Board of Directors (Public)

The Rotherham NHS Foundation Trust

Schedule	Friday 6 September 2024, 9:00 AM — 12:30 PM BST
Venue	Boardroom, Level D
Organiser	Angela Wendzicha

Agenda

9:00 AM	PROCEDURAL ITEMS	
	P122/24.	Chairman's welcome and apologies for absence For Information
	P123/24.	Quoracy Check For Assurance
	P124/24.	Declaration of interest For Assurance
	P125/24.	Minutes of the previous meeting held on 5 July 2024 For Approval
	P126/24.	Matters arising from the previous minutes (not covered elsewhere in the agenda) For Assurance
	P127/24.	Action Log For Decision
9:05 AM	OVERVIEW AND CONTEXT	

	P128/24.	Board Committees Chairs Reports - Committee Chairs i. Quality Committee - Chair's Log - Julia Burrows ii. Finance & Performance Committee - Chair's Log - Martin Temple For Information
	P129/24.	Strategic Risk Appetite Review 2024/25 For Decision - Presented by Angela Wendzicha
	P130/24.	Board Assurance Framework For Decision - Presented by Angela Wendzicha
	P131/24.	Corporate Risk Register Report For Information - Presented by Angela Wendzicha
	P132/24.	Report from the Chairman - Verbal For Information
	P133/24.	Report from the Chief Executive For Information
9:55 AM	CULTURE	
	P134/24.	Staff Story - Leadership and Development - Presentation by Emily Goodwin & Louise Price For Information - Presented by Daniel Hartley
	P135/24.	Adoption of the North West BAME Assembly Anti-Racist Framework For Decision - Presented by Daniel Hartley
10:25 AM	SYSTEM WORKING	
	P136/24.	National, Integrated Care Board and Rotherham Place Update For Information - Presented by Michael Wright

	P137/24.	Partnership Working For Information - Presented by Michael Wright and Martin Temple
10:45 AM	BREAK	
10:55 AM	PERFORMANCE	
	P138/24.	Finance Report For Assurance - Presented by Steve Hackett
	P139/24.	Integrated Performance Report For Assurance - Presented by Michael Wright
11:15 AM	ASSURANCE	
	P140/24.	Maternity and Neonatal Safety Report For Assurance - Presented by Helen Dobson
	P141/24.	Quality Assurance Quarterly Report For Assurance - Presented by Helen Dobson
	P142/24.	Safeguarding Annual Report For Assurance - Presented by Helen Dobson
11:45 AM	REGULATORY AND STATUTORY REPORTING	
	P143/24.	Responsible Officer Report - Q4 2023/24 and Annual Board Report & Statement of Compliance For Information - Presented by Jo Beahan
	P144/24.	Guardian of Safe Working Quarterly Report - Presented by Gerry Lynch For Information

	P145/24.	Controlled Drugs Annual Report For Assurance - Presented by Jo Beahan
12:15 PM	BOARD GOVERNANCE	
	P146/24.	Vice Chair and Senior Independent Director Appointment For Approval - Presented by Mike Richmond
	P147/24.	Fit and Proper Person Report For Assurance - Presented by Mike Richmond
	P148/24.	Annual Board Meeting Dates 2025 For Approval - Presented by Mike Richmond
	P149/24.	Annual Work Plan 2024-25 For Information
	P150/24.	Any Other Business For Discussion
	P151/24.	Questions from Members of the Public on the Business of the Meeting For Discussion
	P152/24.	Date of next meeting - 8th November 2024
	CLOSE OF MEETING	

Draft until approved at 6th September 2024 meeting

The Rotherham NHS Foundation Trust

MINUTES OF THE BOARD OF DIRECTORS MEETING
Friday 05 July 2024, 09:00 – 12:00 pm
Boardroom

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

In attendance:
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
Mrs L Martin, Director of Estates and Facilities
Ms C Rimmer, Corporate Governance Manager (minutes)
Mrs D Timms, Acting Head of Nursing, Care Group 2 (for item P106/24)

Observers:
Mr S Nordkill, Staff Governor
Ms V Ball, Public Governor
D Sharratt (HBSUK)
S Leggett (SystemC)
R Purewal (C2-Ai.com – Healthcare Analytics company)
P Hunter (Sodexo – Catering & Facilities company)

Apologies:
Mr K Malik, Non-Executive Director
Ms H Watson, Non-Executive Director

Item	Procedural Items	Action
P95/24	**CHAIRMAN'S WELCOME & APOLOGIES FOR ABSENCE** Chair opened the meeting, noting the recent change of Government following the previous night's election results.	
P96/24	**QUORACY CHECK** The meeting was confirmed to be quorate.	

P97/24	**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.	
P98/24	**MINUTES OF PREVIOUS MEETING HELD ON 3RD MAY 2024** The minutes were approved as a correct record, subject to minor amendments.	
P99/24	**MATTERS ARISING** There were no matters arising which were not covered by either the action log or agenda items.	
P100/24	**ACTION LOG** The Action Log was received and Log no. 7 was agreed to be closed. The outstanding actions were to remain open and are due for September.	
	OVERVIEW AND CONTEXT	
P101/24	**Board Committees Chairs Reports** i. Quality Committee Ms Burrows escalated four items to the Board as follows: • The Committee received a presentation from Care Group 4 which provided reassurance for the committee on Virtual Ward and assurance that deaths are monitored due to the exclusion from SHMI data. • From the Maternity and Neonatal Safety report, Ms Burrow detailed that a Non-Executive Maternity Safety Champion must be identified, Ms Burrows praised the improvements in the Smoking data, and highlighted the ongoing risk of plastic wallets that signals issues with the Trust's process due to the longevity to receive the supply. • The Committee recommended the BAF score to remain at 12, however this is subject to a full review with the understanding that this will identify movement in the risk scoring due to a number of gaps closed and controls in place. • The Risk Register, noting the need for timescales for movement on risks and escalated the concerns regarding the operation of SDEC. ii. People & Culture Committee	

Dr Shah highlighted the successful PROUD awards which recognised the workforce and people going above and beyond. Dr Shah also updated the Board on Job Planning, discussing that whilst the aspiration is 100%, there are challenges in reporting to align with the financial year. Dr Beahan noted that the 12 month rolling sign off compliance is approximately 70%, whereas, aligning with the financial year, it is 23% and stated the importance of having a job plan in place.

Dr Jenkins discussed the focus on Job Planning to ensure a clear line of sight from Job Plans to productivity to enable better predictions and planning. It was suggested to maintain the financial year reporting, however, from an Executive perspective and internal performance reviews, the 12 month rolling would be acceptable, and would be a better fit for consultants. Mrs Craven supported this and echoed the importance of having Job Plans in place. Mrs Craven summarised that if the Trust is to make a step change, we need to know the underlying capacity. Mrs Kilgariff discussed the work in progress on capacity planning which will be live planning, rather than a year-end review, and this would link in with 12 month rolling Job Planning.

Mr Richmond concluded that this needs to be a systematic process and that flexible capacity is needed to meet changes in demand.

iii. Finance & Performance Committee

Mr Temple presented the Chair's report outlining several items including:

- The Committee received the presentation from Care Group 2 and noted the level of challenges, but with changes in leadership, consolidation is now the focus.
- The issues with the Mexborough project, run by a project group when an operational group is needed.
- The encouraging report on Cancer Services detailing a number of elements going in the right direction.
- Building the foundations for the Estates Strategy, including developing a priority list as a proactive approach to short deadlines for funding.
- The Committee received a report on Cyber Security and the risk from and to external suppliers.

Mrs Craven drew attention to the financial report and the impending ICB recovery plan, querying whether the internal budget holders have been notified to produce a plan. Mr Hackett discussed that there has been no sight of the final plan and or response and summarised that as a system, we will have a challenge and will need to find a solution.

Mr Richmond concluded that this is a live issue for Board level focus due to the collateral impact from the ICB, and the impact for the Trust moving forward.

Regarding Cancer Services, Mr Richmond queried whether there are any consequences in the care pathway from external providers and Mrs Kilgariff detailed that the main impact is the access to oncology support. Mrs Kilgariff also highlighted the delays in tertiary services and that they are looking at which elements can be delivered more locally. Mr Temple noted the Cancer Services

	report received by the committee and the changes in approaches that were encouraging. Dr Beahan updated the Board on discussions with the Cancer Lead Nurse and the plan to produce a Cancer Quality Annual Report, which will report to Quality Committee and then to Board.	
P102/24	**<u>Board Assurance Framework</u>** Ms Wendzicha presented the report, outlining the process of regular monthly meetings taking a deep dive in the BAF with each Executive Lead. For the BAF aligned to the Quality Committee, Mrs Dobson reminded the Board that the scoring reduced from 16 to 12 last year, following completion of outstanding CQC actions, and it was agreed to remain at 12 until a full CQC inspection had taken place. Mrs Dobson detailed that there have been a number of audit reports giving moderate and significant assurance, there have been improvements in Mortality Rates, the suite of metrics for patient safety have improved and concluded that this should now be reflected in the BAF. Mrs Dobson acknowledged the tentative approach to reducing the score, but suggested decreasing the likelihood scoring from 3 to 2 and therefore reduce the score from 12 to 8. Mr Richmond commented that the BAF should be a dynamic document, identifying the risks and putting in effective mitigation, and that the work done should be reflected in the scoring. The Board agreed with the reduction in score to 8. For the BAF risk in relation to partnership working, Ms Wendzicha detailed that this was reduced at the end of last year and there are ongoing additional controls expected to reduce the risks. Mr Wright detailed that they have established workings with other leaders and the Trust is able to influence at PLACE-level. Mr Wright added that the next steps are to look at ethnicity data for more granular information and incorporate further the work by the Public Health Consultant. For the BAF risks aligned to the People and Culture Committee, Mr Hartley outlined that the previous wording of U4 conflates two issues and the view was that the risk relating to resource is adequately monitored in D5, allowing full focus for the aligned BAF risk to be on people and culture; the wording has been reviewed and updated to reflect this notion. Ms Burrows supported the change and queried the timescale for a full review of the BAF. Ms Wendzicha discussed that, subject to the refresh of the Trust strategy, deep dives and workshops with the relevant executives can be actioned to refresh the BAF. The Board approved the rewording of U4. Furthermore, Mr Hartley detailed that the score remains at 12, observing that good progress in mitigations has been made but with the view to show that	**AW**

	momentum can be sustained throughout the next quarter and also factoring the external challenges. Mrs Kilgariff updated the Board on the operational risk D5, noting that key impacts are the demands of the urgent care pathway without the alignment of funding, anaesthetics shortages resulting in lack of theatres, and impacts on waiting times and the non-elective pathway. Mrs Kilgariff suggested the wording is reviewed to ensure clarity and sub-categorisation, linking with the Organisational Priorities. Mr Richmond agreed that the wording is all-encompassing and re-describing would allow for clearer monitoring of effective mitigations. Dr Jenkins discussed that this exemplifies elements of the BAF that need to be reviewed as good intentions are being lost. Mrs Craven agreed and noted that, looking at all seven BAF risks, none have got close to the level set by the Board, but Mr Richmond raised that sometimes mitigations may not improve issues, but halt negative trajectories against increasing demand. For the BAF Risk D8, Mr Hackett updated the Board on the closure of the last financial year on plan, but warned against the pressures of increasing demand. For the new financial year, Mr Hackett detailed that part of the financial plan has been signed off and is a good building block to move forwards. The risk score was recommended to remain at 20, monitored by the Finance and Performance Committee. The Board accepted current position as stated in paper, approved the reduction in score for P1, as discussed, and the rewording of U4.	
P103/24	**<u>Corporate Risk Register Report</u>** Ms Wendzicha introduced the report and outlined the plan over the next month for deep dives with each risk owner to analyse actions completed and identify additional controls and mitigations for risk scores to be reduced. Mr Richmond raised the low compliance rate for Care Group 2 and suggested more support is needed, particularly with the new leadership. Dr Shah queried Risk 6718 and Mrs Kilgariff discussed the work ongoing to prioritise patients and that the overall capacity of the team is being reviewed jointly with Care Group 1, with a business case coming through. Mrs Kilgariff noted that this was a duplicate risk which has now been aligned to one risk under the remit of Care Group 1 with clear actions moving forward.	
P104/24	**<u>Report form the Chairman - Verbal</u>** Mr Richmond discussed that the Trust is now at the beginning of Quarter 2 and with enormous challenges, the Trust is performing strongly in many areas, however, we will be impacted by areas outside our control, such as Industrial Action (IA). Mr Richmond shared concerns that IA has been normalised and the significant impact on operational pressures is unremitting.	

	Mr Richmond cautioned the Board to remain vigilant, assuming the challenges will increase and requested continuation of 100% attention, continuing to be ambitious, have confidence, but to keep strong momentum.	
P105/24	**Report for the Chief Executive** Dr Jenkins introduced the report, summarising that a challenging year is expected. Industrial Action has been managed well, but it takes time and resources. Dr Jenkins discussed the settlement with SAS doctors but outlined the threat of primary care GPs working to contract which would have consequence of increased UECC attendances, affect compliance on referral pathways and patient flow and detailed that a period of planning has commenced. Dr Jenkins highlighted the successful Proud Awards, that a number of consultants are joining the Trust and drew attention to the updates and reports from the ICB and Acute Federation. Regarding GPs, Dr Shah detailed that NSHE had charged ICBs to change the partnerships between the Acute and Primary Care services and the challenges that are still apparent. Dr Shah queried the Trust's connection with Primary Care services and Dr Jenkins explained that the Place partnership is a key connection and that a scoping meeting is scheduled to review how to improve the situation. Dr Beahan detailed the Primary and Secondary care interface and the active engagement here; there are regular meetings with the Chair of the Local Medical Committee (LMC) and Executives have tasked Care Group directors and deputies to think about how to work better together, looking at opportunities in both directions.	
	CULTURE	
P106/24	**Patient Story** The Board welcomed Mrs Timms to the meeting and Mrs Dobson reflected on the importance of reporting the negative stories and the learning gained, as well as the positive stories that are shared. Mrs Timms presented a patient story who had a negative patient experience during her time at the hospital. Mrs Timms explained the errors in communication that occurred and the lack of dignity for the patient when receiving bad news, resulting in a compliant being made and low staff morale on the realisation of their mistakes. Mrs Timms discussed the learning from the incident, particularly in regard to consideration of the patient's understanding of terminology, the best practice for delivering news of a diagnosis and linking better with the Cancer Team. Additionally, there is now increased time for reflection and discussions in Governance and Team meetings. Furthermore, the Senior Leadership team and Clinical Governance Lead met with the patient in their own home, following the complaint and the patient accepted the visit. Mrs Dobson summarised that, from patient surveys, the Trust is aware of the work needed in regards to better communication, privacy and dignity. The	

	patient story demonstrates compassion and learning, but highlights the work needed to embed change. Mrs Ahmed stressed the importance of using plain English for patients. Mrs Dobson highlighted that the Cancer Nurse Specialist would have really been of benefit in this situation to ensure and help patients to understand and that changes are in progress to use the Supportive Care Team to bridge any gaps. Dr Shah raised the importance of Getting It Right First Time (GIRFT) and the importance of wrap around care for situations such as this and awareness of processes when dealing with something that does not usually occur in the service where the patient is admitted. Dr Shah drew parallels to a recent incident surrounding a lack of heart failure review and pressed the importance of easy access to other experts.	
P107/24	**Patient Experience Annual Report** Mrs Dobson presented the report and highlighted the following: • The overall number of formal complaints remains static reflecting on the previous year, however, there have been variations on the number of complaints in specific areas • 95% positive responses in the Friends and Family Test • The changes on data collection for this year; introducing a text survey which replicates CQC questions and outlined the increasing levels of qualitative information with a Quality Improvement (QI) initiative every month Mrs Dobson summarised that it was a positive position; there is still work to do, but can see the green shoots of recovery. Mrs Dobson also updated the Board that the Trust had been shortlisted in three areas for the 2024 Nursing Times Awards. Mr Richmond commended the good news and noted that feedback should be given to those involved. Mrs Kilgariff raised the negative themes in outpatients around waiting times and communication and detailed the linkage with one of the transformation programme's work streams regarding outpatients, and the incorporation of patient experience to ensure patients have a voice. Regarding the demographics for the ethnicity of people making complaints, Mrs Ahmed queried how the work and progress is monitored. Mrs Hobson explained that the data is reviewed monthly to see whether there is impact. Dr Jenkins commended the work but asked whether there is sufficient learning and reflection, and referenced the re-opened complaints data. Mrs Dobson discussed that they are looking at how each Care Group manage complaints and encouraging the processes that have the better outcome and to learn from each other. The new PALS service will also make a difference as an access point to early resolution.	
P108/24	**End of Life Annual Care**	

	Mrs Dobson introduced the report and outlined the journey of the past year which have laid the foundations to move forward for this year. Those building blocks included a new strategy, RESPECT plans, supportive care teams in terms of the nursing structure, experienced End Of Life Care (EOLC) nurse in post, as well as patient centred multidisciplinary training. Mrs Dobson discussed that the Quality Priority for the year was not met, but vast improvements were made and drew attention to the National Audit that showed there are still clear opportunities for further progression. Mrs Craven praised the honest report, acknowledging the position and progress, but that there is still work to do. Mrs Craven highlighted the importance of care plans and whether there is oversight that RESPECT documents are being monitored and followed. Mrs Dobson discussed that a key driver will be close working between the nursing and medical workforce and that there are passionate staff members working across the Community as well as in the Acute setting. Dr Shah queried the level of assurance in regard to the workforce, reflecting on the size of the population and the number of people reaching the end stages of life, and also how it is coordinated with Primary Care settings. Dr Beahan discussed that there are two palliative care consultants, but more are needed. Mrs Dobson expressed that it is everyone's responsibility to put these plans in place and that the Care Group 4 director is very passionate and active, leading the Place-wide EOLC group, to influence at Place level as well as at the Trust.	
	SYSTEM WORKING	
P109/24	**National, Integrated Care Board and Rotherham Place Update** Mr Wright drew attention to news on GP connect, particularly following the focus and link to primary care throughout discussions. Mr Wright also updated the Board on the work with Skills Street and proactive engagement with the future workforce generation, and finally, the continued work to tackle violence and aggression. Dr Shah queried the effect the Trust's approach following news that funding to tackle smoking will finish, and Mr Wright discussed that Public Health England had provided funding and that the Executives felt this should continue and is not for the Trust to fund. Mr Richmond drew attention to the interface between primary and secondary care and whether there had been Place involvement; Mr Wright detailed that there is a gap here as the meetings held previously, have dwindle in attendance and frequency. Mr Richmond highlighted that recent announcements emphasise the collaboration needed and the need to work as closely as possible with colleagues in the whole community. Mr Richmond expressed that it should be a balanced relationship with Place partners, the Trust and GPs.	
	PERFORMANCE	
P110/24	**Finance Report** The Finance report was presented by Mr Hackett, who noted the Month 2 financial positon and deficit to plan outlined in the report. Mr Hackett discussed	

	that the main drive for the total adverse to plan are the slow uptakes in Cost Improvement Programmes (CIP), additional beds open and the high number of attendances, which are driving additional costs. Mr Hackett expected more cost pressures in Month 3 due to Industrial Action, and conversations are being had with key budget holders. Non-Executives raised concerns on the CIP and discussed that more assurance was needed that it will be brought back on track and the impact on resources. Mr Hackett discussed the conversations with budget holders and that there are schemes coming forward that will gather pace and traction.	
P111/24	**Integrated Performance Report** The Integrated Performance Report (IPR) was presented by Mr Wright in its new format, as a dynamic document that is statistical in nature. Benchmarking data is included for assurance on the relative position as well as high level summaries. Mr Wright detailed the areas of challenge for Board oversight, as well as positive performance. Mrs Dobson acknowledged that a number of quality targets are not yet included but will be next month. Regarding C.difficile rates, Mrs Dobson updated the Board on meetings with NHSE and Health Security Agency (HSA), providing assurance that the actions that are being taken are appropriate. From a patient experience perspective, Dr Shah queried the risk to recruit to the PALS service and Mrs Dobson explained that the delay was due to securing finances but had been sorted and the aspiration is to go live next month. From an operational performance perspective, Mrs Kilgariff highlighted the key risks and the actions in place to move forward. Mrs Kilgariff drew attention to the trends triangulating with additional demand and the subsequent impact throughout the patient journey. A large part of the recovery plan, monitored by the Finance and Performance Committee, includes oversight of SDEC, acknowledging the risks and issues raised, and that it is significantly impacted by demand. Mrs Kilgariff discussed the linkage between increased demands at the front door, flowing through to demands in discharge. Mrs Roberts noted the limited Cancer performance metrics to link in with the transformation programme and detail the outcomes. Dr Shah drew attention to the Gynaecology waiting list and the reality of the challenge. Mrs Kilgariff detailed the additional clinics and theatres and that the progress and trajectory is pleasing; there is focus on additionality but continued focus on productivity. Mr Richmond queried the effect on the 12 hour waits against the backdrop of demand, and the risks and mitigations needed to track this. Mrs Kilgariff discussed that the Trust is benchmarking well but peaks are coming through following days of significant bed pressures. For People and Culture, Mr Hartley added that a revamp of appraisals process and paperwork has factored into the delay and that sickness rates remain static	

	and are monitored by the People and Culture Committee with consideration given to the general population health. The IPR was commended as a useful tool, however targets for Quality are still required and generic wording needs to be developed to assist Committees to identify areas of concern quickly and put efficient mitigations in place.	**MW**
	ASSURANCE	
P112/24	**Maternity and Neonatal Safety Report** Mrs Dobson introduced the regular detailed report on maternity and neonatal safety which is in line with national requirements for best practice. Mrs Dobson discussed that the Trust is consistently meeting the target levels and highlighted the improvements in the Smoking data. Junior doctor training is an area of concern, however, this was due to the new rotation and would improve in July. Mrs Dobson noted the further information provided regarding the Birth Trauma report and the letter from NHSE, summarising that for the Trust, there are no areas of concern, but areas of improvement. Referring to the data on breast feeding, Ms Burrow queried the trajectory and suggested similar logic and focus that has been applied successful to smoking, is applied here. Mrs Dobson detailed the work ongoing to encourage first feeds and that it is a key metric to continue to monitor. Dr Jenkins suggested that ethnicity data is included in future reports. Mr Richmond questioned the safety for Obstetrics due to the training data and Dr Beahan reassured that the middle grades must pass their entrustability before working alone and Consultants have to step down, but that it has not caused issues.	**HD**
P113/24	**Safe Staffing and Establishment Review** Mrs Dobson presented the twice yearly review and detailed that staffing is also reviewed on a daily basis to ensure safety. Mrs Dobson discussed that there are no recommendations to change establishment, however, future reconfiguration on wards, to allow for more flex with capacity, may have impact. Mrs Dobson also noted that the community nurse staffing tool has been nationally paused, and the changes for Ward Managers to ensure one day per week is clinical on the wards to promote visible leadership for both patients and staff. Mr Richmond questioned how the UECC staff are bearing the increased pressures and Executives discussed that there is good nurse establishment although there are a shortage of consultants and high pressure on triage. The Clinical Fellows will ease these pressures as well as rotational doctors to fill gaps. Ms Burrows queried the feelings from Ward Managers on the clinical time and Mrs Dobson explained that it has been mixed, with some apprehension surrounding technology; additional catch up sessions have been scheduled to build confidence and skills, which also feeds into a proactive approach for winter.	

P114/24	**Learning From Deaths Report** Dr Beahan introduced the report and highlighted key aspects including: • There is an established team of structured judgement reviewers • 57% of Structured Judgement Reviews (SJR) completed within 60 days • Systems in place for learning • The thematic review, triangulating with EOLC sample survey noting the split comments • Audit actions are now completed • SHMI data remaining as expected with any concerns reported to the monthly mortality meeting • Confidence in coding and triangulation with Clinical Effectiveness and Patient Safety initiatives to prevent deaths Dr Jenkins reflected on how far the work has come and that it is now part of routine and has a good, reliable method. Mr Temple queried the rationale behind the care scores and preventability scores and noted that there is little change. Dr Beahan discussed that poor care is logged on Datix, and discussed at incident review panels, with herself and the Chief Nurse determining next steps, where appropriate; there is meaningful change happening and part of the internal audit will include sharing more information to Care Groups.	
P115/24	**Organ and Tissue Donation Committee Annual Report** Mrs Craven introduced the report and highlighted the following: • Confirmation that the Committee had discharged it's duties • Addition of Tissue to the remit of the committee and the work done to improve engagement with the morgue • Training with the EOLC team to raise awareness • Successful initiative surrounding corneal donations and grafts • Good engagement with nursing teams, with more work to do to improve medical engagement • Letter from the region to the Chief Executive and Medical Director Mrs Craven clarified that even with the changes to national policies on organ donation, registering is still recommended to ensure clarity of wishes for the patient and for the family. Mrs Dobson commended the improvements in engagement and how driven clinical members are, and commended Mrs Craven for her drive and commitment. Mr Richmond queried whether the success is communicated effectively and Ms Parkes confirmed that she will supporting the committee moving forwards. Mrs Ahmed drew attention to different cultural and religious beliefs in terms of organ donation, reflecting that perspectives can change over time for individuals and that maybe this could feed into specific communication campaigns.	

P116/24	**Emergency Preparedness, Resilience and Response (EPRR) Annual Report** Mrs Kilgariff presented the report which is an annual requirement and outlined the delegated authority to Finance and Performance Committee who receive quarterly updates. Mrs Kilgariff noted the clear structure of the team, reporting to her, the strengthened governance and highlighted the training and exercises. Mrs Kilgariff explained the changes to the EPRR assurance core standards and the expectation that compliance will take two years, raising that most Trusts within the ICB are in a similar positon and that some elements of the work are South Yorkshire-wide. Mrs Kilgariff expected to see improvements this year, under the caveat that the set of standards remains the same. Mr Temple summarised that performance has been maintained, but the targets have increased.	
	BOARD GOVERNANCE	
P117/24	**Register of Seal Report** Ms Wendzicha presented the paper in compliance with the current standing orders, detailing the use of the Trust Seal since the last report.	
P118/24	**Annual Work Plan 2024-25** The Board noted the Annual Work Plan and Mrs Kilgariff raised the changes to the operational updates and that this could be removed from the workplan as they would be included in the CEO report.	**AW**
P119/24	**Any other business** There were no other items of business.	
P120/24	**Questions from Members of the Public** No questions were received.	
P121/24	**Date of next meeting** Friday 6th September 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								
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	30.08.24 - Following discussion at ETM, it was agreed that the Fire Strategy needed to be considered at Finance & Performance Committee prior to approval at Board	Open
9	03.05.24	Organisational Priorities	P75/24	Agreed amendments to be made to the final document	MW	Sep-24	29.08.24 - amendments made to final document	Recommend to Close
10	05.07.24	Board Assurance Framework	P102/24	Deep dives and workshops with relevant Executives to refresh the BAF	AW	Sep-24	28.08.24 - Deep dives have been undertaken by the Deputy Director of Corporate Affairs and the process is completed	Recommend to Close
11	05.07.24	IPR	P111/25	Ensure targets for Quality metrics are included and generic wording is reviewed	MW	Sep-24	30.08.24 - This work is in progress and should be completed in time for the next presentation to Board	Open
12	05.07.24	Maternity and Neonatal Safety Report	P112/26	Ethnicity data to be included in future reports	HD	Sep-24	29.08.24 - Ethnicity data now included in the report to Board in September	Recommend to Close
13	05.07.24	Annual Work Plan	P118/24	Update Operational Updates schedule on the workplanner (reporting now included in CEO Report)	AW	Sep-24	12.08.24 - Board Planner updated as requested	Recommend to Close

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: 31st July 2024**	**Chair: Ms Julia Burrows**

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
1	Safeguarding Committee Annual Report	The Committee recommended the Report for Board approval	Board of Directors
2	Legal Quarterly Report	The Committee recommended the Report for Board approval	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:** 31st July 2024	**Chair: Mr Martin Temple**

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
1	FPC/159/24. Operational Priorities Update - Emergency Care	The Committee agreed to advise the Board of the encouraging work across Emergency Care with numerous actions in place with completion dates in sight and on track. The Committee also noted the improvements in compliance with the 4 hour standards, and that the use of Executive Leads to drive the actions is working well.	Board of Directors
2	FPC/164/24. EPRR Core Standards Quarterly Report	The Committee welcomed the improvement in the compliance figures to the core standards and agreed to advise the Board on the detailed action plan that is in place and being worked through. They were assured that the Trust is as prepared now as it was last year when the new core standards were introduced along with the requirement for increased levels of evidence which is being collated and on track for the previously agreed deadline.	Board of Directors
3	FPC/167/24. Integrated Financial Performance Report	The Committee noted the challenging position at Month 3, this will be further noted in Month 4 when the lost activity as a result of industrial action will be included in the figures. The Committee however wanted to advise the Board that the position was in fact better than Month 3 the previous financial year 2023/24 with clearer schemes planned, however winter would be crucial. The Committee agreed to allocate further resources of £125,000 to a specific business case previously agreed at Confidential Board.	Board of Directors

Board of Directors' Meeting
6 September 2024

The Rotherham NHS Foundation Trust

Agenda item	P129/24
Report	**Strategic Risk Appetite Review 2024/25**
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	Links with all Trust Values
Purpose	**For decision** ☒ **For assurance** ☒ **For information** ☐
Executive Summary	The following paper illustrates the outcomes following the review of the Trust Risk Appetite at the Board Strategic session in June 2024. The 17 categories of risk have been reduced to 15 by amalgamating the 3 separate categories relating to quality. Of the 15 categories, 5 have an increased risk appetite (clinical innovation, finance, partnerships and environment), 3 have a reduced risk appetite (IT and cyber security, business/service interruption and inequality) 7 remain unchanged (Commercial, compliance/regulatory, reputation, quality, people and culture, information governance and fire safety).
Due Diligence	The information contained within the report relates to the output from the Board Strategic session on 7 June 2024.
Board powers to make this decision	Matters reserved to the Board
Who, What and When	Subject to approval, the risk appetite will be added to the current Risk Management Policy and communicated to the wider organisation.
Recommendations	It is recommended that the Trust Board: ➢ Review the revised risk appetite statements agreed at the Strategic session in June 2024; ➢ Review and agree the risk appetite statement for People and Culture and Estates; and

	➢ Confirm the position for 2024-25 in relation to the risk appetite categories.
Appendices	Appendix 1 Applying the Risk Appetite Matrix

Strategic Risk Appetite Review 2024/25

1. Introduction

1.1 Risk appetite is defined as 'the amount and type of risk that an organisation is prepared to pursue, retain of take'[1] in order to meet its Strategic Ambitions/Objectives. Risk appetite represents a balance between the potential benefits of innovation and the threats that change inevitably brings. It provides a framework which enables the Trust to make informed management decisions. The benefits of adopting a risk appetite include:

- Supporting informed decision-making;
- Reduces uncertainty;
- Improves consistency across governance mechanisms and decision-making;
- Supports performance improvement;
- Enables focus on priority areas within the Trust; and
- Informs spending and resource prioritisation.

1.2 The following paper illustrates the outputs from the recent review of the Trust risk appetite at the last Strategic Board session in June 2024.

2. Review of the Risk Appetite

2.1 The Trust has, for a number of years used the 5x5 matrix in combination with the Risk Appetite Matrix published by the Good Governance Institute in May 2020 (Appendix 1). The same matrix was used in isolation during the review in June 2024.

2.2 During the review, the Board considered the current risk appetite for each of the categories and voted on an individual basis on Slido. Further debate and discussion ensued before agreement was reached on the final risk appetite.

2.3 The following table illustrate the current risk appetite and the recommended risk appetite for 2024-25. The Board will note that the three separate categories relating to 'Quality' are now recommended to be amalgamated into one category namely 'Quality – Clinical Effectiveness, Patient Experience and Safety'. The 'Workforce' category has been amended to reflect 'People and

[1] ISO 31000 – Risk Management

Culture' and finally the 'IT' category has been amended to include 'Cyber Security'.

2.4 Table 1 below represents the position as at 7 June 2024 and the Board may wish to consider if those conclusions remain valid. In addition, given the 50:50 split for People and Culture (Cautious: Seek) and the 50:50 position in relation to Estates (Open: Seek).

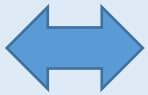
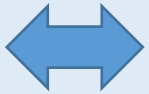
2.5 Table 2 reflects the recently refreshed Strategic Objectives and Ambitions aligned with the suggested risk appetite.

3. Recommendations

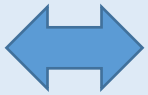
The Board is asked to:

- Review the revised risk appetite statements agreed at the Strategic session in June 2024;
- Review and agree the risk appetite statement for People and Culture and Estates; and
- Confirm the position for 2024-25 in relation to the risk appetite categories.

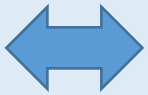
Table 1: Outcome from the Board Strategic Session on 7 June 2024

Risk Type	Strategic Risk Appetite 2022/24	Strategic Risk Appetite Score 2022/24	Revised Risk Appetite 2024-25	Trend	Definition
Clinical Innovation	TRFT has a **LOW** risk appetite for Clinical Innovation risks.	**6-10**	**Open**		We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation.
Commercial	TRFT has a **MODERATE** risk appetite for Commercial gain whilst ensuring quality and sustainability for our services.	**12-15**	**Open**		We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not the overriding factor
Compliance/Regulatory	TRFT has a **LOW** risk appetite for Compliance/Regulatory risk, which may compromise the Trust's compliance with its statutory duties and regulatory requirements.	**6-10**	**Minimal**		We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential.

Risk Type	Strategic Risk Appetite 2022/24	Strategic Risk Appetite Score 2022/24	Revised Risk Appetite 2024-25	Trend	Definition
Financial/Value for Money (VFM)	TRFT has a **LOW** risk appetite for financial risks which may grow the size of the organisation whilst ensuring we minimise the possibility of financial loss and comply with statutory requirements.	**6-10**	**Cautious**		We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern.
Partnerships	TRFT has a **MODERATE** risk appetite for partnerships which may support and benefit the people we serve.	**12-15**	**Seek**		We are eager to innovate and to choose options offering higher business rewards (despite greater inherent risk)
Reputation	TRFT has a **LOW** risk appetite for actions and decisions taken in the interest of ensuring quality and sustainability which may affect the reputation of the organisation.	**6-10**	**Minimal**		Our appetite for risk taking is limited to those events where there is no chance of significant repercussions.

Risk Type	Strategic Risk Appetite 2022/24	Strategic Risk Appetite Score 2022/24	Revised Risk Appetite 2024-25	Trend	Definition
Quality – Clinical Effectiveness, Patient Experience & Safety	TRFT has a **LOW** risk appetite for risk that may compromise the delivery of outcomes for our service users.	**6-10**	**Minimal**		We will avoid anything that may impact on quality outcomes unless absolutely essential. We will avoid innovation unless established and proven to be effective in a variety of settings.
~~**Quality – Patient Experience (including complaints and claims)**~~	~~TRFT has a **VERY LOW** risk appetite for risks that may affect the experience of our service users.~~	~~**1-5**~~			
~~**Quality – Patient Safety (including complaints and claims)**~~	~~TRFT has a **VERY LOW** risk appetite for risks that may compromise safety.~~	~~**1-5**~~			

Risk Type	Strategic Risk Appetite 2022/24	Strategic Risk Appetite Score 2022/24	Revised Risk Appetite 2024-25	Trend	Definition
People & Culture ~~**Workforce**~~	TRFT has a **MODERATE** risk appetite for actions and decisions taken in relation to workforce risks. .	**12-15**	**Cautious (38%)** **Seek (38%)**	**Final decision required**	CAUTIOUS: We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision. SEEK: We are willing to take decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks.
Environment	TRFT has a **LOW** risk appetite for Environmental risks.	**6-10**	**Cautious**		We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.

Risk Type	Strategic Risk Appetite 2022/24	Strategic Risk Appetite Score 2022/24	Revised Risk Appetite 2024-25	Trend	Definition
Estates	TRFT has a **VERY LOW** risk appetite for Plant and Equipment risks.	**1-5**	**Open (38%)** **Seek (38%)**	**To be confirmed**	OPEN: We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably confident we would be able to challenge this successfully. SEEK: We are willing to take decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks.
Information Governance	TRFT has a **LOW** risk appetite for actions and decisions taken in relation to Information Governance risks.	**6-10**	**Minimal**		We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential..
IT & Cyber Security	TRFT has a **LOW** risk appetite for actions and decisions taken in relation to IT risks.	**6-10**	**Minimal**		We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential.

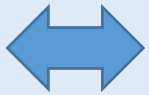
Risk Type	Strategic Risk Appetite 2022/24	Strategic Risk Appetite Score 2022/24	Revised Risk Appetite 2024-25	Trend	Definition
Fire Safety / General Security	TRFT has a **VERY LOW** risk appetite for Fire Safety/General Security risks.	**1-5**	**Minimal**		We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential.
Business / Service Interruption	TRFT has a **LOW** risk appetite for Business/Service Interruption risks.	**6-10**	**Minimal**		Preference for very safe delivery options that have a low degree of inherent risk and only limited reward potential.
Inequality	TRFT has a LOW risk appetite for actions and decisions that may result in Inequality.	**6-10**	**None**		We have no appetite for decisions that could lead to additional scrutiny or attention on the organisation.

Table 2: Risk Appetite aligned to the Strategic Objectives and Ambitions.

Objective	Key Element	Ambition	Risk Appetite
Deliver care that is consistent with CQC 'Good' by the end of 2024/25	QUALITY OF CARE	Focus on providing high quality care & improving the experience of our patients	Minimal
Ensure significant improvement in National Inpatient and UECC Patient Experience Surveys			Minimal
Deliver 4 hour performance of 80% before March 2025	OPERATIONAL DELIVERY	Focus on our operational delivery and improving access to care	Minimal
Eliminate long waiters and go beyond the national ambition in long-waiters and RTT performance			Minimal
Consistently deliver the Cancer Faster Diagnostic Standard			Minimal
Achieve a top quartile engagement measure in the 2024/25 staff survey	PEOPLE & CULTURE	Focus on engaging with our people & improving the organisational culture	Cautious / Seek
Improve attendance by reducing sickness absence by 1%			Cautious/Seek
Ensure that we deliver inclusion by closing the gap between the experience of our people with different protected characteristics			Cautious/Seek
Deliver the financial plan for 2024/25 and deliver year 1 of the plan to return the Trust to a break even position for 2026/27	FINANCIAL SUTAINABILITY	Focus on becoming a financially sustainable & productive organisation	Cautious
Ensure significant improvement across the full range of system productivity metrics			Cautious
Electronic Patient Record (EPR)	EPR TRANSITION	Focus on the transition to a new EPR system before our current system requires changing in 2026	Minimal

Applying risk appetite matrix

RISK APPETITE LEVEL ▶ / RISK TYPES ▼	0 NONE Avoidance of risk is a key organisational objective.	1 MINIMAL Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.	2 CAUTIOUS Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential.	3 OPEN Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.	4 SEEK Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk).	5 SIGNIFICANT Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust.
FINANCIAL How will we use our resources?	We have no appetite for decisions or actions that may result in financial loss.	We are only willing to accept the possibility of very limited financial risk.	We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern.	We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not the overriding factor.	We will invest for the best possible return and accept the possibility of increased financial risk.	We will consistently invest for the best possible return for stakeholders, recognising that the potential for substantial gain outweighs inherent risks.
REGULATORY How will we be perceived by our regulator?	We have no appetite for decisions that may compromise compliance with statutory, regulatory of policy requirements.	We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential.	We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably confident we would be able to challenge this successfully.	We are willing to take decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks.	We are comfortable challenging regulatory practice. We have a significant appetite for challenging the status quo in order to improve outcomes for stakeholders.
QUALITY How will we deliver safe services?	We have no appetite for decisions that may have an uncertain impact on quality outcomes.	We will avoid anything that may impact on quality outcomes unless absolutely essential. We will avoid innovation unless established and proven to be effective in a variety of settings.	Our preference is for risk avoidance. However, if necessary we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place.	We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation.	We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains.	We seek to lead the way and will prioritize new innovations, even in emerging fields. We consistently challenge current working practices in order to drive quality improvement.
REPUTATIONAL How will we be perceived by the public and our partners?	We have no appetite for decisions that could lead to additional scrutiny or attention on the organisation.	Our appetite for risk taking is limited to those events where there is no chance of significant repercussions.	We are prepared to accept the possibility of limited reputational risk if appropriate controls are in place to limit any fallout.	We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders.	We are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks.	We are comfortable to take decisions that may expose the organisation to significant scrutiny or criticism as long as there is a commensurate opportunity for improved outcomes for our stakeholders.
PEOPLE How will we be perceived by the public and our partners?	We have no appetite for decisions that could have a negative impact on our workforce development, recruitment and retention. Sustainability is our primary interest.	We will avoid all risks relating to our workforce unless absolutely essential. Innovative approaches to workforce recruitment and retention are not a priority and will only be adopted if established and proven to be effective elsewhere.	We are prepared to take limited risks with regards to our workforce. Where attempting to innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff.	We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce but could improve the skills and capabilities of our staff. We recognize that innovation is likely to be disruptive in the short term but with the possibility of long term gains.	We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive a positive chan.

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Board of Directors' Meeting
06 September 2024

The Rotherham NHS Foundation Trust

Agenda item	P131/24
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. During July and August 2024 the opportunity was taken to perform a deep dive on each of the BAF risks in order to align them to the approved Trust Priorities. This involved a full review of each risk in terms of the Strategic Ambition, Link to Operational Plan and Risk Description. All of the Controls, Mitigations and Gaps were also reviewed and in most cases amended with a number of historic Controls being archived. The reviews were undertaken by the Executive Director leads and the Deputy Director of Corporate Affairs with a full review of each deep dive being included in the report. The People Committee, Quality Committee and Finance and Performance Committee have each reviewed the Strategic Board Assurance Risks aligned to them as follows: **People & Culture Committee:** Discussed and approved the position in relation to Strategic Risk U4 at the June 2024 Committee. **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 2 2024/25.

Due Diligence	Since presentation at the last Board in July 2024, the relevant sections of the Board Assurance Framework has been discussed at the relevant Board Committees during July 2024, no Committees were held in August 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 approve the BAF Risk scores as follows: ➢ The rating for BAF Risk P1 to remain at 8; ➢ 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 16; and ➢ The rating for BAF Risk D8 to remain at 20. • Review and approve the amendments to the BAF description as follows: ➢ P1 - Link to the Operational Plan amended to 'Deliver care that is consistent with CQC 'Good' by the end 2024-25. Ensure improved performance of at least one quartile in the National Inpatient and UECC CQC Patient Experience Surveys; and ➢ D5 - Link to the Operational Plan amended to 'To deliver 4 hour performance of 80% before March 2025, to go beyond the national ambition on long-waiters and RTT performance and consistently deliver the Cancer Faster Diagnosis Standard by Q4. ➢ D5 – Risk descriptor amended to 'There is a risk we will not deliver our performance priorities (Urgent Care, Elective Recovery and Cancer) because of insufficient resource and increased demand leading to an increase in our patient waiting times and potential for patient deterioration and inability to deliver our Operational Plan.
Appendices	Board Assurance Framework for Quarter 2 2024/25

1. Introduction

The BAF is now in its third year, there are now a total of six Strategic Board Assurance Risks following the inclusion of the financial BAF risk and continues to be monitored on a monthly basis at the Assurance Committees and quarterly at Board.

The following report illustrates the discussion and decisions taken by the relevant Board Assurance Committees and the Executives during Quarter 2 2024/25. As well as the Committee updates a full deep dive of each BAF risk was undertaken involving the Executive Director leads and the Deputy Director of Corporate Affairs. This involved a full review of each risk in terms of the Strategic Ambition, Link to Operational Plan and Risk Description. All of the Controls, Mitigations and Gaps were also reviewed and in most cases amended with a number of historic Controls being archived. 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 2:

Risk aligned to the Quality Committee

2.1 **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.**

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. All updates to the Controls and Gaps are highlighted on the BAF report in red.

Update to the Strategic Ambition, Link to Operational Plan and Risk Description.

The wording for the P1 Strategic Ambition and Risk Description remained unchanged, the Link to the Operational Plan that previously read:

P1: Empower out teams to deliver improvements in care.

It is recommended this be amended to read:

> *P1: Deliver care that is consistent with CQC 'Good' by the end of 2024/25. Ensure improved performance of at least one quartile in the National Inpatient and UECC CQC Patient Experience Surveys.*

This was felt by the Executive Director leads to be a more specific, targeted description of clinical care provision and the Trust Priorities in 2024/25.

Update to the Controls, Mitigations and Gaps

The Controls, Mitigations and Gaps have been completely reviewed and refreshed following a deep dive review conducted in July and August 2024. These are included on the report in a more intuitive manner with key themes relating to the overall BAF and the assurance received for each of the themed areas of patient care.

Review of the Risk Score relating to P1

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 in August 2024 that the consequence score remains the same at 4 (Major).

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 was reduced to 3 (Possible) in 2023 following removal of CQC restrictions on UECC.

It was further agreed at the July 2024 Board of Directors that the Likelihood of the risk should be reduced from 3 (Possible) to 2 (Unlikely), as such the risk rating for BAF P1 should be decreased from 12 to 8 due to the controls in place and the number of audit reports giving moderate and significant assurance, there had also been improvements in Mortality Rates. Following further review in August 2024 the rating is recommended to remain at **8**.

Risk aligned to the Board

2.2 **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.**

The Managing Director is the Executive Director leads for Strategic Risk R2. As part of the continuing review of the BAF, monthly discussions take place with the Managing Director and Deputy Director of Corporate Affairs.

Update to the Strategic Ambition, Link to Operational Plan and Risk Description.

The wording for the R2 Strategic Ambition, Link to the Operational Plan and Risk Description all remained unchanged.

Updates to the Controls, Mitigations and Gaps.

There were minor changes to the Controls, Mitigations and Gaps, the Managing Director continues to attend the various PLACE Commissions, Groups and Boards listed on the BAF report.

Review of the Risk Score relating to R2

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

Risk aligned to the Board

2.3 **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.**

The Managing Director is the Executive Director leads for Strategic Risk O3. As part of the continuing review of the BAF, monthly discussions take place with the Managing Director and Deputy Director of Corporate Affairs**.**

Update to the Strategic Ambition, Link to Operational Plan and Risk Description.

The wording for the O3 Strategic Ambition, Link to the Operational Plan and Risk Description all remained unchanged.

Update to the Controls, Mitigations and Gaps

The Head of Nursing & Governance Corporate Operations is now in post working with the Pathology Partnership, she has provided an in depth update on the current position relating to Gap G1 which can be found highlighted in red in the report.

Review of the Risk Score relating to O3

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

Risk aligned to the People & Culture Committee

2.4 **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**

At time of report publication the last People & Culture Committee (P&CC) had been held in June 2024 and all amendments to the BAF Strategic Ambition, Link to the Operational Plan and Risk Description were presented and approved for recommendation to the Board of Directors, these were formally approved at the July 2024 Board of Directors.

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 in Quarter 2 with the last review being in August 2024. There is also linkage with the BAF and the current Risk Register, as will be highlighted in the Update to the Controls, Mitigations and Gaps relating to U4 section found below. All updates to the Controls and Gaps are highlighted on the BAF report in red.

Update to the Strategic Ambition, Link to Operational Plan and Risk Description.

The wording for the U4 Strategic Ambition and Link to the Operational Plan remained unchanged.

The Risk Description was amended and this was previously approved at the July 2024 Board of Directors.

Update to the Controls, Mitigations and Gaps.

A number of completed and historical Controls were archived with six clear Controls listed, along with sources of assurance provided to various Committees and the Trust Board.

There is one Gap relating to workforce, this Gap relates to unexpected examples of workforce pressure or where the effects of a specific shortage of a workforce is directly responsible for deteriorating delivery in multiple areas of the Trust. The aforementioned Gap is directly linked to a number of risks on the Corporate Risk Register, the resolution of which is preventing the reduction in score for the BAF Risk as follows:

Risk 6723, Consultant Anaesthetic workforce availability, which has knock on effects to patient experience, other departments and overall Trust delivery.

Risk 7069, Band 2 & 3s contract negotiations which is both a patient experience risk and a financial risk to the Trust.

Review of the Risk Score relating to U4

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 was rated at 2 which is 'unlikely, do not expect it to happen/recur but it is possible it may do so. At the beginning of the period of medical workforce industrial action in 2023 the likelihood current score was raised to be a score of 3 which is 'possible, might happen or recur occasionally'.

Following further discussions at the People & Culture Committee in June 2024 it was recommended that BAF Risk U4 remained at 12, following review in August 2024 it was felt that the rating should remain at **12.** It is anticipated however that in line with the explanation of the management of the key risks outlined above this rating will be reduced in subsequent months with the Likelihood score returning to 2.

Risk aligned to Finance and Performance Committee

2.5 **D5: There is a risk we will not deliver our performance priorities (Urgent Care, Elective Recovery and Cancer) because of insufficient resource and increased demand leading to an increase in our patient waiting times and potential for patient deterioration and inability to deliver our Operational Plan.**

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 during Quarter 2 resulting in the following amendments:

Update to the Strategic Ambition, Link to Operational Plan and Risk Description.

At the deep dive review meetings the wording for the D5 Strategic Ambition remained unchanged, however the wording for both the Link to the Operational Plan and the Risk Description were amended as follows:

Link to Operational Plan:

> *D5: Implement sustainable change to deliver high quality, timely and affordable care*

It is recommended that this be amended to read:

> *D5: To deliver 4 hour performance of 80% before March 2025, to go beyond the national ambition on long-waiters and RTT performance and consistently deliver the Cancer Faster Diagnosis Standard by Q4.*

The Executive Director leads considered the above to be more of a true reflection of the Trust Priorities in 2024/25.

The Risk is currently described as follows:

> *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.*

It is recommended this be amended to read:

> D5: *There is a risk we will not deliver our performance priorities (Urgent Care, Elective Recovery and Cancer) because of insufficient resource and increased demand leading to an increase in our patient waiting times and potential for patient deterioration and inability to deliver our Operational Plan.*

Update to the Controls, Mitigations and Gap.

The wording of D5 was amended to refer specifically to the key areas of delivery, Urgent Care, Elective Recovery and Cancer, the link to workforce resource was also removed as it was felt that this was covered in BAF Risk U4. The Controls, Mitigations and Gaps are all themed by the key areas noted above as well as the theme of Winter.

Review of the Risk Score relating to D5

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 to **16** was presented to the July 2024 Finance & Performance Committee for discussion and approval. Following the discussion it was agreed that the risk rating should decrease to **16** and the risk will continue to be reviewed on a monthly basis.

Risk aligned to Finance and Performance Committee

2.6 **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 2024-25 leading to further financial instability.**

The Director of Finance is the Executive Director leads for Strategic Risk D8. The Deputy Director of Corporate Affairs met with the Director of Finance during Quarter 2. The BAF Risk D8 covers the financial situation for the Trust, 2024/25, this risk is renewed for each new financial year.

Update to the Strategic Ambition, Link to Operational Plan and Risk Description.

The wording for the D8 Strategic Ambition, Link to the Operational Plan and Risk Description all remained unchanged apart from the change of date to reflect this BAF now covers the financial year 2024/25.

Update to the Controls, Mitigations and Gaps.

There was an additional Control added to the BAF report relating to the external review of the South Yorkshire system and the reports that will outline areas of the investigation and intervention work to be presented to the South Yorkshire Trusts.

Review of the Risk Score relating to D8

The risk had been graded initially at 20 and following review it was felt that the rating should remain at **20**, it will continue to be monitored on a monthly basis.

Recommendations

The Board 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 2 2024/25, as follows:
  - The rating for BAF Risk P1 to remain at 8;
  - 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 16; and
  - The rating for BAF Risk D8 to remain at 20.

- Discuss and approve the amendments to the Strategic Ambition, Link to Operational Plan and Risk Descriptions as follows:
  - P1: The wording for the P1 Strategic Ambition and Risk Description remained unchanged, the Link to the Operational Plan that previously read:

    P1: Empower our teams to deliver improvements in care, amended to reflect:

    P1: Deliver care that is consistent with CQC 'Good' by the end of 2024/25. Ensure improved performance of at least one quartile in the National Inpatient and UECC CQC Patient Experience Surveys.

- D5: Link to Operational Plan:
  D5: Implement sustainable change to deliver high quality, timely and affordable care.

  It is recommended this be amended to reflect:

  D5: To deliver 4 hour performance of 80% before March 2025, to go beyond the national ambition on long-waiters and RTT performance and consistently deliver the Cancer Faster Diagnosis Standard by Q4.

  The Risk Descriptor:

  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.

  It is recommended this be amended to reflect:

  D5: *There is a risk we will not deliver our performance priorities (Urgent Care, Elective Recovery and Cancer) because of insufficient resource and increased demand leading to an increase in our patient waiting times and potential for patient deterioration and inability to deliver our Operational Plan.*

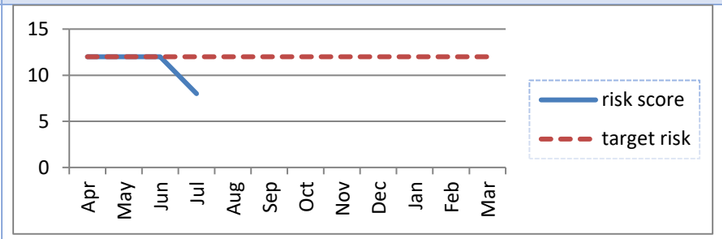
- D8: the date included in the Risk Description was amended.

Alan Wolfe

Deputy Director of Corporate Affairs

30 August 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	8			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*	R2:we will not establish ourselves as leaders in improving the lives of the population we serve	..of insufficient influence at PLACE	..increased ill health and increased health inequalities	2(L)x4(C)=8	8	8			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*	OP3: robust service configuration across the system will not progress and deliver seamless end to end patient care across the system	..of lack of appetite for developing strong working relationships and mature governance processes	..poor patient outcomes	3(L)x4(C)=12	8	8			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 create and maintain a compassionate and inclusive culture	..	.. to an inability to retain and recruit staff and deliver excellent healthcare for patients	3(L)x4(C)=12	12	12			2(L)x4(C)=8	↔	Moderate (12-15)
Delivery: *We will be proud to deliver our best every day, providing high quality, timely and equitable access to care in an efficient and sustainable organisation*	D5: we will not deliver our performance priorities (Urgent Care, Elective Recovery and Cancer)	.. of insufficient resource and increased demand	.. an increase in our patient waiting times and potential for patient deterioration and inability to deliver our Operational Plan.	4 (L)x3(C) = 12	20	16			5(L)x4(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	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)**~~ **8** **2(L)x4(C)**	**3(L)x4(C) =12**	**Very Low (1-5)**		**Previous Score Q4 2023-24**	**Q1**	**Q2**	**Q3**	**Q4**
Link to the Operational Plan: P1: Deliver care that is consistent with CQC 'Good' by the end of 2024/25.Ensure improved performance of at least one quartile in the National Inpatient and UECC CQC Patient Experience Surveys.							**12**	**12**	**8**			
BAF Risk Description						**Linked Risks on the Risk Register & BAF Risks:**				**Assurance Committee & Lead Executive Director**		
P1: There is a risk that we will not embed quality care within the 5 year plan because of lack of resource, capacity and capability leading to poor clinical outcomes and patient experience for our patients.										**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	Implementation of agreed Quality Strategy to provide quality assurance to the Board and external regulators	Quarterly report on Quality Assurance to Quality Committee and Board of Directors to provide update on all aspects of Quality Management System including process management, monitoring, measurement and continuous improvement	July 2024	QC	L1					Chief Nurse		
		Range of tools utilised to measure quality achievements including Tendable Audit programme and Power Bi Quality Dashboards with outcomes reviewed at monthly Care group Performance meetings	July 2024	QC	L1					Chief Nurse		

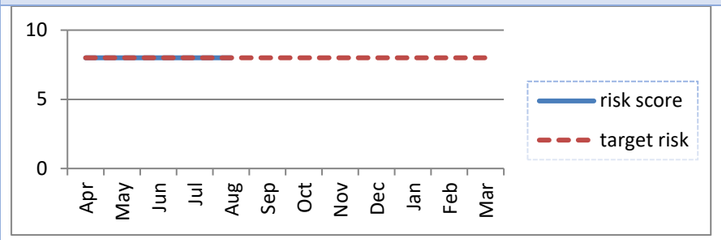
		Exemplar Accreditation Programme established for adult inpatient areas	July 2024	QC					Chief Nurse
		Meeting structure established to provide quality assurance both within Care Groups and corporately through Quality Governance and Assurance Group monthly to quarterly Patient Safety Committee	July 2024	QGAG PSC					Chief Nurse
C2	Ongoing monitoring of Patient Safety and PSIRF implementation through a variety of sources to ensure we keep patients safe and optimise patient outcomes	Ongoing use of Datix incident reporting system to report all adverse incidents or near misses. All incidents rated as moderate or above reviewed at Incident Review panel by CN / MD three times a week. Incidents identified as requiring a PSII or AAR and associated themes and actions reported to Patient Safety Committee and Quality Committee quarterly. Harm Free Panel reviews TVN and IPC incidents monthly. Summary of key findings included in report to Patient Safety Committee and Quality Committee quarterly. Completed PSIIs reviewed in Executive led monthly sign off panel with representation from ICB. Summary of key findings included in report to Patient Safety Committee and Quality Committee quarterly. Actions from PSIIs and AARs monitored to ensure completion within agreed timescales. Monthly report sent to Care Groups and summary included in report to Patient Safety Committee and Quality Committee quarterly. All National Patient Safety Alerts and information received by the Central Alerting System Liaison Officer are shared quarterly through the Patient Safety Committee with completion of action plans monitored by the Quality Governance and Assurance Team	July 2024	PSC QC ETM					Chief Nurse
C3	Mortality and Learning from Deaths	All actions in the 360 Learning from Deaths Audit have been completed. Work continues to further improve the program and to ensure there is no slippage for implemented improvements. Reports detailing the completion rates and timeliness of SJRs		CEC QC Board					Medical Director

		remain as a standing agenda item at the Bi-Monthly Trust Mortality Group (TMG). All SJRs with a Poor Care or judged to have been preventable are logged as incidents on Datix. Following closure the Lessons Lean and Actions are discussed at the TMG. All completed SJRs are sent to the Care Group Mortality Leads, those with learning points together with those Datix'd should be discussed at the respective CSU Clinical Governance Meeting. Compliance for this is being reviewed twice yearly. The SHMI continues to be monitored through the TMG. The response to any Diagnosis Groups Alerts, continue to be managed this Group. The reporting of the above is included in the quarterly Learning from Death report, which is reviewed at the Patient safety Committee, Quality Committee and Board.	July 2024 July 2024 July 2024 July 2024						
C4	Ongoing monitoring of the effectiveness of the newly implemented Clinical Effectiveness Strategy by the Clinical Effectiveness Committee.	The Care Groups report details of their Clinical Audits, Getting it Right First Time Programme (GIRFT), National Clinical Audits - Quality Accounts (NCAPOP & Other) relevant NICE guidance, National Confidential Enquiries into Patient Outcomes and Deaths studies (NCEPOD) and Commissioning for Quality & Innovation Scheme Topics (CQUINs) to the Clinical Effectiveness Committee. There is a Clinical Effectiveness Committee Report at the Quality Committee on a quarterly basis	June 2024	CEC QC					Medical Director
C5	Ongoing monitoring of Patient Experience through a variety of sources to ensure we are on track to improve performance in national inpatient and UECC surveys	Monthly text surveys to a proportion of discharged patients asking questions related to lowest scores on most recent national survey. Results and actions will be presented to Quality Committee in quarterly Patient Experience Report	May 2024	QC					Chief Nurse
		Friends and Family Test offered to all patients. Results shared with Care Groups on a monthly basis and reported at Patient Experience Committee and Quality Committee quarterly	May 2024	QC	L1				Chief Nurse

		Report on Complaints including volume, themes and learning reported at Patient Experience Committee and Quality Committee quarterly	May 2024	PSC QC	L1				Chief Nurse
		Introduction of PALs with monitoring of Key Performance Indicators through Patient Experience Committee and Quality Committee quarterly Results of 4 national surveys (inpatients, UECC, maternity and CYPS) published by CQC. Improvement plans developed and progress monitored quarterly through Patient Experience Committee and Quality Committee		PEC QC PEC QC	L1				Chief Nurse
C6	Three Quality Priorities have been agreed for 2024/25	Rolling monthly update report to Quality Committee resulting in an update being received for each priority quarterly. Template provides data in SPC format, supported by Qi, Effectiveness and Data Analysis teams	July 2024	QC	L1				Chief Nurse
C7	Seek External Assurance to triangulate with internal assurance data	Quarterly reports on progress against self-assessment by Care Groups to Quality Governance & Assurance Group reported through Patient Safety Committee and Quality Committee quarterly		QGAG PSC QC	L2				Chief Nurse
		External body reports such as from NHSE or inspections reported to Quality Committee via the appropriate sub group on quarterly basis		SC QC	L3				Chief Nurse
		Quarterly Safety, Experience or Effectiveness reports to Quality Committee to provide updates on any partnership working with BDGH and details of associated actions	Sept 24	QC	L2				Chief Nurse
		Annual audit reports commissioned within the Quality domain following agreement of Audit & Risk Committee received at both ARC and Quality Committee with action plans monitored to completion. Audits include Internal Audit of Clinical Audit and Nice Implementation, Safeguarding and Medication Safety	June 24	QC	L3				Chief Nurse

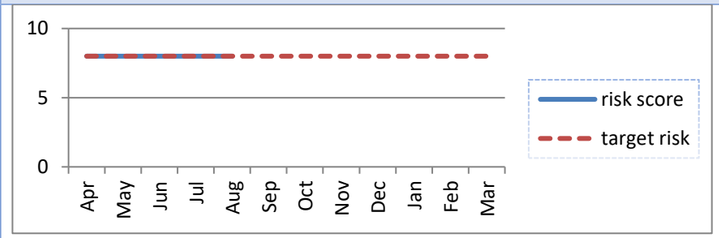
Gaps in Controls or Assurance Quarter 1 2023-24		Actions Required	Action Owner	Date Action Commenced	Date Action Due			Progress Update	
G1	Lack of assurance regards quality of end of life care	Completion of action plan that has been created in response to 360 assurance report and NACEL 2022 alarm outlier status report Strategy went to May 2023 Quality Committee and Board of Directors September 2023 Recruit additional palliative care consultant	Medical Director and Chief Nurse Medical Director	January 2023 September 2023 July 2024	~~May 2023~~ September 2023 May 2023 February 2025			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	
G2	Exemplar Accreditation programme needs to be expanded to all clinical areas beyond adult inpatient wards	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.	
G3	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**					
G4	Seek External Assurance to triangulate with internal assurance data	NHSE invited to undertake an appreciative inquiry into Adult Safeguarding. Report and any associated action plan will be presented to Safeguarding Committee and Quality Committee	Chief Nurse	**April 2024**	October 2024				
		Benchmarking Data will be reviewed to enable relevant services to compare quality and learn from exemplar organisations. Reporting will be through relevant subcommittee and to Quality Committee quarterly. Reports to include increased comparison of data	Chief Nurse	**July 2024**	October 2024				

		with external organisations and all associated actions.							
G5	Development of Trust Quality Strategy		Chief Nurse/Head of Quality Improvement		November 2024			To be presented to September 2024 Quality Committee with plan to include as agenda item at November 2024 Board	
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: **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**		**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		**August 2024**	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		**August 2024**		Level 1				**Control remains ongoing**			
C3	Trust is a member of the Health and Wellbeing Board			**June 2024**		Level 1				**Control remains ongoing**			
C4	Managing Director attends the Health Select Commission	Ran Workshop for Commission December 2023		**July 2024**	**Minutes**	Level 3				**Control remains ongoing**			
C5	Meeting with PLACE colleagues to review IDT position.	Meet at least three times a week to review integrated discharge position.		**July 2024**		Level 1				**Control remains ongoing**			
C6	PLACE Leadership Team meeting every Wednesday morning	Managing Director attends along with other Rotherham PLACE members		**Weekly**		Level 1				**Control remains ongoing**			

Gaps in Controls or Assurance Quarter 1 2022-23		**Actions Required**	**Action Owner**	**Date Action Commenced**	**Date Action Due**			**Progress Update**	
G1	Ethnicity details not on all electronic systems	Public Health Consultant identifying and working on solution. A working group has been established including the Public Health Consultant and the Director of Health Informatics	Managing Director	Ongoing	End of Quarter 1			Work ongoing with Managing Director	

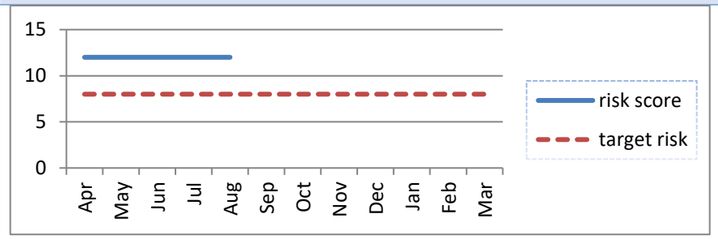
Archived Controls within month – Completed									
Archived Gaps within month – Completed									

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: ***O3: Our Partners: Work together to succeed for our communities.***							**8**	**8**	**8**		
BAF Risk Description						**Linked Risks on the Risk Register & BAF Risks**				**Assurance Committee**	
O3: There is a risk that robust service configuration across the system will not progress and deliver seamless end to end patient care across the system because of lack of appetite for developing strong working relationships and mature governance processes leading to poor patient outcomes.						**Risk**				**Audit Committee and Trust Board** **Chief Executive & 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	**August 24**		Level 1						
C2	Existing collaboration with Barnsley on some clinical services	Gastro service up and running, Haematology service in progress MEOC now opened.	**January 24**		Level 1						
C3	Board to Board, Joint Strategic Partnership and Joint Executive Delivery Group established for oversight and	Meetings of the Strategic Partnership every quarter, Monthly for Delivery Group.	**August 24**	**Reports to Boards on progress**	Level 1						

	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	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			Head of Nursing & Governance Corporate Operations (HoN&GCO) in post and met with Partnership governance and senior management. HoN&GCO update: Monthly Pathology Governance Group with SYPB 20/08/24. Monthly meetings (catch up) with the SYPB Governance manager every month Attend the local Operational Management Team meetings with SYPB however, with the partner organisations with their Head of Pathology and Governance Manager, to take place from September onwards to discuss performance/finance/operational delivery & governance Attend the monthly SYPB Senior management meeting too which was last week. Attend the TRFT HTT as a representative for TRFT along with Consultant Haematologist, which although is related to TRFT and how we are using blood products/demand etc, still links into the SYPB.	
G2	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			Activity reviewed on weekly basis at ETM with full updated report.		
Archived Controls within month – Completed											
Archived Gaps within month – Completed											

Board Assurance Framework People Committee: 2024/25 Quarter 2: Version 2.2

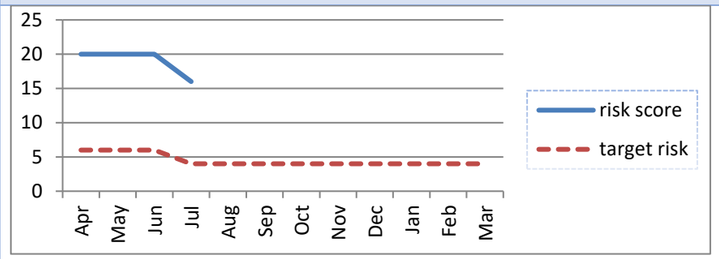
BAF Risk U4

Strategic Theme: Us	BAF Risk Ref	Initial Score	Current Score	Target Score	Risk Appetite/Risk Tolerance	Risk Movement	Board Assurance 2024-25				
							Previous score Q4 2023-24	Q1	Q2	Q3	Q4
Strategic Ambition: **Us:** ***We will be proud to work in a compassionate and inclusive organisation that delivers excellent healthcare for patients.***	**U4**	**3(L)x4(C)=12**	**3(L) x 4(C) = 12**	**2(L)x4(C) =8**	**Moderate (12-15)**					
Link to Operational Plan: ***P3: Supporting our People*** ***P2: Improve engagement with our medical colleagues***							**12**	**12**	**12**		
BAF Risk Description						**Linked Risks on the Risk Register & BAF Risks:** **RISK6801, RISK6888,a RISK6638, RISK6723, RISK6958 and RISK7069**			**Assurance Committee**	
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									**People Committee Director of People**		

Controls and Mitigations ***(what have we in place to assist in securing delivery of our ambition)***		**Assurance Received** *(what evidence have we received to support the control)*	**Date Assurance Received**	**Confirmed By:**	**Assurance Level** *Level 1 = Operational* *Level 2 = Internal* *Level 3 - Independent*
C1	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
C2	Integrated EDI (Equality Diversity Inclusion) Plan	Have current Board approved plan published and on website, will be refreshed for November Public Board 2024.	EDI Plan to P&CC in September 2024 and Board November 2024		Level 1
C3	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. July 24 launched trust wide 'we said, we did' 2024/25.	October 2024 and March 2025 February 2025 P&CC At Care Group P&CC presentations		Level 1

C4	Health wellbeing and attendance work	Going to ETM w/c 15/07/24 and P&CC in October 2024.	End of Quarter 3 2024/25		Level 1					
C5	Development of the Trust Workforce Plan	Current Workforce Plan 2020-24 in place, new plan to be in place from April 2025.	April 2025 P&CC and May 2025 Board		Level 1					
C6	Joint Leadership Programme	Delivery in train and on track	October 2024 P&CC		Level 1					
Gaps in Controls or Assurance Quarter 1 2024-25		**Actions Required**	**Action Owner**		**Date Action Commenced**	**Date Action Due**			**Progress Update**	
G1	Challenges around sufficient workforce to support the recovery plan and mitigate industrial action.	High level risks from Care Groups regarding exceptional workforce challenges monitored via P&CC. Unexceptional workforce challenges are managed by the Care Group Management with risks escalated via Care Group Governance Committees and on to Risk Management Committee if rated 15 or above. Industrial action whilst ongoing will be subject to regular industrial action meetings to mitigate impact.	Divisional Leads & FPC		**Ongoing**				This Gap relates to two outstanding risks rated at 15: Risk7069 - Band 2/3 Healthcare Support Worker job descriptions and re-banding following changes to the National job profiles in 2021. Risk6723 - Anaesthetic Medical Staffing Availability. Both risks are covered by action plans which are due for completion by December 2024.	

Archived Controls within month - Completed
Archived Gaps within month - Completed

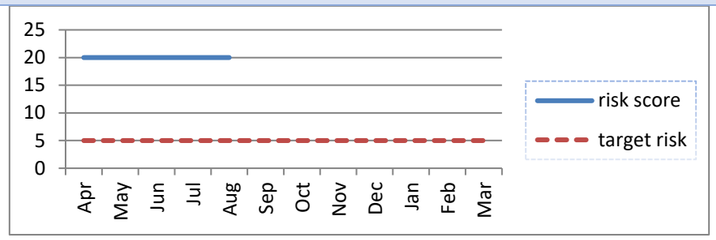
Strategic Theme: Delivery		Risk Scores										
		BAF Risk Ref	Initial Score	Current Score	Target Score	Risk Appetite/Risk Tolerance	Risk Movement	Board Assurance 2024-25				
Strategic Ambition: ***Delivery: We will be proud to deliver our best every day, providing high quality, timely and equitable access to care in an efficient and sustainable organisation***		**D5**	**4(L)x3(C)=12**	**~~5(L)X4(C)=20~~** **4(L)X4(C)=16** Consequence increased due to more significant impact of IA	**2x3=6**	**Very low (1-5)**		**Previous Score Q4 2023-24**	**Q1**	**Q2**	**Q3**	**Q4**
Link to Operational Plan: ***D5: To deliver 4 hour performance of 80% before March 2025, to go beyond the national ambition on long-waiters and RTT performance and consistently deliver the Cancer Faster Diagnosis Standard by Q4.***								**20**	**20**	**16**		
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 our performance priorities (*Urgent Care, Elective Recovery and Cancer*) because of insufficient resource and increased demand 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	**PERFORMANCE:** Care Group Performance meetings chaired by the Deputy CEO.	Performance Meeting minutes and chairs logs Monthly reports within IPR to Finance and Performance Committee and Board Care Group Performance meetings with each CSU		**June 2024** **July 2024 IPR**	**Minutes** **Chair's Log**		Level 1					Managing Director
	PERFORMANCE: Executive Team oversight via IPR	Weekly receipt of Performance IPR		**July 2024**	**ETM minutes Weekly** **ETM minutes Weekly**		Level 1					Weekly Executive Team Meeting Managing Director
C2	**URGENT CARE:** Monitoring waiting times of patients in UECC	Monthly TRFT Urgent Care Meeting Metric included in the Integrated Performance Report Weekly report to ETM		**July 2024**	**Minutes of F&P** **ETM minutes**		Level 1					COO

		Daily review of position and weekly through the acute care performance meeting and ETM Weekly 4 hour performance emergency care target meeting chaired by COO. Waiting times have improved in UECC and monitored against trajectory		**ETM minutes** **ETM minutes** **Action log** **Daily performance report**					
	URGENT CARE: Monitoring right to reside and Length of Stay data	Monthly TRFT Urgent Care Meetings Monthly reports to Finance and Performance Committee and Board Weekly Length of Stay reviews including Care Group Director Improvement with regards to right to reside and IDT caseload Escalation meetings with external partners.	**July 2024 IPR** **July 2024 IPR** **July 2024 IPR**	**Minutes of Urgent Care Meeting** **Weekly ETM minutes** **Weekly ETM minutes**	Level 1				COO
	URGENT CARE: Admission avoidance work remains ongoing	Acute Care Transformation Programme - monthly highlight report and minutes of meetings 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. Oversight through the Rotherham Place Urgent and Emergency Care Group (Previously the A&E Delivery Board)	**July 2024**	**Minutes of Urgent Care meeting**	Level 1				ACT Steering Group – emergency pathway workstream Medical Director Rotherham Urgent and Emergency Care Group COO
C3	**ELECTIVE:** Weekly access meetings with tracker for elective recovery schemes	Elective Delivery Group Weekly Access Meetings Care Group PTL Meetings To include financial allocation from ERF reserve. New weekly PTL for Elective and Cancer week commenced 27/11/2023. Outpatient, Theatre & Endoscopy Transformation Programmes	**July 2024**	**Monthly** **Weekly** **Weekly** **Weekly** **Monthly Highlight Report**	**Level 1** **Level 3 - 360 Assurance audit report - July24**				COO Ass Director of Operations Ass Director of Operations
C4	**CANCER:** Cancer PTL	Rotherham Cancer Strategy & Performance Meeting Cancer Services Quality, Governance & Business Meeting Cancer PTL Meetings. Cancer Improvement Programme	**July 2024**	**6 weekly** **Monthly** **Weekly** **Monthly** **Highlight Report**					COO Ass Director of Operations Cancer Manager

				FPC 1/4ly						
C5	**WINTER:** **Winter planning**	Evaluation of 2023/24 Winter Plan Minutes of Winter Planning Group Winter plan 24/25	**ETM and FPC mins** **Commences August 24**	**Evaluation – FPC mins May 2024** **24/25 plan due September FPC**						COO Dir Ops

Gaps in Controls or Assurance Quarter 1 2022-23		**Actions Required**	**Action Owner**	**Date Action Commenced**	**Date Action Due**			**Progress Update**	
G1	Insufficient funding to support increased levels of non-elective demand – both attendances at UECC and emergency admissions	Discussions with commissioners re funding Additional capacity utilising winter funding but summer months at cost pressure ACT programme to support most effective use of bed base Admission avoidance work with partners	DoF COO					No growth funding in 24/25 contract Additional bed capacity open cost pressure identified in Care Group forecasts ACT programme in place led by Medical Director maximising use of existing capacity Admission avoidance work in conjunction with partners – joint post to support project management	
G2	Lack of consistent SDEC model and trolley capacity across medical and surgical SDECs	ACT programme developing consistent models of care Relocation of medical SDEC to create ringfenced capacity Bed modelling and LoS to be reviewed to create capacity to ringfence trolleys in surgical and gynae SDEC	COO	Q1	Q3			Trolley capacity currently impacted by increased demand on inpatient beds – medicine relocated to B6. Surgery reviewing Los and bed requirements and ASU/SDEC requirements. Gynae dependent on reduction in surgical outliers. Gynae to review how SDEC delivered within existing footprint. Further trust-wide bed modelling being undertaken to review current capacity vs demand on beds. Capital bid submitted to provide increase capacity	
G3	Insufficient validation to support robust management of waiting lists	Review of validation capacity and resource required to support increased size of waiting list and maintain requirement to meet 90% validation Standardise validation processes and embed consistent ways of working Training of existing staff to support validation of waiting list Ensure oversight through regular audits and performance monitoring	Associate Director of Operations, Planning and Performance	Q2	Q4			360 Assure audit undertaken and actions agreed and in process of full implementation Text validation and admin validation in place 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	

								Further Deep Dive Validation Exercise undertaken Lead RTT Validation & Data Quality Officer in place and training and support commenced Review of capacity	
G4	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.	Care Group Leads & FPC					IA Planning undertaken and command and control in place through periods of IA	
G5	Insufficient anaesthetic workforce to support elective recovery	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 care group	Chief Operating Officer Care Group 2 Leadership team					Initial review of capacity required and available workforce undertaken Job plans reviewed and completed Second phase of review to be undertaken	
G6	Financial investment/resources to support recovery of waiting lists	Financial allocation identified in plan for 2024/25 – risk in allocation of ERF given overall financial position	Chief Operating Officer DoF					Plan and process for agreeing additional sessions in place for recovery schemes and investment in line with ERF allocation in 2024/25 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.	**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: D8: To deliver the financial plan for 2024/25 and deliver year 1 of the plan to return the Trust to a break-even position for 2026/27, and to ensure significant improvement across the full range of system productivity metrics.							**20**	**20**	**20**			
BAF Risk Description						**Linked Risks on the Risk Register & BAF Risks** **RISK 7130, RISK6755 and RISK6801**				**Assurance Committee**		
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 2024/25 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	**July 2024 Board**		Level 1				
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	Financial plan submitted to NHSE by 08/05/2024	Submitted on time, still awaiting sign off by NHSE	**July 2024 Board**						
C7	Finance and Performance Committee oversee budget reports	Budget reports presented to Finance and Performance Committee	**July 2024 Board**		Level 1				
C8	System wide delivery of Recovery	Director of Finance attends South Yorkshire DoF Group	**July 2024 Board**		Level 1				

	On plan with mitigations in place to manage winter pressures.	Monthly Finance Report to CEO Delivery Group	**July 2024 Board**		Level 1					
		South Yorkshire Financial Plan Delivery Group			Level 1					
C9	Suitably qualified Finance Team in place	Team in place			Level 1					
C10	Established Capital Monitoring Group	Capital and Revenue Plan signed off by Board	June 2024							
C11	Current Standing Financial Instructions in place	Reviewed and approved by Board			Level 1					
C12	Internal Audit Reports	Internal Audit Financial Reports			Level 3					
		Review of HFMA Improving NHS Financial Sustainability checklist			Level 3					
		360 Assure Head of Audit opinion presented to Risk and Audit Committee initial indications show Significant Assurance overall			Level 3					
C13	Monthly challenge on performance	Monthly Divisional Assurance meetings	June 2024							
C14	Clarity on Financial Forecast	Financial forecast will commence 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.			Level 1					
C15	Deloittes review of South Yorkshire system including investigation and intervention work.	I&I report will be finalised and presented to Senior Leadership Executive for South Yorkshire highlighting areas for improvement	August 24							

Gaps in Controls or Assurance Quarter 1 2022-23		**Actions Required**	**Action Owner**	**Date Action Commenced**	**Date Action Due**			**Progress Update**	
G1	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				
G2	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.	

G3	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						
G4	Financial forecasts come to fruition (Future Risk)	Monthly check and challenge with relevant Divisions and Corporate areas.	Director of Finance						
G5	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
6 September 2024

The Rotherham NHS Foundation Trust

Agenda item	P131/24
Report	**Corporate Risk Register Report**
Executive Lead	Angela Wendzicha, Director of Corporate Affairs
Link with the BAF	The following paper links with all BAF Risks
How does this paper support Trust Values	This paper supports the Trust Value of "Use and Evaluate Information to improve". By having up to date information on the Trust's risks we can use and evaluate this information to take actions and decisions that improve both patients' and staff experience.
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary	The purpose of the Corporate Risk Register Report is to provide to the Board of Directors an overview of all risks rated at 15 or above across the Trust. All of these risks have been discussed and approved at the trust Risk Management Committee. • Of the 20 approved risks, all are within review date. • All risks have action plans in place, however, constant monitoring of action plans is undertaken to ensure completion dates are monitored and updated. The Board will note that following a detailed review of the risks on the Corporate Risk Register a number of risks have been either reduced or closed due to the completion of additional mitigating actions.
Due Diligence	This information has been reviewed through the Risk Management Committee and shared with the Audit & Risk Committee, in a different format, on a quarterly basis.
Board powers to make this decision	N/A
Who, What and When	Once presented, the Director of Corporate Affairs, as Executive Lead will continue to ensure that risks are appropriately identified, recorded, reviewed and managed.
Recommendations	It is recommended that the Trust Board: • Note the content of the Report

	• Note the risks closed or reduced in score
Appendices	Appendix 1 Corporate Risk Register

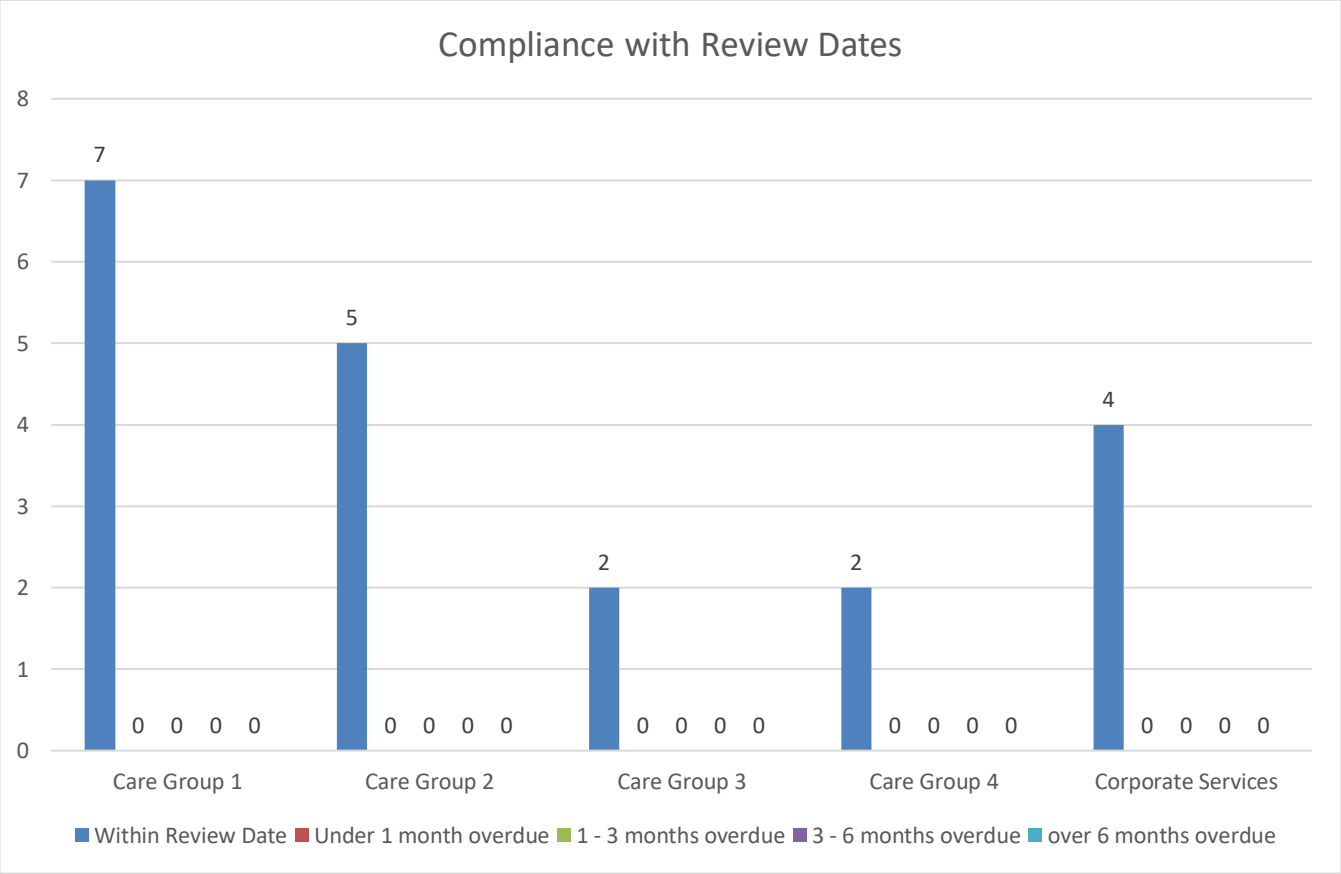
Corporate Risk Register

1. Introduction

The following report provides an update to the Board of Directors following the recent review of all risks scoring 15 on the Corporate Risk Register. The risks contained within this report includes all risks rated at 15 or above recorded on Datix on 27th August 2024. All of these risks have been approved at Care Group level and also approved by the Risk Management Committee. The full Corporate Risk Register can be found at Appendix 1.

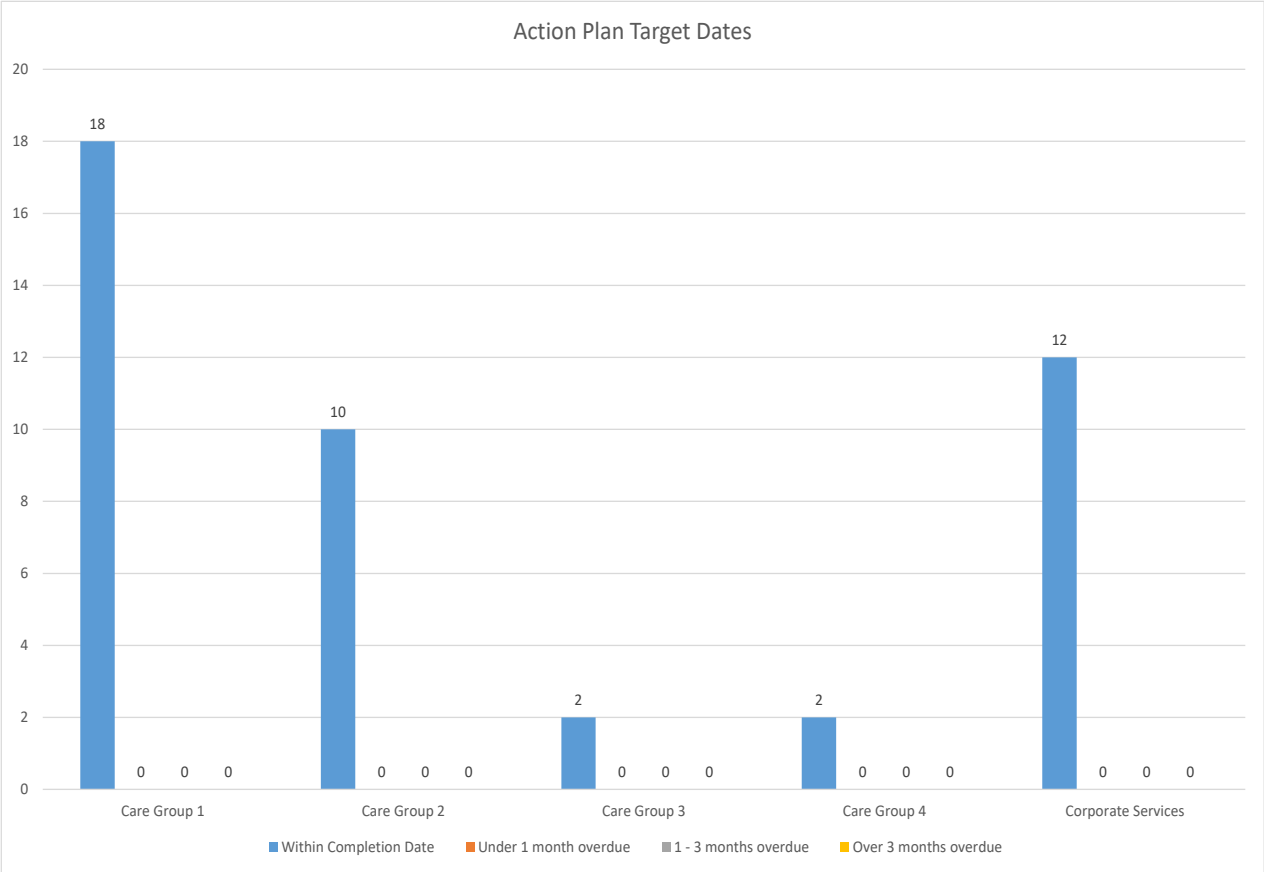
2 Risk Review dates

In terms of compliance with risk review dates, the graph below shows all risks rated at 15 and above for all Care Groups. The graph below provides and overview of compliance with review dates per Care Group and Corporate Services. The Board will note that all risks graded 15 and above are all within their review date.



3 Risk Action Plans

All risks rated at 15 or above have current action plans in place. The Corporate Affairs Department and Risk Management Committee review these action plans and are working with the risk owners where applicable to ensure good practice of this aspect of risk management.



There are currently 20 risks rated at 15 or above with 44 individual open actions. The graph above shows that all action plans are within target date.

4 Changes to Corporate Risks

All Corporate Risks rated 15 and above were presented to Risk Management Committee on 20th August 2024 and the following changes were agreed.

One risk was approved at the August 2024 RMC at a rating of 15:

- **Risk 5599** - Community Cardiac Team capacity resulting in possible clinical risk for heart failure patients.

This risk relates to the capacity to reduce the waiting list, alongside the increasing demand. Work is ongoing to fully assess and mitigate this risk.

A total of 4 risks, with a rating of 15 or above were approved at the August 2024 Risk Management Committee for a reduction in score:

- **Risk 7069** – Band 2/3 Healthcare Support worker job descriptions and re-banding following changes to the National Job profiles in 2021.

  It was acknowledged that the project programme has been working well and with the final approach agreed to carry forward, it was agreed to reduce the score from 20 to 15 with an expectation of further reduction in score when discussed at the September Risk Management Committee.

- **Risk 6800** – Delays in Urgent Care Pathways due to challenges with patient flow.

  Reflecting on Urgent and Emergency Care flow statistics, the risk score was agreed to be reduced from 16 to 12, due to the improved performance in handover times, front door streaming and 12 hour waits.

- **Risk 6627** – Patients that no longer meet Criteria to Reside needing Pathway 1-3 have an increased length of stay.

  Consideration was given to the Urgent and Emergency Care flow statistic, in particular, the Length of Stay data and a reduction in score from 16 to 12 was agreed.

- **Risk 6801** – Industrial Action and effect upon Trust activity.

  With no planned action and most areas accepting the pay awards, the likelihood has decreased and the Risk Management Committee agreed a reduction in score from 20 to 12. The committee acknowledged the junior doctor ballet that had just started and considered the GP collective action which could be included under the remit of this risk and monitored from impact on the risk score.

  There were 4 risks, with a rating of 15 or above, approved at the August RMC for closure:

- **Risk 6755** – Ability to Achieve Financial Control Total for the financial year 2023/24 (Care Group 2)

  This risk was formally closed by RMC due to the financial year end. Confirmation was received that a risk for financial year 2024/25 had been entered on the risk

register to ensure continued monitoring and mitigation, and would be brought to September RMC for approval.

- **Risk 6572** – Special School Accommodation
- Note the content of the Report

The work on the school has been almost completed and the risk regarding the outstanding work involving one room will be addressed through a new risk.

- **Risk 6638** - The Care Groups' ability to ensure sufficient numbers of suitably qualified, competent and experienced Registered Nurses.

It was agreed at July Risk Management Committee that this risk would be closed and be replaced by a new risk entry for the Care Group that is more reflective of the current risks encompassing more staffing groups.

- **Risk 6718** – Hospital Heart Failure patients not being seen or reviewed by Heart Failure specialist nurse in a timely manner due to capacity.

The risk was agreed to be closed following the link and merger with Care Group 1 Risk 7010 which will take this forward, in collaboration with Care Group 4.

5. Recommendations

The Board is asked to:

- Note the content of the report
- Note the risks closed or reduced in score

Alan Wolfe
Deputy Director of Corporate Affairs
August 2024

Corporate Risk Register - Risk rated 15 and above

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')
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	27/08/2024	27/09/2024	Ramsden, Daniel 27/08/2024 14:21:20 Plans on going for installations of UPS/IPS systems with Capital team and estates.	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
6888	23/03/2023	Hazeldine, Victoria	Corporate Services	Lack of clinical psychology support for all services for which it is required	Not meeting national recommendations for the use of psychology support for patients receiving clinical care. Currently the workforce is not reflective of the demand for psychological support therefore creating gaps in service. This is caused by lack of funding which sits across SY ICB which then relates to staff required at each organisation, as well as, lack of clinical psychology support and availability. This results in the risk to patients' physical and phycological health and the Trust being non-compliant with national recommendations.	High 15	High 15	Moderate 9	14/08/2024	13/09/2024	[Rimmer, Claire 14/08/24 16:39:24] Risk reviewed by CR and VH: Risk title updated to include all services which require clinical psychology support. Risk details updated to include all services and add more detail to the risk, cause and impact. Action plan also reviewed and actions added following requests from MHSG. This risk remains static as there has not been a potential for investment into psychology services.	Approved Risk	Escalate Lack of Psychological support for the breast cancer patients	31/08/2023	23/12/2024	14/08/2024	Timms, Mrs. Deborah
													Review of all services which currently require psychology support	14/08/2024	14/02/2025		Hazeldine, Victoria
													Identify gaps in the provision (following the review) and escalate to ICB level	14/08/2024	14/05/2025		Hazeldine, Victoria
7069	14/02/2024	Storer, Cindy	Corporate Services	Band 2/3 Healthcare Support Worker job descriptions and re-banding following changes to the National job profiles in 2021	1a - There is a risk that the consultation process is not managed affectively and line with Trust policy. 2a - There is a risk that agreements with staff side on backpay go back to 2021 as stated which increases the financial risk significantly. 3a – There is a risk, new job descriptions and associated clinical skills frameworks are not followed and implemented in line with Trust policy. 4a – There is a risk that the organisation consultation is delayed resulting in increased backpay and responsibility payments. 5a – There is a risk of trade union action. 6a – There is a risk of local and National media attention if the process is not managed effectively. 7a – There is a risk of organisational unrest and indirect impact on clinical care due to ongoing consultation process affecting workforce and morale.	High 25	High 15	Moderate 10	29/08/2024	27/09/2024	[Rimmer, Claire 29/08/24 10:58:20] Risk rating reduction in from 20 to 15 approved at RMC 20.08.24. The risk to be taken to September RMC for further reduction to 12 as programme was working well and almost complete. As a large number of the actions have been completed, such as, all interviews had taken place, the vast majority of staff had been given their preference and back pay had been agreed and the process commenced it was felt that the 15 rating did not reflect the current risk to the Trust.	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
7130	22/05/2024	Hackett, Steve	Corporate Services	Ability to deliver 2024/25 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	08/08/2024	05/09/2024	[Wallett, Val 08/08/24 10:25:08] M4 financial position is £1.2m deficit to plan. Risk remains around CIP delivery, ERF achievement and additional winter capacity over and above funded bed base. South Yorkshire ICB have commissioned a review by Deloittes to suggest areas of improvement to reduce expenditure run rate. The Executive team will be tasked with making improvements to ensure the financial plan is met by year end.	Approved Risk	Development of Winter plan.	01/04/2024	01/10/2024		Hackett, Steve
													Cost improvement Efficiency Board.	01/05/2024	01/10/2024		Hackett, Steve
													Development of robust capacity plans.	01/06/2024	01/11/2024		Kilgariff, Mrs. Sally
													Theatre improvement programme.	03/03/2023	31/03/2025		Kilgariff, Mrs. Sally
													Outpatient utilisation programme.	23/03/2023	31/03/2025		Kilgariff, Mrs. Sally
									1/8				review available PGDs	20/12/2023	24/07/2024	28/08/2024	Maton, Lynsey
													Improve access to other services	01/02/2024	30/09/2024		Maton, Lynsey

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')
													Improve access to other services	01/02/2024	30/08/2024		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	28/08/2024	29/09/2024	McAuley, Heather 28/08/2024 15:46:20 discussed in governance. Time to initial assessment (TTIA) better but this issue is not being resolved, it the front door who have improved TTIA, but not improved providing pain relief. Clinical Effectiveness lead felt following pain audit - Pain relief for mild pain is poor, slightly better for high pain levels. Re-audit of pain in October.	Approved Risk	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	30/08/2024		Farrow, Lindsay
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 15	High 15	Low 6	27/08/2024	24/09/2024	McAuley, Heather 28/08/2024 14:26:14 discussed in governance meeting. felt there are still issues in accessing good quality data to support performance. hub guidelines being out of date also not supporting care. issues with results still not going back to the right teams.	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	02/07/2024	Reynard, Jeremy
													Consultant Awareness of Issue	02/02/2024	29/11/2024		Reynard, Jeremy
													progression of electronic referrals across care groups and specialities.	01/07/2024	30/12/2024		Staunton, Eamon
									2/8				QI Project	16/11/2023	27/09/2024		Staunton, Eamon
													Portering.	01/10/2023	31/01/2024	20/12/2023	Maton, Lynsey

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')
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	27/08/2024	24/09/2024	McAuley, Heather 28/08/2024 14:37:55 Discussed at Governance meeting 27.08.24 – there has been some challenges in regard to Portering which has maintained the likelihood of the risk. The transfer policy will be checked to give clarity on Portering and out of hours timings, and move forward here. plan for audit on CT use	Approved Risk	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	24/07/2024	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	27/08/2024	29/09/2024	McAuley, Heather 28/08/2024 14:30:11 Discussed at Governance meeting 27.08.24 – With Clinical Fellows now on the rota, the rota has improved with more substantive staff. The risk score was agreed to be reduced to 12 (Consequence 3, likelihood 4) to be approved at RMC for a reduction in score. OOH and GP service teams recruitment also progressing well.	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	02/07/2024	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
									3/8				Work with Executive team on embedding the standards and engagement with the Trust	01/11/2023	05/02/2025		Reynard, Jeremy

ID	Opened	Handler	Division	Title	Description	Risk level (initial)	Risk level (current)	Risk level (Target)	Date REVIEWED	Review date	Progress notes	Approval status	Description	Start date	Due date	Done date	Responsibility ('To')
													standards and engagement with the Trust				
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	27/08/2024	24/09/2024	McAuley, Heather 28/08/2024 13:54:34 Discussed at Care group 1, CSU1 governance meeting. Risk remains high reflecting on a wide-spread of data points, beyond the A&E flow statistics. Reflecting on mortality data there is significant harm to patients, triangulating with the associated wait times, and affects around 5 patients per week. all associated datix linked to risk	Approved Risk	Transformational work, Task and finish group (ACT Programme)	01/02/2024	31/10/2024		Beahan, Dr Jo
													New staffing tool to be implemented	05/06/2023	15/07/2024	19/08/2024	Maton, Lynsey
7010	26/10/2023	Lunn, Mrs. Clare	Division of Integrated Medicine	Delay in heart failure patient reviews	delay in patients being reviewed by heart failure nurse spacialist Delay in patient being cared for on all wards including cardiology Longer length of stay due to none or less frequent reviews Poor clinical outcomes Higher heart failure morbidity cannot facilitate discharges resulting in patient deterioation when an in-patient High staff stress and potential for sickness and burnout.	HIgh 15	HIgh 15	Low 6	15/08/2024	13/09/2024	28/08/2024 16:17:57 Update following review from JB: Business case presented to SLT, additional information requested and service to bring business case back to SLT by end of Sept 2024.	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	11/09/2024		Mitchell, Samantha
					Additional capacity beds opened within the Division. Caused by an				4/8		Rimmer, Claire 28/08/2024 16:14:37		Completion of the SOP for opening a decommissioned area	13/03/2024	01/05/2024	13/06/2024	Benton, Jennifer
													Identification of Golden patients	13/03/2024	01/06/2024	13/06/2024	Benton, Jennifer
													Divisional representation at LLoS review	13/03/2024	01/06/2024	13/06/2024	Benton, Jennifer

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')
7084	13/03/2024	Benton, Jennifer	Division of Integrated Medicine	Operational pressures, opening additional beds impact on patient safety, experience	Additional capacity beds opened within the Division. Caused by an increase in patients requiring a medical inpatient admission. Increased infection resulting in funded beds being closed from an IPC requirement. Increase in LOS and a requirement of IDT involvement. Resulting in adverse impact on patient safety, quality and experience - Increase noted in patient incidents, harm to patients (severity), judicial enquiries, concerns and complaints. Negative impact on Trust reputation/credibility.	High 20	High 15	Moderate 9	28/08/2024	29/09/2024	28/08/2024 10:14:37 Risk reviewed by JB: Current position is 19 unfunded beds on Acute medicine footprint, 9 the same unfunded escalated beds on B5, 3 unfunded escalation beds on Stroke unit. Bed remodelling paper awaiting review from Execs following request for further information. Likelihood score of 5 remains (consequence moderate 3, risk score 15) as causes are a daily occurrence.	Approved Risk	Divisional representation at LEDS review	13/03/2024	01/06/2024	13/06/2024	Benton, Jennifer
													Nurse staffing huddle	13/03/2024	01/06/2024	13/06/2024	Benton, Jennifer
													SHOP Ward round principles	13/03/2024	31/08/2024		Reynard, Jeremy
													Bed Reconfiguration Work	12/07/2024	20/09/2024		Stewart, Paul
													Utilise Perfect Week to enact de-escalation	18/07/2024	30/08/2024		Stewart, Paul
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	26/08/2024	26/09/2024	Windsor, Claire 24/08/2024 17:20:52 Business case rediscussed with new GM, awaiting outcome	Approved Risk	Lack of Critical care Follow-Up - Business Case brief for Rehabilitation and Follow-up Service for Critical Care submitted to service manager on the above date.	01/08/2022	30/09/2024		Timms, Mrs. Deborah
6958	02/08/2023	Agger, Joanne	Division of Surgery	Lack of Rheumatology Consultants to meet service need	Failure to provide a consultant led Rheumatology Service	High 15	High 15	Moderate 9	09/08/2024	27/09/2024	[Agger, Joanne 09/08/24 10:32:31] there will be 2 substantive consultants in post from Sept 24. The 3rd consultant has given back word - this vacancy is going back out to advert. There may be a requirement for ongoing agency support to ensure adequate levels of activity can continue	Approved Risk	consultant recruitment	02/01/2023	31/10/2024		Agger, Joanne
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	29/08/2024	28/09/2024	Ward, Mrs. Sandra 29/08/2024 10:52:19 29/08/2024 - We have recruited to 3 substantive consultants and the deputy general manager is to have a conversation with the clinical lead for anaesthetics with regard to lowering the risk however she is presently on annual leave.	Approved Risk	Phase two - Specification and Commissioning	08/01/2024	30/09/2024	17/07/2024	Agger, Joanne
													Phase Two - Resource agreed/appointed to undertake Phase Two work, starting late summer	01/07/2024	30/09/2024		Agger, Joanne

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')
													Phase two - External review, comparing to national standards and benchmarking practice against other peer trusts	30/09/2024	31/03/2025		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 ambuatory surgical patients to be managed in ASU. Caused by preventing SDEC operating due to inpatients in 10 non funded beds. Medical and surgical patients in ward surgical beds. Resulting in Increased admissions to hospital due to all patients managed in waiting area sometimes for long periods. Preventing streaming/flow of non ambulatory patients from UECC. Poor patient experience and increased length of stay in department. Preventing good early flow through the unit as previously 10 trollies were available at the start of the day to ensure adequate capacity until patients were discharged from short stay beds.	Low 6	High 15	Low 6	01/08/2024	02/09/2024	[Short, Sally Mrs. 12/08/24 11:24:58] 7/8/24 Meeting conducted. For trial of 4 trolleys W/C 26th August in conjunction with the perfect week	Approved Risk	Surgica SDEC Task and Finish Group	01/11/2022	31/03/2024	29/04/2024	Timms, Mrs. Deborah
													Amend Sepia to reflect 23 IP beds and 10 trollies	14/11/2022	09/12/2022	09/12/2022	Thurman (No longer in the Trust), Mr Simon
													Complete Trust bed modelling work	01/04/2022	31/03/2023	18/07/2023	Vasey (No longer with Trust), Benjamin
													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
													Care Group to review impact on patient safety and quality of care	19/07/2024	21/10/2024		Howlett, Darren
													Review bed modelling to understand bed capacity needs	19/07/2024	19/10/2024		Kilgariff, Mrs. Sally
													Care Group to review increase in long length of stay	19/07/2024	19/10/2024		Howlett, Darren
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	19/06/2024	30/09/2024	[Oliver, Lauren 29/07/24 17:03:45] Requested for all Surgical CSU's to identify what they wish for their LocSSIPs to be on the 29/07/24, asked for a response by the 12/08/24.	Approved Risk	Lack of Local Safety Standards for Invasive Procedures (LocSSIPs)	13/04/2023	30/09/2024		Oliver, Lauren
													To establish Trust wide required LocSSIPs	13/06/2024	01/01/2025		Oliver, Lauren
									6/8				In talks with the patient records department to attempt to find a solution	23/02/2023	17/07/2024	10/01/2024	Stables, Sarah

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')
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	19/08/2024	19/09/2024	[Dodd, Jamie Mr. 19/08/24 11:19:05] 19/08/2024: Reviewed by S Stables. New wallets now in use. To discuss at the next Maternity Governance for downgrade or closure.	Approved Risk				
													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 again to Kevin Wilkinson, Laura Allwood and Angela Ford.	19/08/2024	19/09/2024		Stables, Sarah
6421	31/03/2021	Whitfield, Vicky	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	12/07/2024	30/09/2024	[Whitfield, Vicky 12/07/24 17:40:22] Focused work being undertaken to address this, with the support of commissioners: + A multi-agency summit has been held with partners to identify how other teams can provide support to this cohort - and reduce the demand on the CDC. Agreement has been given at a senior level (ICB and RMBC) to set up a task and finish group to implement a new graduated response for this cohort of children + Demand and capacity mapping is being undertaken and is nearly complete. + Pathway redesign has been undertaken by the team to maximise efficiency. A plan to implement the new pathway is being developed. This will include looking at flexible use of staffing and what additional training is required to enable more staff to diagnose Autism. also, updating paperwork and communications with families, including those wishing to complain. + The SEND Exec group will be briefed for a second time on the capacity issues at the CDC on 20th July. The TRFT execs will also be updated in the near future. + An arrangement is in place (awaiting final confirmation) to move 80 children from the CDC caseload for assessment with CAMHS. This will help to reduce the backlog. The CDC team will not need to complete any additional paperwork. + The continuation of the current additional funding provided by the ICB is being requested - as well as additional investment in speech and language therapy + The backlog elimination plan (previously submitted to the ICB in 2022) is being revised to reflect the current numbers (which have increased). The use of Healios (a digital provider) will be explored.	Approved Risk	Support without referral Pathway	18/09/2023	30/09/2024		Wilkinson, Jo
													Funding for further staff	18/09/2023	30/11/2023	02/01/2024	Wilman, Mrs. Johanna
													Psycology Funding	18/09/2023	28/06/2024	03/06/2024	Wilman, Mrs. Johanna
													Joint working with RDASH	18/09/2023	30/07/2024	25/07/2024	Wilman, Mrs. Johanna
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	Low 3	14/08/2024	14/09/2024	20.08.24 RMC - It was proposed to reduce the scoring; a report had been taken to ETM and it was agreed to register for IQIPS accreditation. Work is taking place to reduce the score and work within the framework of IQIPS. This will be discussed at the governance meeting before bringing back to RMC for approval for reduction in the score.	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	19/09/2024		Burgin, Amanda
5599	04/07/2018	Taylor, Ms. Katie	Division of Therapies, Dietetics and Community Care	Community Cardiac Team capacity resulting in possible clinical risk for heart failure patients	1.Risk of patients not receiving care/ review of investigations in a timely manger and resulting in clinical risk 2. Risk of patients admitting to acute setting due to not being reviewed within recommended timescales or waiting list targets 3. Unable to support and facilitate early hospital discharge 4. Increased risk of complaints/litigations from increase in patient dissatisfaction 5. Increase staff stress sickness, burnout and turnover 6. Not meeting NICE HF guidance of patients reviewed by specialist within 2 weeks of referral/discharge	Moderate 9	High 15	Low 6	22/08/2024 7/8	23/09/2024	Taylor, Ms. Katie 22/08/2024 14:36:14 1. Recovery plan email to SLT and time line document attached to risk. 2. The outstanding action re GP HF Champions is an iterative piece of work due to constant referrals from the hospital to our service at discharge. 3. 113 patients have so far been referred back to GP HF Champions 4. Significantly reduced referrals to the service have been noted from two out of 5 of the GP practices in the project. 5 There has been a significant and sustained increase in	Approved Risk	Review of risk requested by business manager	08/06/2022	06/07/2022	17/11/2023	Bell, Miss Beky
													Saturday waiting list initiative	18/11/2023	24/02/2024	20/03/2024	Briggs, Sarah
													Cardiac Network supported work of hub and spoke model- at proposal level	17/11/2023	16/02/2024	20/03/2024	Briggs, Sarah
													Cardiac rehabilitaion offer to all heart failure amber patients on the waiting list	06/11/2023	30/04/2024	20/03/2024	Taylor, Ms. Katie

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')
											5. There has been a significant and sustained increase in referrals since April which is why the waiting list keeps growing despite the mitigating actions -this offsets any benefits of the GP HF Champion project. We have not control over referral rates 6. Staff are working beyond contracted hours on NHSP to		Completion of all amber referrals back to GP HF champions	11/03/2024	30/08/2024		Taylor, Ms. Katie

Board of Directors' Meeting
6 September 2024

The Rotherham NHS Foundation Trust

Agenda item	P133/24
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 for July 2024

1.0 Operational Matters

1.1 The Trust is now consistently achieving over the 78% standard across the non-majors workstreams, with June performance being 89.6% for paediatrics, 93.1% for minor injuries and 91.9% for primary care. In July, the Trust achieved 67.9% overall. From August, eight new Clinical Fellows commenced in post in UECC, along with a redesigned rota to support the peaks in demand across the day. This will increase clinician time into the late evening where demand is challenging.

1.2 The Trust has continued to perform well with ambulance handovers and time to initial assessment in the UECC.

1.3 The number of patients waiting more than 65 weeks for treatment has reduced to just one in June and July. RTT standards were met in Geriatric Medicine, Rheumatology, and Respiratory, with notable improvements in Cardiology, Dermatology, General Surgery, Gynaecology, and Ophthalmology. The Trust successfully achieved 0.1% for the DM01 standard for diagnostics in July.

1.4 **Urgent and Emergency Care Activity:** The month of June continued to see high attendances at UECC with an increase in acuity and in terms of four-hour performance, it achieved 68.7% against a trajectory of 70%. The Trust was on track to exceed 70%, however, Industrial Action and the increase in demand on UECC towards the end of the month had a significant impact on performance.

2.0 Industrial Action

2.1 Doctors in Training took Industrial Action on the 27 June to 02 July 2024. The industrial action did have some impact on elective care, some outpatient appointments and elective lists were stepped down to release clinician time to support emergency pathways.

2.2 In addition, General Practitioners are in the process of taking some form of collective action across Rotherham Place. The Trust is working with Place leaders on plans and any impact that this will have on the Trust which is likely to be across both elective and urgent care services. As always, patient care and patient safety is our priority during any such 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 July 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 held on Friday 9th August 2024 with a focus on patient safety and experience.

Colleagues from each Trust continue to meet via the Joint Executive Delivery Group (JEDG) monthly and the Joint Strategic Partnership Group (JSPG) quarterly. As the Partnership has been in place for over 12 months now, 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.

4.0 Care Quality Commission (CQC) Inpatient Survey 2023

4.1 The Trust has seen a significant improvement across almost all areas on the recently published 2023 CQC Inpatient survey results. We have been ranked as one of the most improved Trusts which is fantastic with 80% of respondents rating their experience as more than seven out of ten. Work is already progressing on those areas which require improvement but this is testament to all the hard work carried out by colleagues.

5.0 People

5.1 The monthly staff Excellence Awards winners for the months of June and July 2024 are as follows:

June 2024

INDIVIDUAL AWARD:	Dr Fiona Hendry, Palliative Care
TEAM AWARD:	Children's Community Nursing Team
PUBLIC AWARD:	ITU/HDU

July 2024

INDIVIDUAL AWARD:	Darren Harwood, Sterile Services
INDIVIDUAL AWARD:	Abby Kilby, E-Roster
TEAM AWARD:	Medical Undergraduate Team
PUBLIC AWARD:	AMU and UECC

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

- Dr H Hashim, Cardiology (01.09.24)
- Mr H Zaki, Ophthalmology (02.09.24)
- Dr H Umair, Rheumatology (02.09.24)
- Dr C Fragkoulakis, Radiology (10.09.24)

5.3 I am very pleased to report that the Trust has been shortlisted in the Nursing Times Workforce Awards 2024 for the following categories:

- Best Employer for Diversity and Inclusion
- Best Employer for Staff Recognition and Engagement
- Best UK Employer of the Year for Nursing Staff

The Trust has also been shortlisted in a further three categories for the Nursing Times Awards 2024 as follows:

- Care of Older People
- Learning Disabilities Nursing
- Infection Prevention and Control

Both ceremonies are due to take place in London, the former being on 28th November 2024 and the latter on 23rd October 2024. I am sure you would like to congratulate our shortlisted nominees, this is a fantastic accolade for our staff as well as the Trust and I would like to take this opportunity to wish all shortlisted nominees the best of luck.

Dr Richard Jenkins
Chief Executive
September 2024

Chief Executive Report

Integrated Care Board Meeting

3 July 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

3 July 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 May and June 2024. Part of this period is covered by the Pre-election Period ahead of the elections on Thursday 4 July 2024, and the content of the paper reflects that.

2. Integrated Care System Update

2.1 Integrated Care Partnership Board.

The May 2024 Integrated Care Partnership meeting received an update on the Children and Young People Alliance's Health Equity Framework. Ruth Brown, Chief Executive of Sheffield Children's Hospital and CEO of the Children and Young People's (CYP) Alliance, as well as Nicola Ennis CYP Alliance Programme Director, updated on the work being done in partnership with the UCL Institute of Health Equity, Barnardo's and two other partner ICSs (Birmingham and Solihull and Cheshire and Merseyside).

The Health Equity Framework has been developed by the Child Health Equity Collaborative and co-produced with children and young people from each of the three ICSs with the purpose of supporting action for greater equity in children and young people's health and wellbeing. This underpins the development of a pilot intervention. There is an ambition for the framework to also be used more widely with other ICSs and partners.

At the end of May 2024, the Children and Young People Alliance Conference was attended by 210 children, young people and professionals from across health, care and wider local government and voluntary organisations. Dame Rachel De Souza, the children's commissioner for England, opened the event on how she is listening to children and young people and taking that voice to Government. More than half of those that attended were young people.

2.2 Operational and Financial Plan 2024/25

The South Yorkshire Integrated Care System submitted its financial and operational plan to NHS England at the beginning of May. This was in response to the requirements set out in the NHS Planning Guidance published in March 2024. The NHS provider organisations and the ICB have worked closely together to develop an integrated response. The ICB has also sought to ensure wider partners where kept informed regarding progress.

The ICB and representatives from SY NHS provider organisations met with Amanda

Pritchard the CEO of NHS England and her team at the end of May to discuss the plan. The plan describes how the operational requirements set out in the planning guidance will be delivered and an intention to achieve a financial performance, equivalent to the 2023/24 outturn, with a deficit across provider organisations of £49m combined with a requirement for the ICB to achieve breakeven. The plan was accepted by NHSE and support for the financial position is expected to be forthcoming.

2.3 Industrial action

Junior doctors voted in favour of extending their mandate for industrial action for another six months and at the time of writing the next planned action was due to take place from 07:00 Thursday 27 June 2024 to 07:00 Tuesday 2 July 2024. As we have previously, 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. The South Yorkshire ICB has continued to provide support through its Incident Co-ordination Centre, which has operated at all times during industrial action as part of our Category 1 Responder duty.

GPs in England are continuing to consider their next steps following the BMA's referendum, where the vast majority of Drs in primary care voted ‘no’ when asked if they accepted the new contract for their service. As independent providers it is unlikely that GPs will take direct strike action, however the BMA is currently balloting its primary care members on proposals to withdraw certain activities which are outside of their contractual responsibilities.

2.4 WorkWell

South Yorkshire has been awarded more than £3.5m to become one of 15 pilot areas across England to help long-term sick and disabled people into work. The region was selected by the Department for Work and Pensions (DWP) and the Department for Health and Social Care (DHSC) as part of the Government’s Back to Work Plan.

WorkWell will build on the successes of South Yorkshire Mayoral Combined Authority’s programme, Working Win, that has supported over 6,500 people with a disability or physical and or mental health condition to either start, stay, or succeed in employment since 2018. Each pilot area will help to deliver the new work and health service. The service will offer a tailored early-intervention work and health support and assessment service, and a single, joined-up gateway to other support services.

One of the main focusses of the Integrated Care Partnership Board in South Yorkshire is the relationship between employment and improving population health. WorkWell will offer low-intensity support to people in work who are struggling due to a health condition or disability, to overcome health related barriers to employment.

The scheme will see partners such as NHS South Yorkshire, the South Yorkshire Mayoral Combined Authority, the four Local Authorities and Job Centre Plus working together to create an integrated work and health system with support services that meet the needs of the area’s communities and employers.

2.5 Primary Care Pilot

South Yorkshire has been chosen as one of seven ICBs to test new ways of working within general practice and to understand how General Practice can be supported further. The aim is to identify operational changes and improvements needed to optimise the general practice operating model, and support GPs and wider practice teams to meet increasing demand and complexity across urgent and proactive care. The programme builds on the national Fuller Stocktake and General Practice Access recovery vision.

General practice is the bedrock of the NHS, and its success is critical to patients and the sustainability of the system. It is widely acknowledged however, that Practices face significant challenges in meeting the unprecedented levels of demand. NHS South Yorkshire is currently working with colleagues across General practice to identify two primary care networks (PCNs) to take part. The data and evidence from the programme should bring benefits for GPs, the wider workforce, and patients, and will help inform future decisions about General Practice resourcing and contracting.

2.6 Montagu Hospital

Work continues with the expansion of services at Montagu Hospital in Mexborough. The Elective Orthopaedic Centre is now operational and patients from across South Yorkshire are being seen and treated there, with plans to expand capacity over the course of the year. This is expected to reduce waiting times for planned surgery.

The Community Diagnostic Centre (CDC) being built on site is also progressing with most of the main structure now in place. The new facility, which will include dedicated MRI and CT scanning rooms, two ultrasound suites, changing rooms for patient use, and a waiting area, is the final phase of the CDC's expansion, which began in 2022. The new imaging suite within the CDC aims to perform 68,000 procedures annually, effectively doubling the diagnostic provision for local residents and offering increased access to appointments in a convenient location. This is expected to be completed in early 2025.

2.7 National infected blood inquiry

The final report by Sir Brian Langstaff KC into the Infected Blood Inquiry was published on Monday 20 May 2024. The independent public statutory inquiry was established to examine the circumstances in which patients were given infected blood and infected blood products between the 1970s to early 1990s. The Inquiry has examined why people were given infected blood and/or infected blood products, the impact on their families, how the authorities (including Government) responded and the nature of any support provided following infection.

The Prime Minister subsequently issued an apology on behalf of successive Governments and the British State, and this was followed by an apology from Amanda Pritchard, Chief Executive of NHS England. Communities in South Yorkshire were impacted by infected blood products and our NHS providers have shared information with those affected.

Blood is now distributed to NHS hospitals by NHS Blood and Transplant (NHSBT), which was established in 2005 to provide a national blood and transplantation service to the NHS. Their services follow strict guidelines and testing to protect both donors and patients and are subject to regular inspections by independent regulators.

2.8 Cyber Security in South Yorkshire

Following recent cyber security issues affecting the NHS nationally we are constantly reviewing our security. NHS South Yorkshire supports the system wide South Yorkshire Cyber Forum where partners are working collectively to build a Cyber Strategy to improve security across all organisations. The Forum is working towards the identification and mitigation of security vulnerabilities using best practice, developing system-wide cyber policies and incident response protocols. The forum is also adopting available risk monitoring tools. This work is being completed in line with the Cyber Assessment Framework and working towards the NHS Cyber Security Strategy for health and adult care to 2030, which is a joint strategy between NHS England and Department of Health and Social Care.

3. NHS South Yorkshire

3.1 Change of Estate

NHS South Yorkshire has now fully implemented its change of estate to co-locate with partner organisations across South Yorkshire where possible. The move into South Yorkshire Fire and Rescue Headquarters in Sheffield took place in spring and we have now co-located our offices in Barnsley to Westgate with Barnsley Metropolitan Borough Council, and in Rotherham to Riverside House with Rotherham Metropolitan Borough Council. All three moves will reduce costs and improve partnership working with organisations involved in health, care and incidents that require multi-agency response.

3.2 Covid-19 spring vaccinations.

The booking process for people in South Yorkshire aged 75 or over, and children and adults with a weakened immune system to have their spring Covid-19 vaccine has now been completed. The vaccinations started in late April 2024 and bookings were open until 30 June 2024. Nearly 100,000 people had had their booster at the time of writing. We will continue vaccinating those who have booked an appointment and will start work on planning ahead of any potential autumn vaccination programme.

3.3 Anti-Racism and Race Equality

Sadly, racism remains a feature of our society and public institutions, including the NHS. In NHS South Yorkshire we are committed to prioritising active anti-racism both in terms of how we deliver our services but also as an employer. Our priorities are better understanding the experience of people from minoritized communities, being a stronger ally, and ensuring our own leadership is more inclusive.

3.3.1 North West Race Equality Framework

NHS South Yorkshire has committed to adopting the North West Race Equality Framework, which sets out a systematic approach to becoming an anti-racist NHS organisation, with clear deliverables and external scrutiny of progress. Pearse Butler, our Chair, facilitates the anti-racism group with EDI leads from our provider organisations, all of whom are committed likewise to adopt the framework.

The framework encourages the tackling of structural racism and discrimination through collaboration, reflective practice, accountability and action. The Framework has five anti-racist principles of prioritising anti-racism, understanding lived experience, growing inclusive leaders, acting to tackle inequalities and reviewing progress regularly. Organisations then measures themselves against a bronze, silver and gold status to track their progress.

3.3.2 South Yorkshire Race Equality Network for Primary Care Staff

NHS South Yorkshire is working with local clinicians and partner organisations to establish a South Yorkshire Race Equality Network for Primary Care staff. The Network is open to all staff working across Primary Care including General Practice, Optometry, Pharmacy and Dentistry. The group will also welcome attendance from allies wanting to improve their understanding of the issues and challenges.

The South Yorkshire Primary Care Race Equality Network can help us do this. The Network will support front-line professionals, promote a culture of wellbeing, and provide a voice to help shape how we work in the future.

4. NHS South Yorkshire Place Updates

4.1 Sheffield

A cancer pre-habilitation and rehabilitation service that helps people prepare for and recover from cancer treatment has now reached 1,000 referrals. The pioneering Active Together service, which is funded by Yorkshire Cancer Research and operated in collaboration with Sheffield Teaching Hospitals NHS Foundation Trust and Sheffield Hallam University, began accepting referrals in early February 2022 and has since expanded to support to a range of tumour groups including gynaecological, lung and colorectal cancers. There are plans to expand to some breast and prostate patients and offer support at sites in Rotherham, Barnsley, and Doncaster over the coming year.

4.2 Doncaster

Doncaster and Bassetlaw Teaching Hospitals have announced the implementation of advanced computed tomography (CT) perfusion software within their services with an ambition improve stroke care. The technology will enable specialists at the Trust to extend the thrombolysis treatment window from its present standard of four and a half hours to nine hours, and the thrombectomy treatment window from six hours to 24 hours, following a partnership agreement with the Neuro Intervention team at Sheffield Teaching Hospitals.

A new Doncaster Dance on Programme is aiming to raise activity levels and reduce isolation in older adults across the city. The programme, which is being delivered by artists from the local charity Darts, who are one of the largest participatory arts organisations in the UK, has completed a 12-week pilot which has seen many people embed strength and balance into their weekly routine as well as them making a positive lifestyle change and increasing social activity. The pilot has proven to increase strength and balance as well as supporting fall prevention and fall reduction.

4.3 Rotherham

The Rotherham NHS Foundation trust has installed a robotic assistant into the Trust's orthopaedic theatre to improve outcomes for patients. The robot will ensure improved accuracy and reliability of bone resections and soft tissue balancing, leading to enhanced surgical outcomes. The technology reduced the need for CT scans meaning clinical staff can reduce patient exposure to radiation. This not only prioritises patient safety but also streamlines the treatment process.

4.4 Barnsley

NHS South Yorkshire is working with a housing provider to improve the living conditions and health of children with asthma. Asthma is the most common long-term medical condition in children in the UK, with around 1 in 11 children and young people living with asthma. South Yorkshire Children and Young People's Alliance are working in partnership with Berneslai Homes, who manage properties for Barnsley Council, to ensure children and young people with asthma who live in a Berneslai Homes property, have the best possible health outcomes. Respiratory nurses at Barnsley Hospital are working closely with the housing provider to ensure the homes of asthma patients are appropriate for their condition.

5. General Updates

5.1 NHS Confed Expo

NHS South Yorkshire made an important contribution to the NHS Confed Expo in June. Dr Jason Page, Rotherham Place Medical Director, and Hannah Young, Communications and Engagement Officer, presenting their work on targeted lung cancer case finding at the Health Inequalities Improvement Theatre. They were joined by David Fitzgerald of the NHS Cancer Programme. Jason and Hannah talked through the approach by the Cancer Alliance that we'd taken in South Yorkshire and the fact that, through targeting individuals and groups and a comprehensive campaign, more than 120,000 people had been seen. This detected undiagnosed lung cancer in 340 people, but also a further 100 patients who had other cancers present.

Gavin Boyle, NHS SY CEO, led a discussion on the use of digital technology in healthcare along with Prof. Tim Chico, a research active Cardiologist in Sheffield and Director of the SY Digital Health Hub, Dr Susan Thomas, the UK Director of Google Health and Dr David Crichton our Chief Medical Officer. The Digital Health Hub is a new partnership led by our two SY Universities – Sheffield Hallam and University of

Sheffield – along with the NHS, Google, the Mayor, local authorities, and other partners.

It is funded through a £4.5m grant from Engineering and Physical Sciences Research Council. Its aim is to use digital technology to address some of our big challenges here in SY but particularly improving population health and tackling health inequality. The partnership is six months into a three-year programme. One area of exploration is how commonly available wearable tech can be used to provide data which could be interpreted alongside clinical information to help people to manage their health or a particular condition better. In partnership with Google and the South Yorkshire Digital Health Hub we've given out 500 Fitbits for a research study on post-surgical rehabilitation.

5.2 Honours

The Chair of Sheffield Children's NHS Foundation Trust, Professor Laura Serrant OBE and Non-Executive Director, Peter Mucklow, have both received a Commander of the Order of the British Empire (CBE), in the King's birthday honours list. Prof Serrant has received her honour for services to nursing in the North East and Yorkshire, and Peter for services to education. Prof Serrant was appointed to the Chair of Board as Sheffield Children's NHS Foundation Trust Chair in January 2024.

5.3 Awards

South Yorkshire health organisations were recognised for their pioneering digital innovations at this year's HSJ Digital Awards. Sheffield Teaching Hospitals NHS Foundation Trust was highly commended in Improving Back-Office Efficiencies Through Digital with their Stroke Trial Tracker pilot. This is a revolutionary trial tracker developed by research nurses and scientists to rapidly assess if patients are suitable to join research studies. Also shortlisted from South Yorkshire were:

- Digital Innovator of the Year - Rotherham Foundation Trust's Transforming Diagnostic Booking system.
- Empowering Patients Through Digital - Rotherham Doncaster & South Humber NHS Foundation Trust's eClinic
- Generating Impact in Population Health Through Digital - Yorkshire Ambulance Service for their Integrated Urgent Care - Place Based Population Health Management Analytics Tool (Demand and Performance)

Barnsley Council were successful at the Local Government Chronicle Awards. They won the Public Health Award for the 'How's thi ticker?' community blood pressure campaign. The Council also won the Economic Development Award for their Supported employment service.

Gavin Boyle
Chief Executive NHS South Yorkshire Integrated Care Board
Date: 3 July 2024

Public Board of Directors Meeting
Friday 6th September 2024

The Rotherham NHS Foundation Trust

Agenda item	P135/25
Report	Adoption of the North West BAME Assembly Anti-Racism Framework
Executive Lead	Daniel Hartley – Director of People
Link with the BAF	The Trust's approach to Equality Diversity and Inclusion influences all the elements of the BAF - Patients, Rotherham, Our Partners, Us and Delivery.
Purpose	**For decision** ☒ **For assurance** ☐ **For information** ☐
Executive Summary	The North West of England BAME Assembly Anti-Racism Framework is a piece of work co-created by the partners involved to create a clear and measurable way of helping Trusts to become actively anti-racist organisations. It sets out guidance to put into action the steps needed to reduce the inequalities that are still evident in our workforce and across society and to become intentionally anti-racist. The Board of Directors is asked to approve and adopt the framework to support TRFT in becoming an anti-racist organisation and in so doing improve the experience of colleagues from ethnic minorities. ETM endorsed adopting the framework on 29th August 2024, as part of our wider commitments to being an inclusive employer. Trusts across the SY ICS/ICB are similarly adopting this framework. It will compliment and strengthen existing approaches to EDI and the self-assessment and actions proposed against the framework will be brought back to November's board meeting as part of a new integrated EDI Plan. As set out in the People and Culture Strategy 2024-2027 this integrated EDI plan will cover actions from this framework, the NHSE 6 High Impact EDI Actions, WRES, WDES, Gender Pay, Public Sector Equality Duty and other inclusion priorities. It will include the public and staff facing anti – racist statement as set out in this framework.
Due Diligence	This recommendation and the NW BAME Assembly Anti-Racism Framework was taken to and supported by the Executive Team on 29th August. It has been discussed between the Chair and CEO and shared with the Chair and Vice Chair of the People and Culture Committee.
Recommendations	The Board of Directors are asked to; Approve TRFT's adoption of the Anti-racism Framework, noting that the actions resulting from this are to be included in the upcoming integrated EDI plan 2024-2027.
Appendices	Appendix 1 – North West BAME Assembly Anti-Racism Framework

NORTH WEST
Black, Asian and Minority
Ethnic Assembly

NORTH WEST BLACK, ASIAN, AND MINORITY ETHNIC ASSEMBLY

Anti-racist Framework

NHS
England
North West

Contents

Foreword

As partners in championing this ambition, the North West Black, Asian and Minority Ethnic Assembly (the Assembly) and NHS England (NHSE) North West believe that the NHS in our region should be unapologetically anti-racist. We also believe that the NHS should take positive action to eliminate racism in our organisations, stand with our colleagues when they experience racism, and eradicate the inequalities in access, outcomes and experience of health care that some of our communities face.

This document provides a framework for all NHS organisations across the North West to work towards the ambition of becoming actively anti-racist organisations. It aims to embrace both the spirit of our commitments and provide NHS organisations with guidance to put into action quickly, the steps needed to reduce the inequalities we still see every day across our workforce and to become intentionally anti-racist.

We all recognise the history and impact of institutional racism across our organisations and the harm caused to both our colleagues and communities through the continued inequalities that we still see across our society. From higher rates of bullying and harassment, disproportionate referrals into disciplinary processes, recruitment and selection where ethnicity still impacts your chance of appointment after shortlisting, all of these issues and many more needed to be tackled intentionally and as a priority by all our organisations.

We are asking our NHS partners across the North West to make a commitment to embrace the intentionally inclusive language and the approach of becoming actively anti-racist organisations. As intentionally inclusive leaders it is vital that we all look at each of the areas set out in this anti-racist framework and seek to embed the change needed to transform our own departments and teams into places where this activity is not seen as just a nice to do, but is seen as mission critical to all that we stand for; and that messaging is backed up by senior colleagues across the region, being clear that actions to tackle inequalities are a priority in all that we do.

Leaders should use the practical steps and suggested actions to support existing change activity, to add focus to future equality action plans and to build on any long-term inclusion strategies you may have. While there is not a one size fits all solution to advancing equity within any one organisation, we hope that the guidance and structure provided will help with the task of co-creating the solutions that will work for your organisation easier.

This document has been produced by The Assembly, the Northern Care Alliance's Inclusion Centre of Excellence, and NHSE North West.

Richard Barker
Co-chair of the North West Black, Asian, and Minority Ethnic Assembly and Regional Director for the North East and Yorkshire & North West regions

Evelyn Asante-Mensah OBE
Co-chair of the North West Black, Asian, and Minority Ethnic Assembly and Pennine Care NHS Foundation Trust

Why does an intentionally anti-racist approach matter?

Racism is very real, both in society and across our NHS organisations. Yet, despite a large number of reports and pledges over the years we have seen inequalities persist and some areas even get worse.

- The NHS is built on a founding principle of equality and social justice. That the service is free at the point of need anchors the NHS in social egalitarianism and makes equal rights part of our core business.
- We have seen a growth of hate incidents and racism across our communities in the UK despite existing equality and human rights legislation. It is more important than ever that as public sector organisations, we contribute to ensuring racism has no place in our society and is addressed across the communities we serve.
- Racism and discrimination are major drivers behind the health inequalities we still see today. It is our role as a health care system to be intentional in tackling those inequalities we see across our communities, but we should also be ensuring discrimination experienced by our staff is not further contributing to the problems.

Our anti-racism journey

Becoming an intentionally anti-racist organisation is a continuous journey that involves leaders and organisations continually reviewing their progress and being intentional about their actions for change.

The Fear, Learning, Growth Zone tool can help you both as an individual and as an organisation to consider honestly where you are on the path to become more anti-racist.

Approaches to move through the zones

FEAR ····· LEARNING ····· GROWTH

Provide clear factual information that challenges and supports the overcoming of any fears that individuals and teams may have with talking about racism and what is needed to address this issue.

Consider more development building on any existing learning; steps and opportunities that increase confidence with existing learning.

Empower inclusive leaders through allyship programmes and activities.

1. Prioritise anti-racism

As the NHS we have always been instinctively supportive of equality as social justice is the bedrock and foundation of our creation as an institution back in 1948. However, prioritising anti-racism work is more than simply caring about equality or stating support for inclusion; it is about ensuring we are giving it the same attention and response as other mission critical work we manage across the NHS.

The two main commodities we give to a task or area of work when we prioritise it are both time and resources. When equality activity is seen as an add-on or a nice to do, other mission critical work is seen as more important; time and resources are directed elsewhere and progress around tackling inequalities slows and stops.

Organisations need to commit to the principle that anti-racism work matters and their leaders need to see it as a priority for them as well. There will always be competing time and resource pressures when it comes to managing any large organisation, but anti-racist organisations understand that investing the time and resources needed to tackle the inequalities that exist across their workforce and services is more effective in the long term and will support them in meeting their other long-term goals.

What does this look like?

Leading from the front

Leadership matters and while being a leader often involves the management of multiple priorities, the amount of dedicated time we give to an issue is a key indicator of how much we have prioritised that area of work.

Dedicated EDI Resource

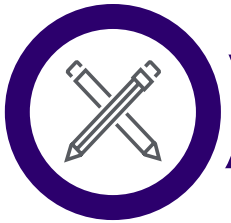
The amount of dedicated resource we have allocated to focus on an area of work is a key indicator of how much it has been prioritised. Equality, diversity and inclusion (EDI) professionals are experienced experts who can support leaders with this work. They must, however, be considered an important part of the organisation's leadership for their activity to be impactful and transformational over the longer term.

Mission Critical

Anti-racism activity needs to be at the heart of all work across an organisation, not simply a central equality action plan. Organisations that have got this right can clearly demonstrate how anti-racist practice is considered mission critical in plans around service delivery and the development of their workforce.

Actions Not Words

Organisations that are committed to anti-racism do more than the minimum ask; their work is driven by a desire to transform and have a big impact on the inequalities they see. This should be clearly visible in the activity and actions of any anti-racist organisation.



2. Understand lived experience

It is everyone's responsibility to tackle racism not just Black, Asian and Minority Ethnic colleagues, but meaningful involvement of people who experience racism and inequalities across your organisation will ensure decisions on how to tackle it are informed by real insights that reflect the different challenges people may face.

Meaningful involvement of people you would like to share their lived experiences involves committing to acting on what you hear and embedding their voices into change focused activity and decision making. Leaders need to be intentional in seeking out lived experience perspectives and considering what may be preventing some people feeling able to be involved.

When reaching out to seek the lived experiences of Black, Asian and Minority Ethnic communities it is important that leaders acknowledge and value intersectionality and understand the need to get more than a single person's perspective. When engaging others to hear their lived experiences, we should be intentional in ensuring we are hearing from a diverse range of voices rather than simply identifying a single individual to invite into a space.

Sharing lived experiences can have a weathering effect on people's wellbeing. Any activity that looks to involve and encourage others to share their lived experiences to support leaders and an organisation make better decisions should also include a clear and intentional focus around the wellbeing of those involved.

What does this look like?

Listen and Learn

Leadership matters and while being a leader often involves the management of multiple priorities, the amount of dedicated time we give to an issue is a key indicator of how much we have prioritised that area of work.

Empowering Your Talent

As well as hearing the lived experiences of staff, it is important that the underutilised potential of talented leaders from ethnic minorities is considered and empowered to support decision making. A key consideration is where you can diversify the decision makers in a space and how you can ensure the full talent potential of your diverse workforce is used.

Growing Cultural Competency

Connecting a diverse range of lived experiences with leaders is vital to improving the cultural competency of an organisation over a longer period of time. Leaders who understand their colleagues, service users and local communities are better placed to make decisions that are fair for all.

Data Plus

Organisations need to be intentional about understanding the experiences of Black, Asian and Minority Ethnic staff and service users.

3. Grow inclusive leaders

Inclusive leadership is vital if an organisation aims to be anti-racist in all that it does and aims to tackle the inequalities it sees across its workforce and services.

Where an organisation has a mature, inclusive leadership culture you will see diversity clearly represented at all levels across the workforce and colleagues will feel they belong and are included at work. On that journey to growing an inclusive leadership culture it is vital that there is an approach and strategy for reducing inequalities, not just at the top of the hierarchy, but also a commitment to increase diversity and reduce inequalities across middle leadership.

Too often the focus around developing Black, Asian and Minority ethnic leaders has been on providing them with more skills and academic development to help them move up to the next level in the leadership ladder; this reinforces a deficit stereotype rather than tackling the institutional racism that has been holding them back. Positive action measures should be targeted on the bias and prejudice that has led to ethnic minority colleagues not being given the opportunities to demonstrate the skills they have.

Inclusive leadership is not a destination. It is a continuous journey to look at how you can do more to reflect and own your own privilege, understand others more, act to tackle bias in the decisions you make, and ensure that change is seen as a positive step to tackle inequalities and injustice rather than simply a threat to the status quo.

What does this look like?

Visibility matters

Our most senior public sector leaders should come from a wider diverse range of backgrounds and should broadly represent the communities they serve. This diversity and visibility help to build communities' trust in our institutions and also lead to better decision-making overall.

Where is your talent?

Understanding your talent trajectory in respect to Black, Asian and Minority Ethnic colleagues helps an organisation know where actions need to be to increase diversity and tackle departmental or structural inequalities. Diversity should be visible across all levels of an organisation.

Levelling up middle leadership and inclusion

If we only focus development on our most senior leaders, commitment to change is often not followed through by those leaders tasked with implementing decisions across the organisation.

Real opportunities

For some time we have seen sending colleagues on dedicated learning programmes as the solution to under representation in leadership roles. However, it is often the case that development does not lead to an opportunity for promotion and reinforces the idea that Black, Asian and Minority Ethnic colleagues need to work harder and earn more to achieve the same as their white peers.

4. Act to tackle inequalities

"Let my actions speak for themselves" is a famous saying that represents the mantra by which an organisation truly committed to anti-racism needs to run.. Words alone can often become a shield through which organisations are able to justify, consciously or unconsciously, their inaction over time, and determine whether they have followed through with meaningful actions to tackle an inequality.

Initiatives like the Workforce Race Equality Standards (WRES), Model Employer plans and others are not a solution in themselves, but can be a positive tool to measure existing inequalities and target actions to have the biggest impact. These tools need to be used actively to support equality activity across an organisation rather than simply as an assurance framework completed once a year and not looked at again.

The inequalities we see across our communities today will only be addressed when organisations use their resources collectively in partnership to tackle their main causes. Building a critical mass of activity around neighbourhoods, localities and our region as a whole is key to the numerous health inequalities and social injustices that harm so many being relegated to history, instead of being a painful reality of today that many are forced to live with.

The amount of action needed to tackle inequalities is large. It reflects the generations of institutional racism and injustice developed over decades in this country. However, when viewed as mission critical and delivered through embedded priorities across all areas of an organisation's structure, the task is not insurmountable and the outcomes will be transformational for our communities as a whole.

What does this look like?

More than a tick box

While assurance frameworks have at times been labelled as just a tick box for an organisation to deliver against, this does not have to be the case. Tools like the WRES and others can be used to prioritise, leverage and monitor real change. Anti-racist organisations use all the resources and tools available to them to achieve their goals of reducing inequalities and tackling discrimination.

Zero tolerance matters

Being anti-racist is an active stance and means more than simply not acting to do harm, but actively tackling the harm we see. Organisations that are on the journey to getting this right are clear in the zero tolerance they have for racism from anyone, including colleagues and service users. It is vital that organisations consider how they handle these types of incidents and constantly learn to do more to tackle racist abuse.

We do this together

Many inequalities are too big to tackle on your own as a single organisation. It is vital that organisations work in partnership to tackle the racial inequalities we see across our communities. When looking at health inequalities, NHS organisations should work with their local community and other statutory sector bodies to tackle these collectively rather than them staying in the too hard to do pile.

Fair and just

The processes that exist across an organisation to look at grievances and disciplinaries for staff should feel fair and equitable for all. Where this is not the case, the outcomes experienced by colleagues lead to mistrust and a clear weathering effect on the wellbeing of Black, Asian and Minority Ethnic staff.

5. Review progress regularly

The NHS is no stranger to performance measures and the need to be intentional about tracking progress with a clear and detailed approach.

However, when it comes to anti-racism and wider equality, diversity and inclusion activity, this often lacks the same rigour in monitoring performance as other areas of our organisations.

Research from the USA has shown us that one of the most important aspects to diversity and equality activity is grounding this work in social accountability and taking time to measure and be clear about whether progress is being made.

While an organisation may have implemented actions elsewhere to tackle and reduce the impact on bias within decision processes and decision making, it is vital that the same consideration is taken when reviewing an organisation's overall performance around anti-racism and equality as a whole. What this means in practice is ensuring progress is reviewed by not just the people who have led or commissioned any activity, and that there is intentional consideration to the diversity of those involved in the reviewing and monitoring progress.

The NHS is the biggest employer in the country. However, as we are split up into hundreds of separate organisations we often look inward for ideas and feedback around change. Through the work of the BAME Assembly, we in the North West have an opportunity to collaborate and ensure reviewing organisational progress is a task that we are able to support each other with; this can be done through ideas and the sharing in equal measure of success and failure to support our anti-racism journey.

What does this look like?

How are we performing?

It is vital that organisations consider the management of performance around inclusion as seriously as they monitor performance of other areas of work. Leaders at all levels should understand how their area is doing in relation to key targets.

What is our approach?

Becoming an anti-racist organisation takes a clear intention to deliver a range of actions and measures consistently over a prolonged period of time. Understanding where the organisation is on its journey to become anti-racist is vital.

Our voices matter

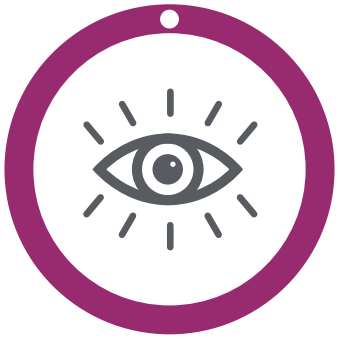
The voices of Black, Asian and Minority Ethnic people should be at the heart of an organisation considering where they are on their journey to become anti-racist. This helps ensure actions that have been meaningful and impactful are prioritised, and where progress has not been made, this is not hidden.

Open and transparent

To have credibility around a statement that an organisation is anti-racist, it is vital the label is not just coming from the organisation itself but that the statement is supported by the community it serves.

The 5 anti-racist principles - Reflection questions

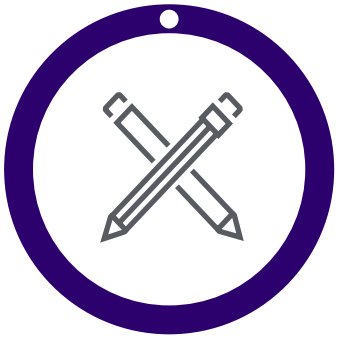
1



PRIORITISE ANTI-RACISM

How much of my time have I actually spent on anti-racism work in the last month?

2



UNDERSTAND LIVED EXPERIENCE

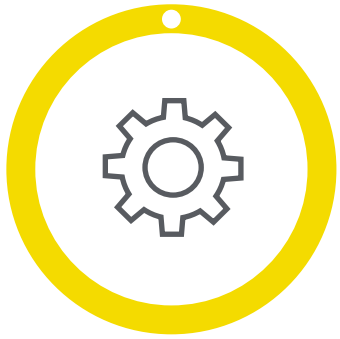
Whose voice and experience is not present, what have I done to address this, and how have I supported others to share their lived experience?

3

GROW INCLUSIVE LEADERS

What does the diversity of my organisation look like and how have I created opportunities for colleagues from ethnic minority backgrounds to grow and be included?

4



ACT TO TACKLE INEQUALITIES

What actions have I taken towards addressing racial inequalities and what impact has been made?

5

REVIEW PROGRESS REGULARLY

How has my organisation built anti-racism into their EDI targets and how is progress being measured?

Framework overview

This framework aims to support organisations on the journey to becoming intentionally and unapologetically anti-racist. The framework encourages the tackling of structural racism and discrimination through collaboration, reflective practice, accountability and action. Through the embedding of the themes, deliverables and actions outlined into structures, processes, policies and culture, organisations will create meaningful and measurable change within their workforce and service delivery.

The framework is organised into three levels of achievement: Bronze, Silver and Gold. Each level builds on the next, encouraging organisations to make incremental changes and take consistent actions towards eliminating racial discrimination in their organisations.

Bronze status

Bronze status signifies that an organisation has taken initial steps towards becoming an intentionally anti-racist organisation. These deliverables are those that embed structures and accountability for the delivery of racial equity in an organisation.

Key Drivers	Direct Deliverables	Supporting Actions
Leading from the front	The appointment of an executive or director level EDI sponsor with a commitment to advancing anti-racism within the organisation.	• This senior director level EDI sponsor has a clear role description, including annual personal development performance goals related to advancing anti-racism. • Must report as a minimum into an executive director and / or chief executive officer and be considered a part of the wider senior leadership team to facilitate and enable change on racial equity.
Anti-racism as Mission Critical	Evidence of how the organisation has acted to make anti-racism work mission critical in the past year.	• An anti-racism statement to be produced and published detailing organisational commitment to racial equity.
Actions Not Words	An organisation must have set and published at least one stretch goal that goes beyond legal or NHS assurance frameworks compliance.	• Implementation of equality and inclusion KPIs with a focus on addressing race-based disparities.
We do this together	The organisation can demonstrate progress over the last 12 months of reducing an identified health inequality.	• The organisation can demonstrate working in partnership to reduce a specific health inequality through an anti-racism lens and publish progress within the organisational annual report.
Zero Tolerance	The organisation must have communicated clearly that it takes a zero-tolerance approach to racist abuse from service users or staff members.	• Explicit processes for addressing instances of racist abuse, discrimination and harassment should be developed within or in addition to current organisational disciplinary procedures.

Silver status

The silver status shows that organisations have embedded structures to ensure commitment and accountability towards achieving anti-racism and have also developed actions to nurture and empower Black, Asian and Minority Ethnic talent, encourage culture change, and improve data collection, quality and reporting.

Key Drivers	Direct Deliverables	Supporting Actions
Empowering Your Talent	Set up a local Black, Asian and Minority Ethnic leadership council within your organisation.	• Ensure Black, Asian and Minority Ethnic talent is intentionally included across organisational talent programmes. Numbers should reflect the need for positive action to increase diversity within leadership roles. • Must have set targets and a published talent trajectory for Black, Asian and Minority Ethnic representation across every level of the organisation. • An organisation should have a dedicated positive action secondment or stretch projects programme in place to give Black, Asian and Minority Ethnic colleagues the chance to gain experience to support with career progression.
Levelling Up Middle Leadership & Inclusion	All leaders at Band 8A and above must have a personal development plan goal agreed around equality, diversity and inclusion, and a process to report annually the percentage of these goals that have been met.	• Leaders / managers to identify actions and create plans within their work to advance anti-racism.
Growing Cultural Competency	Evidence of inclusive leadership education for all executive directors.	• Further education for leaders, including inclusive recruitment, cultural awareness / competency, inclusive leadership, equality strategy and direction. • 75% of executive and non-executive directors and their direct reports have been part of a racial equality reverse mentoring programme over the past three years.
Listen and Learn	An executive director must attend Black, Asian and Minority Ethnic staff network meetings at least four times a year.	• A reciprocal arrangement with Black, Asian and Minority Ethnic staff network chair to attend and contribute to committee / board meetings.
Data Plus	WRES data and workforce data disaggregated by ethnic groups to be presented at board meetings to ensure that racial disparities are monitored and addressed as a part of the business as usual.	• A detailed breakdown by ethnicity of the staff survey report should be presented to the board annually, including the involvement of Black, Asian and Minority Ethnic staff network members to ensure more than just data is presented. • Quarterly monitoring and review of WRES data, workforce data and action plans by executive EDI lead and presented to board and staff networks.

Gold status

To obtain Gold status, the organisation must demonstrate that anti-racism has been embedded throughout all levels of the organisation, with diverse representation at the most senior levels and parity in staff experience, as well as ensuring anti-racism is seen as everyone's business through performance and engagement.

Key Drivers	Direct Deliverables	Supporting Actions
Visibility Matters	An organisation's board of directors diversity by ethnicity must match closely the diversity of the local population or at the minimum include one Black, Asian or Minority Ethnic member (which ever figure is higher).	• Creation and implementation of talent development and pipeline plan for Black, Asian or Minority Ethnic directors or associate non-executive director programme. • Partner with the North West Black Asian and Minority Ethnic Assembly to create a mentorship programme for Black, Asian or Minority Ethnic talent within the organisation.
How are we performing	An organisation must use an EDI performance dashboard that is presented quarterly to board and include performance against the race disparity ratio, WRES, and other race specific targets as appropriate.	• Organisation should record and publish their ethnicity pay gap annually • Intersectional data collection and analysis (by ethnicity, sex, gender, disability and sexual orientation) to be published and presented annually. • Chairs and non-executive directors to be updated annually on the progress on anti-racism plans.
More than a tick box	The organisation must be able to demonstrate two years of consecutive improvements against at least five WRES measures.	• Creation of a cross-departmental WRES actions working group to support and challenge progress on WRES data.
Fair and Just	The organisation can evidence diverse representation within their disciplinary and grievance processes.	• Freedom to Speak Up Champions within the organisation to support in incidents involving racial discrimination.
Our Voices Matter	The organisation should bring together annually Black, Asian and Minority Ethnic staff to review EDI progress and any learning be built into the following year's plans.	• WRES and anti-racism action plans to be co-produced with staff networks.

Regular review

Key Drivers	Deliverables	Supporting Actions
What's our approach	Organisations should review progress against each of the key drivers and direct deliverables within the NHS North-West Anti-Racism Framework at least annually.	Draft an annual action plan to attain initial or next accreditation that is reported on at board to ensure delivery and commitment.
Open and Transparent	The organisation should apply to the North West Black, Asian and Minority Ethnic Assembly to receive feedback against their anti-racism framework at least every two years.	Organisations should liaise with the Assembly / their Assembly member regarding progress and support in attaining recognition.

Support

The North-West BAME Assembly is here to support you in the implementation of this framework in your organisations.

We have a dedicated resource who can assist with strategy, queries, and troubleshooting any issues you may come across on your journey.

Please contact **england.nwbame_assembly@nhs.net** to discuss further.

Recognition

1. Assess your organisation's current progress using the self-assessment tool.
2. Draft action plan towards achieving either Bronze, Silver or Gold status, and implement necessary strategies to achieve the deliverables.
3. Apply to the North West Assembly for recognition. A small panel of Assembly members will review applications, make assessments and recognise successful organisations.

Self-assessment tool

The self-assessment tool has been designed as an assurance checklist. The checklist should be used by organisations as they begin to implement the Anti-Racist Framework to identify which of the key deliverables from the framework are already in place and which are the development areas for the organisation.

When an organisation has identified their gaps using the checklist, actions can then be developed to support the implementation of the framework fully prior to moving towards requesting recognition.

Anti-racist framework checklist

Summary of direct deliverables

Bronze

- [ ] The appointment of a senior director level EDI lead with a commitment to advancing anti-racism within the organisation.
- [ ] Evidence of how the organisation has acted to make anti-racism work mission critical in the past year.
- [ ] An organisation must have set and published at least one stretch goal that goes beyond legal or NHS assurance frameworks compliance.
- [ ] The organisation can demonstrate progress over the last 12 months of reducing an identified health inequality.
- [ ] The organisation must have communicated clearly that it takes a zero-tolerance approach to racist abuse from service users or staff members.

Silver

- [ ] Set up a local BAME leadership council within your organisation.
- [ ] Evidence of inclusive leadership education for all executive directors.
- [ ] All leaders at Band 8A and above must have a personal development plan goal agreed around equality, diversity and inclusion and a process to report annually the percentage of these goals that have been met.
- [ ] An executive director must attend Black, Asian and Minority Ethnic staff network meeting at least four times a year.
- [ ] WRES data and workforce data disaggregated by ethnic groups to be presented at board meetings to ensure that racial disparities are monitored and addressed as a part of the business as usual.

Gold

- [ ] An organisation's board of directors' diversity by ethnicity must match closely the diversity of the local population or at the minimum include one Black, Asian or Minority Ethnic member (whichever figure is higher).
- [ ] An organisation must use an EDI performance dashboard that is presented quarterly to at least a sub-group of the board and include performance against the race disparity ratio, WRES and other race specific targets.
- [ ] The organisation must be able to demonstrate two years of consecutive improvements against at least five WRES measures.
- [ ] The organisation can evidence diverse representation within their disciplinary and grievance processes.
- [ ] The organisation should bring together annually Black, Asian and Minority ethnic staff to review EDI progress and any learning be built into the following year's plans.

Sample action plan

Once the self-assessment is complete, an action plan to address the gaps should be developed. The action plan should identify a responsible person or team, a target completion date, and progress updates.

Level	Action	Person/ Team	Timescale	Target completion date	Progress	Comments
Bronze	The appointment of an executive / director level EDI sponsor.	HR	6 months		Ongoing	Proposal taken to board; nominated sponsor to be appointed at next meeting.
	Senior director level EDI sponsor has a clear role description, including annual personal development performance goals related to advancing anti-racism.	HR	12 months		Ongoing	HR to explore the addition on an anti-racism PDP goal to role descriptions; meeting to discuss progress and next steps scheduled for 07/08.
	Must report as a minimum into an executive director and / or chief executive officer and be considered a part of the wider senior leadership team to facilitate and enable change on racial equity.	HR	6 months		Ongoing	Once senior sponsor appointed, meetings with Exec directors and chief executive to be scheduled on a six monthly basis to provide updates.

Resources

To support your journey towards becoming an unapologetically anti-racist organisation, we have compiled a list of resources to assist in the development of your strategies, plans and actions.

NHS North West Black, Asian and Minority Ethnic Strategic Advisory Group

National Education Union Anti Racism Framework

NHS Leadership Academy Allyship Toolkit

NHS Leadership Academy Resources on Racism

NHS Employers Resources to Tackle Racism

NHS England WRES 2022 Data Analysis Report

NHS England Patient Carer Race Equality Framework

NHS Race and Health Observatory

NHS Confederation BME Leadership Network

Change the Race Ratio Guidance - KPMG

Board Diversity More Action Less Talk

Why companies Need a Chief Diversity Officer

Competency Framework for Equality and Diversity Leadership

Diversity Management That Works - CIPD

Embed Anti-Racism in the NHS

Guide to Establishing Staff Networks - CIPD

WRES Board Briefing BAME Leadership Council Case Study - NHS England

Building Narrative Power for Racial Justice and Health Equity

Lived Experiences of Ethnic Minority Staff in the NHS - The Kings Fund

A Case for Diverse Boards - NHS England

Taskforce on Increasing Non-Executive Director Diversity in the NHS - NHS Confederation

Develop a Strong Talent Pipeline from Entry Level to Executive Roles - CBI

Practical Guide Bridging the Gap - CBI

Six Traits of Inclusive Leadership - Deloitte

Northern Care Alliance NHS Foundation Trust Intentional Inclusion Model

Black Jobs Matter - Personnel Today

Health Inequalities Hub Case Studies - NHS England

BMA Charter for Medical Schools to Prevent and Address Racial Harassment

Hospital CEO on Zero Tolerance - BBC News

Addressing Race Inequalities Needs Engagement - The Kings Fund

A fair experience for all: Closing the ethnicity gap in rates of disciplinary action across the NHS workforce - NHS England and NHS Improvement

Health Education England Diversity Performance Dashboard

Civil Service Diversity and Inclusion Dashboard
The Value of Lived Experience - HPMA Newsletter

Diversity and the Case for Transparency - PWC

Shattered hopes: Black and minority ethnic leaders' experiences of breaking the glass ceiling in the NHS - BME Leadership Network NHS Confederation

No more tick boxes: a review on the evidence on how to make recruitment and career progression fairer - NHS England

If your face fits: exploring common mistakes to addressing equality and equity in recruitment- NHS England

Board of Directors' Meeting
6 September 2024

The Rotherham NHS Foundation Trust

Agenda item	P136/24
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: In July, the Government announced that they had accepted the recommendations of the independent NHS pay review bodies. This means that, with effect from 1 April 2024, the following pay awards have been approved: • **Agenda for Change staff** A 5.5% consolidated uplift will be made to all Agenda for Change staff on NHS terms and conditions. • **Doctors and Dentists** A consolidated 6% uplift for Consultants, Speciality and Specialist (SAS) doctors, and Doctors and Dentists in training. Doctors and Dentists in training will also receive a consolidated uplift of £1,000. South Yorkshire has been awarded more than £3.5m to become one of 15 pilot areas across England to help long-term sick and disabled people into work. Organisations across Rotherham Place have very recently been nominated for a number of high-profile awards. The Rotherham NHS Foundation Trust has been nominated in a number of categories in the Nursing Times awards.

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 July and August 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 In July the Government announced that they had accepted the recommendations of the independent NHS pay review bodies. This means that, with effect from 1 April 2024, the following pay awards have been approved:

- **Agenda for Change staff**
  A 5.5% consolidated uplift will be made to all Agenda for Change staff on NHS terms and conditions.

- **Doctors and Dentists**
  A consolidated 6% uplift for Consultants, SAS doctors, and Doctors and Dentists in training. Doctors and Dentists in training will also receive a consolidated uplift of £1,000.

Salary scales for specialty and specialist doctors on the 2021 contracts, and for the staff grade, specialty and associate specialist group of practitioners on pre-2021 contracts, have been increased by 6% to basic pay from 1 April 2024. These pay values supersede those published in Pay and Conditions Circular (M&D) 4/2024.

For doctors and dentists in training, the government has accepted the DDRB recommendation for a 6% increase to pay points plus a consolidated increase of £1000 from 1 April 2024, but this will be calculated and processed once the referendum on the negotiated pay offer is concluded. The rates of pay for these doctors remain temporarily unchanged but will be updated in due course.

3.0 South Yorkshire Integrated Care Board (SYCIB)

3.1 South Yorkshire has been awarded more than £3.5m to become one of 15 pilot areas across England to help long-term sick and disabled people into work. The region was selected by the Department for Work and Pensions and the Department for Health and Social Care as part of the Government's Back to Work Plan.

WorkWell will build on the successes of South Yorkshire Mayoral Combined Authority's programme, Working Win, which has supported over 6,500 people with a disability or physical and or mental health condition to either start, stay, or succeed in employment since 2018. Each pilot area will help to deliver the new work and health service. The service will offer a tailored early-intervention work and health support and assessment service, and a single, joined-up gateway to other support services.

One of the main focusses of the Integrated Care Partnership Board in South Yorkshire is the relationship between employment and improving population health. WorkWell will offer low-intensity support to people in work who are struggling due to a health condition or disability, to overcome health related barriers to employment.

The scheme will see partners such as NHS South Yorkshire, the South Yorkshire Mayoral Combined Authority, the four Local Authorities and Job Centre Plus working together to create an integrated work and health system with support services that meet the needs of the area's communities and employers.

4.0 Rotherham Place

4.1 Rotherham Place Board received a report on foster caring. Across Yorkshire and Humber around 580 foster carers are required and in the past year Rotherham has secured additional foster carers and bed placements have increased but more are still required to achieve the ambition and main priority of recruiting, retaining and growing the best in house foster carers locally so that children's needs are best met in family settings with high quality care and support, in stable, local placements providing the best value to the Council and its residents. A total of seventeen new foster carers were recruited in the 2023/24 financial year across Rotherham. Place partners including the Rotherham NHS Foundation Trust are supporting the work and promotion of the Rotherham Metropolitan Borough Councils Foster Caring Team which includes an article on the hub.

4.2 In July, Pace Board members received an update on progress being made on Prevention and Health Inequality transformation enabling group. It was noted the outcomes assurance framework which is part of the Core 20plus5 dashboard is shared with Place Board. Prevention is embedded within Rotherham's high priority programmes including peer support, physical activity, smoking cessation, wider determinants and upstream prevention messaging and outreach. The Trust Board will receive a further update on the ongoing work on health inequalities in October, which will be presented by the Public Health Consultant. Further information in relation to activities at the Trust is also provided at paragraph 4.8 below.

4.3 The Rotherham Place Board received an update on Maternity, Children and Young People. A number of positive updates were provided which have been summarised below:

- Hard copy of the Start for Life Pack and Family Hubs guide was developed and made available in July. It is planned that these will be published and included in the Baby Packs.
- Twenty peer support workers have been trained to support breastfeeding. 'The Big Latch On' had seventy-nine attendees at Grimm & Co, the first officially recognised breast feeding friendly business
- The children and young people's social emotional and mental health (SEMH) continuum was launched in July alongside a workforce competency framework and guidance documents
- The ICB has identified £45k funding and is working with TRFT to mobilise the Sleep Pathway with an expected launch date in quarter 3.
- The accessibility strategy and equipment policy have been implemented ensuring children are able to access local educational provision which meets their SEND and Health needs.

The update also included challenges currently faced across Rotherham Place. One of which is currently being discussed relating to a reduction in funding in for the Smoking at the Time of Delivery Service. The proposed model for delivery is not in line with the maternity tobacco delivery model and may reduce uptake of the service.

4.4 Organisations across Rotherham Place have very recently been nominated for a number of high-profile awards as detailed below:

The Rotherham Care Homes Hydration Project has been shortlisted for two awards: for the hydration team and for a Chief Allied Health Professional Officer Award. The Hydration project designed and implemented an intensive, comprehensive training program on Hydration for care home staff, which has shown excellent results in reducing infections, antibiotic use and ambulance call outs, as well as improving communication and engagement with the wider multi-disciplinary team.

Rotherham, Doncaster and South Humber NHS Foundation Trust have been shortlisted for two Nursing Times Awards 2024 in relation to their Neurodevelopment Transformation Work in the categories of:

- Nursing in Mental Health
- Children's Services

The Trust has also been shortlisted in a number of categories in the Nursing Time Awards 2024, details of which are in the Chief Executives report.

The Rotherham NHS Foundation Trust saw significant improvement in the national Care Quality Commission annual inpatient survey. The Health Service Journal ran an article in August that referred to the Trust being one of eight trusts which it determined had significantly improved their scores.

4.5 As of Thursday 25th July 2024, Mental Health Matters started operating Rotherham Safe Space, providing out-of-hours mental health support for adults when other services are often closed. The new service expands the support available to five nights a week, Thursday to Monday (6pm – midnight) including bank holidays, and will introduce a drop-in offer, with no need for a referral or appointment.

The Safe Space has also moved to a new location on Sheffield Road and has worked with the local community to create a calming and welcoming environment. Support is also available virtually via phone or video call.

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

4.7 The Trust was represented at the most recent meeting of the Health Select Commission and gave a brief presentation on the role of the Managing Director and how the Trust works with the Health Select Commission. The presentation was essentially an introduction to how the Trust's relationship with the Commission works, specifically aimed at providing information to new members of the Commission, as they start their new roles.

4.8 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:

- The Healthy Conversations work to develop health coaching and brief advice skills is continuing. Two lunchtime lectures in July were well attended and well-received. More bespoke training is in development for specific staff groups, commencing with F1 doctors in September. Further programmes are being worked up for volunteers, porters, healthcare assistants and nursing staff.

- The work to tackle missed appointments has commenced in Cancer services. Tools are being developed to address opportunities for quality improvement and will be rolled out across all care groups. The work has identified a number of potentially effective interventions, including:
    - Predictive analytic tools to identify those most at risk of missing appointments so that contact can be made in advance of appointments
    - Practical interventions that can support patients to attend
    - Better communications, such as reviewing appointment letters and ensuring that expectations about appointments are clear
    - Developing the care navigator role to support access, experience and to address wider patient needs
- The Rotherham Health and Wellbeing Strategy is being reviewed for the 2025-2035 period. A round of consultations with patients and service providers across Rotherham will commence in September, with a draft strategy being produced around Christmas 2024. The Trust's Consultant in Public Health is leading this work- for all enquiries please contact Andrew.Turvey1@nhs.net

4.9 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. Lightweight body worn cameras are in use at the Trust. Obtaining footage through body worn cameras allows SYP to gather evidence if an incident were to take place and to ensure that offenders are taken through a legal process. Recently, a man caught on camera abusing and threatening colleagues at the Trust was prosecuted and given a custodial sentence.

Michael Wright
Managing Director
September 2024

Rotherham Place Partnership Update: July / August 2024

Place-based Partnership and Integrated Care HSJ Award: The Rotherham Care Homes Hydration Project

The shortlist has been announced for the prestigious 2024 HSJ Awards with South Yorkshire healthcare providers shortlisted in an impressive five categories including Rotherham.

The **Rotherham Care Homes Hydration Project** has been shortlisted for two awards: for the hydration team and for a CAHPO award (Chief Allied Health Professional Officer Award).

The HSJ award is in the category of Place Based Partnership and Integrated care, which celebrates the excellent communication and teamwork that has been shown.

Congratulations! 👏👏👏👏👏

The Hydration project designed and implemented an intensive, comprehensive training program on Hydration for care home staff, which has shown excellent results in reducing infections, antibiotic use and ambulance call outs, as well as improving communication and engagement with the wider multi-disciplinary team.

It has been led by Rotherham Place Medicines Optimisation, and involved a full multi-disciplinary working group established by Laura Tordoff and Ella Hancock (left) from Rotherham Place and fully implemented by Katherine South (right) from the TRFT Dietetic department. The project successfully trained over 1100 staff across 45 care homes. This work is now being spread across the rest of South Yorkshire, and the creation of an online training package.

Winners for the awards will be announced on 21 November at the HSJ Awards Ceremony in London.

To find out more about each of the awards visit Shortlist 2024 | HSJ Awards

RDASH statutory annual members meeting with a difference

On Saturday 20th July 2024, RDASH held its first Fun Day at Clifton Park in Rotherham. Over 3,500 attended the fun day and enjoyed traditional games, face painting, It's a knockout, a rounders tournament and the opportunity to 'soak' our Chief Executive, Toby Lewis & Chief Operating Officer, Richard Chillery in the stocks!

Partners from across Rotherham attended the fun day to man information stalls and engage with visitors to share details of Mental Health support available across the Borough.

The Annual Members Meeting was held in the afternoon where staff and members of the public had the opportunity to ask questions of the Board of Directors and hear about progress of the RDASH strategy and delivery of the 28 promises.

Nursing Times Awards 2024 Shortlist

Rotherham, Doncaster and South Humber NHS Trust have been shortlisted for two Nursing Times Awards 2024 in relation to their Neurodevelopment Transformation Work in the categories of:

- Nursing in Mental Health
- Children's Services

Rotherham NHS Foundation Trust have been shortlisted for three Nursing Times Awards 2024 in the categories of:

- Care for Older People - Person-centred approach to reconditioning
- Learning Disabilities Nursing - Learning disabilities and autism team
- Infection Prevention and Control - Development in infection prevention and control

Congratulations to everyone! 👏👏👏👏👏👏

Rotherham Safe Space

As of Thursday 25th July 2024, Mental Health Matters will be operating **Rotherham Safe Space**, providing out-of-hours mental health support for adults when other services are often closed.

The new service expands the support available to five nights a week, Thursday to Monday (6pm – midnight) including bank holidays, and will introduce a drop-in offer, with no need for a referral or appointment.

The Safe Space has also moved to a new location on Sheffield Road and has worked with the local community to create a calming and welcoming environment. Support is also available virtually via phone or video call.

Further information can be found on the website - www.mhm.org.uk/rotherham-safe-space

OFSTED Focussed Visit in May

Communication was received from the Regional Improvement Support Lead (RISL) at the Department of Education to recognise the positive feedback in the recent Ofsted Focused Visit. The fantastic partnership work in supporting our children is reflected in the Ofsted letter, other areas highlighted by the RISL from the Ofsted letter included:

- the 'unstinting' leadership team's vision to outcomes for the most vulnerable children.
- the commitment to child protection procedures, policies and initiatives
- management of S47 enquiries, risks of abuse and harm, Child in Need and Child Protection Plans and swift engagement of other agencies
- the child's voice, multi-agency safeguarding arrangements and use of family networks to increase support for families and children

The RISL added that *"there is recognition of the importance of the work that goes on across all of Rotherham's services between the various inspections and visits, but it was pleasing that the hard work in the child protection space had been recognised in such a candid and public way.*

How valuable must it be for families to spend time with your teams in their most vulnerable times".

Appreciation goes out to all involved across partners, particularly RDaSH CAMHs and TRFT colleagues.

Fostering Rotherham

Toni Traynor, Fostering Service Manager and Laura Marshall, Fostering Marketing Manager joined the Place Board meeting in July. They learned that there is a national shortage of foster carers in England with Rotherham Fostering competing with other local authorities and independent fostering agencies.

Across Yorkshire and Humber around 580 foster carers are required and in the past year Rotherham has secured additional foster carers and bed placements have increased but more are still required to achieve the ambition and main priority of recruiting, retaining and growing the best in house foster carers locally so that children's needs are best met in family settings with high quality care and support, in stable, local placements providing the best value to the Council and its residents.

The different types of fostering were set out and the key requirements for fostering.

A number of supportive actions were agreed in support and partners agreed to publicise events and raise awareness through staff briefings.

Below are links to the Fostering Rotherham media pages:

https://www.facebook.com/FosteringRotherham/ - Facebook page

https://www.instagram.com/fosteringrotherham/?hl=en-gb - Instagram page

https://x.com/fosterrotherham - X page

https://www.linkedin.com/company/fostering-rotherham/?originalSubdomain=uk - LinkedIn page.

Public Board of Directors' Meeting
6 September 2024

The Rotherham NHS Foundation Trust

Agenda item	P137/24
Report	**The Rotherham NHS Foundation Trust and Barnsley Hospital NHS Foundation Trust Partnership Programme Update**
Executive Lead	Dr Richard Jenkins, Chief Executive Michael Wright, Deputy Chief Executive Martin Temple – Non Executive Director
Link with the BAF	TRFT: There is a risk robust service configuration across the system will not progress and deliver seamless end-to-end patient care across the system because of a of lack of appetite for developing strong working relationships and mature governance processes leading to poorer patient outcomes
How does this paper support Trust Values	Ambitious: The programmer plan is ambitious and stretches both organisations to improve, learn from each other and be the best that they can be. Caring: The programme has a clear patient quality focus with work being undertaken which will improve the quality of care offered across both organisations. Together: the paper demonstrates how The Rotherham NHS FT (TRFT) and Barnsley Hospital NHS FT (BHNFT) have been working together in partnership with the ambition of improving the quality and sustainability of services
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	The partnership between BHNFT and TRFT is built upon the foundations of historic collaboration between the two Trusts, through joint working initiatives including the Barnsley and Rotherham Integrated Laboratory Services. Both Trusts formally agreed to a strategic partnership in 2022, facilitated by the appointment of Dr Jenkins as the permanent joint Chief Executive. Since 2022, the partnership has strengthened, both in terms of the formal governance structure which has been put in place in order to ensure delivery of the partnership programme, and subsequently the collaboration that has taken place between the two organisations. This partnership has been based on the organisations learning from the other, proactively sharing best practice and exploring opportunities for collaboration.

	A key part of the collaboration is the delivery of the Partnership Programme. This programme sets out the agreed areas of work over the coming year. Following a successful programme in 2023/24 which includes such elements as the Gastroenterology service development and the NHS Graduate Management Trainees, a programme was agreed for 2024/25. The programme for 24/25 was developed following engagement across the leadership of both organisations and has been agreed by both Board of Directors and the Joint Strategic Partnership Group (JSPG). The programme is set out against three main pillars. These are: 1) New defined programmes of work 2) Collective Influence and Mutual Support 3) Moving to routine delivery of existing partnership work The enclosed report sets out the key areas of work and objectives within each of these pillars. The attached progress report (appendix one) outlines progress made to date.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	Elements of this paper have been considered and reviewed at Joint Executive Delivery Group (JEDG) and Joint Strategic Partnership Group (JSPG) and both Trust Board of Directors Updated information has been included within the highlight report following presentation JSPG to reflect progress.
Board powers to make this decision	
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 report
Appendices	Appendix 1 – Partnership Programme and Progress Update

1.0. Introduction

1.1. The partnership between BHNFT and TRFT is built upon the foundations of historic collaboration between the two Trusts, through joint working initiatives including the Barnsley and Rotherham Integrated Laboratory Services. Both Trusts formally agreed to a strategic partnership in 2022, facilitated by the appointment of Dr Jenkins as the permanent joint Chief Executive

1.2. Since 2022 the partnership has strengthened, both in terms of the formal governance structure which has been put in place in order to ensure delivery of the partnership programme, and subsequently the collaboration that has taken place between the two organisations. This partnership has taken the form of each organisation learning from the other, proactively sharing best practice and exploring opportunities for collaboration.

2.0. Governance Structures

2.1. The support the strategic partnership the following governance was established.

2.2. **Joint Strategic Partnership Group (JSPG):** Comprising both Chairs, a Non-Executive Director from each Trust, both Managing Directors, the Joint Director of Corporate Governance, Joint Chief Executive and the Deputy Director of Strategy and Delivery from TRFT. This group meets quarterly and works on behalf of both Trust Boards to have oversight on the development and delivery of a partnership programme.

2.3. **Joint Executive Delivery Group (JEDG):** Chaired by the Joint Chief Executive, this group consisting of the Medical Directors, Chief Operating Officers, Managing Directors, Joint Director of Communications, Joint Director of Corporate Governance and the Assistant Director of Strategy & Planning from BHNFT and Deputy Director of Strategy and Delivery from TRFT is responsible for driving the delivery of the joint work programme on an ongoing basis

3.0. The Partnership Programme (2023/24)

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

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

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

3.2. **Clinical Services Review:** The initial work to support and strengthen the Gastroenterology services across both Trusts was concluded and transferred back into ‘business as usual’. The next service for collaboration was identified as Haematology. The project has a formal governance structure including engagement from our clinical teams. The development of an assessment matrix has allowed the decision regarding

a single inpatient unit to be clinically led and support any public engagement which will be required. It is also evident that this programme will continue for a significant period of time.

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

3.4. **Joint Leadership Development**: The programme continues and will run through to quarter 3 of 2024/25. Initial feedback from participants has been positive. See paragraph 5.5 for further detail.

3.5. **Joint Roles:** The Trust continues to explore the possibilities of joint roles across teams and have appointed a Joint Director and a Joint Deputy Director of Communications, strengthening, and adding resilience to both organisations' teams. The Joint Director of Corporate Governance and Joint Head of Procurement have been in place for some time. There is also currently, for a fixed period of time, a Joint Interim Chief Pharmacist in place.

3.6. **Joint Clinical Leaders:** The first Joint Clinical Leads session was held in February, bringing together over 60 leaders from both Trusts. With positive feedback received, with the next session planned for September 24.

3.7. **NHS Graduate Trainees**: The partnership was successful in bidding to host Graduate Management Trainee's. Four trainees joined the partnership in September 2023. The feedback from the trainees has been positive regarding their experiences and the level of support and guidance they have received. Additionally, their placement managers who manage them on a day-to-day basis have been really positive around the tangible contribution they are already making to their teams. The partnership applied to host trainees again in 2024 and has been successful with three trainees joining in September 24.

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

4.0. The Partnership Programme (2024/25)

4.1. In line with the approach undertaken in 2023/24, a structured work programme has been developed and is included in Appendix 1, which includes a progress update. This is based on engagement across both organisations and consideration of the ongoing programme of work already in place.

4.2. The programme of work is structured around three main pillars. These are:

- New defined Programmes of Work
- Collective Influence and Mutual Support
- Moving to routine delivery of existing partnership work (business as usual)

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

5.0. New Defined Programmes of Work

5.1. The defined programmes of work are areas in which the partnership is aiming to deliver a defined piece of work and/or programme of work. The first two of these programmes are continuations from our 2023/24 programme.

5.2. **Joint Clinical Services:** A key part of the partnership is to allow, where suitable, services to work together to provide better, more sustainable services to our communities. Initially this work commenced with a formal programme of work looking at Gastroenterology services across the two Trusts. Following the completion of that programme and the transfer back into business as usual, Haematology was identified as the next service which could benefit from this collaboration.

5.3. This work is ongoing and is likely to go beyond 2024/25 with the aim of strengthening both services and providing a model of care which is high quality and sustainable across both Trusts.

5.4. **Joint Leadership Development:** A leadership development package was commissioned in 2023/24 to support the triumvirate leadership in working effectively across the leadership team, between the leadership teams, between the leadership team and the Trusts Executives and between the leadership team and external partners. In late 2023, an external partner was appointed to deliver this programme of work.

5.5. **Clinical Service-Learning Opportunities:** Building on the success and positive feedback of the Haematology engagement event, the partnership has set out a programme of work to enable and allow service leads (clinical and non clinical) to come together in a semi-facilitated workshop format to connect. This will allow services to share learning, explore areas for further collaboration as well as providing a wider network of support for our teams. Over the coming years it is expected that all services will have an opportunity to be part of a workshop.

5.6. **Corporate Team Opportunities:** To augment the programme of work on clinical services a focus on our corporate teams will also take place. This will again focus on areas where collaboration may provide opportunities for improvement and efficiencies. There is no set expectation on how teams should collaborate and as such could range from simple shared learning to fully integrated teams.

6.0. Collective Influence and Support

6.1. Through 2023/24, the Trusts have been able to support each other and provide a collective voice (when appropriate) into regional and national discussions. This continues in 2024/25 with a focus on two specific areas:

6.2. **Financial Recovery:** Both organisations have a challenging financial recovery plan to deliver over the next 2 years. The drivers and solutions to these challenges will have some similarities, but also be different in both organisations. The ability to share insight, ideas and approaches across the Trusts will be invaluable in supporting the individual organisations to deliver the ambition. To support financial grip and control, the Chief Executive now leads a weekly meeting with The Director of Finance and Managing Director from each Trust attending the meeting.

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

7.0. Routine Delivery of Existing Partnerships (Moving to Business as Usual)

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

8.0. Appendix One: Programme Outline and Programme Update

BHFT & TRFT Partnership Programme 2024-25		Q1	Q2	Q3	Q4
DEFINED PROGRAMMES OF WORK					
Joint Clinical Services	Continue to develop and deliver the Haematology collaboration and undertake a review and learning from the Gastroenterology programme	• Agree the Haematology IP model across both organisations • Undertake a review of the Gastroenterology programme with a focus on the financial benefits	• Continued delivery and implementation of the Haematology collaboration		
Senior Leadership Development Programme	Complete the Senior Leadership Development Programme, ensuring that have developed and raised expectations of our leaders	• Undertake the final sessions of the leadership development programme		• Undertake a review of the effectiveness of the programme and opportunities for further cohorts	
Clinical Service-Learning Programme	Introduce a programme of clinical service learning between the two Trusts, offering teams the opportunity to come together to share learning and opportunities	• Agree programme / session approach • Agree prioritisation of initial y1 services • Undertake and evaluate the approach with one service	• Finalise the programme following review of single service • Roll out on a monthly basis to other services	• Rolling programme to deliver session for 10 teams across 24/25	
Corporate Team Opportunities	Complete a full review of corporate team structures and agree (and implement) appropriate changes to ways of working and structures to improve effectiveness and efficiency	• Complete corporate area reviews with each Executive Director pairing • Share initial findings and opportunities at Joint ETM	• Confirm proposed changes to roles/structures via appropriate mechanisms • Agree areas of focus for ways of working collaboration and development • Develop corporate team collaboration session outline to enable each team to identify potential joint working opportunities and roll out across teams		
COLLECTIVE INFLUENCE AND MUTUAL SUPPORT					
Financial Recovery and Back to Balance	Collaborate on programme of work to deliver financial balance in both organisations by the end of 25/26, maximising opportunities to work together in order to reduce costs and increase income	• Finalise each internal Trust 'Back to Balance' plan based on final financial plan submissions	• Adopt Acute Federation Productivity Metrics within Partnership Dashboard • Share learning and opportunities	• Share learning from opportunities and challenges identified from productivity metric comparison on ongoing basis	
System and Acute Federation Delivery	Engage collaboratively on key System and Acute Federation programmes to ensure successful delivery and appropriate engagement from our teams	• Ensure MEOC delivery improves in order to meet national expectations • Proactively support new Pathology service go-live in April	• Engage with Acute Federation Service Sustainability Reviews and ensure appropriate input from our two trusts		
MOVING TO BUSINESS AS USUAL					
Promotion and enabling of the collaboration	Continue to provide the opportunities, culture and permission for teams to actively seek out the collaborative as a place of support, development and opportunity	• Develop a communication plan for the collaborative across both organisations that gives staff and teams insight into what the collaborative offers	• Implement the communication plan and part of BAU comms		

NHS The Rotherham NHS Foundation Trust

NHS Barnsley Hospital NHS Foundation Trust

BHFT & TRFT Partnership Programme 2024-25

PROGRESS UPDATE – JULY 2024

DEFINED PROGRAMMES OF WORK

Joint Clinical Services	Continue to develop and deliver the Haematology collaboration and undertake a review and learning from the Gastroenterology programme	• Bed modelling complete and IP model has been provisionally agreed. • Work ongoing to understand the communication needed with public and partners	• Work has now commenced on the clinical model of care • Business Case Brief presented to both ETMs outlining the move towards a joint IP unit	• Consultant Job Descriptions / Job Plans and Advert being constructed with adverts to be out shortly	G
Senior Leadership Development Programme	Complete the Senior Leadership Development Programme, ensuring that have developed and raised expectations of our leaders	• Leadership programme progressing as planned • Shadow Board sessions have taken place with really positive feedback in most cases	• Feedback has generally been positive, but concerns have been raised on the time commitment needed to fully engage with the programme	• Teams have focused on using 'real word' issues as part of the programme	G
Clinical Service-Learning Programme	Introduce a programme of clinical service learning between the two Trusts, offering teams the opportunity to come together to share learning and opportunities	• Initial service has been identified (Diabetes) • Discussion to take place with clinical and service leads to support local ownership	• There are delays in agreeing initial session and engaging with local leads. In part due to operational pressures and focus on wider SY engagement around service reviews	• Session to take place at Joint Clinical Leads in September to kick start the programme	A
Corporate Team Opportunities	Complete a full review of corporate team structures and agree (and implement) appropriate changes to ways of working and structures to improve effectiveness and efficiency	• Facilitated conversations starting to take place with executive pairs • Not all sessions have taken place. However, in many areas there are ongoing discussions happening	• Some initial ideas have been generated with work starting to deliver that work • Will review plans with corporate leads in Q3	• Across multiple areas this collaborative work is already taking place	A

COLLECTIVE INFLUENCE AND MUTUAL SUPPORT

Financial Recovery and Back to Balance	Collaborate on programme of work to deliver financial balance in both organisations by the end of 25/26, maximising opportunities to work together in order to reduce costs and increase income	• Financial position within both Trust (and the wider system) have significant financial challenges • Both organisations have developed and shared plans regarding back to balance plans	• Weekly focus meetings taking place with CEO, MDs and DoFs from both Trusts • SY ICS are implementing system wide measures to support financial recovery	• Financial presentation has taken place at Joint Clinical Leads session and at BHFT to engage with clinical leaders • Sharing of processes around financial recovery across both Trusts
System and Acute Federation Delivery	Engage collaboratively on key System and Acute Federation programmes to ensure successful delivery and appropriate engagement from our teams	• Trusts working collectively to engage and support MEOC and Pathology Go Live • Likely the partnership will take a more active role in MEOC to address operational challenges	• Acute Fed have adopted to the collaborative approach to Service reviews. • The progression of this work is taking considerable time / energy	• Meeting to take place in August to discuss services for prioritisation

MOVING TO BUSINESS AS USUAL

Promotion and enabling of the collaboration	Continue to provide the opportunities, culture and permission for teams to actively seek out the collaborative as a place of support, development and opportunity	• Joint Director and Deputy Directors of Communications have been appointed • Joint Clinical Leads session took place in February and next session to take place on 10th September	• Joint Snr Leaders now routine. Last session took place in August with a focus on Quality • Joint ETMs now diarised, with the next one to take place in September • Initial discussion taken place regarding sharing of information expertise into BHFT • Collaboration taking place to develop a new standard Clinical Lead Job Description • Joint Board to Board took place in July

NHS The Rotherham NHS Foundation Trust

NHS Barnsley Hospital NHS Foundation Trust

Board of Directors' Meeting
6 September 2024

Agenda item	P138/24
Report	**Finance Report**
Executive Lead	Steve Hackett, Director of Finance
Link with the BAF	D8: We will not be able to sustain services in line with national and system requirements because of a potential deficit in 2024/25 leading to further financial instability.
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 July 2024 (Month 4 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 July 2024 (Month 4 2024/25:
	
	  ○ Financial results for July 2024.

	- A control total deficit to plan of £393K in month and £1,240K year to date; - 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 £230K). • Section 3 – Income and Expenditure Account Forecast Out-Turn o An initial forecast out-turn up to 31st March 2024 of £14,428K deficit to plan and equally the control total. o The Trust will not be submitting a forecast adverse variance to plan to the Integrated Care Board or NHSE but assumes appropriate management action and the use of reserves will enable the Trust to deliver its overall plan by 31st March 2025, a year end deficit of £6,302K. • Section 4 – Capital Expenditure for July 2024 (Month 4 2024/25) o Results for July 2024 show expenditure of £529K in month and £1,017K year to date against a budget of £2,256K, an under-spend of £1,239K (55%). Schemes are progressing and it is expected that the Trust will spend its full capital allocation. o 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 have been revised and updated in line with budget holder expectations. • Section 5 – Cash Flow 2024/25 o A cash flow graph showing actual cash movements between April 2023 and July 2024. A month-end cash value as at 31st July 2024 of £12,416K, which is £433K favourable to 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 Monitoring Group, chaired by the Director of Finance.

	○ More comprehensive and detailed reports of the financial results have been presented to Finance & Performance Committee and the Executive Team.
Board powers to make this decision	Within Section 4.5 of Standing Financial Instructions – Budgetary Control and Reporting – paragraph 4.5.1 states that *"The Director of Finance will devise and maintain systems of budgetary control. These will include:* *(a) Financial reports to the Board, in a form approved by Finance & Performance Committee on behalf of the Board."*
Who, What and When (What action is required, who is the lead and when should it be completed?)	• Overall financial performance is discussed at the monthly performance meetings. • CIP performance was discussed at the Efficiency Board meeting held on 7 August 2024. • Capital expenditure was reviewed at the Capital Monitoring Group held on 19 August 2024. • The Finance & Performance Committee members received the finance report electronically on 16 August 2024 to provide an opportunity for feedback given that there was no formal Committee meeting held in August. Any issues for escalation from Committee Members 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			Forecast	Prior Month
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Variance £000s	FV £000s
I&E Performance (Actual)	(675)	(1,051)	(377)	(3,226)	(4,449)	(1,223)	(14,413)	(13,453)
I&E Performance (Control Total)	(613)	(1,006)	(393)	(2,979)	(4,219)	(1,240)	(14,428)	(13,453)
Capital Expenditure	1,088	529	559	2,256	1,017	1,239	0	0
Cash Balance	780	2,378	1,598	11,983	12,416	433	0	0

1.2 The Trust has over-spent against its I&E Performance (control total) in July 2024 by £393K and year to date by £1,240K. 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.

1.3 These figures include an under performance on elective recovery activity of £790K year to date, it is expected that this will be recovered through additional targeted schemes and from a review to provide assurance that the coding of activity is appropriately recorded and captured.

1.4 Capital expenditure is behind plan in month and year to date, with cumulative spend of £1,017K against a budget of £2,256K. Approval to spend capital funding, across the Trust's priorities, has been agreed and the forecast is to fully deliver against plan. 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 July 2024 remains strong at £12,416K and is better than plan by £433K.

2. Income & Expenditure Account for July 2024 (Month 4 2024/25)

2.1 The table below shows the financial results subjectively (by type of expenditure). The Trust has delivered a deficit to plan in July 2024 of £393K and £1,240K year to date.

Summary Income and Expenditure Position	Annual plan £000s	Month			Year to date			2024/2025
		Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Monthly Trend / Variance
Clinical Income	334,332	28,476	28,574	98	111,903	112,690	787	
Other Operating Income	22,312	1,960	2,227	267	7,872	8,674	802	
Pay	(228,626)	(19,150)	(20,612)	(1,462)	(77,451)	(82,314)	(4,863)	
Non Pay	(97,375)	(9,265)	(10,049)	(784)	(37,110)	(39,429)	(2,319)	
Non Operating Costs	(5,131)	(375)	(319)	57	(1,501)	(1,262)	239	
Reserves	(33,178)	(2,321)	(873)	1,448	(6,939)	(2,809)	4,130	
Retained Surplus/ (Deficit)	**(7,667)**	**(675)**	**(1,051)**	**(377)**	**(3,226)**	**(4,449)**	**(1,223)**	
Adjustments	1,365	61	45	(16)	246	230	(16)	
Control Total Surplus/ (Deficit)	**(6,302)**	**(613)**	**(1,006)**	**(393)**	**(2,979)**	**(4,219)**	**(1,240)**	

2.2 Clinical Income is ahead of plan year to date due to the true up position on the 2023/24 ERF and income associated with the consultants pay reform. These figures include an adverse year to date position on ERF in 2024/25 of £790K. The overall ERF target for

South Yorkshire ICB and the Trust is 103% of 19/20's activity (priced at current tariff), for variable activity the plan is based on 2023/24 outturn uplifted for 2024/25 tariff.

2.3 Other Operating Income is ahead of plan in month and year to date with increased income from staff recharges (£513K), which will be an offset to the pay over-spend, and increased research, education and training income (£244K).

2.4 Pay costs are over-spending by £4,863K year to date. Bank and agency expenditure is not currently being maintained within the gross establishment budget, and contributing to this is £1,329K under-delivery against the planned cost improvements.

2.5 Non Pay costs are over-spending by £2,319K year to date. The overspend is largely related to Drugs and Clinical Supplies £1,964K, Energy & Utilities £144K, building consumables £180K and under-delivery against cost improvement plans of £460K which are offset by under-spends for clinical negligence £148K and other patient's expenses £430K.

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

2.7 £4,130K has already been released from Reserves year to date, this is to cover the under-delivery of CIP, additional capacity over and above the winter plan and Industrial Action.

3 Forecast Out-Turn Performance to 31st March 2025

3.1 The table below shows the forecast out-turn position for the financial year 2024/25. The Trust is forecasting to deliver a £14,428K deficit to plan.

Summary Income and Expenditure Position	Annual plan £000s	Forecast outturn (Full Year) £000s	Forecast Variance (Full Year) £000s	Actual Variance (YTD) £000s	Forecast Variance £000s	Total Variance £000s	2024/2025 Monthly Trend / Variance
Clinical Income	334,332	336,169	1,838	787	1,051	1,838	
Other Operating Income	22,312	24,952	2,641	802	1,839	2,641	
Pay	(228,626)	(244,616)	(15,990)	(4,863)	(11,128)	(15,990)	
Non Pay	(97,375)	(104,822)	(7,447)	(2,319)	(5,128)	(7,447)	
Non Operating Costs	(5,131)	(4,716)	416	239	176	416	
Reserves	(33,178)	(29,048)	4,130	4,130	(0)	4,130	
Retained Surplus/ (Deficit)	(7,667)	(22,080)	(14,413)	(1,223)	(13,190)	(14,413)	
Adjustments	1,365	1,350	(15)	(16)	(2)	(15)	
Control Total Surplus/ (Deficit)	(6,302)	(20,730)	(14,428)	(1,240)	(13,192)	(14,428)	

3.2 Within Clinical Income, the estimated ERF YTD under delivery against divisional targets is reflected. No further under or over delivery of ERF is forecast. Additional income is forecast from other variable activities, it also includes the true up of 2023/24's ERF and variable income, and income relating to the consultants pay reform which was notified of post plan submission.

3.3 Other Operating Income is forecasting increases in income from research, development, education & training (£847K), SLAs (£267K) and staff recharges (£1,724K). This additional income will equally be offset by further increases in pay and non-pay expenditure.

3.4 Pay is showing a significant deterioration in performance but this does include, as yet, undelivered annual CIP budget of £5,021K and premium agency costs of £5,003K.

3.5 Non Pay costs are similarly showing a significant deterioration in performance linked to continued increasing costs most notably within premises £1,382K, undelivered CIPs £2,702K, and drugs and clinical supplies £5,211K, which are partly offset by forecast underspends in clinical negligence, patient expenses and travel (net total of £1,857K).

3.6 Non Operating Costs reflect increased income from interest receivable on money deposited with Government banking services.

3.7 The Trust will not be submitting a forecast adverse variance to plan to the Integrated Care Board or NHSE. It assumes that with appropriate management action and the use of reserves, these will enable the Trust to deliver its overall plan by 31st March 2025, a year end deficit of £6,302K. This position assumes that the Elective Recovery Fund and Efficiency targets will be met, costs will be funded for periods of Industrial Action and actions are taken with regards additional capacity.

3.9 Cost reduction and CIP delivery are key to improving the forecast outturn position, and are required to be proactively managed across all services, and for action plans to be implemented. This remains a significant risk to the Trust delivering against its overall plan. This was addressed at July's efficiency Board with Care Groups and Corporate Services leads.

4. Capital Programme

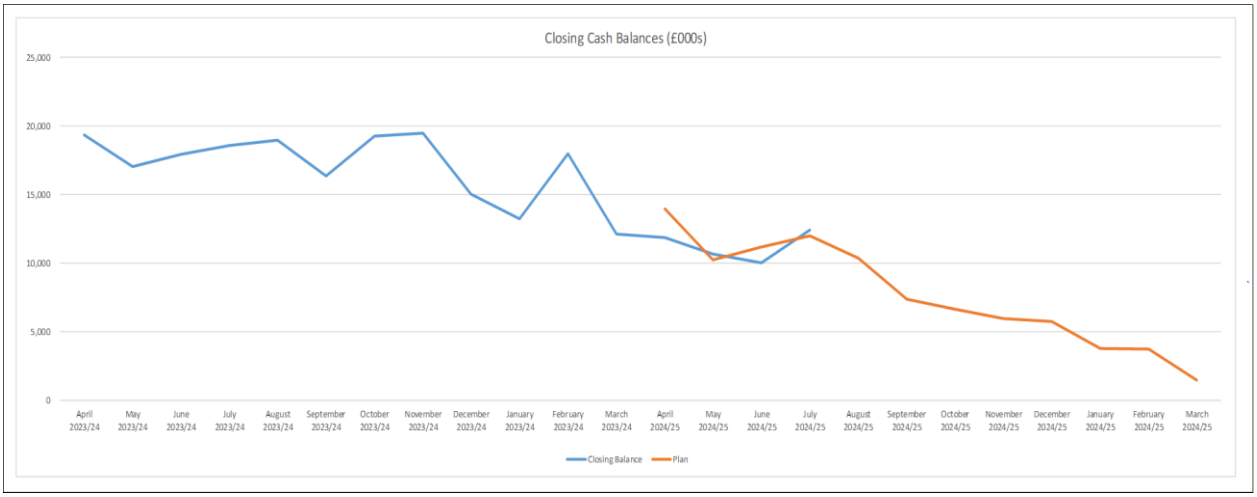
4.1 During July 2024 the Trust incurred capital expenditure of £529K, and year to date it is £1,017K. Schemes are progressing and it is expected that the Trust will spend its full capital allocation.

Capital Expenditure	Month			Year to date			Forecast	Prior Month
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Variance £000s	Forecast Variance £000s
Estates Strategy	229	134	95	527	322	205	0	0
Estates Maintenance	330	185	145	604	224	380	0	0
Information Technology	397	192	205	794	409	385	0	0
Medical & Other Equipment	132	18	114	331	62	269	0	0
Other	0	0	0	0	0	0	0	0
TOTAL	1,088	529	559	2,256	1,017	1,239	**0**	**0**

4.2 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 have been 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 £1,598K. Cash remains strong with a closing cash balance of £12,416K as at 31st July 2024. This has allowed the Trust to earn interest on its daily cash balances of £303K year to date.



Steve Hackett
Director of Finance
12 August 2024

Board of Directors Meeting
6 September 2024

Agenda item	P139/24
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) provides a monthly overview of the Trust's performance across four key areas: Operational Delivery, Quality, Finance, and Workforce. This report covers data from July 2024, where available, and outlines performance in relation to established national, local, or benchmarked targets. Statistical Process Control (SPC) charts are used throughout this report. A brief explanation of the main features of these charts is provided at the back for your 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 – July 2024

Board Meeting

Integrated Performance Report - July 2024

Performance Matrix Summary

NHS The Rotherham NHS Foundation Trust

Variation	Assurance: Pass	Assurance: Hit or Miss	Assurance: Fail
Special Cause: Improvement	**VERY GOOD: LEARN AND CELEBRATE** • Stillbirth rate	**GOOD: CELEBRATE AND UNDERSTAND** • Patients moved to PIFU • Readmissions • Turnover (12 month rolling)	**CONCERNING: CELEBRATE BUT TAKE ACTION** • Number of 65+ Weeks, Referral To Treatment %
Common Cause	**GOOD: CELEBRATE AND UNDERSTAND** • Urgent 2 Hour Community Response • Combined Positivity Score • SHMI • MAST - Core • MAST – Job Specific	**STATIC: INVESTIGATE AND UNDERSTAND** • FDS, 31 Day Standard, 62 Day Standard • Discharge Date = Discharge Ready Date • A&E Attendances from Care Homes, Admissions from Care Homes, Pts on Virtual Ward • Patients Spending > 12 hrs in A&E, 12 hr trolley waits, Bed Occupancy, LoS > 21 Days • Waiting List Size, DM01 • VTE Risk Assessments • Care Hours per Patient Day • Patient Safety Incident Investigations • Medication Incidents • Pressure Ulcers Cat 3 and above per 1000 days • Complaints (per 10k contacts) • Patient Harm Falls per 1000 bed days • C. diff infections • Vacancy Rate (total)	**CONCERNING: INVESTIGATE & TAKE ACTION** • 4 hour performance • Ambulance Handover Times >30min • Avg time to see clinician • Breast milk first feed • Sickness Rates (12 month rolling) • Sickness Rates • Appraisal Rates (12 month rolling)
Special Cause: Concern	**CONCERNING: INVESTIGATE AND UNDERSTAND**	**CONCERNING:INVESTIGATE & TAKE ACTION** • Overdue Follow-ups • 1:1 Care in Labour	**VERY CONCERNING: INVESTIGATE & TAKE ACTION** • Number of 52+ Weeks • Criteria to Reside is No • Appraisal Rates (12 month rolling)

Performance Matrix Summary - Quality

The Rotherham NHS Foundation Trust

Variation	Assurance: Pass	Assurance: Hit or Miss	Assurance: Fail
Special Cause: Improvement	**VERY GOOD: LEARN AND CELEBRATE** • Stillbirth rate	**GOOD: CELEBRATE AND UNDERSTAND** • Readmissions	**CONCERNING: CELEBRATE BUT TAKE ACTION**
Common Cause	**GOOD: CELEBRATE AND UNDERSTAND** • Combined Positivity Score • SHMI	**STATIC: INVESTIGATE AND UNDERSTAND** • VTE Risk Assessments • Care Hours per Patient Day • Complaints (per 10k contacts) • Patient Safety Incident Investigations • Medication Incidents • Pressure Ulcers Cat 3 and above per 1000 days • Patient Harm Falls per 1000 bed days • C. diff infections	**CONCERNING: INVESTIGATE & TAKE ACTION** • Breast milk first feed
Special Cause: Concern	**CONCERNING: INVESTIGATE AND UNDERSTAND**	**CONCERNING:INVESTIGATE & TAKE ACTION** • 1:1 Care in Labour	**VERY CONCERNING: INVESTIGATE & TAKE ACTION**

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"	"As expected" (103.9)	Mar-24	N/A	P		-	S
Readmissions (%)	-	8.6	Jun-24	-	-	L	-	GI
VTE Risk Assessments (%)	95.0	96.4	Jul-24	☑	?			S
Care Hours per Patient Day	7.3	6.7	Jun-24	☒	?			S
Combined Positivity Score (%)	95.0	96.2	Jul-24	☑	P		-	G
Complaints (per 10k Contacts)	8	8.3	Jul-24	☑	?		-	S
Patient Safety Incident Investigations	3	5	Jun-24	☒	?		-	S
Medication Incidents	-	86	Jul-24	-	-		-	S
Pressure Ulcers (Cat 3/4/STDI and Unstageable per 1000 bed days)	-	2.6	Jun-24	-	-		-	S
Patients Falls (Moderate and Above per 1000 bed days)	0.19	0.24	Jul-24	☒	?		-	S
C. difficile Infections	2	5	Jul-24	☒	?			S

*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

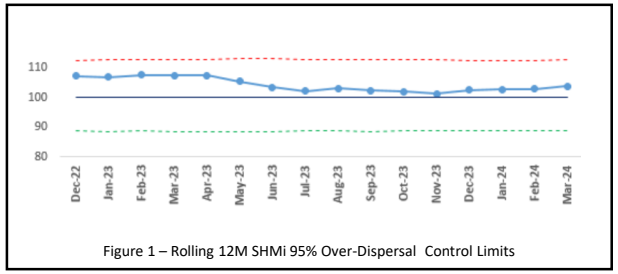


Figure 1 – Rolling 12M SHMi 95% Over-Dispersal Control Limits

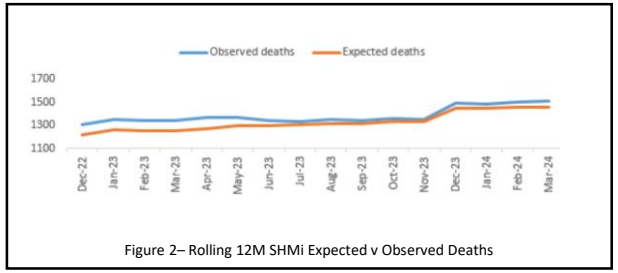


Figure 2– Rolling 12M SHMi Expected v Observed Deaths

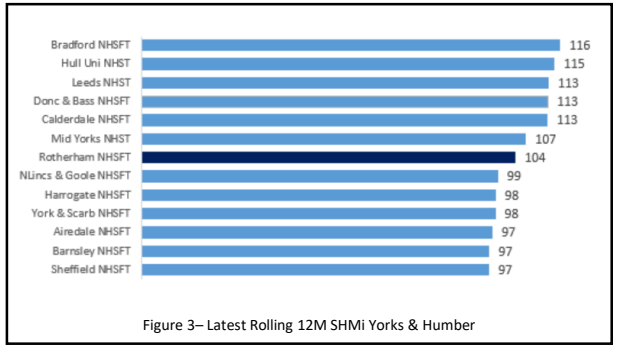


Figure 3– Latest Rolling 12M SHMi Yorks & Humber

TRFT's SHMI remains in the 'As Expected Band'

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
- There are 3 SHMI banding, As Expected, Higher or Lower. TRFT's SHMI has consistently been As Expected, since July 2021
- 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
- In contrast to metrics such as waiting time targets, all NHS Trusts cannot be below the 100 England Average figure

Metric	Current	Target	Exec Owner	Organisational Lead
Latest Rolling 12 Month SHMI -Mar 24	103.9	-	Jo Beahan	John Taylor
Expected Deaths	1455	-		
Observed Deaths	1515	-		
Trust Banding	Expected	Expected		

What actions are planned?

- To monitor and report the monthly published SHMI values
- To highlight when SHMI values are in the higher than expected band (95% Over-dispersion Control Limit)
- The Trust Mortality Group meets every other months to review and decide on any required investigations/reviews based on the Investigation Pyramid

What is the expected impact?

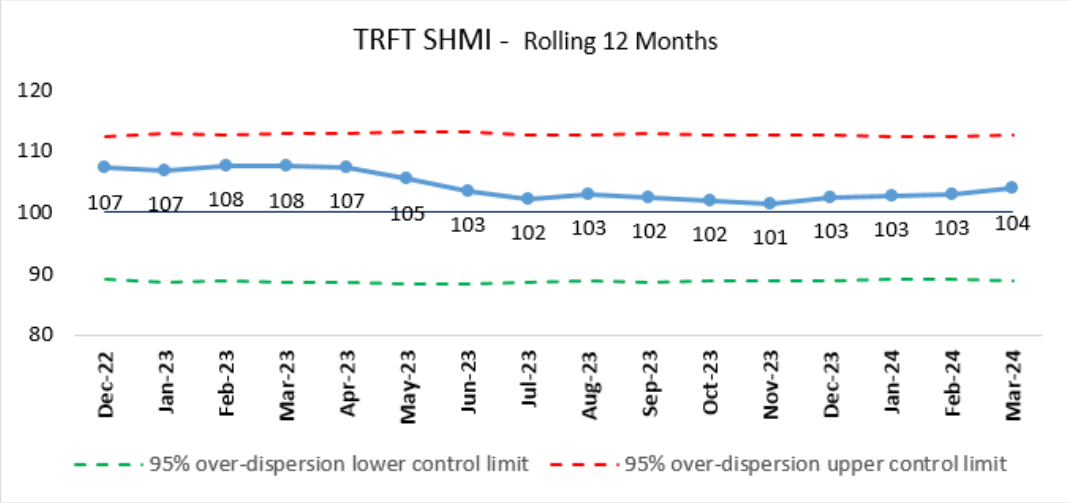
- Investigations or reviews resulting from SHMI investigation will give the Trust Assurance when more deaths are observed than expected
- Intelligence from SHMi investigations/reviews may lead to changes/improvements in practice

Potential risks to improvement?

- The SHMI isn't monitored and reported on routinely & correctly
- The Trust Mortality Group's response to areas of concern isn't robust and the correct investigations aren't requested/completed
- That intelligence from any investigations/reviews isn't acted upon

SHMI: Summary Hospital-Level Mortality Indicator - Update

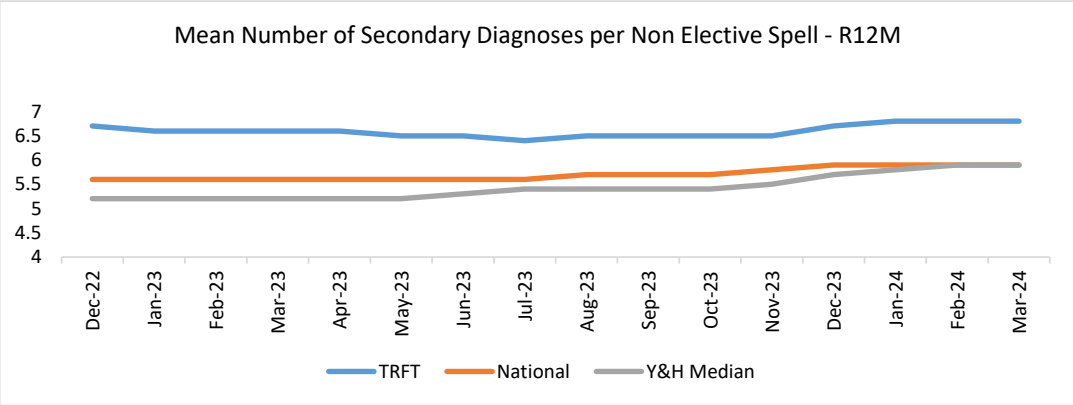
SHMI Update



This chart shows that TRFT has consistency been in the As Expected band.
The trend pattern shows Common Cause Variation, within this band.

Interpretation Guidance NHS England June 2024

'Where a trust has an 'as expected' SHMI, it is inappropriate to conclude that their SHMI is lower or higher than the national baseline, even if the number of observed deaths is smaller or larger than the number of expected deaths. This is because the trust has been placed in the 'as expected' range because any variation from the number of expected deaths is not statistically significant



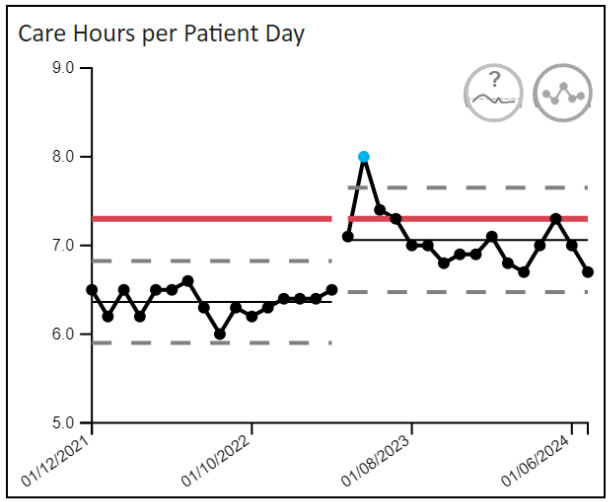
The depth of co-morbidity coding is important for the SHMI as having an accurate view of patient comorbidities will ensure and accurate expected %risk of death for each inpatient admission. Of note not all comorbidities factor into the SHMI algorithm.

This chart shows that TRFT depth of coding for non elective spells has been consistently higher than the National figure and the Yorkshire & Humber median. This is related to a mix of the TRFT's casemix having a higher prevalence of co-morbidities and/or better capture of these co-morbidities.

The increase between Nov-2023 and Dec 2023 seen in all 3 lines is due to inclusion of Covid activity into the SHMI data, which had previously been excluded.

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.
- Our current CHPPD performance is showing common cause variation, averaging out at 7.
- Planned interventions are expected to lead to improvement.

Metric	Value	Target	Exec Lead	Ops Lead
Care Hours per Patient Day	6.7	7.3	Helen Dobson	Cindy Storer

What actions are planned?

- Continued 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.
- Second acuity and data collection for the SNCT taking place with analysis and professional judgement planned for August 2024.

What is the expected impact?

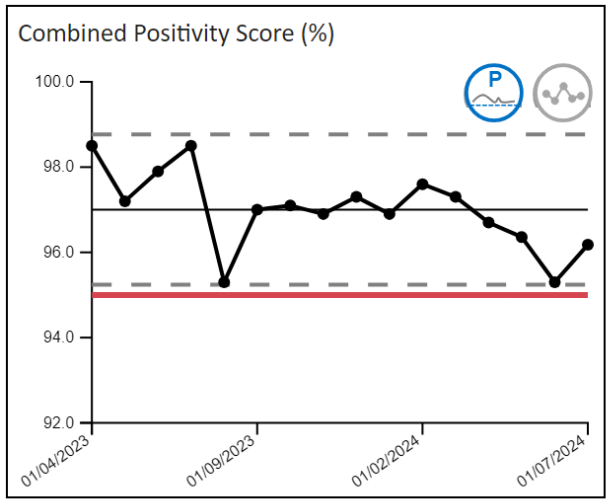
- CHPPD planned versus actual within 5% range
- Clinical quality and safety outcomes are maintained and unwarranted variation reduced across ward areas.

Potential risks to improvement?

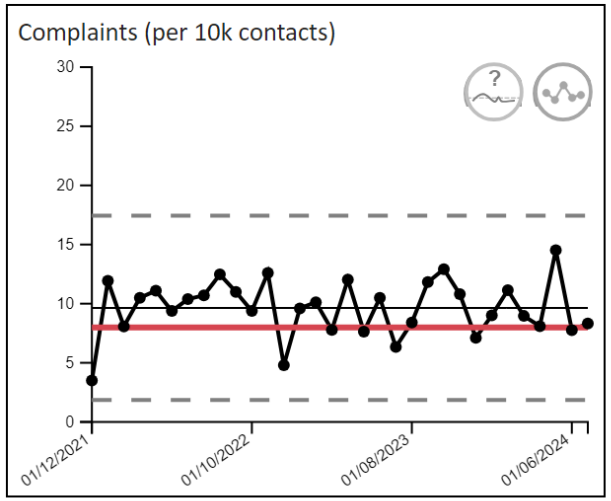
- Needing to open additional beds using existing establishments
- Roster KPI not being met
- Turnover of Nurses, Midwives and HCSW

Subtheme: Patient Experience

Data, Context and Explanation



- 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. Our Combined Positivity Score is consistently meeting our target of 95% of Patient saying they would recommend our services.



- Patients can complain about any aspect of NHS care, treatment or service and this is written into the NHS Constitution.
- The number of complaints continues to be monitored. There has been a consistent rate of written complaints per month over the last three years.

Metric	Value	Target	Exec Lead	Ops Lead
Combined Positivity Score (%)	96.2	95.0	Helen Dobson	Cindy Storer
Complaints (per 10k contacts)	8.3	8.0	Helen Dobson	Cindy Storer

What actions are planned?

- The new Patient Advice and Liaison Service (PALS) opened in August 2024
- Care Group one had the first Monopoly Board training on front line resolution and complaints in August 2024
- The Carers Promise is ready to launch, pending arrival of the badges and lanyards
- The Purple Butterfly Boxes are ready to launch, pending arrival of the memory boxes

What is the expected impact?

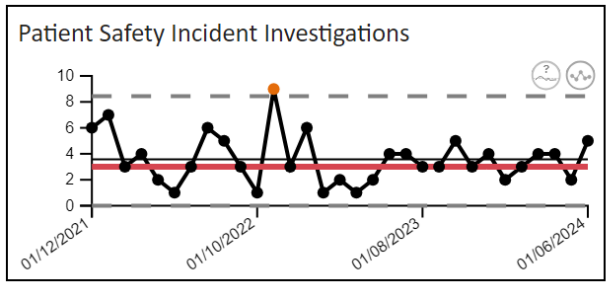
- FFT Continued Positivity score above 95
- The PALS service aims to promote local resolutions to concerns earlier in the process leading to a reduction in formal complaints per 10k contacts

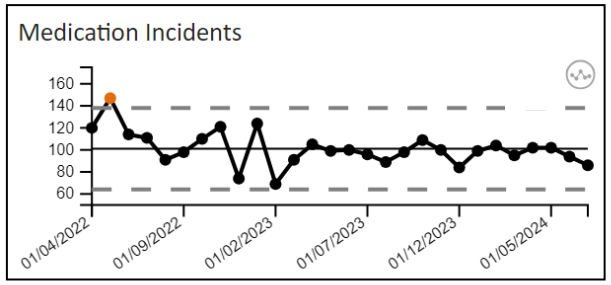
Potential risks to improvement?

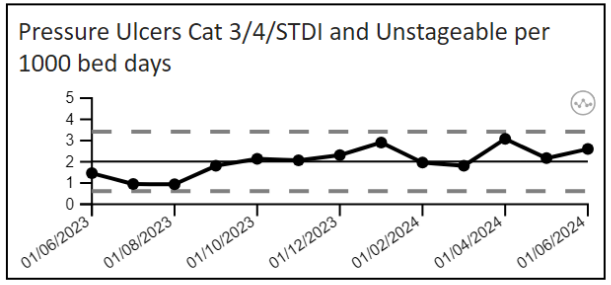
- Orders have been placed for some of the consumables for the Qi but have not yet arrived
- Formal launched waiting until after the school holidays are over to maximise patient and public awareness

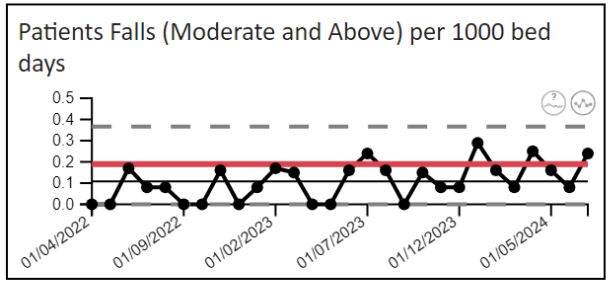
Subtheme: Care Incidents

Data, Context and Explanation









- Patient Safety Incident Investigations are completed when a patient has been involved in a moderate harm incident and significant learning identified. Number of PSI remain consistent per month.
- Medication incidents that are reported through the Datix system can occur for a number of reasons. Over the last 18 months, the Trust has consistently seen just shy 100 incidents reported per month. The aim for 2024/25 is to reduce that down to average of 90 per month (10% reduction)
- Pressure ulcers (PU) remain a concern and are considered, the main, an avoidable harm associated with healthcare delivery. Treating pressure damage costs the NHS more than £3.8 million every day and causes both physiological & psychological harm. The trust PUs rate remains stable at 2 per month.
- The number of patient falls at moderate harm is remaining consistent at present, at times achieving the 0.19 per 1000 bed days target, however there are months, like this one where that has not been the case.

Metric	Value	Target	Exec Lead	Ops Lead
Patient Safety Incident Investigations	5	3	Helen Dobson	Victoria Hazeldine
Medication Incidents	86	-	Jo Beahan	Victoria Hazeldine
Pressure Ulcers Cat 3/4/STDI and Unstageable per 1000 bed days	2.6	-	Helen Dobson	Victoria Hazeldine
Patients Falls (Moderate and Above) per 1000 bed days	0.24	0.19	Helen Dobson	Victoria Hazeldine

What actions are planned?

- To establish an acceptable rate of medication incidents per 1000 bed days (data is still being collated, performance is static)
- 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.
- A Falls Prevention Lead is proposed for the Trust to help reduce the total number of all falls and moderate harm falls through Qi projects and education

What is the expected impact?

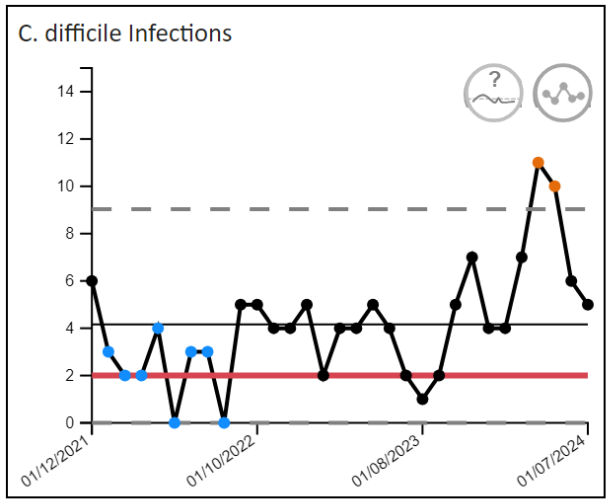
- Stabilisation of PSII's with adequate evidence of shared learning
- Reduction in the total number of falls
- Reduction in the number of CAT 3/4/SDTI and unstageable pressure ulcers

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 ratios
- 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

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 first two months of 24/25 have shown significantly higher than expected rates. This is reviewed monthly at Harm Free Care panels and the emerging themes linked to antimicrobial stewardship and prescribing practices. Action are in place to address (see planned action box). It is noticeable that, at present, we will continue to see infections higher than target.
- Nationally there is a trend for increasing rates of C. diff with a renewed focus on AMR. Rates per 100,000 bed days from UKHSA have not yet been published for Q1, once there are then benchmarking detail will be provided within this report.

Metric	Value	Target	Exec Lead	Ops Lead
C. difficile Infections	5	2	Helen Dobson	Jen Hilton

What actions are planned?

- Harm Free panel continues with continued themes on antibiotic prescribing identified.
- National Standards of Healthcare Cleanliness (2021) have been re-launched.
- New microbiologists appointed and start date anticipated November
- 13 new Florence Nightingale Champions have passed their IPC course
- 3 areas have achieved 6 consecutive months of the Golden Commode

What is the expected impact?

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

Potential risks to improvement?

- Intermittent microbiology support to lead strategically across the Trust, support proactive ward rounds and input into Trust Harm Free Care Panel. Now appointed to but wont start until November 2024

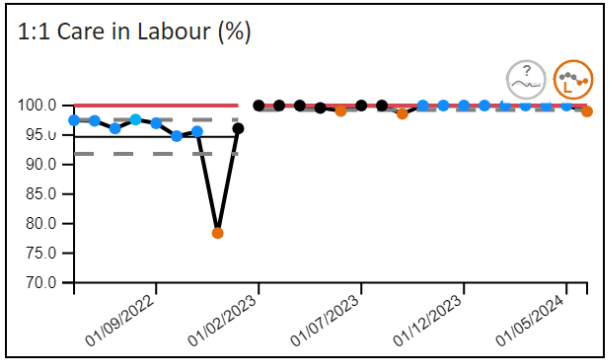
Maternity

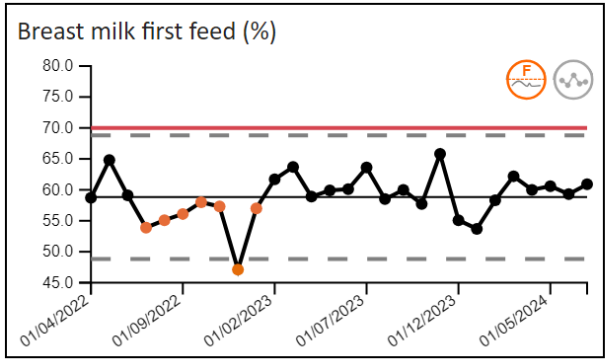
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
1:1 Care in Labour (%)	100.0	99.0	Jun-24	✗	?	L	-	C
Breast milk first feed (%)	70.0	60.9	Jul-24	✗	F			C
Stillbirth rate (per 1000 births)	4.66	2.4	Jul-24	✓	P	L	-	VG

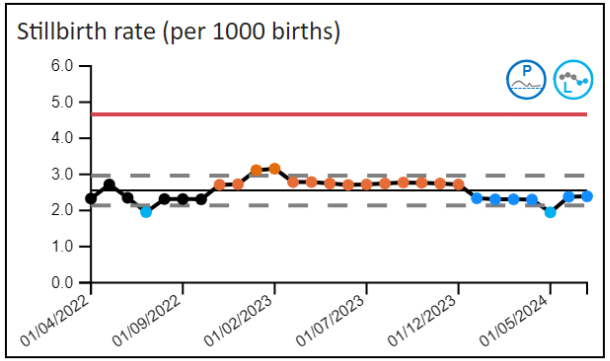
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

Subtheme: Maternity

Data, Context and Explanation







- 1:1 care in labour remains at a high performance level, the slight reduction in month this month is related to BBAs who have not had an opportunity to be provided with 1:1
- Breast Milk First Feed % continues to be below the Trust target, with an average of 60.9 % against a Trust target of 66%. (but is meeting 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 supporting the Unicef Baby Friendly (BFI) infant feeding standards.
- Still Birth Rates remain consistently lower than the NHS England ambition, of a rate of 2.4 per 1000 births at TRFT.
- We are currently seeing a significant reduction since January 2024 and expect currently performance levels to remain consistent following high compliance with the SBL Care Bundle.

Metric	Value	Target	Exec Lead	Ops Lead
1:1 Care in Labour (%)	99.0	100.0	Helen Dobson	Sarah Petty
Breast milk first feed (%)	60.9	70.0	Helen Dobson	Sarah Petty
Stillbirth rate (per 1000 births)	2.4	4.66	Helen Dobson	Sarah Petty

What actions are planned?

- 1:1 care in labour is a standard for CNST, birth rate plus data is monitored through maternity and neonatal safety paper to monitor compliance.
- Breast milk first feed :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.
- Stillbirth rate: Continuous improvement with the Saving Babies Lives care bundle version 3 implementation – TRFT currently at 93% 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 June 2024 highlighted compliance at 93% 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.

Performance Matrix Summary – Finance and Performance

The Rotherham NHS Foundation Trust

Variation	Assurance: Pass	Assurance: Hit or Miss	Assurance: Fail
Special Cause: Improvement	**VERY GOOD: LEARN AND CELEBRATE**	**GOOD: CELEBRATE AND UNDERSTAND** • Patients moved to PIFU • Outpatients New - Procedures • Daycases	**CONCERNING: CELEBRATE BUT TAKE ACTION** • Number of 65+ Weeks • Referral To Treatment % • Clinic Utilisation • Discharged before 5pm
Common Cause	**GOOD: CELEBRATE AND UNDERSTAND** • Urgent 2 Hour Community Response	**STATIC: INVESTIGATE AND UNDERSTAND** • FDS, 31 Day Standard, 62 Day Standard • Discharge Date = Discharge Ready Date • A&E Attendances from Care Homes, Admissions from Care Homes, Pts on Virtual Ward • Patients Spending > 12 hrs in A&E, 12 hr trolley waits, Bed Occupancy, LoS > 21 Days • Waiting List Size, DM01 • Model Hospital Daycase Rate • Outpatients, Inpatients, Daycases (% of 19/20) • Length of Stay > 7 days, Mean Length of Stay (Elective exc. Daycases) • A&E Attendances, INOs, 2ww Referrals, Outpatients New – Attendances, Outpatients Follow Up – Attendances, Outpatients Follow Up Procedures	**CONCERNING: INVESTIGATE & TAKE ACTION** • 4 hour performance • Ambulance Handover Times >30min • Avg time to see clinician • Capped Theatres Utilisation • Did Not Attend • Inpatients Non-Electives • Referrals
Special Cause: Concern	**CONCERNING: INVESTIGATE AND UNDERSTAND**	**CONCERNING:INVESTIGATE & TAKE ACTION** • Overdue Follow-ups • Mean Length of Stay (Non-elective)	**VERY CONCERNING: INVESTIGATE & TAKE ACTION** • Number of 52+ Weeks • Criteria to Reside is No

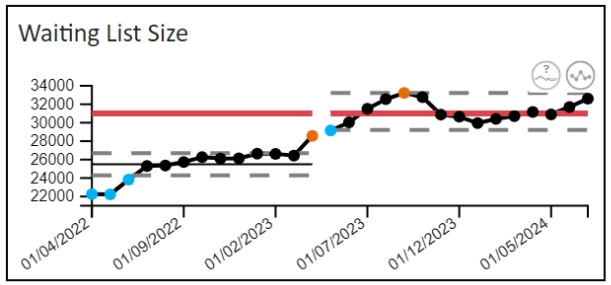
Elective Care and Cancer

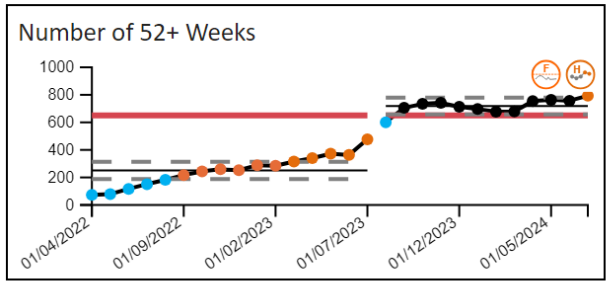
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
Waiting List Size	30,500	32,605	Jul-24	✗	?			S
Number of 52+ Weeks	650	793	Jul-24	✗	F	H		VC
Number of 65+ Weeks	0	1	Jul-24	✗	F	L		C
Referral To Treatment (%)	92.0	62.0	Jul-24	✗	F	H		C
OP Activity moved or Discharged to PIFU (%)	2.0	3.0	Jul-24	✓	?	H		G
Overdue Follow-ups	-	16,623	Jul-24	-	-	H	-	C
DM01 (%)	1.0	0.1	Jul-24	✓	?			S
Faster Diagnosis Standard (%)	77.0	80.3	Jun-24	✓	?			S
31 Day Treatment Standard (%)	96.0	96.6	Jun-24	✓	?			S
62 Day Treatment Standard (%)	70.0	79.9	Jun-24	✓	?			S

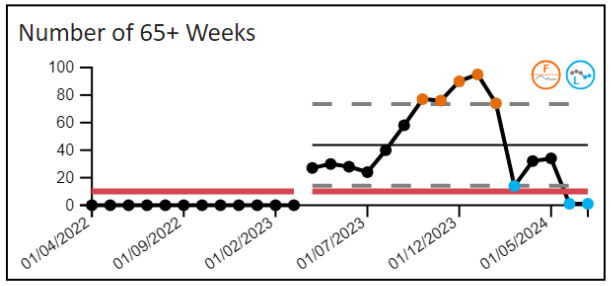
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

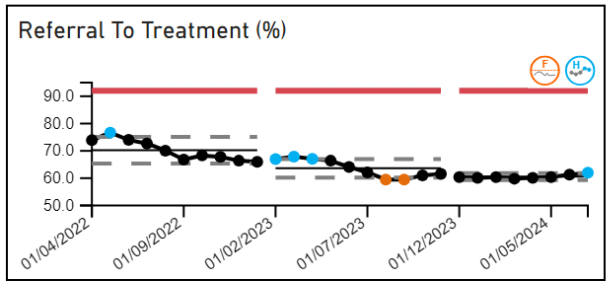
Subtheme: Long Waiters

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 July 2024 and achieved the trajectory of less than 10 patients by the end of June, with just one patient waiting over 65 weeks in July.
- The Trust has also committed to reducing the number of patients waiting over 52 weeks by 50% by March 2025.
- The growth in the waiting is 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. Respiratory has now achieved compliance with the RTT standard.

Metric	Value	Target	Exec Lead	Ops Lead
Waiting List Size	32,605	31,000	Sally Kilgariff	Andrea Squires
Number of 52+ Weeks	793	650	Sally Kilgariff	Andrea Squires
Number of 65+ Weeks	1	10	Sally Kilgariff	Andrea Squires
Referral To Treatment (%)	62.0	92.0	Sally Kilgariff	Andrea Squires

What actions are planned?

•Development and approval of 2024/25 ERF schemes which will be delivered by March 2025.
•Approval of an additional 6 haematology weekend clinics throughout August and September 2024 which will reduce the number of patients waiting for their first outpatient appointment and improve RTT.
•Approval of a locum consultant in Diabetes & Endocrine between July to September 2024 which will reduce the number of patients waiting for a first outpatient appointment and improve RTT.
•Approval of insourcing solutions to provide anaesthetic and theatre staff between July to March 2025 to ensure maximisation and efficiency of theatre lists.

What is the expected impact?

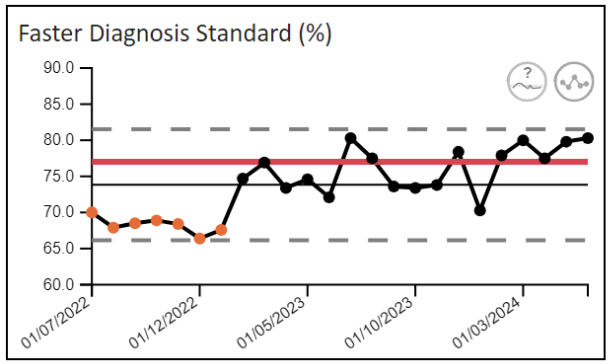
•Improved RTT position in Haematology by September 2024, supporting the Trust to achieve RTT status in at least 5 specialties by March 2025.
Improved RTT position in Diabetes & Endocrine by September 2024, supporting the Trust to achieve RTT status in at least 5 specialties by March 2025.
•Sustained achievement of zero patients waiting longer than 65 weeks for surgery from July 2024 onwards and a reduction in the number of patients waiting longer than 52 weeks by March 2025.

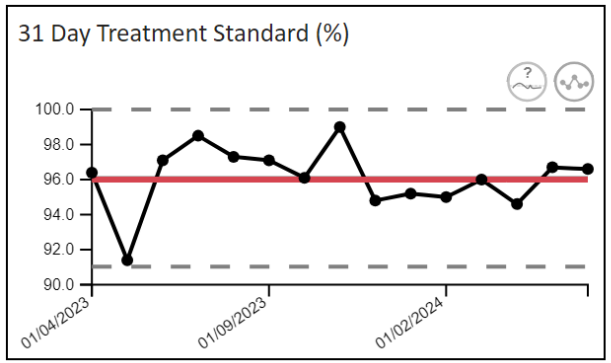
Potential risks to improvement?

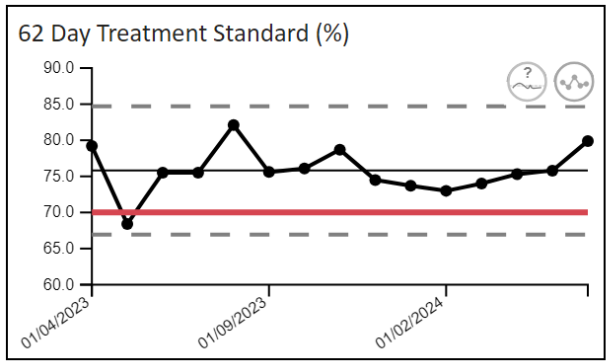
- Clinician agreement and availability to undertake additional sessions as required to support the outpatient and theatre activity approved, particularly over the holiday period.
- Potential impact of any future industrial action affecting availability of doctors or nurses.
- Availability of insourcing provision to support additional activity.
- Availability of financial resource to support additional activity.
- Risk of identification of long waits through enhanced validation of waiting list.

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 Trust achieved this standard in June 2024.

•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. The Trust achieved this standard in June 2024.

• A Cancer transformation programme has been developed and is moving at pace to deliver these objectives and improve personalised care and support for our patients.

Metric	Value	Target	Exec Lead	Ops Lead
Faster Diagnosis Standard (%)	80.3	77.0	Sally Kilgariff	Andrea Squires
31 Day Treatment Standard (%)	96.6	96.0	Sally Kilgariff	Andrea Squires
62 Day Treatment Standard (%)	79.9	70.0	Sally Kilgariff	Andrea Squires

What actions are planned?

•Development of a Patient Quality Improvement Group to gain a greater understanding of our patients needs – focus groups commence September 2024.
•Development of a robust improvement plan for UGI by September 2024.
•Establish breach review meetings with all services by September 2024.
•Increase straight to test pathway utilisation in LGI and UGI by September 2024.

What is the expected impact?

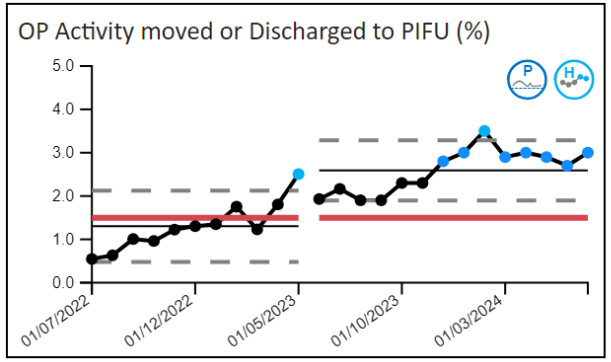
•Improve the Faster Diagnosis Standard in Lower GI further from 62.3% to above 70% by March 2025.
•Improve the Faster Diagnosis Standard in Upper GI further from 73.5% to above 77% by March 2025.
•Reduce the number of patients waiting longer than 104 days for treatment following diagnosis of cancer.
•Improve the National Patient Experience Survey responses further for 2024.

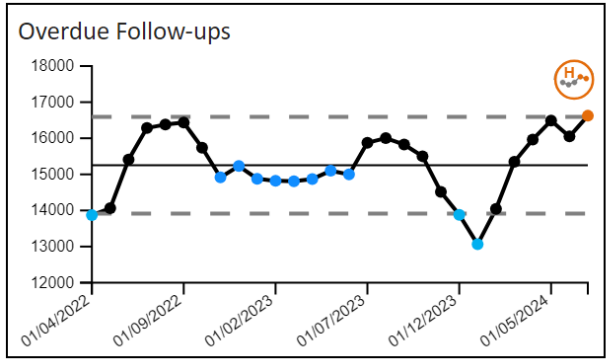
Potential risks to improvement?

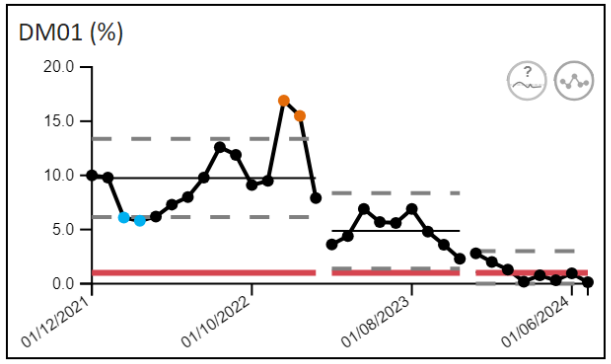
•Reliance on insourcing to support endoscopy capacity continues which if unavailable may impact the ability to achieve the FDS and 62 Day standard in Lower GI.
•Workforce challenges in both Lower GI and Urology continue to impact cancer pathway progression and improvement work with consultant vacancies and sickness absence.
•The new cancer improvement team are supported by fixed term funding and sustainability of these roles is therefore a concern this puts a risk around x2 transformational programmes.

Subtheme: Diagnostics & Follow-ups

Data, Context and Explanation







•In 2024/25, the national planning guidance set an objective to continue to implement outpatient transformation approaches, including patient-initiated follow-up (PIFU).

•The Trust have therefore set the objective to ensure 1.5% of patients waiting for an outpatient follow-up appointment is moved or discharged to PIFU by March 2025.

•The number of patients waiting for an overdue follow-up appointment increased by 449 patients in June 2024; with notable increases seen in Ophthalmology, Respiratory and Rheumatology.

•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. The Trust is currently maintaining achievement of this objective.

Metric	Value	Target	Exec Lead	Ops Lead
OP Activity moved or Discharged to PIFU (%)	3.0	1.5	Sally Kilgariff	Andrea Squires
Overdue Follow-ups	16,623	-	Sally Kilgariff	Andrea Squires
DM01 (%)	0.1	1.0	Sally Kilgariff	Andrea Squires

What actions are planned?

•Roll out of SMS validation for all patients overdue a follow-up appointment is on track for September 2024 delivery.
•Approval of additional Ophthalmology weekend clinics will commence in September 2024, which will ensure patients waiting for an overdue follow-up appointment are prioritised affectively.
•Delivery of mutual aid via Montagu CDC to increase Endoscopy provision is now in place, which will ensure the Trust continues to be compliant with DM01 standards following the change to reporting requirements at the end of September 2024.

What is the expected impact?

•All patients overdue a follow-up appointment will have confirmed that they still want/need a follow-up appointment by September 2024 to ensure we are prioritising care for those who most need it.
•Endoscopy will achieve the DM01 standard of having zero patients waiting more than 6 weeks for their diagnostic procedure from July 2024 and continue to achieve the standard following changes to guidance regarding surveillance patients in September 2024.

Potential risks to improvement?

- Addition of overdue surveillance patients in endoscopy to DM01 from September 2024 may impact on DM01 performance.
- Reliance on insourcing and mutual aid to support endoscopy capacity continues which if unavailable may impact the ability to achieve the DM01 standard from September 2024.
- Availability of financial resource to support additional activity.
- Impact of the transfer of long waits in DM-1 as a result of any mutual aid across the system.

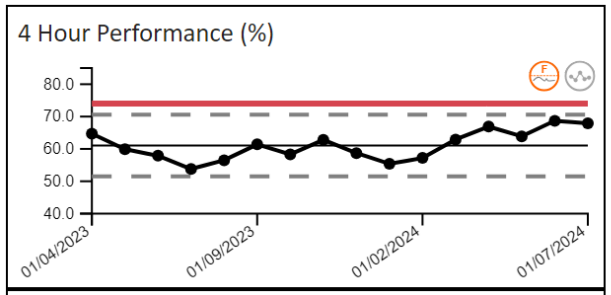
Non-elective and Flow

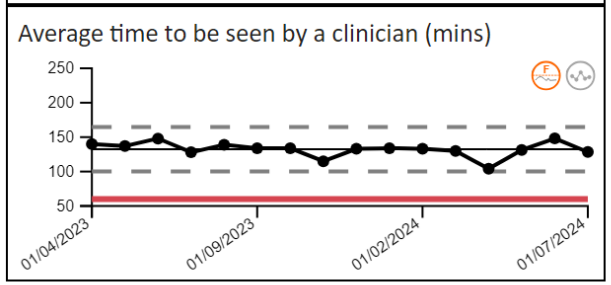
Metric	Trust Target	Latest Data	Period	Achieved in Month)	Assurance	Variation	Quartile	Grid*
4 Hour Performance (%)	74.0	67.9	Jul-24	☒	F			C
Ambulance Handover Times >30 mins (%)	0.0	11.5	Jul-24	☒	F			C
Average time to be seen by a clinician (mins)	60.0	128.4	Jul-24	☒	F		-	C
Patients spending >12 hours in A&E from time of arrival (%)	2.0	2.4	Jul-24	☒	?			S
12hr Trolley Waits	0	0	Jul-24	☑	?		-	S
Bed Occupancy (%)	92.0	90.1	Jul-24	☑	?			S
Length of Stay over 21 Days	68	55	Jul-24	☑	?		-	S
Patients where Date of Discharge = Discharge Ready Date (%)	85.0	83.4	Jun-24	☒	?		-	S
Criteria to Reside is No (%)	10.0	19.5	Jul-24	☒	F	H	-	VC

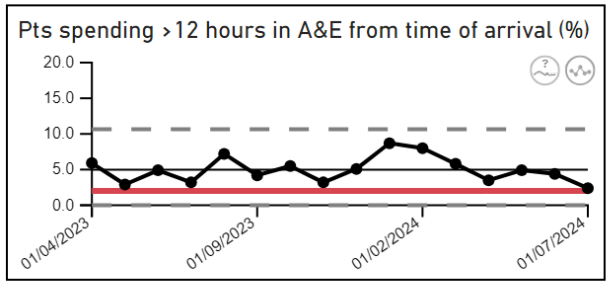
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

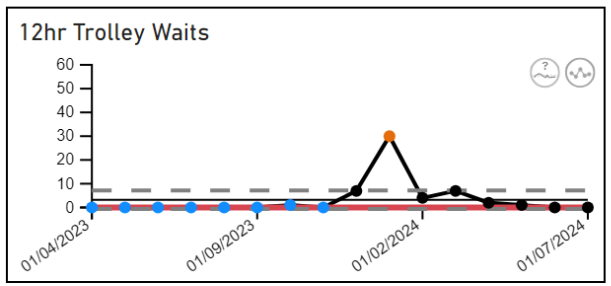
Subtheme: Emergency Care - Waiting Times

Data, Context and Explanation









•In 2024/25, the national planning guidance set an objective for all Trusts to achieve the 4 hour performance standard of 78% by March 2025.

•Performance in July was on track to achieve 70% however junior doctors industrial action had an impact on flow throughout the organisation impacting on 4 hour performance towards the end of the month.

•In order to achieve the 4 hour performance standard the Trust is focusing on improving the average time a patient waits to be seen by a clinician.

•The number of patients spending more than 12 hours in the department is also a key national focus. July saw a positive reduction in this metric also.

•The Trust has set a standard to achieve zero trolley waits in line with national guidance.

Metric	Value	Target	Exec Lead	Ops Lead
4 Hour Performance (%)	67.9	74.0	Sally Kilgariff	Lesley Hammond
Average time to be seen by a clinician (mins)	128.4	60.0	Sally Kilgariff	Lesley Hammond
Pts spending >12 hours in A&E from time of arrival (%)	2.4	2.0	Sally Kilgariff	Lesley Hammond
12hr Trolley Waits	0	0	Sally Kilgariff	Lesley Hammond

What actions are planned?

- Key focus will be on developing Primary Care plans to improve collaborative working across OOH and UECC to reduce the number of patients breaching 4hrs overnight.
- Work continues to develop SDEC and the Investigation Area on B6 to support the relocation of CHAT to B6 which aims to reduce patient waiting times.
- 8 New clinical fellows and a new medical rota will commence in August 2024 increasing doctor capacity in UECC at peak times.
- Changes to process for TTIA to reflect front door senior review

What is the expected impact?

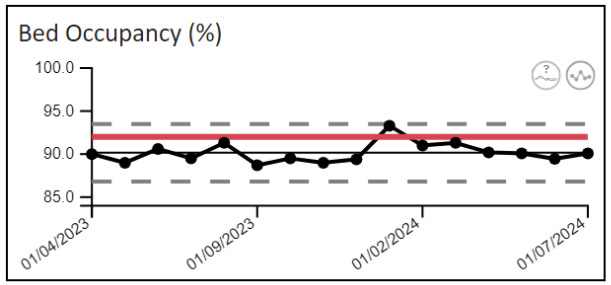
• Non-admitted performance for Primary Care and Minor Injuries will continue to improve from August 2024 onwards.
•The time patients wait to receive an initial assessment will improve from August 2024 onwards due to new process.
•The number of patients spending more than 12 hours total time in the department will continue to reduce and be sustained from August 2024.

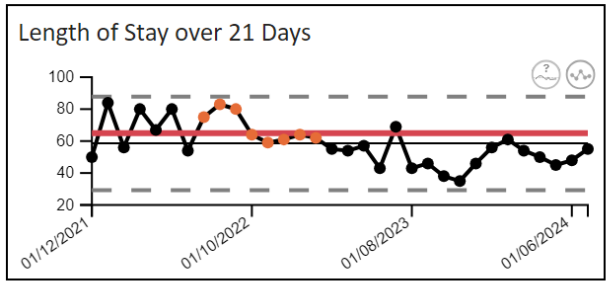
Potential risks to improvement?

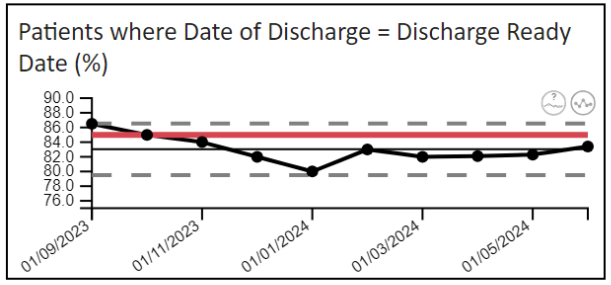
• Attendances may continue to increase which will negatively impact on the Trusts ability to achieve the 4 hour performance standards.
•Further periods of IA, including impact of potential action in primary care.

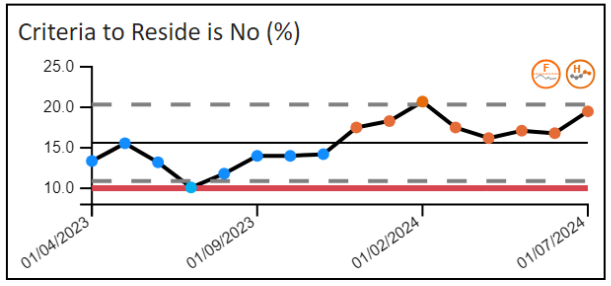
Subtheme: Inpatient Flow

Data, Context and Explanation









•92% is recognised as optimum bed occupancy. This has been impacted by increased non-elective demand, however, occupancy rates have been supported by additional capacity being opened across the Trust and maintained following Winter.

•June 2024 saw the standard for patients with a length of stay >21 days improve, with 48 patients having a length of stay >21 days against the standard of 65. Further work will focus on reducing length of stay for patients >14 and 7 days.

•In July 2024, Criteria to Reside was 19.5%, which was a decline from June 2024. Due to challenges experienced across all discharge pathways, more focused work is planned to take place to achieve the Trust standard of 10%.

Metric	Value	Target	Exec Lead	Ops Lead
Bed Occupancy (%)	90.1	92.0	Sally Kilgariff	Lesley Hammond
Length of Stay over 21 Days	55	65	Sally Kilgariff	Lesley Hammond
Patients where Date of Discharge = Discharge Ready Date (%)	83.4	85.0	Sally Kilgariff	Lesley Hammond
Criteria to Reside is No (%)	19.5	10.0	Sally Kilgariff	Lesley Hammond

What actions are planned?

• Perfect week has taken place in July 2024 supported a reset and enabled us to close escalations beds. This week also highlighted challenges around movement into the late evening so an additional Perfect Twilight will commence on Bank Holiday Monday supporting 1600 to 0000. Area to pick up

- •Flow after 5pm
- •Number of successful planned discharges
- •Highlighted Golden patients
- •C2R understanding the data to reduce the % number across the trust
- •Deep dive of patients moved after midnight

What is the expected impact?

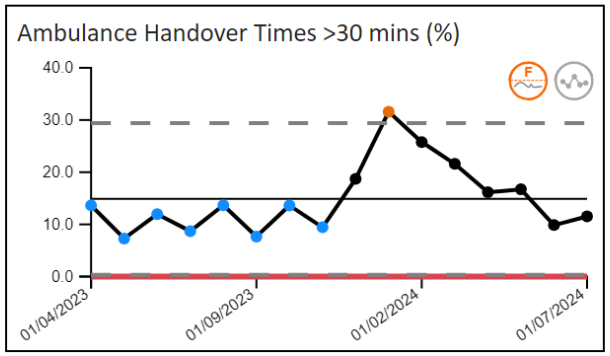
• Reduce in patient moves.
•No moves after midnight
•Greater understanding of challenges after 6pm
• To achieve empty beds on assessment areas by 18.00 each day.
• To ensure flow continues from UECC into assessment areas.
•Improve patient flow and adherence to acute care standards
•Patients will be in thr right bed at the right time

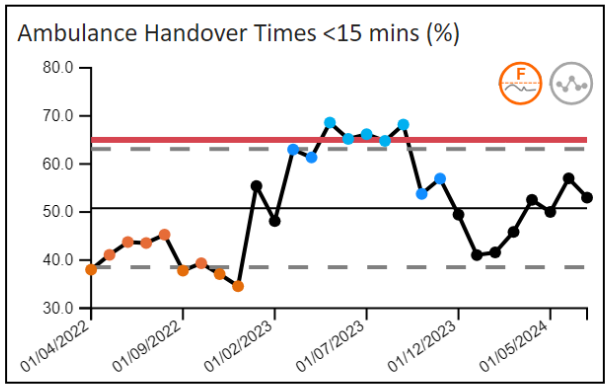
Potential risks to improvement?

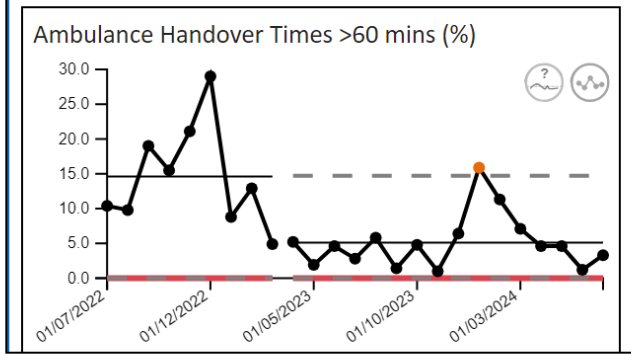
• Increase demand through UECC sustained
• De-escalation of inpatient beds not possible due to ongoing pressures
• Increased demands fails to reduce bed occupancy

Subtheme: Emergency Care - Ambulance

Data, Context and Explanation







•The Operational Planning Guidance set an objective to achieve an average of 30 minutes to handover a patient by March 2025.

•Achievement of this standard is dependent on compliance with two other standards; patients must wait less than 15 minutes for handover and patients must not wait over 60 minutes for handover.

•In July 2024, the Trust compliance with Ambulance handover times <15 minutes improved yet remained below the standard of 65%. Similarly, Ambulance handover times >60 minutes improved although did not meet the standard of 0.0%.

•The ability to hand patients over within the designated timescales may be negatively impacted by the increase in demand for UECC services.

Metric	Value	Target	Exec Lead	Ops Lead
Ambulance Handover Times >30 mins (%)	11.5	0.0	Sally Kilgariff	Lesley Hammond
Ambulance Handover Times <15 mins (%)	53.0	65.0	Sally Kilgariff	Lesley Hammond
Ambulance Handover Times >60 mins (%)	3.3	0.0	Sally Kilgariff	Lesley Hammond

What actions are planned?

- The Trust will take part in a National working group supported by ECIST which has been developed to support improvement across ambulance handovers times.
- Focused work with the Yorkshire Ambulance Service to analyse and improve data validation will continue to ensure accurate reporting of TRFT ambulance data nationally by Q3 of 2024.
- They have developed a digital text message that will alert operational leaders to any challenges with Ambulance handovers.

What is the expected impact?

•There will be an improvement in ambulance handover times prior to winter and TRFT sustained high levels of performance
•Improved access to information will support action from teams to ensure that ambulance handovers are a priority

Potential risks to improvement?

• A possible increase in ambulance attendances or batching of ambulances may negatively impacting on the ability to hand patients over within the designated timescales.
•Ongoing demands for UEC services
•Peaks in demands for services

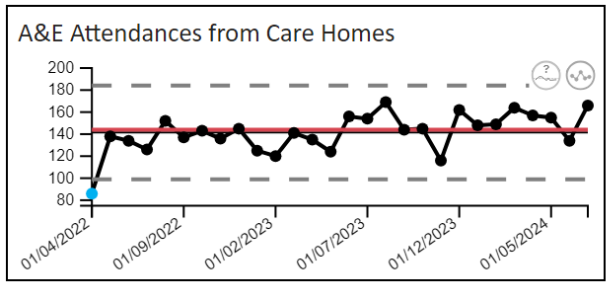
Community

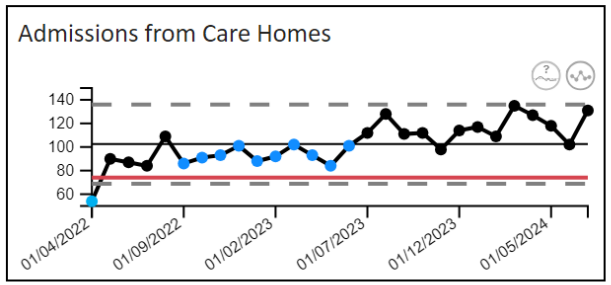
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
A&E Attendances from Care Homes	144	166	Jul-24	✗			-	S
Admissions from Care Homes	74	131	Jul-24	✗			-	S
Number of Patients on Virtual Ward	80	71	Jul-24	✗			-	S
Urgent 2 Hour Community Response (%)	70.0	77.0	May-24	✓			-	G

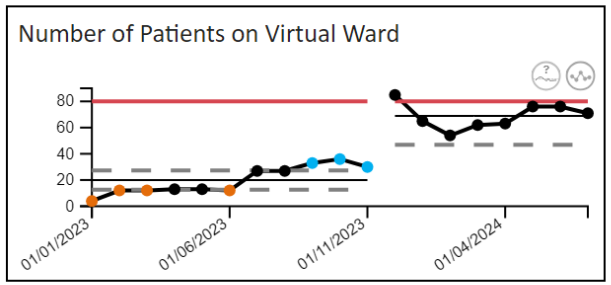
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

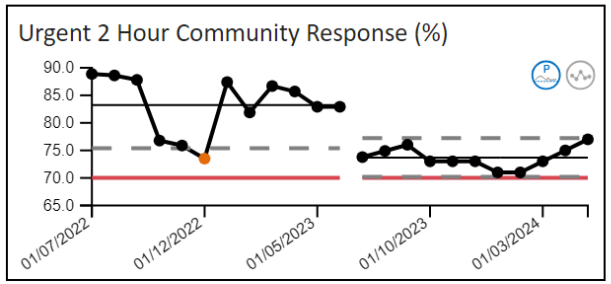
Subtheme: Community

Data, Context and Explanation









•In July 2024 166 patients attended A&E from Care Homes across Rotherham against the Trust standard of 144. This is a decrease in performance from June 2024. The Trust promotes the use of the Transfer of Care Hub (TOCH) to avoid conveyance and works closely with YAS through the push model to reduce attendances. Further analysis is being undertaken when the conveyances occur – out of hours.

•Admissions from Care Homes increased in July 2024. 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 expedite discharge when appropriate. The ratio of admissions to attendances remains static.

•The number of patients on Virtual Ward decreased in July 2024, with an average of 72 patients being cared for via this model against a Trust standard of 80. The number of patients on the ward is based on the average occupancy throughout the month. Occupancy reached a peak of 90 on the 4 July 2024. Capacity was impacted by annual leave and sickness this month.

•The National standard for the 2 hour urgent community response is 70% of appropriate referrals. May 2024 saw the Trust meet this standard with 77.0% of patients receiving an urgent community response within 2 hours. The volume of patients referred to the service increased from April to May by 195 referrals, 33% increase.
•Work continues on data collection and validation, which will support the Trust in sustaining compliance with this standard.

Metric	Value	Target	Exec Lead	Ops Lead
A&E Attendances from Care Homes	166	144	Sally Kilgariff	Penny Fisher
Admissions from Care Homes	131	74	Sally Kilgariff	Penny Fisher
Number of Patients on Virtual Ward	71	80	Sally Kilgariff	Penny Fisher
Urgent 2 Hour Community Response (%)	77.0	70.0	Sally Kilgariff	Penny Fisher

What actions are planned?

•Work continues to develop the risk assessment and hazard log for the Virtual Ward as well as implementation of a Dashboard to provide visibility of capacity.
•Development of a Heart Failure pathway is ongoing.
•Introduction of a virtual ward assessment tool to assess the intensity of care required based on patient acuity is underway.
•Review of specialist planned nursing activity to identify any UCR activity continues, including a review of the Directory of Service and Data quality.

What is the expected impact?

•Increased offer to patients and increased referrals, thereby increasing our VW bed numbers by September 2024.
•Improved pathway to include more diagnoses and improve VW offer by August 2024.
•Categorisation of patients into three general acuity levels, each assigned a specific weight to inform occupancy ratios beyond patient numbers by August 2024.
• Continue to increase patient volumes and improved systems and processes, along with staff well-being.

Potential risks to improvement?

- Resource availability may impact on the ability to deliver improvement work.
- Workforce retention and wellbeing may impact on the ability to deliver improvement work

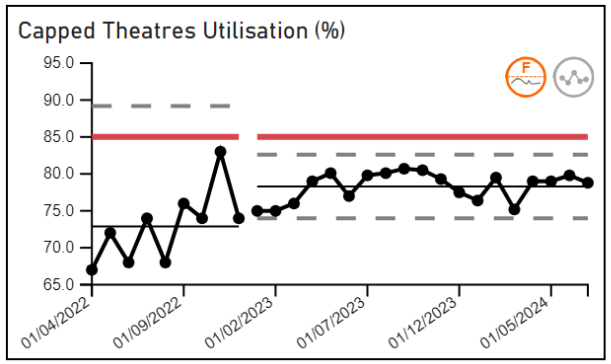
Productivity Priorities

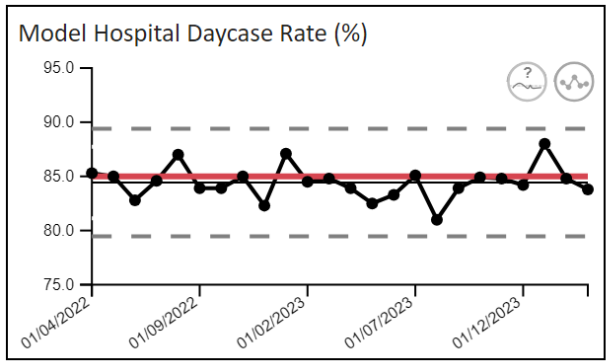
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
Clinic Utilisation (%)	85.0	79.1	Jul-24	☒	F	H	-	C
Capped Theatres Utilisation (%)	85.0	78.8	Jul-24	☒	F			C
Model Hospital Daycase Rate (%)	85.0	83.8	Mar-24	☒	?			S
Did Not Attend (%)	7.0	8.2	Jul-24	☒	F			C
Outpatients (% of 19/20)	103.0	109.0	Jul-24	☑	?		-	S
Inpatients (% of 19/20)	103.0	94.0	Jul-24	☒	?		-	S
Daycases (% of 19/20)	103.0	94.0	Jul-24	☒	?		-	S
Length of Stay over 7 days	-	185	Jul-24	-	-		-	S
Mean Length of Stay (Non-elective)	-	5.3	Jul-24	-	-	H		C
Mean Length of Stay (Elective excluding Daycases)	-	2.4	Jul-24	-	-			S
Discharged before 5pm (%)	70.0	65.4	Jul-24	☒	F	H	-	C

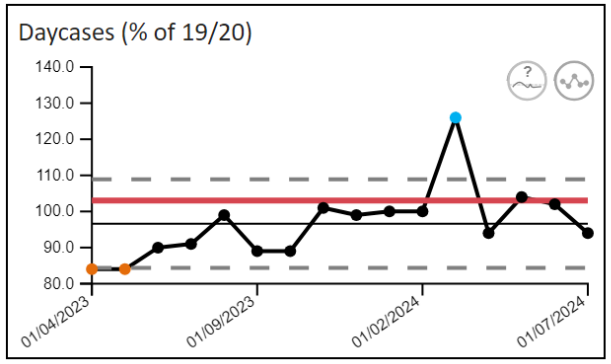
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

Subtheme: Theatres

Data, Context and Explanation







•National planning guidance has set a trajectory of 85% capped theatre utilisation (operating time of planned theatre sessions).

•Trust Capped Theatre Utilisation is inconsistent, with current utilisation of 78.8% against the 85% standard. Non-compliance with the 6-4-2 Scheduling process and list booking process continue to impact on utilisation.

•In July 2024 the Trust Day Case rate remained stable at 83.8% against the 85% standard, daycase activity decreased in month to 94% against a Trust standard of 103%. Work continues to improve the rate further across a variety of targeted specialties.
•Activity impacted by industrial action in June/July .

Metric	Value	Target	Exec Lead	Ops Lead
Capped Theatres Utilisation (%)	78.8	85.0	Sally Kilgariff	Jodie Roberts
Model Hospital Daycase Rate (%)	83.8	85.0	Sally Kilgariff	Jodie Roberts
Daycases (% of 19/20)	94.0	103.0	Sally Kilgariff	Jodie Roberts

What actions are planned?

- The Theatre booking tool will be further developed in Q2 and utilised across at least 5 surgical specialities by the end of September 2024.
- •Increased pre-op assessment sessions have been agreed to support scheduling and utilisation following 6-4-2 principles and ensuring we are booking out to 6 week by September 2024.
- Increased focus on T&O day cases

What is the expected impact?

- Improvement in theatre utilisation
- Improved overall scheduling
- Increase in use of day cases theatres from T&O
- Improvement in forward view and reducing on the day cancellations.
- Improved booking out to 6 weeks

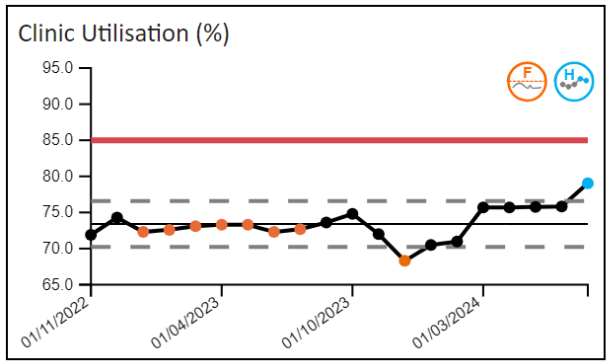
Potential risks to improvement?

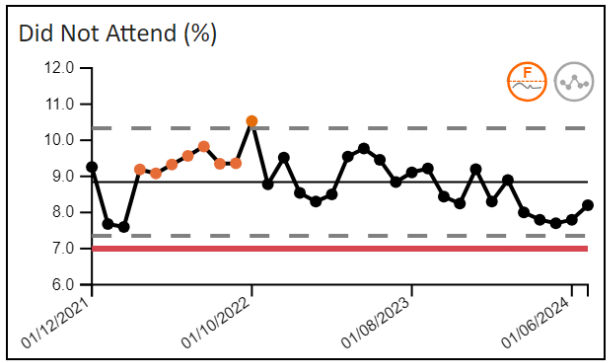
- Anaesthetic rotas may continue to impact on the ability to run theatre activity which significantly impacts on T&O
- Capacity to deliver pre-op assessment may impact on patients available and fit for surgery

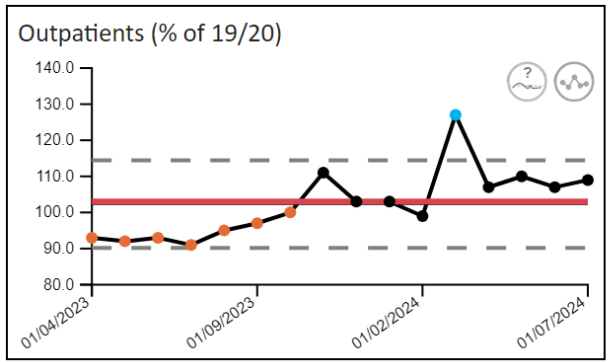
•High levels of staff absence impacting on lists been used

Subtheme: Outpatients

Data, Context and Explanation







•Clinic Utilisation is key to productivity and underutilised clinics is a key focus for the Trust this year, with the current rate at 79.1% against a standard of 85%.

•Trust DNA rates has deteriorated in July to 8.2% against a standard of 7%. Work is focused on reducing the variability and meeting the needs of our local population when attending for outpatient appointments to improve attendance via digital reminders.

•Outpatient productivity provides the organisation with the greatest opportunity to increase activity levels and improve outcomes for patients. June 2024 saw activity of 109% against a target of 103% of 2019/20 levels.

•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 (%)	79.1	85.0	Sally Kilgariff	Jodie Roberts
Did Not Attend (%)	8.2	7.0	Sally Kilgariff	Jodie Roberts
Outpatients (% of 19/20)	109.0	103.0	Sally Kilgariff	Jodie Roberts

What actions are planned?

•Increased capacity to deliver first outpatient appointments across numerous specialities to support activity levels by September 2024.
•Ongoing work with the contact centre and specialities to ensure cancellations are backfilled timely to improve utilisation further by September 2024.

What is the expected impact?

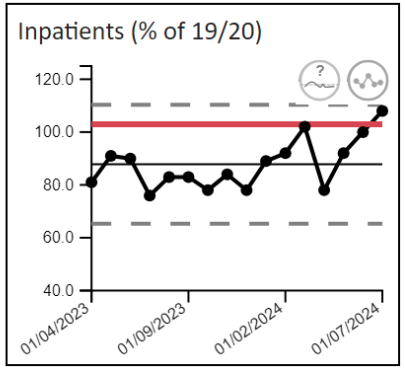
•Increase in clinic utilisation by 5% by Q3 2024/25.
•Reduction in patients that DNA to 7% by Q4 2024/25
•Increase in outpatient activity by 2% by Q3 2024/25.

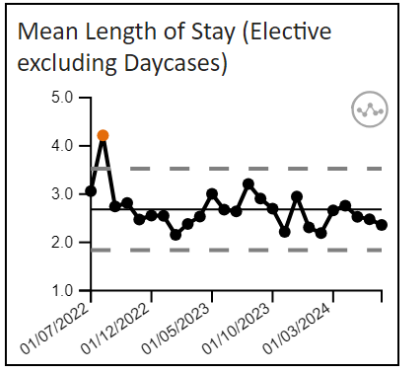
Potential risks to improvement?

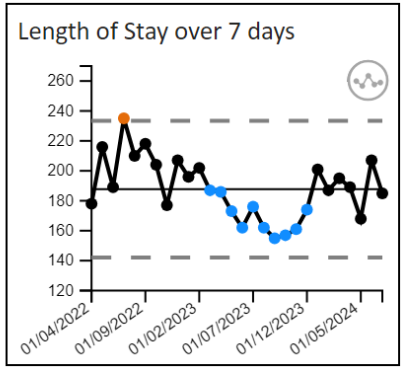
•Capacity in the contact centre to ensure that clinics are fully utilised, and any cancellations are back filled.
•Consultants' workforce absence may impact on the ability to sustain high levels of activity through summer months.
•Patient availability may impact on the ability to improve clinic utilisation, particularly backfilled appointments.
•Possible future Industrial Action may impact on ability to deliver outpatient appointments and improvement work.

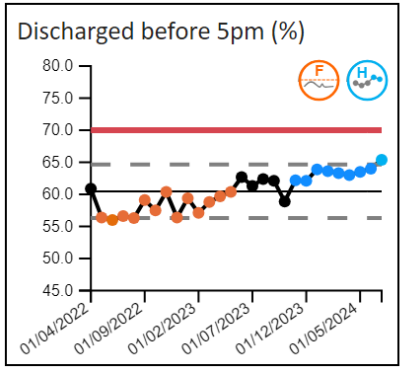
Subtheme: Inpatients

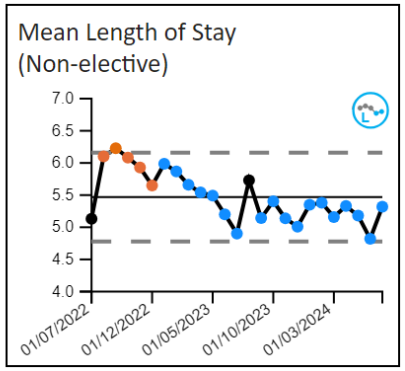
Data, Context and Explanation











•The number of inpatients has decreased in July 2024 to 94% against a Trust standard of 103% of 2019/20 levels.

•Length of stay over 7 days has remained static with increases noted across winter months. 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.

•Mean length of stay for Non-elective patients has remained relatively stable under 5.5 days.

•Mean length of stay for elective patients has remained static since 2022. Focused work to decrease length of stay on surgical wards is imperative to support the elective recovery programme.

•Patients discharged before 5pm are steadily increasing with July 2024 performance of 65.4% against a standard of 70%. Work continues to focus on improving discharge rates earlier in the day.

Metric	Value	Target	Exec Lead	Ops Lead
Inpatients (% of 19/20)	108.0	103.0	Sally Kilgariff	Jodie Roberts
Length of Stay over 7 days	185	-	Sally Kilgariff	Jodie Roberts
Mean Length of Stay (Non-elective)	5.3	-	Sally Kilgariff	Jodie Roberts
Mean Length of Stay (Elective excluding Daycases)	2.4	-	Sally Kilgariff	Jodie Roberts
Discharged before 5pm (%)	65.4	70.0	Sally Kilgariff	Jodie Roberts

What actions are planned?

•Increase daily numbers through the discharge lounge by 5 further patients.
•LLOS reviews completed by MDT
•Focus on LOS in surgical specialities
•Increase Consultant support to LOS reviews by September 2024.

What is the expected impact?

•Increase number of patients discharged before 5pm to 70% by Q3 2024.
•Reduction of 7 day LOS patients by 10%
•Reduction in average LOS in Surgery

Potential risks to improvement?

•Increased complexity of patients and a reliance on out of hospital care
•Increased number of beds open to deal with demand and thorough discharge planning ahead of time
•Ability for the discharge lounge to manage significant increase in numbers and transport to support earlier discharge (peaks and troughs in demand)
•CRU is not open on a Sunday which adds a challenge to weekend discharges

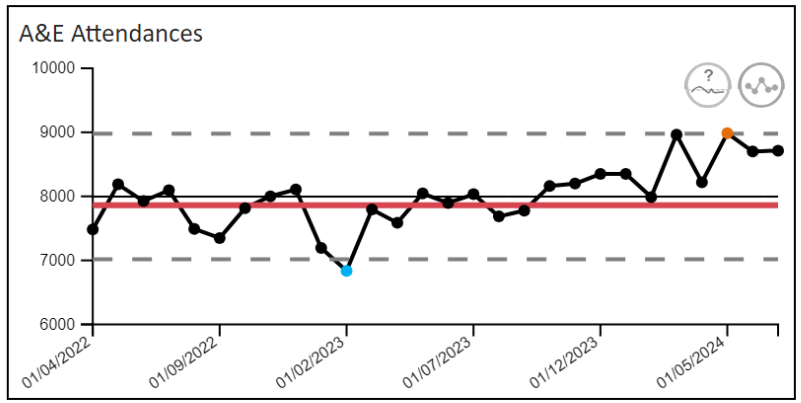
Activity

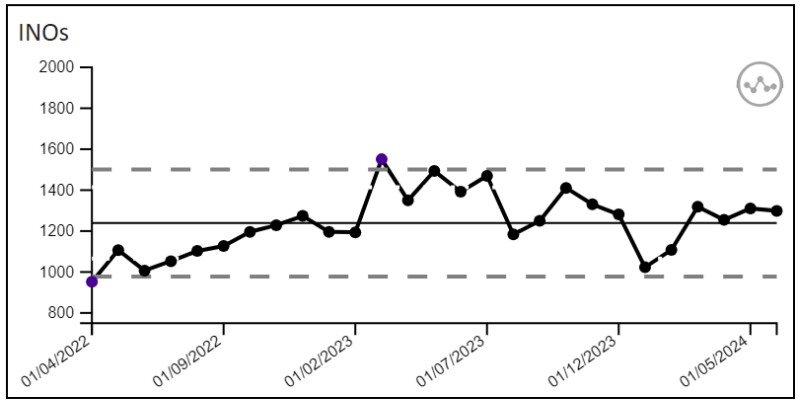
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
A&E Attendances	8,124	8,702	Jul-24	☒	?		-	S
INOs	-	1,360	Jul-24	-	-		-	S
Inpatients - Non-Electives (exc INOs)	-	2,631	Jul-24	-	-	H	-	C
Referrals	-	8,464	Jul-24	-	-	H	-	C
2ww Referrals	-	1,210	Jul-24	-	-		-	S
Outpatients New - Attendances	7,799	8,149	Jul-24	☑	?		-	S
Outpatients New - Procedures	911	1,120	Jul-24	☑	?	H	-	GI
Outpatients Follow Up - Attendances	15,984	17,297	Jul-24	☒	?		-	S
Outpatients Follow Up - Procedures	4,361	3,949	Jul-24	☒	?		-	S
Daycases (all, non ERF)	2,456	2,283	Jul-24	☒	?	H	-	GI
Inpatients – Electives (all, non ERF)	479	457	Jul-24	☒	F	H	-	GI

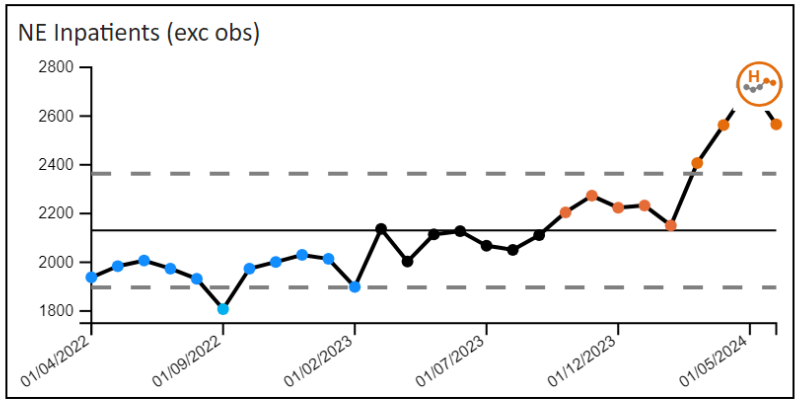
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

Subtheme: Non-Elective Activity

Metric	Value	Target	Exec Lead	Ops Lead
A&E Attendances	8,714	7,862	Sally Kilgariff	Jodie Roberts
INOs	1,299	-	Sally Kilgariff	Jodie Roberts
NE Inpatients (exc obs)	2,566	-	Sally Kilgariff	Jodie Roberts

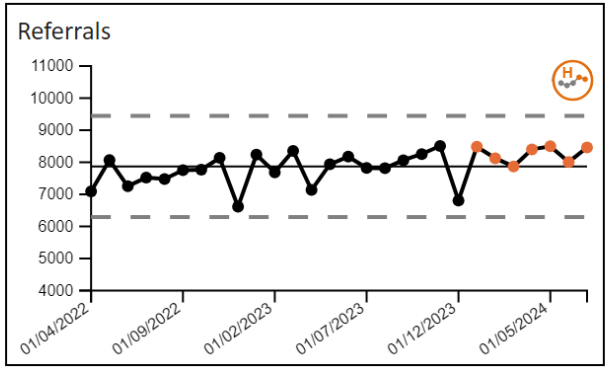


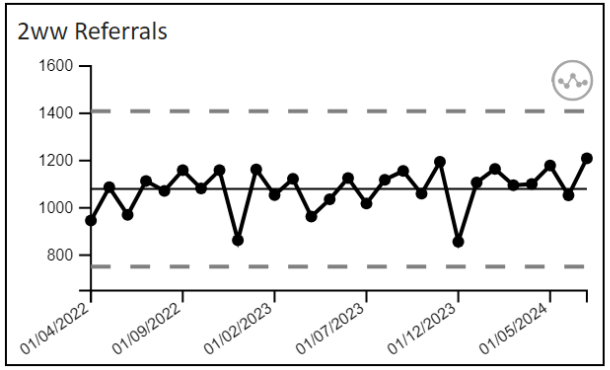


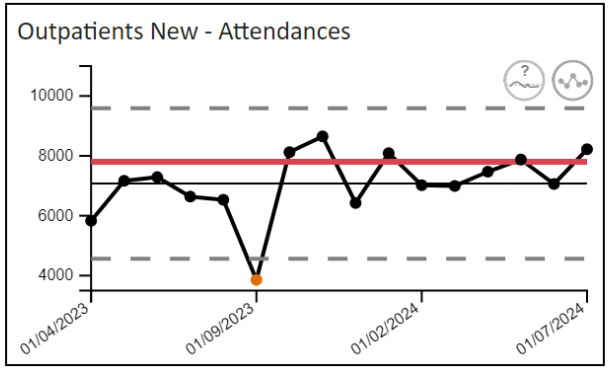


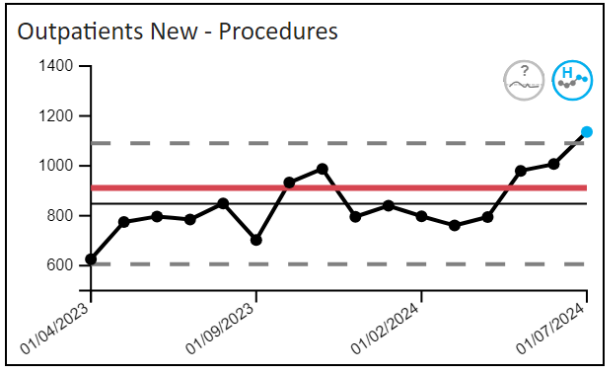
Subtheme: Outpatients & Referrals

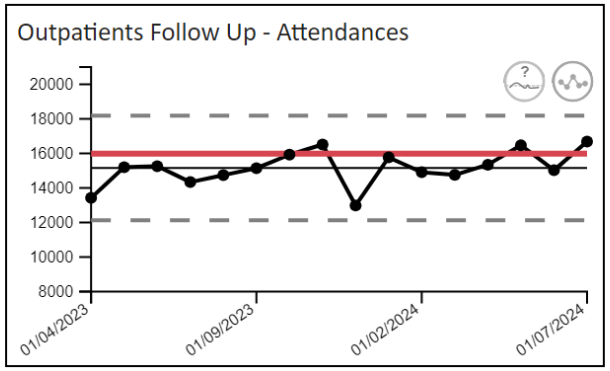
Data

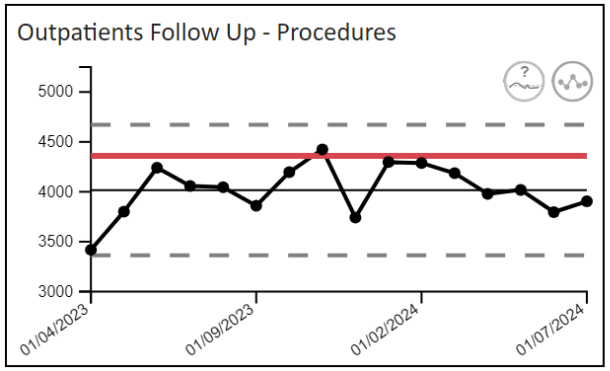












Metric	Value	Target	Exec Lead	Ops Lead
Referrals	8,464	-	Sally Kilgariff	Jodie Roberts
2ww Referrals	1,210	-	Sally Kilgariff	Jodie Roberts
Outpatients New - Attendances	8,219	7,799	Sally Kilgariff	Jodie Roberts
Outpatients New - Procedures	1,136	911	Sally Kilgariff	Jodie Roberts
Outpatients Follow Up - Attendances	16,680	15,984	Sally Kilgariff	Jodie Roberts
Outpatients Follow Up - Procedures	3,904	4,361	Sally Kilgariff	Jodie Roberts

What actions are planned?

- Additional internal sessions to increase Outpatient activity by September 2024.
- Continuation of existing insourcing schemes and exploring further insourcing /outsourcing opportunities to be in place by September 2024.
- Identified activity recording issues being addressed to ensure correct activity mapping and appropriate income is being recognised in ERF by September 2024 and backdated to April 2024.
- Increases in referrals need to be analysed in greater detail and a plan agreed to address issues/concerns

What is the expected impact?

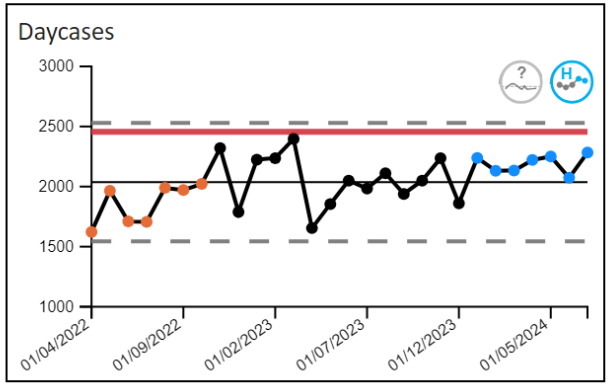
- Internal additional sessions and insourcing/outsourcing schemes will support delivery of 103% ERF target and contribute to improving the income position.
- Correction of activity recording issues will ensure activity is correctly aligned and the appropriate income is received.
- Early calculations indicate c£1m full-year-effect associated with revised recording of OPProcedures
- Referrals increasing above 19/20 levels will increase waiting times and waiting list numbers and insufficient capacity will be available to meet the increased demand

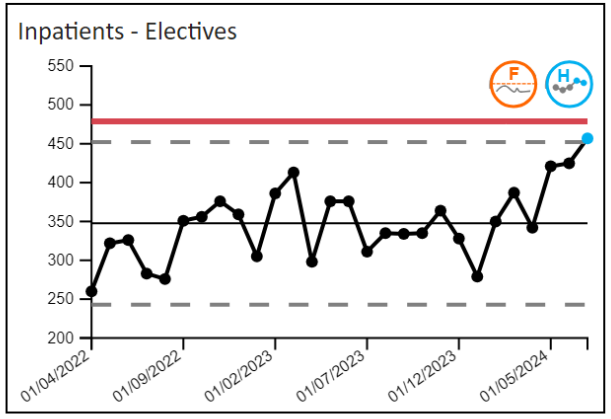
Potential risks to improvement?

- 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 underutilised, 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
- Commissioners fail to recognise overall increases in referrals

Subtheme: Elective Activity

Data, Context and Explanation





- Day case activity is slightly over performing against target in July.
- Elective activity has seen a real improvement year-to-date in comparison to 23/24 performance. Whist it remains slightly behind plan casemix looks richer representing patients presenting with increased/more complex co-morbidities or patients requiring more complex procedures
- Elective and Daycase performance is in the right direction and expected to continue improving as Capacity and Demand work gets underway

Metric	Value	Target	Exec Lead	Ops Lead
Daycases	2,283	2,456	Sally Kilgariff	Jodie Roberts
Inpatients - Electives	457	479	Sally Kilgariff	Jodie Roberts

What actions are planned?

- Additional internal sessions to increase Elective/Day case activity by September 2024.
- Continuation of existing insourcing schemes and exploring further opportunities to be in place during September 2024.
- Identified activity recording issues being addressed to ensure correct activity mapping and appropriate income is being recognised in ERF by September 2024 and backdated to April 2024.

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.
- Early calculations indicate c£1m associated with correction to recording of Planned Trauma.

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 underutilised, 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

Apr 24 to Jul 24

Key Headlines	Month			YTD			Forecast	Prior Month
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Variance £000s	Forecast variance £000s
I&E Performance (Actual)	(675)	(1,051)	(376)	(3,226)	(4,449)	(1,223)	(14,413)	(13,453)
I&E Performance (Control Total)	(613)	(1,006)	(393)	(2,979)	(4,219)	(1,240)	(14,428)	(13,453)
Efficiency Programme (CIP)	930	1,312	382	2,954	1,337	(1,617)	(6,133)	(8,157)
Capital Expenditure	1,088	529	559	2,256	1,017	1,239	0	0
Cash Balance	780	2,378	1,598	11,983	12,416	433	0	0

Performance Matrix Summary – People and Culture

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** • Turnover (12 month rolling)	**CONCERNING: CELEBRATE BUT TAKE ACTION**
Common Cause	**GOOD: CELEBRATE AND UNDERSTAND** • MAST - Core • MAST – Job Specific	**STATIC: INVESTIGATE AND UNDERSTAND** • Vacancy Rate (total)	**CONCERNING: INVESTIGATE & TAKE ACTION** • Sickness Rates (12 month rolling) • Sickness Rates • Appraisal Rates (12 month rolling)
Special Cause: Concern	**CONCERNING: INVESTIGATE AND UNDERSTAND**	**CONCERNING:INVESTIGATE & TAKE ACTION**	**VERY CONCERNING: INVESTIGATE & TAKE ACTION** • Appraisal Rates (12 month rolling)

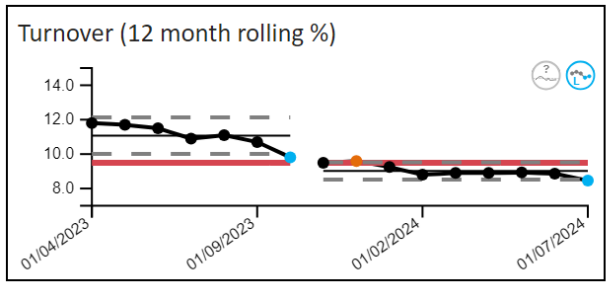
People and Culture

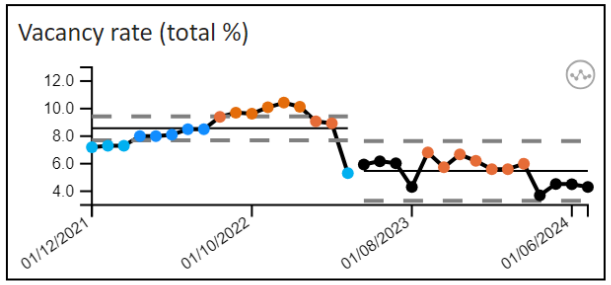
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
Turnover (12 month rolling %)	8.0-9.5	8.5	Jul-24	☑	?	L		G
Vacancy Rate (total %)	-	4.3	Jul-24	-	-		-	S
Sickness Rates (12 month rolling %)	4.8	6.0	Jul-24	☒	F		-	C
Sickness Rates (%)	4.8	6.0	Jul-24	☒	F			C
Appraisal Rates (12 month rolling %)	90.0	62.0	Jul-24	☒	F	L	-	VC
Appraisals Season Rates (%)	90.0	45.4	Jul-24	☒	F		-	C
MAST – Core (%)	85.0	91.2	Jul-24	☑	P		-	G
MAST – Job Specific (%)	85.0	88.8	Jul-24	☑	P		-	G

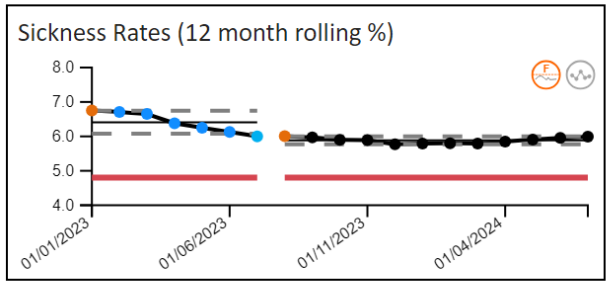
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

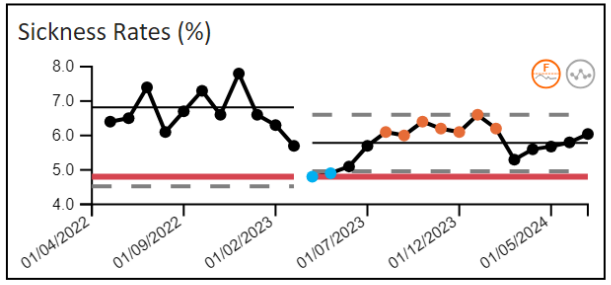
Subtheme: People

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 is in a strong position. A significant reduction was noted in May 23, down from 9% to 6%, recent trends indicate that may fall again to 4%.

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 %)	8.5	9.5	Daniel Hartley	Paul Ferrie
Vacancy rate (total %)	4.3	-	Daniel Hartley	Paul Ferrie
Sickness Rates (12 month rolling %)	6.0	4.8	Daniel Hartley	Paul Ferrie
Sickness Rates (%)	6.0	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?

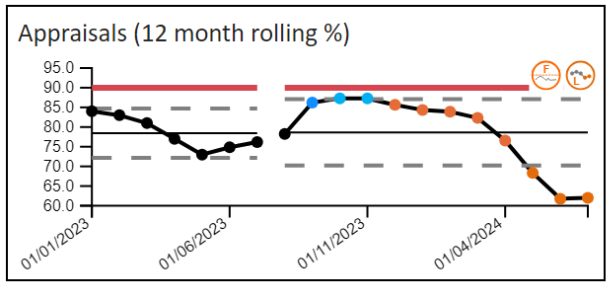
- Continued strong performance on retention and vacancy rates
- Improvement in sickness absence rates

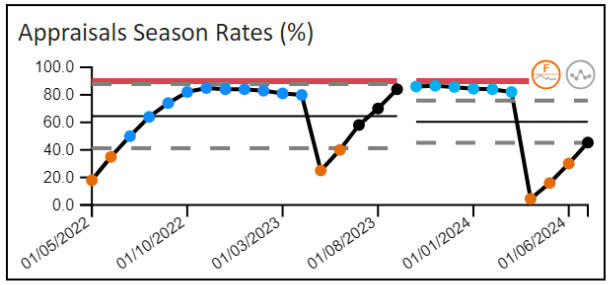
Potential risks to improvement?

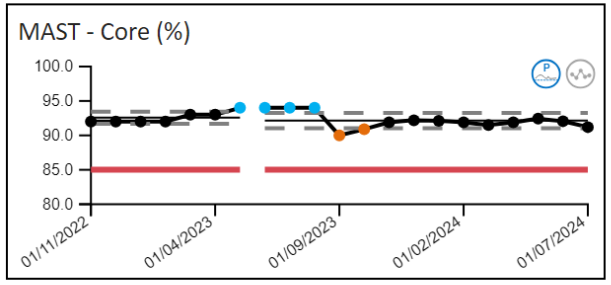
- Continued impact of ill-health of staff on attendance

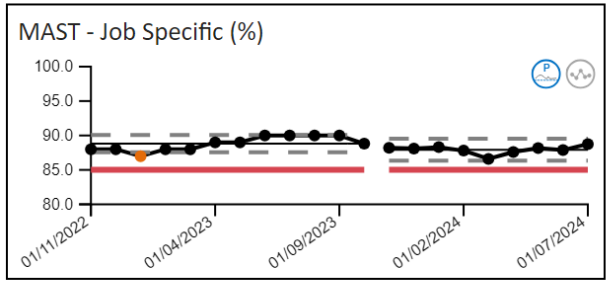
Subtheme: MAST & Appraisals

Data, Context and Explanation









Rolling 12 month appraisal performance has continues to reduce. 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. This is expected to show improvement in coming months.

New seasons appraisal completion rate performance is 45%, and is expected to improve as appraisal season progresses. 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 %)	62.0	90.0	Daniel Hartley	Paul Ferrie
Appraisals Season Rates (%)	45.4	90.0	Daniel Hartley	Paul Ferrie
MAST - Core (%)	91.2	85.0	Daniel Hartley	Paul Ferrie
MAST - Job Specific (%)	88.8	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

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

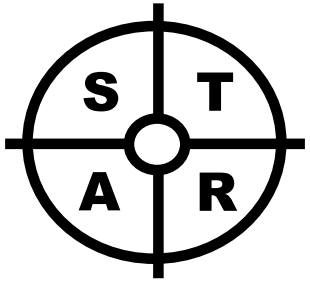
Assurance Icons

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):** This continues to be in common cause, with an average for the current period of 7.1 against a target of 7.3.
- **Mortality**: The Trust's SHMI has consistently remained in the desired "As Expected" band, out of the three SHMI categories (As Expected, Higher, or Lower), since July 2021.
- **C. difficile infections:** After a period of exceptionally high infections (April-May 2024), these have returned to common cause although they remain above target. These rates are reviewed monthly at Harm Free Care panels, with emerging themes pointing to antimicrobial stewardship and prescribing practices.
- **Friends and Family Test**: The Trust consistently achieves the target of 95% for this measure, with an average score over the past 18 months of 97%.

OPERATIONAL PERFORMANCE

- **Elective waits:** The Trust is in the first quartile for 65 week waits with just one patient at the end of July. 52-week waits are second quartile, although progress in reducing 52-week waits has been limited.
- **Cancer**: all three metrics (Faster Diagnosis, 31- and 62-Day Standard) were achieved in month for the second month in a row.
- **DM01**: performance against this metric is top in the country and has now been achieving against target since March 2024.
- **4 Hour Performance:** gains have been made against this metric with the past five months achieving above the mean, potentially indicating the start of a shift demonstrating a significant improvement.
- **21 Day Length of Stay:** this metric has shown a sustained improvement, and the reduction in patients staying longer than 21 days is ahead of plan. Patients with no criteria to reside, remain a challenge.
- **2 Hour Urgency Community Response**: this metric continues to achieve target and is expected to continue to do so, additionally the past four points are on an upward trajectory which may indicate the start of a trend demonstrating significant improvement.
- **Did Not Attend (DNA)**: the proportion of appointments where patients DNA continues to miss target and there may be opportunity for improvement as the Trust is in the third quartile.
- **Referrals**: there has been a sustained increase in the number of referrals leading to increased pressure on services.

PEOPLE AND CULTURE SUMMARY

- **Sickness absence rate:** performance is now broadly static following improvement during 2023/24 and as a result is 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. Other Trusts in SY have seen a deterioration in performance here and actions are being taken through the HWB and attendance programme to tackle this.
- **Appraisal rate completion:** continues to be below the target. Some of this is due to the knock-on impact of a slower than usual start to the appraisal season, the impact of industrial action etc. Care Groups and corporate teams are prioritising these to make further progress on both holding quality appraisals and recording them.
- **Retention performance:** continues to be strong and in within our target range.
- **Vacancy rate:** performance is a function of the relationship between retention, recruitment and establishment size, and is in a good position.

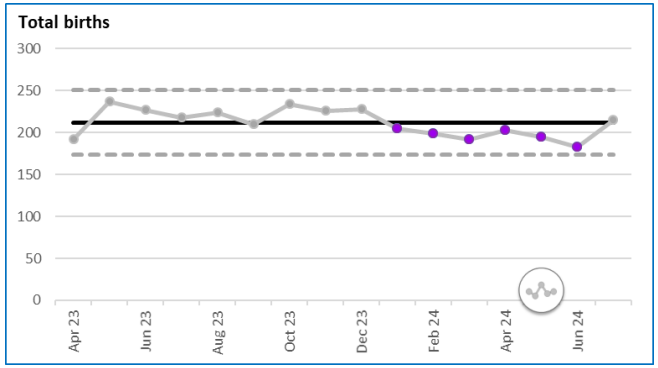
Board of Directors' Meeting
6 September 2024

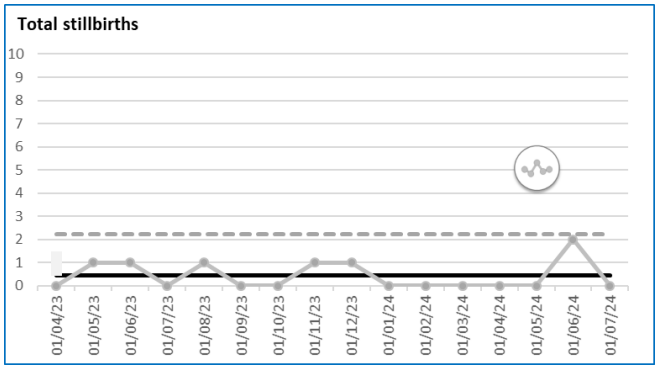
The Rotherham NHS Foundation Trust

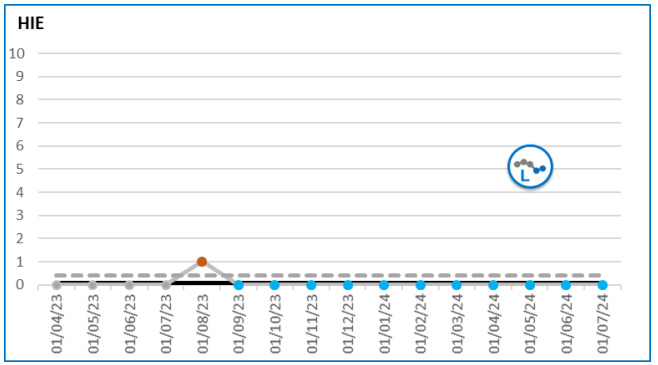
Agenda item	P140/24
Report	**Maternity and Neonatal Safety**
Executive Lead	Helen Dobson, Chief Nurse
Link with the BAF	P1: There is a risk that we will not embed quality care within the 5-year plan because of lack of resource, capacity and capability leading to poor clinical outcomes and patient experience for our patients.
How does this paper support Trust Values	High Standards for the services we deliver, aim to be outstanding, delivering excellent and safe healthcare.
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary	It is a national requirement for The Board of Directors to receive a monthly update on Maternity Safety, which goes through Quality Committee. This month's paper is a full maternity and neonatal safety report. • The Perinatal oversight maternity dashboard data is represented below in the Safety Statistical Process Control charts (SPC). The new data which has just been released from MBRRACE for 2022 can now be seen. • The Biannual Maternity and Neonatal Independent Senior Advocate (MNISA) report presented in the paper, sharing an overview of activity for TRFT and South Yorkshire. • There were x2 Patient Safety Investigation Incidents (PSII) declared in Maternity services in July 2024. • Maternity Incentive Scheme (MIS) Year 6 work and progress with the Saving Babies Lives care bundle is on track however, challenges for Maternity Incentive Scheme include anaesthetic attendance at the required training and pre-term births within Rotherham remaining over the 6% target • TRFT will begin to offer the RSV vaccination from the 1st of September 2024. Challenges have been identified around the extra resources required to deliver the programme to all eligible women. • The Avoiding Term Admission to the Neonatal Unit rate (ATAIN) increased in July to 9% with 20 babies admitted to the neonatal unit for further observation. Details include a theme of babies requiring increased respiratory support, IV fluid support and Transient tachypnoea of the newborn (TTN).
Due Diligence	This paper has been prepared by the Head of Midwifery and shared through Maternity and Family Health Divisional Business and Governance, the Maternity and Neonatal Safety Champions and Quality Committee

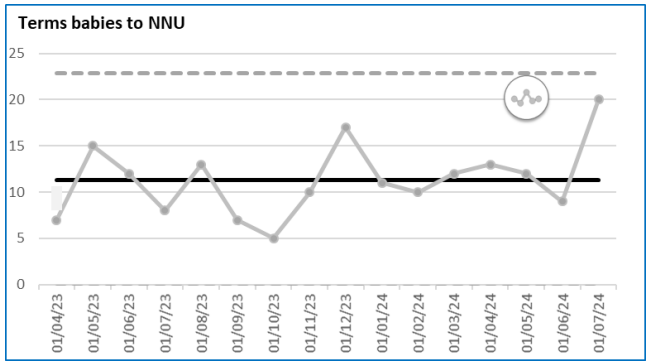
Board powers to make this decision	The Trust Board are required to have oversight on the maternity safety work streams.
Who, What and When	Helen Dobson, Chief Nurse, is the Board Executive Lead. The Head of Midwifery attends Quality Committee and Trust Board bi-monthly to discuss the Maternity and Neonatal Safety agenda.
Recommendations	It is recommended that the Trust Board are assured by Maternity and neonatal outcome data and update provided.
Appendices	1. Maternity and Neonatal independent Advocate Biannual report

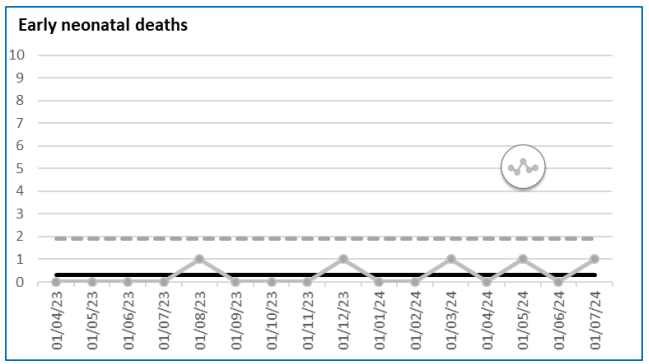
Maternity Safety Statistical Process Control charts (SPC)

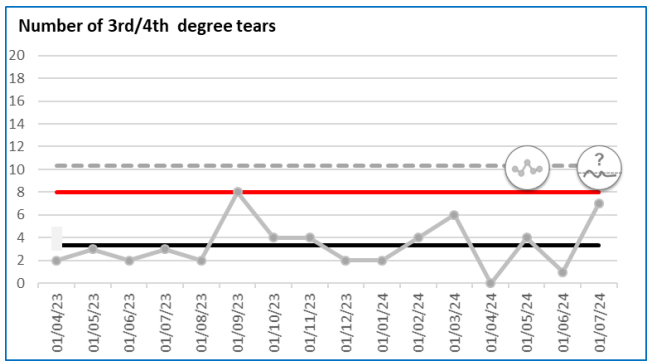


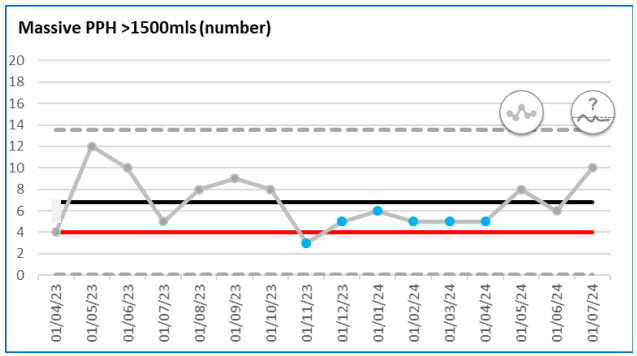


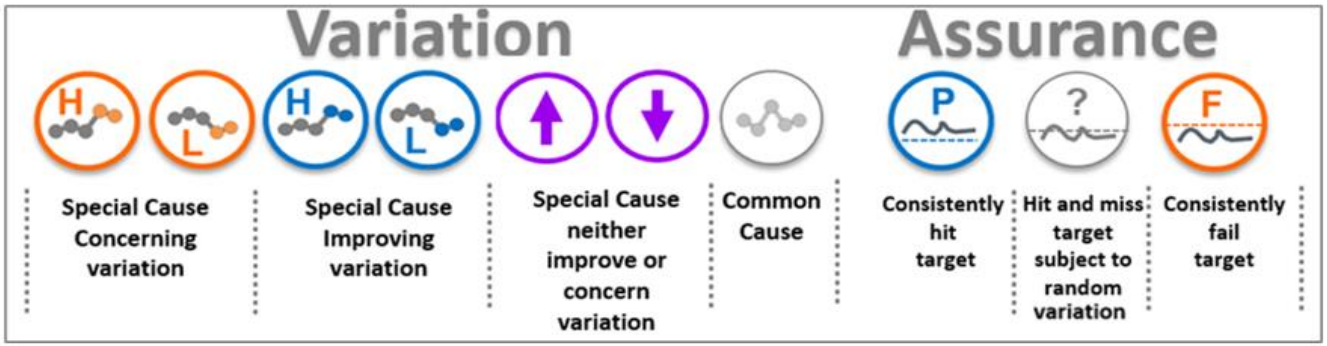












TRFT Maternity Dashboard: General

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Smoking at booking %	Jul 24	10.4%	6.0%			10.8%	4.8%	16.7%
Smoking at birth %	Jul 24	10.8%	6.0%		F	10.5%	6.3%	14.7%
Number of bookings	Jul 24	242	-			248	192	304
Booking < 13 weeks	Jul 24	90.1%	90.0%			89.9%	84.1%	95.6%
Booking < 10 weeks	Jul 24	70.7%	90.0%		F	71.6%	60.5%	82.7%
Personalised Care Plan	Jul 24	98.8%	95.0%			97.8%	94.7%	101.0%
Total Induction rate	Jul 24	37.5%	32.8%			37.7%	29.0%	46.3%
Augmentation IOL	Jul 24	33	-			42	22	62
Augmentation 1st Stage	Jul 24	12	-			14	-1	28
Augmentation 2nd stage	Jul 24	2	-			3	-1	7
Shoulder dystocia	Jul 24	1	2			2	-4	9
Massive PPH >1500mls (number)	Jul 24	10	4			7	0	14
Massive PPH >1500mls (%)	Jul 24	4.6%	2.0%			3.2%	0.1%	6.3%
Number of 3rd/4th degree tears	Jul 24	7	8			3	-4	10
3rd/4th degree tears in normal birth	Jul 24	2	-			2	-4	8
3rd/4th degree tears in normal birth (%)	Jul 24	1.8%	2.8%			1.8%	-3.4%	7.1%
3rd/4th degree tears assisted birth	Jul 24	5	-	H		1	-2	5
3rd/4th degree tears assisted birth (%)	Jul 24	26.3%	6.0%			7.2%	-17.1%	31.4%
Number of eclamptic fits	Jul 24	0	-			0	0	0
Pressure ulcers	Jul 24	0	-	L		0	-1	1
Optimal Cord Clamping	Jul 24	90.0%	-			90.1%	84.0%	96.2%
APGARS 0-6 @ 1 minute	Jul 24	13	-			11	-3	25
APGARS 7-10 @ 1 minute	Jul 24	202	-			200	165	234
Skin to skin	Jul 24	85.1%	80.0%			82.1%	72.3%	91.8%
Breastfeeding	Jul 24	60.3%	72.7%		F	59.8%	52.1%	67.5%

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.	June 2024 perinatal mortality meeting (PMRT) cancelled due to Dr's industrial action.	Review of Neonatal death, learning identified and an action plan has been formulated. See Narrative in point 4	Minutes and details pending				
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.	2 cases referred in June. 1 case referred to MNSI for baby requiring cooling. MRI shows no signs of HIE, therefore case rejected by MNSI. 1 case referred for a maternal death 1 case remains ongoing.	2 cases ongoing, same as previous months finding, still attempting to gain consent for MNSI to investigate recent maternal death.	1 ongoing case reported in April, report anticipated next month. Unable to gain consent for maternal death. Working with South Yorkshire advocate to continue to gain consent.				

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.	17 recorded as moderate. Following MDT X1 remained moderate and for further investigation x1 level of harm death for further investigation by MNSI.	In July there were 109 incidents logged of which 25 cases graded as Moderate – following review, all but one remained moderate.	Awaiting August data				
2b. Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training	All staff groups are over the required 90% compliance range. See point 7.0 in report.	Training compliance of Obstetric trainees has declined to below 90% due to new rotation of trainees. Training for all other disciplines is >90%	See section 12.2	90% for all disciplines with the exception of junior Doctors.	90% for all disciplines with the exception of junior Doctors. The new programme for obstetric Anaesthetists requires a full day MDT training from April 24	90% of all disciplines with the exception of junior doctors (89%) and anaesthetics. (28%). Plan in place.	90 % for all disciplines with the exception of Anaesthetic colleagues see section 11.1	No training in August 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	Doctor strike managed well with senior cover. No issues to escalate.	No staffing issues to escalate for the month of July 24.	August report in next month's paper				
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.	New MNVP substantive role recruited to. To start in Aug 24. Work plan reviewed with LMNS.	Parents and carer panel focus group feedback received from MNVPs. Narrative in report for August.	New MNVP lead now in post – to explore resources from Sand's and Tommy's to support Equality and Equality plan.				

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	No walk around in June. Planned for community 2nd July 24.	Community walk around with Board level safety champion – Narrative within Sept report.	Escalations to safety champion around the lack of theatre space for planned LSCS and around the ongoing NND case that will be heard by the Coroner				
5.HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil				
6.Coroner Reg 28 made directly to Trust	0	0		0	0	0	0	0				
7.Progress in achievement of CNST 10	Achieved	Achieved	Achieved	Achieved New standards began for 24/25	Ongoing	Ongoing	Ongoing	Ongoing				

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 the 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 MBRRACE-UK have published their annual *State of the Nation Report* (2024) in which the UK perinatal deaths of babies born in 2022 are published. The Statistical Process Control charts (SPC) (Table 2.2 below), has been updated to demonstrate how Rotherham Foundation Trust is performing against the ambition to half the rates of perinatal mortality from 2010 to 2025. The key national messages from this report are;

- Extended perinatal mortality (all stillbirths and neonatal deaths) rates decreased across the UK in 2022, after a rise in 2021.
- Compared to 2021, stillbirths in all nations of the UK, except Scotland, decreased in 2022.
- There was shown to be an increase in the neonatal mortality rates per 1000 live births in England and Wales compared to the 2021 data.

Table 2.1 show how TRFT compare with Trusts in the region for all extended perinatal deaths. Table 2.2 demonstrates our ongoing figures in comparison to national data.

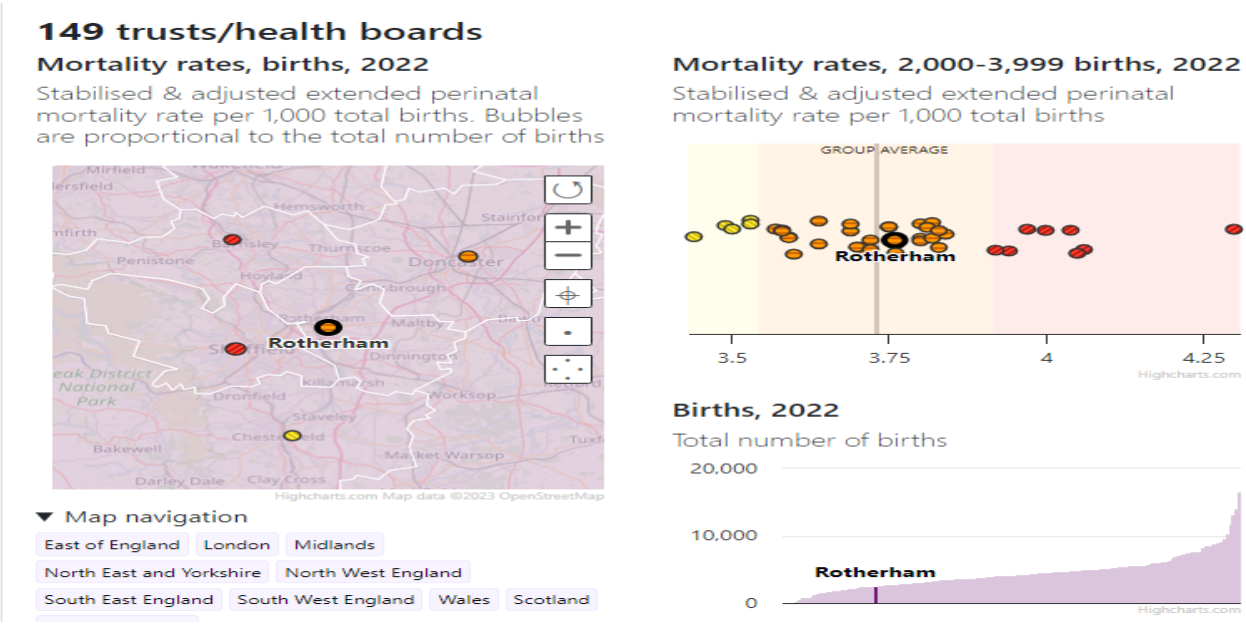
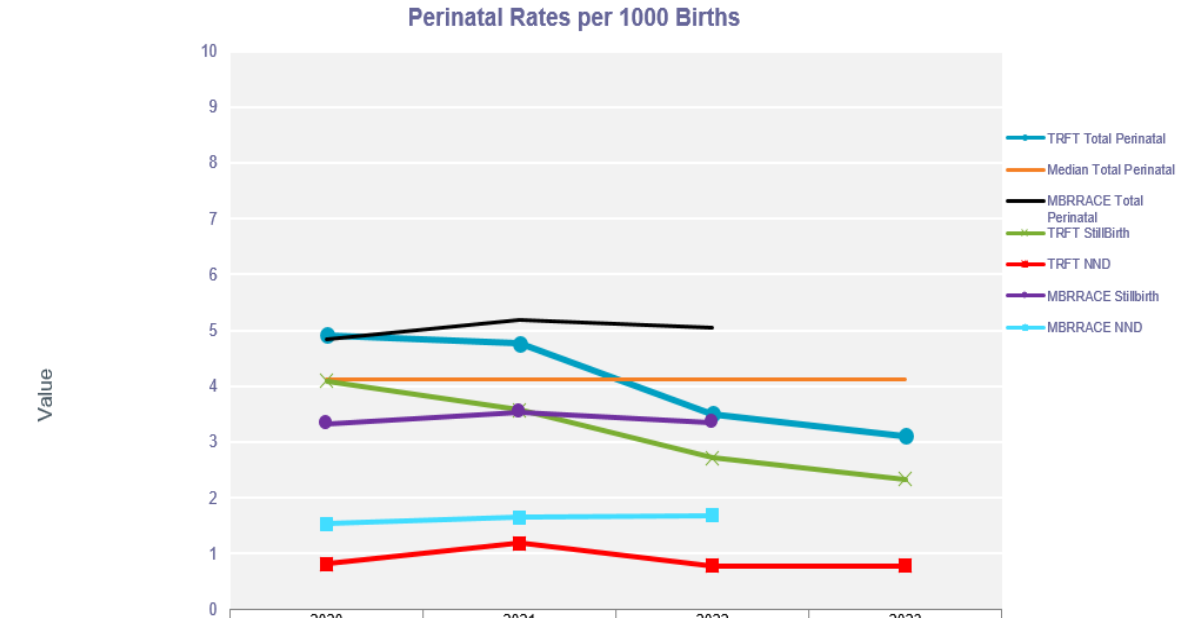


Table 2.1 TRFT in comparison to region

Within Table 2.2, it can be noted that the UK total perinatal death rate per 1000 births is 5.04 and TRFT data for the same time period of 2022 shows a rate of 3.5 per 1000 births. The national data also indicates that mortality for premature babies improved for all gestations within 2022 apart from babies born between 32 and 36 weeks gestation. Following a review of TRFT preterm births, this gestation makes up the largest gestation group of all pre-term babies. Quality Improvement (QI) work is ongoing to attempt to reduce all preterm births at TRFT. The TRFT annual perinatal review meeting is also planned for October 2024 in which all 2023 perinatal deaths will be reviewed with support from external partners.



	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
MBRRACE Total Perinatal	4.85	5.19	5.04	
TRFT StillBirth	4.09	3.57	2.72	2.33
TRFT NND	0.82	1.19	0.78	0.78
MBRRACE Stillbirth	3.33	3.54	3.35	
MBRRACE NND	1.53	1.65	1.69	

Table 2.2 Total perinatal deaths

3 Perinatal Mortality Summary for month of July 2024

3.1 A woman booked to birth at Doncaster attended TRFT maternity services at 27 weeks pregnant and birthed her baby with an emergency Caesarean section. This was an off pathway birth for TRFT (not born in the right level of neonatal unit for gestation), baby was transferred to the Sheffield Teaching Hospital (STH) and sadly died at 4 days of age. This case has been logged as a Patient Safety incident Investigation (PSII) by Doncaster and a PMRT and off pathway birth review will be undertaken and presented to the perinatal panel in due course with any learning shared.

3.2 A woman who had booked for her care at TRFT but attended the fetal medicine unit at Sheffield suffered a late fetal loss at 23/40 at STH. As the birth took place in Sheffield, this case is not presented within the table below.

3.3 Table 3.1 reports perinatal data from July 2024 in comparison to the last two years data as a rolling tracker.

	2022 Total:	2023 Total:	01/01/2024 – 30/06/2024	In Month: July 2024
Total Stillbirths (All)	7	6	2	-
Stillbirths >37 weeks	1	1	-	-
Stillbirths 24 - 36+6 weeks	6	5	2	-
Intrapartum Stillbirths	1	-	-	-
MTOP Anomaly >24 weeks	0	2	-	-
Adjusted Stillbirths	7	6	2	-
Total Neo-Natal Deaths (NND)	8	4	4	-
ENND >24 weeks up to 7 days of life	7	2	1	-
LNND 7-28 days	1	1	1	-
Adjusted Neonatal Deaths – All gestation (EXCL MTOP)	2	2	1	-
Total Adjusted Perinatal (24 wk – 28 days)	9	8	3	-
MTOP ENND	1	-	-	-
Stillbirth Elsewhere (booked at RFT)	0	-	-	-
Neo-Natal Deaths Elsewhere (outside of TRFT)	2	2	3	1
Maternal Deaths	0	1	1	-
NVF <24 weeks	12	10	8	-
NPMRT entered	12	10	5	-
NPMRT Closed	14	10	5	-

Table 3.1 TRFT perinatal deaths

3.4 The rolling figure of stillbirths and neonatal deaths from July 2023 to July 2024 are as demonstrated within Table 3.2 below;

Adjusted Perinatal Mortality (excludes deaths due to congenital anomalies and MTOP) **Adjusted Total Perinatal 2.79/1000 births**		
Type of death	**Number**	**Rate per 1000 births**
Stillbirth	**5**	**1.99**
Neonatal Death	**2**	**0.80**

Table 3.2 Adjusted perinatal deaths

4 PMRT Real Time Data Monitoring Tool

4.1 In July 2024 – August 2024, no new PMRT cases were closed, or reports published.

4.2 Following the reviewing of a neonatal death, a new LMNS Standard Operating Procedure (SOP) has been created and is currently going through the Local Maternity and Neonatal System (LMNS) governance to update the process of how cases are managed when parents request for a PMRT to be reopened.

4.3 Whilst there have been no themes or trends identified from this timeframe, learning from the PMRT case of the neonatal death which occurred on Christmas Day included, gaining an impact statement from the family to be used within the maternity MAST training to improve bereavement communication with families. A

detailed action plan has been created and will be shared via the Maternity and Neonatal Safety Champions meeting.

5 Maternity and New-born Safety Investigation (MNSI) formally known as Healthcare Safety Investigation Branch (HSIB) and Maternity Patient Safety Investigations (PSII)

5.1 Since the commencement of MNSI (formally HSIB) maternity investigations in 2018, TRFT have reported 23 cases for external review. Of the 23 cases, 9 were rejected, leaving 14 cases progressing to a full external investigation (Table 5.1).

5.2 One case is ongoing for a baby having seizures at 36 hours of age and abnormal head CT which occurred in March 2024. Staff interviews have taken place, and the report is expected to be published in September 2024.

5.3 A further case that was referred to MNSI in June 2024 was a maternal death which occurred in the same month. During the August MNSI Trust update, MNSI shared that they were planning to stand this case down due to a lack of response from the woman's partner. To date MNSI have been unable to gain consent to proceed with the external investigation. Consequently, TRFT maternity services are working with the Maternity and neonatal advocate to contact the family to support engagement and gain consent.

5.4 In Table 5.1 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	20/12/19	2 safety recommendations
1902	430	HIE/Cooling	13/03/20	No safety recommendations
1903	555	Maternal Death	03/02/20	No safety recommendations
1909	1185	HIE/Cooling	30/06/20	2 safety recommendations
1912	1509	HIE/Cooling	18/08/20	4 safety recommendations
2007	2295	HIE/Cooling	18/01/21	No safety recommendations
2009	2470	NND	01/04/21	3 safety recommendations
2101	2893	HIE/Cooling	20/07/21	6 safety recommendations
MI-00	3385	HIE/Cooling	18/10/21	No safety recommendations
MI-00	3662	NND	22/11/21	No safety recommendations
MI-00	5238	Stillbirth	24/05/22	1 safety recommendation
MI-00	28038	HIE/Cooling	22/02/24	No safety recommendations

Table 5.1 MNSI breakdown

5.5 Following the quarterly MNSI meeting with TRFT in which both national and local data is discussed and compared. Table 5.2 shows the national deprivation codes of cases referred for investigation. The high levels of deprivation of codes 1 and 2 triangulate with the TRFT data of moderate harms sustained by the women who use our service.

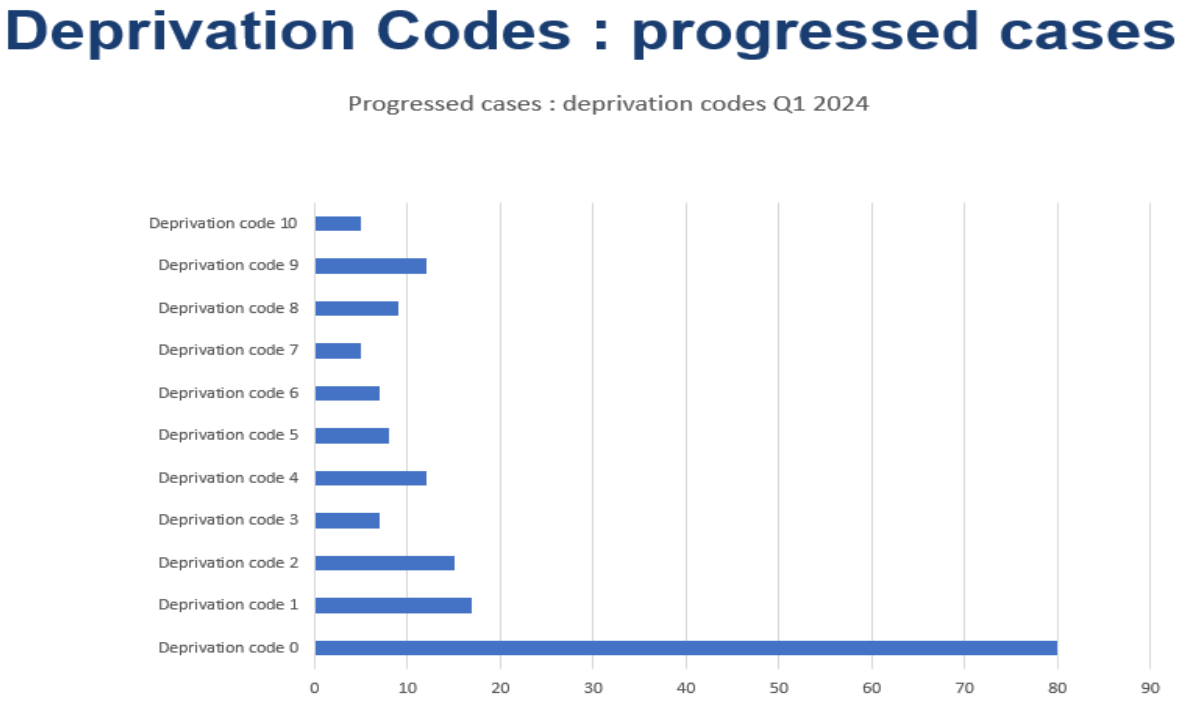


Table 5.2 MNSI deprivation

5.6 MNSI ongoing cases and progress (Table 5.6)

Ref	Case Ref	Type	Start date	Overview	Progress
167978	MI-037282	MNSI	22/04/2024	Pathological CTG. Seizures at 36 hours old with abnormal head CT and MRI.	Report expected in Sept 24
170988	N/A	MNSI	Pending	Maternal death following a cardiac arrest. Woman brought to UECC.	MNSI unable to gain consent from family. MNSI to archive at this time.

Table 5.6.

5.7 Following the maternal death in June 2024, (although a cause of death had not been concluded), a rapid review was undertaken, and some areas of improvement were identified and implemented. This included improving the Meditech documents in which staff calculate and record a VTE score and undertaking a VTE audit which has been shared at the clinical effectiveness meeting. Further work is ongoing with community midwifery teams to educate

women on taking thromboprophylaxis medication and recognising any signs which may suggest a VTE incident.

5.8 Table 5.7 illustrates the current PSII investigations been undertaken in maternity and neonatal services.

5.9 A review of all cases referred to the MNSI in 2023 to present demonstrated that all families have received full duty of candour along with information of the function and remit of MNSI. There has been one case referred to the NHS Resolution (NHSR) due to a possible HIE injury, however following investigation no HIE was diagnosed, therefore the family did not require information about the NHSR role and purpose as would normally be the case. Offering families involved in maternity incidents Duty of Candour, information of NHSR and MNSI are all a requirement of CNST year 6.

Ref	Type	Overview	Progress
172732	PSII	35/40 vaginal breech birth, traumatic birth with injury to baby.	Scoping and timeline development
172732	PSII	Bowel and bladder injury following LCSC	Scoping and timeline development
170822	PSII	IUFD: Scan pathway not followed	Draft in progress

Table 5.7

6 Coroner Regulation 28 made directly to Trust

TRFT Maternity have no Coroner Regulation 28 orders.

7 Learning from recent closed investigations cases

Table 7.1 highlights the closed PSII cases, and the learning identified.

Ref	Type	Overview	Learning
168816	PSII	29 day old death of a baby – overlay at home	All processes and guidelines were followed however, learning identified for improvements in documentation and communication between services.
164265	PSII (joint with CYPS)	28/40 preterm birth requiring extensive resuscitation.	Communication, triage calls, equipment. coroners' case.

Table 7.1

8 Below is an update on the 3 Year Delivery plan for Maternity and Neonatal services for July 2024

8.1 Listening to women: The LMNS Maternity and Neonatal Independent Senior Advocate (MNISA) has produced a bi-annual report which reviews the pilot of the service to date (Appendix 1). Within the report, data and themes are shared, Table 8.1, TRFT referrals can be seen in relation to other Trusts within the region.

Table 8.1 Regional referrals to MNISA

8.2 This new service has had a positive uptake of families at TRFT who are involved in either an MNSI case or a PSII investigation. The primary role of the MNISA is to offer unbiased, individual advocacy to families going through an investigation into the care they received.

8.3 The top three themes that have been found to be present in the cases the MNISA has been involved in within the region are:

- Communication (not understanding or being made aware of the plan of care for the baby.
- Bad news delivered in a way that was harmful to the parent.
- Communication, not involved in decision making/feeling coerced to make a decision.

8.4 Following a review of the last 12 months complaints the top three themes were midwifery care, medical care and staff attitudes. More detail can be seen in Table 8.4 as the narrative of these complaints. Within the 21 complaints from August 2023 to July 2024, often women felt that they were not listened to or that their choices were not considered. This aligns with the feedback within the MNSIA report and will be shared with the MNVP to continue to find co-designed solutions.

8.5 The level of complaints for the whole of the midwifery service from August 2023 to July 2024 as a percentage of the births equates to 0.84%. Whilst the service treats all complaints and concerns seriously, the ratio of complaints to births remains relatively low.

Complaint type	Number	Narrative, repeated words from complaints.
Midwifery Care	11	Not listened to, not believed, lack of explanation, Post traumatic stress disorder (PTSD)
Medical care	5	Poor level of care,
Attitude of staff	5	Not listened to, poor level of care, dismissive, not had a choice, lack of empathy

Table 8.4 August 23 to July 24 top themes and trends for complaints

8.6 Information shared by the MNISA will be shared with the new MNVP lead who has commenced in post in August 2024 to develop co-produced solutions to the themes identified.

8.7 Other information which can be triangulated with the MNSI data (Table 5.2) and the TRFT moderate harm data (Table 10.2), is the deprivation score of the women and families who have used the new advocacy service. Most cases that the MNISA is involved with have a deprivation score of 1 or 2. This evidence highlights that more focused work within the most deprived areas of Rotherham is required.

8.8 To support this the new vulnerabilities team named the Blossom Team are currently updating and creating an inclusion criteria for referral. This will be worked on with the MNVP to ensure that it reaches the most deprived areas of Rotherham.

8.9 The MNVP engagement with the CQC Picker Survey Action Plan

In July 24, the temporary MNVP lead undertook a focused panel group with parents and carers at the Rotherham United Community Trust. Topics discussed with the service users included reviewing the Best Start in Life Leaflet, reviewing the updated Personalised Care Plan document and exploring how the discharge process could be improved. Table 8.9 demonstrate the service user feedback that will be shared with the ward team to explore further and develop solutions with the MNVP.

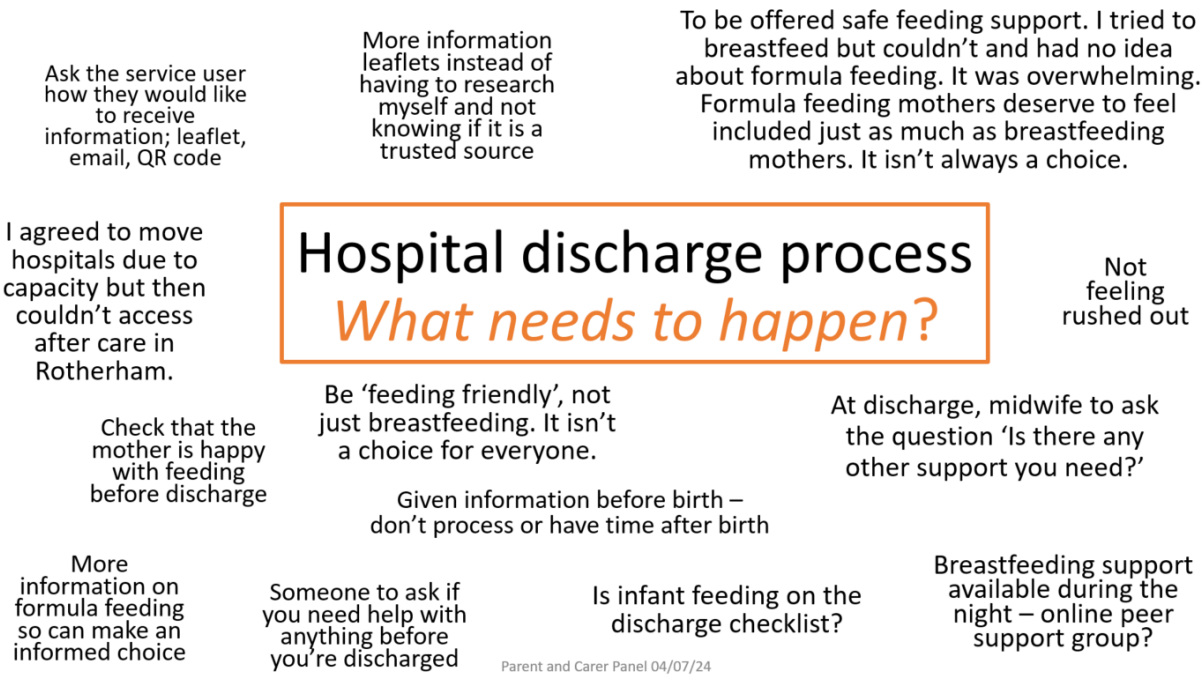


Table 8.9 Service user feedback of the discharge process

9 Developing our Workforce

9.1 The Maternity, neonatal and medical workforce requirements, continues to be monitored closely. Maternity and neonatal services undertake daily staffing huddles to assess acuity, flow and staffing gaps on the day and a weekly forward view. Further analysis will be presented in the biannual safer staffing paper in November 2024.

9.2 Midwifery staffing can be seen in Table 9.2. The maternity leave, long term sick and planned leavers result in the total gaps of 13.65 WTE for August 2024. NHSP is being used only when the gaps equate to above the designated headroom for sickness to maintain grip and control. The current budgeted establishment, which is in line with Birthrate+ shows an over recruitment of 0.48 WTE.

	2024/25								
Trajectory	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Contracted Vacancies	-3.24	-1.64	-0.48	-0.48	-0.48	-0.48	-0.48	-0.48	-0.48
Maternity leave	7.28	7.28	8.08	6.12	5.76	5.12	7.12	8.12	10.12
Long term sickness	2.64	3.80	4.12	7.08	4.56	0.00	0.00	0.00	0.00
Upcoming Leavers	0.00	0.20	0.00	0.00	3.61	4.41	5.37	5.37	5.37
Other - see detail	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20
Total Gaps	**6.88**	**9.84**	**11.92**	**12.92**	**13.65**	**9.25**	**12.21**	**13.21**	**15.21**
New Starters (reducing gaps)	0.00	-0.09	0.00	0.00	0.00	-0.64	-0.64	-1.44	-2.44
New Starters - students/NQM's	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-6.08	-6.08
Trajectory - for planning	**6.88**	**9.75**	**11.92**	**12.92**	**13.65**	**8.61**	**11.57**	**5.69**	**6.69**
% Workforce Gaps	**7.0%**	**9.9%**	**12.1%**	**13.1%**	**13.8%**	**8.7%**	**11.7%**	**5.8%**	**6.8%**

Table 9.2 Midwifery establishment

9.3 Future challenges can be seen with the projection of above 15.21 WTE total gaps for the month of December 2024. It is anticipated that the recruitment of 6.08 WTE Early Career Midwives (ECM) will reduce this gap to 6.69 WTE.

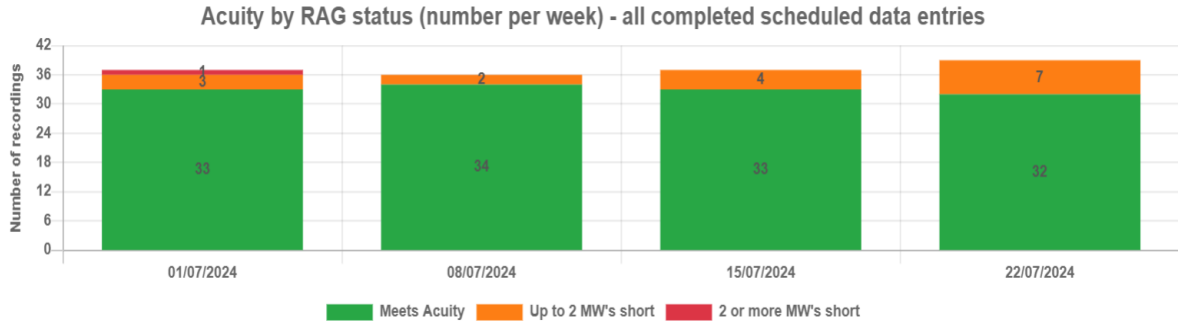


Table 9.3

9.4 Table 9.3 highlights the acuity data for labour ward for July 2024 and demonstrates that midwifery staffing met acuity 88% of the time, with 11% showing that the unit was short by up to 2 Midwives and that on 1% of occasions, more than 2 midwives were needed to meet acuity, 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%.

9.5 Medical workforce locum covers can be seen in Table 9.4 as of July 2024 along with the reasons for the requirement.

Grade of Dr	No of shifts	Reason	Internal/External
ST1/2	14	4 x Reduced duties 1 x Strike 2 x Emergency 1 x Carers leave 6 x Vacancy	14 internal
ST3/7	26	17 x Vacancy 6 x Additional Theatres 2 x Strike 1 x Additional clinic	26 Internal
Consultant	52	17 x Annual/Study/Carer Leave 15 x Additional clinics 7 x Additional Theatres 7 x Vacancies 1 x Strike 3 x Sickness Absence 2 x Reg on-calls stepping down	52 internal

Table 9.4 Medical vacancies

9.6 Table 9.5 below represents July 2024 workforce data. Sickness rates have increased, absence is managed in line with the sickness and absence policy. 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)	1	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	6.04%	July 24 data, 1.79% short term 4.25% long term
Obstetric compliance at mandatory consultant escalation	100%	No Datix incidents reported
Compliance with twice daily face to face ward round	100%	Datix

10 Developing a Safety Culture

10.1 Training has been arranged for a large group of staff of all levels and disciplines involved in maternity and neonatal care, including anaesthetic staff and Trust solicitors to attend the UK Birthrights training. The half-day session will be delivered to 50 staff members and cover following topics:

- To ensure all participants understand where human rights come from and how they apply to maternity care.
- To ensure all participants understand the implications of Montgomery v Lanarkshire, and other legal cases that are relevant to consent and informed choice.
- To ensure all participants have the opportunity to put this understanding into practice by working in small groups looking at real life cases with women and birthing people.

10.2 The new Freedom To Speak Up Guardian will be attending the next Maternity Leadership meeting to share how her role can be used within the unit.

10.3 Dr Rumit Shah Non-Executive Director (NED) has commenced in his new role as the Maternity and Neonatal Safety Champion and attended his first meeting with

the wider team in August 24. This is a welcomed appointment and escalations have already been made from the staff to the NED around theatre capacity for elective LCSC and around the planned Coroners case which is a neonatal death from December 2023. The case has been investigated as a PSII and reviewed via the PMRT process in July and August 2024. Learning has been identified and an action plan has been developed to support the learning from this incident.

10.4 Quality Improvement work continues to achieve the Year 6, CNST 10 standards. Table 10.4 displays the current compliance of TRFT.

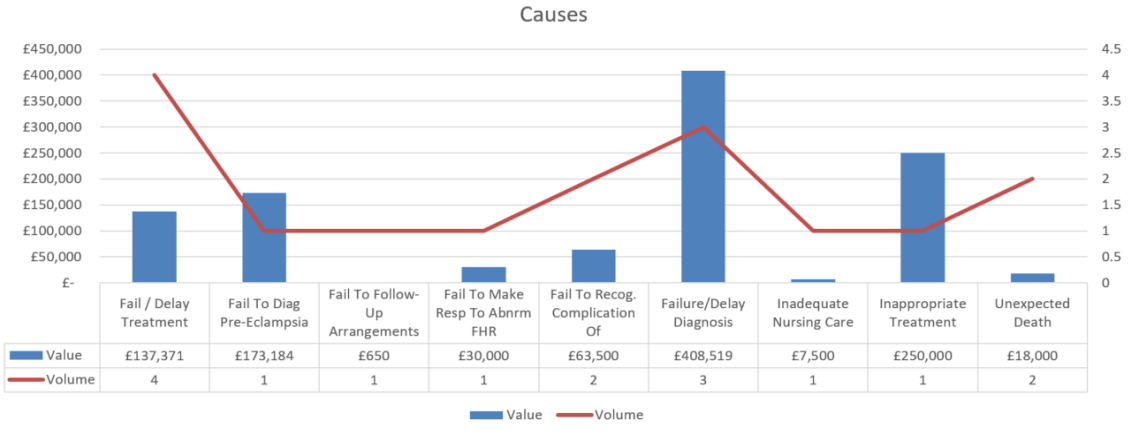
No	Safety Action	Compliance	Progress/Challenges
1	PMRT		Compliant up to August 2024
2	Digital		Achieved full compliance – all 10 data quality requirements passed.
3	Transitional Care		QI work continues, no challenges anticipated
4	Clinical workforce		Awaiting further Medical workforce audit
5	Midwifery workforce		Complaint up to August 2024
6	Saving Babies Lives V3		Progress has been demonstrated to the LMNS each quarter. Next review due in September 2024
7	MNVP – working with families		New LMNS chair person in post as of August 2024, no challenges anticipated
8	Training		Challenges around Anaesthetic attendance at training due to capacity
9	Board assurance		All processes in place
10	HSIB compliance		Compliant up to August 24

Table 10.4 CNST current compliance

10.5 Following a further review of the Obstetric legal scorecard, we have reviewed the data from complaints and Datix to triangulate with the information from claims. Within Table 10.5, it can be seen what the top themes were along with the monetary cost to the Trust in 2023, the top three causes were a failure to recognise and diagnose, a failure to recognise a complication and inappropriate treatment.

CNST 2023 - Obstetrics

NHS Resolution



	Fail / Delay Treatment	Fail To Diag Pre-Eclampsia	Fail To Follow-Up Arrangements	Fail To Make Resp To Abnrm FHR	Fail To Recog. Complication Of	Failure/Delay Diagnosis	Inadequate Nursing Care	Inappropriate Treatment	Unexpected Death
Value	£137,371	£173,184	£650	£30,000	£63,500	£408,519	£7,500	£250,000	£18,000
Volume	4	1	1	1	2	3	1	1	2

Table 10.5 Rotherham Claims Scorecard

10.6 The top themes for Datix's within obstetrics for a clinical incident were; admission to the NNU or re-admission for Jaundice to the postnatal ward, undiagnosed small baby, and post-partum haemorrhage. The top themes from complaints is expressed in Table 8.4. Whilst no clear link has been made between Datix, complaints and the legal score card, it could be assumed that listening to women better and focusing care for the most deprived may still improve all aspects of the maternity risk data.

10.7 In response to the top Datix themes, TRFT are involved in a national research project exploring post-partum haemorrhage (PPH) improvements and a thematic review will be commenced to gather data on this issue. Saving Babies Lives V3 has a workstream looking at the improvement of small babies and a QI project is underway looking at avoiding term admission called the ATAIN project.

10.8 From an overall legal perspective TRFT Maternity are placed within the area of best claims experience relative to levels of activity. Table 10.8 shows Rotherham as the purple dot towards the green line.

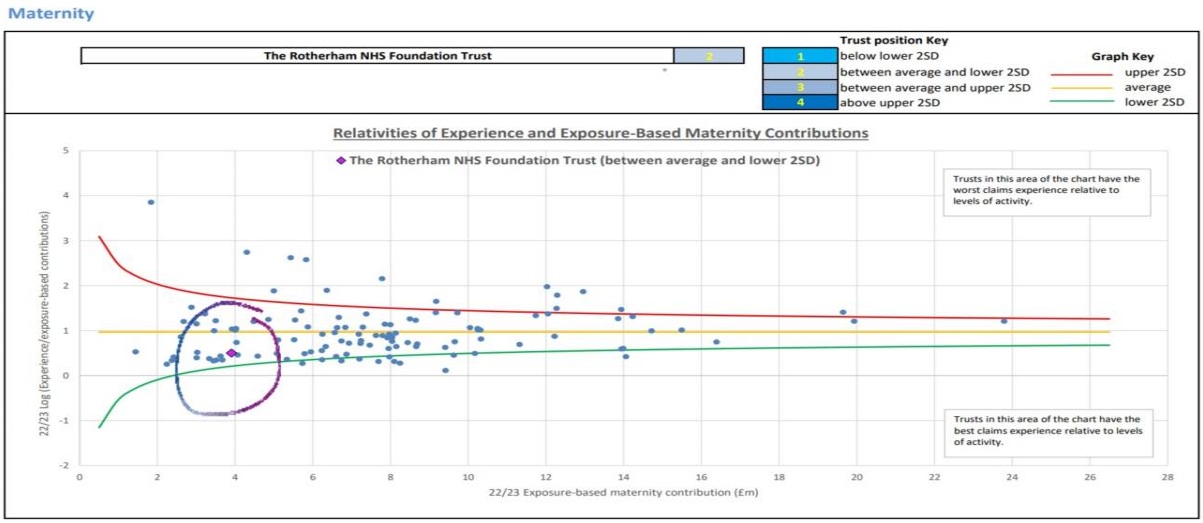


Table 10.8 TRFT in comparison to other Trusts for best claims experience

10.9 Table 10.9 highlights the number of women who suffered a moderate harm in the month of July 2024. In July there were 25 incidents reported as a moderate harm. All cases have been examined at the Maternity Weekly Datix meeting by a senior MDT. Following MDT review x2 case remained moderate and are to be investigated as PSII investigations as highlighted in table 5.7. Deprivation and ethnicity scores have been collected for this group (Table 10.10. 10.11) and show that for July, poorer outcomes were sustained by the women who live in the poorest areas of Rotherham and were white British.

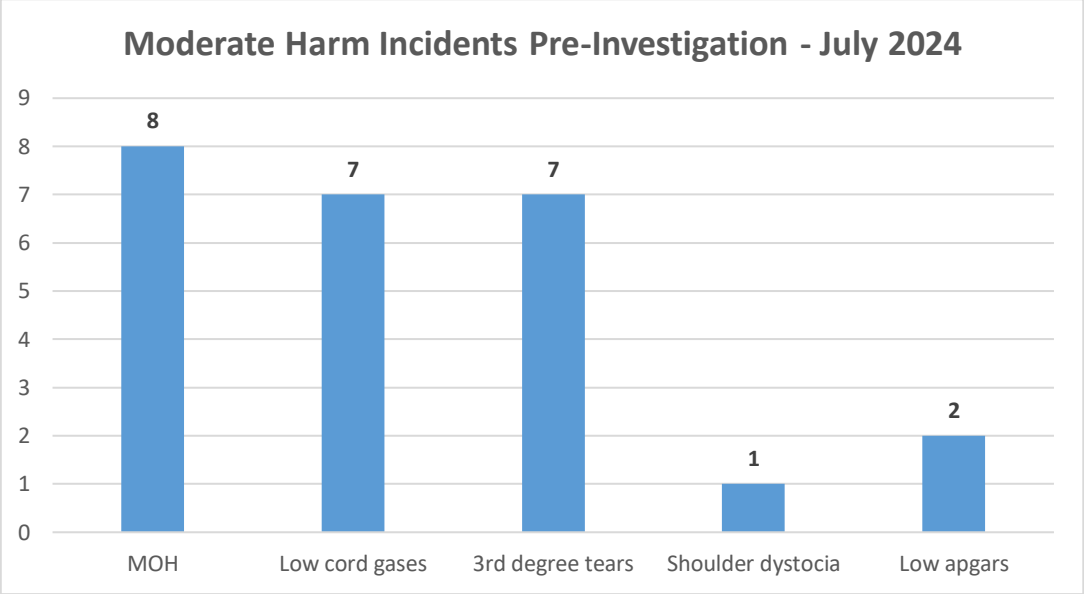


Table 10.9 Moderate harms in maternity

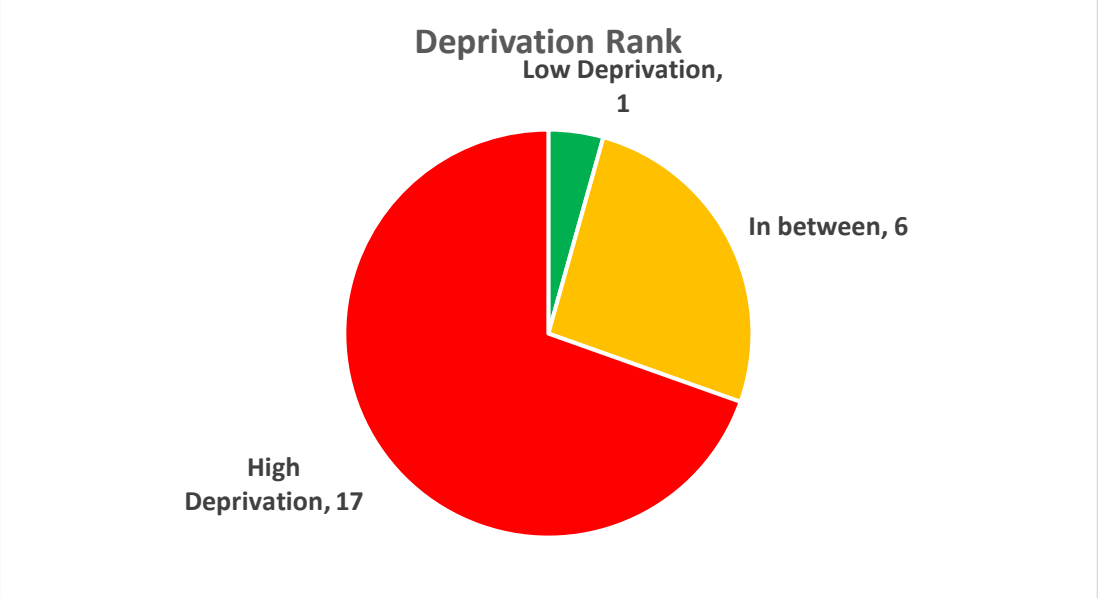


Table 10.10 Women's deprivation of moderate harms suffered

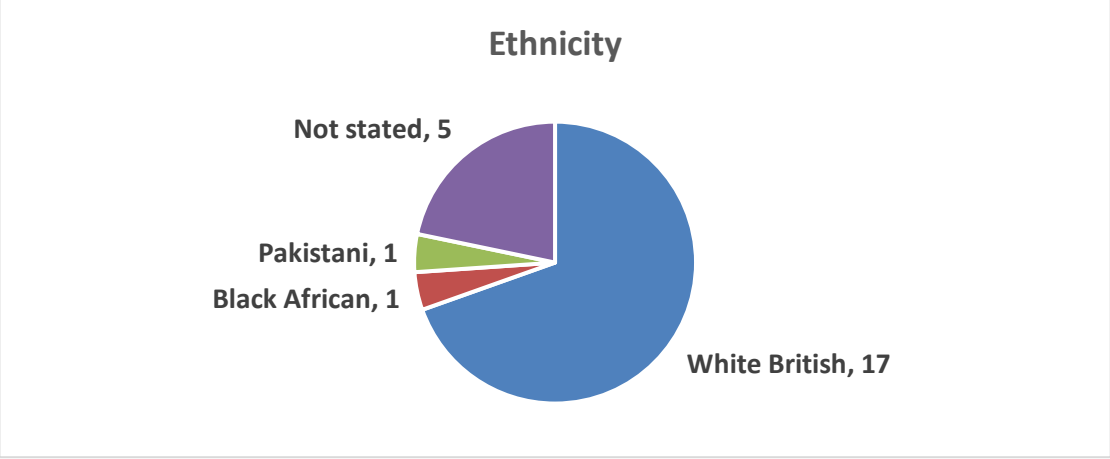


Table 10.11 Ethnicity of women who suffered moderate harms

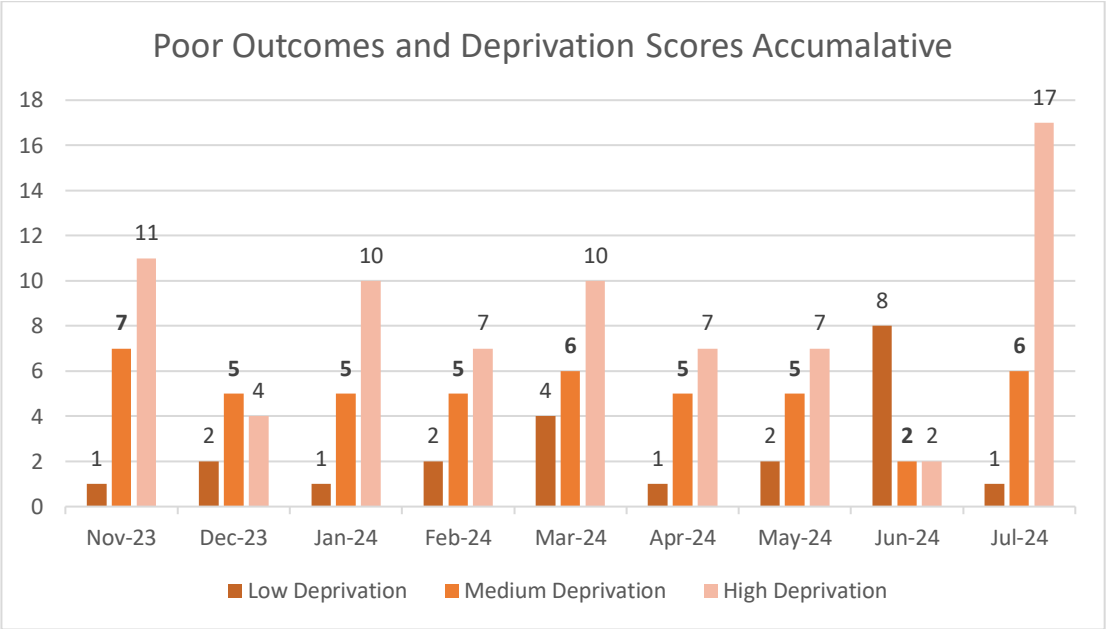


Table 10.12 Ongoing surveillance of derivation scores and moderate harms

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

11.1 The Division continues to work towards the three-year core curriculum local training plan (Table 11.1), which has had input from service users (MNVP) to create its content 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:

11.1.1 Fetal Monitoring training

11.1.2 Multiprofessional Maternity emergencies

11.1.3 Neonatal life support training

MATERNITY DASHBOARD DATA Post Mast July 24 Total Compliance	Obstetric Consultants	Obstetric Registrars (ST3-7)	Obstetric Trainees (ST1-2)	Midwives (All bands)	NHSP Midwives	Clinical Support staff	Obs Anaes	Non Obs Anaes
Module 3: PROMPT (has attended day within last 12months)	100%	100%	100%	96%	100%	95%	40%	84%
Module 6: NLS *SCBU staff and paediatric staff reported on separately	92%	93%	100%	88%	100%	89%	N/A	N/A

Fetal Monitoring training for July 24	Midwives (including NHSP)	**98% compliance**

	Obstetric career SHO/Registrars and Ob Cons	**100% compliance**

Table 11.1 PROMPT, NLS Training and Fetal monitoring training**.**

11.2 Challenges remain around gaining the 90% target expected for CNST remains with the anaesthetic teams being able to attend the PROMPT full day of training. Work is ongoing with the Clinical Lead for anaesthetics to plan training to meet the end of November 2024 deadline. Work is also ongoing to more accurately record the neonatal medical team's compliance with the Newborn Life Support (NLS) guidance and review training packages to ensure that this meets the Year 6 CNST standards for neonatal resuscitation.

12 Saving Babies Lives V3 (SBLV3)

12.1 In June 2024, a fourth LMNS assessment to review the TRFT's evidence of compliance for SBLV3 was undertaken. The evidence reviewed was for quarter 4 of 2023/24 and each of the 6 elements were presented to the visiting panel as assurance of progress. To achieve Year 6 CNST standard 6, evidence of continual improvement towards meeting the 100% achievement of the whole of the 6 elements must be demonstrated. Table 12.1 demonstrates TRFT's progression since the beginning of the implementation timeframe.

	Baseline Assessment	Assessment 1	Assessment 2	Assessment 3
Review Quarter	**Q1 23/24**	**Q2 23/24**	**Q3 23/24**	**Q4 23/24**
Assurance Review Date	**25/09/23**	**19/12/23**	**26/03/24**	**27/06/24**
Element 1	20%	90%	90%	90%
Element 2	20%	65%	95%	100%
Element 3	50%	100%	100%	100%
Element 4	40%	80%	100%	100%
Element 5	26%	67%	85%	93%
Element 6	33%	67%	67%	67%
TOTAL	26%	71%	89%	93%

Table 12.1, TRFT progress for SBLV3

12.2 Remaining challenges for the outstanding actions include:

- Element 1 (Reducing smoking) Fully implementing the Very Brief Advice training to all women facing practitioners.
- Element 5 (Pre-term) Medical job plans still required funding and operationalising. Since the review in Q4, the funding has been identified and job plans are being updated.
- Element 5 (pre-term) Preterm birth rates remain above the target of 6%. QI work continues. Regionally this remains a challenge and pre-term interventions require, whilst showing improvements but need to remain consistent.
- Element 6 (Pre-existing diabetes) The recruitment of a Diabetic specialist nurse recruitment was an issue as whilst the role was out to advert, following the first interviews, no appropriate candidate was found. Since the inspection, this has now been recruited to.

12.3 The next LMNS assurance visit is planned for September 2024 where a further improvement will be demonstrated towards the 100% implementation target.

13 Avoidable Admission into the Neonatal Unit (ATAIN)

13.1 Term admissions into the neonatal unit for the month of July 2024 (Table 13.1) have seen a sharp rise in numbers with 20 cases being admitted for further observation. Details include a theme of babies requiring increased respiratory support, IV fluid support and Transient tachypnoea of the newborn (TTN). Work is underway to undertake an MDT review of all cases to ensure that none of the cases were avoidable and any learning will be added to the TRFT rolling action plan which is assisting work to keep term admissions below the 6% target. Action plans are also shared with the LMNS and within the Safety Champion meetings locally.

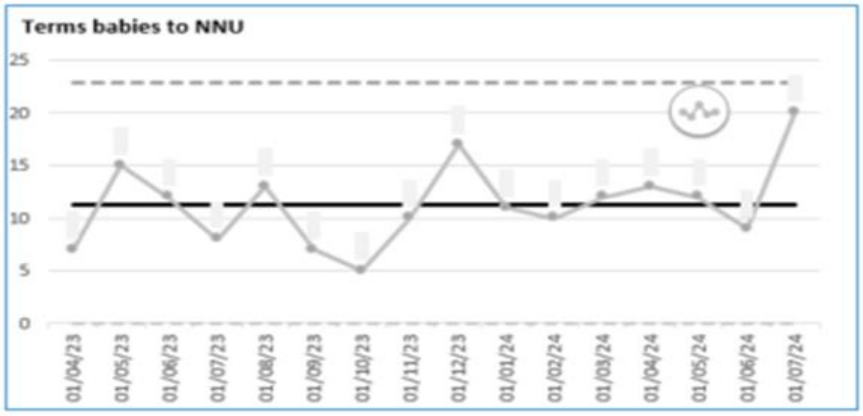


Table 13.1 Term admissions to the NNU

14 Respiratory Syncytial Virus (RSV) Vaccination Programme.

14.1 From 1 September 2024, pregnant women can have a free vaccine in each pregnancy, to protect their babies against respiratory syncytial virus (RSV). RSV is a common virus which can cause a lung infection called bronchiolitis. In small babies this condition can make it hard to breathe and to feed. Most cases can be managed at home but around 20,000 infants are admitted to hospital with bronchiolitis each year in England. Infants with severe bronchiolitis may need intensive care and the infection can be fatal. RSV is more likely to be serious in very young babies, those born prematurely, and those with conditions that affect their heart, breathing or immune system.

14.2 All women who are at least 28 weeks pregnant on 1 September 2024 should be offered a single dose of the RSV vaccine through commissioned services. From this time, pregnant women will become eligible as they reach 28 weeks gestation and will remain eligible up to birth.

14.3 Most vaccinations will be delivered by commissioned provider trusts. General practices will also be commissioned through the GP contract, as an essential service, to offer and provide RSV vaccination in pregnancy on an opportunistic or on-request basis from 28 weeks of pregnancy. It will be important that all pregnant women are aware of their eligibility and are offered vaccination against RSV as part of their routine care.

14.4 TRFT have begun to work on costing the roll out of the new vaccination and offer this to all women who are eligible. Currently, minimal funding is available to support the administration of the vaccination which will be offered from the Antenatal Greenoaks clinic one day a week. The uptake of the vaccination will be monitored and further offers of funding are being explored to increase the current availability of administration.

14.5 A SoP is currently being developed to aid staff to record and recall women who may have previously refused the vaccine and to document when the vaccine has been administered.

15 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.	

16 Red Risks/Risk register highlights

There are currently no Obstetric risks graded over Moderate 12. There are 11 risks graded at Moderate 12 for Obstetrics.

17 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
6 September 2024

The Rotherham NHS Foundation Trust

Agenda item	P141/24
Report	**Quality Assurance Report (including Care Quality Commission)**
Executive Lead	Helen Dobson, Chief Nurse
Link with the BAF	P1: There is a risk that we will not embed quality care within the 5-year plan because of lack of resource, capacity and capability leading to poor clinical outcomes and patient experience for our patients.
How does this paper support Trust Values	Ambitious – The Trust is working to achieve a CQC rating of Good and beyond. Caring – The Trust is working to achieve a CQC rating of Outstanding for the Caring Domain Together – The Trust is working together with senior leaders, clinical teams and external stakeholders to deliver safe, high quality care for the population of Rotherham
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	During the last year there have been a number of changes made in the way that we are assured of the quality of care being delivered at TRFT. This paper sets out the structure behind the assurance process. Going forward, this quarterly report will provide updates across all domains outlined in this report for completeness.
Board powers to make this decision	N/A
Recommendations	It is recommended that the Trust Board: • Note the content of the Report • Note the progress made in progressing the Quality Assurance Programme • Support the proposal to develop a Clinical Quality Strategy
Appendices	None

1. Introduction

1.1 The purpose of this paper is to provide assurance of clinical quality in TRFT. To achieve this, a Quality Management System (QMS) structure will be used, supported by a Quality Strategy. The QMS aims to enhance patient care, improve operational efficiency, and foster a culture of excellence and continuous improvement.

1.2 A QMS in the NHS refers to the structured system of processes, procedures, and responsibilities for achieving quality policies and objectives. It helps ensure that the NHS delivers high-quality healthcare services that meet patient needs and comply with regulatory requirements.

1.3 Key components typically include:

- Policy and Planning - Establishing quality policies and objectives aligned with the overall mission and goals of the NHS.
- Process Management - Defining and managing processes and procedures to ensure consistency and quality in service delivery.
- Documentation - Maintaining comprehensive documentation of processes, procedures, and quality standards.
- Training and Competence - Ensuring staff are properly trained and competent to perform their roles effectively.
- Monitoring and Measurement - Regularly measuring performance against established quality standards through audits, feedback, and key performance indicators.
- Continuous Improvement -Implementing mechanisms for continuous improvement based on performance data, patient feedback, and incident reports.
- Risk Management - Identifying, assessing, and mitigating risks to patient safety and service quality.
- Compliance - Ensuring adherence to relevant laws, regulations, and standards, such as those set by the Care Quality Commission (CQC) in the UK.

1.4 This paper will set out the process and structure for delivering each of the components above along with the relevant assurance for Q1. The quarterly Quality Assurance paper will continue to follow this format in 2024/25 to provide an up to date position and details of any mitigations or risks.

2.0 Policy and Planning

2.1 A Quality Strategy is in the early stages of development to drive quality governance, assurance and improvement. This will be shared with the Quality Committee for approval in Q3, following development through the Quality Committee workshop.

2.2 There are two Quality of Care objectives included in the Trust Operational Priorities for 2024/25:

- Deliver care that is consistent with CQC ‘Good’ by the end of 2024/5
- Ensure improved performance of at least one quartile in the national inpatient and UECC patient experience surveys

2.3 There are three Quality Priorities for 2024/5:

- Diabetes Management

- Acute Pain Management
- Frailty Assessments

2.4 Progress against the Operational and Quality Priorities is reported to Quality Committee through highlight reports on a quarterly basis. The focus in Quarter 1 has been establishing baseline positions, setting up Task and Finish groups and agreeing appropriate actions. At the end of Quarter 1, progress is on track with mitigations in place for any identified risks to achievement.

2.5 Further work to strengthen the role of the Quality Committee in providing quality assurance to the Board of Directors is planned with a workshop being held in November 2024 to identify where improvements can be made.

3.0 Process Management

3.1 Processes are managed through two distinct but connected pathways – one within Care Groups and a Corporate structure.

3.2 Within Care Groups, Clinical Service Units hold monthly governance meetings which report into Care Group Governance meetings. Agendas for these include patient safety, patient experience, clinical effectiveness, risk management and shared learning from incidents, concerns and complaints. Each Care Group meets with the Executive Team at a monthly Performance meeting where quality performance management is presented and discussed.

3.3 Corporately, there are structures in place to monitor processes and gain assurance for all corporate services involved with providing quality assurance. These comprise of six key meetings that report directly into Quality Committee on a quarterly basis:

- Patient Safety Committee
- Patient Experience Committee
- Clinical Effectiveness Committee
- Infection Prevention, Control and Decontamination Committee
- Medication Safety Committee
- Clinical Effectiveness Committee

3.4 Within the Patient Safety reporting structure, there is a well established process now for identifying and responding to patient safety incidents. This follows the PSIRF process and incorporates the Harm Free Care Panel (to look at themes relating to Tissue Viability and Infection Control), Incident Review Panel (where all incidents scored as Moderate harm or greater are reviewed) and Incident Sign off Panel (where the learning from all Patient Safety Incident Investigations is reviewed). Learning from these events has an established dissemination process through both Care Groups and Corporate teams.

4.0 Documentation

4.1 Maintaining comprehensive documentation of processes, procedures, and quality standards is the responsibility of the relevant corporate team and is monitored through the appropriate committee as described in section 3.3. This includes policies, audits, risks and incidents relevant to their specialty and escalating any issues or concerns to Quality Committee for assurance.

4.2 Care Groups also maintain responsibility for maintaining relevant and accurate documents within their areas.

5.0 Training and Competence

5.1 Quarterly reports from all committees into Quality Committee include updated positions against nationally and locally mandated training compliance. Performance against training compliance is also addressed through the monthly performance meetings with executives.

5.2 In Q1, overall training compliance has achieved targets but there are some areas of lower compliance, particularly with medical staff. It is acknowledged that some of this is driven by anomalies within reporting systems not supporting trainees moving between organisations and the Medical Director is closely involved in addressing any areas where improvements can be made.

5.3 The need for additional training has to be balanced against responsible use of resources and an Education Governance Framework has been established to support this.

6.0 Monitoring and Measurement

6.1 A broad range of methods are used to ensure continuous monitoring and measurement is occurring. The Clinical Effectiveness Committee report on a range of measures both internal and external to the organisation including national and local audits, NICE guideline compliance, CQUINs and outcomes from the GIRFT programme.

6.2 The Tendable audit programme remains a valuable tool to measure how well we comply with agreed standards. This is however only a monitoring tool and it is outcomes from actions taken as a result of findings that will drive improvements.

6.3 Triangulation with other feedback sources remains a vital element. This includes patient experience data (concerns, complaints, compliments, FFT and surveys), feedback from partners (local authority, ICS, Healthwatch, voluntary sector) and feedback from staff (staff survey, FTSU).

6.4 The development of the Exemplar Accreditation programme has provided us with a method of comparing similar areas against an agreed set of metrics that includes a wide range of quality metrics to enable ratings to be given, celebrate achievements and provide additional support where necessary.

6.5 In Quarter 1, 9 wards have undertaken accreditation with 4 achieving the bronze award. Work has commenced on developing key performance metrics for maternity and children's areas for accreditation in Q2. Assessment areas, UECC, Community and additional clinical areas are all in early planning phases but a lack of national benchmark opportunities is delaying development and this will need to be a gradual process over the next eighteen months.

7.0 Continuous Improvement

7.1 Now that the Qi team is fully established, they are contributing to a range of projects including Transition, Gynaecology Outpatients and Endoscopy. Quality Improvement is reported quarterly via the Patient Safety Committee and the report includes updates on training, ongoing projects (127 registered) and the impact of interventions. The most common themes emerging from chosen projects are patient safety, patient experience and person centred care. The team are also supporting the Diabetes and Pain Management Quality Priorities.

7.2 Training has now transitioned to the ILSY (South Yorkshire) system wide delivery model which has been co-developed by TRFT and Barnsley Hospital.

7.3 The Qi team are heavily involved in the recently commenced Exemplar Accreditation programme and are also supporting initiation of a number of small scale projects for early career colleagues such as newly registered nurses and AHPs undertaking preceptorship.

8.0 Risk Management

8.1 There is a monthly Risk Management Committee with attendance from all Care Groups and Executive Director leadership. As well as considering all risks rated 12 or greater, there is a focus on completion of action plans and regular updates in line with the risk management policy. This has significantly improved over the last year. With the majority of risks now have current SMART action plans.

9.0 Compliance

9.1 As an NHS Trust, we must meet the regulations set out by the Health and Social Care Act 2008 (regulated Activities) Regulations 14. Compliance is monitored by the CQC as part of their regulatory activities, to ensure that basic standards of care, based on the CQC fundamental standards, are met. The Quality Committee agenda is structured to ensure all of these elements are monitored and appropriate assurance is received.

9.2 The Trust currently have an overall 'Requires Improvement' rating from the CQC. It is noted that with recent changes to the CQC assessment framework and changes to their internal structure, they have been struggling to achieve their ambitions in terms of completing regular inspections so the organisation are not clear when we can expect to receive a future inspection. We will continue to aim to deliver care equivalent to a CQC rating of 'Good' or greater with assurance provided through the newly created self-assessment framework and by undertaking benchmarking activities with local organisations and high performing comparable Trusts.

9.3 Within Quarter 1, we have not undertaken self-assessment work as the priority has been on the forming of the new Care Groups and the early implementation of the Exemplar Accreditation programme. All Care Groups have access to the self-assessment documentation and are beginning to populate this with scrutiny expected to commence to Quarters 3 and 4.

9.4 Compliance with CQC requirements is now monitored through the Quality Governance and Assurance Group which meets monthly. This group has responsibility for ensuring that CQC requirements are being met and reports into the Patient Safety Committee.

9.5 Compliance and assurance is also provided through other external processes on an ad-hoc basis. In Q1, the Trust received Significant Assurance for the Learning from Incidents report from the internal auditors. An Appreciative Inquiry into Adult Safeguarding has commenced via the NHS England team which will be reported in Q3.

9.6 Compliance is reported externally to the Trust to the ICB and CQC. The ICB receive regular bi-monthly quality assurance updates through the Contract Quality Meeting attended by the Medical Director and Chief Nurse. This in turn is escalated to NHS England if required through the System Quality Group.

9.7 Outside of the inspection programme, CQC receive assurance through quarterly engagement meetings and through ad-hoc queries to which we provide a written response. In Q1 there have been four routine enquiries from CQC. The first three were

closed down following receipt of the response from the Trust. Enquiry four, related to the impact of increased attendances on UECC and AMU has only been submitted this week and feedback has not yet been received.

10.0 Conclusion

10.1 A Quality Management Structure has been outlined to ensure that all aspects of Quality Assurance are addressed within this report.

10.2 Ongoing monitoring will continue through the various committees reporting into the Quality Committee.

10.3 The development of a Quality Strategy to underpin this will strengthen the Quality Assurance process.

Board of Directors' Meeting
6 September 2024

The Rotherham NHS Foundation Trust

Agenda item	P142/24
Report	**Safeguarding and Vulnerabilities Team Annual Report**
Executive Lead	Helen Dobson, Chief Nurse and Executive Lead for Safeguarding
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	This paper supports the Trust in being ambitious to continually improve the quality of safeguarding practice through the delivery of robust safeguarding arrangements. At the core of safeguarding activity is the importance of giving the best possible care to patients, with safeguarding embedded throughout all care that is delivered. The safeguarding team provides care and support to staff who have been exposed to difficult situations. For safeguarding to be successful and impactful, it requires partnership working, and this report highlights the strength of the Rotherham Safeguarding Partnerships and the contribution that TRFT makes to the safeguarding system.
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	The Annual Report provides a summary of the safeguarding activity undertaken across the Trust, and wider Safeguarding Partnerships during this annual period of 2023-24. This report provides assurance that all statutory duties have been undertaken in accordance with legislation, including all NHS England priority safeguarding issues; • Modern Day Slavery • PREVENT (counter terrorism) • Child Exploitation • Female Genital Mutilation (FGM) • Deprivation of Liberty Safeguards (DOL's) and Mental Capacity Act (MCA) • Domestic Abuse • Looked After Children

Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	Annual Report presented to Operational Safeguarding Group 22nd May 2024 Annual Report presented to Mental Health Steering Group 17th June 2024 Annual Report presented to Safeguarding Committee 20th June 2024 Annual Report presented to Quality Committee 31st July 2024
Board powers to make this decision	NHSE Safeguarding Assurance The Children Act (1989) and (2004) Section 11 compliance The Care Act (2014) compliance
Who, What and When (what action is required, who is the lead and when should it be completed?)	No actions required
Recommendations	It is recommended that the Trust Board accept this paper as providing assurance that TRFT are appropriately discharging their safeguarding duties in line with legislative and contractual obligations. The report highlights significant work across all work-streams to continuously improve, and deliver high quality safeguarding actions which should be celebrated.
Appendices	Safeguarding Annual Report 2023-2024

Safeguarding & Vulnerabilities Team
Annual Report 2023-24

Foreword

As the Executive Lead for Safeguarding, it is my pleasure to introduce The Rotherham NHS Foundation Trust Annual Safeguarding Report for 2023-24. This has provided an opportunity of reflection to review the safeguarding work undertaken across the Trust this year and whilst the past year has continued to be challenging as the NHS continues to experience significant operational pressures, there is a lot to celebrate and be proud of with the safeguarding work undertaken across the Trust, and by the achievements and progress made by the Safeguarding systems across Rotherham and South Yorkshire. TRFT has continued in its commitment to ensuring that we help all residents of Rotherham live lives free from abuse and neglect.

Safeguarding can be complex and emotive work, and to safeguard effectively requires all agencies to work together in a collaborative and supportive way to develop seamless and effective safeguarding plans. We would like to thank our safeguarding partners across Rotherham for working with us to safeguard the people of Rotherham.

This report provides assurance to the Trust Board and our regulators, our patients and their families, and our partner agencies that everyone working at The Rotherham NHS Foundation Trust see safeguarding as part of their core business, and that we recognise that safeguarding children, young people and adults is a shared responsibility, with the need for effective joint working between partner agencies and professionals, so that vulnerable groups in society are protected from harm. We all have a role to play in ensuring our patients and their families receive outstanding care.

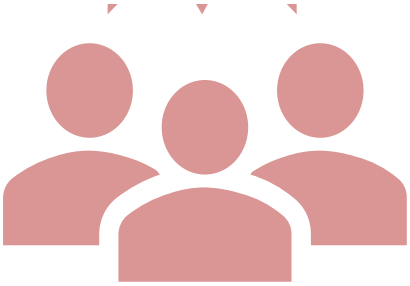
Helen Dobson

Chief Nurse and Executive Director for Safeguarding.

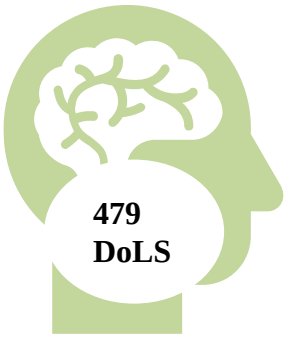
Contents

TRFT Safeguarding Infographics 2023-24

Quality Assured & processed 99 legal statements



1080 MASH cases
240 MADA meetings



Trust Wide Training compliance
Adults L2 92%
Children L2 89%

30 MARAC Meetings attended

38 TRFT referrals

780 Adult Safeguarding Referrals

1369 Child Safeguarding Referrals

1. Introduction

Welcome to the TRFT 2023-24 Annual Safeguarding & Vulnerabilities Report. The purpose of this report is to provide a declaration of assurance that the Trust is fulfilling its duties and responsibilities in relation to promoting the welfare of children, adults and families who come into contact with our services. This report encompasses all areas of the safeguarding & vulnerability agenda including Safeguarding Adults and Children, Domestic Abuse, Mental Capacity and Deprivation of Liberty Safeguards (DoLS), Prevent, Mental Health, and includes an update on work undertaken to support Autistic People, and People with a Learning Disability.

The national safeguarding agenda continues to evolve as we learn from research, data analysis and serious incidents; The Safeguarding Team are active participants in national and local safeguarding forums to ensure that TRFT, and Rotherham consider the impact of learning and update & deliver best practice in safeguarding. The TRFT safeguarding team work closely with the clinical divisions to embed any learning and takes a continuous improvement approach to safeguarding practice.

The Safeguarding Team continues to provide a range of support options to clinical areas to ensure a Think Family ethos is embedded, and that we work together to respond to emerging themes. We recognise that supporting staff to ensure all patients and service users are protected is pivotal in ensuring safe and effective safeguarding for all age groups, and that policies and procedures are inclusive.

2 Safeguarding Policy and Statutory Guidance

Safeguarding is governed by a plethora of legislation, policy and guidance. Non-exhaustive lists are below. The local policies and procedures we have in place at TRFT are reflective of these.

Legislation that impacts on Safeguarding:

- Human Rights Act 1998
- The Children Act 1989, revised 2004
- The Care Act 2014
- Care Quality Commission Health and Social Care Act 2008
- The Sexual Offences Act 2003
- Serious Crime Act 2015
- The Mental Health Act 1983 and 2007
- The Mental Capacity Act 2005
- The Modern Slavery Act 2015
- The Domestic Abuse Act 2021
- The Terrorism Act 2000
- The Equality Act 2010
- FGM Act 2003

Policy & Guidance that impacts on Safeguarding:

- Serious Violence Strategy 2018
- Health and Social Care Act 2022
- Deprivation of Liberty Safeguards 2007
- Working Together to Safeguard Children 2023
- Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff: Fourth edition: January 2019
- Adult Safeguarding: Roles and Competencies for Health Care Staff First edition: August 2018
- United Convention on the Rights of the Child 1989
- Looked after Children: roles and competencies of healthcare staff December 2020

3 Safeguarding Governance and Accountability

The Chief Nurse is the Board Executive lead for safeguarding and is accountable for safeguarding across the organisation.

The Chief Nurse is supported by the Deputy Chief Nurse, the Head of Safeguarding, and the Safeguarding and Vulnerabilities Team who provide leadership at all levels, both within TRFT and across the Rotherham Safeguarding Partnerships to underpin the objectives of the safeguarding partnerships.

Safeguarding Governance is fully embedded within the governance structure at every level.

3.1 NHSE Appreciative Enquiry

During Quarter 1, NHS England completed an Appreciative Enquiry into safeguarding children practices at TRFT, with key lines of enquiry:

- Leadership of Safeguarding
- Quality Improvement- internal processes for learning and improvement following review of individual cases, and organisational vs system learning.
  The appreciative enquiry included focus groups with staff, a review of policies procedures and documents, and a site visit to observe safeguarding practice in action. The full report has been shared with Trust Board which highlights the progress made by the Trust to improve safeguarding practices.

3.1.1. Aspirations and opportunities identified include:

- To establish a single electronic system to record body maps
- Maintain a stable workforce
- To share 'strengths' from within maternity with adults, building effective connectivity across safeguarding practices
- To strengthen the safeguarding supervision policy in relation to medical workforce

3.1.2 Good practice identified:

- Safeguarding is part of everyday practice, with staff talking about safeguarding
- The safeguarding culture has shifted as a result of the changes made by the Improvement Plan.
- Staff have ownership of the safeguarding priority and want to safeguard patients to keep them safe.
- Learning from serious incidents is shared across UECC, and the wider Trust via learning events and peer supervisions
- The visibility of the safeguarding team has led to increased engagement and collaborative working.

As we move into a new financial year, a phase 2 Appreciative Enquiry into Safeguarding Adult practice is in progress, with the site visit scheduled towards the end of Quarter 1.

4 External Governance and Accountability

4.1 Safeguarding Standards Assurance

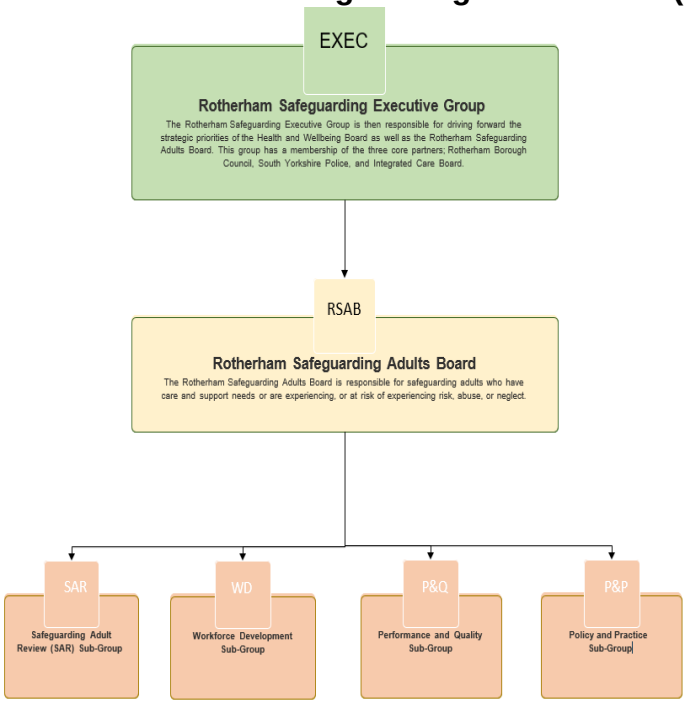
As part of providing assurance to the Integrated Care Board (ICB), TRFT has conducted the self -assessment assurance document, with all areas assessed as 'Blue/Embedded in practice', or 'Green/fully compliant with continuous improvement'. No additional information was required from the ICB.

Domain	Blue/ Embedded assurance	Green/ compliant assurance
Safeguarding assurance & accountability (16)	14 domains	2 domains
Learning & practice Improvement (10)	10 domains	4 domains
Partnership working (6)	4 domains	2 domains
Embedding safeguarding (7)	5 domains	2 domains
Wider Safeguarding agenda (12)	10 domains	2 domains

TRFT are consistent and effective partners, appropriately represented at all levels across all of the Safeguarding Partnerships, with the Trusts Safeguarding Team proactively working with, and influencing the work-streams to enhance integrated working and develop policy and strategies to strengthen processes that ensure that individuals are safeguarded from abuse and harm, and ensuring that early intervention is available for everyone who needs it.

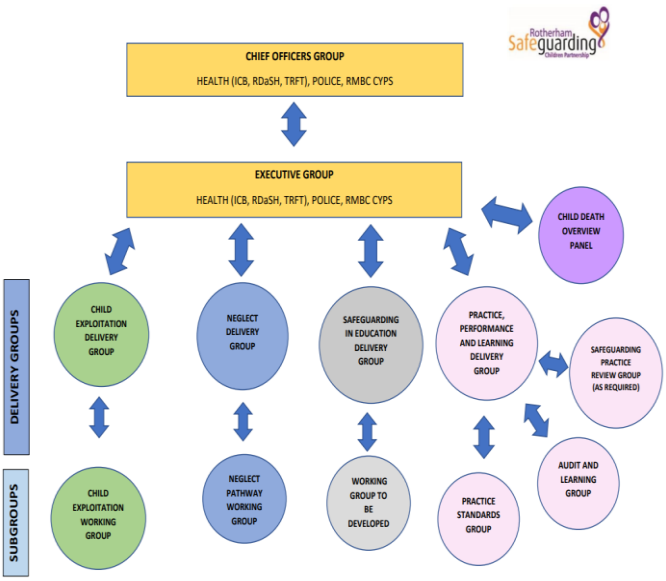
"TRFT have been a key member of Rotherham's Safeguarding Adult's Board since its inception. Colleagues have contributed significantly to the Board and its subgroups, in particular the performance and quality subgroup which been chaired by the Trust. We are continuing to strengthen our safeguarding partnership arrangements in response to our 2023 peer challenge, and the Trust is a key player in delivering our three year strategy and action plan.
Many Thanks to all at TRFT for their support of the work of the Safeguarding Adult Board."
Moira Wilson
Independent Chair
Rotherham Safeguarding Adult Board.

4.2 Rotherham Safeguarding Adult Board (RSAB)



- TRFT are represented at all levels of the RSAB, with the ICB representing all health partners at the Executive Group.
- TRFT have supported with the peer review of the SAB and in establishing the new structure.
- TRFT co-chair the SAR sub-group, which is responsible for reviewing significant incidents and commissioning SARs, and ensuring the action plans are completed, with changes implemented to improve the safeguarding practice across the borough.
- Performance and Quality Subgroup is co-chaired by TRFT. The group reviews the performance data. This is currently RMBC data, but it is hoped this could be expanded to all partners, with the development of a new data scorecard this year.
- Policy and Practice Sub-group is co-chaired by TRFT. This year a new threshold document has been developed which will support decision making and assist staff when faced when situations that concern them. This has been included in the new Think Family study day for 2024

4.3 Rotherham Safeguarding Children Partnership (RSCP)



TRFT have remained a consistent and reliable partner of the RSCP, working with partner agencies to improve our collective response to safeguarding children and young people. There is a lot of work across the partnership, with sub groups as shown in the chart, and additional focused working groups for targeted pieces of work. To ensure the best use of the specialist resource, the safeguarding team are working with the ICB and RDaSH safeguarding teams to strengthen the health voice and reduce duplication where appropriate.

- Quality Standards Group – TRFT deputy chair this meeting which reviews multiagency practice and shares learning from cases. TRFT are consistent members of this group and have taken many cases to the group for review. As part of safeguarding awareness week, the group produced a short film to showcase the impact the group has on improving practice across the borough.
- Policy, Practice and Learning Group is responsible for reviewing and developing multiagency guidance. This year, TRFT requested that safeguarding children around dogs was considered for multiagency guidance, and new guidance has been published. The new guidance seeks to support professional clinical judgement, and reduce referrals that are not required, whilst ensuring all children impacted by dogs are safeguarded appropriately.
- Review Group- TRFT have contributed to all Practice Reviews. Two reviews have been commissioned and processes are in place for these to progress.
- TRFT has provided significant support to the Child Death Overview Panel which is chaired by public health.
- TRFT chair the new Neglect Delivery Group which has published a new strategy which aims to reduce, and eliminate childhood neglect in the borough. The new strategy focuses on professional knowledge, the introduction and roll out of the NSPCC screening tool, engagement with the community to alert families to the signs of neglect, and a pathway for support.

- New strategies have been published for the child exploitation and early helps groups, which TRFT have contributed to.

"TRFT are a consistent and reliable partner around the Rotherham Safeguarding Children Partnership (RSCP). They actively contribute to discussion and decisions, offering constructive challenge at key parts within the process and partnership.
Representatives from TRFT support the partnership through the dedicated sub-groups and assist on relevant task and finish groups. During the last year TRFT has supported with the developments made to the revised governance structure and the new neglect strategy, and continues to assist as we review all the strategies and work across the partnership.
Thank you to all at TRFT for your continued support."

Darren Downs
Independent Chair
Rotherham Safeguarding Children Partnership

4.3 Safer Rotherham Partnership (SRP)

TRFT are a consistent member of the SRP, with members of the safeguarding team regular contributors at the Multi agency risk assessment conference (MARAC) for high risk domestic abuse. MARAC meeting frequency has increased from Q4 to ensure that safety plans are in place as soon as possible.

Key areas include:

- Contributed to Domestic Homicide Review work
- Chair a new work stream to develop a pathway for survivors of non-fatal strangulation
- Regular attendance and participation at Chanel panel
- Attendance and contribution to Domestic and Sexual Abuse Core Priority Group.
  Community MARAC is a multiagency meeting where individuals with multiple complexities are discussed and plans put in place to help them stay safe. This has increased from fortnightly to weekly during this period.

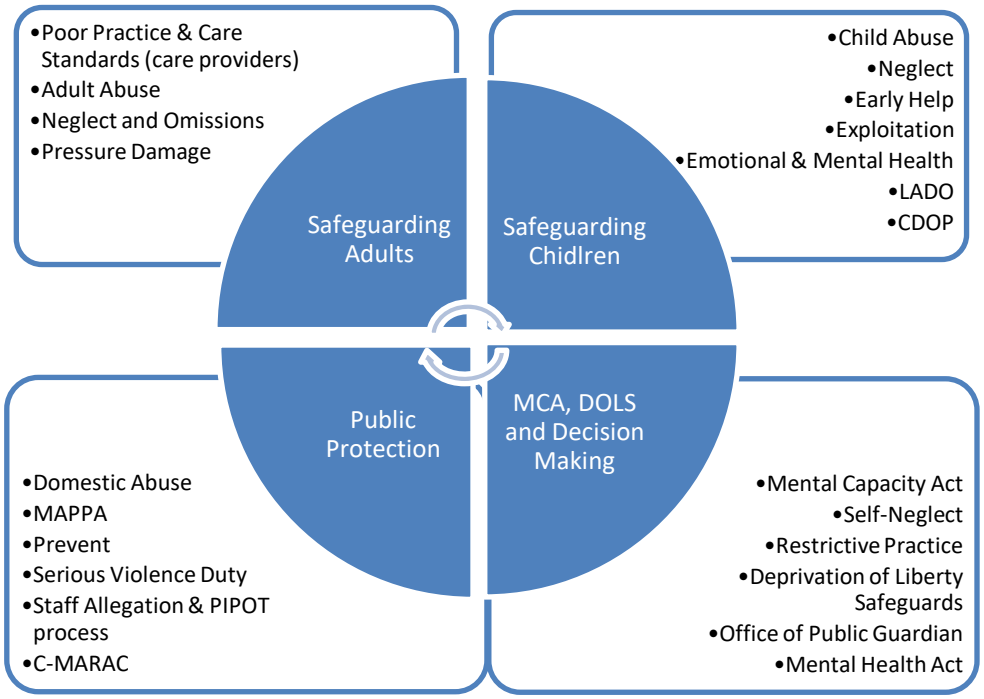
5 Current Position of TRFT Safeguarding and Vulnerabilities Team

There have been some personnel changes to the Safeguarding and Vulnerabilities team, including a new Head of Service, the creation of a new Lead Nurse post for MCA and a new Nurse Advisor joining the team.

The Safeguarding Team has established a new single point of contact, which provides advice and support across the full safeguarding agenda via a newly created duty practitioner process.

The safeguarding adults and children's teams have integrated, and are working closely as a Think Family Safeguarding Team. The team members either have, or are working towards a core set of skills across the whole safeguarding agenda, with individuals who have additional expertise in

specific areas. This approach enables professional growth and development, as well as being able to provide holistic support in a think family ethos whilst managing the finite resource.



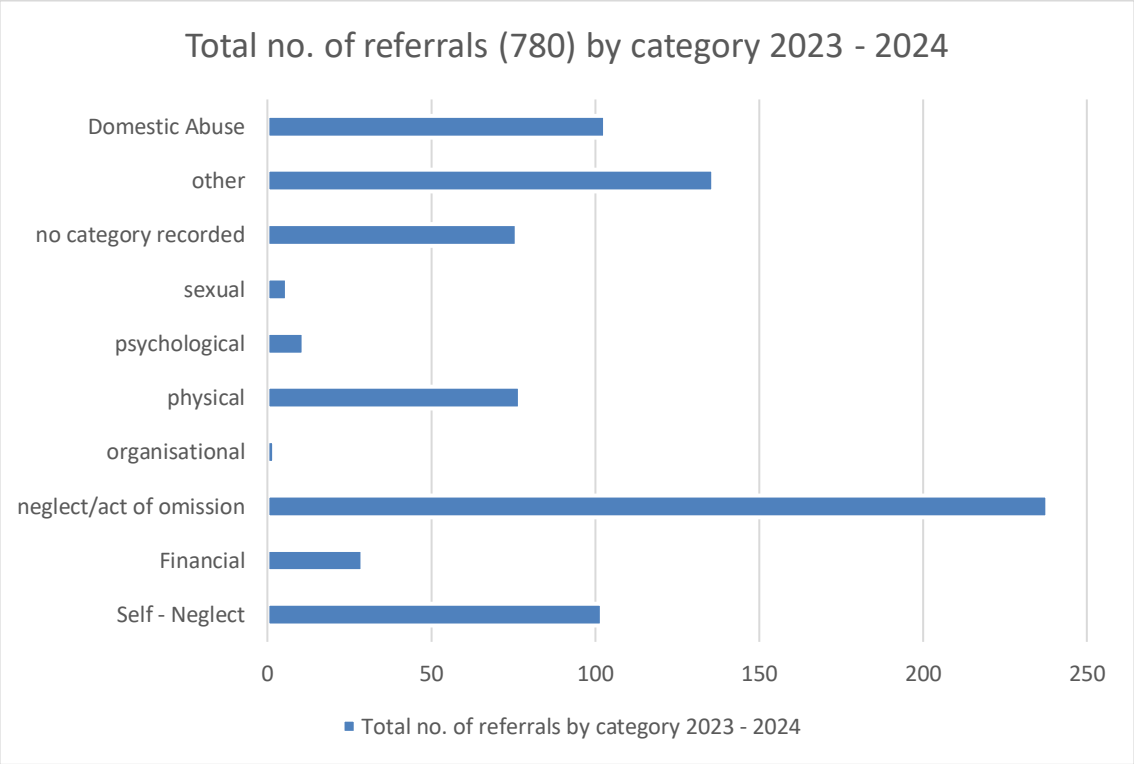
- TRFT are compliant with all statutory and regulatory requirements.
- All staff have access to the Trust policies and procedures which have been updated to reflect current research and guidance, are evidence based and take account of new legislation. They are aligned to the Rotherham multi-agency safeguarding procedures.
- The safeguarding team has coordinated and delivered a robust audit programme across the clinical services, which shows improvement in safeguarding practices.
- Masterclasses, Stop the Shifts and Safeguarding Workshops have been delivered throughout the year on Mental Capacity & Decision Making, Domestic Abuse, Perplexing Presentations and Fabricated Induced Illness, and we delivered a multiagency simulation of child abuse in UECC. The short, bite size sessions to update staff following legislative changes, process changes, or embed learning/best practice continue to be popular and support the delivery of key messages.
- Safeguarding begins with robust recruitment, with all new recruitments within the Trust, meeting the DBS standards and are appropriately vetted by references.

6 Safeguarding Adult Incidents, Referrals and Trends:

The chart below shows the breakdown of adult safeguarding referrals by theme, with the Neglect and Acts of Omission being the main area of concern (238 referrals), followed by Domestic abuse (103) and Self-neglect (102). There are 136 recorded as 'other' which includes concerns relating to other situations that increase vulnerability, including homelessness and housing, cuckooing, substance misuse and mental health/self-harm. This mirrors the national profile

with a current focus on self-neglect and supporting individuals who are making unwise choices with high risk outcomes is an area of national practice focus.

The safeguarding team have developed relationships this year with the local authority quality contracts team and now attend the monthly meeting to review concerns relating to care homes and domiciliary care providers; the safeguarding team are able to share in concerns from across the Trust, and provide feedback to the relevant clinical teams to ensure concerns are escalated and shared to improve practice.



7 Safeguarding Children Incidents, Referrals and trends

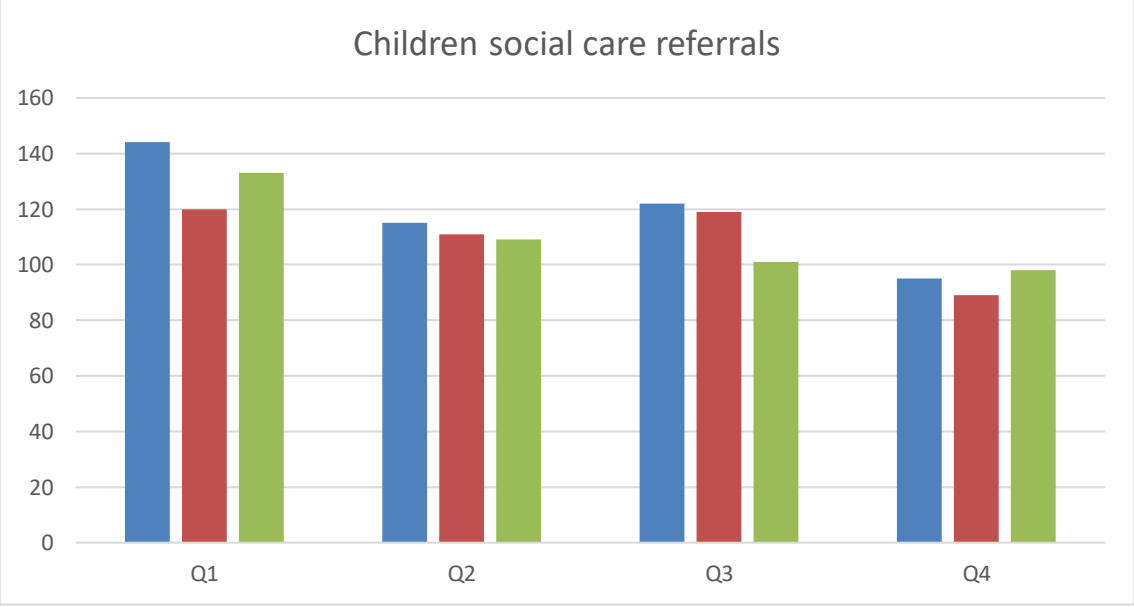


Chart shows monthly breakdown of referrals throughout the year (April 2023-Mar 2024).

Children's referrals

During this annual period there were 1369 referrals made in relation to safeguarding children. Throughout the year, the majority of the referrals are submitted from UECC, with concerns relating to the parents/carers of children presenting as a key reason for referral. This occasionally relates to alcohol and substance misuse, or domestic abuse, but the majority of referrals relate to the emotional and mental health needs of the adults, and referrals are submitted for their children/ children in their care.

Outcomes of referrals from UECC come via the safeguarding team due to the nature of the work in UECC, and to ensure that the information is shared with community services working with the child/family. It is expected that they complete a paediatric liaison order when they complete a referral to ensure prompt information sharing from the acute site to community services.

Referrals from community children's services are documented within the SystmOne records, and the practitioners are responsible for ensuring they receive an outcome from any referral made. Maternity referrals often are planned from either a history that requires a referral or a decision from MASH baby clinic that a referral is required.

Paediatric Liaison

Paediatric liaison is a key part of the team, with the focus on the role being to share information between agencies to ensure that all safeguarding information is shared, including out of area. The data shows 1405 paediatric liaison orders were raised during this annual period. Referrals include all attendances for babies under 14 days old, all acutely unwell children who have required transfer out, all child deaths, and where safety concerns are present e.g. accident prevention.

The paediatric liaison nurse role delivers the CONI scheme for the Trust (care of next infant for those parents who have experienced a SUDIC), and key worker role for child death, alongside supporting with the team training and supervision commitments. This year they have been nominated for a Proud Award.

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	2023									2024			Grand Total
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Count of referrals	136	133	142	112	116	108	122	89	112	98	123	114	1405

8 Supervision

Supervision is the cornerstone to embedding safeguarding practice and learning from incidents, it also supports staff emotional resilience in processing the emotive elements of incidents. Outcomes are not always easy for staff to accept, examples include adults making unwise and risky decisions regarding relationships, or declining interventions that would help them live safer.

Group supervision continues to be delivered by the safeguarding team for all Trust areas who require this compliance, with a mixture of face to face and teams meeting. Moving forward, we hope to phase out the teams sessions as face to face provides much richer discussions and improved opportunities for engagement.

We now have 33 trained safeguarding supervisors who are working in UECC, Therapies, Children's Ward, and Community Complex Care Team, therefore enabling these areas to provide additional sessions to staff working in those areas.

The additional supervisors will complement the offer from the safeguarding team, and will boost the compliance with the offer of additional sessions in the departmental area in which they work. UECC now have 4, and Midwifery areas will have 8. It is expected that compliance will improve as we move into 2024-25. Those areas without trained supervisors are being encouraged to support this model to help improve practice within the departments.

There remains a risk on the risk register regarding reliability of the ESR data for safeguarding supervision compliance. There is significant variance across the divisions, with community services achieving 100%

Group Supervision Trust Wide ESR data	69.7%
1:1 Supervision Trust Wide ESR data	46%

In addition to the group sessions for the Trust additional bespoke sessions have been delivered by the safeguarding, based on arrangements made for the teams involved, or additional based upon need at the time or following an incident.

Areas that have had bespoke sessions include:

- Dental team
- Integrated sexual health
- Children's therapies
- 0-19 team leaders
- ENP and ANP UECC staff
- children's diabetes team
- Obstetrics and gynaecology consultants
- Maternity MAST days
- UECC staff
- children's ward
- Vulnerabilities specialist nurse
- Critical Care

Support is still offered to the medics in paediatrics and UECC once a month for their supervision sessions.

The safeguarding team have increased the supervision being delivered to the adult facing workforce, and although this is not mandatory, it is good practice and will ensure learning from incidents. The team has focused on the community workforce who manage complex community patients. All community teams have

been offered support, and the safeguarding team continues to increase its visibility across the community.

9 Domestic Abuse Incidents

What is MARAC?
The multiagency risk assessment conference (MARAC) is a multi - agency meeting that discusses high-risk domestic abuse cases, for adult victims and young people aged 16+. Actions are taken to reduce the risk of survivors/victims of abuse and disrupt perpetrator behaviour.
There are 270 MARACs running across the country.

MARAC representatives are crucial to the success of MARAC, bringing relevant risk information held by their organisation, sharing that information appropriately and collaborating with other representatives to create action plans to reduce risk and increase safety for individuals and families. MARAC is a process through which agencies create coordinated action plans to reduce the risk of serious physical harm and homicide. At the heart of the MARAC process is the working assumption that no single agency or individual can see the complete picture of risk, but all may have insights that are crucial to improving safety.

- A total of 1397 children were discussed at MARAC in 2023/24. This is an increase of 54 comparable to 2022/23 (1343).
- 747 survivors/victims were discussed. This was a very slight decrease in the number of victims from 766 to 747.
- 12 pregnant women were discussed at MARAC, this is a reduction from 33 in 22/23 to 12 in 2023/24.
- 12 victims/survivors aged 16-17 years of age were discussed, the same as last year.

Recognising Domestic Abuse

The safeguarding team have strengthened the process this year, now requesting all domestic abuse incidents and assessments are shared with the team for oversight. Due to this change, data for the full year is not available.

- Quarters 1 and 2 – 16 DASH and 7 HARK assessments completed
- Quarters 3 and 4 – 23 DASH and 45 HARK assessments completed
- Referrals to MARAC - 38 during this annual period.

Throughout the year, we have actively encouraged individual practitioners to spend time with the MARAC representative and attend MARAC meetings. 12 individuals who work across the community and in the acute trust have successfully taken this up. This has enabled them to gain a better understanding of the process, support victims when disclosures are made and have been able to contribute to joint action plans to reduce risk.

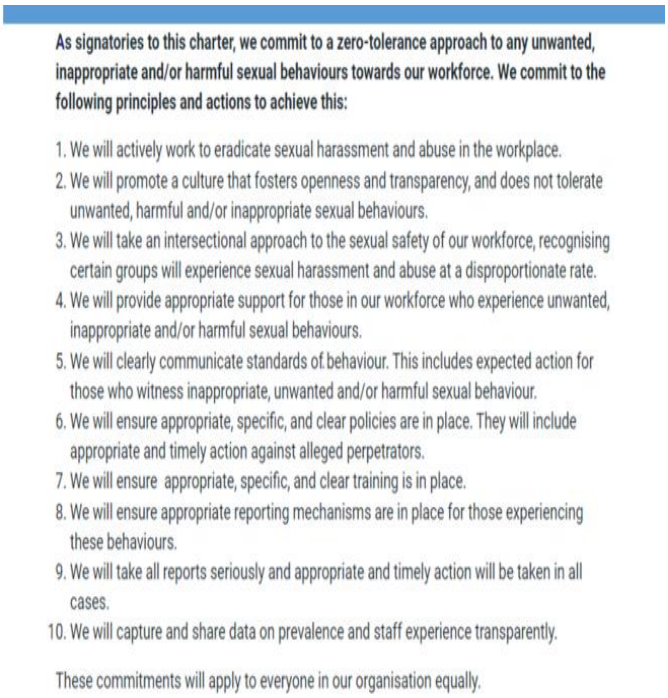
What is Non-fatal strangulation?

Section 70 of the Domestic Abuse Act specifies that non-fatal strangulation is a specific crime.
Safe Lives found that those who have experienced non-fatal strangulation are 8 times more likely to be killed than someone who has not experienced NFS.

Rotherham is learning from other areas and has established a multiagency working group to establish a pathway to medical treatment for those experiencing NFS.

The Safer Rotherham Partnership funded a webinar for professionals across the borough to increase understanding of non-fatal strangulation which was attended by several members of TRFT staff. The safeguarding team have been actively raising awareness of these presentations and we have new leaflets and posters with QR codes on displayed in key areas. We are working closely with the ICB Named Doctor to raise awareness across primary care, especially for those who may present with a hoarse voice or change in voice for them to consider NFS as a possible cause. Awareness raising and training will continue throughout 24-25 as we hope to launch and embed the multiagency pathway.

The Sexual Safety Charter



As signatories to this charter, we commit to a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours towards our workforce. We commit to the following principles and actions to achieve this:

1. We will actively work to eradicate sexual harassment and abuse in the workplace.
2. We will promote a culture that fosters openness and transparency, and does not tolerate unwanted, harmful and/or inappropriate sexual behaviours.
3. We will take an intersectional approach to the sexual safety of our workforce, recognising certain groups will experience sexual harassment and abuse at a disproportionate rate.
4. We will provide appropriate support for those in our workforce who experience unwanted, inappropriate and/or harmful sexual behaviours.
5. We will clearly communicate standards of behaviour. This includes expected action for those who witness inappropriate, unwanted and/or harmful sexual behaviour.
6. We will ensure appropriate, specific, and clear policies are in place. They will include appropriate and timely action against alleged perpetrators.
7. We will ensure appropriate, specific, and clear training is in place.
8. We will ensure appropriate reporting mechanisms are in place for those experiencing these behaviours.
9. We will take all reports seriously and appropriate and timely action will be taken in all cases.
10. We will capture and share data on prevalence and staff experience transparently.

These commitments will apply to everyone in our organisation equally.

The safeguarding team have reached out via newsletters and social media to ensure that all staff know they can access sensitive support if they are experiencing domestic abuse. This is also included in Trust induction and the domestic abuse policy. The safeguarding team work closely with Security, The People Team and clinical leaders to support individuals living with domestic abuse.

The Trust are proud to have signed up to the NHSE sexual safety charter, and the safeguarding team are working in partnership with the People Team to raise awareness of this with staff.

10 Adult Safeguarding Caused Enquiries

TRFT received 36 enquiries throughout 2023/24 regarding the care that TRFT services provided. The main themes through these enquiries were predominantly related to pressure damage. All enquiries are reviewed and investigated by the clinical team, with expert input from the Tissue Viability Team and Safeguarding Team where appropriate.

Where the concern related to a specific allegation against a staff member, these were appropriately considered in line with the Person in a Position of Trust (PIPOT) guidance. A new managing allegations against staff policy has been developed and will be rolled out once approved through governance.

The learning from these investigations is shared across the team, and where appropriate across the care group or organisation.

The investigations, including any lessons identified are shared with the local governance groups, in supervision with local teams, and wider across the trust and via the monthly bulletin.

11 Safeguarding Champions and Safeguarding Awareness

To align our 'Think Family' approach to safeguarding, we have replaced our safeguarding adult and safeguarding children champions, and created one set of Think Family Champions. A new champion handbook and contract has been launched, with 131 champions identified across the clinical teams. The champions have a pivotal role in embedding changes to safeguarding practice in the local areas and are a point of contact and signposting within the local teams.

The champions sessions are used to share learning from incidents, provide updates on policy development, and seek feedback from clinical areas on any safeguarding challenges. This year the safeguarding team arranged a domestic abuse workshop which was supported by the local specialist service, Rotherham Rise. The Safeguarding Team, in partnership with the People Team are promoting support for staff who are experiencing domestic abuse.

The Safeguarding Team have participated in various campaigns to raise awareness of safeguarding issues, including the 16 days of action for domestic abuse, International Ending FGM Day, and Safeguarding Awareness Week. To increase engagement with staff and share the positive work taking place in safeguarding across the Trust, a new Twitter/X account has been established, with some posts gaining over 6000 views.

12 Policies, Procedures and Clinical Audit

All policies and procedures have been updated and reviewed in line with changes to legislation, practice and lessons learned from Practice Reviews. The safeguarding team have supported the development of partnership guidance into the management of children bitten by dogs to ensure a proportionate response. The safeguarding team have participated and contributed to 4 partnership audits including:

- Early Help and Joint Area Inspection (JTAI) mock audit
- Looked after children and care leavers audit
- Persistent absence and exclusion from education
- Safeguarding Assurance and Serious youth & knife crime mock JTAI

The Safeguarding Team have carried out a robust audit programme, which has included:

- Missed opportunities for safeguarding in UECC
- Re-audit of the 16-17 year olds pathway
- Child Protection Medical Assessment documentation
- SCBU Safeguarding documentation on Meditech

The audits are discussed and reviewed at Safeguarding Operational Group and have provided high levels of assurance, with the Think Family approach embedded within UECC. Referrals are consistently made for children where adults have presented with domestic abuse, mental health concerns, and substance/alcohol related attendances.

13 Mental Capacity Act (MCA) and Deprivation of Liberty (DoLS)

What is a Deprivation of Liberty?
Deprivation of Liberty Safeguards are put in place to ensure that individuals over 18 who lack mental capacity to make their own decisions, who are not free to leave, and who are under continuous supervision and control receive appropriate care and treatment, and that any restrictions are the least restrictive option available.

With no changes now planned to the legislation, the safeguarding team have focussed on the Mental Capacity Act and increasing clinician's confidence with the process. The Mental Capacity Act came into action in 2007, and staff have accessed a lot of training on the principles since then, but we continue to hear concerns about capacity and staff seeking further training. When this is broken down, staff are confident with administering care for those who lack capacity to consent, but where there are difficult decisions and/or unique circumstances to the clinical setting, there is a hesitancy. This is where the safeguarding team have focused their support, in building confidence with the clinicians. We have developed simple resources and 7 minute briefings on a variety of topics, including medication refusal, and the safeguarding team continues with stop the shifts and sessions for champions.

The Safeguarding Team keeps a live log of all DoLS applications within inpatient settings, and monitor where extensions are required. All DoLS applications are reviewed by the Safeguarding Team to check that any restrictions are proportionate, in the patient's best interest, and least restrictive option available. The Safeguarding Team support with best interest meetings where there are complex decisions being made.

No applications made to the local authority have been rejected or found to be inappropriate, and no challenges have been made by individuals or their representatives on the restrictions in place. No cases have required court of protection applications.

During this review period we submitted 475 applications for Deprivation of Liberty Safeguards.

DoLS requests	2023/2024	Total	2022/2023	Total
Q1	120	122	95	95
Q2	99	221	93	188
Q3	123	345	135	323
Q4	133	**475**	118	441

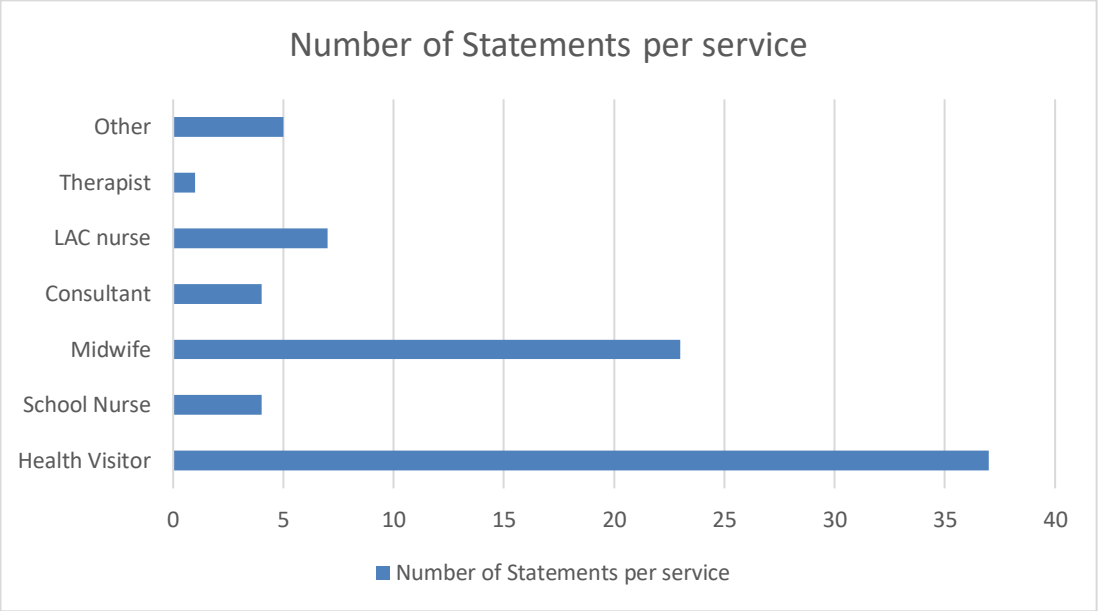
14 Court and Legal Statements

TRFT has not taken any patient care decisions to the Court of Protection during this annual period but has sought legal advice on a small number of patients where this was being considered a possibility.

The safeguarding team quality assure all legal statements and during this year, have all received an update from the Trust solicitor, who they work in partnership with.

The safeguarding Team have coordinated, and quality assured 99 legal statements for safeguarding children matters.

Where staff are called to give evidence in person within proceedings, either in family court or crown court, the safeguarding team work with the Trust Solicitor to prepare practitioners for attendance, and have attended court this year to support staff.



15 Child Exploitation

Following successful recruitment, the Trust appointed a new lead nurse for child exploitation. The role is co-located with the multiagency Evolve team at the police station, with multiagency working at its core. They attend both the weekly multiagency child exploitation (MACE) meetings, the weekly risk assessment meetings with youth justice services and daily intelligence meetings to share any information pertinent to the disruption of exploitation.

The role of the nurse is to:

- Work with children and young people who are exploited either sexually and/or criminally
- Offering health assessments and support with identified outstanding health needs
- Offering health assessment to every young person who has been referred to the youth justice service
- Tailored support to each young person to ensure identified health needs are met
- Working as part of a multi-agency team which includes social care, police, early help, CAMHS, Roads, youth justice, education
- Sharing of information relevant to the risk of exploitation which includes UECC attendances, A&E out-of-area sexual health.

Typical Caseload Data:

The caseloads change each month as young people are added to youth justice programmes, or are identified as being at risk or/ experiencing exploitation, but a typical months data:

- 44 young people on the Evolve (child exploitation) caseload
- 30 young people on the youth justice caseload- this is set to increase as all young people will now be referred for a health assessment, although all may not engage.
- 6 reviews and 2 initial meetings at MACE

The health assessments identify over 25% of young people have diagnosed Special Educational Needs or an Education and Health Care plan in place, that is in addition to those awaiting assessment. 25% of the young people are looked after children. The child exploitation nurse works closely with the looked after nurse team, and will be presenting updates on the work being done to the Operational Safeguarding Group.

16 Child Death Review

The death of a child is a devastating loss that profoundly affects bereaved parents as well as siblings, grandparents, extended family, friends and professionals who were involved in caring for the child in any capacity. As a Trust, we pride ourselves on delivering a high standard of care and support for bereaved parents and families. The role of the Keyworker has been fundamental for us achieving our aim of offering timely, appropriate and compassionate support to all bereaved parents. This role is integrated into the Paediatric Liaison Nurse role and has worked well, providing availability of the service as recommended in Child Death Review Statutory Guidance 2018. The work of the keyworker has proved insightful into the worries, fears and issues parents hold onto following the unexpected death of their infant/child. The keyworker is the "voice of the parent" at all professional meetings. Standards are in place for the keyworker role to ensure that there is consistency of delivery.

Review and analysis of all children who have died and resident in Rotherham

In 2023/2024 Rotherham recorded 14 child deaths in total, three fewer deaths than the previous year and more in line with previous Rotherham averages for a year. As of April 24, there are currently twenty-nine active cases progressing through the child death review process. Fifteen of these cases date back over a year as coronial inquests; specialist pathology reports, criminal investigation and capacity within Rotherham Safeguarding Children Partnership administrative arrangements, delay the review process. The Trust has liaised with the partner agencies and worked extensively in partnership to address the issues identified. Exceptional CDOPs have taken place during 2023 to reduce the backlog, which will continue to be monitored through Rotherham CDOP.

Number of Rotherham child deaths on a financial yearly basis from 2016

2023/ 2024	2022/ 2023	2021/ 2022	2020/ 2021	2019/ 2020	2018/ 2019	2017/ 2018	2016/ 2017
14	17	23	11	13	22	20	15

Rotherham Child Deaths 1st April 23 – 31st March 24

Expected deaths	Q1	Q2	Q3	Q4	Unexpected deaths	Q1	Q2	Q3	Q4
Child resident in Rotherham	1	2	1	2	Child Resident in Rotherham	1	4	2	1
Died out of area	0	3	0	0	Died out of area	0	2	2	0

Joint Agency Response (JAR)

The Trust has co-ordinated and chaired eight JAR meetings. The meetings have continued to be held via teams and as a result are well attended, with excellent engagement from health, police, social care and education; all meetings have been held within the required timescale. The JAR meeting frequently receives feedback from attendees highlighting the meeting has not only been beneficial in putting a multi-agency plan of support in place for bereaved families, but is also supportive and empathetic to professionals involved in care of the child/family.

Coroner's Officers are invited to all JAR meetings and meeting minutes of JAR and CDRM are shared with the Coroner in line with statutory guidance.

Child Death Review Meeting (CDRM)

The CDRM occurs for all child deaths, irrespective of a death being expected or unexpected. To avoid duplication of services a CDRM may take place in existing meetings or as a stand-alone meeting. The Trust is responsible for coordinating and chairing CDRMs and gathering information from external Trusts where a child may have died. Not all external Trusts are as developed as our Trust in their Child Death Review services and obtaining such information has, at times, been problematic, contributing to unnecessary delay in Rotherham cases being presented at Rotherham CDOP.

A pathologist has attended all Child Death Review meetings (CDRM) when a post-mortem has been performed. This has received positive feedback from pathology services and their contribution at the CDRM has been of value. The CDRMs for all child deaths have worked effectively in terms of attendance and participation.

TRFT supported Rotherham Child Death Overview Panel (CDOP) in coordinating and hosting its second on-line Learning Event "Preventing Child Drowning", with over 130 professionals attending, from as far away as Cumbria. A case presentation at CDOP identified a teenager, who had Attention Deficit Hyperactivity Disorder and Autism, and was unable to swim. The child sadly drowned in a local reservoir. The review identified the difficulties parents experience in securing swimming lessons for children with additional needs.

Preparation for the event highlighted children, who are neurodiverse, are more likely to be attracted to water and often demonstrate high level of risk taking behaviours.

Outcomes following the event include increased visibility for the registered charity and Rotherham Leisure services now provide one to one swimming lessons for children with learning difficulties. The event received very positive feedback.

TRFT Celebrations

1. Direct contact and liaison with the National Child Mortality Database Programme has proved valuable in supporting the child death review service to remain compliant with CDR statutory guidance e.g., a grading

system used to identify modifiable factors; reporting death occurring overseas.
2. Development of an effective pathway for sharing learning from CDOP within TRFT and the wider partnership.
3. The Lead Nurse continues to offer bespoke training within the Trust about the Child Death Review process and supports paediatric and obstetric medical induction days and the appointment of new Consultants in these fields.
4. Work has commenced with National Child Mortality Data programme to review information available to parents/carers with a child who has a significant disability.
5. Work is nearing completion to embed the role of the medical examiner and impact of *"National Medical Examiners Good Practice Series: Medical examiners and child deaths"* (The Royal College of Pathologists, 2022), on the child death review process within the Trust.
6. Key professionals in the Trust CDR team are members of the association of Child Death Review Professionals, keeping the Trust current and forward thinking in national child death policy, procedure and learning.

What are our plans for 2024-2025?

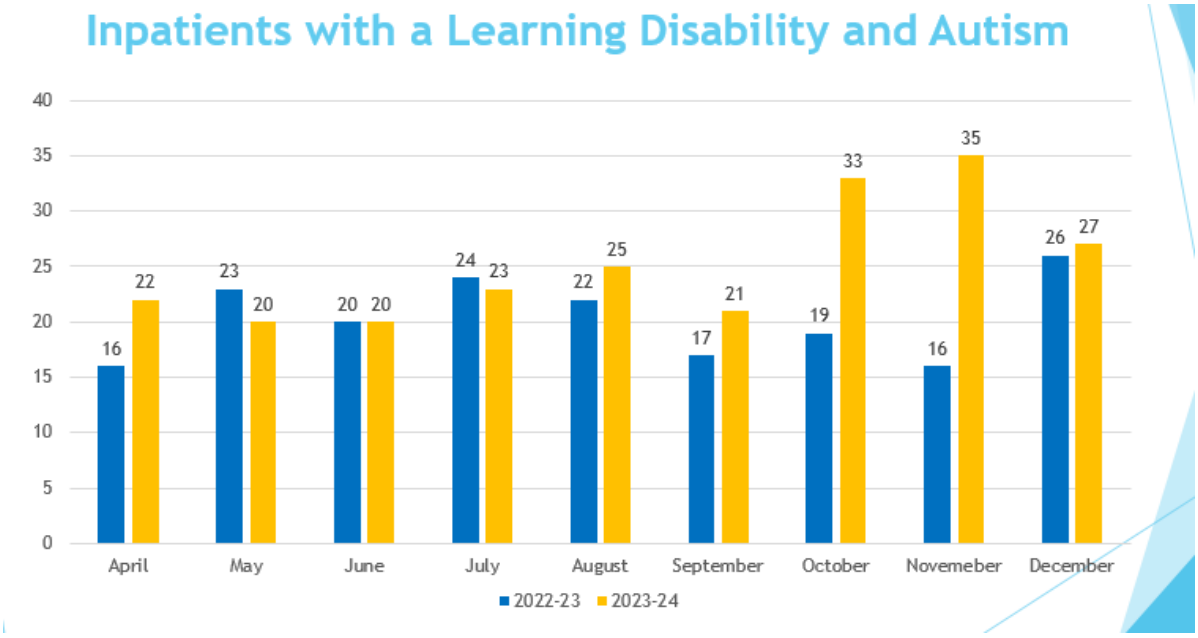
- The facilitation of an on-line CDOP Learning Event for multi-agency front line professionals working with children and families.
- Review of the pathway for children on a palliative care pathway in the community and they are brought to Rotherham Hospital
- Review and implement pathways so the Trust is complaint with *"National Medical Examiners Good Practice Series: Medical examiners and child deaths"* (The Royal College of Pathologists, 2022), with reference to non-coronial child deaths in the Trust and community.
- To participate in South Yorkshire CDOP thematic review.
- Review provision of bereavement support for families / carers following the death of a child resident in Rotherham and explore funding for options.
- TRFT, as part of the CDOP will consider how we support and influence future strategies to reduce the harm of social deprivation.
- Lead Nurse Child Death Review will continue to contribute to the TRFT self-assessment in relation to Bereavement Care Standards and identify actions for TRFT.

17 Learning Disability and Autism Team

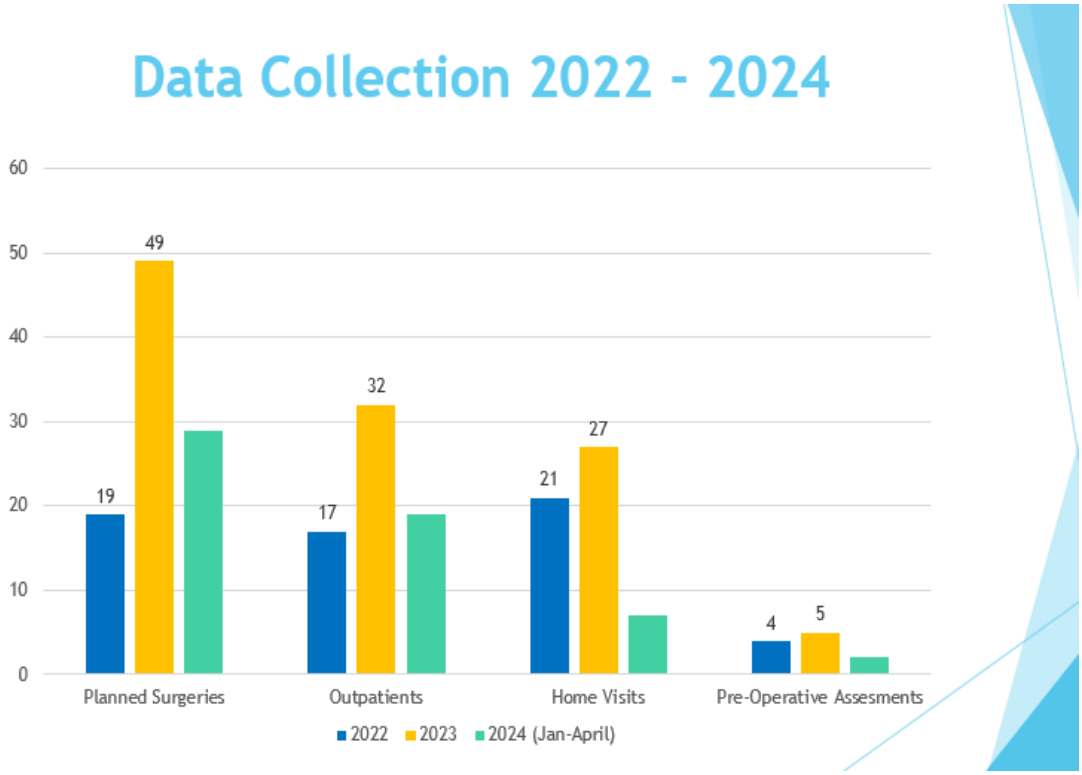
The Learning Disability and Autism Team continue to see an increase in the number of individuals they support to access healthcare within TRFT. The data below shows the significant increase in individuals seen, and supported by the team. With a 21% increase in inpatients being supported by the Learning Disability and Autism Team. The Matron for the service is currently studying advanced clinical practice which will enhance the service further by providing more community based treatment and support. As a non-medical prescriber, the Matron has been able to support the surgical pathway with pre-admission prescriptions. This is done in collaboration with the consultant and is making a positive impact on the surgical pathway experience.

"My son had elected surgery at Rotherham Hospital, he has autism and learning difficulties and came through with a hospital passport. The passport was completed by the learning disability team and were second to none, and was so kind and understanding. A huge giant thank you has to go to this team, as I do not believe the surgery would have happened without their planning, understanding and continued support.
We were home safe at about lunchtime and all had gone as planned, absolutely fabulous.

Thank you to you all"



The team provides specialist support to clinical teams during the whole clinical pathway. The team will visit and support at home, completing passports and liaising with the clinical teams regarding reasonable adjustments. They provide support during the consent process, and on the day of the visit will support in out-patients, on the ward, or in theatre. The chart below shows the increase in individuals being able to access surgery with the care and support of the team, with an 88% increase in planned surgeries from 2022 to 2023, and already this year in the first quarter they have supported over 50% of last years total.



The team has been luckily enough to receive the help and support of our hospital charity over the past year. They have kindly funded a second batch of our Learning Disability and Autism Staff resource files. There are files which are created to help and assist our general colleagues at times when the specialist support is not available. They contain information about the Hospital and Autism passports, communication aids and tips. Lots of pictorial information. Information on gathering information for easy read material and basic information around, 'what a learning disability is' and 'what Autism is'. It gives guidance around the internal resources for people with a learning disability and autistic people we have in the Trust and also across PLACE.

We were fortunate to receive a second amount of funding to purchase our second batch of sensory bags. This equipment was requested directly from our experts with experience, who attend our bi monthly patient experience group for people with a learning disability and people with autism. The sensory bags include, noise cancelling head phones, light therapy equipment, fidget toys and a weighted lap blanket. Another great example of Ask, Listen and Do!

World Autism Acceptance Week 2024

Empowering healthcare: Supporting individuals with autism

This week has been World Autism Acceptance Week, an internationally recognised day that aims to raise awareness about autistic individuals throughout the world.

In celebration, we thought it would be a fantastic opportunity to catch up with Jenny Turedi (Learning Disabilities and Autism Matron) and Nicola (Specialist Practitioner), two members of the Trust's dedicated Learning Disability and Autism team to find out how the Trust supports patients on the autistic spectrum.

"At the core of our approach lies the implementation of reasonable adjustments tailored to meet the diverse needs of individuals with autism. From the moment a patient steps into our care, every effort is made to ensure their comfort and well-being," says Jenny proudly.

Often the simplest measures have the most impact on individuals with autism. These could include providing written communication aids for those who may struggle with verbal interactions, or offering sensory equipment in waiting areas to alleviate anxiety, are just a few examples of the team's proactive approach.

"We believe that even the smallest adjustments can make a significant difference in the lives of individuals with autism," says Nicola, one of our Nursing Associates at the Trust.

Recognising the importance of clear communication and understanding, he team have developed a comprehensive 54-page resource booklet for staff informing them on many initiatives that promote inclusive healthcare.

These include, but are not limited to, the Hospital Passport, information about reasonable adjustments, how to communicate with people with autism, how to involve family members, and more.

One of the most powerful measures in place at the Trust is our flagging system within the hospital. It ensures that individuals with Autism are identified from the moment they enter our care," said Jenny proudly. "This allows for tailored support and accommodations throughout their journey."

These initiatives aim to foster a deeper understanding of autism spectrum disorders among healthcare professionals, empowering them to provide patient centred care that goes beyond medical treatment.

Through collaboration with community partners and experts by experience, the team has pioneered initiatives that are not only effective but also person-centred. "We actively seek feedback from patients and their families, ensuring that their voices are heard and their needs are met," says Jenny.

Innovative solutions, such as the introduction of sensory boxes and therapy equipment in our emergency departments, further enhance the quality of care for individuals with autism. "We are breaking down barriers and paving the way for a future where individuals with autism receive the support and respect they rightfully deserve," concludes Nicola.

On reflection, the compassion, innovation, and commitment to making reasonable adjustments that The Rotherham NHS Foundation Trust is transforming the healthcare landscape for individuals with Autism.

We'd like to say thank you to Jenny, Nicola and the wider Learning Disability and Autism team. They remind us that with empathy and understanding, we can create a world where everyone, can access the care they need and deserve.

Rotherham leads the way in inclusive healthcare for individuals with autism

The Rotherham NHS Foundation Trust is proud to champion inclusive healthcare across the borough for individuals with autism.

Through the implementation of proactive measures and innovative solutions, the Trust is breaking down barriers and setting new standards for accessibility and support in healthcare settings.

"At the Trust we are committed to providing exceptional care to all individuals, including those with autism," says Joanne Beahan, Medical Director at The Rotherham NHS Foundation Trust. "Our initiatives are driven by a deep understanding of the unique needs of individuals with autism and learning from people with experience, to making healthcare experiences more accessible and comfortable for them."

Key initiatives include the implementation of a comprehensive flagging system within the hospital, ensuring that individuals with autism are identified from the moment they enter care. This allows for tailored support and accommodations throughout their healthcare journey.

"We believe in taking a proactive approach to inclusive healthcare," says Joanne. "By identifying individuals with Autism early on and making reasonable adjustments, we can provide personalised patient centred care that meets their specific needs."

In addition, The Rotherham NHS Foundation Trust has introduced sensory equipment and therapy tools in emergency departments to provide additional support for individuals with autism during stressful situations.

"Our goal is to create a welcoming and inclusive environment where every individual feels understood and supported," emphasised Jenny Turedi, Learning Disabilities and Autism Matron at The Rotherham NHS Foundation Trust. "Through collaboration with community partners and experts by experience, we are continuously striving to improve our services and ensure that individuals with autism receive the care they deserve."

If you have any questions or concerns about inclusive healthcare for individuals with Autism, we encourage you to take action today. In the first instance, please speak with your GP, who can provide guidance and support tailored to your specific needs.

18 Prevent

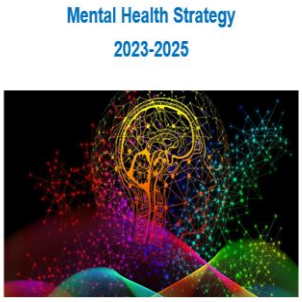
What is the Prevent Duty?
The Prevent Duty was introduced through the Counter Terrorism Strategy and Security Act 2015 and the Duty required health bodies, local authorities, higher education institutions, prisons, probation and the police to consider the need to Safeguard people from being drawn into terrorism.

TRFT use the e-learning for health Preventing Radicalisation training. All staff and volunteers working in the NHS are required to have an understanding of the risk factors for those vulnerable to exploitation for radicalisation.

There have been 2 referrals for Prevent this year, neither progressed to Channel Panel where individual cases are considered and a support package is determined, based on individual risks and their needs. TRFT are represented at Channel, and share information into the meeting as required. There have been no missed opportunities identified for TRFT this year. Information Rotherham Prevent partners has completed a benchmarking self-assessment, with peer challenge taking place to agree grading.

Benchmark	Final Agreed Score	Recommendations
Multi-agency partnership group	Exceeding	Improved engagement with elected members in the region, particularly Humberside local authorities.
Local Risk Assessment Process	Exceeding	Risk assessment could be updated quarterly, and communication with staff could be improved to ensure they are sighted on current threat and risks in the area.
Partnership Plan	Exceeding	
Referral pathway	Exceeding	
Training Programme	Exceeding	
Reducing Permissive Environment	Exceeding	Improved communication with private sector in relation to venue hire best practice (preventing extremist speakers)
Communication and Engagement	Exceeding	Further work to engage with the community.

19 Mental Health



TRFT has launched it mental health strategy, underpinned by the Trust values, and the cross government strategy, No health without mental health (2011). The implementation of the TRFT strategy is progressed and scrutinised by the Mental Health Steering Group, which includes representatives from partner agencies.

The safeguarding team represent TRFT at the operational and strategic suicide prevention groups, which are managed through Public Health. There has been significant progress made across TRFT in relation to supporting individuals with Mental Health concerns. Management and support plans are developed with partners for those who use our UECC services frequently, this enables them to be seen and supported quickly by the right clinician who can understand their needs. Monthly meetings with the Mental Health Act team at RDaSH are in place that reviews individuals who have been subject to the Mental Health Act at TRFT. A supportive approach to de-escalation and restrictive care has started to be rolled out, with the first cohort of staff trained in safe restrictive care methods.

Mental Health Liaison

The Mental Health Liaison Team have worked hard to improve their 1 hour target KPI compliance for UECC patients, and the data produced by RDaSH shows 83% of patients in UECC are seen within 1 hour of being fit for assessment. Breaches are often due to referrals being received during handover between night and day staff. Almost all breaches are between 1 and 3 hours, with anything outside of this due to a change in the patient condition, and them no longer being fit for assessment. There is good collaborative assessments completed between alcohol liaison and mental health liaison, which improves the experience for the patient and reduces the time taken to assess. Ward KPIs are consistent with 98.5% of referrals responded to within 24 hours.

Section 136 of the Mental Health Act

The chart below shows mental health activity across the Trust, with 30 patients detained under Section 136 in UECC during this annual period. The safeguarding team do not have the data on whether these individuals required physical healthcare alongside their mental health, but this will now be collated. We know that during this annual period, Section 136 of the Mental Health Act was used 871 times across South Yorkshire, with 120 from the Rotherham area. Of the 30 individuals that were brought to TRFT, not all were Rotherham residents. Work is ongoing by the ICB to look at the use of the 136 beds, including a plan to increase capacity further.

There is little use of the holding power section 5.2, and the safeguarding team have worked with the Mental Health Liaison Team to deliver training and raise

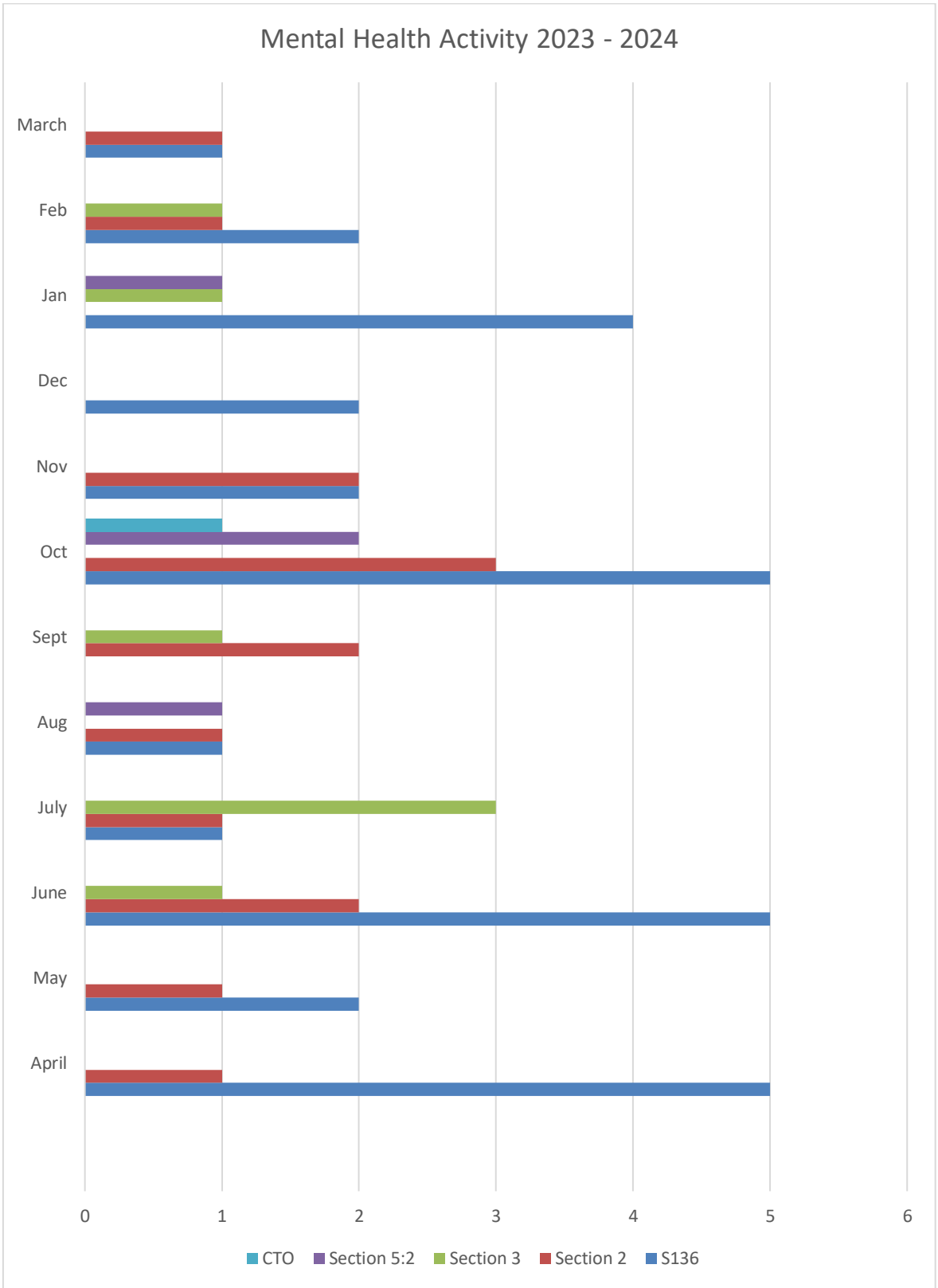
awareness of section 5.2, and how this may assist with the assessment and management of some patients.

Medical Emergencies in Eating Disorders (MEED)

MEED has remained on the Trust agenda, but there has been a significant reduction in admissions related to MEED this year. Following a long admission, the team on A1 worked closely with mental health and safeguarding colleagues to successfully discharge a patient home on Section 17 leave, and managed her transition into the community safely. It is very unusual for an acute hospital to discharge in this way. The patient story was shared at Mental Health Steering Health Group.

Right Care Right Person (RCRP)

This year saw the role out of the Right Care Right Person (RCRP) approach by South Yorkshire Police. The safeguarding team have worked closely with UECC, security and policing colleagues to implement this approach and resolve any concerns swiftly. The safeguarding team attend both tactical and strategic groups in relation to this, and any calls made to the police from 'health' where police did not attend are reviewed by the operational group. As a Trust we have had very few escalations, with good internal processes in place before calling the police. Phase 3 has been fully implemented, and the national team are now considering an appropriate police response to calls for under 18s. Once agreed there will be stakeholder engagement and TRFT will be working in partnership with the police to implement any further guidance.


Mental Health Activity 2023 - 2024
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S136

20 Multiagency Practice Reviews (MARs)

Safeguarding Adult Reviews (SAR's), Domestic Homicide Reviews (DHR's) and Safeguarding Child Practice Reviews (SCPRs) continue to form a significant of work for the Safeguarding Team. During this annual period, 2 multiagency reviews have been published across the 3 safeguarding partnerships, learning from these has been shared across the organisation. There are currently 6 multiagency reviews taking place, which TRFT are contributing. The Safeguarding Team disseminate the learning through the governance structure, supervision, training and the bulletin.

There have been no specific learning points or actions for TRFT in any of the reviews.

A learning and reflection day has taken place following the publication of safeguarding adult reviews where the theme was self-neglect. The multiagency policy and procedures has been updated following this, and the learning has been shared.

21 Training

The safeguarding team continues to deliver training as a key part of the role.

The Think Family training is delivered twice a month, with 375 staff attending the sessions during this year. The sessions evaluate very positively as they follow a case study throughout the day. There have been some issues with non-attendance, and managing the waiting list, but the team have been able to increase from 30 up to 60 participants since March and the Care Group triumvirates are supporting with encouraging attendance at the sessions.

For this annual period TRFT clinical staff have achieved (Trust Wide data):

Adult SG Level 2	93.2%
Adults SG level 3	100%*
Children SG level 2	89%
Children SG level 3	88.9%
Basic Prevent Awareness	90.7%
Preventing Radicalisation	93.7%
Safeguarding Team Level 4	100%
Dementia	99%
Oliver McGowan E-learning	47.6% **
Mental Health Awareness (3 years)	95.7%
Mental Health Act (2 years)	59.9%***

Non-clinical staff achieved:

Adult SG level 1	92.4%
Children SG level 1	90.9%

*The Safeguarding Adult level 3 competency is allocated to a small cohort of staff. This intercollegiate guidance is being reviewed and it is anticipated that this will be allocated to a large proportion of the adult workforce, which will affect competency during the next year. A plan is in place to elevate the Think Family study day to include this competence.

**The Oliver McGowan e-learning was launched to all staff during quarter 4, it is particularly positive that almost 50% of staff have completed the tier 1 e - learning to date. The tier 2 training is being launched in April 2024

*** The 2 yearly Mental Health Act training is delivered face to face by RDaSH colleagues. There is ongoing work to review the individuals who require this training, which focuses on the Trust receiving patients detained under the Mental Health Act.

Trust's first UECC Safeguarding Children's Simulation Session a huge success

The Trust's first safeguarding children's simulation session took place on Thursday, and our newly-appointed colleagues from UECC were invited to participate. Run by Heidi Johnson, Safeguarding Children's Nurse Advisor, Karen Clithero, Paediatric Liaison Nurse, and Rachel Stoneman, Paediatric Sister within Urgent and Emergency Care, the session included using the simulation baby and actors to create a realistic scenario that colleagues could learn from.

The scenario was of a young child who had come into UECC with injuries that didn't match the story the child's parents gave. Using resources like the multi-agency threshold descriptors, Heidi, Karen and Rachel created an open, honest environment where all participants were welcomed to ask any questions. The key takeaways included; 'don't ever underestimate the power of asking questions, and using your professional curiosity', 'safeguarding is everyone's business', and 'your referral may save a child's life'.

Feedback from participants was overwhelmingly positive – Nick, who joined the Trust eight weeks ago, described how it's always really important to ask questions, and that after the session they feel confident in knowing who they can ask for help, guidance or support – and others in the group echoed this. Learning by doing was also highlighted as the ideal way to learn for this group, meaning the simulation aspect of the session was highly useful. Heidi would like to thank Nicole Radford, Social Worker in Rotherham's Multi-Agency Safeguarding Hub (MASH) for assisting with the session.

Safeguarding Team Development

The Safeguarding Team seek opportunities to maintain our competence and have participated in:

- Non-Fatal Strangulation
- Hoarding and Self Neglect Multiagency Learning Day
- Mental Capacity National Masterclass
- Fraud and Scam Awareness
- Learning from Safeguarding Adult Reviews

22 Risk Management

There has been considerable progress on safeguarding risks, with 2 remaining in place at this time.

- Recording Arrangements to evidence Safeguarding Supervision Compliance
  This risk relates to the unreliability of the ESR data for safeguarding supervision and was added in June 2021.

  During this annual period the safeguarding team have continued to work closely with Learning and Development colleagues, and Family Health division continue to maintain a local database of compliance.

  The safeguarding team have completed a needs analysis and removed staff who no longer require the competence.

  This is viewed as an approved risk, with a score of 12 (Moderate risk)

- Medical Workforce non-compliance with Safeguarding MaST
  This risk is Trust wide and relates to the medical workforce where there is poor compliance across all divisions, with exception of community.
  This was opened in January 2024 and has a score of 12 (Moderate risk).

Targeted communications to medical workforce from the Medical Director have been sent, and signposting for staff to access the correct training and MaST compliance will form part of pre-appraisal and appraisal conversations.

23 Conclusion

This has been another challenging year across the NHS, and TRFT has remained compliant throughout this annual period in discharging all contractual and statutory safeguarding duties. The level of safeguarding activity demonstrates that safeguarding practice is embedded across clinical practice, and whilst we continue to drive practice forward and improve outcomes for those affected by abuse, we are proud of how staff have continued to be professionally curious where they have concerns. The Safeguarding Team has made positive progress with the objectives this year, and have lead, and supported a number of work-streams across the system, continuing to be a consistent and reliable partner to the safeguarding partnerships.

24 Glossary of terms

CDOP	-	Child Death Overview Panel
CDR	-	Child Death Review
CE	-	Child Exploitation
DASH	-	Domestic Abuse, Stalking, Harassment and Honour based violence Assessment Tool
DHR	-	Domestic Homicide Reviews
DOLS	-	Deprivation of Liberty Safeguards
ESR	-	Electronic Staff Record
HARK	-	Harassment, Attack, Rape, Kick
IDVA	-	Independent Domestic Violence Advisor
ISVA	-	Independent Sexual Violence Advisor
ISH	-	Integrated Sexual Health
LAC	-	Looked After Children
LADO	-	Local Authority Designated Officer
LPS	-	Liberty Protection Safeguards
MADA	-	Multiagency Domestic Abuse meeting
MARAC	-	Multiagency risk assessment conference
MASH	-	Multiagency Safeguarding Hub
MCA	-	Mental Capacity Act
MHA	-	Mental Health Act
PIPOT	-	Person in Position of Trust
RSAB	-	Rotherham Safeguarding Adult Board
RSCP	-	Rotherham Safeguarding Children Partnership
SAR	-	Safeguarding Adult Reviews
SARC	-	Sexual Assault Referral Centre
SCPR	-	Safeguarding Child Practice Reviews
SUDIC	-	Sudden Unexpected Death in Childhood
UECC	-	Urgent and Emergency Care Centre

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

The content of this template is updated periodically so it is important to review the current version online at NHS England » Quality assurance *before completing.*

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative

While some of the statements in this section lend themselves to yes/no answers, the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to use concise narrative responses in preference to replying yes/no.

1A – General

The board/executive management team of

can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year:	Current Medical Director has attended the RO training, has a licence to Practice and has personal Appraisal and Revalidation Records
Comments:	A deputy RO has been appointed to ensure any conflict of interest or bias is correctly managed. The deputy RO has attended both the RO training and appraiser training.
Action for next year:	Amendment to Job Description of Deputy Medical Director to formally recognise the Deputy RO role including the devolved responsibilities

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Action from last year:	Defined cost centre for Appraisal and Revalidation to ensure that all costs associated with providing the RO function are clear and are constantly reviewed
Comments:	Dedicated cost centre developed with revised budgetary management processes and clear contract management for subscriptions
Action for next year:	New process for securing future pipeline of medical appraisers with appropriate financial governance.

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Action from last year:	Monthly calibration between starter and leaver staff lists and GMC Prescribed Connection list. Medical Establishment list provided monthly to capture all starters and Leavers
Comments:	Liaising with outgoing/incoming Medical Practitioners to ensure that safe transfer of information both in and out of the Trust
Action for next year:	Appraisal and Revalidation function is aligned to Medical Workforce team to ensure a seamless transfer of medical starters and leavers. Medical Practice Information Transfer forms completed in a timely and efficient manner.

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year:	Medical Appraisal Policy has recently been re-written to take into account the changes to the Good Medical Practice and to align with the impending changes to the IT platform which hosts our appraisal portfolios.
Comments:	The Policy will require reviewing when the platform is changed, the changes required will purely be reference to the new IT platform and not procedural.
Action for next year:	Policies which support medical appraisal and revalidation will form part of a new policy tracker which is managed through the Joint Local Negotiating Committee. Two key policies for the forthcoming year will be a revised Maintaining High Professional Standards policy and the Enhanced Support/Remediation Policy.

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Action from last year:	A peer review has been undertaken with Barnsley Hospital, who is similar in staff and patient numbers. The findings were positive and gave assurance that our doctors are receiving a good standard of appraisal, and the appraisers are performing well.
Comments:	The feedback from the review have been shared and discussed at the Appraiser Forum meeting
Action for next year:	Ensure the recommendations have been implemented by all appraisers by auditing a sample of appraisals.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Action from last year:	The most recent Appraisal/ARCP document is requested from all new starters, whether they are locum or short term, this enables us to ensure the doctor can maintain their appraisal history. For doctors who are new to the UK a priming appraisal is offered to ensure the doctor is educated about Appraisal and Revalidation. Medical HR liaise with relevant departments to ensure all International Medical Graduates (IMG) are given a comprehensive induction and can initially work supernumerary
Comments:	Ensure all departments give suitable/timely induction.
Action for next year	Look further into supporting CPD, Governance and feedback.

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year:	A Revalidation checklist is used to ensure all relevant requirements are completed 12 months prior to the Revalidation date. Where External work is declared a letter of good standing is provided by the doctor from their place work stating any complaints, SI and outlying Clinical outcomes
Comments:	Pre appraisal checklists continue to be sent out to doctors 3 months prior to their appraisal month which include information about complaints, SI, reflection statements if they have been requested to attend coroners court, and a reminder to be up to date with their mandatory Training.

Action for next year:	Ensure MSF and Audit include data from external work.

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year	All missed/incomplete appraisals have a reason recorded. If a postponement is required then the RO must give their approval
Comments:	The IT platform logs any missed or incomplete appraisals and can be reviewed in an easy dashboard view for the Responsible Officer.
Action for next year:	Maintain the dashboard and report findings to ROAG

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year:	The Medical Appraisal Policy was ratified through the Trusts Governance Processes this has been reviewed to ensure the policy is in line with the new GMC Good Medical Practice Guidance.
Comments:	The policy will be reviewed by the appraisal team when the new IT platform is introduced
Action for next year:	The Policy may need to be amended when the IT platform changes to ensure accurate information is logged. The policy will be reviewed with key stakeholders including the Joint Local Negotiating Committee

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year:	The current appraisers facilitate 10 appraisals per year, the number of appraisers can be variable due to work load and scope of work changes.
Comments:	Continue to be pro-active in the recruitment of appraisers to ensure we maintain a sufficient Appraiser group, and ensure the recruitment is proportionate to the number of doctors requiring appraisals within that care group.

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

Action for next year	Ensure the correct ratio is maintained between appraiser/appraisee so there is flexibility to carry out timely appraisals.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Action from last year:	Appraiser meetings have taken place with an opportunity to review individual feedback
Comments:	Appraiser Forum agendas and minutes provide evidence of the learning points discussed. Appraisal team to check appraiser MAST compliance, especially Information Governance and Equality and Diversity.
Action for next year:	Continue with Appraiser Forum meetings, and sharing of information from external bodies (network events).

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year:	Each appraisal is quality assured by the Associate Medical Director for Appraisal and Revalidation. Issues must be promptly resolved
Comments:	Where the AMD has acted as the appraiser for a doctor, those appraisals are reviewed by the Deputy RO who will have final sign off for assurance purposes.
Action for next year:	With the introduction of new IT software the overall sign off process should be improved. This should increase efficiency and improved alignment to information governance procedures.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Action from last year:	GMC connect online portal clearly identifies which doctors are due for their revalidation. The platform easily identifies those within “notice period” which is the 4 months prior to their Revalidation date. This makes it easy for the team to prioritise the revalidations recommendations.
Comments:	Progress reports on Revalidation recommendations Revalidation Checklist, completion dates and GMC connect data confirming timely submissions

Action for next year:	Ensure all doctors are aware of their responsibilities in ensuring that they are adequately prepared well in advance of their Revalidation date. This includes ensuring timely engagement with Multi-Source Feedback surveys. There will be a continuation of revalidation checklists. Provide assurance reports to Responsible Officer Advisory Group (ROAG) to ensure visibility of metrics. Revalidation is now on the dashboard presented at ROAG

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Action from last year:	The AMD for Appraisal and Revalidation completes the Revalidation Checklist for the Responsible Officer to review.
Comments:	Revalidation checklists are routinely completed for each doctor nearing Revalidation to ensure all relevant information is available. Medical appraisal and revalidation managers ensure each doctor approaching revalidation has an electronic evidence file with shortcut links to all revalidation evidence so the AMD and RO can easily check against the checklist.
Action for next year:	AMD emails all doctors who have evidence missing to discuss possibility of making a deferral to give more time to collect necessary evidence. Medical appraisal and revalidation support managers to prompt doctors who are missing evidence when their checklist is created a year in advance of their revalidation date.

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year:	All doctors are sent a data pack well in advance of their appraisal date, this includes complaint, SI and MAST information
Comments:	The data pack include their appraisal month, their appraiser's name, complaints, SI, coroners request, MSF report (if they have collected within that year), and a reminder to ensure their MAST is up to date.
Action for next year:	There are policies in place for supporting/responding to concerns about Medical professionals,

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Action from last year:	All doctors are provided with a data pack which includes complaint and Si information for the doctor to reflect on and discuss as part of their appraisal.
Comments:	The above are examples of good practice as quoted in NHS England Appendix F.
Action for next year:	Review of medical and dental policies pertaining to the appraisal and revalidation function with involvement of key stakeholders.

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Action from last year:	All doctors are sent an email reminder which includes, appraisal month, Si & complaint information and MAST compliance
Comments:	As detailed in 1D(i) information is shared with the doctors prior to their appraisal month which includes complaints, SI, coroners request, MSF and a MAST reminder.
Action for next year:	Consolidation of key information into one reported which is then uploaded onto the appraisal portfolio. This will also support the appraiser in exercising their role.

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year:	The Trust has an Enhanced Support Policy in place – currently under review. The policy aligns to the MHPS
Comments:	Check with RO regarding Enhanced Support Policy or something similar
Action for next year:	Review of MHPS policy and Enhanced Support Policy with involvement of key stakeholders including the JLNC.

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Action from last year:	Discuss at ROAG which consists of Lay and Non-Executive Director representation.
Comments:	Currently use the PPPA template, to ensure that this aligns with MHPS.
Action for next year:	Audit of process in place for managing concerns about medical and dental colleagues. The audit will be aligned to the requirements outlined in the MHPS policy whilst taking into account any new national guidance in particular the GMC's Fair to Refer.

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Action from last year:	For all doctors who have had a previous Designated Body a Transfer of Information is sent for RO to RO information. All doctors who work outside the organisation are expected to include a statement of good standing from that employer stating complaint and SI information.
Comments:	An audit has been completed to check that a Transfer of Information document was sent for all new starter and received in a timely manner. Any issues to be shared with the RO
Action for next year:	Maintain above protocols and re-audit

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year:	Review of clinical governance arrangements in place for doctors subject to interventions made by the trust.
Comments:	Review MHPS policy and Fair to refer document
Action for next year:	Review of MHPS policy and Enhanced Support Policy with involvement of key stakeholders including the JLNC.

	Audit of process in place for managing concerns about medical and dental colleagues. The audit will be aligned to the requirements outlined in the MHPS policy whilst taking into account any new national guidance in particular the GMC's Fair to Refer.

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Action from last year:	Recommendations from national reviews, reports and enquiries are disseminated through the Trust governance processes.
Comments:	Review of GMC Good Medical Practice disseminated to medical colleagues and local policies and procedures reflected new regulatory changes. Relevant trust policies and procedures updated. The NHS England Improving the Working Lives of Doctors in Training reviewed at the Trust Executive Team and presented to JLNC.
Action for next year:	The NHS England recommendations associated with improving working lives of doctors in training will be reviewed via trust governance processes such as JLNC, Junior Doctor Forum and People Committee. The recommendations will also be embedded as part of the wider People Promise/People Strategy project.

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	Recommendations from the Messenger review to reduce the variation in leadership structures and ensure that medical professional are in receipt of appropriate training to overcome the flawed assumption that simply acquiring seniority translates into leadership skills and knowledge when entering into a new clinical leadership role.
Comments:	Successful implementation of a Trust wide medical leadership and development programme which hosted a series of workshops to support clinicians entering into their first clinical leadership position.
Action for next year:	Continuation of workshops through lunchtime lectures to allow for "bite-size" leadership knowledge sessions to be attended by all clinicians with subjects chosen relevant to their leadership roles.

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year:	The recruitment team have processes in place to check all pre-employment checks as per NHS Employers Guidance

Comments:	In relation to qualification this is initially checked by the GMC and the candidate would not be able to obtain this registration without the correct qualification. The original Medical Degree from each successful candidate is required as part of the pre-employment checks.
Action for next year:	Continue as per guidance and audit practices

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Action from last year:	Ensuring that there is harmonisation of overriding professional standards as a doctor with the overall adherence to the Trust values and behaviour framework.
Comments:	Contributing to a positive working and training environment ensuring that behaviours modelled are consistent with the principles laid out by regulatory bodies are not conflicting.
Action for next year:	Ensuring that all doctors model the behaviours expected and they are free from discrimination of any kind. Work continues on the psychological and sexual safety agenda. Confidence to call out behaviours inconsistent with values, enhancing freedom to speak up opportunities/listening events.

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Action from last year:	All policies and procedures adhere to the latest Equality and Diversity legislation. EIA available on each policy relating to A&R
Comments:	
Action for next year:	Consider how policies can be further enhanced for Trust initiatives such as veteran aware and the wider inclusion agenda

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Action from last year:	The Trust has a Freedom to Speak up Policy which supports and endorses the Freedom to Speak up review (2015). The Trust advertises Trust wide the members of staff signed up as freedom to speak up Guardians.

Comments:	Doctors are provided with details of complaints and SI`s which give them an opportunity to take part in reflective learning emphasising a culture of openness
Action for next year:	Ensure that doctors continue to receive complaint and SI information to enable them to reflect and discuss at their appraisal meeting

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Action from last year:	The Trust provides clinicians with copies of any complaints prior to their appraisal for reflection and discussion with their appraiser
Comments:	Ensure that there is a mechanism embedded in sharing data about doctors to doctors to enable them to adequately prepare for appraisal Signpost to freedom to speak up guardians
Action for next year:	Documentation within appraisal portfolios Audit of quality assurance in appraisal portfolios.

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Action from last year:	Numbers remain very low thus unable to provide an analysis
Comments:	The RO Advisory Group continues to meet quarterly to discuss such issues. This compliments the discussions with the GMC (Employment Liaison Officer) and the Quarterly RO`s report to Board
Action for next year:	Review of action plan associated with the MWRES to gain a greater understanding of issues faced by our medical and dental colleagues including ensuring that we are able to collect the right data to be able to provide assurance that we are inclusive employer and no doctor or dentist is in receipt of less favourable treatment owing to their background.

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Action from last year:	The RO and Appraisal team attended the NHS England Network meeting
Comments:	The number of Network meetings have reduced in frequency but the ones that are organised are readily attended by the Appraisal team
Action for next year:	Ensure attendance at NHS England Network meetings and cascade information to the Appraisers at the Forum Meetings

Section 2 – metrics

Year covered by this report and statement: 1April 2023 - 31March 2024

All data points are in reference to this period unless stated otherwise.

2A General

The number of doctors with a prescribed connection to the designated body on the last day of the year under review. This figure provides the denominator for the subsequent data points in this report.

Total number of doctors with a prescribed connection on 31 March 2024	272

2B – Appraisal

The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions is as recorded in the table below.

Total number of appraisals completed	**261**
Total number of appraisals approved missed	**10**
Total number of unapproved missed	**1**

2C – Recommendations

Number of recommendations and deferrals in the reporting period.

Total number of recommendations made	69
Total number of late recommendations	0
Total number of positive recommendations	64
Total number of deferrals made	5

Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	5

2D – Governance

Total number of trained case investigators	7
Total number of trained case managers	5
Total number of new concerns registered	26
Total number of concerns processes completed	8
Longest duration of concerns process of those open on 31 March	16 weeks
Median duration of concerns processes closed	6 months
Total number of doctors excluded/suspended	1
Total number of doctors referred to GMC	1

2E – Employment checks

Number of new doctors employed by the organisation and the number whose employment checks are completed before commencement of employment.

Total number of new doctors joining the organisation	118
Number of new employment checks completed before commencement of employment	118

2F Organisational culture

Total number claims made to employment tribunals by doctors	0
Number of these claims upheld	0
Total number of appeals against the designated body's professional standards processes made by doctors	0
Number of these appeals upheld	0

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
1. External review of appraisal system has now been completed and the findings presented at the ROAG meeting. The suggested changes have been implemented by sharing information with and education of appraisers at appraiser forum meetings. The compliance with these changes is monitored by the appraisal lead in the review of each completed appraisal to ensure it meets standards and requirements. 2.Appraisal platform tender and implementation. New appraisal platform has been identified and we are in the process of migrating information, training and implementation. This should be completed by October 2024.
Actions still outstanding
Current issues
Appraisal budget to be funded by individual Care groups, to share the cost fairly, a business case has been submitted to seek board. approval
Actions for next year (replicate list of 'Actions for next year' identified in Section 1):
Ensure adequate number of appraisers with each doing a maximum of 10 appraisals each appraisal year. Ensure all appraisals are reviewed by appraisal lead to ensure consistency and quality of appraisals.

Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):
Medical colleagues received high quality of appraisal as supported by the feedback received and the proud award nomination for the appraisal team. Our appraisal rate was 96%. New appraisers have been appointed and trained. External review suggested that we are providing good quality of appraisals and the changes suggested have been implemented, and will be reviewed this year. Appraisal Forum meetings have been well attended and information sharing has been taking place including an excellent update from the GMC representative on the new Good Medical Practice.

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	

Name:	
Role:	
Signed:	
Date:	

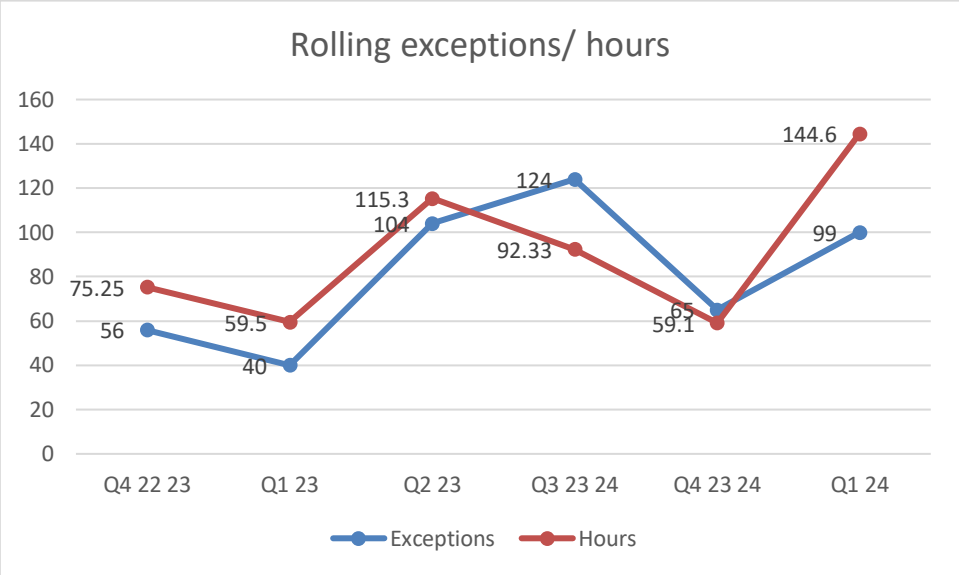
Board of Directors Meeting/People Committee
6 September 2024

Agenda item	P144/24
Report	**Guardian of Safe Working Quarterly report Q1 24**
Executive Lead	Dr Jo Beahan, Medical Director
Link with the BAF	P1
How does this paper support Trust Values	Ambitious- for improvement in working conditions and patient safety. Caring- for colleagues and patients. Together- solutions are proposed after discussion has identified problems.
Purpose	**For decision** ☐ **For assurance** ☐ **For information** ☒
Executive Summary (including reason for the report, background, key issues and risks)	Under the 2016 Junior doctor contract a quarterly and annual report from the Guardian of Safe Working is required to provide assurance to the Board that working in the trust is safe. The contract specifies maximal shift durations, total hours per week and hours worked without breaks. A dispute over national pay and conditions for junior doctors has reached a potential resolution with an improved offer from government being put to members. NHSE have prioritised improving the quality of junior doctors' working lives with a range of initiatives. A new Director of medical education has taken up post. The GSW would like to thank the outgoing DME, Dr. Jon Clark, for his help and support to the trainees over many years of tenure and to wish Mr. Alex Kocheta well in his new position. The number of exception reports and additional hours worked have ticked up this quarter driven by increased numbers from surgery and orthopaedics. As always, the most junior doctors in medicine account for the largest proportion. Overall hours worked are not unsafe. The intensity of working, however, is always high in Medicine and workload and staffing are sometimes flagged as unsafe; especially by the most junior trainees.

<table>
<tr><td>Due Diligence
(include the process the paper has gone through prior to presentation at Board of Directors' meeting)</td><td>The Report collates information from the Allocate system for exception reporting, the Junior Doctors' forum monthly meetings, the Datix system, personal communication and assorted email correspondence.
It has been prepared by Dr G Lynch, RFT Guardian for Safe Working, and sponsored by Dr J Beahan, Executive Medical Director.</td></tr>
<tr><td>Board powers to make this decision</td><td>[This section should refer to the relevant section of the constitution, SO, SFIs, scheme of delegation etc.]</td></tr>
<tr><td>Who, What and When
(what action is required, who is the lead and when should it be completed?)</td><td>Dealing with the issues raised in junior doctor forum which takes place monthly-JDF attendees including medical staffing, MD, DME and GSW.</td></tr>
<tr><td>Recommendations</td><td>The Board is asked to note this report.</td></tr>
<tr><td>Appendices</td><td>
<u>Exception Report 1st Quarter details (as of 28/6/24) by ward/specialty</u>

<u>Working hours</u>:
<table>
<tr><th>(Sub) Specialty</th><th>Exceptions</th><th>Daytime Hours</th><th>Nightime hours</th></tr>
<tr><td>A1 Cardiology</td><td>6</td><td>8.25</td><td></td></tr>
<tr><td>A1 HCOP</td><td>6</td><td>6.91</td><td></td></tr>
<tr><td>A2 HCOP</td><td>7</td><td>5.5</td><td></td></tr>
<tr><td>A4 HCOP</td><td>12</td><td>17.16</td><td></td></tr>
<tr><td>A3 Respiratory</td><td>7</td><td>7</td><td></td></tr>
<tr><td>A5 Diabetes</td><td>4</td><td>3.20</td><td></td></tr>
<tr><td>A5 Gastro</td><td>11</td><td>15.5</td><td></td></tr>
<tr><td>AMU</td><td>13</td><td>11.33</td><td></td></tr>
<tr><td>Medical Division total</td><td>66</td><td>74.85</td><td></td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td>Orthopaedics</td><td>5</td><td>24.33 (incl 20 TOIL)</td><td>0.25</td></tr>
<tr><td>GP</td><td>5</td><td>12</td><td></td></tr>
<tr><td>Obs and gynae</td><td>1</td><td>2.5</td><td></td></tr>
<tr><td>General surgery ASU</td><td>6</td><td>5.5</td><td>5</td></tr>
<tr><td>General Surgery B10</td><td>15</td><td>14.33</td><td>4.33</td></tr>
<tr><td>Paediatrics</td><td>1</td><td>1.5</td><td></td></tr>
<tr><td>Total</td><td>33</td><td>60.16</td><td>9.58</td></tr>
</table>
<u>Exception reports for missed educational opportunities</u>

Three exception reports for missed educational opportunities were filed from Medicine- these are dealt with by the DME
</td></tr>
</table>



Immediate safety concerns

3 ISCs were logged and correlate with the 3 Datixes from Medicine below.

Triangulation with Datix system

Search of the Datix system revealed 6 incidents in the past quarter where lack of trainee staff are mentioned-
3 from Medicine relating to a vacant SHO slot for 3 nights
2 from Surgery relating to workload, 1 from a weekend where distribution of labour was an issue.
1 from Paediatrics relating to an unfilled registrar slot
All were graded as no harm incidents

Guardian fines

No fines have been levied this quarter

Qualitative examples from Exception reports

“Consultants understaffed, our consultant had to cover frailty, he could then only see around 8 patients. Very poor staffing - leaving only F1 & F2 on the ward for 33 unwell patients as all medically fit patients move to B5.

“Supposed to have two zero days per 10 weeks rota (ten week rolling rota). At end of first cycle now - no zero days rostered. D/W…, recommended to exception report.”

Unable to attend protected foundation teaching as ward round was still taking place at 1pm.

Actions to mitigate issues

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

The GSW, DME, and foundation director have raised any serious problems highlighted in Exception reports as soon as possible to the divisional leadership in medicine, as well as to medical workforce where appropriate; in particular any which might pose genuine immediate threats to safety.

New JCFs have been employed in medicine-this will help to reduce workload and exceptions.

Issues for Junior doctor forum

The GSW and DME will co-chair the Junior or Resident doctor forum and alternate weekday meetings to help attendance.
This forum is the vehicle for trainees to raise concerns and issues and for management and medical workforce to respond. As well as doctors in training, it is attended by representatives from medical workforce, the care groups, MD, DME and GSW.

Concerns addressed include- Rotas and staffing, missed educational opportunities, IT/ Meditech and equipment issues consultant supervision, Lack of WOWs, label printers, accommodation, issues with lack of bleeps and DECT phones and the new wifi phone system, locum induction and Meditech access.

The current work pattern of A4/B5 will be discussed at JDF to ensure it prioritises safety of patients flowing through the hospital.

Division of workload on surgical weekends will be discussed to make sure it is equitable and fair.

Immediate risks to safety and any departures from contract will be flagged up as soon as possible to the divisions by the GSW and DME.

NHSE have mandated measures to improve working lives: including timely rotas, increased availability of self-rostering improved payroll accuracy and reduced burden of Statmand training, amongst others and the JDF will discuss implementation of these.

Board Of Directors
06 September 2024

The Rotherham NHS Foundation Trust

Agenda item	P145/24
Report	**Controlled Drugs Annual Report 2023**
Executive Lead	Dr Joanne Beahan, Medical Director
Link with the BAF	P1: There is a risk that we will not embed quality care within the 5 year plan because of lack of resource, capacity and capability leading to poor clinical outcomes and patient experience for our patients.
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	This annual report presents a summary of controlled drug incidents reported via Datix for the period January 2023 to December 2023. The Chief Pharmacist is the Controlled Drugs Accountable Officer for the Trust and reports Trust CD incidents into the CD Local Intelligence Network hosted by NHS England with CQC, police, and other organisations where CDs are used in attendance, the aim to share intelligence of controlled drugs issues and share learning and good practice. Overall, patient harm from controlled drugs is very low. Use of the Medicines Management audit via Tendable on a monthly basis at ward level has provided visibility of issues and the opportunity to address them in a timely manner. Pharmacy CD audits are planned to occur quarterly from Feb 2024. These need to be conducted through the Tendable app in order to provide greater visibility and cross referencing with other medicines audits in Tendable. The annual report was presented to Medication Safety Committee and Quality Committee in January. The board planner will be reviewd for next year to ensure the 2024 report is presented at a timely date.
Recommendations	For noting
Appendices	None

Controlled drug incidents reported January 2023 – December 2023

1. Introduction

This annual report provides an analysis of the controlled drug (CD) medication incidents reported via DatixWeb between January 2023 and December 2023. It includes all incidents related to Schedule 2, 3, 4 and 5 Controlled Drugs.

2. Controlled drugs: statistics and observations

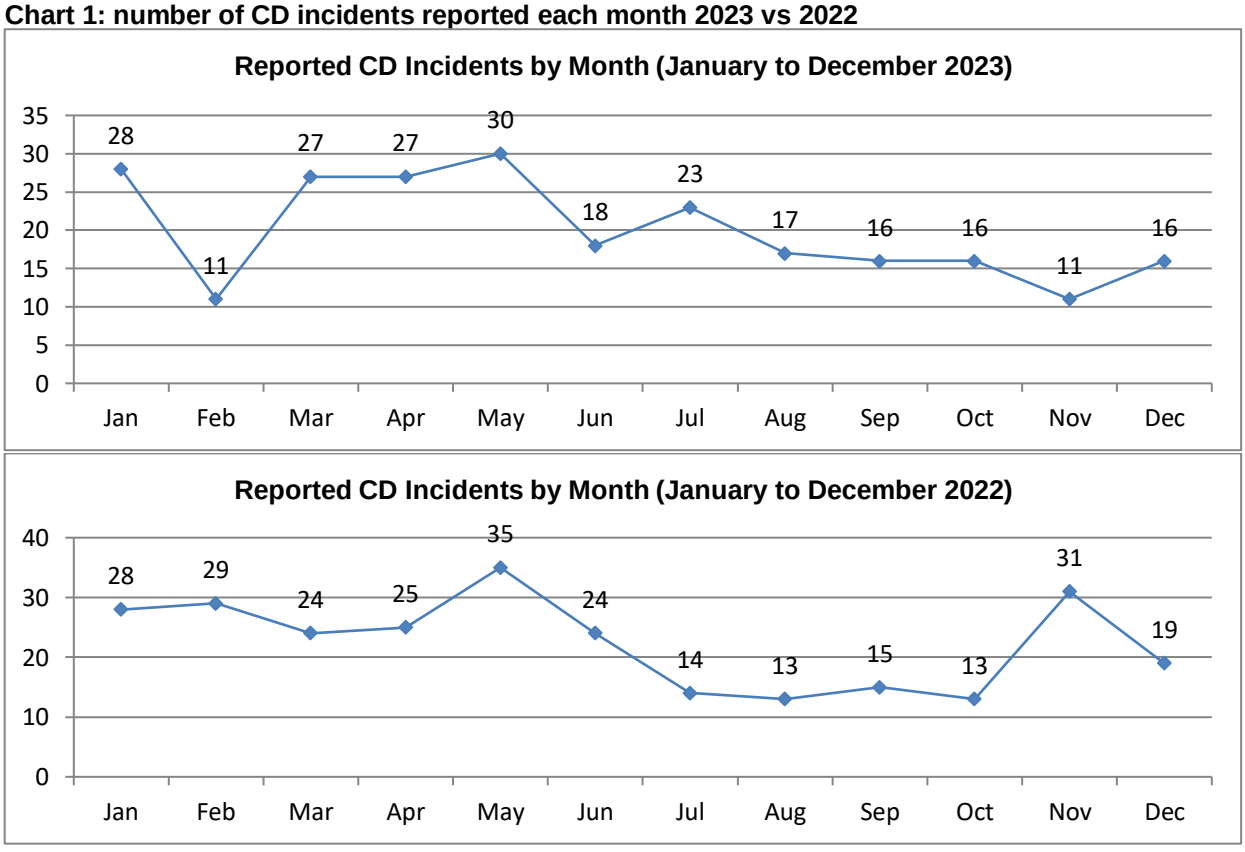
2.1 Incident data categorisation

The Medication Safety Officer (MSO) and Lead Medication Safety Technician categorise medication incidents in accordance with the National Reporting and Learning System (NRLS) categories, into which Trust incident data feeds. They also ensure that all relevant fields in the Datix reports are completed.

2.2 Number of CD incident reports

Chart 1 shows the number of CD incidents reported every month for the period January to December 2023. In total, 240 controlled drugs incidents were reported over the 12 month period. For comparison, in 2022, a total of 270 controlled drugs incidents were reported over the 12 month period.

Chart 1: number of CD incidents reported each month 2023 vs 2022



2.3 Harm from CDs

There were 224 (93.3%) 'no harm' incident reports and 16 (6.7%) 'low' harm reports. There were no incidents with a higher (moderate, severe, death) level of harm. In 2022,

there were 244 (90%) ‘no harm’ reports, 24 (9%) ‘low’ harm reports and 2 (1%) ‘moderate’ harm reports.

2.4 Incidents by stage of care

The incidents broken down by stage show there were:

- 148 administration incidents
    - these were mainly documentation related
- 23 prescribing incidents
- 18 dispensing incidents
- 2 patient adverse reaction
- 49 ‘other’ incidents – these were mainly documentation related e.g.:
    - daily CD checks at ward level not done (or not recorded as done)
    - discrepancies in liquid volumes versus cumulative balance (however there is an allowance for a 10% discrepancy with liquids and these incidents were within these limits)
    - second signatures missing in registers

2.6 Incidents by adverse event

The 16 LOW HARM incidents broken down by stage show:

- 1 adverse reaction
- 1 contra-indication to the use of the medication
- 4 Dose or strength was wrong or unclear
- 1 Expiry date wrong, omitted or passed
- 2 Medicine not administered
- 1 mismatch between patient and medicine
- 2 Omitted medicine/ingredient during Dispensing process
- 1 wrong drug administered
- 1 wrong route for administration
- 2 Other

3. Improvements in Dispensary

Significant improvements in recording CDs in registers and other Drugs of Potential Abuse, and triangulating stock balance with actual stock and stock level on the Pharmacy system. This has been vastly improved because of the implementation of a digital CD storage system, which reduces the chances of picking errors and also produces a digital register that can be triangulated with the dispensing system.

4. Further actions required

Pharmacy audits of controlled drugs need to be built in Tendable and cross correlated with monthly Medicines Management audits done locally by ward teams.

Continue linking with the CD Local Intelligence Network (CDLIN) (the Chief Pharmacist is the Controlled Drugs Accountable Officer for the Trust and reports Trust CD incidents into the CDLIN, hosted by NHS England with CQC, police, and other organisations where CDs are used in attendance; the aim to share intelligence of controlled drugs issues and share learning and good practice).

Review the need to report documentation-related CD incidents via DatixWeb, as these are not patient harm causing, and triangulate through Tendable audits. This will reduce the number of CD incidents reported and allow focus on patient level CD incidents. Currently, of the 224 ‘no harm’ reports, around 80% are documentation related, e.g. crossing out in CD register, missing second signature in register, daily CD stock check not taken place, which has no direct impact on patient care or harm.

The Chief Pharmacist is responsible for taking the above actions with a target date of completion during 2024.

6. Conclusion

Incident data suggests patients are not experiencing harm from controlled drugs and that good progress and improvement is being made with documentation in CD registers through daily checks, monthly auditing and quarterly Pharmacy checks

Osman Chohan
Chief Pharmacist
Controlled Drugs Accountable Officer
January 2024

Board of Directors' Meeting
6 September 2024

Agenda item	P146/24
Report	**Vice-Chair and Senior Independent Director Roles**
Executive Lead	Dr Mike Richmond, Chair Angela Wendzicha, Director of Corporate Affairs
Link with the BAF	Due to the nature of the roles, the paper links with all BAF Risks
How does this paper support Trust Values	The paper supports all Trust Values
Purpose	**For decision** ☒ **For assurance** ☐ **For information** ☐
Executive Summary	In accordance with the Code of Governance for NHS Provider Trusts, provision is made for the appointment of a Vice Chair and a Senior Independent Director. It is good practice to review this position on an annual basis and is usually carried out to coincide with the annual appraisal process. The process has now been completed and the Board is asked to support the continuation of the current position that Kamran Malik continue as Vice Chair for a further year and Heather Craven continue as Senior Independent Director for the duration of her current term of office.
Due Diligence	The appointment of the Vice Chair and Senior Independent Director is a matter for the Board and as such the paper has not been presented in any other forum.
Board powers to make this decision	Matters Reserved to the Board
Who, What and When	Following discussion and decisions made by the Board, the outcome will be shared with the Council of Governors at their meeting on 10 September 2024.
Recommendations	It is recommended that the Board: ➢ Support Kamran Malik as Vice Chair for a further year; and ➢ Support Heather Craven as Senior Independent Director for the duration of her current term of office. ➢ Note the above will be shared with the Council of Governors at their meeting on 10 September 2024

1. Introduction

1.1 The current Code of Governance and the Matters Delegated to the Board of Directors both make provision for the appointment of a Vice Chair and a Senior Independent Director from the cohort of existing Non-Executive Directors.

1.2 The Vice Chair deputises for the Chair in the event of their absence or unavailability but also presides over meetings where the Chair declares a pecuniary interest that prevents him from taking part in any matter before the Board of Directors.

1.3 The Senior Independent Director supports the Chair and makes themselves available to members of the Trust and or Council of Governors in the event concerns have been raised. In addition, the Senior Independent Director supports the Chair by being a source of advice for them.

2. Proposal to appoint the Vice Chair and Senior Independent Director

2.1 It is proposed that the two roles remain separate in order to share the burden.

2.2 Following the recent annual appraisal process, the Board is asked to support the following:

a) Kamran Malik remain as Vice Chair for a further year and
b) Heather Craven remain as Senior Independent Director for the remainder of her current term of office

3. Recommendations

The Board is asked to:

- Support Kamran Malik as Vice Chair for a further year
- Support Heather Craven as Senior Independent Director for the remainder of her current term of office and
- Note the above will be shared with the Council of Governors at their meeting on 10 September 2024.

Angela Wendzicha, Director of Corporate Affairs
On behalf of
Dr Mike Richmond, Chair

Board of Directors' Meeting
6 September 2024

The Rotherham NHS Foundation Trust

Agenda item	P147/24
Report	**Fit and Proper Person Report**
Executive Lead	Angela Wendzicha, Director of Corporate Affairs
Link with the BAF	Not applicable
How does this paper support Trust Values	Links with all Trust values
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary	In response to the review carried out by Tom Kark KC, published in 2019, NHS England developed a new Fit and Proper Person Test Framework. The purpose of the revised Framework is to strengthen and reinforce accountability and transparency for Board members. The aforementioned Framework was effective from 30 September 2023. The following report sets out the process carried out to ensure the Chair, Dr Mike Richmond, has been in a position to confirm that all Board members, irrespective of voting status have been deemed 'fit and proper persons' and make the necessary submission to NHS England before the required deadline. There is a requirement in accordance with the Framework to share the report at the next available Trust Board held in public.
Due Diligence	The report was presented to the Non-Executive Director Nomination and Remuneration Committee on 30 July 2024 to coincide with the presentation of the annual appraisals.
Board powers to make this decision	Not applicable, no decision required.
Who, What and When	The process will be repeated prior to the annual appraisals in early 2025.
Recommendations	It is recommended that the Board note the content of the report and that following the checks in accordance with the Fit and Proper Person Framework, the members of the Board are deemed Fit and Proper Persons.
Appendices	None

1. Introduction

1.1 In 2019, Tom Kark KC published his review of the then current Fit and Proper Person Test as set out by Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. As a result of this review, NHS England published its response to the recommendations by developing a Fit and Proper Person Test (FPPT) Framework which also takes into account the requirements of Regulation 5 of the aforementioned Regulations.

1.2 The Framework was effective from 30 September 2023 and implemented by all Boards from this date. The purpose and aim of strengthening the Framework is to ensure that current Board members, irrespective of voting rights, can demonstrate that they are fit and proper persons.

1.3 The Framework applies to Board members of NHS organisations and the term 'board member' in this context refers to:

- Executive and Non-Executive Directors irrespective of voting rights
- Interim (all contractual forms) as well as permanent appointments
- Those deemed to be 'directors' within Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

2. FPPT Requirements

2.1 For context, in 2014, the Government introduced the Fit and Proper Person Requirement through Regulation 5 as set out in paragraph 1.1. The Regulation requirements are that:

a) the person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged
b) the person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland
c) the person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986
d) the person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it
e) the person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland
f) the person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.

2.2 The duty to take account of 'fit and proper' requirements are continuous and ongoing. For the purposes of the revised Framework, NHS England considers it appropriate for NHS organisations to be able to consistently demonstrate, on an annualised basis that a formal assessment of fitness and properness for each board member has been

undertaken. NHS Trust have to therefore consider carrying out the assessment alongside the annual appraisal.

2.3 The Chair should ensure that the Trust cans demonstrate that the appropriate systems and processes are in place to ensure that all new and existing board members are, and continue to be, fit and proper.

2.4 A fully documented FPPT assessment will be required for all new appointments in addition on an annual basis includes assessment of the following:

a) Good character
b) Possessing qualifications, competence, skills required and experience
c) Financial soundness
d) Self-attestation

2.5 For joint roles, that support closer working between NHS organisations, the full FPPT is completed by the designated employing organisation and in concluding their assessment, the Chair will confirm with the relevant organisations confirming the outcome.

3. Responsibility of the Chair

3.1 In accordance with the new Framework, the Chair is accountable for taking all reasonable steps to ensure the FPPT process is effective and that the desired culture of the organisation is maintained to support and effective FPPT regime. The Chair is responsible for:

a) Ensure the NHS Organisation has proper systems and processes in place so it can make the robust assessments required by the FPPT.
b) Ensure the results of the full FPPT, including the annual self-attestations for each board member, are retained by the employing NHS organisation.
c) Ensure that the FPPT data fields within ESR are accurately maintained in a timely manner.
d) Ensure that the board member references/pre-employment checks (where relevant) and full FPPT (including self-attestation) are complete and adequate for each board member.
e) Ensure an appropriate programme is in place to identify and monitor the development needs of board members.
f) On appointment of a new board member, consider the specific competence, skills and knowledge of board members to carry out their activities, and how this fits with the overall board.
g) Conclude that the board member is fit and proper.

4. Declaration of the Chair

4.1 As Chair of The Rotherham NHS Foundation Trust confirm that the FPPT requirements have been completed and adhered to for the year 2024-25. In doing so, I have determined that, based on those checks, that all Board members of The Rotherham

NHS Foundation Trust are deemed Fit and Proper Persons in accordance with the Framework as set out by NHS England.

5. Recommendation

The Board is asked to note the declaration from the Chairman as set out in section 4.1 above that members of the Board of Directors, irrespective of voting rights, have been deemed Fit and Proper Persons.

Angela Wendzicha
Director of Corporate Affairs

On behalf of

Dr Mike Richmond
Chair

Board of Directors' Meeting
6th September 2024

The Rotherham NHS Foundation Trust

Agenda item	P148/24
Report	**Annual Board Meeting Dates 2025**
Executive Lead	Angela Wendzicha, Director of Corporate Affairs
Link with the BAF	The following paper links with all BAF Risks
How does this paper support Trust Values	This paper supports the Trust Value of "Use and Evaluate Information to improve". By having up to date information on the Trust's risks we can use and evaluate this information to take actions and decisions that improve both patients' and staff experience.
Purpose	**For decision** ☐ **For assurance** ☐ **For information** ☒
Executive Summary (including reason for the report, background, key issues and risks)	The dates for the Board Meetings in 2025 are as follows: Board of Directors: January 10th 2025 - 09:00 - 15:30 Strategic Board Forum: February 7th 2025 - 09:00 - 15:00 Board of Directors: March 07th 2025 - 09:00 - 15:30 Strategic Board Forum: April 4th 2025 - 09:00 - 15:00 Board of Directors: May 2nd 2025 - 09:00 - 15:30 Strategic Board Forum: June 6th 2025 - 09:00 - 15:00 Board of Directors: July 4th 2025 - 09:00 - 15:30 Strategic Board Forum: No Forum in August 2025 Board of Directors: September 5th 2025 - 09:00 - 15:30 Strategic Board Forum: October 3rd 2025 - 09:00 - 15:00 Board of Directors: November 7th 2025 - 09:00 - 15:30 Strategic Board Forum: December 5th 2025 - 09:00 - 15:00 Meeting invites will be issued following the September 2024 Board of Directors.

Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	N/A
Board powers to make this decision	N/A
Who, What and When (what action is required, who is the lead and when should it be completed?)	N/A
Recommendations	It is recommended that the Trust Board: • Note the content of the Report.
Appendices	None

Board Planner

Event/Issue

Action	TRUST BOARD MEETINGS		2024 Jan	March		May	June	July	Sept	Nov	2025 Jan	March
			12	8		3	11	7	8	1		
			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				●						
	Public and Patient Involvement Strategy	CN										
	SYSTEM WORKING											
	SYB ICS and ICP report	DCEO	●	●		●		●	●	●	●	●
	SYB ICS CEO Report (included as part of CEO report)	CEO	●	●		●		●	●	●	●	●
	Partnership Working	NED				●			●			
	SYB ICS - Wider Needs of Rotherham Community	Public Health		●					●			
	CULTURE											
	Patient Story	CN		●				●		●		●
	Staff Story	DoW	●			●			●		●	
	Annual Staff Survey	DoW		●								
	Staff Survey Action Plans	DoW				●						
	Freedom to Speak Up Quarterly Report	CN	●			●			●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						●				
	PERFORMANCE											
	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	●	●		●		●	●	●	●	●
	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							●			
	Infected Blood Inquiry	MD							● dfd			
	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		●		●				●		●
	Cancer Annual Report???	MD										
	Controlled Drugs Annual Report	MD							●			●
	NHSE Self-Assessment for Placement Providers 2024	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				●				●		
	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	Chair							●			
	Annual (re)appointment of Board Vice Chair	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	
	CORPORATE TRUSTEE (AD HOC)											
	Approved Minutes (Oct 23, Jan, 24, Mar 24 plus confidential)							•				
	Chair's Logs (Oct 23, Jan 24, Mar 24, May 24)							•				
	Terms of Reference							•				
	Summary of Performance Against Objectives							•				
	Objectives to f24/25							•				
	Financial plan and budget 24/25							•				
	Cancer Appeal							•				
	Legacy Giving							•				
	Annual CFC Report							•				