Learning From Deaths: Quarterly Report 2023/24 Q4**
Executive Lead	Dr Jo Beahan, Medical Director
Link with the BAF	**P1:** There is a risk that we will not embed quality care within the 5 year plan. **OP3**: There is a risk that robust service configuration across the system will not progress and deliver seamless end-to-end patient care across the system. **D5:** There is a risk that we will not deliver safe and excellent performance.
How does this paper support Trust Values	**Ambitious** – demonstrates that the Trust strives to deliver the highest standards and quality of care possible. **Caring** – demonstrates that the Trust strives to give outstanding, compassionate care, including around end of life care. **Together** – demonstrates that the Trust strives to ensure that quality improvement and the learning from deaths is achieved through a multidisciplinary approach.
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☒
Executive Summary	**<u>NHS Better Tomorrow LFD SJR Improvement Programme</u>** TRFT's SJRs are now being completed by a team of SJR Reviewers who are trained in the SJR process and have dedicated time to complete. This process is designed to significant increase the timeliness, completeness and quality of TRFT's SJRs. The quality, completion rates and timeliness have all significantly increased. However the timeliness target of 90% SJR completions within 60 days of death hasn't being met for 2023/24. **<u>360 Assurance LFD Governance Audit Action Plan</u>** The final report for the follow up audit was presented to the Trust in June 2023. Of the 3 High Risk findings identified in the 2021/22 Re-Audit, two now have significant assurance. The other was given limited assurance with a completion deadline of March 2024. This has now been successfully completed. **<u>Mortality Indicators</u>** The latest **SHMI** Score (latest Month Jan 2024) is **102.6**. TRFT are in the 'As Expected' Band.

Due Diligence	This report is produced by the Learning from Deaths and Mortality Manager with a final review by the Deputy Medical Director.
Powers to make this decision	N/A
Who, What and When	The Trust is working hard to establish a Learning from Deaths process which provides intelligence which is used by the Trust to enhance care for present and future patients. A major component of the Learning from Deaths process is the case note review of selected deaths. TRFT uses the Structured Judgement Review (SJR) method. The objective of the review method is to look for strengths and weaknesses in the caring process, to provide information about what can be learnt about hospital systems where care goes well, and to identify points where there may be gaps, problems or difficulties in the care process. A new SJR Review Team (7 reviewers), who are trained and have protected time to complete SJRs started in April 2023. This will deliver good quality and timely SJRs. This will provide good intelligence for the Trust, including information from individual reviews and more importantly from the Thematic Analysis of cohorts of SJRs. The Trust's objective is to use this intelligence to drive improvements. This means disseminating the intelligence to Trust Groups/Individuals, who have the expertise to devise and implement changes to care processes and procedures. Learning from Deaths is managed by the Learning from Deaths & Mortality Manager. It is co-ordinated via the Trust Mortality Group, chaired by the Deputy Medical Director, with oversight and assurance through the Trust's Patient Safety Committee and the Quality Committee.
Recommendations	It is recommended that the Board notes the progress on the planned improvements to the Learning from Deaths programme and the latest SHMI values.
Appendices	Learning from Deaths, Thematic Analysis Report 2023/24 Q4 SHMI Report – Latest Month's Data Jan 2024

1.1 Learning from Deaths Quarterly Report: 2023/24 Q4

	Due Date	SJR Data	SHMI Latest Month
This Report	-	2023/24 Q4	01/12/2023
Next Report	05/09/2024	2024/25 Q1	01/03/2024

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

1.0 SJR Completion Figures

Discharge Date	Adult Inpatient & UECC Deaths	SJR Requested	Completed	Outstanding	% Completed	Overall Care Score < 3	Preventa-bility Score < 4
Apr-23	89	13	13	0	100%	3	2
May-23	77	15	15	0	100%	4	0
Jun-23	81	13	13	0	100%	2	0
Jul-23	52	14	14	0	100%	5	0
Aug-23	79	13	13	0	100%	2	0
Sep-23	83	21	21	0	100%	4	0
Oct-23	88	15	15	0	100%	5	0
Nov-23	87	18	17	1	94%	2	1
Dec-23	111	30	30	0	100%	3	0
Jan-24	121	19	17	2	89%	2	0
Feb-24	95	17	13	4	76%	2	0
Mar-24	107	32	18	14	56%	2	0
				0			
2023/24	1070	220	199	21	90%	36	3
2023/24 Q1	247	41	41	0	100%	9	2
2023/24 Q2	214	48	48	0	100%	11	0
2023/24 Q3	286	63	62	1	98%	10	1
2023/24 Q4	323	68	48	20	71%	6	0

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

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

SJR Timeliness Figures

Month of Discharge	% Completed < 60 Days
Apr-23	46%
May-23	33%
Jun-23	46%
Jul-23	36%
Aug-23	38%
Sep-23	67%
Oct-23	67%
Nov-23	72%
Dec-23	77%
Jan-24	68%
Feb-24	47%
Mar-24	53%
2023/24 YTD	57%
2023/24 Q1	41%
2023/24 Q2	50%
2023/24 Q3	73%
2023/24 Q4	56%

2022/23 Year end Figures

SJRs Completed	45%
Completed <60 Days of Death	24%

SJRs completed by the SJR Review Team are of a much better quality with more free text narrative. However timeliness figures whilst much better than the 2022/23 figures require further improvement.

The 90% target for completing all SJRs within 60 days isn't being met. 57% represents a significant improvement on the figure for 2022/23 (24%). However, with reviewers being funded, a 100% completion rate, with 90% being within 60 days of death is expected.

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

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

Summary & Distribution 2023/24 Q4 SJR Thematic Analysis

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

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

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

Category of Problem
Medication or Treatment
Escalation
Assessment/Opinion/Review
Tests/Results/Monitoring
Location of Care/Bed Availability/Inappr
End of Life/Palliative Care/DNACPR
Communication

Groups Distributed to
Deteriorating Patient Group
Medicine Safety Committee
Patient Safety Committee
Results Flagging & Notification
Safeguarding Operational Group
Clinical Governance - Medicine & its CSUs
Clinical Governance - Surgery & its CSUs
End of Life Group
Sepsis QI Group
Parenteral Nutrition & NG Feed T&F
Quality Governance & Assurance Group
Divisional Mortality Meeting - Medicine
Divisional Mortality Meeting - Surgery
Trust Mortality Group

Next Report:

The next Thematic Analysis Report will be completed in Sept 2024 for 2024/25 Q1 SJRs.

1.1 Learning from Deaths – LeDer, Learning Disabilities & Autism

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

Deaths for these patients are identified by a Learning Disability Flag and an Autism Flag in the Trust's Mortality Insights Power BI Reports, indicated by the Medical Examiner after a scrutiny, a request from the Matron for Learning Disabilities and Autism, or by a request from a ICB LeDer Team.

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

LeDer Requests & SJR Figures for Adults with a Learning Disability

Discharge Month	SJR Requested	SJR Completed	SJR Outstanding	Overall Care Score < 3	Preventability Score < 4
Apr-23	1	1	0	1	0
May-23	1	1	0	0	0
Jun-23	1	1	0	0	0
Jul-23	0	0	0	0	0
Aug-23	2	2	0	1	0
Sep-23	2	2	0	0	0
Oct-23	1	1	0	1	0
Nov-23	2	2	0	1	0
Dec-23	4	4	0	0	0
Jan-24	1	1	0	0	0
Feb-24	0	0	0	0	0
Mar-24	3	1	2	0	0
2023/24 YTD	18	16	2	4	0

Update

The Trust now (since Feb 2024) has a flag in its Mortality Insights Power BI Report which highlights deaths for patients with a Serious Mental Illness (SMI). The flag uses national recognised SMI ICD10 Codes coded during the patient's last admission. This means that the Trust process for identifying these patients for SJR is now more robust and doesn't solely rely on them being identified during a Medical Examiner Scrutiny.

SJRs have been requested for all 2023/24 SMI deaths identified using this flag.

1.2 NHS Better Care Tomorrow LFD Improvement Programme (SJR+)

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

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

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

1.3 360 Assurance Re- Audit May 2023 LFD Governance

All the remaining actions points from the May 2023 Re-Audit have now been completed.

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

Of the 3 High Risk finding identified in the 2021/22 Re-Audit, 2 were given significant assurance. The other was given limited assurance and given a deadline of 31/03/2024 for completion. This was completed by the deadline.

The Final Action – Completed March 2024.

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

How the Remaining Action Point was fulfilled

Completed SJRs (c21) are being sent to Division's Mortality Leads every 4 weeks**.** The split is roughly 13 to Medicine, 6 to Surgery and 2 to UECC. The SJRs are grouped according the last treating CSU. Those judged to have had poor care and /or been likely preventable are highlighted.

The ask for the Division's Mortality Leads is to complete a brief 1-2 minute review of each SJR and decide which need to be individually disseminated to the CSU, and discussed at their Clinical Governance meeting or separately held Mortality meeting. SJRs should be selected if they have learning points related to both good and poor care. All those judged to have had poor care and /or been likely preventable should automatically be disseminated.

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

These minutes were used to compile a report which was uploaded to the 360 Portal as evidence, to demonstrate compliance with the remaining action point. This report was uploaded in March 2024. It was subsequently reviewed and assessed by the 360 Auditors who would happy with the progress and marked this action as complete

1.4 Learning from Deaths in the Divisions

Monthly Mortality meetings are held in the Divisions of Medicine, Surgery and by the Urgent & Emergency Care Team. Reviewed deaths are presented and discussed. These can be a SJR, a local review or both.

Mortality is also discussed at CSU meetings, either as agenda item in the CSU Governance meeting or a separately held CSU Mortality meeting.

Every 4 weeks completed SJRs (c21) are distributed to the Medicine, Surgery and UECC Mortality leads. The ask is for a brief review to be undertaken in order to select a small cohort of SJRs with learning points (both positive and negative). These SJRs in addition to those where the Overall Care Score is poor or judged to have been more than likely preventable are disseminated to the CSUs for discussion at their Governance or separately held Mortality meeting.

All SJRs where the Overall Care Score is poor or the death is judged to have likely preventable are entered as an incident on Datix. These SJRs and the reasons for their poor care score or preventability are then reviewed following the governance process. These cases can be referred to panel where an incident can be declared, a Patient Safety Incident Investigation undertaken, resulting in an After Action Review.

Update

Clinical and administrative pressures in the Division of Surgery have seen some of their Divisional Mortality meeting cancelled over the Autumn/Winter.

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The Rotherham NHS Foundation Trust

03/06/2024

Learning From Deaths
Thematic Analysis SJRs 2023/24 Q4

Content

This report contains the Thematic Analysis of Structured Judgement Reviews (SJRs) completed for deaths in 2023/24 Q4. 48 were completed.

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

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

Purpose of Thematic Analysis in Learning From Deaths

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

:Identify new problems

:Identify the reappearance of problems

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

:Provide evidence for problems that are reported anecdotally

:Identify good practice

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

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

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

Content

Thematic Analysis 2023/24 Q4: Comments Detailing Poor Care

Thematic Analysis 2023/24 Q4: Comments Detailing Good Care

Data Tables

The Rotherham NHS Foundation Trust

Thematic Analysis 2023/24 Q4:

Comments Detailing Poor Care

Delay/Omission/Choice - Medication or Treatment

The patient's current dose of furosemide was not prescribed until the 3rd. She did have a stat dose on the 2nd, so missed a single dose.
The pulling through of standard meds and their prescription is being worked on by HI

Several issues in her ongoing care. Initially she was treated with teicoplanin only for a presumed UTI which would is unlikely to be effective, this was rectified on Day 3 by the addition of ciprofloxacin.

She had episodes of hypoglycaemia and had her insulin omitted for a few days which led to hyperglycaemia and high ketones which then required treatment with IV insulin and VRII. This should have been more closely monitored with regular blood sugar monitoring and consideration of long acting basal insulin or at least PRN with regular sugar monitoring.

My main concerns is that I don't feel that the clinical teams really noted the results of the investigations fully and didn't make appropriate modifications to therapies. My concern lies with the fact that the patient was anaemic at presentation, was found to have cirrhotic liver disease on imaging (CT and US) and had deranged coagulation throughout her admission. Despite this there was never any consideration given to the appropriateness of continuing her oral anticoagulation.

Anticoagulation was missed for 48h. Anticoagulation protocol should be followed to avoid healthcare associated VTE.

Lidocaine patches, not appropriate analgesia for headache.

Documented on 2 separate occasions had missed antibiotics and no one knew why, needed investigation and shouldn't have happened

NG tube placement - no complications but not completed in a timely manner (guidewire left in situ resulting in delay in feeding)

Delay/Omission - Escalation

Nursing team should have a clear understanding about the goals of treatment for a patient. In this case the patient was approaching EoL and scored highly on NEWS2 but the nursing team were unsure how to respond to this. Reviews of the patient were requested rather than calling the relative in and focussing on EoL care.

Delay/Omission - Assessment/Opinion/Review

delay in triage, but did not have impact on outcome

At one point there is documentation that no surgical consultant was taking responsibility for this lady with medical team and palliative care involved as consults. The clinician making this comment proceeds to treat and assess this lady with compassion and a clear plan when she worsens . The issue of consultant seems then to be resolved .

Thyroid function in November 2023 was abnormal. Does not appear to have been acted on or communicated to GP for follow-up

Patient reviews should involvement assessment of the patient not just of the organ/bone of interest to the specialty.

1. Processses around Rapid Access Chest Pain Clinic, are these as timely as possible, should the patient have been referred from the SDEC attendance?
2. Review of pts on ICU by Medical team

Delay/Omission/Interpretation - Tests/Results/Monitoring

She had episodes of hypoglycaemia and had her insulin omitted for a few days which led to hyperglycaemia and high ketones which then required treatment with IV insulin and VRII. This should have been more closely monitored with regular blood sugar monitoring and consideration of long acting basal insulin or at least PRN with regular sugar monitoring.

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No documentation of the procedure and no output recorded from abdominal drain even when asked for multiple times and she had documented AKI. While this is not good practice for the procedure it is impossible to judge the procedure its self as it very difficult to find any documentation of this or of aftercare instructions

Patient never had urine sample sent during her admission.

Very poor documentation of urine output throughout admission
There was issues in the fluid balance monitoring and response to this, iv cannula sighting and delay in IV fluids, food charts are poorly filled out.

There appears to be no acknowledgement of declining oral input by the medical team and no action of negative fluid balance - there is no good way to view a whole day and ongoing negative balance this may have prompted actions, instead each episode is filled in in isolation

End of Life/Palliative Care/DNACPR

Nursing team should have a clear understanding about the goals of treatment for a patient. In this case the patient was approaching EOL and scored highly on NEWS2 but the nursing team were unsure how to respond to this. Reviews of the patient were requested rather than calling the relative in and focussing on EOL care.

Although commencement of EOL care had been considered on multiple occasions, it would have been appropriate to have palliative care involved early; especially in the context of this patient clearly being in the final year of his life.

Should have been consideration of EOL care, given the repeated admissions and patient morbidities

I think the decision for EOL care should and could have been made sooner as she had a worsening AKI and was anuric with low BP. On this basis death seemed inevitable for a few days before the decision was taken. No issues once decision made.

No documentation of any palliative care initiation overnight despite documentation of poor cough and secretions and no palliative medications given on MAR summary. Next documentation is of his verification of death. No communication with next of kin.

it would have been better to consider EOL care sooner

Better communication about elective admission, better and more realistic communication with families. If notes say ""if deteriorates keep comfortable" then should do that and not continue to do further Investigations and referrals

Poor communication around DNACPR status, meant she had a resus attempt that shouldn’t have occurred.

This lady ideally should have been managed on an EOL pathway.

Location of Care/Bed Availability/Inappropriate Moves

Patient remained in hospital until he died due to problems finding a care home who would accept him.

There was a delay to being able to get a bed for the patient.

It is a shame that we do not have the mechanisms available to not admit a frail elderly lady who has had a fall, but sustained no injury.

We did nothing for this lady. She had stated she did not want to come to hospital, and she had been deteriorating for several months. She may well have deteriorated anyway, but I suspect the hospital admission worsened not improved this. This admission was not in her interest or bidding.

given her advanced care plan and wish not to be in hospital it was a failure of community care for this lady.

No issues except length of time in the UECC, presumably for bed issues

May have been better managed in community. Patient ultimately wanted to go home but died in hospital.

Good care in hospital but should not have been admitted.

Communication

Nursing team should have a clear understanding about the goals of treatment for a patient. In this case the patient was approaching EOL and scored highly on NEWS2 but the nursing team were unsure how to respond to this. Reviews of the patient were requested rather than calling the relative in and focussing on EOL care.

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Thyroid function in November 2023 was abnormal. Does not appear to have been acted on or communicated to GP for follow-up

came in for elective procedure - it is difficult to find documentation for this and she is not fully clerked in on the ward

no food chart and patchy fluid balance , this man was deteriorating in intake over several days and these may have been helpful

?Patient education for management of heart failure. The purpose of medications may have been unclear to the patient.

Improve comms within ED team/ Community Hospital Admission Avoidance Team when referring patient and making plan of care in order to reduce failed discharges.

The Rotherham NHS Foundation Trust

Thematic Analysis 2023/24 Q4:

Comments Detailing Good Care

Delay/Omission/Choice - Medication or Treatment

Excellent example of MDT and specialist teams working together to deliver holistic care for a complex patient.

excellent care no delays and good recognition of worsening and actions taken

As documented this man had excellent escalation and consideration as to all treatments
career and family with him and LDT involved to advocate for him

Excellent palliative care from the start of her admission with reviews from both nurses and consultants. Excellent use of syringe driver for symptom control.

Delay/Omission - Escalation

As documented this man had excellent escalation and consideration as to all treatments career and family with him and LDT involved to advocate for him

Delay/Omission - Assessment/Opinion/Review

Early senior review with excellent consideration/ documentation of possible differential diagnosis and appropriate investigations. Early specialist and MDT(PNS, SALT, specialist pharmacy and mental health teams) input into management of an extremely co-morbid and complex patient to co-ordinate holistic care for the patient.

Excellent documentation of reviews from the Acute Response Team

End of Life/Palliative Care/DNACPR

Excellent palliative care from the start of her admission with reviews from both nurses and consultants. Excellent use of syringe driver for symptom control.

Palliative care reviews were fundamental to ensuring she had as good symptom control as possible . The communication and involvement of the family in this care was excellent .

Excellent documentation from A&E medical team and acknowledgement of severe frailty and limits of treatment (RESPECT form). Clear rationalisation for differential diagnosis and investigations, along with explanation of risk vs benefit of possible treatment modalities; in the context of the patient's advanced pathology/ comorbid state.

Excellent documentation of switch of focus to ensuring patient's comfort and dignity on the last days of life

Excellent end of life care. Palliative care specialist nurses reviewed daily with commencement of syringe driver for symptom control and transfer to purple butterfly room - palliative bed where she died.

Given her multiple problems she received excellent care from the medical team and palliative care team

Good communication and use of palliative care team to look at hospice possibilities and also in starting syringe driver.

Excellent Palliative care given despite difficult communication with family with some denial on families part. Palliative medications given and reviewed daily.

Communication

Palliative care reviews were fundamental to ensuring she had as good symptom control as possible . The communication and involvement of the family in this care was excellent .

Excellent documentation from A&E medical team and acknowledgement of severe frailty and limits of treatment(RESPECT form). Clear rationalisation for differential diagnosis and investigations, along with explanation of risk vs benefit of possible treatment modalities; in the context of the patient's advanced pathology/ comorbid state.

Excellent documentation of communication with family; leading up to the death of the patient.

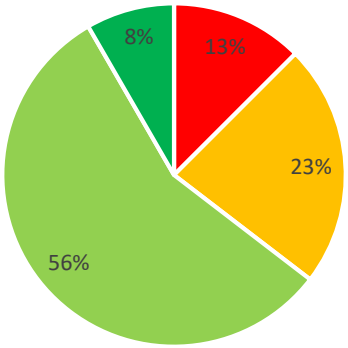
excellent documentation of communication with patient and family as to likely outcome

Learning Disability Team involved and own career stayed with him as well as family - excellent communication with them

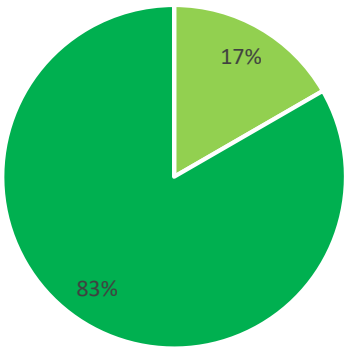
Excellent note by Clinician in ED, around the conversation with family. Very clear.

Data Tables

Overall Care Score	SJRs
1 - Very Poor	0
2 - Poor	6
3 - Adequate	11
4 - Good	27
5 - Excellent	4
Not Recorded	0
Total	48



Preventability	SJRs
1 - Definitely preventable	0
2 - Strong evidence	0
3 - Possibly (more than 50:50)	0
4 - Possibly (less than 50:50)	0
5 - Slight evidence	8
6 - Definitely not preventable	40
Not Recorded	0
Total	48



Comment Relates to	Negative Comments	Positive Comments
Delay/Omission/Choice - Medication or Treatment	8	4
Delay/Omission - Escalation	1	1
Delay/Omission - Assessment/Opinion/Review	5	2
Delay/Omission/Interpretation - Tests/Results/Monitoring	6	0
End of Life/Palliative Care/DNACPR	9	8
Location of Care/Bed Availability/Inappropriate Moves	8	0
Communication	11	6
Total	48	21

Type	Problems
Problems leading to readmission	6
Problems in assessment	3
Problem with medication	5
Problem with nutrition	2
Problem with infection control	3
Problem related to operation	0
Problem in clinical monitoring	6
Problem in treatment plan	6
Problem in resuscitation	2
Problem in IV fluids	2
Problems in communication	2
Problems in relatives communication	5
Problems in team communication	5
Problem of any other type	2
Total	49

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Latest Publication Date: 13/06/2024
Latest Data Month: Jan-24

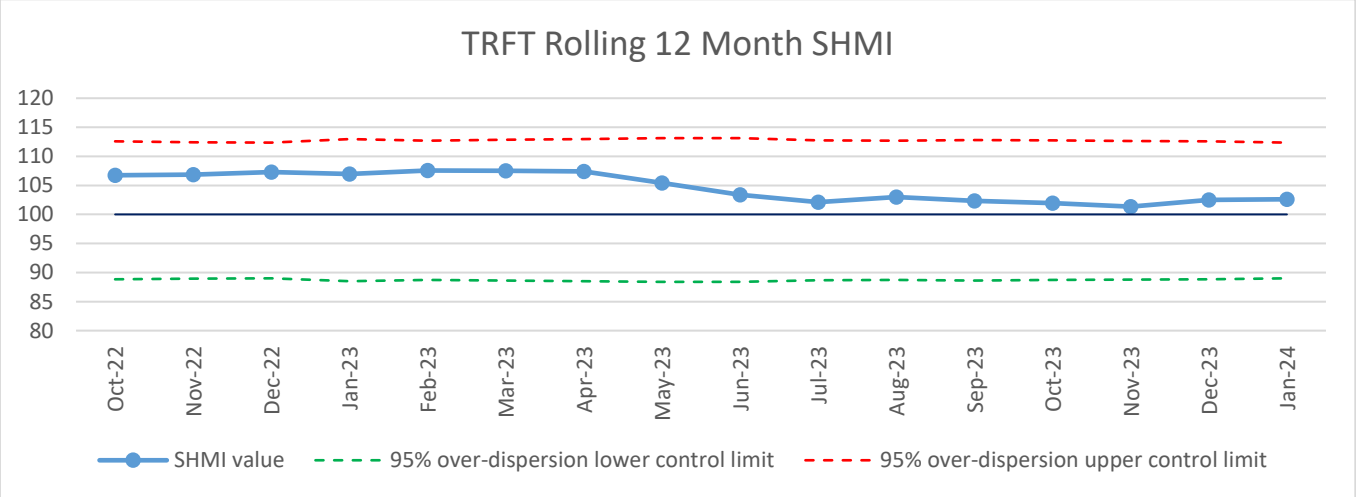
TRFT SHMI Report

Summary

TRFTs latest Rolling 12 Month SHMI Value is 102.6. TRFT remain in the Band 2 'As Expected' band. The previous value was 102.5.

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

- Fluid & Electrolytes

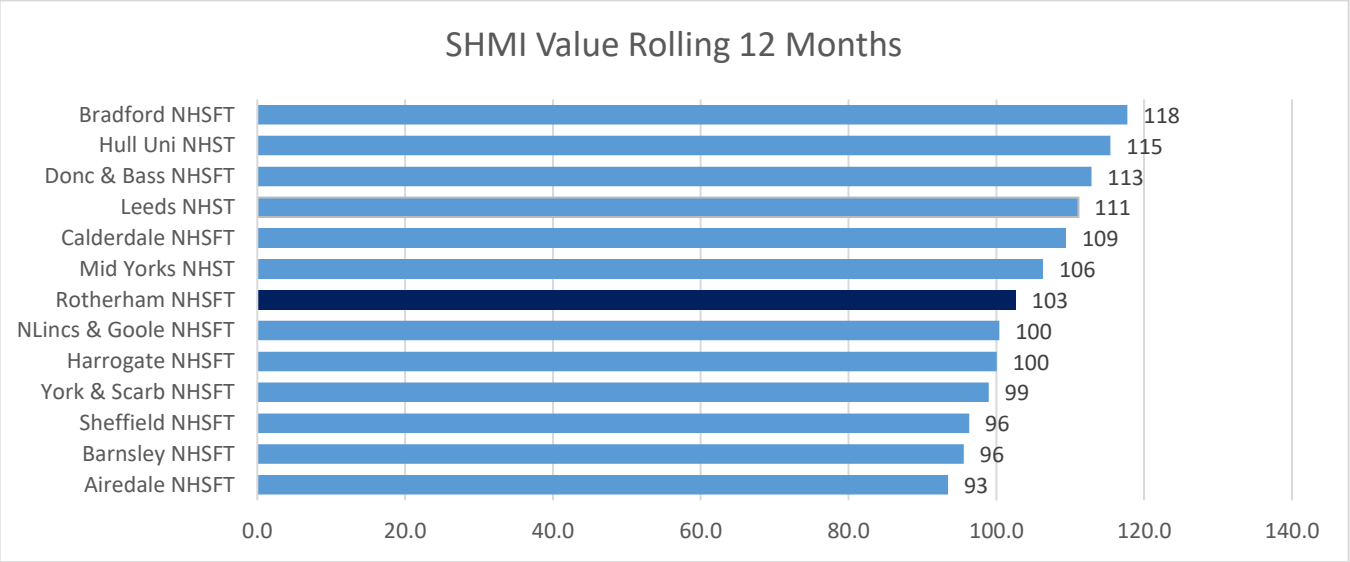


TRFT Latest SHMI Value

End Month	SHMI value	SHMI banding	Number of spells*	Observed deaths	Expected deaths
Jan-24	102.63	2	50615	1485	1445

* Excluded Day Cases and Regular Attendances

Region Comparator - Yorkshire & Humber Non Specialist Trusts



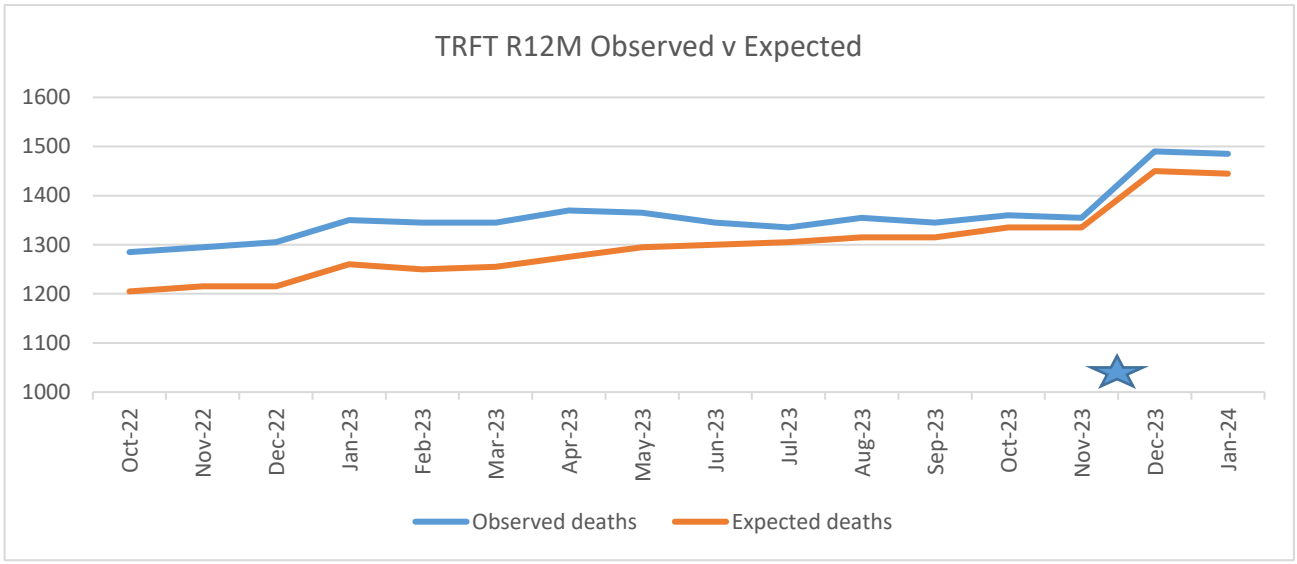
SHMI Diagnostic Group Breakdown

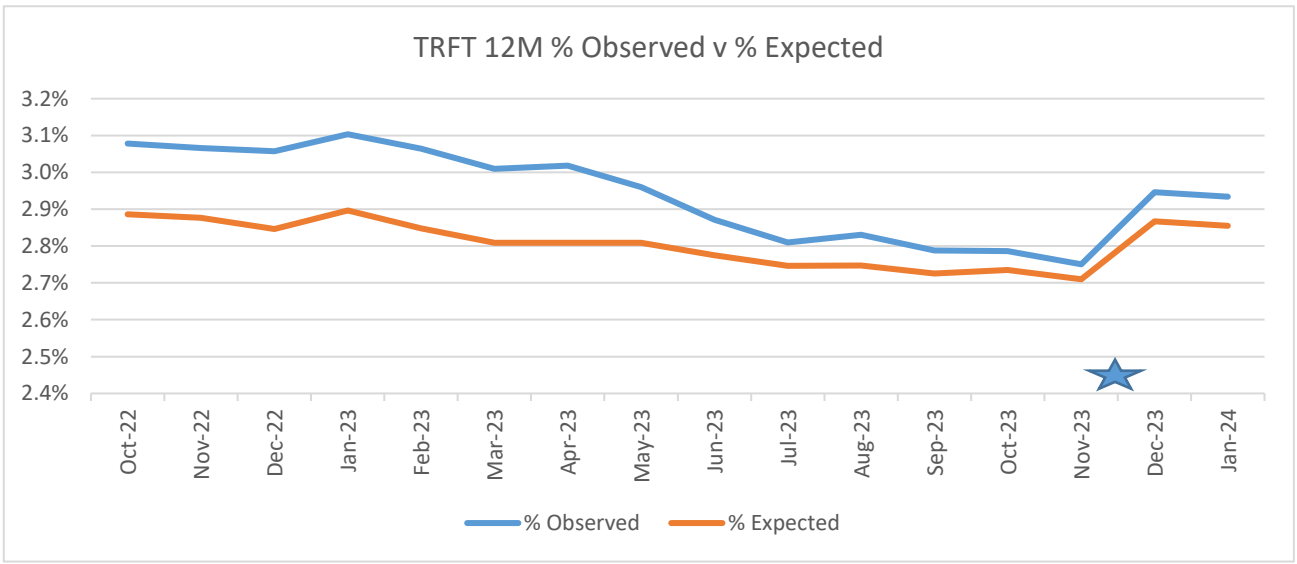
Diagnosis Group	Number of spells	Observed deaths	Expected deaths	SHMI Value	SHMI banding
Fluid and electrolyte disorders	390	35	20	165.6	1
Septicaemia (except in labour), Shock	620	160	135	120.1	2
Cancer of bronchus; lung	55	20	20	90.5	2
Secondary malignancies	125	20	25	78.9	2
Acute myocardial infarction	410	35	30	120.0	2
Pneumonia (excluding TB/STD)	1600	240	230	104.7	2
Acute bronchitis	1210	25	25	104.4	2
Gastrointestinal hemorrhage	390	15	15	78.0	2
Urinary tract infections	1010	25	35	73.1	2
Fracture of neck of femur (hip)	325	30	25	126.9	2

Coding Data

TRFT Rank of 13	3rd Highest	3rd Highest	2nd Highest	6th Highest	2nd Highest
Yorks & Humber Region Non Spec Provider Trusts	**% of Spells: Primary Diagnosis is a Sign & Symptom**	**% of Spells: Invalid primary diagnosis code**	**MEAN Secondary Diagnoses per Spell Non Elective**	**% of Spells with palliative care**	**% of deaths with palliative care**
Harrogate NHSFT	18.6	3.9	4.7	1.8	37
NLincs & Goole NHSFT	17.7	0.1	4.9	1.3	24
Rotherham NHSFT	16.9	2.6	6.8	2.0	52
Bradford NHSFT	16.2	6.4	3.6	1.1	34
Barnsley NHSFT	14.0	0.0	7.5	2.3	38
Airedale NHSFT	13.9	0.0	4.7	1.2	26
York & Scarb NHSFT	13.1	0.0	5.9	1.3	28
Donc & Bass NHSFT	11.1	0.0	4.9	2.4	53
Hull Uni NHST	9.4	2.1	5.8	2.2	35
Sheffield NHSFT	9.4	0.0	4.9	1.8	36
Mid Yorks NHST	9.1	0.5	6.7	2.1	38
Calderdale NHSFT	8.0	0.0	6.5	2.3	42
Leeds NHST	5.8	0.0	6.3	2.0	32
England	13.5	1.5	5.9	2.1	43

Comparison of the SHMI Observed and Expected Deaths





SHMI Methodology Change Dec 2023 (May 2024 release):

Covid Activity was included in the SHMI after being excluded. This increased spell, expected and observed death numbers.

Board of Directors' Meeting
5th July 2024

The Rotherham NHS Foundation Trust

Agenda item	P115/24
Report	Organ and Tissue Donation Committee Annual Report
Executive Lead	Heather Craven, Non-Executive Director
Link with the BAF	n/a
How does this paper support Trust Values	The papers underpin all of the Trust values
Purpose	**For decision** ☐ **For assurance** ☐ **For information** ☒
Executive Summary (including reason for the report, background, key issues and risks)	The following report includes: • Achievements and issues that the Committee has overseen during the year • An annual report detailing how the committee has discharged its duties according to its terms of reference, including a committee effectiveness review by its members and attendees • A letter from the Director of Organ and Tissue Donation and Transplantation to the Trust • A summary report on the Actual and Potential Deceased Organ Donation for 2023/24, with a detailed the Actual and Potential Deceased Organ Donation for 2023/24 available in the reading room
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	The Organ and Tissue Donation Committee is a nationally mandated committee
Board powers to make this decision	As above
Who, What and When (what action is required, who is the lead and when should it be completed?)	The Board is asked to note the reports and highlight any issues it wishes the committee to address.
Recommendations	As above

Appendices	1. Organ and Tissue Donation Committee – Review of the year 2. Organ and Tissue Donation Committee Annual Report 3. Letter from the Director of Organ and Tissue Donation and Transplant 4. Summary Report - Actual and Potential Deceased Organ Donation for 2023/24 Available in the Reading Room: 5. Detailed Report - Actual and Potential Deceased Organ Donation for 2023/24

Organ and Tissue Donation Committee

Review of the year

Introduction

The Organ and Tissue donation committee has discharged its duties according to its terms of reference during the year as outlined in a separate report.

This report sets out the achievements and issues that the committee has overseen during the year.

Review of the year

Each meeting the committee receives a report from Clare Jones who is the Lead Nurse-Organ Donation for the Yorkshire Organ Donation Service Team which summarises the activity that the Trust has been involved in and any issues that the Trust needs to address.

Review of our activity indicated that whilst we were performing well on organ donation, we were not performing well on tissue donation and as a result further engagement was needed. The committee's name was changed to include tissue donation in line with best practice and Cindy Storer was brought onto the committee to help develop further training and engagement through palliative care. Work has been carried out around corneal tissue which has resulted in our first donation in 2024-20225.

Engagement with colleagues in the morgue was initially challenging and although some improvement was achieved there have been recent personnel changes so this is an area to monitor.

An annual letter is sent to Dr Jenkins and Jo Beahan summarising our activity for the whole year based on the data the committee review and acts on during the year and the request is that this is presented at board.

The summary report is attached, and the detailed report is in the reading room.

In summary

- The Trust referred 22 patients to the NHSBT'S Organ Donation Team, which was 100% referral rate with no opportunities missed, 2022-2023 1 missed.
- Of these referrals 12 met the referral criteria for donation and a specialist nurse took part in 8 organ donation discussions with families of eligible donors and there were no occasions when a specialist nurse was missing.
- From 7 consented donors the Trust facilitated 5 actual solid organ donors resulting in 14 patients receiving life saving or life changing transplants

A service was held during Organ Donation week in the Chapel where the families of organ donors and staff involved in the service were invited to a service of celebration and remembrance. A service is now planned to be held each year.

Following consultation with the Chief Nurse and the Chief Nurse for Children's services a decision was taken to engage in the Waiting to live campaign for children waiting for transplants and this will be launched in the coming months.

Summary

The Board is asked to note the report and highlight any issues it wishes the committee to address.

Organ and Tissue Donation Annual Report 2023-24

The Rotherham NHS Foundation Trust

1. Introduction

1.1 In accordance with its Terms of Reference (Section relating to 'Reporting'), the Organ and Tissue Donation Committee ("the Committee") is required to provide the Quality Committee with assurance and any concerns identified will be shared or escalated to the relevant committee group for an appropriate response. The Committee will produce an annual report on its work in order to demonstrate how it has discharged its' responsibilities. In addition, under the section relating to 'Monitoring and review', the Committee is required to carry out an annual self-assessment of its performance.

1.2 In order to fulfil the requirements detailed above, the following report illustrates the findings following a review of the work carried out by the Committee against its approved Terms of Reference. In addition, the findings of the survey on the effectiveness of the Committee can be found at Appendix 1.

2. Purpose of the Organ and Tissue Donation Committee

2.1 The purpose of the Committee is set out in the approved Terms of Reference. In summary, the Committee is responsible for raising awareness, ensuring that donation is accepted and viewed as usual, not unusual.

2.2 The Committee is expected to discharge the above through monitoring the development, implementation and oversight of the following:

a) The Committee will ensure local policies and all operational aspects of donation are reviewed, developed and implemented in line with current and future national guidelines and policies;

b) The Committee will be responsible for producing an annual report to Quality Committee and 6 month update, monitoring donation activity from all areas of the hospital;

c) The Committee will ensure submission of the data to NHSBT on an agreed basis and to receive and analyse comparative data from other hospitals and will participate in all relevant national audit processes;

d) The Committee will promote communication about donation activity to all appropriate areas of the hospital and community to ensure that the information is received and understood and;

e) The Committee will identify and ensure delivery of educational programmes to meet recognised training needs.

3 Overview of Activity

3.1 The Committee has met on a quarterly basis.

3.2 The Committee has raised any escalations to the Quality Committee via the Committee Chair.

3.3 The Committee has reviewed and monitored a number of key themes during the last financial year as follows:

- Trust compliance with National Organ Donation policy, local policies, End of Life Care and other related policies
- NHSBT correspondence and reports
- Update reports for Patient Experience Committee
- MAST and Organ Donation
- PDA reviews
- Promotion of Organ Donation
- Regional and National updates
- Updates from the Human Tissue Authority Working Group
- Organ Donation Week
- Income and expenditure reports relating to Committee funds

3.4 The Committee received detailed information relating to the above by way of formal reports, presentations or verbal updates.

4 Membership of the Organ and Tissue Donation Committee

4.1 The Committee is chaired by a Non-Executive Director.

4.2 In addition to the Non-Executive Director, the membership of the Committee comprises the following members of staff: Clinical Lead for Organ and Tissue Donation, Deputy Chief Nurse, Specialist Nurse – Organ Donation, End of Life Care Lead Nurse, Lead Advanced Clinical Practitioner, ITU Consultant/ Link Nurse, UECC Consultant/ Link Nurse, Theatres Representative, Mortuary representative, Communications representative, Community Representative and Chaplaincy representative..

4.3 The Committee has the authority to request attendance from any other colleague for specific agenda items should they be required.

4.4 Meetings of the Committee are not open to members of the public.

5 Meetings and Quoracy

5.1 During the last financial year the Committee has met on a quarterly basis, holding meetings virtually.

5.2 In accordance with the Terms of Reference, a quorum shall be made up of five members including the Chair, Deputy Chair or nominated lead and 50% of membership. At the time of the report, the Committee has been consistently quorate.

6 Reporting to the Quality Committee

6.1 The Committee provides assurance to the Quality Committee and any concerns identified will be shared or escalated to the relevant committee group for an appropriate response.

6.2 All agendas will have a standing agenda item for “escalation” and escalation has been the responsibility of the Chair.

6.3 Moving forward into the next financial year, the Committee will provide a 6 monthly report to the Quality Committee, as well as an annual report.

7 Annual Review of Committee Effectiveness

7.1 As part of the annual report process, an anonymous survey was conducted on the effectiveness of the Committee. The survey asked for feedback in relation to the following:

- Understanding the purpose and Duties of the Committee
- Committee business covers matters set out in the Terms of Reference
- Review of activities against those delegated to it by the Terms of Reference
- How the Committee has made decisions in how it operates in terms of attendees and level of information
- Frequency of meetings and balance of skill, experience and knowledge
- Member and attendees and appropriateness of the same
- Appropriate preparation for the meeting
- Administration of the meeting including quality of the papers
- Support and challenge at the meeting

7.2 There was a moderate response to the survey with a total of 5 members and attendees completing the survey. The findings from the survey can be found at Appendix 1.

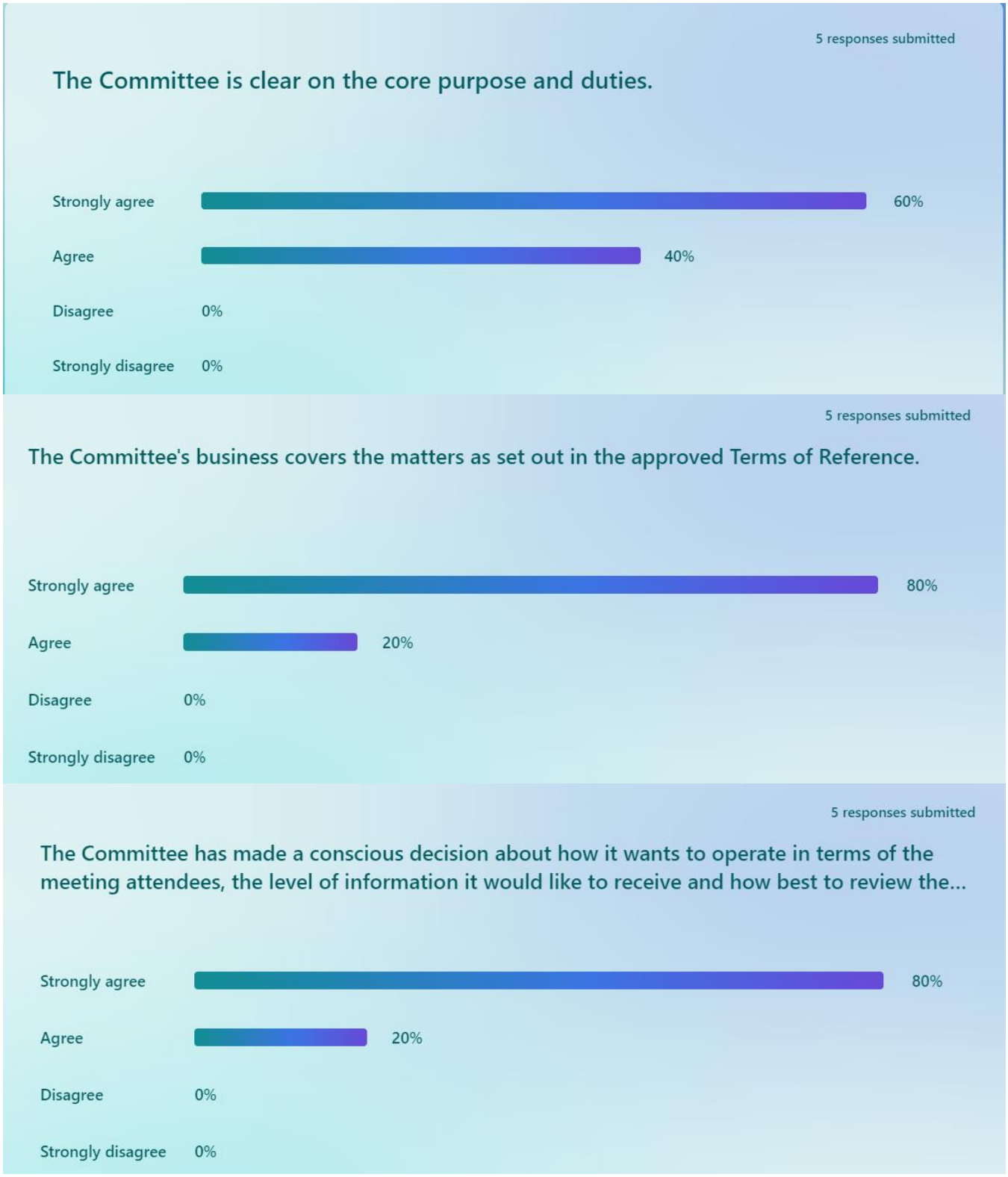
7.3 Positive responses were submitted on all of the questions with one respondent commenting that there is “a good mix of professional colleagues”.

8 Conclusion

8.1 Following review of the current Terms of Reference the Organ and Tissue Donation Committee has fulfilled its duties under the Terms of Reference.

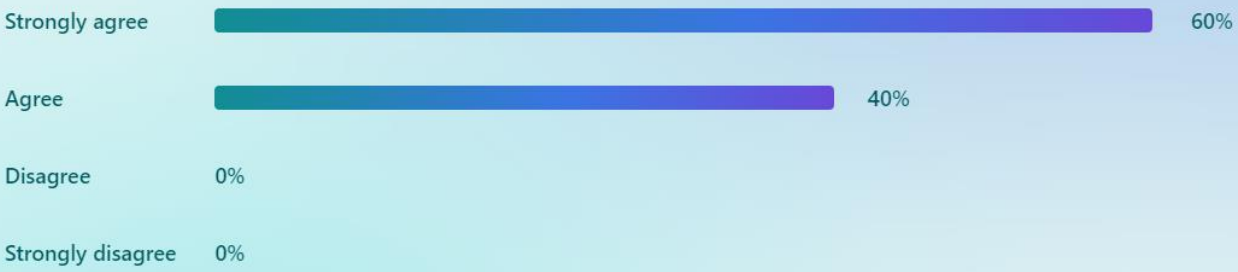
8.2 The results and comments from the effectiveness survey will help to inform improvements to further strengthen the business of the Committee.

Appendix 1
Committee Effectiveness Survey



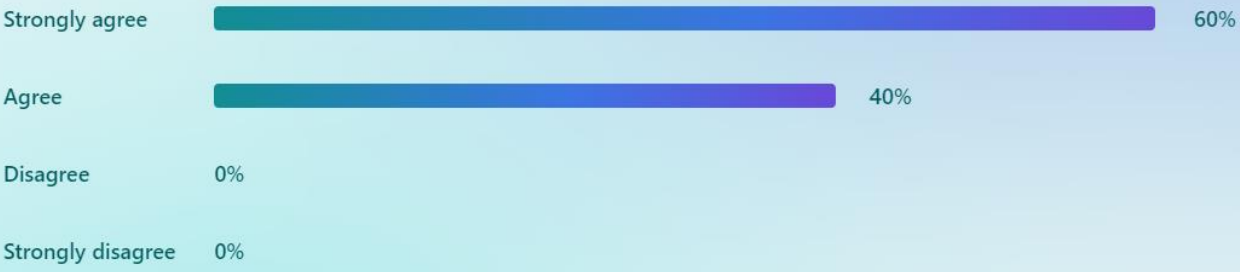
5 responses submitted

There is appropriate detailed discussion focused on decisions required and decision making is clear.



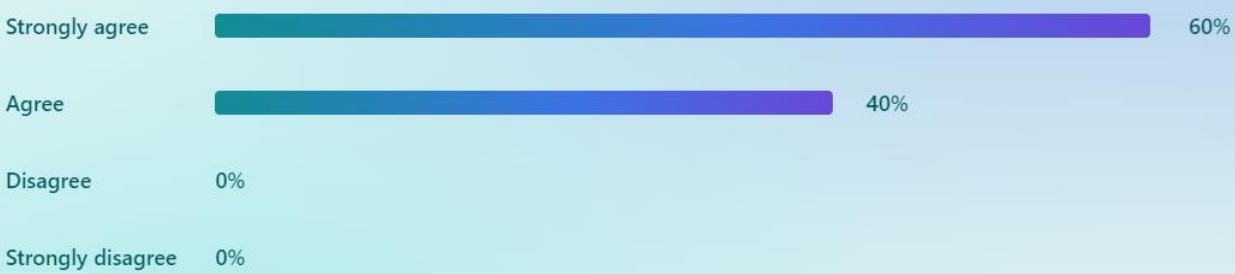
5 responses submitted

The frequency of meetings is appropriate and enables the Committee to effectively carry out its duties.



5 responses submitted

The Committee has the right balance of experience, knowledge and skill.



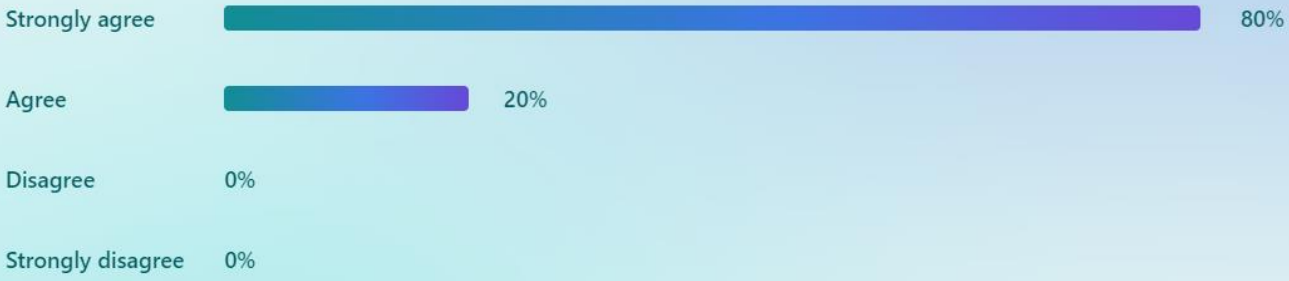
5 responses submitted

Please add commentary to support your response to Question 8.

"A good mix of professional colleagues "

5 responses submitted

The members and attendees of the Committee as detailed in the Terms of Reference are appropriate for the business of the Committee.



5 responses submitted

Members of the Committee are properly prepared for the meetings and contribute where appropriate.

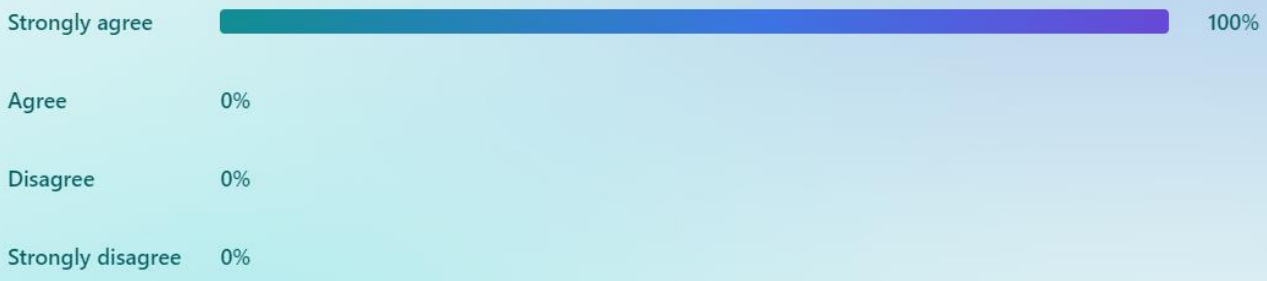
5 responses submitted

Please add commentary to support your response to Question 11.

"Information received in plenty of time "

5 responses submitted

All members and attendees of the Committee behave with courtesy and respect towards each other, and all views are respected in a non-judgemental way.



5 responses submitted

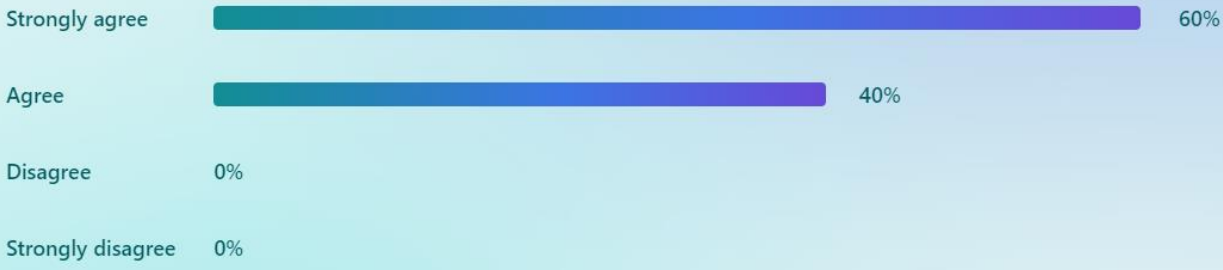
Papers are received with sufficient time to allow for proper consideration and understanding.

5 responses submitted

The quality of Committee papers allows me to perform my role effectively at the Committee.

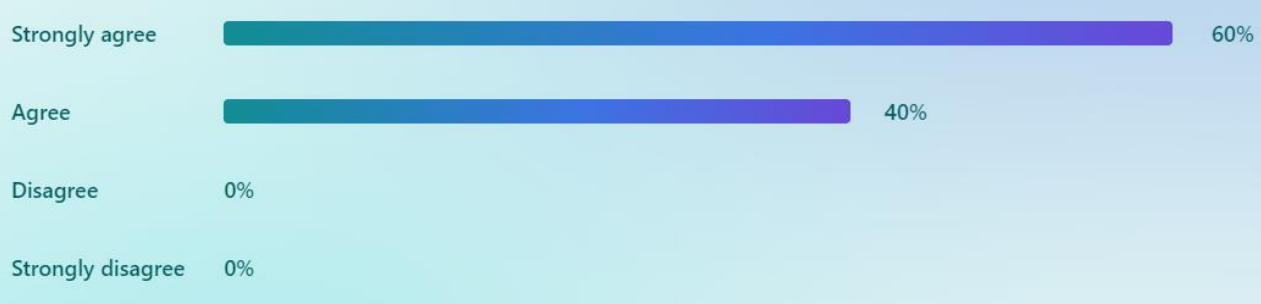
5 responses submitted

Sufficient time is given to the proper debate and understanding of both quality and operational/performance agenda items.



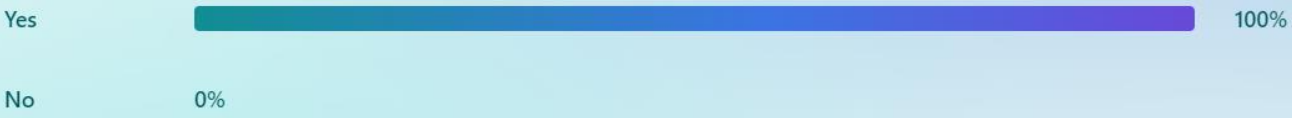
5 responses submitted

Members and attendees provide genuine support and challenge in order to evaluate levels of assurance.



5 responses submitted

Each agenda item is closed appropriately so that I am clear about the conclusion, who is doing what, when and how this is going to be monitored.



5 responses submitted

The Committee has an action log that is used effectively to ensure completion of outstanding matters.

5 responses submitted

The Committee meetings are chaired effectively and with clarity of purpose and outcomes (keeping on time, checking consensus between members).

5 responses submitted

The Committee has adequate administrative support.

5 responses submitted

Minutes clearly identify debate, action and who is responsible for them.

NHS
Blood and Transplant
www.nhsbt.nhs.uk

May 2024

Dear Dr Jenkins and Jo Beahan,

The number of donors and transplants in the UK have continued to improve and we are returning to pre-pandemic levels. Please accept our recognition and thanks for the effort of your staff.

This letter explains how your Trust contributed to the UKs deceased donation programme.

Organ and tissue donation and transplantation activity - 2023/24

From 7 consented donors, The Rotherham NHS Foundation Trust facilitated 5 actual solid organ donors resulting in 14 patients receiving a transplant during the time period. Additionally, 14 corneas were received by NHSBT Eye Banks from your Trust.

Quality of care in organ donation - 2023/24

The referral of potential organ donors to our Organ Donation Service and the participation of a Specialist Nurse for Organ Donation in the approach to family members to discuss organ donation are key steps in ensuring the success of organ donation.

- Your Trust referred 22 patients to NHSBT's Organ Donation Services Team; no referrals were missed (100% referral rate) and 12 met the referral criteria for inclusion in the UK Potential Donor Audit.
- A Specialist Nurse participated in 8 organ donation discussions with families of eligible donors. There were no occasions when a Specialist Nurse was absent for the donation discussion.
- Thank you for missing no opportunities to follow best practice out of 20 during the time period. This compares with 1 (6%) out of 16 in 2022/23.
- In North East and Yorkshire, 32% of the population have registered an NHSBT Organ Donor Register (ODR) opt in decision. This compares to 42% of the population nationally.

Up to date Trust metrics are always available via our Power BI reports found here:
https://www.odt.nhs.uk/statistics-and-reports/potential-donor-audit-report/.

What we would like you to do

- Ensure your Trust supports your Organ Donation Committee and Clinical Lead for Organ Donation in promoting best practice as they seek to minimise missed donation opportunities.
- Discuss activity and quality data at the Board with support from your Organ Donation Committee Chair.
- Recognise any successes your Trust has had in facilitating donation or transplantation, especially during the ongoing NHS pressures.
- An opt-in registration on the NHSBT Organ Donor Register results in the highest rates of consent, please support your Organ Donation Committee in their efforts to promote the NHSBT Organ Donor Register where possible.

Deemed Consent Legislation - England

England introduced deemed consent (Max and Keira's Law) in May 2020. In England between 20 May 2020 – 31 March 2024 there were 1812 occasions when consent was deemed from 3215 occasions where deemed consent applied.

Why it matters

In 2023/24, 643 people benefited from a solid organ transplant in the North East and Yorkshire. However sadly, 69 people died on the transplant waiting list during this time.

Thank you once again for your vital ongoing support for donation and transplantation.

Yours sincerely,

Anthony Clarkson
Director of Organ and Tissue Donation and Transplantation
NHS Blood and Transplant

Actual and Potential Deceased Organ Donation 1 April 2023 - 31 March 2024

NHS Blood and Transplant

The Rotherham NHS Foundation Trust

Organ Donation and Transplantation 2030: Meeting the Need

In 2023/24, from 7 consented donors the Trust facilitated 5 actual solid organ donors resulting in 14 patients receiving a life-saving or life-changing transplant. Data obtained from the UK Transplant Registry.

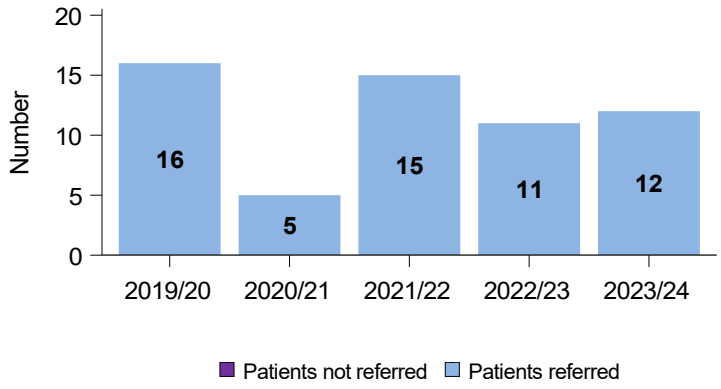
In addition to the 5 proceeding donors there were 2 consented donors that did not proceed.

Best quality of care in organ donation

Referral of potential deceased organ donors

Goal: Every patient who meets the referral criteria should be identified and referred to NHS Blood and Transplant's Organ Donation Service

Aim: There should be no purple on the chart

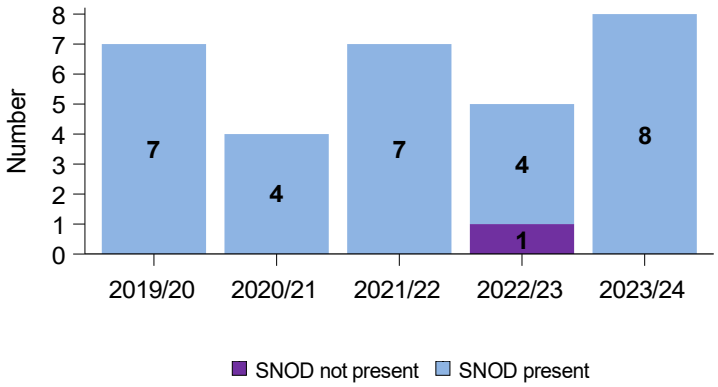


The Trust referred 12 potential organ donors during 2023/24. There were no occasions where potential organ donors were not referred.

Presence of Specialist Nurse for Organ Donation

Goal: A Specialist Nurse for Organ Donation (SNOD) should be present during every organ donation discussion with families

Aim: There should be no purple on the chart



A SNOD was present for 8 organ donation discussions with families during 2023/24. There were no occasions where a SNOD was not present.

Why it matters

- If suitable patients are not referred, the patient's decision to be an organ donor is not honoured or the family does not get the chance to support organ donation.
- The consent rate in the UK is much higher when a SNOD is present.
- The number of patients receiving a life-saving or life-changing solid organ transplant in the UK is increasing but patients are still dying while waiting.

Further information

Further information on potential donors after brain death (DBD) and potential donors after circulatory death (DCD) at the Trust are shown below, including a UK comparison. Data obtained from the Potential Donor Audit (PDA).

Key numbers comparison with UK data, 1 April 2023 - 31 March 2024

	DBD		DCD		Deceased donors	
	Trust	UK	Trust	UK	Trust	UK
Patients meeting organ donation referral criteria[1]	6	2029	6	5331	12	6911
Referred to Organ Donation Service	6	2017	6	4949	12	6522
Referral rate %		*99%*		*93%*		*94%*
Neurological death tested	6	1534				
Testing rate %		*76%*				
Eligible donors[2]	6	1426	4	3635	10	5061
Family approached	6	1259	2	1849	8	3108
Family approached and SNOD present	6	1215	2	1672	8	2887
% of approaches where SNOD present		*97%*		*90%*		*93%*
Consent ascertained	5	858	1	1023	6	1881
Consent rate %		*68%*		*55%*		*61%*
- Expressed opt in	4	533	1	637	5	1170
- Expressed opt in %		*95%*		*85%*		*89%*
- Deemed Consent	1	246	0	323	1	569
- Deemed Consent %		*58%*		*47%*		*51%*
- Other*	0	78	0	63	0	141
- Other %*		*52%*		*34%*		*42%*
Actual donors (PDA data)	4	788	1	710	5	1499
% of consented donors that became actual donors		*92%*		*69%*		*80%*

[1] DBD - A patient with suspected neurological death
DCD - A patient in whom imminent death is anticipated, ie a patient receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours

[2] DBD - Death confirmed by neurological tests and no absolute contraindications to solid organ donation
DCD - Imminent death anticipated and treatment withdrawn with no absolute contraindications to solid organ donation

* Includes patients where nation specific deemed criteria are not met and the patient has not expressed a donation decision in accordance with relevant legislation

Note that a patient that meets both the referral criteria for DBD and DCD organ donation is featured in both the DBD and DCD data but will only be counted once in the deceased donors total

For further information, including definitions, see the latest Potential Donor Audit report and up to date metrics via our Power BI reports at:
https://www.odt.nhs.uk/statistics-and-reports/potential-donor-audit-report/.

Board of Directors
05 July 2024

The Rotherham NHS Foundation Trust

Agenda item	P116/24
Report	**Emergency Preparedness Resilience & Response**
Executive Lead	Sally Kilgariff, Chief Operating Officer
Link with the BAF	OP3: robust service configuration across the system will not progress and deliver seamless end to end patient care across the system D5: we will not deliver safe and excellent performance
How does this paper support Trust Values	**Ambitious**: Ensuring the Trust is delivering high quality services and a a level of compliance with EPRR core standards **Caring**: Ensuring robust emergency planning arrangements to ensure patients can be seen and cared for in all eventualities **Together**: Working collaboratively with partners to deliver services and achieve the core standards required
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	This report outlines the Trust's Emergency Preparedness, Resilience and Response (EPRR) arrangements for the period 2023/24 to the Board of Directors. The EPRR core standards assurance process requires a report to be delivered to a public board stating its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	The paper has been presented to Executive meeting and Finance and Performance Committee and was supported.
Board powers to make this decision	The Board of Directors is required to receive an annual update as part of the Core Standards process. The Board of Directors has delegated oversight of the Trust's EPRR activities and assurance to the Finance and Performance Committee who receive regular updates.
Who, What and When (what action is required, who is the lead and when should it be completed?)	The EPRR core standards assurance process requires an annual update paper to be presented to a Public Board meeting.
Recommendations	The Board of Directors are asked to note the content of this report.

Appendices	Report attached – no further appendices

Background

The Civil Contingencies Act (CCA 2004) outlines a single framework for civil protection in the United Kingdom. Part 1 of the Act establishes a clear set of roles and responsibilities for those involved in emergency preparedness and response at a local level. As a category one responder, the Trust is subject to the following civil protection duties:

- Assess the risk of emergencies occurring and use this to inform contingency planning
- Put in place emergency plans
- Put in place business continuity management arrangements
- Put in place arrangements to make information available to the public about civil protection maters and maintain arrangements to warn, inform and advise the public in the event of an emergency
- Share information with other local responders to enhance coordination
- Cooperate with other local responders to enhance coordination and efficiency

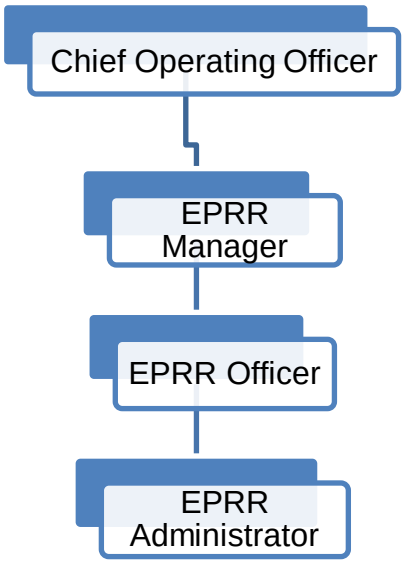
The NHS Emergency Preparedness Resilience and Response (EPRR) Framework (2022)[1] describes how the NHS in England will go about its duty to be properly prepared for dealing with emergencies. The document provides the framework to help NHS Funded Organisations meet the requirements of the CCA 2004, the NHS Act 2006, the Health and Care Act 2022 and the NHS Standard Contract. The EPRR core standards assurance process requires a report to be delivered to a public board stating its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements.

This paper outlines the Trust's EPRR arrangements including resourcing, governance, risk assessment, incident response plans, a summary of incidents where command and control processes have been activated, organisational learning, training and exercising, audit and concluding with the current EPRR assurance process and update on progress against the improvement plan.

[1] B0900_emergency-preparedness-resilience-and-response-framework.pdf (england.nhs.uk)

EPRR Resourcing

The Chief Operating Officer is the Trust's Accountable Emergency Officer (AEO) responsible for EPRR. The Trust's EPRR arrangements are resourced as below;



The past year has been challenging for the EPRR team given necessary abstractions from core duties to support the planning, incident management and recovery from multiple periods of industrial action whilst also recovering their programme of work post pandemic. The introduction of an evidence based core standards assurance check and challenge process by the regional NHS England EPRR team, including significantly higher standards for compliance in comparison to previous years has also increased demands of the team. Whilst EPRR resourcing is currently sufficient and appropriate, a formal review will be undertaken to assess if increased demand warrants a proportionate addition to the Trust's EPRR resourcing. The review will be aligned to agreed methodology currently being developed by the South Yorkshire Integrated Care Board EPRR team.

Governance

Governance is delivered through the EPRR group which has representation from across the Trust, a Terms of Reference and meets monthly chaired by the Director of Operations. Relevant matters, including any key issues and risks are escalated to the Chief Operating Officer. The meeting reports directly into the Executive Team Meeting, with minutes of the meeting received by that committee on a monthly basis.

Risk Assessment

The Trust manages a specific EPRR risk register, the content of which is drawn from the national risk register, South Yorkshire Local Resilience Forum community risk register, the North East & Yorkshire NHS England EPRR risk register, along with any locally identified organisational risks. The register is reviewed quarterly by the Trust EPRR group and informs a programme of work. Relevant risks are recorded on the corporate risk register.

Incident Response Plans

A suite of emergency plans, reviewed annually is in place and available for all Trust staff to access and view online via the Hub. Hard copies of each plan are retained in the Incident Control Centre and at operational level. Plans are exercised according to an agreed schedule. Any new or existing Trust wide plans which have been significantly updated are presented to the

Executive Team for approval whilst other plans reviewed are approved by the Trust EPRR group with Director level oversight.

The planning and exercising process includes collaboration with other resilience partners.

Each service across the Trust has their own business continuity plan. Plans are reviewed at least annually and following an incident when the plan is activated. Hard copies of plans are held with operational teams for immediate access when required.

Response to and recovery from emergencies and business continuity incidents is managed through embedded command, control, coordination and communication (4C) processes, mirroring national, regional and local arrangements.

Incidents

A number of incidents have resulted in the Trust activating its 4C processes and business continuity plan over the past year, summarised below;

April	
11 – 14th	Industrial Action – Doctors in Training
May	
1-2nd	Industrial Action – Ambulance Service
June	
2nd	Industrial Action – Ambulance Service
8th	Trust wide Power Outage (External cause)
14 – 17th	Industrial Action – Doctors in Training
23rd	Industrial Action – Ambulance Service
26th	Industrial Action – Ambulance Service
July	
13 – 18th	Industrial Action – Doctors in Training
20 – 22nd	Industrial Action – Consultants
August	
11-15th	Industrial Action – Doctors in Training
17th	Power Outage – RCHC
24th	Ward B10 Power Outage
24-25th	Industrial Action – Consultants
September	
19-21	Industrial Action – Consultants
20-23	Industrial Action – Doctors in Training
October	
2-4th	Industrial Action – Consultants & Doctors in Training
16th	Loss of Water – RCHC
20-22nd	Adverse Weather – Storm Babet
November	
6th	IT Outage – Netcall & Safemove
20th	IT Outage – Telephony
December	
20-23rd	Industrial Action – Doctors in Training
January	
3-9	Industrial Action – Doctors in Training
February	
2nd	Sewerage Pipe Burst – UECC
24 – 28th	Industrial Action – Doctors in Training
March	

13-16th 22nd 29th	Industrial Action – Doctors in Training Portable Telephony (DECT) outage Adverse Weather (Snow)

The Trust also established its 4C process throughout the Winter period.

Organisational Learning

Following each incident resulting in the activation of Trust 4C processes, a structured debrief including colleagues involved in the response and recovery phases of the incident is held with a report produced highlighting both areas of good practice and learning. Debriefs also take place following exercises. Reports are considered by the Trust EPRR group and identified owners assigned to complete approved recommendations, plans updated and learning shared. A recommendation and action tracker is maintained by the EPRR team and reviewed by the EPRR group quarterly.

Training & Exercises

Over the past 12 months the following has been delivered;

Training

- Decision Logging
- On Call Induction
- Major Incident Response
- Security Incident Management
- Incident Control Room Activation
- Adverse Weather Preparedness
- Principles of Health Incident Command – This course is mandatory for all colleagues performing the role of Director on call, Senior Manager on Call and the Clinical Site Operations Team.

Exercising

- Exercise Trojan - Cyber Security
- Exercise Parlez - Major Incident Communications
- Business Continuity Incidents
- Lockdown Incidents
- Exercise Miasma - Chemical, Biological, radiological, Nuclear & Hazardous materials (CBRN/HAZMAT

The NHS EPRR Framework requires the Trust to complete the following:

Exercise Type	Minimum Frequency	Completed
Communication Exercise	6 monthly	22 August 2023 22 February 2024
Table-top	Annually	6 December 2023
Live Play	3 Yearly	6 September 2023
Command Post	3 Yearly	Industrial Action throughout the reporting period

Incident Control Centre (ICC) Equipment Test	3 monthly	11 October 2023 22 February 2023 Exercises scheduled for Q1 and Q2 were stood down due to Industrial Action and other incidents associated with operational pressures however the EPRR team did ensure the ICC equipment was tested and remained fully functional.

Audit

NHS England and Yorkshire Ambulance Service completed an interim audit of the Trusts' preparedness to deal with a Chemical Biological Radiological Nuclear (CBRN) / Hazardous Material (HAZMAT) incident. The audit process had been updated to include specific CBRN/HAZMAT core standards included within the annual EPRR assurance process requiring a more rigorous portfolio of evidence. The audit outcome stated the Trust is 'partially prepared pending further evidence' in being able to deal with any type of CBRN/HAZMAT incident. Several recommendations arose from the audit which the EPRR team are addressing alongside colleagues from the Urgent & Emergency Care Centre.

360 Assurance undertook an audit with Health Informatics colleagues to provide independent assurance on the effectiveness of arrangements in place to learn lessons from IT business continuity test exercises and live events resulting in an audit opinion of 'limited assurance', recommending actions for both Health Informatics and the EPRR team. The audit report commented there were weaknesses in the design and/or inconsistent application of the framework of governance, risk management and control that could result in failure to achieve the objectives of the system under review. Accompanying the assurance were a total of six actions ranging from medium to high priority. All actions are being addressed and will be completed within the agreed timeframe.

EPRR Assurance

All NHS organisations are required to complete an EPRR core standards annual self-assessment process of compliance, the minimum requirements commissioners and providers of NHS funded services must meet. The 2023/24 process saw the introduction of an evidence based check and challenge process led by the regional EPRR team including a significantly higher standard for compliance in comparison to last and previous year's processes, requiring Trusts to submit plans, policies and supporting evidence, assessed for compliance by the regional team which is out with of national arrangements in all but one other region who piloted the process last year. This resulted in the Trust's compliance rating reducing significantly which was mirrored across other Trusts across the ICB footprint. Of the 62 core standards, 22 were fully compliant, 39 partially compliant and 1 non-compliant leading to an overall assessment of non-compliant, accompanied by an improvement plan and programme of work. Quarterly updates are provided to the Finance and Performance Committee.

Recommendation

The Board of Directors are asked to note the content of this report outlining the Trust's readiness and preparedness activities that have been undertaken.

Craig Patchett
Emergency Planning & Business Resilience Manager
June 2024

Board of Directors' Meeting
05 July 2024

Agenda item	P117/24
Report	**Register of Seal Report**
Executive Lead	Angela Wendzicha, Director of Corporate Affairs
Link with the BAF	Not applicable for this report.
How does this paper support Trust Values	This report supports the core value of Ambitious ensuring the Board complies with the requirements it sets out in its Constitution in relation to the signing and sealing of documents with third parties
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☒
Executive Summary	The following register of use of the Trust Seal is presented to the Trust Board in accordance with Section 10.3 of the current Standing Orders. The last report to Board was February 2023. The Trust Seal was last applied to November 2023 and April 2024 as described in the attached register.
Due Diligence	This report has not been, and is not required to be considered by any other Committee.
Board powers to make this decision	No decision is required by the Trust Board, however, the Board will note that the current Trust Standing Orders (Section 10.3) requires a report to be made to the Board when the Seal has been applied.
Who, What and When	No additional action is required. The Director of Corporate Affairs will be charged with compliance with the relevant procedures and will be supported by the Deputy Director of Corporate Affairs during this process.
Recommendations	It is recommended that the Board receives and notes the content of the report.
Appendices	Register of application of the Seal since the last report to Board in February 2023.

Register of Use of the Trust Seal

1. Introduction

1.1 In accordance with Section 10.3 of the current Standing Orders.

"An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal."

1.2 The last report to the Board on matters relating to the Trust Seal was February 2023.

2. Use of the Trust Seal

2.1 Since the last report, the Trust Seal has been applied on two occasions as follows:

Document Sealed	Date of Sealing	Officers Attesting the Seal
Deed of Amendment and Restatement: Veolia Resource Efficiency	09 November 2023	Michael Wright Steve Hackett
Lease of Electricity Sub-Station Accommodation at Rotherham Hospital Northern Power Grid	11 April 2024	Steve Hackett Angela Wendzicha

3. Recommendations

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

Board Planner

Event/Issue

Action	TRUST BOARD MEETINGS		2024								2025	
			Jan	March		May	June	July	Sept	Nov	Jan	March
			12	8		3	11	7	8	3		
			M10	M12		M2		M4	M6	M8	M10	M12
	PROCEDURAL ITEMS											
	Welcome and Apologies	Chair	•	•		•		•	•	•	•	•
	Quoracy Check	Chair	•	•		•		•	•	•	•	•
	Declaration of Conflicts of Interest	Chair	•	•		•		•	•	•	•	•
	Minutes of the previous Meeting	Chair	•	•		•		•	•	•	•	•
	Action Log	Chair	•	•		•		•	•	•	•	•
	Matters arising (not covered elsewhere on the agenda)	Chair	•	•		•		•	•	•	•	•
	Chairman's Report (part 1 and part 2)	Chair	•	•		•		•	•	•	•	•
	Chief Executive's Report (part 1 and part 2)	CEO	•	•		•		•	•	•	•	•
	STRATEGY & PLANNING											
	TRFT Five Year Strategy 6 month Review	CEO				•				•		
	Operational Plan: 6 Month Review	DCEO				•				•		
	Annual Operational Planning Guidance	COO									•	
	Winter Plan	COO								•		
	Digital Strategy	CEO						•dfd	•	•		
	Estates Strategy	DoF	•					•dfd	•		•	
	People and Culture Strategy	DoW				•						
	Quality Improvement Strategy.	CN								•		
	Fire Safety Strategy (via ETM)	DOE				•						
	SYSTEM WORKING											
	SYB ICS and ICP report	DCEO	•	•		•		•	•	•	•	•
	SYB ICS CEO Report (included as part of CEO report)	CEO	•	•		•		•	•	•	•	•
	Partnership Working	NED				•			•			
	SYB ICS - Wider Needs of Rotherham Community	Public Health		•					•			
	CULTURE											
	Patient Story	CN		•				•		•		•
	Staff Story	DoW	•			•			•		•	
	Annual Staff Survey	DoW		•								
	Staff Survey Action Plans	DoW										
	Freedom to Speak Up Quarterly Report	CN	•			•			•dfd	•	•	
	Gender Pay Gap Report and Action Plan	DoW		•								•
	Integrated EDI Plan - WRES, WDES, PSED	DoW							•			
	Patient Experience and Inclusion Annual Report	CN						•				
	End of Life Annual Report	DCN						•				
	ASSURANCE											
	Integrated Performance Report:	COO	•	•		•		•	•	•	•	•
	Maternity including Ockenden	CN	•	•		•		•	•	•	•	•
	Safe Staffing & Establishment Nurse review (6 monthly)	CN	•					•			•	
	Safe Staffing & Establishment Nurse review	CN		•								
	Reports from Board Assurance Committees	NEDs	•	•		•		•	•	•	•	•
	Finance Report	DoF	•	•		•		•	•	•	•	•
	Operational Update, Including Recovery and Winter Update	COO	•	•		•		•	•	•	•	•
	Car Parking Review (via ETM)	DOE				•		•				
	Summary of review on Laboratory safety prior to TUPE of staff	MD		•								
	ASSURANCE FRAMEWORK											
	Governance Report	DoCA	•	•		•		•	•	•	•	•
	Board Assurance Framework	DoCA	•	•		•		•	•	•	•	•
	Quarterly Risk Management Report	DoCA		•		•		•		•		•
	Corporate Risk Register	DoCA	•	•		•		•	•	•	•	•
	Annual Review of risk appetite	DoCA						•				
	Assurance Board Committee ToRs - Audit & Risk Committee	DoCA						•				
	Assurance Board Committee ToRs - FPC, QC, PC	DoCA		•								
	Health and Safety Annual Report	DoE							•			
	Quality Assurance Quarterly Report	CN		•		•			•	•		•
	SIRO Annual Report	DCEO						•dfd	•			

	Safeguarding Annual Report	CN							•			
	Organ Donation Annual Report	HC						•				
	POLICIES											
	Health and Safety Policy (review date August 2026)	DoE							•			
	Freedom to Speak Up Policy (Updated when National Policy available)	CN										
	Management of Complaints and Concerns Policy (review due 2025)	CN										
	Procurement Policy (due for renewal February 2026)	DoF										
	Risk Management Policy (due April 2026)	DoCA										
	REGULATORY AND STATUTORY REPORTING											
	Annual Report and Audited Accounts	DoF					•					
	Audit & Risk Committee Annual Report	Com Chair					•					
	People & Culture Committee Annual Report	Com Chair					•					
	Finance and Performance Committee Annual Report	Com Chair					•					
	Quality Committee Annual Report	Com Chair					•					
	Nomination and Remuneration Committee Annual Report	Com Chair					•					
	Annual Quality Account (approval)	CN					•					
	Data Security and Protection Toolkit Recommendation Report	SIRO						•dfd	•			
	Quarterly Report from the Responsible Officer Report (Validation)	MD	•			•			•		•	
	ANNUAL Responsible Officer report (Validation)	MD				•						
	Quarterly Report from the Guardian of Safe Working	MD	Q4 •			•			Q2 •	Q3 •		
	ANNUAL Report from the Guardian of Safe Working	MD				•					•	
	Learning from Deaths Quarterly Report	MD		•		•		•		•		•
	Learning from Deaths Annual Report	MD							•			
	Emergency preparedness, resilience and response (EPRR) assurance process sign off/Annual Report	COO						•				
	Legal Report	DOCA		•		•			•	•		•
	Controlled Drugs Annual Report	MD							•			
	BOARD GOVERNANCE											
	Executive Team Meetings report	CEO	•	•		•		•	•	•	•	•
	Assurance Committee Chairs Logs	NEDs	•	•		•		•	•	•	•	•
	Register of Sealing (bi-annual review)	DoCA						•			•	
	Register of Interests (bi-annual review)	DoCA				•				•		
	Register of use of electronic signature (bi-annual review)	DoCA							•		•	
	Review of Board Feedback	DoCA						•				
	Review of Board Assurance Terms of Reference	DoCA										
	Review of Standing Financial Instructions	DoF								•		
	Review of Scheme of Delegation	DoF								•		
	Review of Standing Orders	DoCA								•		
	Review of Matters Reserved to the Board (ad hoc)	DoCA										
	Constitution	DoCA							•			
	Annual (re)appointment of Senior Independent Director (requires Governor input) included in Chairs Report	Chair							•			
	Annual (re)appointment of Board Vice Chair (part of Chair's report)	Chair							•			
	Annual Board Meeting dates - approval	DoCA							•			
	Fit and Proper Person	DoCA							•			
	Escalations from Governors	Chair							•	•	•	•
	Remuneration Committee Chair Assurance Report	Chair								•		
	Nomination Committee Chair Assurance Report	Chair								•		
	Annual Planner	Chair	•	•		•		•	•	•	•	•
	Annual Refresh of Committee membership (part of Chairs Report)	Chair				•						
	Audit & Risk Committee minutes	Chair	•			•		•			•	
	Quality Committee minutes	Chair	•	•		•		•	•	•	•	•
	People & Culture Committee	Chair	•	•		•		•	•	•	•	•
	Finance & Performance Committee minutes	Chair	•	•		•		•	•	•	•	•
	Nomination Committee minutes (ad hoc)	Chair				•		•	•	•		
	Remuneration Committee Annual Report	Chair							•			
	Remuneration Committee minutes (ad hoc)	Chair							•	•		
	Going Concern	DoF		•								•
	Segmental Reporting	DoF		•								•
	Accounting Policies	DoF		•								•

	Ad Hoc Business Cases for consideration by Board value in excess of £1m											
	Out-patient Pharmaceutical Dispensing Services	COO				•						
	Board feedback		RS	SH		HW		JBe	MT	MW	RS	SH
	NED Review of complaints files (Quarterly)		KM			JB		HW		MT	New NED	