Council of Governors

The Rotherham NHS Foundation Trust

Schedule	Tuesday 10 September 2024, 5:00 PM — 7:00 PM BST
Venue	Board Room, Level D
Organiser	Angela Wendzicha

Agenda

5:00 PM PROCEDURAL ITEMS

COG/38/24. Chairman's Welcome and announcements - Verbal
For Noting - Presented by Mike Richmond

COG/39/24. Apologies for absence and quoracy check - Verbal

Section 17.4 of Constitution;
A meeting of the Council of Governors shall be quorate if not less than half of the elected Governors are present.
For Noting - Presented by Mike Richmond

COG/40/24. Declarations of Interest - Verbal
For Noting - Presented by Mike Richmond

COG/41/24. Minutes of the previous meeting held on 15 May 2024
For Approval - Presented by Mike Richmond

COG/42/24. Matters arising from the previous minutes (not covered elsewhere on the agenda) - Verbal
For Discussion - Presented by Mike Richmond

COG/43/24. Action Log
For Decision - Presented by Mike Richmond

COG/44/24. Chair's Report - Verbal
For Noting - Presented by Mike Richmond

5:15 PM REPORT FROM NON EXECUTIVE CHAIRS OF BOARD COMMITTEES

COG/45/24. Report from the Non-Executive Director Chairs of the Board Assurance Committees:

i. Quality Committee - Julia Burrows
ii. People & Culture Committee - Hannah Watson
iii. Finance and Performance Committee inc. Finance Report - Martin Temple
iv. Audit and Risk Committee - Kamran Malik
v. Charitable Funds Committee - Steve Hackett

For Noting

COG/46/24. Integrated Performance Report
For Assurance - Presented by Michael Wright

COG/47/24. Partnership Update
For Noting - Presented by Michael Wright

6:15 PM GOVERNOR REGULATORY AND STATUTORY REQUIREMENTS

COG/48/24. Governance Report - Annual Appointment of Vice Chair and Senior Independent Director
For Approval

6:25 PM SUB GROUPS OF THE COUNCIL OF GOVERNORS

COG/49/24. Member Engagement Group Report - Presented by Geoff Berry
For Noting

6:35 PM COMMITTEE GOVERNANCE

COG/50/24. Issues to be escalated to Board of Directors - Verbal
For Approval

COG/51/24. Council of Governors Work Plan
For Noting

COG/52/24. Any Other Business
For Discussion

COG/53/24. Next meeting to be held on 20th November 2024

CLOSE OF MEETING

Draft until approved at 10th September Council of Governors meeting

MINUTES OF THE MEETING OF THE COUNCIL OF GOVERNORS HELD ON WEDNESDAY, 15 MAY 2024 IN THE BOARDROOM, LEVEL D, ROTHERHAM FOUDATION TRUST AND MS TEAMS

Chair: Dr M Richmond, Chair

Public Governors: Mr G Rimmer, Public Governor Rotherham Wide & Lead Governor
Mr A Ball, Public Governor Rotherham Wide
Mr M Skelding, Public Governor Rotherham Wide
Ms I Ogbolu, Public Governor Rotherham Wide
Mr A A Zaidi, Public Governor Rotherham Wide
Mr M Ukpe, Public Governor Rotherham Wide (from 5.30pm)
Mr M Ayub, Public Governor Rotherham Wide
Mrs D Mondal, Public Governor Rotherham Wide

Staff Governors: Mr M White, Staff Governor

Partner Governors: Dr J Lidster, Partner Governor Sheffield Hallam University

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

Mr K Malik, Non-Executive Director
Ms J Burrows, Non-Executive Director
Mr M Temple, Non-Executive Director
Dr R Jenkins, Chief Executive
Mr S Hackett, Director of Finance
Ms A Wendzicha, Director of Corporate Affairs
Mr A Wolfe, Deputy Director of Corporate Affairs
Mrs H Dobson, Chief Nurse
Mr M Wright, Managing Director
Ms C Rimmer, Corporate Governance Manager (minutes)

Apologies: Ms H Watson, Non-Executive Director
Mrs H Craven, Senior Independent Director
Dr R Shah, Non-Executive Director
Cllr J Baker-Rogers, Partner Governor RMBC
Mrs J Mallinder, Partner Governor VAR
Mrs M Gambles, Public Governor Rotherham Wide
Mr M Smith, Partner Governor Barnsley and Rotherham Chamber of Commerce
Mr G Berry, Public Governor Rest of England
Mrs P Keta, Staff Governor
Ms R Bell, Staff Governor

ITEM	PROCEDURAL ITEMS	ACTION
COG/18/24	**CHAIRMAN'S WELCOME AND ANNOUNCEMENTS** Dr Richmond welcomed all those present, and those attending virtually.	
COG/19/24	**APOLOGIES FOR ABSENCE & QUORACY CHECK** The apologies were noted and the meeting was confirmed to be quorate.	
COG/20/24	**DECLARATION OF INTEREST** Dr Jenkins and Ms Wendzicha's interest, in terms of their joint roles at both the Trust and Barnsley Hospital NHS Foundation Trust, were noted. Ms Wendzicha also noted a declaration in terms of the Lead Governor appointment.	
COG/21/24	**MINUTES OF THE PREVIOUS MEETING** The minutes of the meeting held on the 21 February 2024 were approved as a correct record.	
COG/22/24	**MATTERS ARISING FROM PREVIOUS MINUTES (NOT COVERED ELSEWHERE IN THE AGENDA)** No matters were raised.	
COG/23/24	**ACTION LOG** The Council received the action log and agreed for Log no. 2, 3 and 4 to be closed. Regarding Log no. 1, Ms Wendzicha recommended to the Council that this action remain open until the information is received from the Medical Director as proposed. It was also suggested that the Medical Director attend a Governor Forum to give further opportunity for Governors' learning and development in regard to Mortality data and information. The Council agreed for the action to remain open and welcomed the presence of the Medical Director at the next Governors Forum.	
COG/24/24	**CHAIR'S REPORT**	

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	Dr Richmond provided a verbal update to the Council outlining the commendable challenges and deliverables of the Trust, as the financial year comes to a close. Reflecting on the time spent in various jurisdictions, Dr Richmond did not recall periods of such unrest and industrial action that the NHS has had to stand up against, and the Trust had risen to the challenge. Dr Richmond thanked Board colleagues and Executives for the favourable finish. Dr Richmond highlighted that a challenging financial plan was set which has been over delivered, unpinned by a strong Cost Improvement Programme (CIP). The organisational governance has strengthened, the relationship with CQC has improved and awareness of risks has been enhanced. Dr Richmond continued that the staff survey results were very positive and that the Trust is rated nationally as one of the most improved; this further signifies the ethos and principles of continuous improvement. Furthermore, Dr Richmond discussed that there is ongoing progress with recruitment and retention, and clinical areas are reporting positive indicators. The Health Informatics team are positioning Rotherham at the forefront of innovation and effective patient data sharing, and there have been significant and sustained improvements in the emergency department. Dr Richmond praised the operational teams and requested that the Chief Executive filter this commendation through to colleagues.	
COG/25/24	**REPORT FROM NON EXECUTIVE DIRECTOR CHAIRS OF BOARD ASSURANCE COMMITTEES** i. Quality Committee Ms Burrows presented the report, outlining key highlights for the Council. Firstly, Ms Burrows confirmed the approval of the Quality Priorities for 2024/25 and the Organisational Objectives, and the challenge posed from the Quality Committee to ensure a comprehensive and ambitious approach. Secondly, Ms Burrows updated the Council on the patient safety aspects; CHPPD data and the triangulation of reporting, and the move from HSMR to SHMI as a more reliable and robust indicator. And finally, in terms of patient experience, the new PALS service was highlighted and the quality improvement plan including self-assessment, which has had a lot of focus and initial results are encouraging.	

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	Mr White queried the 4 hour performance target and Mrs Dobson clarified that it is a national target and discussed the vast amount of people attending the emergency department impacting on patient experience as well as clinical experience. Mr Temple highlighted the further oversight from the Finance and Performance Committee and the actions taken to increase capacity in the emergency department and the aspirations to develop even further to be fit for purpose. Mr White queried the quarterly report from patient safety and Mrs Hobson explained that it captures overarching themes and trends to be able to make substantive changes. Mr Skelding questioned the frequency of data collection and whether the target has ever been met. Mrs Dobson confirmed it is live data, updated continuously and the results differ day by day, with some days achieving and exceeding the target. ii. People Committee Mr Temple introduced the Committee report, on behalf of Dr Shah, drawing attention to the Divisional updates; the Community Division highlighted the diverse and extensive range of services in their portfolio and the positive staff survey results, and Surgery division attended the committee for two consecutive meetings to provide further assurance on actions to address behaviour and culture concerns. Mr Temple continued that the People and Culture Strategy 2024-2027 was approved and was acknowledged as of high quality, with excellent stakeholder engagement. The committee also received the staff survey results and praised the impressive degree of transformation. Finally, Mr Temple discussed the engagement and health and wellbeing reporting and the comprehensive programme in the Trust. iii. Finance and Performance Committee incl. Finance Report Mr Temple presented the report as Chair of the Committee and outlined the divisional reporting from Family Health, UECC and Medicine. Family Health presented a good financial position although reported issues in the volume of agency staff needed and longstanding challenges in Gynaecology. UECC highlighted the sheer scale of challenge with vast attendance rates and complicated Mental Health cases, but the committee were impressed with the positive results and morale within the division and strong leadership. Medicine presented some challenges with performance and updated the committee on	

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	the merger with UECC with positive results of staff working together. Mr Temple reminded the Council that 33 days of the financial year was lost to Industrial Action, which has had a vast impact, yet the Trust has achieved all its deliverables. Drafting the Financial Plan for this year (2024/25) has been an immense task, coupled with challenges with external guidance. Mr Temple concluded that there is a lot to be learnt from this year, and productivity is a key word at the forefront of our minds. Mr Hackett summarised the financial report included in the papers and noted that the accounts are still in the process of being audited. Mr White queried the plan for future coupled with the sheer scale of pressure on UECC, particularly regarding mental health patients. Mr White raised that this is a conversation happening in lots of forums and seems to be a bigger and bigger issue, and asked how the Trust is going to address the challenges as a priority. Dr Jenkins explained the rise and prevalence in mental health conditions post-covid and referred to the interaction of mental health conditions and presentation at UECC. Dr Jenkins discussed that they are aware of the long delays and impact on patients as well as staff and the Trust is working with other partners to move forward and improve the situation. iv. Audit and Risk Committee Mr Malik presented the Audit and Risk Committee report and highlighted three key aspects to the Council. Firstly, Mr Malik recognised the improved maturity of risk management in the Trust, with good identification of risks and actions in place to mitigate the risks, summarising that it is a significant step forward. Secondly, the approved audit plan for the year and counter fraud plan, highlighting that they are reactive plans to the needs of the Trust. Finally, Mr Malik drew attention to the Committee's focus on elective referral to treatment waiting lists and the actions to be agreed by June this year. v. Charitable Funds Committee Mr Hackett presented the report on behalf of Mrs Craven and introduced the structure of the meetings, covering both governance of the charity and strategic direction. Mr Hackett	

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	commended the journey of the charity and significant growth over the past couple of years; there has been remarkable progress conducting larger appeals, most notably the Tiny Toes Appeal, which has been successful in supporting the refurbishment of the Neonatal unit and developing the partnership working between the charity and the Trust. Mr Hackett also noted the progress in the structure and authorisation processes within the charity, and the involvement of Fund Stewards to develop clearer management of funding for different care groups. Dr Richmond also commended the remarkable progress of the charity.	
COG/26/24	**INTEGRATED PERFORMANCE REPORT** Mr Wright presented the paper, noting that the Integrated Performance Report (IPR) is presented to all Board Assurance committees and information included in the chair's reports. Mr Wright discussed the 4 hour target and the decreased number of breaches this year than previously, noting the improvement in ambulance handovers. Mr Wright also highlighted the higher sickness rates and triangulated with the Organisational Objectives to reduce sickness rates by 1% moving forwards. Mr Wright summarised the positive scoring in patient safety, mortality and a strong elective recovery position in March.	
COG/27/24	**ORGANISATIONAL PRIORITIES 2023/24 – END OF YEAR REPORT** Mr Wright summarised that there were thirty deliverables for the year and just four have not been achieved. Further focus on the 76% target will continue, a business case is in development for a full electronic patient records and there are numerous talks with other local partners to help find the best solution to move forward.	
COG/28/24	**ORGANISATIONAL PRIORITIES 2024/25** Mr Wright introduced the report, presenting the priorities going forward into the new financial year which focus on Quality of Care, People and Culture, Financial Sustainability and Operational Delivery. Mr Wright summarised that the objectives and targets are ambitious to go over and above	

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	national trajectories, and that the Trust must keep pushing forwards. Dr Richmond commented on the clear high ambitions from the Board and Executives and that much is achievable, subject to external events, such as Industrial Action. Mr White raised the importance of culture; succeeding as a Trust when everyone pulls together. Mr White discussed that, at a grassroots level, staff are feeling part of something and queried how the Trust can build on this identity as one unit. Mr White fed back to the Council that staff are still very busy, but that it feels more positive and vibrant. Mr Wright discussed that the Team Brief, walkarounds, conversations with colleagues, behavioural framework and Freedom to Speak Up are relative here in developing a strong culture. Culture is difficult to measure, however, the staff survey is demonstrative, as are in-patient surveys. Ms Ogbolu queried the longer waiting times, issues affecting the waiting times, and whether this could be included into the priorities. Dr Richmond discussed that when there is a pressing need or emerging risk, this would be dealt with dynamically. Dr Jenkins added that there are multiple things going on behind the scenes alongside the priorities presented.	
COG/29/24	**FIVE YEAR STRATEGY REFRESH** Mr Wright discussed that the Five year strategy was launched in 2022, however, as the Chairman detailed in their report at the start of the meeting, a lot has been achieved since then and it is time to revisit our ambition. There are other changes to consider as well, such as the perception of the NHS, the relationship of the workforce, the clear economic challenges, and partnership developments with South Yorkshire Integrated Care Board (SYICB) and Barnsley. Mr Wright also noted the changes to staff; the new Executive Team and new Chairman. Mr Wright summarised that the strategy is a good, viable document but now, further ambition needs to be incorporated; a refresh is needed whilst holding onto the elements that still have value. Mr White discussed the change in image of the NHS, particularly regarding waiting lists and that staff see this. Mr White hoped that tackling waiting lists is of high priority and shared that this is most urgently needed from a staff perspective.	

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	Mr Rimmer queried whether any particular areas are to be refreshed. Mr Wright discussed the work developing with Public Health colleagues, digitisation and culture and that there will be some tangible results to achieve. Dr Jenkins raised that it is a more tonal change, as we are in a position now to be more ambitious; the journey to 'good' has been great, but now we are looking to what is next. Mr Rimmer commended the journey of development for the Trust.	
COG/30/24	**ANNUAL QUALITY ACCOUNT 2023/24** Mrs Dobson presented the Quality Accounts, which will be publically available on the Trust website by end of June. Mrs Dobson noted that the report was still in draft format and explained that all the information contained in the report has been presented to the Quality Committee over the year. Mrs Dobson summarised that the overall position, across the domains of the six main sub-committees, shows improvement in all areas (in varying degrees) and that the robustness in audits has improved. Mrs Dobson highlighted that they are still awaiting statements from key stakeholders, including from the Council of Governors. Mr Rimmer discussed that he would respond on behalf of the Council and will discuss with Mrs Dobson outside of the meeting.	
	GOVERNOR REGULATORY AND STATUTORY REQUIREMENTS	
COG/31/24	**GOVERNOANCE REPORT: GOVERNOR ELECTIONS** Mr Wolfe updated the Council that the elections are still live and the Trust has been working with an external provider (CES) to conduct the elections. Currently, there is a secret ballot for the two Staff Governor seats available, as four candidates were nominated. For the Public seats, five nominations were received and were uncontested. The new Governors will be introduced to members at the Annual Members Meeting in September. Mr Zaidi noted his availability for another term next year, if the Council was in need.	
COG/32/24	**LEAD GOVERNOR NOMINATION: RESULTS** Dr Richmond opened this item by thanking Mr Rimmer for his considerable input to the Trust for many years. As a Governor	

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	from 2014, Mr Rimmer has seen significant change and pride should be taken in the part played here. Dr Richmond continued that the influence that governors bring to any organisation is significant and that Mr Rimmer had served with distinction; Dr Richmond thanked Mr Rimmer again for all his efforts and good work. . Mr Rimmer thanked Dr Richmond and highlighted the journey of the organisation throughout his time as a governor; it was a very different place for staff, to be a governor, and a patient. Mr Rimmer raised that the leadership and strong Board has taken the Trust to a whole different level and it is a positive place to be. Ms Wendzicha thanked the governors for submitting their votes for a new lead governor. Ms Wendzicha announced that Geoffrey Berry had been voted as Lead Governor, to take over from Mr Rimmer.	
	SUB GROUPS OF THE COUNCIL OF GOVERNORS	
COG/33/24	**MEMBER ENGAGEMENT GROUP REPORT** Mr Rimmer updated the Council that the group reconvened in March and that it is crucial that this area is progressed. Mr Rimmer highlighted some frustrations in communications and engagement, however the new governors and full staff compliment will help here. The Governors Surgery is scheduled to be refreshed and there have been some good ideas that the new Lead Governor can take forward. Dr Richmond echoed the importance of this area of focus and Mr Rimmer acknowledged Ms Wendzicha's work to progress this area. Mrs Dobson discussed that the input from Governors has been really valuable in the past and queried the awareness for new Governors on the support to help them fulfil their roles, such as, nurse-led walkarounds. Mrs Dobson suggested connecting with the Patient Experience team. Mr Rimmer agreed that the walk arounds were a great learning experience and Ms Wendzicha confirmed that there would be a comprehensive induction for new governors that would also be open to existing governors for a refresh.	
	COMMITTEE GOVERNANCE	
COG/34/24	**ISSUES TO BE ESCALATED TO BOARD OF DIRECTORS** None were noted.	

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COG/35/24	**COUNCIL OF GOVERNORS WORK PLAN** The Council noted the planner.	
COG/36/24	**ANY OTHER BUSINESS** i) Mr Zaidi gave trust member and public feedback following his daily walkarounds; patients have difficulties with IT and phone messages and Mr Zaidi challenged that there should be a simpler way to inform patients that are technologically inexperienced. Mr Zaidi added that this was a frequent complaint from members. Dr Jenkins queried the specifics of the feedback to be able to take action and help the patient and also discussed that this is an area of thought for the new centralised NHS app. Mrs Dobson discussed the new PALS service being brought to the main reception, which should help here and provide a clearer platform for patients to seek help/give feedback. Mr Zaidi challenged that the issues raised are not properly being addressed and Dr Richmond suggested that this was discussed outside of the meeting, to be able to reach out to the patient directly to bring a resolution. ii) Mr White gave feedback from staff members on the length of time to report safeguarding incidents. Mr White understood the need for robust procedures in place, but highlighted the difficulty for staff, when a report may take up to 3.5 hours to complete. Mr White asked the Non-Executives and Executives their view on the subject and the level of risk with time demanding reporting that staff may look the other way. Mrs Dobson raised that there is high safeguarding scrutiny and the forms are from the local authority, rather than the Trust. Some areas with a higher volume of safeguarding concerns have different processes, such as a daily safeguarding huddles, and that the Safeguarding team are well resourced and can help with these processes. iii) Mr Rimmer queried whether there was any update in regard to Non-Executive Director (NED) recruitment. Dr Richmond explained that the recruitment process is live and progressing. iv) Ms Wendzicha reminded the governors of the South Yorkshire & Bassetlaw Acute Federation Trust Governors Engagement Event on 11th June (via Teams), and also the feedback forms for NED appraisals.	

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	v) Mr Ukpe queried the Trusts' approach to data governance, particularly moving to a cloud database. Mr Wright explained that the Trust has an Information Governance (IG) Team and the Director of Health Informatics leads on governance. Mr Wright extended an invitation to discuss outside of the meeting for further information on the Trusts' approach.	
	NEXT MEETING TO BE HELD ON TUESDAY, 10 SEPTEMBER 2024	

Council of Governors Action Log

Log No	Meeting date	Report/ agenda title	Min Ref	Action	Lead Officer	Time scale	Response	Open/close
	2024							
1	21.02.24	Report from Non-Executives, Quality Committee	8/24i	Further information to be presented to Governors on the achievements surrounding HSMR.	Dr Jo Beahan, Medical Director	May-24	Information on HSMR will be provided to the Governors separately by the end of the month. 15.05.24 - request to leave open until information received by Governors. 05.09.24 - reports shared with all Governors and presentation on Learning from Deaths recieved at August Governors Forum.	Rec to close

Open
Rec to close
Closed

COUNCIL OF GOVERNORS MEETING: 10 September 2024

Agenda item: **COG/45/24**

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

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

Action required: To note

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

2.0 Care Group Updates

2.1 Since the last report to the Council of Governors, the QC have received presentations from the Senior Management Teams from Care Group 3 (May) and Care Group 4 (June).

2.2 Within the Care Group 3 presentation, Clinical leads from the three key areas of Sexual Health, Children and Young People, and Maternity and Gynaecology were invited to provide updates. In depth discussions were held on the gynaecology waiting lists as an issue that had fluctuated over the years due to the impact of various challenges; the committee were assured by the plan in place and trajectories, as well as the development of sustainable solutions for long term changes in this area.

2.3 The Committee received the presentation from Care Group 4 updating the committee on key aspects, such as the work with Care Homes and preventative work on hospital admissions and the collaborative discussions with PLACE to share pathways and learning. The Care Group also gave further clarity and reassurance on Mortality data from Virtual Ward.

3.0 Chief Nurse and Medical Director Highlight Report

3.1 The Trust has largely operated at escalation Level 2 and 3 in June and July 2024. Performance against the 4 hour standard was 68.7% in June and was at 66.5% for July (target is 76%). There is an additional focus currently on reducing number of patients in the department for more than 12 hours with a 12 hour wait in department at 2.1% in June compared to a regional average of 4.4%. The increase in demand has continued.

3.2 The Chief Nurse and Medical Director continue to visit a number of clinical areas each month, both across the main site and also community settings.

3.3 TRFT have been nominated in three categories at the national Nursing Times awards. These are:

- Health Care of Older People
- Infection Prevention and Control

- Learning Disability and Autism

4.0 Quality Priorities 2024/25

4.1 The Committee has received the quarterly reports on the three quality priorities for 2024/25 which are: Acute Pain Management, Frailty Assessments, and Diabetes Management.

4.2 Reports on Acute Pain Management and Frailty Assessments provided updates in relation to the baseline data and initial progress to set the foundations for more comparable reports throughout the year. For Acute Pain, the committee requested more triangulation between waiting list management and UECC data, and for Frailty reporting, the committee proposed more focus is given on how the process leads to outcomes for patients.

4.3 Diabetes Management is a Trust Quality Priority and is also a PLACE priority. The committee received data mapping for the Trust outlining the key objectives and targets which is to create a 20% reduction in the number of avoidable/unwarranted harm for adult patients with diabetes admitted to the Acute hospital by March 2025.

5.0 Organisational Priorities

5.1 The committee is tasked with monitoring delivery against this year's Organisational Priority 1: Focus on High Quality Care and Improving the Experience of Patients.

5.2 The overarching measure of success for this priority is the national CQC inpatient survey. For the 2023 inpatient survey the trust has scored 43/64 using Picker and is the most improved trust overall compared to 2022 results. It is anticipated that the full results will be available in September 2024 for inpatient survey and October for UEC CQC survey.

6.0 Integrated Performance

6.1 The Committee receives a monthly report on integrated performance including key quality metrics. A new reporting structure has been introduced this year to provide a high-level report for the Assurance Committees, with work ongoing to fully develop the data sets and targets once all the data points have been collected.

6.2 The Trust Banding for SHMI (Summary Hospital-Level Mortality Indicator) remains 'As Expected' and targets were achieved on Combined Positivity Score, Patient Safety Investigations (PSIs), Complaints and Patient Falls (Moderate and above) per 1000 bed days. C. Difficile infection rates have been higher than expected reflecting the national trend for increasing rates of C. Difficile and a review by NHSE of the work undertaken at TRFT provided assurance that all the appropriate actions were being taken.

7.0 Patient Experience Committee

7.1 The committee received the Patient Experience Annual Report which highlighted the strong performance in complaint handling with 100% of complaints acknowledged within 3 working days, 100 % of complaints were graded upon receipt and the response rate to formal complaints responded to in the agreed timescale was 100%.

7.2 The report also detailed a full year of Quality improvement initiatives that have taken place for the benefit of our patients and in co-production with the clinical teams in Care Groups.

7.3 The committee commended the vast amount of work and progress, and provided constructive feedback to further advance the performance and reporting such as, triangulation between complaints and litigation, consideration of themes and trends for areas with negative trends in complaints, and finalisation of a SMART action plan for the year.

8.0 Safe Staffing and Quality

8.1 The committee were assured by the bi-monthly report. The CHPPD (Care Hours Per Patient Day) data was triangulated with other measures of quality and safety, such as Harm data, to provide assurance as the national bench marking remains low. A deep dive into the data collection is underway to determine any gaps in the data sets, compared to other Trusts.

8.2 Furthermore, the committee noted the excellent progress with recruitment and retention whilst acknowledging the challenges around sickness levels.

9.0 Patient Safety

9.1 The quarterly report in May provided an overview of activity overseen by the Patient Safety Committee.

9.2 It was reported that there was an increase in moderate harm over the winter period (Q4) and that it was expected with increased activity. Attention was also drawn to the national PEWS implementation and the committee was reassured that the implementation and associated risks are being managed through the Resus Group.

10.0 Infection Prevention & Control Committee

10.1 The committee report received in June included the Annual Report as well as the IPC BAF (issued by NHSE) Self-Assessment.

10.2 The committee were assured that TRFT is fully compliant with the Care Quality Commission (CQC) Health and Social Care Act 2008 (Regulated Activities) regulations 2014, regulation 12 (2)(h)), regulation 15 (2).

11.0 Clinical Effectiveness Committee

11.1 The quarterly report in June presented the TRFT Clinical Effectiveness Strategy 2024-29, the CEC Annual Report, final reporting on 2023/24 Quality Priority,

progress against NICE implementation, updates to policies and procedures, as well as the Internal Audit report detailing Significant Assurance.

11.2 The committee commended the hard work and reflected on the degree of improvement over the past year.

12.0 Quality Accounts

12.1 The committee approved the final draft Annual Quality Accounts which was presented in draft format to the Council of Governors in May.

12.2 The Quality Accounts have been approved and published on the Trust website. The report provides an opportunity for patients, carers, colleagues and the wider general public to review the work of the Trust and make comparisons with other NHS organisations.

13.0 Board Assurance Framework and Risk Register

13.1 The Committee continues to receive monthly update reports regarding the risks rated at 15 or above, which have been monitored and checked at the monthly Risk Management Committee and also the Issues Register, which is managed by the Audit and Risk Committee. The committee takes an active role in scrutinising risks aligned to the committee to prompt deep dives into the mitigating actions and performance, relative to the risk.

13.2 The BAF (Board Assurance Framework) continues to be monitored monthly, with meetings taking place with the relevant Executive Directors, and the updated BAF is presented to the Committee. The Committee approved a refresh of the BAF for 2024/25, aligning with the Organisational Priorities and current gaps and controls.

Julia Burrows
Non-Executive Director and Chair of Quality Committee

COUNCIL OF GOVERNORS MEETING: 10 September 2024

Agenda item:	**COG/45/24**
Report:	**People and Culture Committee**
Presented by:	**Hannah Watson, Non-Executive Director and Vice-Chair of the People & Culture Committee**
Author:	**Dr Rumit Shah, Non-Executive Director and Chair of the People & Culture Committee**
Action required:	**To note**

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

2.0 Care Group Updates

2.1 Since the last report to the Council of Governors, the P&CC has received a presentation from the Senior Management Team from Care Group 1 – Medicine & UECC (June).

2.2 Care Group 1 highlighted the key data and rationale, relevant for the committee, plans to move forward as one Care Group following the merger of Medicine and UECC, and also outlined actions to address any concerns. The Care Group acknowledged that sickness rates are a big challenge and detailed the ongoing work to improve engagement and to change the culture, but that there are immense pressures on all.

3.0 Organisational Priorities

3.1 The committee is tasked with monitoring delivery against the Organisational Priorities 2024-25 Priority 2: People and Culture. June's report detailed that the positive trend in performance relating to staff retention/turnover is continuing. Further work in this area will be supported at a strategic level through the appointment of key People Team members.

4.0 Job Planning

4.1 The Committee takes an active role in monitoring Job Planning performance, reiterating the importance of job planning and the focus needed to determine the barriers to moving forward. Although significant progress has been made and improvements to the quality of job plans, the 2023/24 year end position stood at 68% (with a target of 90%).

4.2 The Job Planning Assurance Group provides assurance to the Committee that the Trust is adhering to the processes and procedures laid out in the Job Planning Policy and takes into account any changes to national guidance in relation to Job Planning.

5.0 Board Assurance Framework (BAF) and Risk Register

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

5.2 The BAF (Board Assurance Framework) continues to be monitored monthly, with meetings taking place with the relevant Executive Directors, and the updated BAF is presented to the Committee. A full review of all controls and gaps was conducted in June and a refresh of the narrative, aligning to the Trust Organisational Priorities, was agreed at Board of Directors in July.

6.0 Proud Awards

6.1 The Committee agreed that the recently held Trust Proud Awards had been a great success with a lot of hard work being undertaken by a number of teams' across the Trust, especially Communications.

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

COUNCIL OF GOVERNORS MEETING: 10 September 2024

Agenda item:	**COG/45/24**
Report:	**Finance and Performance Committee (FPC)**
Author and Presented by:	**Martin Temple, Chair of FPC**
Action required:	**To note**

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

2.0 Divisional Updates

2.1 Since the last report to the Council of Governors, the FPC have received a presentation from the Senior Management Teams from Care Group 2 (May), Care Group 3 (June) and Care Group 4 (July).

2.2 Care Group 2 – the Committee welcomed the presentation, noting there were a number of new staff in post, with a need for a period of consolidation.

2.3 Care Group 3 – the Committee welcomed the presentation, noting they were assured by the clear analysis and the clarity put forward in regard to the sizeable tasks and challenges, including specific targets to move forward.

2.4 Care Group 4 - The Committee recognised the challenges being experienced with regard to finance and CIP.

3.0 Integrated Financial Performance Report

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

3.2 At the July meeting, the Committee reviewed Month 3 data. It was noted that it was a challenging position. Month 4 would include the lost activity as a result of industrial action. It was noted that CIP, capital and cash positions are behind plan.

3.3 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 and the winter plan would be discussed at a future meeting.

4.0 Integrated Performance Report

4.1 A monthly update is received by the Committee and progress continues to be made. The new format of the IPR and Operational Update report were received

and it was felt they were an improvement in the right direction in assisting discussion and understanding on IPR.

4.2 The latest report highlighted that 65+ weeks had been achieved in month, 52+ weeks had not been achieved and was 757 against a target of 650, RTT was at 92% and elective recovery was starting to improve. The Trust was the only Trust in South Yorkshire who had achieved the 31 days standard and it was felt to be a positive picture overall.

5.0 Cost Improvement Programme

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

5.2 M3 position showed the Trust was just over £6m against a target of £12.7m, however a large proportion is non-recurrent. It was recognised that the Care Groups had had a slow start but Care Group 3 was up to 40%.

5.3 It was acknowledged that the CIP is more challenging this year than last and there was no assurance that the target will be reached.

6.0 Organisational Priorities

6.1 There were 3 operational priorities aligned to the Finance & Performance Committee in 2024/25 – Cancer, Emergency Care and Electives – and the Committee receives an update on each one on a quarterly basis.

6.2 An update on Cancer was received in June and the report focused on the cancer performance and the improvement work taking place in Cancer Services. It was recommended that this was shared with Board members for information and awareness of the next steps to build on the achievements made in the first quarter.

6.3 July's meeting received an update on Emergency Care and it was 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.

7.0 Cyber Security

7.1 The committee received an update on cyber security, which gave clarity and context to the media reports on cyber-attacks at other Trusts and assurance on the protective ring for TRFT from NSHE.

7.2 The discussions highlighted key areas of risk, specifically the external supply chain, and the effect on the Trust if an external provider was attacked. It was recommended for more planning in this aspect, linking with procurement and reflecting on continuity plans from previous adverse events.

8.0 Board Assurance Framework and Risk Register

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

9.0 Internal Audit Report

9.1 There were two Internal Audit reports that had highlighted concerns and update reports had been provided to the Committee.

9.2 Elective RTT Waiting Lists – an update report was received at the May meeting and there was evidence of an action plan and good progress in completing the actions identified.

9.3 IT Business Continuity – Governance and Learning from Incidents/Exercises – it was noted that a number of changes had been put in place and there was confidence that these were appropriate.

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

10.1 The Committee received the update acknowledging the progress against the action plan. 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.

11.0 Estates Strategy

11.1 The Committee received a verbal update on the Estates Strategy at the June meeting and it was suggested to the Board that a prioritisation process is developed and agreed for a proactive approach to future funding opportunities.

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

Council of Governors: 10th September 2024

Agenda item:	**COG/45/24**
Report:	**Finance Report**
Presented by:	Martin Temple, Non-Executive Director
Author:	Steve Hackett, Director of Finance
Action required:	For noting

Introduction

This detailed report provides the Council of Governors 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
  - An initial forecast out-turn up to 31st March 2024 of £14,428K deficit to plan and equally the control total.
  - The Trust will not be submitting a forecast adverse variance to plan to the Integrated Care Board or NHSE but assumes appropriate management action and the use of reserves will enable the Trust to deliver its overall plan by 31st March 2025, a year end deficit of £6,302K.
- Section 4 – Capital Expenditure for July 2024 (Month 4 2024/25)
  - 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.

- 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

    - 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.

1. Key Financial Headlines

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

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

Key Headlines	Month Plan £000s	Month Actual £000s	Month Variance £000s	Year to date Plan £000s	Year to date Actual £000s	Year to date Variance £000s	Forecast Variance £000s	Prior Month 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 Plan £000s	Month Actual £000s	Month Variance £000s	Year to date Plan £000s	Year to date Actual £000s	Year to date Variance £000s	2024/2025 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

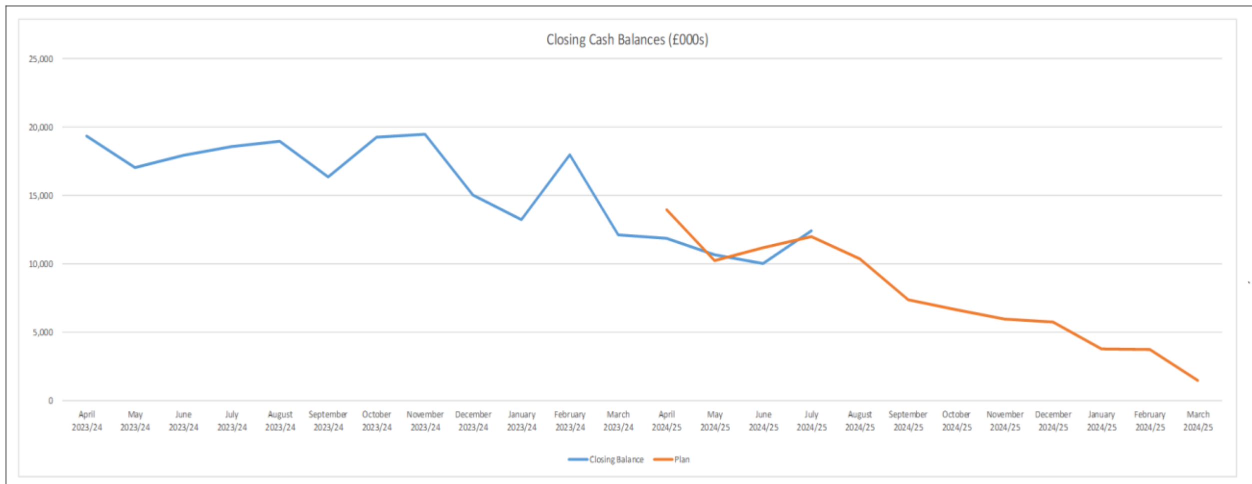
4.1 During July 2024 the Trust incurred capital expenditure of £529K, and year to date it is £1,017K. Schemes are progressing and it is expected that the Trust will spend its full capital allocation.

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

Agenda item: **COG/45/24**

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

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

Author(s): **as above**

Action required: **To note**

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

2.0 Risk Register, Emerging Risks and Issues Log

2.1 The Committee received the latest risk register report including the emerging risks and issues log.

2.2 The Committee recognised the direction of travel with regard to risk management, including the actions that mitigate and move risks.

2.3 Care Groups 1, 2 and 3 were near full compliance with an overall compliance rate of 93%. The recent restructure of care groups had seen Care Group 4's risk register substantially increase with the addition of risks aligned to Medical Physics and Medical Imaging.

2.4 The issues register contains 5 issues currently and there were 5 areas of emerging risks identified.

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

3.0 Standards of Business Conduct Annual Report

3.1 The Committee noted the current position with 227 staff completed out of a total of 372 required to complete a declaration of interest annual return. Due to the current gaps in compliance, it was agreed to strengthen the process to improve compliance and this will be monitored on a regular basis and escalated where appropriate.

4.0 Annual Governance Statement

4.1 The Committee received the Annual Governance Statement which was recommended to the Board of Directors.

5.0 Annual Report

5.1 The Committee received the Annual Report which had been drafted in line with the Annual Reporting Manual, published by NHS England. The Committee recommended this to the Board of Directors.

6.0 Internal Audit

6.1 The Committee received the Head of Internal Audit Opinion and Annual Report. The Head of Internal Audit Opinion had concluded a 'Significant Assurance Opinion' and significant assurance had been given to all three elements of the audit.

7.0 Annual Accounts

7.1 The Committee received the Annual Accounts for 2023/24.

8.0 External Audit

8.1 The Committee received the External Audit Completion Report.

9.0 Quality Accounts

9.1 The Committee received the Quality Accounts and noted the positive feedback and comments from stakeholders.

10.0 Board Assurance Committees Annual Reports

10.1 The Committee received and noted the annual reports from the three Board Assurance sub committees : Quality Committee, People and Culture Committee and Finance and Performance Committee.

11.0 Data Security and Protection Toolkit Report

11.1 The Committee welcomed the confirmation that the Trust had achieved substantial assurance for the DSPTK for five years running. It was highlighted that there were 160 information assets, which are reviewed twice a year, and the Information Governance Committee (IGC) monitors this. An annual report is produced which covers all areas for the IGC.

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

COUNCIL OF GOVERNORS MEETING: 10 September 2024

Agenda item: **COG/45/24v**

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

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

Action required: **To note**

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

2.0 Charity Strategy

2.1 The committee received the bi-monthly progress report against the agreed objectives for 2024/25. A restructure within the charity team has now been completed to allow for more focused time for fundraising and community engagement.

2.2 A new funding structure has been implemented including Fund Stewards, Charity Ambassadors and updates to the funding policies and application forms, which have been shared to all members of staff.

2.3 Work is ongoing to finalise the volunteer recruitment process for charity volunteers (which differ from Trust volunteers) to assist and support the fundraising efforts of the charity team.

2.4 As part of the objectives for the charity, a new CRM (Customer Relations Management) system has been procured and will become operationalised in September.

3.0 Finance Report

3.1 The Committee noted the good performance in terms of income generation and, whilst commitments are increasing as the Charity develops, the cash position remains good.

5.0 Charity Appeals and Fundraising

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

5.2 The business breakfast networking event has gone from strength to strength, expanding beyond the capacity of the hospital event spaces to Magna. These events have established positive relationships with local businesses, some of which have led to donations, gifts in kind, or volunteer time.

5.2 The Tiny Toes appeal has been the headline campaign and has been a remarkable success. Thanks to the incredible generosity and support of our community, we have achieved our goal of raising funds towards the redevelopment of the Neonatal Unit. An official opening ceremony is scheduled for 24th September.

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

- 'It's A Knockout'
- Book Sale
- Golf Day
- Rotherham Polar Plunge
- Christmas Fair
- Spring Fair
- Tiny Toes Toddle

6.0 Risk Information

6.1 A deep dive into the charity risks was conducted in July which resulted in the closure of some historical risks and a refresh of the risk register in line with the current risks to the charity, reflecting on the charity's growth and development, and the current economic climate.

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

COUNCIL OF GOVERNORS MEETING: 10 September 2024

Agenda item: Integrated Performance Report **46/24**

Report: Report from: Michael Wright – Managing Director

Action required: To note

1.0 Introduction

1.1 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.

1.2 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.

1.3 It is recommended that the Council of Governors note the Trust's performance against the metrics presented in the Integrated Performance Report and receive assurance on the basis of this report.

Michael Wright
Managing Director
September 2024

Board Meeting

Integrated Performance Report - July 2024

The Rotherham NHS Foundation Trust

Performance Matrix Summary

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

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	X	F	H		VC
Number of 65+ Weeks	37	74	Feb-24	X	?			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.

NHS
The Rotherham
NHS Foundation Trust

SHMI: Summary Hospital-Level Mortality Indicator

Data, Context and Explanation

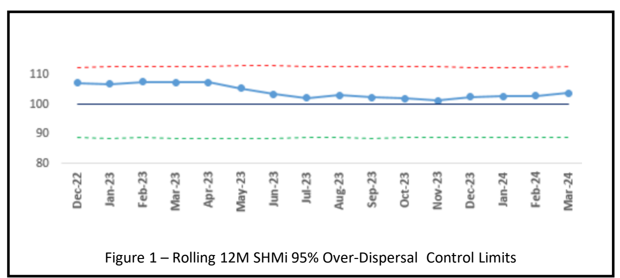


Figure 1 – Rolling 12M SHMi 95% Over-Dispersal Control Limits

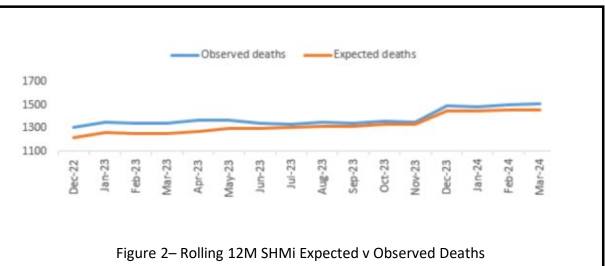


Figure 2– Rolling 12M SHMi Expected v Observed Deaths

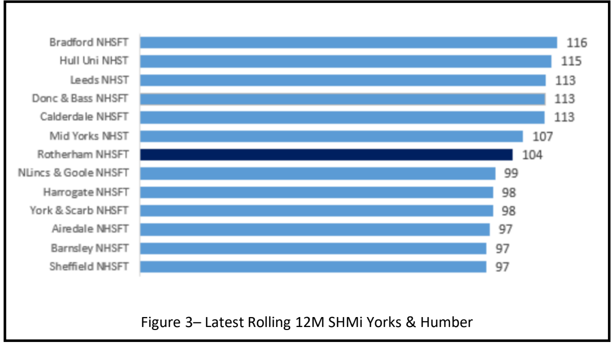


Figure 3– Latest Rolling 12M SHMi Yorks & Humber

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

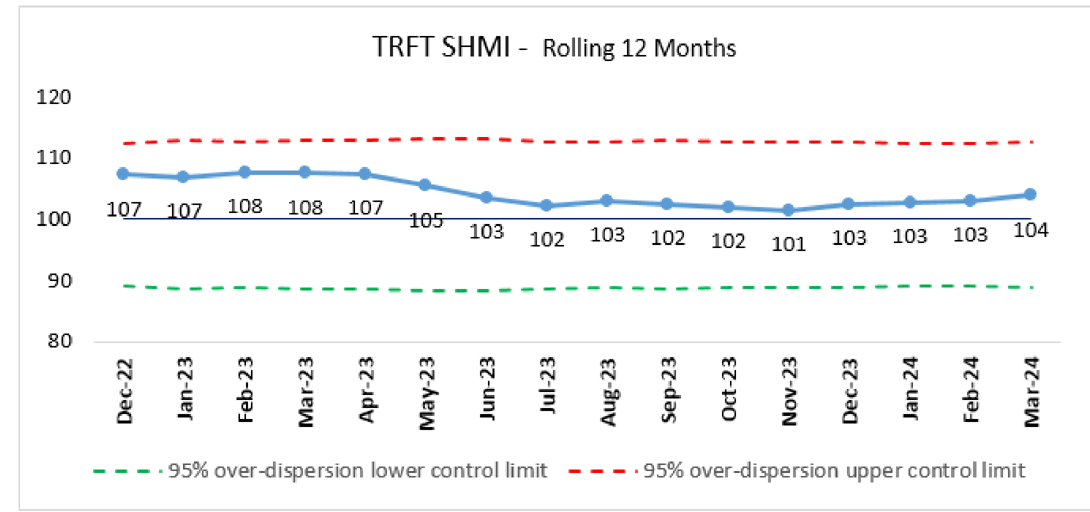
What is the expected impact?

- 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

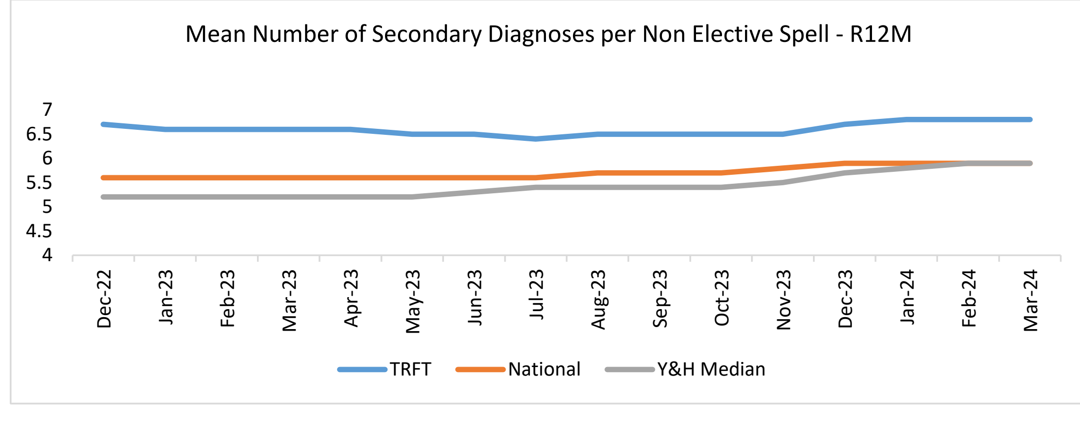
SHMI Update



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



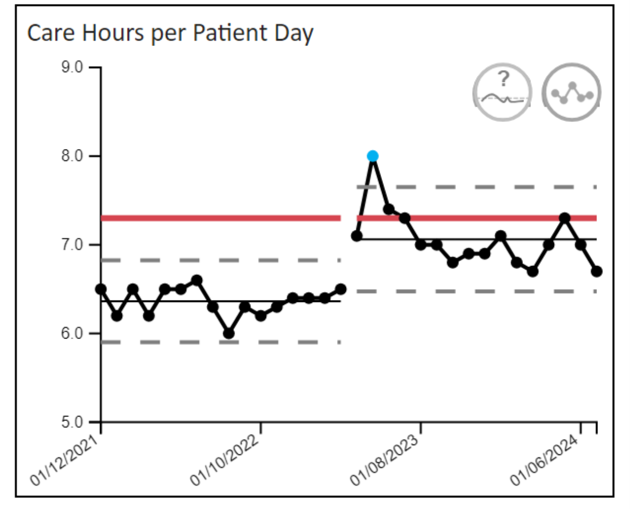
The depth of co-morbidity coding is important for the SHMI as having an accurate view of patient comorbidities will ensure and accurate expected %risk of death for each inpatient admission. Of note not all comorbidities factor into the SHMI algorithm.

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?

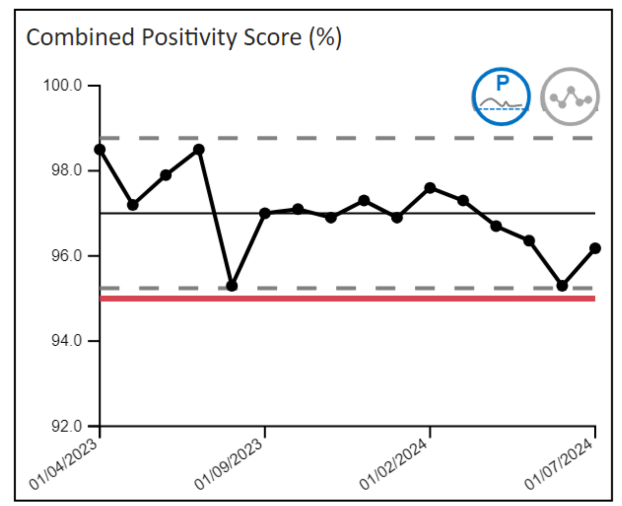
- CHPPD planned versus actual within 5% range
- Clinical quality and safety outcomes are maintained and unwarranted variation reduced across ward areas.

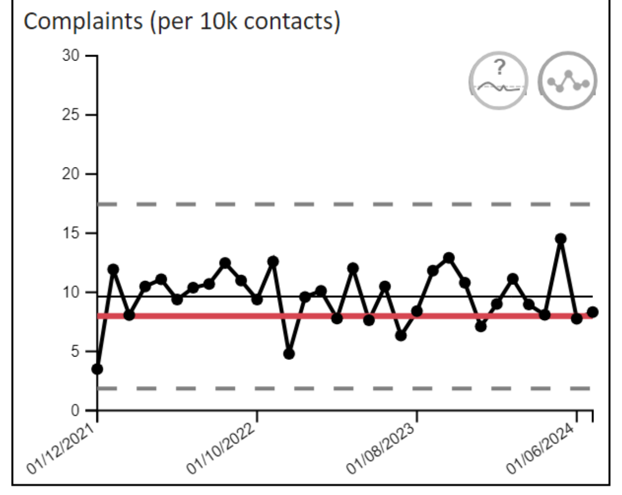
Potential risks to improvement?

- 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?

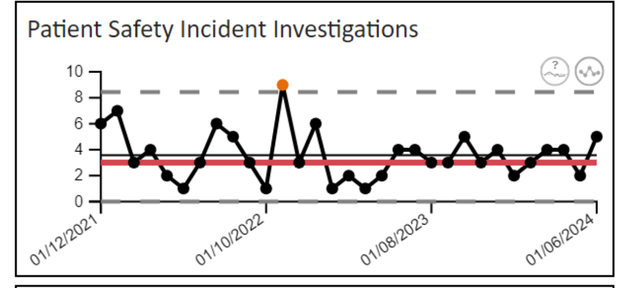
- FFT Continued Positivity score above 95
- The PALS service aims to promote local resolutions to concerns earlier in the process leading to a reduction in formal complaints per 10k contacts

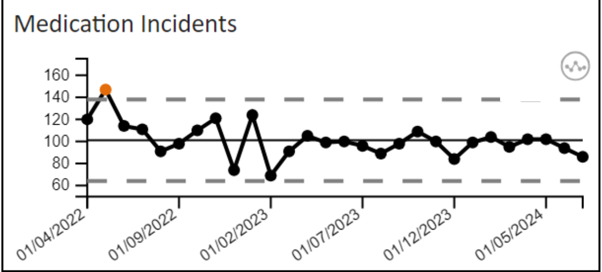
Potential risks to improvement?

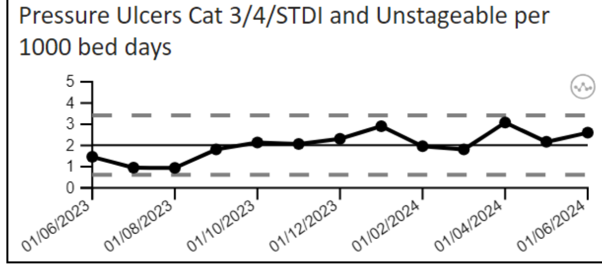
- Orders have been placed for some of the consumables for the Qi but have not yet arrived
- Formal launched waiting until after the school holidays are over to maximise patient and public awareness

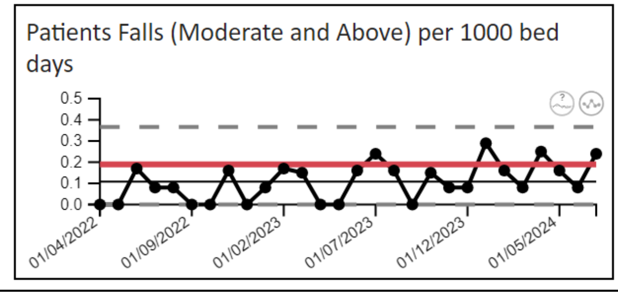
Subtheme: Care Incidents

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?

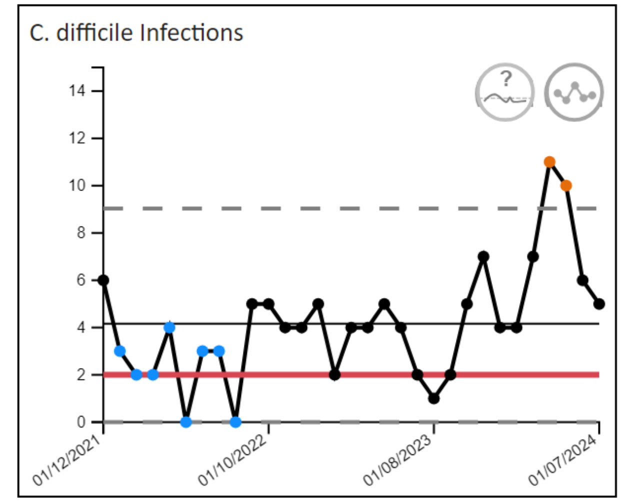
- Stabilisation of PSII's with adequate evidence of shared learning
- Reduction in the total number of falls
- Reduction in the number of CAT 3/4/SDTI and unstageable pressure ulcers

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

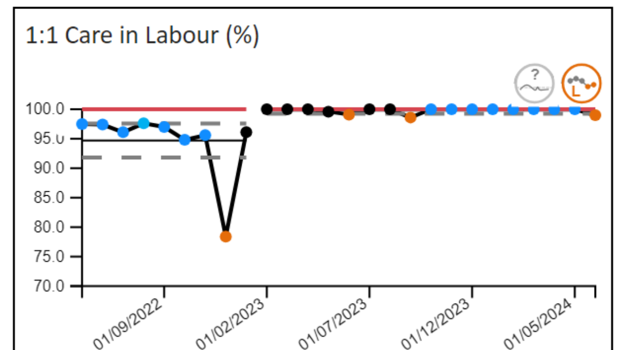
Maternity

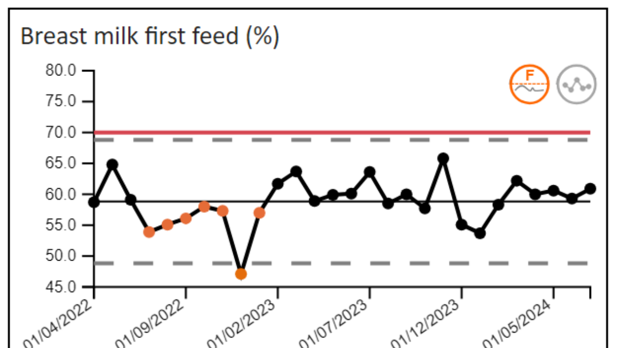
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
1:1 Care in Labour (%)	100.0	99.0	Jun-24				-	C
Breast milk first feed (%)	70.0	60.9	Jul-24					C
Stillbirth rate (per 1000 births)	4.66	2.4	Jul-24				-	VG

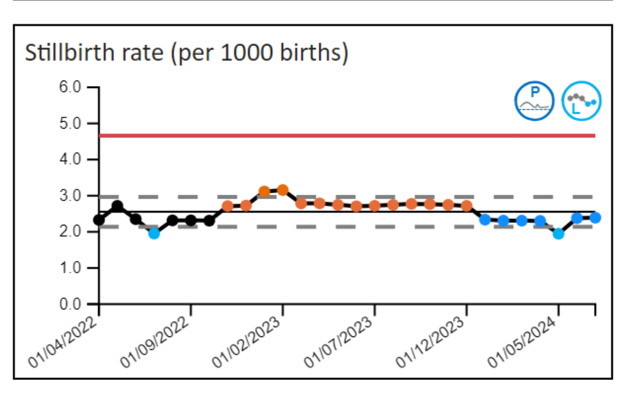
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

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

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

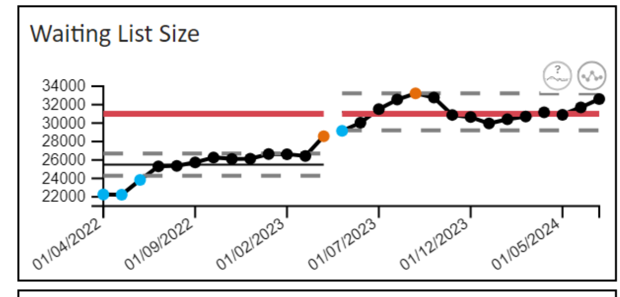
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
Waiting List Size	30,500	32,605	Jul-24					S
Number of 52+ Weeks	650	793	Jul-24		F	H		VC
Number of 65+ Weeks	0	1	Jul-24		F	L		C
Referral To Treatment (%)	92.0	62.0	Jul-24		F	H		C
OP Activity moved or Discharged 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

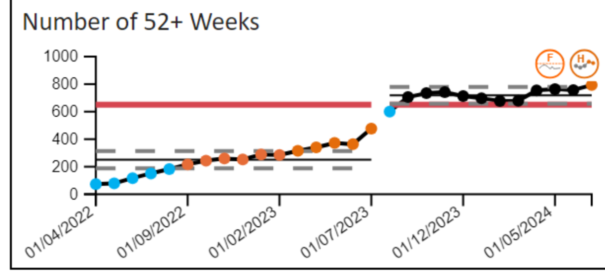
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

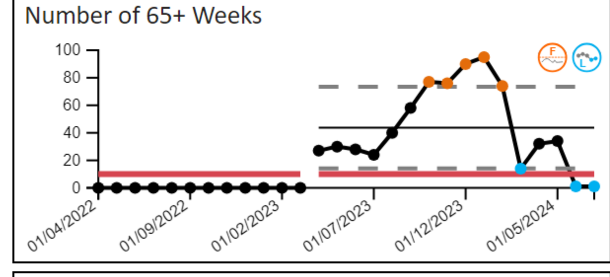
NHS
The Rotherham
NHS Foundation Trust

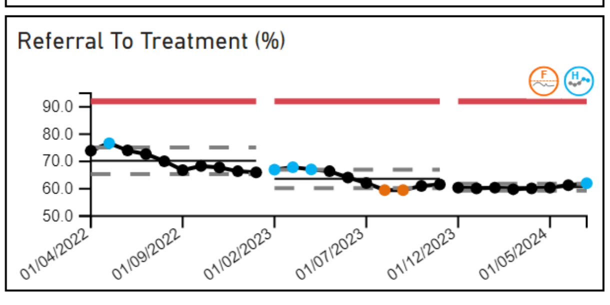
Subtheme: Long Waiters

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?

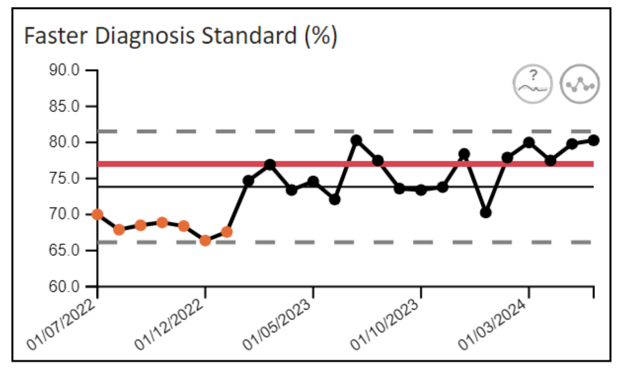
•Improved RTT position in Haematology by September 2024, supporting the Trust to achieve RTT status in at least 5 specialties by March 2025.
Improved RTT position in Diabetes & Endocrine by September 2024, supporting the Trust to achieve RTT status in at least 5 specialties by March 2025.
•Sustained 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.

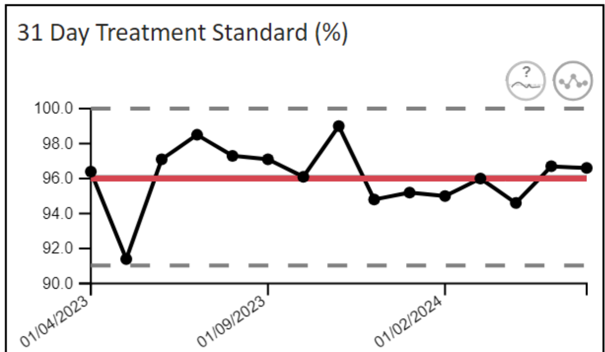
Potential risks to improvement?

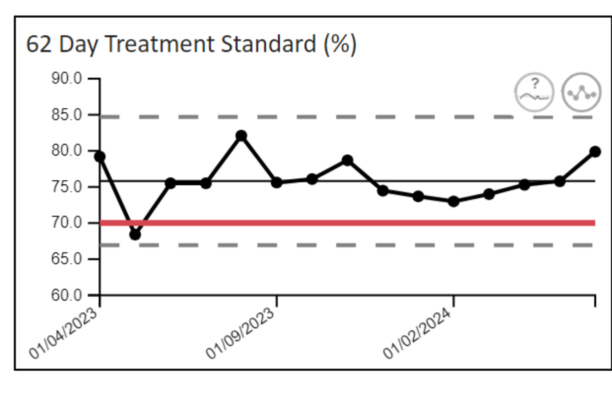
- Clinician agreement and availability to undertake additional sessions as required to support the outpatient and theatre activity approved, particularly over the holiday period.
- Potential impact of any future industrial action affecting availability of doctors or nurses.
- Availability of insourcing 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?

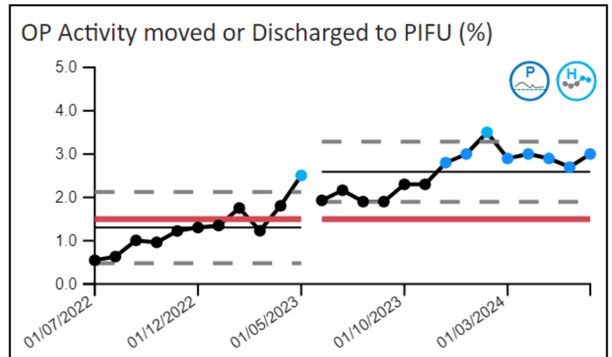
•Improve the Faster Diagnosis Standard in Lower GI further from 62.3% to above 70% by March 2025.
•Improve the Faster Diagnosis Standard in Upper GI further from 73.5% to above 77% by March 2025.
•Reduce the number of patients waiting longer than 104 days for treatment following diagnosis of cancer.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

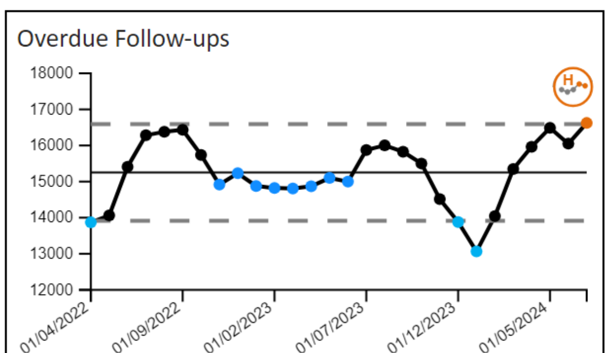
Potential risks to improvement?

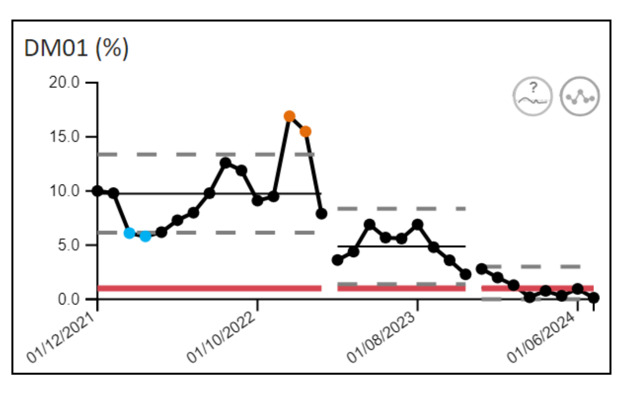
•Reliance on insourcing to support endoscopy capacity continues which if unavailable may impact the ability to achieve the FDS and 62 Day standard in Lower GI.
•Workforce challenges in both Lower GI and Urology continue to impact cancer pathway progression and improvement work with consultant vacancies 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.

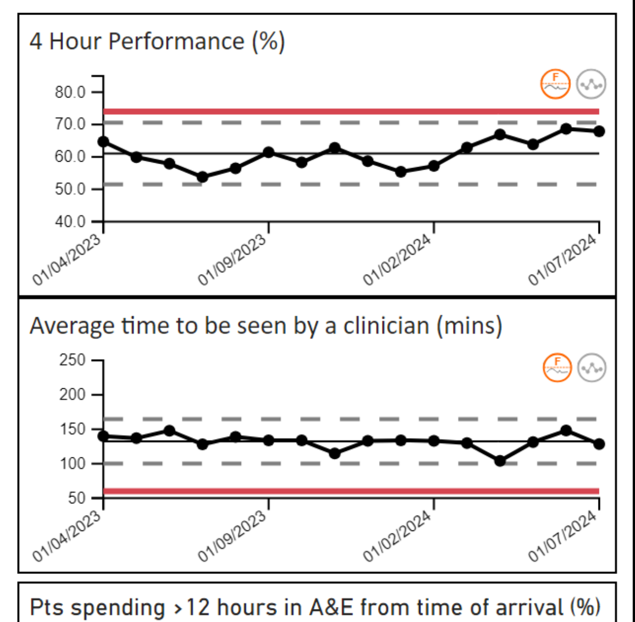
Non-elective and Flow

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.

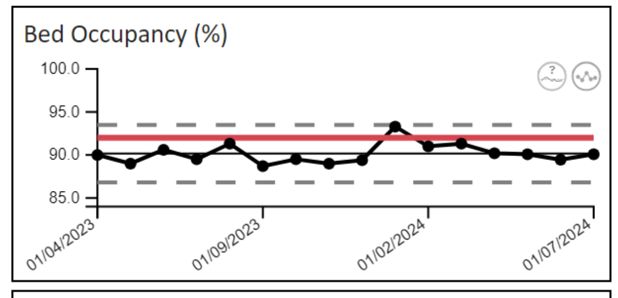
Potential risks to improvement?

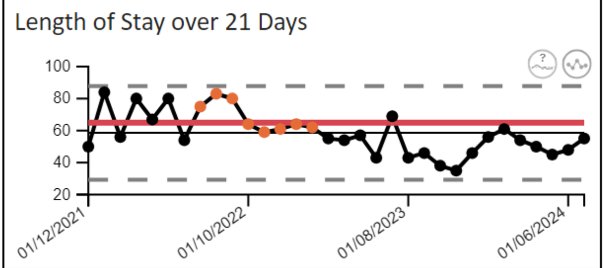
• Attendances may continue to increase which will negatively impact on the Trusts ability to achieve the 4 hour performance standards.

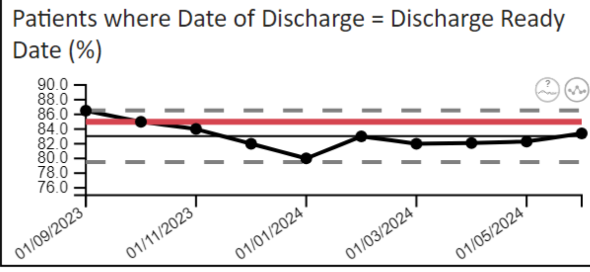
•Further periods of IA, including impact of potential action in primary care.

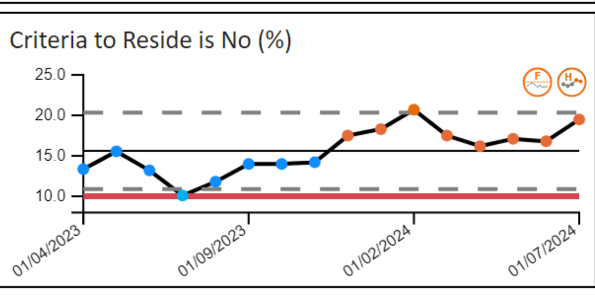
Subtheme: Inpatient Flow

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?

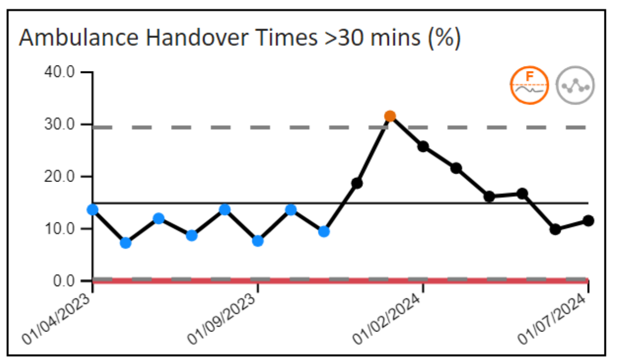
• Reduce in patient moves.
•No moves after midnight
•Greater understanding of challenges after 6pm
• To achieve empty beds on assessment areas by 18.00 each day.
• To ensure flow continues from UECC into assessment areas.
•Improve patient flow and adherence to acute care standards
•Patients will be in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

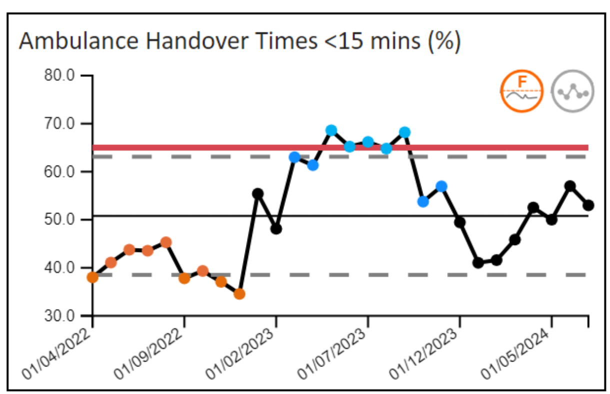
Potential risks to improvement?

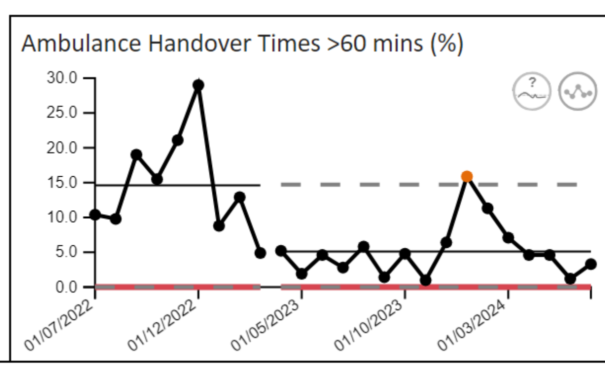
• Increase demand through UECC sustained
• De-escalation of inpatient beds not possible due to ongoing pressures
• Increased demands fails to reduce bed occupancy

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

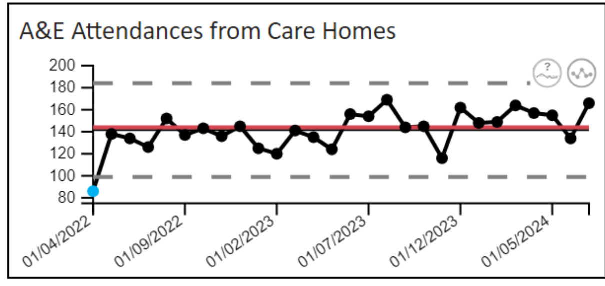
Community

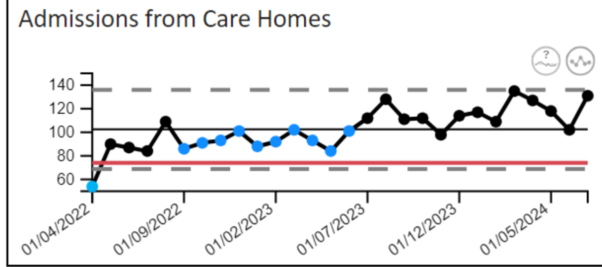
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
A&E Attendances from Care Homes	144	166	Jul-24				-	S
Admissions from Care Homes	74	131	Jul-24				-	S
Number of Patients on Virtual Ward	80	71	Jul-24				-	S
Urgent 2 Hour Community Response (%)	70.0	77.0	May-24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

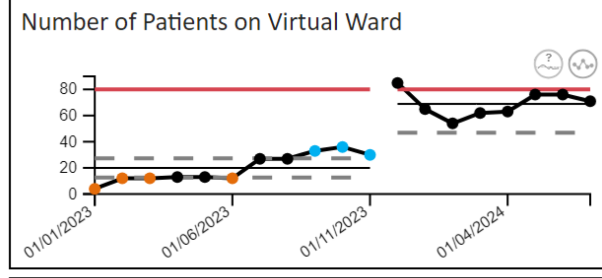
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

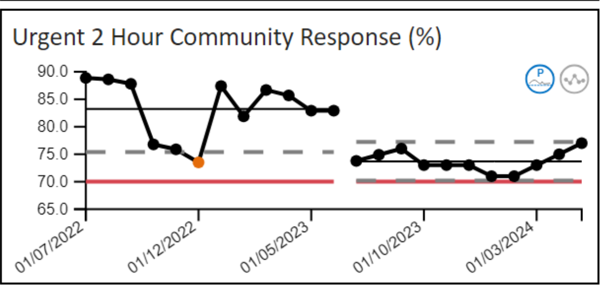
Subtheme: Community

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

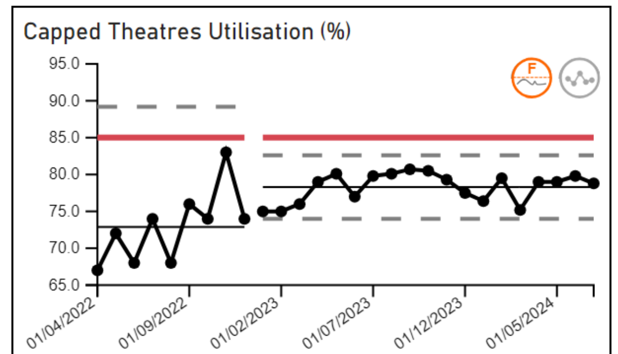
Productivity Priorities

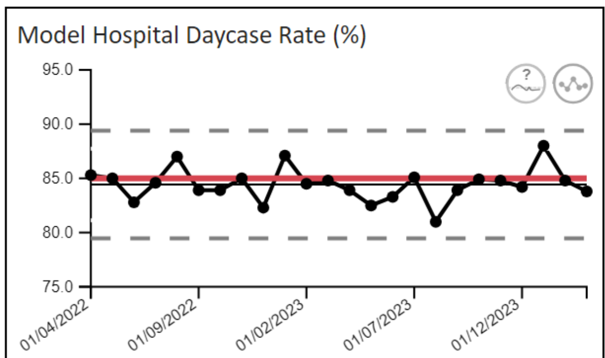
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
Clinic Utilisation (%)	85.0	79.1	Jul-24	☒	F	H	-	C
Capped Theatres Utilisation (%)	85.0	78.8	Jul-24	☒	F			C
Model Hospital Daycase Rate (%)	85.0	83.8	Mar-24	☒	?			S
Did Not Attend (%)	7.0	8.2	Jul-24	☒	F			C
Outpatients (% 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

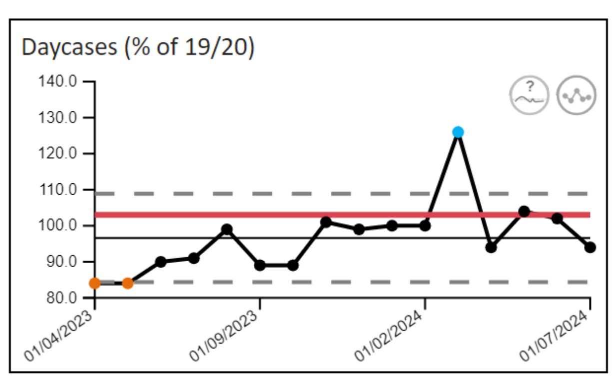
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

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

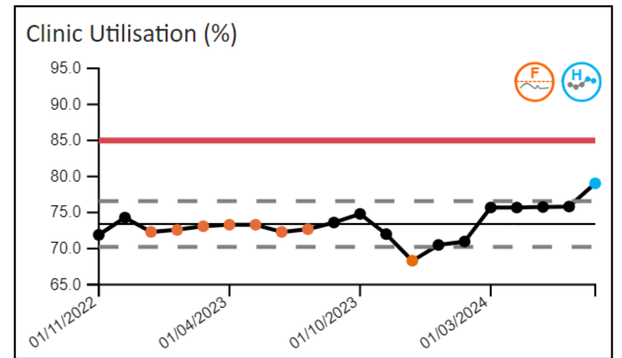
Potential risks to improvement?

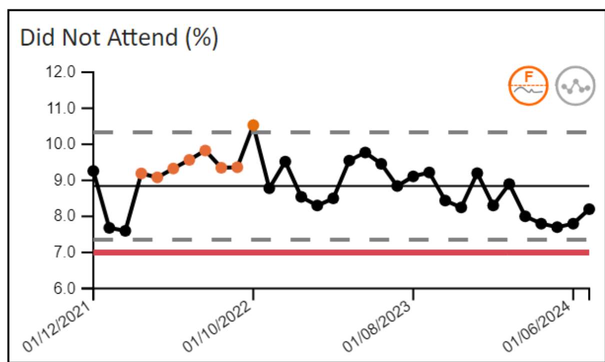
- Anaesthetic rotas may continue to impact on the ability to run theatre activity which significantly impacts on T&O
- Capacity to deliver pre-op assessment may impact on patients available and fit for surgery

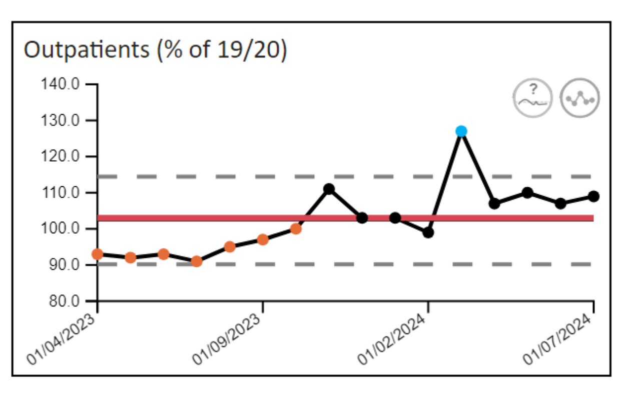
•High levels of staff absence impacting on lists been used

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?

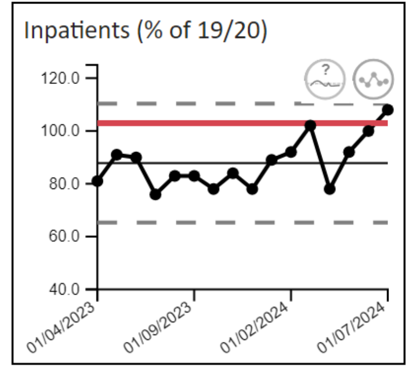
•Increase in clinic utilisation by 5% by Q3 2024/25.
•Reduction in patients that DNA to 7% by Q4 2024/25
•Increase in outpatient activity by 2% by Q3 2024/25.

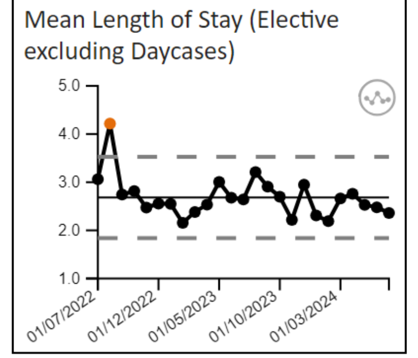
Potential risks to improvement?

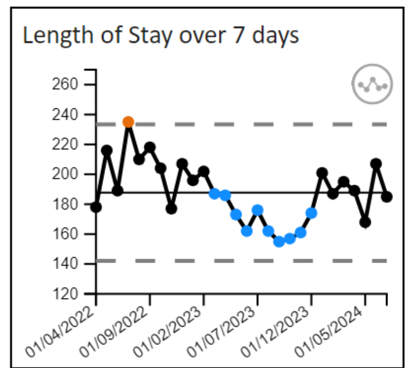
•Capacity in the contact centre to ensure that clinics are fully utilised, and any cancellations are back filled.
•Consultants' workforce absence may impact on the ability to sustain high levels of activity through summer months.
•Patient availability may impact on the ability to improve clinic utilisation,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

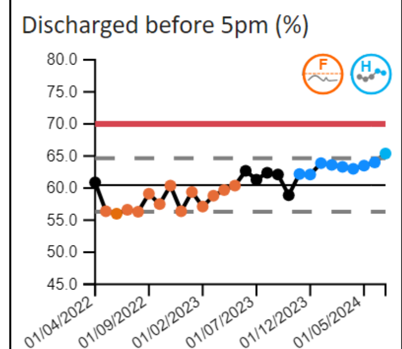
Subtheme: Inpatients

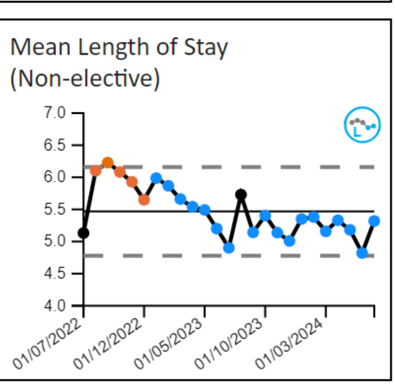
Data, Context and Explanation











•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

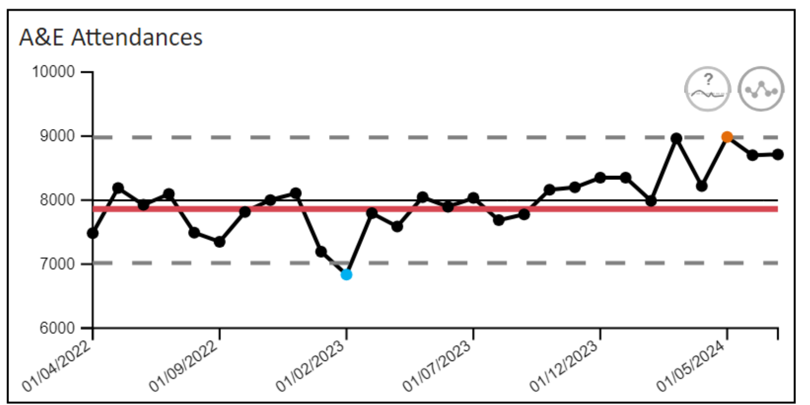
Activity

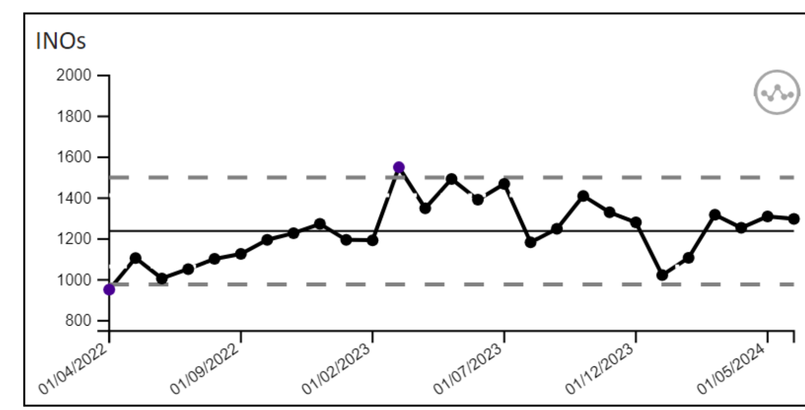
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
A&E Attendances	8,124	8,702	Jul-24	☒	?		-	S
INOs	-	1,360	Jul-24	-	-		-	S
Inpatients - Non-Electives (exc INOs)	-	2,631	Jul-24	-	-	H	-	C
Referrals	-	8,464	Jul-24	-	-	H	-	C
2ww Referrals	-	1,210	Jul-24	-	-		-	S
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

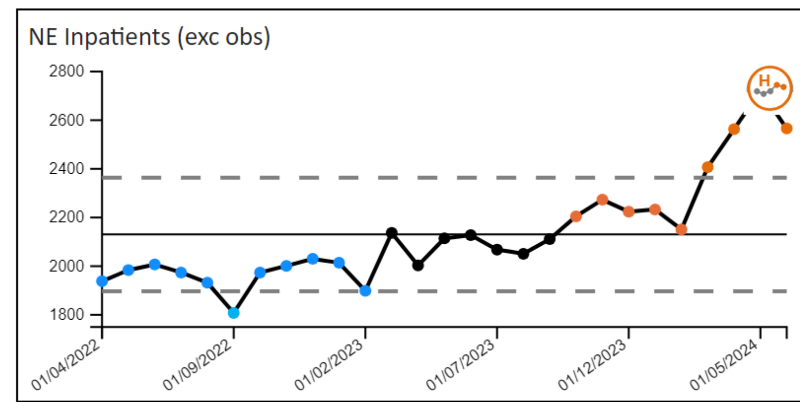
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

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

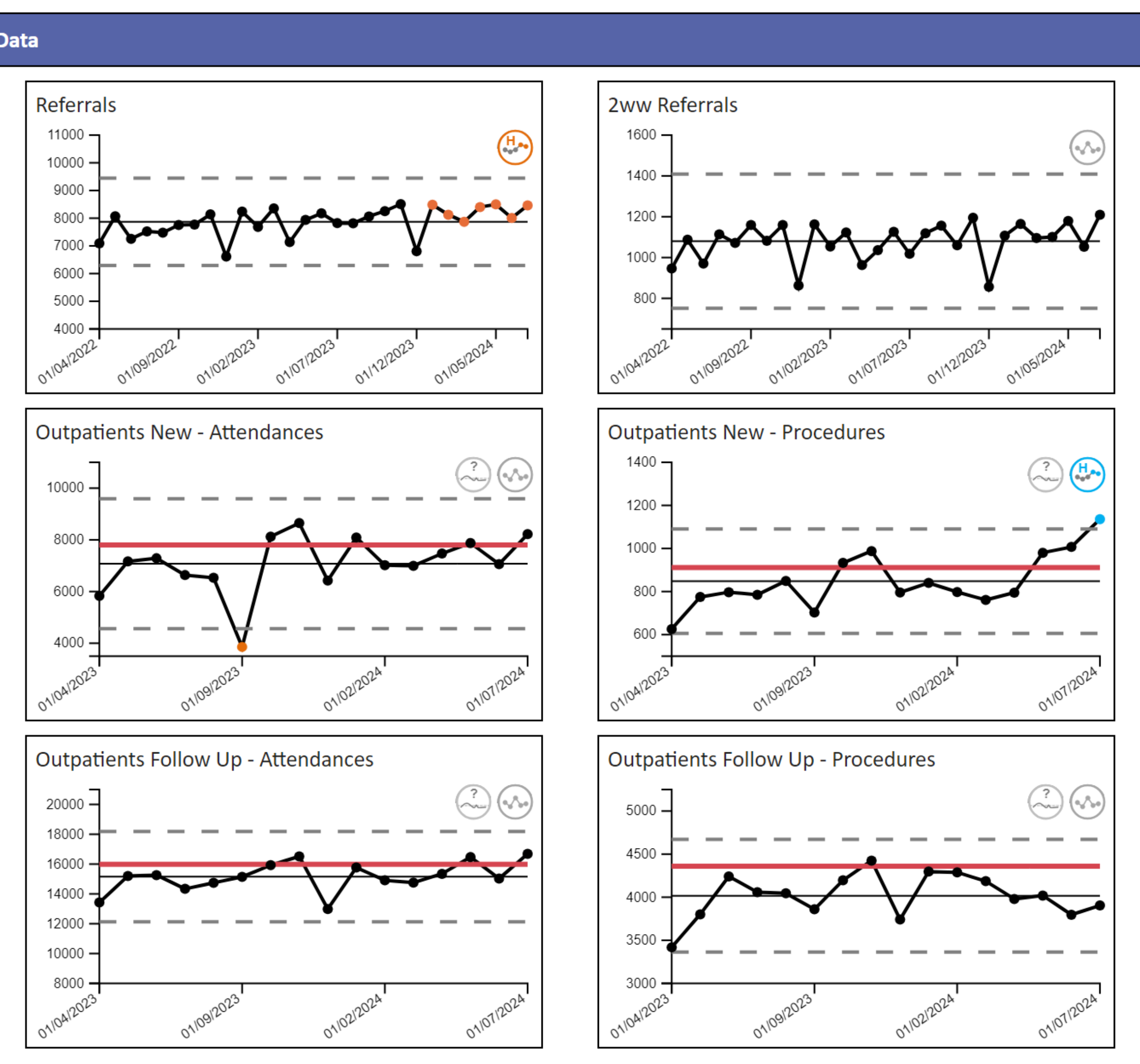






Subtheme: Outpatients & Referrals

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?

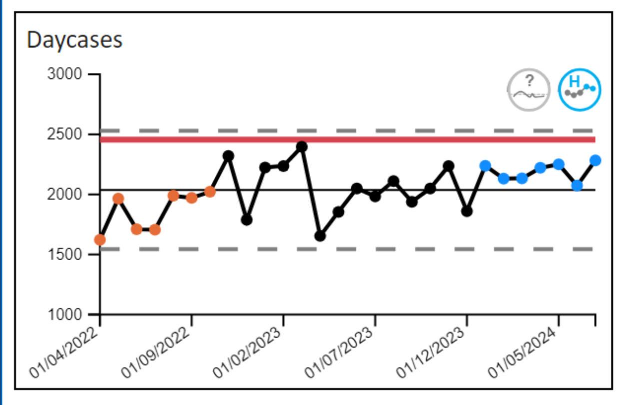
- Internal additional sessions and insourcing/outsourcing schemes will support delivery of 103% ERF target and contribute to improving the income position.
- Correction of activity recording issues will ensure activity is correctly aligned and the appropriate income is received.
- Early calculations 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

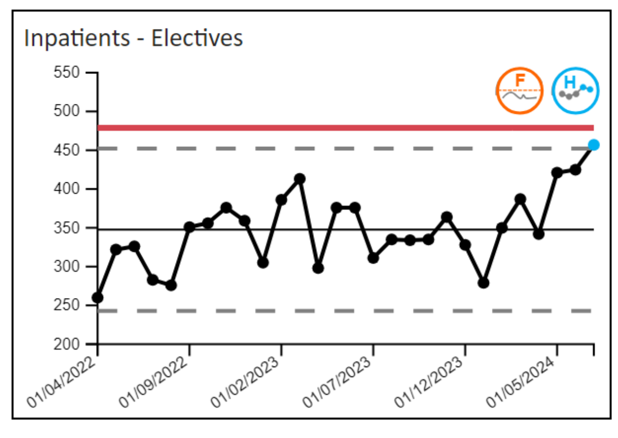
Potential risks to improvement?

- 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

Apr 24 to Jul 24

Key Headlines	Month Plan £000s	Month Actual £000s	Month Variance £000s	YTD Plan £000s	YTD Actual £000s	YTD Variance £000s	Forecast Variance £000s	Prior Month 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

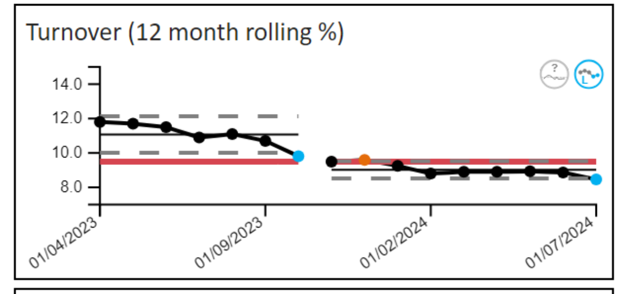
Variation		Assurance: Pass	Assurance: Hit or Miss	Assurance: Fail
	Special Cause: Improvement	**EXCELLENT: LEARN AND CELEBRATE**	**GOOD: CELEBRATE AND UNDERSTAND** • Turnover (12 month rolling)	**CONCERNING: CELEBRATE BUT TAKE ACTION**
	Common Cause	**GOOD: CELEBRATE AND UNDERSTAND** • MAST - Core • 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)

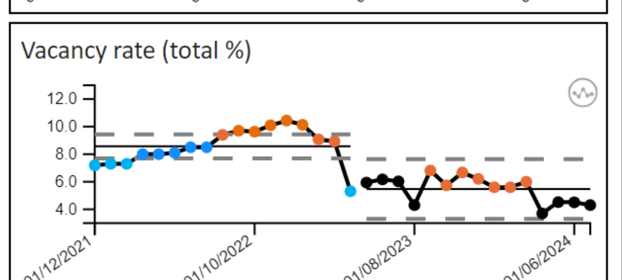
People and Culture

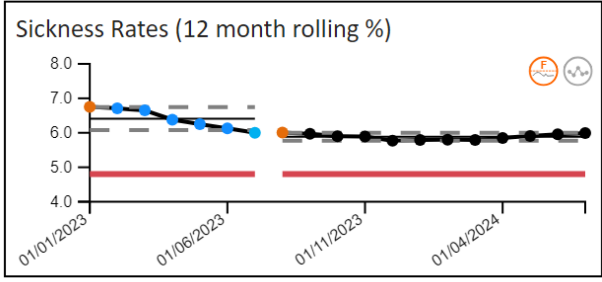
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
Turnover (12 month rolling %)	8.0-9.5	8.5	Jul-24					G
Vacancy Rate (total %)	-	4.3	Jul-24	-	-		-	S
Sickness Rates (12 month rolling %)	4.8	6.0	Jul-24				-	C
Sickness Rates (%)	4.8	6.0	Jul-24					C
Appraisal Rates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

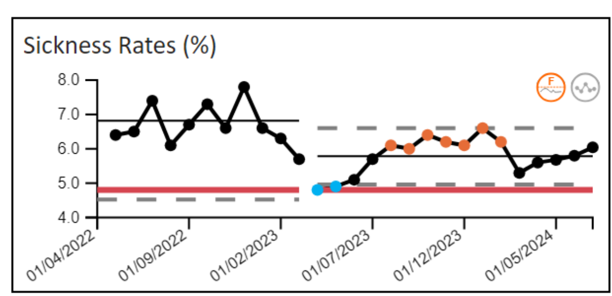
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

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?

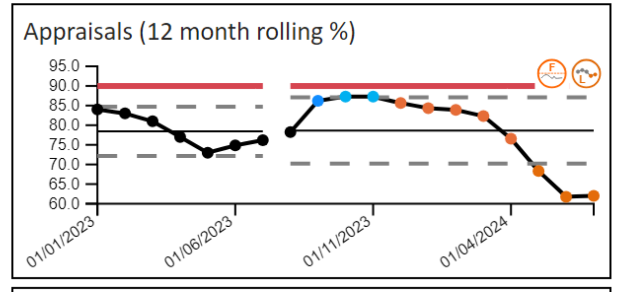
- Continued strong performance on retention and vacancy rates
- Improvement in sickness absence rates

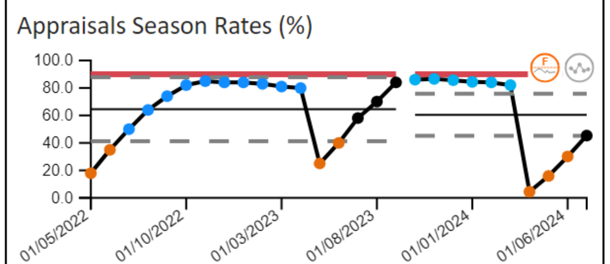
Potential risks to improvement?

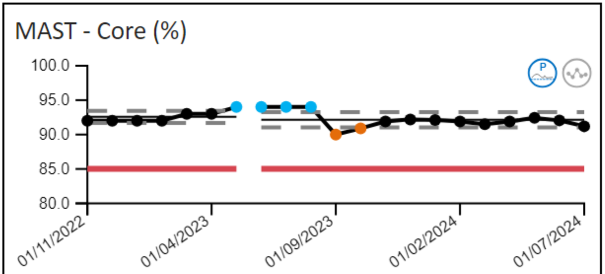
- Continued impact of ill-health of staff on attendance

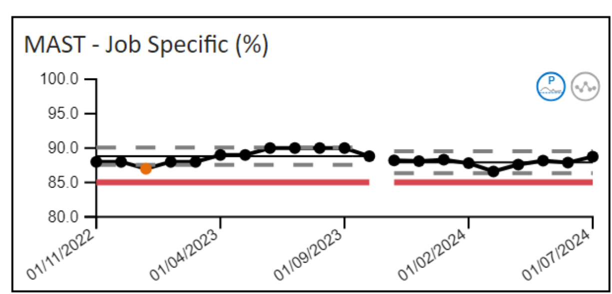
Subtheme: MAST & Appraisals

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

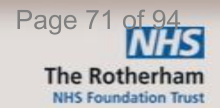
APPENDIX: SPC Summary Icons Key

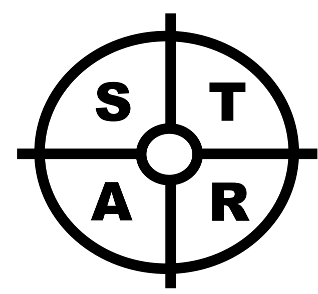
Assurance Icons

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.
F	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.
P	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
H	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?
L	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?
H	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.
L	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.





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	S T A R
Readmissions (%)	Proportion of readmissions within 30 days from the same Treatment Function specialty back to same Treatment Function specialty.	-	-	S T A R
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	S T A R
Care Hours per Patient Day	The Number of Care Hours per patient day.	National	7.3	S T A R
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	S T A R
Complaints	The number of formal complaints received.	Local	-	S T A R
Patient Safety Incident Investigations	The number of Patient Safety Incident Investigations that take place.	Local	0	S T A R

Metric	Definition	Target Type	Target Value	DQ STAR
Medication Incidents	The number of recorded medication incidents	Local	-	S T A R
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	-	S T A R
Patient Falls	The number of Patients Falls (Moderate and Above) per 1000 bed days	Local	0	S T A R
C. difficile Infections	The number of recorded C. difficile infections	Local	0	S T A R
1:1 Care in Labour (%)	Proportion of women in established labour who receive one-to-one care from an assigned midwife.	Local	75.0	S T A R
Breast milk first feed (%)	The percentage of babies born that receive maternal or donor breast milk as their first feed	National	70.0	S T A R
Stillbirth rate (per 1000 births)	The number of still births per 1000 live births	Local	4.66	S T A R

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	S T A R
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	S T A R
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	S T A R
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	S T A R
Ambulance Handover Times <15 mins (%)	Proportion of Ambulance Handovers where the time recorded was as waiting less than 15 mins for handover.	-	-	S T A R
Ambulance Handover Times >60 mins (%)	Proportion of Ambulance Handovers where the time recorded was as waiting over 60 mins for handover.	National	0.0	S T A R
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	S T A R

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.

Council of Governors: 10th September 2024

Agenda item:	**COG/48/24**
Report:	**Partnership Update**
Presented by:	Michael Wright, Managing Director
Action required:	For noting

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

Programme	Aim	Progress	Progress / Issues	Next steps	RAG
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

Programme	Aim	Progress	Progress / Issues	Next steps
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

Programme	Aim	Progress	Progress / Issues
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

Council of Governors: 10th September 2024

Agenda item: **COG/48/24**

Report: **Governance Report – Annual Appointment of Vice Chair and Senior Independent Director**

Presented by: Mike Richmond, Chair

Action required: For ratification

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 Council of Governors 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 Council of Governors 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

Angela Wendzicha, Director of Corporate Affairs
On behalf of
Dr Mike Richmond, Chair

COUNCIL OF GOVERNORS MEETING: 10 September 2024

Agenda item: **COG/49/24**

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

Author and Presented by: Geoffrey Berry, Lead Governor and Chair of GME

Action required: To note

1.0 The GME continues to meet on a quarterly basis, with the last meeting held on 4th June 2024.

2.0 Membership Engagement

2.1 The group received an update from Rachael Dawes, Head of Fundraising at Rotherham Hospital and Community Charity on the charity's journey over the past few years, and discussed the collaborative approach to promote both membership and the charity. The charity regularly distributes membership leaflets at their events and promotes the role of the Governor to their networks, and Governors are becoming more involved in their various events.

2.2 Regarding membership data, it was raised that approximately only 4% of the local population are members, signalling the limited awareness of the role.

3.0 Governors Surgery

3.1 The group were presented with initial designs for a Governor Surgery refresh and membership banner designs. More work is in progress to finalise and launch more avenues for Governors to gather feedback and seek members and public views.

3.2 The committee discussed that there is more work to be done with partner governors as a route to areas of the population that need further engagement and recruitment.

4.0 Recommendation

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

4.2 It is also recommended that the Council review the group membership moving forwards to ensure good engagement and progress towards objectives.

Geoffrey Berry
Lead Governor
Chair of Governors Membership Engagement Group

Calendar of Business for Council of Governors 2024

REPORT - ORDER		2024			
		Feb	May	Sep	Nov
		21	15	10	20
Procedural items					
Welcome and announcements	Chair	/	/	/	/
Apologies and quoracy check	Chair	/	/	/	/
Declaration of Interest	Chair	/	/	/	/
Minutes of the previous meeting	Chair	/	/	/	/
Matters arising and action log	Chair	/	/	/	/
Chairman's report	Chair	/	/	/	/
Report from the Non-Executive Chairs of Board Committees					
Report from Audit Committee	NED Chair	/	/	/	/
Report from Finance and Performance Committee (inc. Finance Report)	NED Chair	/	/	/	/
Report from Quality Committee	NED Chair	/	/	/	/
Report from People & Culture Committee	NED Chair	/	/	/	/
Report from Charitable Funds Committee	CFC Chair	/	/	/	/
Integrated Performance Report (for information)	Man. Dir.	/	/	/	/
Progress Report (for information)	Man. Dir.	/	/	/	/
Partnership Working	Man. Dir.			/	
Organisational Priorities 2024/25	CEO		/		
Five Year Strategy Update (every 6 months)	CEO		/		/
Quality Priorities	CN	/			
Quality Account	CN		/		
Annual Report (through Annual Members Meeting)	DoCA			/	
Annual Accounts (through Annual Members Meeting)	DoF			/	
Financial Plan	DoF				/
Governor Regulatory and Statutory Requirements					
Governance Report	DoCA	/	/	/	/
Constitution – formal review Last review October 2018	DoCA				/
Constitution – Partner Governors	DoCA				/
Governors Standing Orders (linked to Constitution review) To be reviewed every 3 years as a minimum or in conjunction with any changes to Constitution. Last review October 2018	DoCA				/
Appointment of Vice Chair (as needed)	DoCA			/	
Appointment of Senior Independent Director (as needed)	DoCA			/	
Appointment / Reappointment of NED's (as needed)	NomComm				
Appointment/Reappointment of Chair (as needed)	NomComm				
Outcome of Chair and NED Appraisals	NomComm			/	
External Auditors (contract renewal) Contract with Mazars LLP effective from 2024 for 3 years	DoCA				

Key:

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

Calendar of Business for Council of Governors 2024

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

Key:

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

Calendar of Business for Council of Governors 2024

CONFIDENTIAL

REPORT - ORDER		2024			
		Feb	May	Sept	Nov
		21	15	10	20
Procedural items					
Nomination Committee Report (if held)	Chair	/	/	/	/
Nomination Committee Approved Minutes (if held)	Chair	/	/	/	/
Nomination Committee Terms of Reference	Chair			/	

Key:

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