Board of Directors (Public)

The Rotherham NHS Foundation Trust

Schedule	Friday 10 January 2025, 9:00 AM — 12:00 PM GMT
Venue	Boardroom, Level D
Organiser	Angela Wendzicha

Agenda

9:00 AM	PROCEDURAL ITEMS	
	P1/25.	Chairman's welcome and apologies for absence For Information - Presented by Dr Mike Richmond
	P2/25.	Quoracy Check For Assurance - Presented by Dr Mike Richmond
	P3/25.	Declaration of interest For Assurance - Presented by Dr Mike Richmond
	P4/25.	Minutes of the previous meeting held on 08 November 2024 For Approval - Presented by Dr Mike Richmond
	P5/25.	Matters arising from the previous minutes (not covered elsewhere in the agenda) For Assurance - Presented by Dr Mike Richmond
	P6/25.	Action Log For Decision - Presented by Dr Mike Richmond
	OVERVIEW AND CONTEXT	

9:15 AM	P7/25.	Board Committees Chairs Reports - Committee Chairs i. Quality Committee - Chair's Log - Julia Burrows ii. People & Culture Committee Chair's Log - Hannah Watson iii. Finance & Performance Committee - Chair's Log - Martin Temple For Assurance
10:00 AM	P8/25.	Review of the Risk Appetite for People and Culture For Approval - Presented by Angela Wendzicha
	P9/25.	Board Assurance Framework For Decision - Presented by Angela Wendzicha
	P10/25.	Corporate Risk Register Report For Discussion - Presented by Angela Wendzicha
10:15 AM	P11/25.	Report from the Chairman - Verbal For Information - Presented by Dr Mike Richmond
10:20 AM	P12/25.	Report from the Chief Executive For Information - Presented by Dr Richard Jenkins
	CULTURE	
10:25 AM	P13/25.	Staff Story For Information - Presented by Daniel Hartley
10:50 AM	P14/25.	Medical Education Report and GMC Training Survey For Assurance - Presented by Jo Beahan
10:55 AM	SYSTEM WORKING	
	P15/25.	National, Integrated Care Board and Rotherham Place Update For Information - Presented by Dr Richard Jenkins

11:00 AM	BREAK	
11:05 AM	PERFORMANCE	
	P16/25. Finance Report For Assurance - Presented by Steve Hackett	
	P17/25. Integrated Performance Report For Assurance - Presented by Helen Dobson, Sally Kilgariff, Steve Hackett and Jo Beahan	
11:35 AM	ASSURANCE	
	P18/25. Maternity and Neonatal Safety Report including CNST Sign Off Presented by Sarah Petty For Assurance	
	P19/25. Safe Staffing & Establishment Nurse review (6 monthly) For Decision - Presented by Helen Dobson	
	REGULATORY AND STATUTORY REPORTING	
	P20/25. Learning from Deaths & Mortality Quarterly Report For Assurance - Presented by Jo Beahan	
	P21/25. Guardian of Safe Working Hours Quarterly Report For Assurance - Presented by Jo Beahan	
11:55 AM	BOARD GOVERNANCE	
	P22/25. Escalations from Governors - No Esclations For Discussion - Presented by Dr Mike Richmond	

P23/25. Board Annual plan
For Noting - Presented by Dr Mike Richmond

P24/25. Any Other Business
For Discussion - Presented by Dr Mike Richmond

P25/25. Questions from Members of the Public on the Business of the Meeting
For Discussion - Presented by Dr Mike Richmond

P26/25. Date of next meeting - Friday 07 March 2025

CLOSE OF MEETING

Draft until approved at the 10th January 2025 meeting

The Rotherham NHS Foundation Trust

MINUTES OF THE BOARD OF DIRECTORS MEETING
Friday 11th November 2024, 09:00 – 12:00 pm
Boardroom

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

In attendance: Ms A Wendzicha, Director of Corporate Affairs
Mrs J Roberts, Director of Operations/Deputy COO
Mrs E Parkes, Director of Communications
Mr J Rawlinson, Director of Health Informatics
Mrs L Martin, Director of Estates and Facilities
Mr A Wolfe, Deputy Director of Corporate Affairs (minutes)

Observers:
Mr M Ayad, Public Governor
Mr D Simms, Head of Business Intelligence and Data Warehouse
Ms J Webb, Lead Cancer of Unknown Primary CNS, Acute Oncology and Unknown Primary Team service (For item P65/24)
Mr J Edwards, Acacium Group
Mr A Tice, Member of the public (09:00 to 09:25)
Mr M Suter, Member of the public (09:00 to 09:25)
Ms M O'Leary, Member of the public (09:00 to 09:25)
Mr S Merriman, Member of the public (09:00 to 09:25)

Apologies: Mrs L Martin, Interim Director of Estates and Facilities

Item	Procedural Items	Action
P153/24	**CHAIRMAN'S WELCOME & APOLOGIES FOR ABSENCE** Dr Richmond welcomed all to the meeting and noting the upcoming Remembrance Day, the Board and observers present were invited to respect a short period of reflection in silence.	

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P154/24	**QUORACY CHECK** The meeting was confirmed to be quorate.	
P155/24	**DECLARATIONS OF INTEREST** Dr Jenkins' interest in terms of his joint role as Chief Executive of both the Trust and Barnsley Hospital NHS Foundation Trust was noted. Ms Wendzicha's interest in terms of her role as Director of Corporate Affairs of the Trust and Director of Corporate Affairs at Barnsley Hospital NHS Foundation Trust was noted. Mrs Parkes' interest in terms of her role as Director of Communications and Marketing of both the Trust and Barnsley Hospital NHS Foundation Trust was noted.	
P156/24	**MINUTES OF PREVIOUS MEETING HELD ON FRIDAY 6TH SEPTEMBER 2024** The minutes were approved as a correct record, subject to a minor amendment raised by HD concerning a paragraph contained within agenda item P140.24 Maternity and Neonatal Report which required rewording, HD to provide the amended wording to AMW.	**HD**
P157/24	**MATTERS ARISING** There were no matters arising which were not covered by either the action log or agenda items. At this stage, a male member of the public stood up and commenced shouting and pointing in an aggressive manner towards the Chair and Chief Executive. Despite being asked to stop shouting and sit down, he continued to raise his voice in an aggressive manner demanding to know when the Board would be discussing the matter relating to the staff residences. The Chief Executive attempted to explain that he had been meeting with the individuals concerned but the disruptive behaviour continued. The Chair stated that the meeting was not a public meeting and again requested that he sit down. The Chairman attempted to continue with the Board meeting, however, the individual continued to shout over the Chairman. The Chairman asked the individual to leave due to his disruptive behaviour, however the individual continued to shout and therefore the Chairman adjourned the Board meeting for a period of fifteen minutes and support from the security team was sought. The four individuals subsequently left the meeting at 09:25 hours.	

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P158/24	**ACTION LOG** The Action Log was received and Log numbers 11, 14, 15 and 16 were agreed to be closed. The outstanding action number 17 was to remain open and is due for December 2024. With regards to Log number 8 and the Fire Strategy, it was agreed that the action should remain open in light of the ongoing work relating to fire safety. The new Director of Estates and Facilities, when commenced in post, should undertake a further review of the fire safety position and a report should be brought back to the Board in early 2025.	**DoE&F**
	OVERVIEW AND CONTEXT	
P159/24	**Board Committees Chairs Reports** i. Quality Committee (QC) Ms Burrows highlighted the following items from the Quality Committee as follows: • Increased pressure on all departments, use of communications on long waits in UECC and increased risk to patient safety which needed to be owned by the Board. • The BAF risk P1 reviewed and the score is recommended to remain at 8. • Infection control, the Committee wished to alert the Board to the high rates of Clostridium difficile (C.diff) which were an outlier a few months again and remain a concern, also to raise the issue about the lack of a scheduled deep clean programme. • The Committee received Patient Incident Response Plan. • The Committee alerted the Board to an issue relating to data quality for reports received due to sickness in a specific department which was a single points of failure that should be addressed. Dr Richmond asked if a deep clean programme was being pursued with option appraisals; it was confirmed that the new Director of Estates and Facilities would pick this up. According to the national cleaning standards a scheduled deep clean is not required, however the rest of the South Yorkshire region's hospitals have it as an annual scheduled event. As such any increase of infections within the Trust is likely to trigger internal and external questions, agreed to be brought back to Board. Mrs Craven noted that the Health & Safety annual report for 2023/24 had not highlighted any issues, however there had been a number of issues raised since April. Dr Richmond agreed that these should be further raised to Board. ii. People & Culture Committee (P&CC) Mrs Watson highlighted the successes of Trust staff as evidenced by the increased number of nominations and awards recently received. She felt this was a credit to the Trust and the Trust should not hide such success. She noted that there had been a lot of discussion about risk appetite, and how this was often dependant on outside bodies so increasingly there was a need to push harder with external organisations and this should be a multi-committees approach. She also noted the WRES and WDES progress and that there was a paper at Board for approval. Finally she informed the Board that Mrs Kilgariff	**DoE&F**

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had agreed to join the Committee as many items discussed were linked to operational performance.

iii. Finance & Performance Committee (F&PC)

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

- There were many encouraging elements with many parameters in the upper quartile, although to achieve this it was expensive, which then causes issues for finance.
- Care Group 1 have issues around the volumes attending through UECC with winter levels continuing through the summer. Whilst the staff are doing a remarkable job keeping going, it is again proving to be expensive. There was lengthy discussions regarding the existing model based on what demand is expected to be; but has demand changed significantly and there is now a need to review the model.
- The Committee discussed level of CIP which at the time looked more worrying than it does in the up to date papers.
- With regards to the Cyber report, it was acknowledged that the Trust can never rest and had done well so far facing the challenges posed, the IT strategy was approved.
- The Pharmacy contract was approved.

Dr Jenkins maintained that it was important to keep in mind the increased demand is a regional, if not, a national issue and is driving costs and risks across the system. He confirmed that work is being done on a regional basis, but is made worse by the problematic nature of the region, with a less healthy population and difficulties accessing primary care. Mrs Craven added that this had been an escalation from the Quality Committee also, with a sustained increase over a number of months, it's not an easy thing to solve but the issue needs to be kept at Board level review. Mr Temple agreed but added that the impact on staff needs to be kept in focus as well, as they are under a lot of pressure with the flow from community.

Dr Richmond stated that the Board needed clarity to what the exact increase in demand has been as the F&PC papers noted a 15% rise, however this appeared to be different in different reports. There was a definite need to keep the Board sighted, with Dr Jenkins agreeing this was an ongoing matter for the Board. Mrs Craven noted that the position going into winter a lot tougher than the Trust has experienced previously. Mrs Kilgariff confirmed that schemes of recovery work were being undertaken presently and next month's F&PC was the Emergency Care presentation, where the data for review will be accurate. Dr Richmond concluded that the Board were hugely encouraged with the work undertaken so far and appetite seen for new schemes.

iv. Audit and Risk Committee (A&RC)

Mr Malik raised the issue regarding the current position of the Trust's Standards of Business Conduct, which is disappointing in terms of compliance data. He warned that this needed to increase and that the Committee wanted to raise again the single point of failure related to the extraction of the data.

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	360 Assure had reported on a number of audits they had completed, this included the CIP which had an opinion of limited assurance, as did Medicines Management. The Risk Management audit had the opinion of Significant Assurance. With regards to the CIP, Mr Wright clarified that 360 had not been assured that a full year programme had been identified, but had the opinion of Significant Assurance regarding how progress was being managed. Dr Beahan acknowledged the Medicines Management opinion and confirmed that structures where in place but needed tightening and that a new Chief Pharmacist starts in January 2025. Ms Wendzicha confirmed that it would be investigated as to why the CD report had dropped off the work plan as from her perspective it was on the plan and had been shared. Mr Hartley acknowledged the issue regarding the Standards of Business Conduct data and confirmed that steps had been taken to improve resilience within the department. Dr Richmond was provided with confirmation from Mr Hackett that there was no link between the limited assurance given for Medicines Management and area of significant expenditure related to medicines found in the finance report, as the finance issue is related to increased usage with plans in place for later in year to address costs.	**AMW**
P160/24	**<u>TRFT Strategic Risk Appetite Review 2024/25:</u>** Ms Wendzicha outlined that this had been reviewed previously at Board and there were two areas around the risk types People and Culture and Estates still to confirm. Mr Hartley confirmed that there had been some discussion at the People & Culture Committee about appetite and the specific wording produced by the Good Governance Institute which the Trust were following. The P&CC had differing views but agreed that when related to people and culture and how we treat our people this was an area the Trust needed to be cautious on. However when related to the part of overall culture, on the Trust's journey to excellence, there needed to be more of an open or seek attitude with a need to innovate more for an open and inclusive culture. Mrs Watson felt that there was a bit missing in how the appetite is used when defining people and workforce as opposed to culture, or sickness, and wondered where would that element sit, Mr Hartley was in agreement. Dr Jenkins pointed out that for all of the domains the level of risk is higher than we want them to be, the reason for this, is for the Trust to use in decision making processes, such as a business case, as the appetite score was not quite same as a target risk score on a risk register. Mr Hartley explained that when he was looking at the Trust people and the appetite he was led by the relevant employment law, and will always follow policies that include appropriate consultation and employment models. Ms Wendzicha to work with Mr Hartley and wording to be brought back to Board for final approval. With regards to Estates, Mr Hackett maintained that this again could be viewed in two ways, with estates safety then the Trust should be cautious, however with estates build then it could be more open, overall he concluded that it is based on estates safety so the risk appetite should be cautious. The Board approved the risk appetite for Estates was Cautious.	**DH/AW**

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P161/24	**Board Assurance Framework** Ms Wendzicha introduced the paper explaining that one to one meetings with Executive Leads had occurred and the BAF risks were aligned to the appropriate Committees for check, challenge and scrutiny, she noted one error in the Executive Summary regarding the recommendation related to D5, this was to remain at a rating of 12. With regards to the BAF risk ratings the recommendation was that risks P1, O3 and R2 should all remain rated at 8. Dr Richmond raised the risk R2 relating to the Trust's work with the wider Rotherham Place noting the rise in the demand of the care pathway, and queried how can the Trust increase its influence at Place and the ICB, in order to hold Place to account for the shared ownership of the pathway. Dr Jenkins maintained that the Trust was represented itself quite strongly at the ICB Alliance Board with work being undertaken in granular level with Place Directors as action owners. Mrs Kilgariff spoke to the risk D5 explaining that the Consequence score had been increased due to the industrial action, and although it is rare to change the Consequence score, the sustained impact of the action had been accepted with the increase previously agreed at Board. The F&PC had previously agreed to reduce the Consequence score back to 3 due to the decreased impact of the industrial action and the improvements seen in elective diagnostics, challenges remain in urgent care, so the Likelihood to remain at 4 with an overall rating of 12. The Board approved the position within the Board Assurance Framework.	
P162/24	**Corporate Risk Register Report** Ms Wendzicha introduced the report and provided an overview on how risks are managed within the organisation. This paper had previously been presented the Audit & Risk Committee at the end of October 2024. It was noted that an opinion of Significant Assurance had been received from 360 Assure for the Risk Ward to Board audit. She confirmed that the Department will not be complacent now but would continue the hard work with the Care Groups, including scrutiny of all risk actions, named individuals, end dates for actions, and the improving journey for risk review dates. She acknowledged that there were still some small pockets where work needed to be undertaken but check and challenge continued at the Risk Management Committee (RMC). With regards to the report she informed the Board that there was a change to the format, with the report now including more details to strengthen the information presented to allow the Board increased oversight of risks. Mrs Craven welcomed the new report as she feels it gives the Assurance Committees and Board more assurance. She feels that it also really highlights specific issues more, an example being the risk around analgesia in UECC, which is included in different reports. In this case the risk is rated at 15, but it seems the action plan deadline has been extended deadline and wondered if this is correct, as if the risks is in three places then that should be a red light and a priority for the risk owner. Dr Beahan, agreed with the principle but added that	

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	in this particular case, pain management is a quality priority for the Trust as well as the UECC survey highlighting it as an issue, so work is being undertaken to mitigate it, and that should be included within the recorded risk as an update. Dr Shah raised a potential issue with stagnation of risks which he feels he keeps seeing month after month, he asked if they should be closed after two years, or a more robust timeline be added, Dr Richmond confirmed that such risks cannot be static as it's a dynamic process. Ms Wendzicha stated that the layering of the processes involved in risk management had now been put in place, the Department had started with the high level risks, then the moderate risks and now working towards the lower risks rated at eight and nine. Included within those are risks that appear static, and it's an ongoing piece of work with staff to understand risks as they gain understanding of when it right to close a risk or identify that the actions wrong or they done everything within the power of the Trust and it's an external issue.	
P163/24	**Report form the Chairman - Verbal** Dr Richmond referenced the ongoing work with the ICB who were due to hold a strategic session on the 19th November, this will include updates regarding the financial situation which remains a major concern, and how it may impact the Trust going forward.	
P164/24	**Report for the Chief Executive** Dr Jenkins introduced the report, noting the pressure the Trust has been under, but also that in the operational space there has been a lot to be proud of, in areas such as cancer, diagnostics and there is a lot of work going into emergency care. The Trust might not be hitting targets but improvements can be seen. He informed the Board that SK had delivered a presentation at a regional level which was extremely well received and reflected well on team members. There are regular meetings to reduce spend due to the considerable financial challenge and currently it is not clear where South Yorkshire will land at year end. He noted there was also a lot for staff to celebrate, the excellence awards showing there are lots of good things going on with a lot of amazing things happening, he highlighted that the NHS may be very challenged but lots of good work is being produced. Dr Jenkins highlighted work being undertaken related to paediatrics and that the Trust needs to ensure there is an approach for children and young people which is not a chronological approach, Mrs Kilgariff confirmed that the Trust has started to look at elective times spilt out from adults to children and that Mrs Dobson will be picking this up through Children's Trustwide Strategy Group. Professor Congdon raised the matter of Sheffield Children's Hospital's upcoming National Centre for Child Health Technology and that it was important for the Trust to be involved, Dr Jenkins fully agreed, confirming that it was important that when such a facility is named as a South Yorkshire centre that the Trust are involved, as it's not just a Sheffield facility.	

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	CULTURE	
P165/24	**Patient Story - Oncology** The Board welcomed Ms J Webb from the Acute Oncology Service, she explained that this was a new service implemented as evidence shows patients were not always receiving appropriate care. The Service will see all patients who have received a new cancer diagnosis and it is more of a responsive service, who will also see all brain tumour patients as there is no service at the Trust. The service works in close liaison with the Sheffield Western Park Cancer Hospital and often, following discussions between the teams, additions to a treatment plan might be made. The team also have access to the Sheffield systems including Chemocare. The patient Ms Webb was to talk about was a 53 year old lady, at first she didn't want to attend the Hospital or UECC, however she was encouraged by her family to do so. Upon attendance there was an alert directly to the team from the UECC, with team staff attending immediately. They found a patient coming to the end of treatment with poor prognosis, she was on oxygen support at home. She gave a history of struggling to get good support so the team teams arranged for support and discussed with the patient her anxieties about coming in so a drain could be fitted. The patient unfortunately later died, but she was at home. Her husband later wrote to the team praising team members, and in particular the Macmillan Development Nurse, for the excellent care his wife had received. Dr Richmond noted that from a patients point of view to have end of life in their personal place was excellent. Dr Beahan agreed that it had been an incredibly powerful story, but there was a need to ensure all patients get same level of care. It was confirmed that the team try to support the patients at the point where the patient would normally be still waiting for confirmation of their diagnosis, the team will treat as cancer until proven not. Dr Beahan highlighted that currently the patients with acute oncology needs at their end of life often don't want to go into UECC and work was ongoing on how do the Trust move these patients into community instead with the appropriate resource, with it likely to require a shift in knowledge in order to develop these pathways. She also noted that this was ultimately a national question of how do we avoid UECC, and the work is at a regional level with work ongoing also with Western Park Hospital.	
P166/24	**Integrated Equality, Diversity and Inclusion Plan** Mr Hartley introduced Mr Hashim Din, the Head of OD, Wellbeing and Inclusion, he took the paper as read but had two things he wanted to highlight. The paper included in the bundle sets out the progress made so far and that the People and Culture Strategy would be underpinned by the EDI plan. Mr Din explained that NHS trusts traditionally have produced the plan on an annual cycle, he however is looking at a longer term vision of three year plan. This would allow the plan to work more holistically and be able to measure what needs changing, taking forward the best bits of the old plans, as well as the new. This would be a phased approach, with a set programme of work each year to focus and allow tangibility for staff understanding, with the plan set out a coherent and logical way.	

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	He had noted some very visible commitments by the Trust since he commenced in post, such as the adoption of the North West Anti-racism Agenda, which will build on progress each year so it becomes business as usual at the Trust. With regards to the plan it sets out enablers, such as strong staff networks and leadership. Everyone will have objectives by the end of the plan as EDI does matter as it is a link between civility and saving lives. Dr Richmond confirmed that the Executive mid-year reviews will link the NEDs with objectives, to go along side every executive who had one confirmed at the start of year for EDI. The Board approved the Integrated Equality, Diversity and Inclusion Plan.	
P167/24	**Progress on Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES)** Mr Hartley again introduced Mr Din to talk to the paper, he confirmed that this was one of many reports that the Trust has to produce relating to people so it matters that we are getting more diverse and are treating people the same. He confirmed that overall the Trust continues to have more BAME and disabled colleagues. He noted that it was positive to see levels of discrimination between colleagues and between colleagues and their managers reducing, however there remained an issue with patients and visitors towards colleagues. This has been identified as a national issue, with possible effects from the Covid lockdowns, such as after effects of isolation and being cut off from loved ones, which along with the current financial environment is leading to increased patient's frustration. This however is not acceptable, and discrimination should be a regular standing item throughout Trust meetings with letters sent to offenders. Mr Malik raised the matter of what was in the control of the Trust and what was outside of its control, an example being shortlisting for jobs is within, but bullying harassment is not. However, shortlisting is not improving and requires a deep dive as previously undertaken in 2022, possible reasons cited included a new NHS Jobs website and visa changes, but the Trust still needed to understand whether its attracting more diverse applicants, are we shortlisting them or offering them positions. Dr Jenkins noted that there are between 150 and 160 international nurses, which skews the figures somewhat but it was clear that the Trust was starting to see high band BAME clinical staff but not managerial, and this needed to be reviewed at some point in the future.	
P168/24	**Sexual Safety** Mrs Dobson and Mr Hartley presented the paper which was a commitment laid out in the EDI; the Trust had previously signed up to the Sexual Safety Charter in 2023. Mrs Dobson highlighted the various tools and pledges made by the Trust, including amongst other items having policies for domestic abuse and also sexual misconduct, providing appropriate staff training and provision of support for staff. There was also detail on the recently adopted posters highlighting sexual safety. She also confirmed that it was important that the Trust work on the toolkit in order to provide staff with the required skills, and there is a training needs analysis which is ongoing with the wider staff group.	

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	Mr Hartley noted that the Executives appear at the Corporate Induction and there had recently been staff asking if the Trust had signed up to the Charter. Mr Hartley and Mrs Dobson are leading on this together, so that the Trust has male and female leads, rather than just a female as is at most other Trusts. Dr Beahan noted that with regards to the staff survey the resident doctors in training are not included with the Trust being an outlier for sexual safety for resident doctors and this should be included going forward. Mr Hartley agreed to action. The Board approved the Trust's approach to sexual safety.	**DH**
P169/24	**Freedom to Speak Up Quarterly Report** HD introduced Ms H Khaira the Freedom to Speak Up (FtSU) Lead, she explained that she had started in the role in March 2024 and this was her first attendance at Board. She presented the Quarter 2 report with some key points such as the Trust had adopted the national policy in July 2024, there had been an increase in the number of concerns raised when compared to the previous quarter. The figures had started small but were slowly rising during the year with three in Quarter 1, rising to nine in Quarter 2 and up to eleven in month two of Quarter 3. She informed the Board that various staff groups had raised concerns, including the Medical staff group, who are historically quiet. Feedback remains difficult as people don't want to engage once the concern has been closed off. It was stressed that an increase in concerns is a positive not a negative, and Ms Khaira had attended a lot of Trust meetings since she started, believing that her clinical background had helped a lot in her role. She had also been receiving some positive feedback, mainly around how the individual felt they had been heard and taken seriously and also regarding accessibility to raise the concern. Mrs Dobson noted a factual correction on page 156 of the report which listed the FtSU Non-Executive Director Lead as Mrs Craven when it is actually Mr Malik. Ms Khaira confirmed that the number of FtSU Champions had increased from 8 to 13 with the majority of staff groups now represented, noting that she was still looking for more Champions to come forward.	**HD**
	SYSTEM WORKING	
P170/24	**National, Integrated Care Board and Rotherham Place Update** Mr Wright provided the Board with some national context noting that the Trust's own growth in non-elective activity is being mirrored nationally with figures similar to pre-pandemic. There had been focused activity at Place with regards to the Urgent Community Response target and the Cancer 28-day Faster Diagnosis Standards. He noted the challenges across UECC but added that there was an improving trajectory. Work continues with schools and colleges to support T-level placements and finally that Skills Street, an immersive careers experience for children aged between 5 and 18, is being established at Gulliver's Kingdom and due to open April 2025. He continues to attend the Heath Select Commission for local organisations. The paper was noted.	

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	STRATEGY & PLANNING	
P171/24	**Five Year Strategy Six Month Review** Mr Wright highlighted some of the recent Trust achievements such as the introduction of the Exemplary Accreditation System, the continuing work of the QI practitioners, who now number a total of 143 staff, and are gaining a lot of external interest. He also commented on the Trust's emphasis on increased local social value, examples being the encouragement of local businesses to get involved with the Trust to submit tenders for Trust work and the ongoing development of the relationship with Gulliver's Kingdom. The paper was noted.	
P172/24	**Operational Plan Six Month Review** Mr Wright introduced the paper which is a high level update on progress made during the first six months of delivery. He outlined the positive inpatient survey position, the good engagement of staff with the 2024 Staff Survey, with encouraging response rates. With regards to operational delivery he wanted to call out the 65 week wait position which had also been highlighted by the ICB at review. On the area of financial sustainability he noted the current CIP position and the need for improvement. Mr Wright was asked to talk through the Inpatient Survey for the benefit of the new NEDs, he deferred to Mrs Dobson who outlined that the Trust participate in four of these each year. The survey will be of patients who were in the hospital in the November of the year, they receive a letter the following January or February and it can be a protracted process. The Trust are historically coming from a low starting point, however last year's response was very positive with the Trust rating in the Health Service Journal's list of top ten improved organisations nationally. She noted that whilst this was a huge improvement there was still a need to get on top of waiting times and reduced noise at night, which are the key issues. Mrs Dobson also briefly mentioned the Maternity survey and UECC Picker surveys, these are currently under data embargoes and awaiting publication by the CQC, she confirmed that the Trust were looking forward to the release of the results later in November, and a report will come to Board.	
P173/24	**Winter Plan** Mrs Roberts presented the paper highlighting that there had been a plan to take lessons from previous years and to then see what the Trust can do better. The Plan aims to increase timely access to care, for both non-elective and elective patients. The Trust continue to support staff, with a predicted difficult period upcoming and managing the beds both in the Trust and in the Community setting. There had been an ask to look at a 'when full capacity' protocol with services to support seven days of flow and a colocation of Community Services with the use of the Woodside site and the Integrated Discharge Team all being in same place.	

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	She outlined the Community In-reach who are coming into the Trust and working on plans with the acute teams, there is also a pilot with Yorkshire Ambulance Service (YAS), where the physiotherapists go out to homes with YAS staff to see if the need for an ambulance could be avoided. There are also two new Trust Assessors who will work very closely with the regional care homes, they will complete patient assessments and review in the care home setting or usual residence with an aim to support the care homes in taking patients back earlier. There is also work ongoing around bed reconfiguration, with a focus on getting the right bed in the right place, rather than just more beds, and this was a shared risk with mitigating actions shared out across wards. She outlined that there has been an increased ask of partners and the broader system with a warning that winter is starting earlier and potentially lasting longer, with ongoing work looking further ahead into January and February, so far, there has been a positive response. With regards to staff wellbeing there are a number of actions underway, including increased senior leadership visibility, exploration of how to manage teams and manage life balance of staff. There have been listening events with focus on covering shifts, reducing staff movements and a Trust wide approach to the problem as it's not just limited to Care Group1. Dr Richmond and the Non-Executives praised the impressive amount of detail and planning going into the Winter Plan, noting the increased pressure of the timing of the Christmas period extending over the weekend. There was also discussion around the level of cooperation there is with the wider regional network, care homes and Rotherham Place. It was agreed that the work undertaken should be celebrated and shared with the wider Trust staff group.	
P174/24	**<u>Digital Strategy</u>** Mr Rawlinson listed a number of key points including the reason for why this strategy had taken a little longer, twelve months, to be produced. He confirmed that it had been through a number of committees, it was also due to constant changes and updates, which is the nature of cyber security. There were other issues such as the new government and their aim to move from analogue to digital. He outlined that the transformational and operational changes are grouped around the enablers of: • Digital systems • Technology • Information • People and Governance There were also specific areas and risks he wanted to highlight including changes to EPR and a new system, there were also a lot of other old systems that need to be changed, however the Trust is restricted by access to external funding, with for example ESR to have some external investment to be accessed at the earliest in 2027. There is also the impact of AI to meet challenges and a need for dedicated medical input. The Strategy had been presented to the Finance & Performance Committee where it had been strongly endorsed. Dr Jenkins commended what he saw as a good piece of work, and cautioned that it would need to be a dynamic live strategy due to the nature of the topic. Mrs Watson believed that the Trust shouldn't leave people behind and needed to keep staff skills up, whilst Ms Burrows warned that there was a real danger	

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	people could get too keen on shiny stuff, when it is important that the basics have to be right, an example being the issue of not enough electrical sockets in the Boardroom. The Board approved the Digital Strategy	
P175/24	**Quality Improvement Strategy** Mrs Dobson presented the paper which she admitted had been to board previously, it had required a number of changes following the need to develop a local Quality Improvement tool to replace QSIR. The strategy builds on what was done before and also includes plans for next few years. Mr Hartley felt that it could emphasise facilitation and implementation of the QI team a bit more, Mrs Dobson agreed as the QI team are doing a lot of good work across trust. The Board approved the Quality Improvement Strategy.	
	PERFORMANCE	
P176/24	**Finance Report** The Finance report was presented by Mr Hackett, who noted the Month 6 financial positon and deficit to plan outlined in the report. Mr Hackett discussed that there was a £6.3m deficit that had been aggregated across South Yorkshire to £49m. He confirmed that some additional funding had been approved which will have a positive impact in the Trust's cash position with a change from £6m to £600k. There was an in month deficit of £550k, with challenges with the non-elective pathway and the need to support additional beds. The Improvement Board had met twice providing challenges to all budget holders to prepare plans for this month's Improvement Board, with meetings held over the last few months. He added that managing winter is key, as it was a risk and also an opportunity. He noted the national £22.6bn allocated in the October budget to come to the NHS, however he admitted that he doesn't know how much will be available this year as the full details are not available, at this point in time he remains hopeful of some additional resource. Mrs Craven noted that the CIP is critical as to whether the Trust achieve target and would like to see multi-year CIPs with these tied in to back to balance plan. Mr Hackett was in agreement, noting that there changes to high cost drugs was on the way and these would affect from next year. Dr Jenkins was also in agreement regards multi-year CIPs tied in to the three year back to balance programme. This would identify areas and schemes which could be short term and long term, with a lot of transformation needed, the Board also needed to bear in mind that the Government are due to publish the NHS 10 year plan in May 2025. Dr Shah queried if anything can a be done at regional level, Mr Hackett informed the Board that he is now chair of South Yorkshire Procurement Collaborative whose portfolio covers multi-years, he confirmed that they have made inroads already including a number of contracts that are being looked at. He also noted that staffing remains an area of constant focus as it was problematic due to supply and demand. Mr Wright highlighted to the Board that the Efficiency Board minutes are now produced by IA, however he cautioned that this was a very	

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	short meeting with limited attendance, so AI at this point would not be suitable for all meetings.	
P177/24	**Integrated Performance Report** The Integrated Performance Report (IPR) was presented by Mr Wright, he noted that in terms of Quality the mortality figures were as expected, previous issues with the C. Difficile infection position as an outlier regionally had stabilised to be in a far better position and the Friends and Family Test target had been achieved. Dr Richmond noted the average time to be seen by a clinician just over 2 hours and queried whether there was any opportunity for that to be shortened, Dr Beahan was positive that there was opportunities as a lot influences this, it is a challenge but work is ongoing with a UECC plan and the clinical fellows now embedded. Mrs Craven noted the new metrics, but highlighted the need to look at data quality with a lot of reds and greens in the report, Mrs Kilgariff had been working through the operational matrix and challenged the data, she gave the DM01 position as an example of the need to understand what the data is telling us with the front sheet summary being deceptive.	
	ASSURANCE	
P178/24	**Maternity and Neonatal Safety Report** Mrs Dobson introduced Mrs Petty who explained that the paper was required as part of national reporting, noting that as such it was a very detailed report. She highlighted that the Trust's rate of stillbirth deaths is below the regional rate. The rolling figure of stillbirths and neonatal deaths is 2.39/1000, however the position will change in the October data due to a recent cluster of four stillbirths, the service is undertaking a deep dive review. The report provides assurance for CNST that the Trust currently meets the Birth rate plus midwifery staffing recommendations, although there is a challenge with regards to recent maternity leave. Mrs Petty confirmed that with regards to the cluster of stillbirths the Board will get a more detailed report in due course and that two other local trusts had also seen an upturn in deaths.	
P179/24	**Quality Assurance Quarterly Report** Mrs Dobson presented the paper which provides an update of clinical quality within the Trust. The report shows how the Trust is delivering against the quality domain of the operational plan, she admitted that there had been a slow start, however plans are in place for next year. She confirmed that there had been a review of Trust Policies with 95% of them within review date, there had been a previous review last year and she confirmed that those that are not within review date are not of high risk. There had been assurance from the wards with the exemplar accreditation programme results, with all 13 adult wards now completed. A report will be taken to the Quality Committee. The next phase will be Maternity and Paediatrics followed by the UECC. The Trust have paused assessment against the CQC domains following advice from CQC themselves when they attended site, they were also very positive, and advised to deep dive areas of high incidents, such as falls prevention and discharge.	

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	REGULATORY AND STATUTORY REPORTING	
P180/24	**Learning from Deaths & Mortality Quarterly Report** Dr Beahan introduced the paper, she highlighted that the SHIM score remains within the expected band at 104. She outlined that this was an amended report which drills down on Quarter 1, along with including more details on the 'so what' and an update on how learning is being taken forward, the next iteration will also more details on the action plans. She also acknowledged that there are due to be coding changes soon which will affect the SHIM data, the data set may change slightly but this won't be seen until the January 2025 data release. Dr Beahan confirmed that there is also an update from medical examiner, which is a statutory requirement, as is the requirement to review community deaths with the operation recently moving to a seven day service. Dr Shah raised the subject of the Structured Judgement Reviews (SJR), and the poor completion figure, which he deemed to be unacceptable, when there are so many Doctors signed up to undertake than and this has been signed into job plans. He queried how they could be encouraged to do more in a timely fashion, Dr Beahan clarified that currently two are on sickness absence, with one having been given notice, and the roles are currently out to advert for vacant positions. Paper referenced UECC and that long stays potentially increased mortality, Dr Beahan confirmed that this was true nationally, but locally it can't be confirmed for definite presently and she can't say that a long stay directly caused a death, Dr Jenkins noted that a long stay is not necessarily causation. There was an ask for a more detailed report focusing on the long stay patients, Dr Beahan agreed that this would be provided at the next Board.	**JBe**
P181/24	**NHSE Self-Assessment for Placement Providers 2024** Dr Beahan presented the report which she informed the Board was a statutory obligation, as well as being a lengthy document to complete. Challenges identified included training space, facilities and staff burn out and wellbeing. She outlined the next steps which included to achieve development of the course, investigate the Operating Department Practitioners (ODPs) apprentice route, increase recruitment retention. With regards to the education quality intervention report Dr Beahan reported that the Trust was seen positively especially with the medical students who had rated it the top Trust in South Yorkshire. She added that there was to be a further survey, looking at resident doctor's improved working lives and this would be taken to the People & Culture Committee and then the Board at a future date. The Board approved the self-assessment.	
	BOARD GOVERNANCE	
P182/24	**Review of Standing Financial Instructions** Mr Hackett highlighted that there had been an extensive review in 2023 and there were only minor changes, these had been approved by the Audit & Risk Committee the previous month. The Board approved the Standing Financial Instructions.	

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P183/24	**Review of Standing Orders** Ms Wendzicha presented the paper which detailed the annual review of the standing orders and was part of a suite of constitutional documents to be presented to the Board. There had been a review in 2023 previously and the 2024 minor amendments were listed in the executive summary, there had been a further amendment from the A&RC which had recommended the paper for approval, subject to the amendment being made. The Board approved the Standing Orders.	
P184/24	**Reservation of Powers to the Board and Delegation** Ms Wendzicha highlighted the paper which was the final one of the suite of constitutional documents and sets out the delegated powers to the Board. The paper previously been presented at Executive Team Meeting. The Board approved the Reservation of Powers to the Board and Delegation.	
P185/24	**Application of the Company Seal Report** Ms Wendzicha provided an overview of the report insofar as it sets out the circumstances and timings when the Trust Seal has been applied. Ms Wendzicha further explained that such presentation to Board is on accordance with the approved Standing Orders. The Board noted the content of the report.	
P186/24	**Nominations and Remuneration Committee Terms of Reference** Ms Wendzicha informed the Board that as part of the annual cycle, minor amendments have been made to the Terms of Reference and recommended for approval by the Nomination and Remuneration Committee. The Board approved the amended Terms of Reference.	
P187/24	**Audit and Risk Committee Terms of Reference** Ms Wendzicha outlined that the Terms of Reference were due to be reviewed as part of the annual review cycle in January 2025, but as the HFMA handbook had been published the review had been brought forward with the Audit and Risk Committee recommending approval at the October meeting. The Board approved the Terms of Reference for the Audit and Risk Committee.	
P188/24	**Escalations from Governors - No Escalations** There were no escalations from the Council of Governors.	

	Board Annual plan Mrs Watson noted that there were some clashes, with committees meeting in the same week, Ms Wendzicha will discuss with Mrs Watson separately. Noted	
P189/24	**Any other business** There were no other items of business.	
P190/24	**Questions from Members of the Public** No questions were received.	
P191/24	**Date of next meeting** Friday 10th January 2024	

Chair:

Date:

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Board Meeting; Public action log

Log No	Meeting	Report/Agenda title	Minute Ref	Agenda item and Action	Lead Officer	Timescale/ Deadline	Comment/ Feedback from Lead Officer(s)	Open /Close
2024								
16	06.09.24	Strategic Risk Appetite Review	P129/24	A further review of the wording for the People and Culture risk was required, amendments to be made and criculated to the Board	AW	Nov-24	Foillowing discussions with the Executive lead a revised risk appetite on the agenda for November 2024.	**Recommend to close**
17	06.09.24	Report from the Chief Executive	P133/24	Increased public awareness of positive achievements by the Trust and move towards positive momentum in marketing	EP	Dec-24	Due in December 2024	Open
18	08.11.24	MINUTES OF PREVIOUS MEETING	P156.24	Agenda item P140.24 Maternity and Neonatal Report which required rewording, HD to provide the amended wording	HD	Jan-25	Alternative wording provided - Action complete.	**Recommend to close**
19	08.11.24	Action Log	P158.24	The new Director of Estates and Facilities, when commenced in post, should undertake a further review of the fire safety position and a report should be brought back to the Board in early 2025	DofE&F	Mar-25	Not due until March 2025	**Open**
20	08.11.24	Board Committees Chairs Reports	P159.24	Quality Committee - Health & Safety annual report for 2023/24 was taken to the October QC, there were issues, surrounding an increase in C Diff infections and the lack of a scheduled ward deep clean programmme and general Estates issues such as Theatre Doors and work required to ward A7 ceiling that should be further raised to Board. A deep dive report from the new DofE&F was requested	DofE&F	Mar-25	Not due until March 2025	**Open**
21	08.11.24	Board Committees Chairs Reports	P159.24	Quality Committee - Investigation as to why the Controlled Drug report had dropped off the QC work	AMW	Jan-25	The Controlled Drug report is on the plan and had not dropped off.	**Recommend to close**
22	08.11.24	TRFT Strategic Risk Appetite Review 2024/25	P160.24	Ms Wendzicha to work with Mr Hartley and wording for People and Culture risk appetite to be brought back to Board for final approval	DH/AW	Jan-25	Final draft on the agenda at the January 2025 meeting for approval.	**Recommend to close**
23	08.11.24	Sexual Safety	P168.24	Mr Hartley agreed to action resident doctors in training being included in the Staff Survey	DH	Jan-25	Resident Doctors are included in the Staff Survey for the Trust that they are based at.	**Recommend to close**
24	08.11.24	Freedom to Speak Up Quarterly Report	P169.24	Report to be amended to state Mr Malik is the FtSU NED lead.	HD	Mar-25	Amended for the next report due to be presented at the Board in March 2025	**Recommend to close**
25	08.11.24	Learning from Deaths & Mortality Quarterly Report	P180.24	Report to contain more detail focusing on the long stay patients	Jbe	Jan-25	On the agenda	**Recommend to close**

Open
Recommend to Close
Complete

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

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

Committee / Group: Quality Committee	**Date: 18th December 2024**	**Chair: Ms Julia Burrows**

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
1	Board Assurance Framework	The committee noted the controls in place for the risk and approved the risk score for BAF Risk P1 to remain at 8.	Board of Directors
2	Maternity and Neonatal Safety Full Report -	The Committee welcomed the CNST presentation noting that standards were well embedded with a lot of MDT work ongoing. The Committee also noted the effectiveness of the Executive's role in the evidence collection for the report with the increased levels of check and challenge raising the quality of the evidence presented and that all actions had been achieved. The committee supported the CNST position to recommend sign off to Board.	Board of Directors
3	Learning From Deaths Quarterly Report	The Committee noted the report and agreed to advise the Board of Directors to the slight dip in compliance recently, there is an action for a thematic review in place, to identify and improve reviews and work ongoing in conjunction with 360 Assure around Learning from Deaths being reviewed and discussed at Care Group governance meetings. It was also noted that compliance with learning from deaths dipped in Q1 but had improved in Q2.	Board of Directors

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

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

Committee / Group: People and Culture Committee	**Date: 13th December 2024**	**Chair: Dr Rumit Shah**

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
1	Achievements of Our People	The Committee noted that the Barnsley Hospital Board of Directors Chief Executive's Report includes Excellence Award winners plus other awards. A horizon scanner for future developments and initiatives, including future awards could be developed for this Trust also.	Board of Directors
2	Bank, Agency and Additional Sessions	The Committee noted the improvements made in bank and agency spend, with considerable progress in the reduction in agency spend since last year at £1.6m less at month 7 compared to last year.	Board of Directors
3	Job planning report	The Committee recognised and commended the significant progress made, with as of 30th November 2024 a total of 76% sign off of all job plans for the financial year 2024/25. This is an 18% increase month on month. The Committee did also acknowledge that there is further to go in order to achieve the 95% target.	Board of Directors

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
4	Medical Education Report and GMC Training Survey	The Committee welcomed the new report and advised that it should be presented to the Board as a positive move to improve the working lives of doctors in training and an example of how the Trust could work towards Teaching Hospital status.	Board of Directors
5	Guardian of Safe Working Hours	The Committee noted the report, recognising that AMU in particular had been experiencing some long standing issues due to additional capacity, however it wished to advise the Board that a number of proactive actions had been put in place and these were gaining traction with input from General Managers, doctors and Heads of Nursing.	Board of Directors

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

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

Committee / Group: Finance & Performance Committee	**Date:** 27th November 2024	**Chair: Mr Martin Temple**

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
1	Care Group Performance Escalation Summary	The Committee agreed that the Care Group 4 Community Appointment Day had been very positive for patients and staff. The Communications Team are to publicise the event and the Committee believed that it would be a good example of a future Board Patient Story presentation.	Board of Directors
2	Board Assurance Framework	The Committee agreed that the Board of Directors should be advised of the proposed increase in the BAF risk D5 from 12 to 15 due to the continuing increased demand on some Trust services such as the UECC. The Committee agreed that the Likelihood of the risk should be increased to 5 from 4, however noted that this does not apply for all Trust services, only those such as urgent care. It also noted that the BAF is a dynamic document and this increase could be reversed in the coming months if demand were to subside.	Board of Directors
3	Final Submission - EPRR Annual Assurance Core Standards Process	In accordance with the approved Reservation of Powers to the Board and Schedule of Delegation, the Committee approved the Final Submission EPRR Report. The final submission document is available in the review room on Convene.	Board of Directors

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

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

Committee / Group: Finance & Performance Committee	**Date:** 18th December 2024	**Chair: Mr Martin Temple**

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
1	Presentation - Care Group 3	The Committee noted the presentation from the Care Group and agreed to advise the Board that currently the biggest financial risk is the Care Group's CIP due to the current gap, however there are plans in place to address this. Overall the Committee felt Assured that although there were gaps the plans were in place by the Care Group.	Board of Directors
2	Mexborough Elective Orthopaedic Centre – Operational Update	The Committee welcomed the update which outlined the progress made since January 2024, they could see that some operational snags remained but these generally sit with the other organisations who make up the partnership and the Rotherham services continued to improve. The Committee agreed to advise the Board that there is to be further review of overhead costs with the partner Trusts and the MEOC Board.	Board of Directors
3	Financial Reporting	The Committee noted the optimistic view that the projection for Year End was still doable as long as the Care Groups and Corporate Services are able to hit their trajectories.	Board of Directors

Board of Directors' Meeting
10 January 2025

The Rotherham NHS Foundation Trust

Agenda item	P8/25
Report	**Strategic Risk Appetite: People and Culture**
Executive Lead	Angela Wendzicha, Director of Corporate Affairs
Link with the BAF	The following paper links with all BAF Risks
How does this paper support Trust Values	Links with all Trust Values
Purpose	**For decision** ☒ **For assurance** ☒ **For information** ☐
Executive Summary	The Board approved a number of risk appetite categories at the meeting held in September 2024 with the exception of the risk appetite relating to People, Culture and Estates. The risk appetite for Estates was approved at the Board meeting held in November 2024 with further work required to agree the risk appetite for People and Culture. Following further discussion, the following report recommends the risk appetite for the aforementioned categories as People – Seek Culture – Seek
Due Diligence	The paper is an update following the Risk Appetite paper agreed at the Board in September 2024 and November 2024.
Board powers to make this decision	Matters reserved to the Board
Who, What and When	Subject to approval, the risk appetite will be added to the current Risk Management Policy and communicated to the wider organisation.
Recommendations	It is recommended that the Trust Board: ➢ Approve the risk appetite for People and Culture
Appendices	Appendix 1 Risk Appetite aligned to the Trust objectives Appendix 2 Applying the Risk Appetite Matrix

Strategic Risk Appetite Review: People and Culture 2024/25

1. Introduction

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

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

1.2 The Board of Directors reviewed the Trust Risk Appetite categories at the Strategic Board session in June 2024, the outputs of which were approved at the Board meeting on 6 September 2024 with the exception of the risk appetite relating to People and Culture and Estates. The Board considered again in November 2024 and approved the risk appetite relating to Estates and it was agreed that further consideration be given to the risk appetite for People and Culture further exploring what is intended by people and culture.

1.3 The following paper provides a reminder of the Board approved risk appetite now included in the Board Assurance Framework in addition to recommendations relating to the risk appetite for People and Culture.

2. Review of the Risk Appetite

2.1 The Board, at the meeting in September, approved the following risk appetite categories all of which have been aligned to our strategic objectives and Appendix 1:

[1] ISO 31000 – Risk Management

a. Clinical Innovation – Open
b. Commercial – Open
c. Compliance/Regulatory – Minimal
d. Financial/Value for Money – Cautious
e. Partnerships – Seek
f. Reputation – Cautious
g. Quality of Care – Cautious
h. Environment – Cautious

People and Culture

2.2 The Board survey resulted in a direct spilt between 'cautious' and 'seek'. Following discussion at the People and Culture Committee on 25 October 2024, consensus was reached that the definitions within the Good Governance Institute matrix did not fully suffice (Appendix 2). Further discussions have taken place with the recommendation that the risk appetite relevant to this category is split into two separate categories; People/Workforce to reflect our employment models and Culture with the recommended risk appetite as follows:

People/Workforce Risk Appetite

Seek: We are willing to pursue workforce innovation for the benefit of our people and therefore willing to take risks which may have implications for our workforce but could improve the skills and capabilities of our staff. We are willing to innovate despite greater inherent risk.

Culture Risk Appetite

Seek: We are willing to take greater risks and choose options that will develop a positive, inclusive culture for the benefit of our patients, carers and staff.

Recommendations

The Board is asked to:

- Approve the risk appetite for People and Culture.

Appendix 1: Risk Appetite aligned to the Strategic Objectives and Ambitions.

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

Good Governance Institute

Applying risk appetite matrix

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

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BOARD OF DIRECTOR'S MEETING
10 JANUARY 2025

The Rotherham NHS Foundation Trust

Agenda item	P9/25
Report	**Board Assurance Framework**
Executive Lead	Angela Wendzicha, Director of Corporate Affairs
Link with the BAF	Links with all BAF risks
How does this paper support Trust Values	The Board Assurance Framework is a key element that provides evidence of good governance and therefore supports all three core values, Ambitious, Caring and Together.
Purpose	**For decision** ☒ **For assurance** ☒ **For information** ☐
Executive Summary	The development of the new Board Assurance Framework has continued on a monthly basis. The People Committee, Quality Committee and Finance and Performance Committee have each reviewed the Strategic Board Assurance Risks aligned to them as follows: **People & Culture Committee:** Discussed and approved the position in relation to Strategic Risk U4 at the December 2024 Committee. In addition the Committee discussed the outstanding matter relating to the risk appetite with further work carried out outside the meeting for approval at Board. **Finance and Performance Committee:** Discussed and approved the position in relation Strategic Risk D5 and D8 relating to future financial risk at the November and December 2024 meetings. **Quality Committee:** Discussed and approved the position in relation to Strategic Risk P1 at the November and December 2024 meetings. The Board will continue to review and approve the recommended scores for Strategic Risks R2 and O3 which have been reviewed in October by the Managing Director and Deputy Director of Corporate Affairs. The attached report illustrates the position in relation to the Board Assurance Framework for months 2 and 3 of Quarter 3 2024/25.

Due Diligence	Since presentation at the last Board in November 2024, the relevant sections of the Board Assurance Framework have been discussed at the relevant Board Committees during November and December 2024.
Who, What and When	The Director of Corporate Affairs will continue to work with Executive colleagues in order to review and update the BAF on a monthly basis thus highlighting any risks or issues that have the potential to disrupt achieving our Strategic Ambitions.
Recommendations	It is recommended that the Board of Directors: • Discuss and note the progress made in the Board Assurance Framework; ➢ The rating for BAF Risk P1 to remain at 8; ➢ The rating for BAF Risk R2 to remain at 8; ➢ The rating for BAF Risk O3 to remain at 8; ➢ The rating for BAF Risk U4 to remain at 12; ➢ The rating for BAF Risk D5 to be increased from 12 to 15; and ➢ The rating for BAF Risk D8 to remain at 20.
Appendices	Board Assurance Framework for Quarter 3 2024/25

1. Introduction

1.1 The development of the new Board Assurance Framework (BAF) to align with the 5 Year Strategy was commenced during Quarter 1 2022/23 following which monthly reviews have taken place with the relevant Executive leads, Board Committees and Board. The BAF was further reviewed as a result of the Strategy refresh in July 2024.

1.2 The BAF has now entered its third year in 2024/25 and continues to be monitored on a monthly basis at the Board Committees and at every full Board held in public.

1.3 The following report illustrates the discussion and decisions taken by the relevant Board Assurance Committees and the Executives during months 2 and 3 of Quarter 3 2024/25.

1.4 The Risk Appetite levels previously agreed at the Board have been included, agreed levels for People and Culture are yet to be agreed and a further paper is presented to the Board meeting for approval.

1.5 In terms of target scores, the Board will note that the following risks are currently at target score despite having gaps in controls and mitigations; therefore a further detailed review of the scoring will take place during January 2025:

- P1: Quality of Care currently at the target score of 8
- R2: Leadership within the system currently at the target score of 8
- O3: Collaboration with our partners currently at the target score of 8

1.6 For ease of reference, the corresponding BAF report contains all updates in red font, and where an action or gap is partially completed this appears in blue font.

2. Outcome of the Reviews carried out in months 2 and 3 of Quarter 3.

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

Risk aligned to the Quality Committee

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

Updates to the Controls, Mitigations and Gaps

2.2 Following the review additional commentary has been added to the controls and assurance section of the BAF Risk as follows:

2.3 For Control C1, the Exemplar Accreditation Programme has been completed for adult areas now including Paediatrics and Maternity. The PSIRF Plan and Policy have now been completed for C2.

Gap G3 relating to challenges around sufficient workforce to support recovery plans continues to be largely mitigated, with savings as a result of increased grip and control now being evidenced. The CDifficile rates have now started to plateau and related policies are being reviewed for G7.

Review of the Risk Score relating to P1

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

2.5 The initial likelihood score agreed for Quarter 1 2022/23 was 4 (Likely) defined in accordance with the aforementioned matrix as 'will probably happen/recur but is not a persisting issue. This likelihood score was reduced in May 2023 to 3 (Possible) following the lifting of the CQC conditions in 2023.

2.6 It was agreed at the July 2024 Board of Directors that the likelihood should be reduced further to 2 and the risk rating for BAF P1 should be decreased from 12 to 8 due to the controls in place and the number of audit reports giving moderate and significant assurance, in addition to improvements in Mortality Rates. Following consideration, the scoring is recommended to remain at **8**.

2.7 Taking the above into consideration, it was recommended the risk score remains at **8** at the end of Quarter 3, therefore at target score**.** Additional focused review around the scoring will take place in January 2025.

3 Risk aligned to the Board

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

Updates to the Controls and Mitigations

3.1 The only change to the controls or gaps was the addition of Gap G2 relating to the gap that Non-elective activity continues to increase, the Managing Director continues to work with PLACE with demand reducing initiatives.

Review of the Risk Score relating to R2

3.2 It is recommended that the score remains at **8** which the Board will note is at target score and will be further reviewed in January 2025.

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

Update to the Controls and Mitigations

3.3 Updates continue to be added in relation to the Gap G1, these are related to the ongoing governance structure for the Network and provided by the Head of Nursing & Governance, Corporate Operations.

Review of the Risk Score relating to O3

3.4 It is recommended that the score remains at **8** and in line with the other risks at target score will be further reviewed in January 2025.

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

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

4.1 The new form of wording seen above for U4 was agreed at the June 2024 P&CC and Board in July 2024.

4.2 The Director of People is the Executive Director lead for the current BAF Risk U4. As part of the review process, the Deputy Director of Corporate Affairs met with the Director of People throughout Quarter 3 on a monthly basis with the last review being in December 2024, this review held with the Deputy Director of People.

Update to the Controls and Mitigations

4.3 There were a number of updates relating to the Controls, Mitigations and Gaps during the quarter, these can be found in the BAF report highlighted in red.

Review of the Risk Score relating to U4

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

4.5 Following further discussions at the People & Culture Committee in September 2024, following review in December 2024 it is recommended that BAF Risk U4 remains at **12.**

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

skills and capabilities of our workforce. This will be further reviewed at the January 2025 Board.

5. Risk aligned to Finance and Performance Committee

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

5.1 The Director of Finance and the Chief Operating Officer are the Executive Director leads for Strategic Risk D5. The Deputy Director of Corporate Affairs met with the Director of Finance and Chief Operating Officer monthly during Quarter 3.

Update to the Controls and Mitigations

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

Review of the Risk Score relating to D5

5.2 The risk had been graded initially at **15** and following further discussion at December 2023 Board it was agreed that the Consequence should be raised to 4 and the rating should be increased to **20** due to pressures of industrial action. A recommendation for a reduction of the risk rating was taken to the April 2024 Finance & Performance Committee for discussion and approval. Following the discussion it was agreed that the risk rating should remain at **20**. The risk rating was then reduced at the July 2024 Finance & Performance Committee to **16**, it was then reduced to **12** at the October 2024 Committee as the Consequence was reduced to 3, following the end of Industrial Action.

5.3 The risk was further discussed at the November 2024 Finance & Performance Committee for discussion and approval. Following the discussion it was agreed that the Likelihood should be increased to 5 due to the sustained capacity demand the Trust was experiencing and the risk rating should increase from 12 to **15**; the risk will continue to be reviewed on a monthly basis.

5.4 The Board will note the fluctuating risk score which has been, over the last six months due to the response to real time operational pressures.

D8: There is a risk that we will not be able to sustain services in line with national and system requirements because of a potential deficit in 2024-25 leading to further financial instability.

6 BAF Risk D8 covers the financial situation for the Trust, 2024/25, this risk is an annual risk covering the financial year only.

Update to the Controls and Mitigations

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

Updates to Gaps in Assurances

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

Review of the Risk Score relating to D8

6.3 The risk had been graded at **20** and will continue to be monitored on a monthly basis.

Recommendations

The Board of Directors is asked to:

- Discuss and note the outcomes following review of the BAF Risks with the individual Executive Leads and

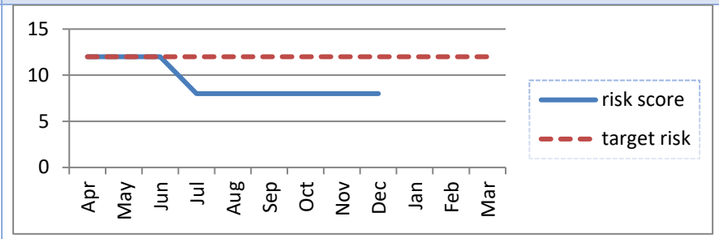
- Approve the recommendations from the Board Committees in relation to the risk scores Quarter 3 2024/25.

Alan Wolfe

Deputy Director of Corporate Affairs

January 2025

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

Strategic Theme: Patients	**Risk Scores**										
	BAF Risk Ref	**Initial Score**	**Current Score**	**Target Score**	**Risk Appetite/Risk Tolerance**	**Risk Movement**	**Board Assurance 2024-25**				
Strategic Ambition: **Patients:** ***We will be proud that the quality of care we provide is exceptional, tailored to people's needs and delivered in the most appropriate setting for them***	**P1**	**4(L)x4(C)=16**	~~**12**~~ ~~**3(L)x4(C)**~~ **8** **2(L)x4(C)**	~~**3(L)x4(C) =12**~~ **8** **2(L)X4(C)**	~~**Very Low (1-5)**~~ **CAUTIOUS**		**Previous Score Q4 2023-24**	**Q1**	**Q2**	**Q3**	**Q4**
Link to the Operational Plan: P1: Deliver care that is consistent with CQC 'Good' by the end of 2024/25.Ensure improved performance of at least one quartile in the National Inpatient and UECC CQC Patient Experience Surveys.							**12**	**12**	**8**	**8**	
BAF Risk Description						**Linked Risks on the Risk Register & BAF Risks:** **RISK6623, RISK5761, RISK6809, RISK6800, RISK6630, RISK6762, RISK6627, RISK6886, RISK6284, RISK5238, RISK6723, RISK6958, RISK6857, RISK6801, RISK6888, RISK6718 and RISK6421**				**Assurance Committee & Lead Executive Director**	
P1: There is a risk that we will not embed quality care within the 5 year plan because of lack of resource, capacity and capability leading to poor clinical outcomes and patient experience for our patients.										**Quality Committee Chief Nurse and Medical Director**	

Controls and Mitigations ***(what have we in place to assist in securing delivery of our ambition)***		**Assurance Received** *(what evidence have we received to support the control)*	**Date Assurance Received**	**Confirmed By:**	**Assurance Level** *Level 1 = Operational* *Level 2 = Internal* *Level 3 - Independent*				
C1	Implementation of agreed Quality Strategy to provide quality assurance to the Board and external regulators	Quarterly report on Quality Assurance to Quality Committee and Board of Directors to provide update on all aspects of Quality Management System including process management, monitoring, measurement and continuous improvement	November 2024 Board November 2024	QC	L1				Chief Nurse
		Range of tools utilised to measure quality achievements including Tendable Audit programme and Power Bi Quality Dashboards with outcomes reviewed at monthly Care group Performance meetings. From October 24 added in subject matter expert and senior nurse review to tenderable audits - monthly rota through to March 2025 with increased visibility of Senior Nurses.	November 2024 Monthly	QC	L1				Chief Nurse

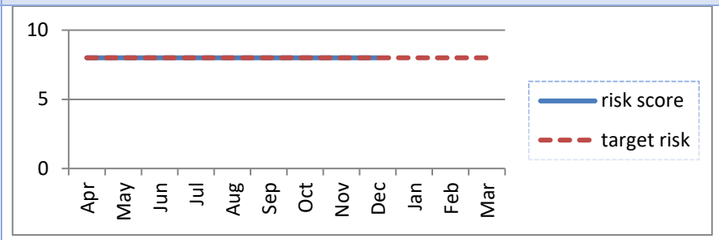
		Exemplar Accreditation Programme established for adult inpatient areas. Completed adults, paediatrics and maternity.	November 2024	QC					Chief Nurse
		Meeting structure established to provide quality assurance both within Care Groups and corporately through Quality Governance and Assurance Group monthly to quarterly Patient Safety Committee	November 2024	QGAG PSC					Chief Nurse
C2	Ongoing monitoring of Patient Safety and PSIRF implementation through a variety of sources to ensure we keep patients safe and optimise patient outcomes	Ongoing use of Datix incident reporting system to report all adverse incidents or near misses. All incidents rated as moderate or above reviewed at Incident Review panel by CN / MD three times a week. Incidents identified as requiring a PSII or AAR and associated themes and actions reported to Patient Safety Committee and Quality Committee quarterly. Harm Free Panel reviews TVN and IPC incidents monthly. Summary of key findings included in report to Patient Safety Committee and Quality Committee quarterly. Completed PSIIs reviewed in Executive led monthly sign off panel with representation from ICB. Summary of key findings included in report to Patient Safety Committee and Quality Committee quarterly. Actions from PSIIs and AARs monitored to ensure completion within agreed timescales. Monthly report sent to Care Groups and summary included in report to Patient Safety Committee and Quality Committee quarterly. All National Patient Safety Alerts and information received by the Central Alerting System Liaison Officer are shared quarterly through the Patient Safety Committee with completion of action plans monitored by the Quality Governance and Assurance Team. Operation plan PSIP updated for coming year to go to Patient Safety Committee October 24. PSIRF Plan and Policy completed	November 2024 November 2024	PSC QC ETM					Chief Nurse
C3	Mortality and Learning from Deaths	All actions in the 360 Learning from Deaths Audit have been		CEC QC					Medical Director

		completed. Work continues to further improve the program and to ensure there is no slippage for implemented improvements. Reports detailing the completion rates and timeliness of SJRs remain as a standing agenda item at the Bi-Monthly Trust Mortality Group (TMG). All SJRs with a Poor Care or judged to have been preventable are logged as incidents on Datix. Following closure the Lessons Lean and Actions are discussed at the TMG. All completed SJRs are sent to the Care Group Mortality Leads, those with learning points together with those Datix'd should be discussed at the respective CSU Clinical Governance Meeting. Compliance for this is being reviewed twice yearly. The SHMI continues to be monitored through the TMG. The response to any Diagnosis Groups Alerts, continue to be managed this Group. The reporting of the above is included in the quarterly Learning from Death report, which is reviewed at the Patient safety Committee, Quality Committee and Board. Learning from Deaths report to go to Board in January 25	November 2024 November 2024 November 2024 November 2024	Board					
C4	Ongoing monitoring of the effectiveness of the newly implemented Clinical Effectiveness Strategy by the Clinical Effectiveness Committee.	The Care Groups report details of their Clinical Audits, Getting it Right First Time Programme (GIRFT), National Clinical Audits - Quality Accounts (NCAPOP & Other) relevant NICE guidance, National Confidential Enquiries into Patient Outcomes and Deaths studies (NCEPOD) and Commissioning for Quality & Innovation Scheme Topics (CQUINs) to the Clinical Effectiveness Committee. There is a Clinical Effectiveness Committee Report at the Quality Committee on a quarterly basis	November 2024 Next is January 2025	CEC QC					Medical Director
C5	Ongoing monitoring of Patient Experience through a variety of sources to ensure we are on track to improve performance in	Monthly text surveys to a proportion of discharged patients asking questions related to lowest scores on most recent national survey. Results and actions will be presented to Quality Committee in	November 2024	QC					Chief Nurse

	national inpatient and UECC surveys	quarterly Patient Experience Report All on track							
		Friends and Family Test offered to all patients. Results shared with Care Groups on a monthly basis and reported at Patient Experience Committee and Quality Committee quarterly	May 2024	QC	L1				Chief Nurse
		Report on Complaints including volume, themes and learning reported at Patient Experience Committee and Quality Committee quarterly	November 2024	PSC QC	L1				Chief Nurse
		Introduction of PALs with monitoring of Key Performance Indicators through Patient Experience Committee and Quality Committee quarterly Results of 4 national surveys (inpatients, UECC, maternity and CYPS) now published by CQC. Improvement plans developed and progress monitored quarterly through Patient Experience Committee and Quality Committee	Launched November 2024 November 2024 - public - Inpatients, UECC, Maternity. CYPS	In 2025	L1				Chief Nurse
C6	Three Quality Priorities have been agreed for 2024/25	Rolling monthly update report to Quality Committee resulting in an update being received for each priority quarterly. Template provides data in SPC format, supported by Qi, Effectiveness and Data Analysis teams	November 2024	QC	L1				Chief Nurse
C7	Seek External Assurance to triangulate with internal assurance data	Quarterly reports on progress against self-assessment by Care Groups to Quality Governance & Assurance Group reported through Patient Safety Committee and Quality Committee quarterly	October 2024	QGAG PSC QC	L2				Chief Nurse
		External body reports such as from NHSE or inspections reported to Quality Committee via the appropriate sub group on quarterly basis	October 2024	SC QC	L3				Chief Nurse
		Quarterly Safety, Experience or Effectiveness reports to Quality Committee to provide updates on any partnership working with BDGH and details of associated actions	Sept 24	QC	L2				Chief Nurse
		Annual audit reports commissioned within the Quality domain following agreement of	June 24	QC	L3				Chief Nurse

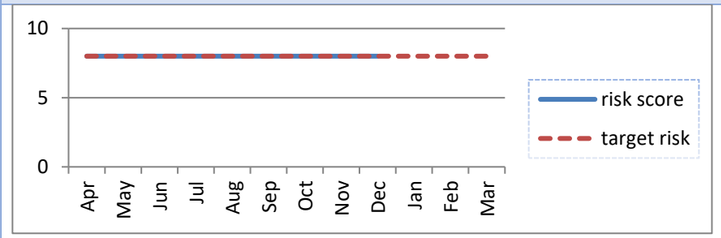
		Audit & Risk Committee received at both ARC and Quality Committee with action plans monitored to completion. Audits include Internal Audit of Clinical Audit and Nice Implementation, Safeguarding and Medication Safety. Safeguarding and Medication 360 audits completed	October 2024										
Gaps in Controls or Assurance Quarter 1 2023-24		**Actions Required**	**Action Owner**		**Date Action Commenced**	**Date Action Due**			**Progress Update**				
G1	Lack of assurance regards quality of end of life care	Completion of action plan that has been created in response to 360 assurance report and NACEL 2022 alarm outlier status report Strategy went to May 2023 Quality Committee and Board of Directors September 2023	Medical Director and Chief Nurse	January 2023 September 2023	~~May 2023~~ September 2023 May 2023				Action plan created and shared internally and with external organisations Awaiting completion of NACEL and 360 audit action plan. NACEL to be four times per annum from 2024 NACEL 2024 has commenced, new Lead Nurse for End of Life now in post Paper to ETM regards restructure of team approved and End of Life will now sit Corporately - December 2023 NACEL to change to a rolling programme of audit All actions Completed - not archived as rolling programme The situation is ongoing and improving, awaiting a full year of improvement work and full report. Consultant Post recruited into, awaiting commencement into role.				
		Recruit additional palliative care consultant	Medical Director	July 2024	February 2025								
G2	Exemplar Accreditation programme needs to be expanded to all clinical areas beyond adult inpatient wards	Strategic planning session with Heads of Nursing	Chief Nurse	19/06/2023	December 2023 April 2025				To go live from April 2024, with raising awareness sessions to be held January to March 2024. Lead wards in three divisions identified. Initial planning sessions have taken place with ward managers from A7, A5, B10 and Rockingham. Programme gone live and on track, this will now be an ongoing process across trust with inpatient adult wards completed. Criteria to be agreed for other departments and teams, Children's and Maternity in October 2024 and UECC in April 2025. Completed further areas to be explored such as UECC.				
G3	Challenges around sufficient workforce to support the recovery plans around staff absence in theatres and anaesthetics and industrial action now mitigated.	High level risks from Care Groups regarding workforce challenges monitored via P&CC. Industrial action whilst ongoing will be subject to regular	Divisional Leads & FPC	**Ongoing**					Tighten up controls around NHSP due to financial position and monitoring any impact. Proven grip and control with savings been seen.				

		industrial action meetings to mitigate impact.							
G4	Seek External Assurance to triangulate with internal assurance data	NHSE invited to undertake an appreciative inquiry into Adult Safeguarding. Report and any associated action plan will be presented to Safeguarding Committee and Quality Committee	Chief Nurse	**April 2024**	October 2024			Report complete and plan to be presented at next Safeguarding Committee November 2024 Awaiting report	
		Benchmarking Data will be reviewed to enable relevant services to compare quality and learn from exemplar organisations. Reporting will be through relevant subcommittee and to Quality Committee quarterly. Reports to include increased comparison of data with external organisations and all associated actions.	Chief Nurse	**July 2024**	October 2024				
G5	Development of Trust Quality Strategy		Chief Nurse/Head of Quality Improvement		November 2024			To include as agenda item at March 2025 Board	
G6	Medicines Management Limited Assurance at 360 Assure internal audit	Development and completion of action plan which will be monitored through the Medication Safety Committee and the QC	Medical Director	**November 2024**				Plan has been developed and is now being monitored through the MSC.	
G7	CDiff rates	Development and completion of an antimicrobial action plan	Chief Nurse	**November 2024**				For further development. Rates have started to plateau over last few months. Policies in process of review.	
Archived Controls within month- Completed									
Archived Gaps within month - Completed									

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

Gaps in Controls or Assurance Quarter 1 2022-23		**Actions Required**	**Action Owner**	**Date Action Commenced**	**Date Action Due**	**Progress Update**
G1	Ethnicity details not on all electronic systems	Public Health Consultant identifying and working on solution.	Managing Director	Ongoing	~~End of Quarter 1~~ End Quarter 4	Work ongoing with Managing Director

		A working group has been established including the Public Health Consultant and the Director of Health Informatics							
G2	Non-elective activity continues to increase	To continue to work with PLACE with demand reducing initiatives	Managing Director	Ongoing	End of Quarter 4				
Archived Controls within month – Completed									
Archived Gaps within month – Completed									

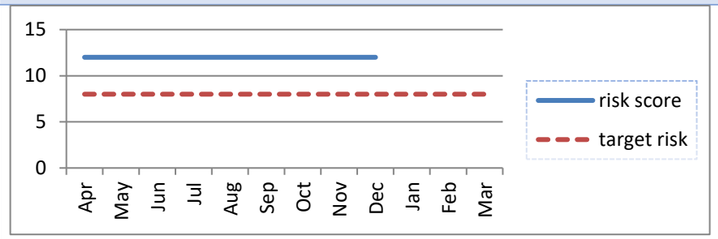
Strategic Theme: Patients	Risk Scores										
	BAF Risk Ref	Initial Score	Current Score	Target Score	Risk Appetite/Risk Tolerance	Risk Movement	Board Assurance 2024-25				
Strategic Ambition: **Our Partners: *We will be PROUD to collaborate with local organisations to build strong and resilient partnerships*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

Controls and Mitigations ***(what have we in place to assist in securing delivery of our ambition)***		**Assurance Received** *(what evidence have we received to support the control)*	**Date Assurance Received**	**Confirmed By:**	**Assurance Level** *Level 1 = Operational* *Level 2 = Internal* *Level 3 - Independent*				
C1	The Trust is a member of the South Yorkshire & Bassetlaw Acute Federation	Reports received by the Trust Board every two months from Chief Executive Report	**November 24**		Level 1				
C2	Existing collaboration with Barnsley on some clinical services	Gastro service up and running, Haematology service in progress MEOC now embedded.	**July 24**		Level 1				
C3	Board to Board, Joint Strategic Partnership and Joint Executive Delivery Group established for oversight and	Meetings of the Strategic Partnership every quarter, Monthly for Delivery Group.	**November 24**	**Reports to Boards on progress**	Level 1				**Additional Board to Board meeting with Barnsley scheduled for 11 February 2025**

	delivery of partnership plan										
Gaps in Controls or Assurance Quarter 3 2024/25		**Actions Required**	**Action Owner**		**Date Action Commenced**	**Date Action Due**			**Progress Update**		
G1	New Pathology Partnership model with new governance arrangements following TUPE. New arrangements will need to embed with assurance provided to TRFT	Identified colleague to lead on target operational model for TRFT, Managing Director to attend Governance meetings	Managing Director		Started 01/04/2024	End of Quarter 1 Head of Nursing (Governance & Quality) to be embedded in role and start receiving assurance from governance at Pathology Partnership			Head of Nursing & Governance Corporate Operations (HoN&GCO) in post and met with Partnership governance and senior management. HoN&GCO update: Monthly Pathology Governance Group with SYPB 20/08/24. Monthly meetings (catch up) with the SYPB Governance manager every month Attend the local Operational Management Team meetings with SYPB however, with the partner organisations with their Head of Pathology and Governance Manager, to take place from September onwards to discuss performance/finance/operational delivery & governance Attend the monthly SYPB Senior management meeting too which was last week. Attend the TRFT HTT as a representative for TRFT along with Consultant Haematologist, which although is related to TRFT and how we are using blood products/demand etc, still links into the SYPB. The work with the partnership is progressing, the Governance aspect is becoming embedded and cross-partnership working is establishing. Started holding the Operational/Governance monthly meetings with Finance along with TRFT Finance Team and HR. Not held in December due to operational pressures across both sites but will recommence in January 25. The HoN&GCO attends the Governance board and senior leadership monthly meetings & forward any information coming from them which may affect TRFT. They are reported also through our Corporate Operations Team .Operational and Governance meetings each month.	
	Pathology Partnership model	Formal reporting to Board on the Pathology Partnership outputs to be established.	Managing Director		November 2024	End Quarter 3					
G2	Mexborough Elective	Director of Operations and COO meeting regularly with	Managing Director		April 2024	~~July 2024~~			Activity reviewed on weekly basis at ETM with full updated report.		

	Orthopaedic Centre (MEOC) - Not filling capacity leading to increased reputational and financial risk to TRFT	colleagues internally to increase fill rate			Ongoing until satisfactory capacity sustained.			In an improving position, activity reviewed weekly at ETM and now past 70%	
Archived Controls within month – Completed									
Archived Gaps within month – Completed									

BAF Risk U4

Strategic Theme: Us	**Risk Scores**										
	BAF Risk Ref	**Initial Score**	**Current Score**	**Target Score**	**Risk Appetite/Risk Tolerance**	**Risk Movement**	**Board Assurance 2024-25**				
Strategic Ambition: **Us:** ***We will be proud to work in a compassionate and inclusive organisation that delivers excellent healthcare for patients.***	**U4**	**3(L)x4(C)=12**	**3(L) x 4(C) = 12**	**2(L)x4(C) =8**	**Moderate (12-15)** **Risk Appetite decision to be confirmed at People Committee December 24**		**Previous score Q4 2023-24**	**Q1**	**Q2**	**Q3**	**Q4**
Link to Operational Plan: ***P3: Supporting our People*** ***P2: Improve engagement with our medical colleagues***							**12**	**12**	**12**	**12**	
BAF Risk Description						**Linked Risks on the Risk Register & BAF Risks:** **RISK6888, RISK7182 and RISK6723**				**Assurance Committee**	
U4: there is a risk that we do not create and maintain a compassionate and inclusive culture which leads to an inability to retain and recruit staff and deliver excellent healthcare for patients										**People Committee Director of People**	

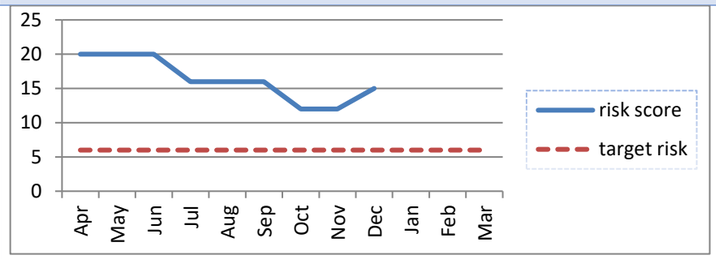
Controls and Mitigations ***(what have we in place to assist in securing delivery of our ambition)***		**Assurance Received** *(what evidence have we received to support the control)*	**Date Assurance Received**	**Confirmed By:**	**Assurance Level** *Level 1 = Operational* *Level 2 = Internal* *Level 3 - Independent*
C1	New People & Culture Strategy	There will be a 6 month and 12 month review presented to the P&CC. 6 month review completed	October 2024 and April 2025 P&CC	P&CC Dec 24 P&CC Nov24	Level 1
C2	Integrated EDI (Equality Diversity Inclusion) Plan	Have current Board approved plan published and on website, will be refreshed for November Public Board 2024. EDI plan underpins WRES and WDES signed off at Board	EDI Plan to P&CC in October 2024 and Board November 2024	P&CC Dec 24 Board Nov24	Level 1
C3	Delivery of the People Promise – staff experience	Review progress against the Trust 'We said we did' plan and Care Groups to present progress on their 'We said we did plans'. Regular Corporate Bulletins sent via Communications NHS Staff survey outcomes and scores to be presented at People Committee and then the March 2025 Board of Directors. July 24 launched trust wide 'we said, we did' 2024/25.	October 2024 and March 2025 February 2025 P&CC At Care Group P&CC presentations	P&CC Oct 24 Ongoing confirmation from Care Groups	Level 1

C4	Health wellbeing and attendance work	Going to ETM w/c 15/07/24 and P&CC in October 2024. 360 audit gave limited assurance on how managers manage long term sickness, audit to be rerun late 2024/25 5 working groups supporting work Out to tender for Occupational Health contract	End of Quarter 3 2024/25 Quarter 4 2024/25	P&CC Oct 24	Level 1 Level 2					
C5	Development of the Trust Workforce Plan	Current Workforce Plan 2020-24 in place, new plan to be in place from April 2025. Focus groups and 1 to 1 stakeholder meetings happening	April 2025 P&CC and May 2025 Board		Level 1					
C6	Joint Leadership Programme	Delivery in train and on track	October 2024 P&CC		Level 1					Value Circle completed programme of work, formal evaluation and feedback awaited

Gaps in Controls or Assurance Quarter 1 2024-25		**Actions Required**	**Action Owner**	**Date Action Commenced**	**Date Action Due**			**Progress Update**	
G1	Challenges around sufficient workforce to support the recovery plan and mitigate industrial action.	High level risks from Care Groups regarding exceptional workforce challenges monitored via P&CC. Care Group 1 Care Group 2 Care Group3 Care Group4 Corporate Services Unexceptional workforce challenges are managed by the Care Group Management with risks escalated via Care Group Governance Committees and on to Risk Management Committee if rated 15 or above. No Industrial action at this time, but situation monitored	Divisional Leads & FPC	As per each risk, further details can be found in the P&CC Risk Report				This Gap relates to three outstanding risks rated at 15 or above, please see Risk Report for further details: Care Group 1 - Risk7182 - The division's ability to ensure sufficient numbers of suitably qualified, competent and experienced RN. Rated 20 Care Group 2 - Risk6723 - Anaesthetic Medical Staffing Availability. Rated 15 Corporate Services - Risk6888 - Lack of clinical psychology support for all services for which it is required. Rated 15	
G2	Joint Leadership Programme	Programme of work to be completed with feedback report						Formal evaluation and feedback awaited	

Archived Controls within month - Completed

Archived Gaps within month - Completed

Strategic Theme: Delivery	Risk Scores										
	BAF Risk Ref	Initial Score	Current Score	Target Score	Risk Appetite/Risk Tolerance	Risk Movement	Board Assurance 2024-25				
Strategic Ambition: ***Delivery: We will be proud to deliver our best every day, providing high quality, timely and equitable access to care in an efficient and sustainable organisation***	**D5**	**4(L)x3(C)=12**	~~**5(L)X4(C)=20**~~ **Dec23 Consequence increased due to more significant impact of IA** ~~**4(L)X4(C)=16**~~ **July24 Likelihood decreased as pressures eased.** **4(L)X3(C))=12 Pay deal agreed, no further periods of IA for trust staff planned. Return to initial consequence.** **5(L)X3(C)=15**	**2x3=6**	~~**Very low (1-5)**~~ **MINIMAL**		**Previous Score Q4 2023-24**	**Q1**	**Q2**	Q3	Q4
Link to Operational Plan: ***D5: To deliver 4 hour performance of 80% before March 2025, to go beyond the national ambition on long-waiters and RTT performance and consistently deliver the Cancer Faster Diagnosis Standard by Q4.***							**20**	**20**	**16**	**15**	
BAF Risk Description						**Linked Risks on the Risk Register & BAF Risks**				**Assurance Committee & Lead Executive Director**	
D5: There is a risk we will not deliver our performance priorities (*Urgent Care, Elective Recovery and Cancer*) because of insufficient resource and increased demand leading to an increase in our patient waiting times and potential for patient deterioration and inability to deliver our Operational Plan.						**~~Risk 5761,~~ ~~Risk 6569~~, RISK6800, RISK6627, RISK6762 ~~RISK6414~~, RISK6755, RISK6638, RISK6718, RISK6723, RISK6958, RISK6888, RISK6598 , and RISK6801**				**Finance and Performance Committee** **Director of Finance & Chief Operating Officer**	
Controls and Mitigations ***(what have we in place to assist in securing delivery of our ambition)***		**Assurance Received** *(what evidence have we received to support the control)*		**Date Assurance Received**	**Confirmed By:**	**Assurance Level** *Level 1 = Operational* *Level 2 = Internal* *Level 3 - Independent*					
C1	**PERFORMANCE:** Care Group Performance meetings chaired by the Deputy CEO.	Performance Meeting minutes and chairs logs Monthly reports within IPR to Finance and Performance Committee and Board		**Dec 2024** **Dec 2024 IPR**	**Minutes** **Chair's Log**	Level 1				Managing Director	

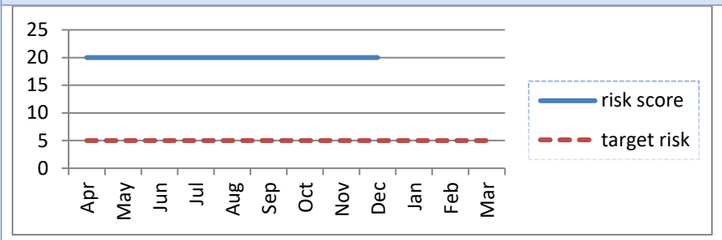
		Care Group Performance meetings with each CSU							
	PERFORMANCE: Executive Team oversight via IPR	Weekly receipt of Performance IPR	**Dec 2024**	**ETM minutes Weekly** **ETM minutes Weekly**	Level 1				Weekly Executive Team Meeting Managing Director
C2	**URGENT CARE:** Monitoring waiting times of patients in UECC	Monthly TRFT Urgent Care Meeting Metric included in the Integrated Performance Report Weekly report to ETM Daily review of position and weekly through the acute care performance meeting and ETM Weekly 4 hour performance emergency care target meeting chaired by COO. Waiting times have improved in UECC and monitored against trajectory	**Dec 2024**	**Minutes of F&P** **ETM minutes** **ETM minutes** **ETM minutes** **Action log** **Daily performance report**	Level 1				COO
	URGENT CARE: Monitoring right to reside and Length of Stay data	Monthly TRFT Urgent Care Meetings Monthly reports to Finance and Performance Committee and Board Weekly Length of Stay reviews including Care Group Director Improvement with regards to right to reside and IDT caseload Escalation meetings with external partners. 360 internal audit about to commence	**Dec 2024 IPR** **Dec 2024 IPR** **Decct 2024 IPR**	**Minutes of Urgent Care Meeting** **Weekly ETM minutes** **Weekly ETM minutes**	Level 1				COO
	URGENT CARE: Admission avoidance work remains ongoing	Acute Care Transformation Programme - monthly highlight report and minutes of meetings The Rotherham Urgent and Emergency Care Group established from September 2022 (replaced A&E Delivery Board and Urgent and Community Transformation Group). It is chaired by the Deputy Pace Director and deputy chair COO. Oversight through the Rotherham Place Urgent and Emergency Care Group (Previously the A&E Delivery Board)	**Dec 2024**	**Minutes of Urgent Care meeting**	Level 1				ACT Steering Group – emergency pathway workstream Medical Director Rotherham Urgent and Emergency Care Group COO
C3	**ELECTIVE:** Weekly access meetings with tracker	Elective Delivery Group Weekly Access Meetings Care Group PTL Meetings	**Dec 2024**	**Monthly** **Weekly** **Weekly**	**Level 1** **Level 3 - 360 Assurance audit report - July24**				COO Ass Director of Operations

	for elective recovery schemes	To include financial allocation from ERF reserve. New weekly PTL for Elective and Cancer week commenced 27/11/2023. Outpatient, Theatre & Endoscopy Transformation Programmes		**Weekly** **Monthly Highlight Report**					Ass Director of Operations
C4	**CANCER:** Cancer PTL	Rotherham Cancer Strategy & Performance Meeting Cancer Services Quality, Governance & Business Meeting Cancer PTL Meetings. Cancer Improvement Programme	**Dec 2024**	**6 weekly** **Monthly** **Weekly** **Monthly** **Highlight Report** **FPC 1/4ly**					COO Ass Director of Operations Cancer Manager
C5	**WINTER:** **Winter planning**	Evaluation of 2023/24 Winter Plan Action log of Winter Planning Group Winter plan 24/25 which meets fortnightly Winter Plan supported at November Board. Some elements of Winter Plan enacted early due to high levels of demand.	**ETM and FPC mins** **Commenced August 24** **24/25 plan went to September FPC, ETM and Nov Board**	**Evaluation – FPC mins May 2024**					COO Dir Ops

Gaps in Controls or Assurance Quarter 1 2022-23		**Actions Required**	**Action Owner**	**Date Action Commenced**	**Date Action Due**			**Progress Update**	
G1	Insufficient funding to support increased levels of non-elective demand – both attendances at UECC and emergency admissions	Discussions with commissioners re funding Additional capacity utilising winter funding but summer months at cost pressure ACT programme to support most effective use of bed base Admission avoidance work with partners	DoF COO					No growth funding in 24/25 contract Additional bed capacity open cost pressure identified in Care Group forecasts ACT programme in place led by Medical Director maximising use of existing capacity Admission avoidance work in conjunction with partners – joint post to support project management November attendances remain high, 9.3% above 2023/24 and 7.9% above the contract plan for the year. Escalation bed capacity has remained open.	
G2	Lack of consistent SDEC model and trolley capacity across medical and surgical SDECs	ACT programme developing consistent models of care Relocation of medical SDEC to create ringfenced capacity Bed modelling and LoS to be reviewed to create capacity to ring-	COO	Q1	Q3			Trolley capacity currently impacted by increased demand on inpatient beds – medicine relocated to B6. Surgery reviewing Los and bed requirements and ASU/SDEC requirements. Gynae dependent on reduction in surgical	

		fence trolleys in surgical and gynae SDEC						outliers. Gynae to review how SDEC delivered within existing footprint. Further trust-wide bed modelling being undertaken to review current capacity vs demand on beds. Capital bid submitted to provide increase capacity Plans in place for SDEC to remain on B6 during winter - trolley capacity is being ring-fenced from patient beds. Revised Capital Bid submitted to regional team September 2024 - still awaiting response from regional and national teams. Medical SDEC functional; on S6 and ring-fenced from inpatients. Funding for capital scheme approved. New dashboard in place giving visibility of all SDECs. QI events held to further develop pathways.	
G3	Insufficient validation to support robust management of waiting lists	Review of validation capacity and resource required to support increased size of waiting list and maintain requirement to meet 90% validation Standardise validation processes and embed consistent ways of working Training of existing staff to support validation of waiting list Ensure oversight through regular audits and performance monitoring	Associate Director of Operations, Planning and Performance	Q2	Q4			360 Assure audit undertaken and actions agreed and in process of full implementation Text validation and admin validation in place Waiting list review meeting established to oversee and implement actions in relation to 360 audit Positive feedback received from 360 in relation to revised governance arrangements Further Deep Dive Validation Exercise undertaken Lead RTT Validation & Data Quality Officer in place and training and support commenced Review of capacity Increased validation being undertaken with Care Groups. Ongoing validation monitiored on a weekly basis via access meeting with each care group.	

								Renew of validation resource within the Trust has been undertaken with proposal to strengthen arrangements and increase capacity being developed.	
G4	Challenges around sufficient workforce to support the recovery plan and mitigate industrial action.	High level risks from Care Groups regarding workforce challenges monitored via P&CC. Industrial action whilst ongoing will be subject to regular industrial action meetings to mitigate impact.	Care Group Leads & FPC					IA Planning undertaken and command and control in place through periods of IA. Pay offer accepted by consultants and junior doctors No further IA planned for Trust staff awaiting confirmation of any collective actions GPs will take. Continue to monitor impact of GP collective action on UECC attendances.	
G5	Insufficient anaesthetic workforce to support elective recovery	Specific challenges in relation to anaesthetic cover to support full theatre timetable impacting on elective recovery programme. Deep dive into underlying issues being undertaken with the care group	Chief Operating Officer Care Group 2 Leadership team					Initial review of capacity required and available workforce undertaken Job plans reviewed and completed Second phase of review to be undertaken. Specification developed, external review to be undertaken. Request for anaesthetic expertise being sought from national GIRFT team. Anaesthetic expertise from Clinical Leads via GIRFT programme agreed - dates scheduled in December.	
G6	Financial investment/resources to support recovery of waiting lists	Financial allocation identified in plan for 2024/25 – risk in allocation of ERF given overall financial position	Chief Operating Officer DoF					Plan and process for agreeing additional sessions in place for recovery schemes and investment in line with ERF allocation in 2024/25 plan - now being implemented. Positive impact on both activity and waiting times. Continuation of ERF schemes Schemes being implemented.	
Archived Controls within month – Completed									
Archived Gaps within month - Completed									

Strategic Theme: Us	Risk Scores											
	BAF Risk Ref	**Initial Score**	**Current Score**	**Target Score**	**Risk Appetite/Risk Tolerance**	**Risk Movement**	**Board Assurance 2024-25**					
Strategic Ambition: Delivery: We will be proud to deliver our best every day, providing high quality, timely and equitable access to care in an efficient and sustainable organisation.	**D8**	**5(L) X 4(C)=*20***	***5(L) X 4(C)=20***	***1(L)x4(C) =4***	***~~Low (6-10)~~*** ***CAUTIOUS***		**Previous Score Q4 2023-24, as D7**	**Q1**	**Q2**	**Q3**	**Q4**
Link to Operational Plan: D8: To deliver the financial plan for 2024/25 and deliver year 1 of the plan to return the Trust to a break-even position for 2026/27, and to ensure significant improvement across the full range of system productivity metrics.							**20**	**20**	**20**	**20**		
BAF Risk Description						**Linked Risks on the Risk Register & BAF Risks** **RISK 7130, RISK6755 and RISK6801**					**Assurance Committee**
D8: There is a risk that we will not be able to sustain services in line with national and system requirements because of a potential deficit in 2024/25 leading to further financial instability.						**Risk**					**Finance and Performance Committee** **Director of Finance**

Controls and Mitigations ***(what have we in place to assist in securing delivery of our ambition)***		**Assurance Received** *(what evidence have we received to support the control)*	**Date Assurance Received**	**Confirmed By:**	**Assurance Level** *Level 1 = Operational* *Level 2 = Internal* *Level 3 - Independent*
C1	Improvement of clinical productivity to levels experienced in 2019/20 without central funding for outsourcing clinical activities	Monthly Elective Programme Meeting chaired by Chief Operating Officer	**Nov 2024 Board**		Level 1
C2	CIP Track and Challenge in place		**Nov 2024 Board**		Level 1
C3	Contingency of £3m in place.		**Nov 2024 Board**		Level 1
C4	Winter funding allocated in reserves of £1.2m.		**Nov 2024 Board**		Level 1
C5	Elective recovery fund £6.0m		**Nov 2024 Board**		Level 1
C6	Financial plan submitted to NHSE by 08/05/2024	Submitted on time, still awaiting sign off by NHSE	**Nov 2024 Board**		
C7	Finance and Performance Committee oversee budget reports	Budget reports presented to Finance and Performance Committee	**Nov 2024 Board**		Level 1
C8	System wide delivery of Recovery	Director of Finance attends South Yorkshire DoF Group	**Nov 2024 Board**		Level 1

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

Gaps in Controls or Assurance Quarter 1 2022-23		**Actions Required**	**Action Owner**	**Date Action Commenced**	**Date Action Due**			**Progress Update**	
G1	Adherence to expenditure Run Rate as per financial plan	Monthly budget reports. Expenditure profile produced monthly throughout year. Reserves Policy in place. F&PC oversight. Internal audit systems budgetary control audit. External audit annual accounts.	Director of Finance	Q1	Ongoing				
G2	Potential reduction of cash balances due to expenditure higher than income which would result in late payments to suppliers. Impact to invest in capital projects.	Situation acceptable currently, future risk	Director of Finance					For Gaps G4-G7 awaiting further national guidance to fully assess the position. The Trust will run out of cash at some point during the second half of the financial year 2024/25.	

								The Trust has received £5.7m additional income as part of South Yorkshire agreed £49m deficit plan. This means the Trust has improved its cash position. The Trust will now likely have to borrow cash in Qtr 1 or Qtr 2 of 2025/26 depending on the financial settlement in that year.	
G3	Increased cost improvement programme due to national reductions in funding to the South Yorkshire allocation linked to funding formula suggesting South Yorkshire is overfunded.	Future income risk	Director of Finance						
G4	Financial forecasts come to fruition	Monthly check and challenge with relevant Divisions and Corporate areas.	Director of Finance					Month 6 - Trust is £2.2m adverse to plan, requiring remedial action plans from all Care Groups and Corporate areas.	
G5	Continuing industrial action leading to increased financial outlay in order to cover medical and clinical shifts. Also linked to challenges around sufficient workforce to support the recovery plan (including industrial action).	Regular industrial action meetings to mitigate impact. Finance team are currently working on a cost per day figure for future forecasting.	Director of Finance.	Reports to F&PC					
G6	Additional bed capacity as a result of increased non elective demand, which is non-funded due to block contract arrangements. Current risk £140K per month.	External support through Place to control demand on non-elective pathway.	Managing Director						
Archived Controls within month – Completed									
Archived Gaps within month – Completed									

Board of Directors
10th January 2025

The Rotherham NHS Foundation Trust

Agenda item	P201/25
Report	**Risk Register Report (including Corporate Risk Register)**
Executive Lead	Angela Wendzicha, Director of Corporate Affairs
Link with the BAF	The following paper links with all BAF Risks.
How does this paper support Trust Values	This paper supports the Trust Value of 'Together'
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☒
Summary (including reason for the report, background, key issues and risks)	This report provides an update to the Board for the review of all risks scoring 15 and above in addition to management information in relation to all open risks rated 8 and above. The key points arising from the report are: • As at 31st December 2024 there are 21 risks out of a total of 260 Trust-wide Approved risks that are out of review date. This shows a compliance rate of 92%. • An increased level of scrutiny has been applied to action plans for all approved risks rated 8 and above to address stagnation of risks and ensure reviews consider the work completed or still required (see Section 3) • A deep dive for risks rated 12 (opened before November 2022) has been presented to Risk Management Committee this quarter and a summary provided in this report. This review analyses the movement in risk scoring, responding to actions completed or changes in environment. • The Trust is in a strong position regarding its Risk Management Processes since the full review and introduction of the revised Risk Policy and Risk Management Processes in 2022. The additional scrutiny and challenge of the risk action plans, as reported below, will increase control of the Trust's risks and their management.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	All risks scoring 15 and above have been presented to and approved by the Risk Management Committee. The relevant risks are presented to the appropriate Board Assurance Committees, Executive Team Meeting and finally the Board of Directors.
Board powers to make this decision	Not Applicable

Who, What and When (What action is required, who is the lead and when should it be completed?)	Once presented, the Director of Corporate Affairs, as Executive Lead will continue to ensure that risks are appropriately identified, recorded, reviewed and managed.
Recommendations	It is recommended that the Board of Directors: • Note the content of the report; • Note the ongoing work carried out to further strengthen the risk register
Appendices	1. Corporate Risk Register - 15 and above risks

1. Introduction

1.1 The following report illustrates the evidence and progress the Care Groups are making in considering their risks, issues and emerging risks. The following information provides an update to the Board for the review of all risks scoring 15 and above in addition to management information in relation to all open risks rated 8 and above. The data analysed within this report was exported from Datix on 31st December 2024; any updates or changes subsequently within the database, will not be recorded in this report. Please note that whilst all of these risks have been approved at Care Group level not all have been considered or approved at the Risk Management Committee (RMC), this includes all risks rated at 12 or below which are discussed and approved at Care Group Governance meetings.

1.2 As at 31st December 2024 the Trust had a total of 260 Approved risks recorded on Datix, these are risks rated between 8 and 25, as follows:

High Risks: rated 15 - 25 and RMC Approved: = 21

Moderate Risks rated 8 - 12 and Care Group Approved = 239

1.3 This report does not contain any details to risks rated at 6 or below, these are Controlled/Managed Risks as follows:

Low Risks: Controlled/Managed Risks: rated 1 - 6 = 437

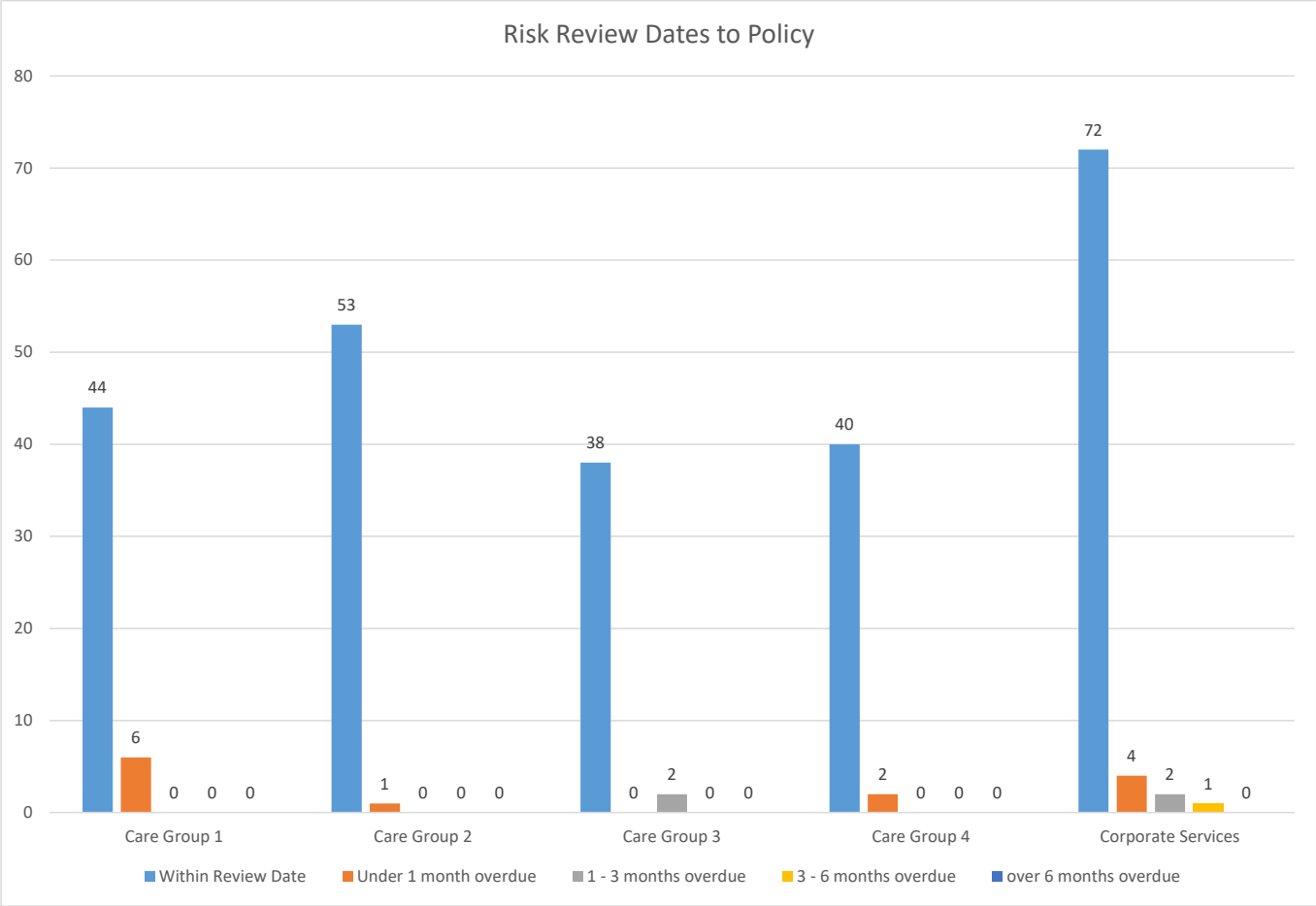
1.4 The following report illustrates the overview and analysis of the risks by review dates, action plans, Emerging Risks and the Issues Log.

2. Risk Review dates

2.1 In terms of compliance with risk review dates, the graph below shows all risks rated at 8 and above for all Care Groups. This graph is to provide the Board of Directors with

a view regarding the current Trust position for the management and review of risks. In accordance with the Risk Policy review dates are as follows:

- High Risks - Monthly review
- Moderate Risks - Three Month review
- Low Risks - Annual review



2.2 Trust-wide compliance with review dates has returned to 91%, this from a slightly lower position in October and November of 85%. This rise mirrors compliance data seen earlier in the year with the levels in June/July/August were at 91%. Care Group 1 have the lowest individual compliance at 88%, and Care Group 2 the highest at 96%. There are no risks whereby a review is overdue over 6 months.

2.3 There was one risk that was out of date for review between three and six months, there were also four risks that was out of date for review for between one and three months, there were also sixteen risks overdue for one month, further details regarding these risks and their risk ratings can be found below in section 2.4.

2.4 Care Group 1

There were six risks that were one month overdue:

Risk 6691, this risk relates to the effect of un-embedded 4 hour and Acute Care Standards on Emergency Department, last reviewed at the end of November, this risk is rated at 16 and for monthly review.

Risk 7084, this risk relates to operational pressures, opening additional beds impact on patient safety, experience, the risk was reviewed at the end of November but as rated at 20 should be reviewed monthly.

Risk 5967, risk relates to the insufficient provision of medical cover within the UECC and GP out of hours service, last reviewed beginning of November, subject to monthly review as rated at 15.

Risk 6969, relates to the lack of integration of IT services and lack of procedures/protocols against IT requests, reviewed at the beginning of November. Risk rated at 15.

Risk 7027, risk relates to the inability to provide analgesia and other time critical medications in UECC in a timely manner, last reviewed beginning of November, subject to monthly review as rated at 15.

Risk 7001, risk relates to the inability to get patients to CT in a timely manner, last reviewed beginning of November, subject to monthly review as rated at 15.

Care Group 2

There was one risk that was one month overdue:

Risk 6809, risk relates to the lack of Local Safety Standards for Invasive Procedures (LocSSIPs), the risk is rated at 15 and has not been reviewed since the November.

Care Group 3

There two risks that were between one and three months overdue:

Risk 6445, the risk relates to the recording arrangements of Safeguarding Supervision where compliance is unreliable. The risk is rated at 12 and was last reviewed in July, but should have been reviewed in October 2024.

Risk 5932, the risk relates to the risk of patients not receiving of Parenteral Nutrition

(PN) in the Trust due to the lack of PN prescribers. The risk is rated at 12 and was last reviewed in July, but should have been reviewed in October 2024.

Care Group 4

There were two risks that was one month overdue

Risk 7030, the risk relates to the inadequate number of Consultant Radiologists to meet demand. This risk is rated at 9 and should have been reviewed in October 2024.

Risk 5599, the risk relates to the Community Cardiac Team capacity resulting in possible clinical risk for heart failure patients. The risk is rated at 15.

Corporate Services

There were four risks that were one month overdue, two that were between one and three months overdue, and one that was between three and six months overdue for review:

Risk 4946, risk relates to the risk of failure to meet national target for Cancer Outcomes Data Set Return, rated at 9.

Risk 2678, risk relates to the lack of Assurance on training compliance with Medical Devices potentially affecting patient safety, rated at 9.

Risk 6801, risk relates to the risk of industrial action and effect upon Trust activity, risk rated at 12, should have been reviewed in November 2024.

Risk 6888, the risk relates to the lack of clinical psychology support for all services for which it is required, last reviewed at the end of October, risk rated at 15 and subject to monthly review.

Risk 3349, the risk relates to asbestos – Management and Control of Exposure to all site users, risk rated at 8, should have been reviewed in October 2024.

Risk 6912, the risk relates to long waits within UECC for mental health patients being admitted for detention under the Mental Health Act. The risk is rated at 15.

Risk 5791, the risk relates to Amb (out patient) Orders created by locum or rotating staff do not return to appropriate Attending Clinician, the risk is rated at 12 and required review in August 2024, risk owner has been contacted directly.

2.3 All Care Group management teams are provided with a monthly data sheet which includes all Approved Risks which are the risks rated at 8 and above, highlighting risks that are overdue for review. There is the expectation that these risks are addressed and discussed at the Care Group Governance meetings. Corporate Services risks owners are contacted by the Corporate Affairs Team, as Corporate Services do not currently have overarching Governance meetings.

3 Risk Action Plans

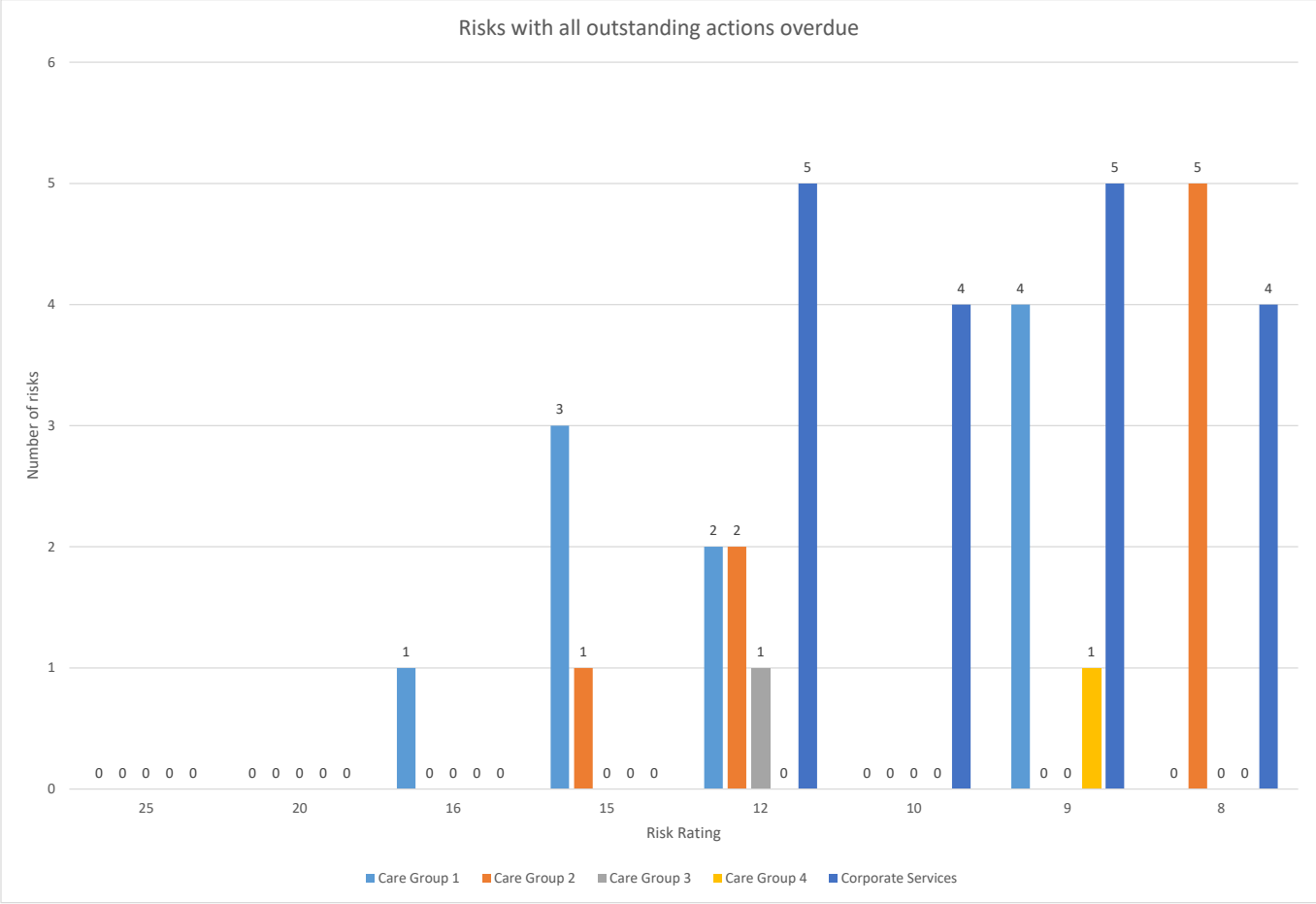
3.1 The scrutiny of action plans now includes focus on action plans in place that have all actions marked as completed, action plans that are out of date, as well as risks with no action plan in place.

3.2 The Trust now has the highest number of risks with recorded action plans since the formal risk management process commenced in 2022. However areas where processes can be strengthened have been highlighted as follows:

- Individual actions within an action plan that are overdue of completion date with no recorded escalation.
- Risks with action plans that are recorded as complete, however there is no reduction of rating, closure of risk or a record of additional action to mitigate the risk

3.3 The graph below includes the data on risks with action plans only. All of these risks have action plans, however one or more individual action has been found to be out of date.

3.4 There is a total of 5 High Rated risks across the four Care Groups that have individual actions that are overdue for review as per policy, further details can be found below in section 3.5.



3.5 Care Group 1

Risk 7027, the risk relates to the inability to provide analgesia and other time critical medications in UECC in a timely manner. This risk is rated at 15. There is one action which had a deadline of 29 November 2024 for completion. The action is a long term one, looking at Sepia functionality and an instruction has been sent to the Risk Owner.

Risk 5967 - the risk relates to insufficient provision of medical cover within the UECC and GP out of hours service and involves a long term plan to develop the role of senior clinical fellows within UECC.

Risk 6969, risk relates to a lack of integration of IT services and lack of procedures/protocols against IT requests Care Group 4. The overdue action involves all consultants to be made aware of the issues and review the imaging and forward to appropriate speciality.

Risk 6691, relates to the effect of un-embedded 4 hour and Acute Care Standards on

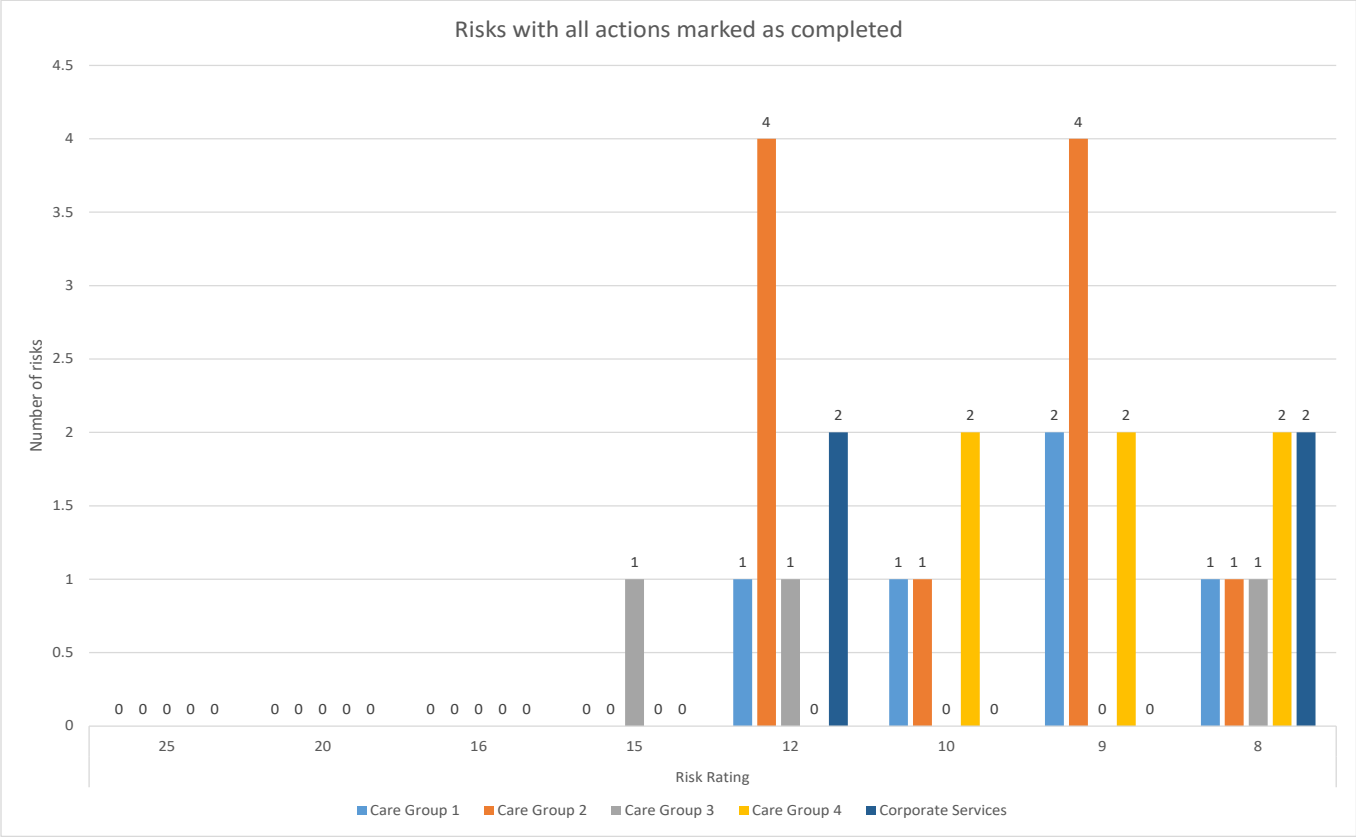
Emergency Department. The slightly overdue risk involves a Task and finish group established by the Chief Operating Officer to develop a full capacity plan and review bed capacity across the Trust. The ACT programme is now chaired by the Medical Director as lead executive.

Care Group 2

Risk 6762, the risk relates to the inpatient beds in the trolley area ASU, the action is for the Care Group to review impact on patient safety and quality of care (action assigned by COO), a reminder has been sent to the action owner as completion was due at the end of October 2024.

3.6 All actions closed

The graph below includes the data on risks with action plans only. All of these risks have action plans, however, all individual actions have been marked as complete with no subsequent reduction in rating or risk closure. There was one high risk marked as actions complete from Care Group 3.



3.7 Care Group 3

Risk 6421 Backlog of children waiting to be seen for assessment Child Development Centre (CDC), rated at 15 - all actions have been recorded as complete, however there has been no reduction in the rating, no additional actions and the risk remains open. This has been raised with the Care Group and additional actions have been listed in the progress notes, however not in the action plan and therefore the expectation is that these are translated into an action plan prior to the next Risk Management Committee.

4 Review of Risks Rated 12

5.1 The following section analyses Risks rated at 12 that were opened before 01/11/2022. This section has previously focused on review date compliance and progress notes, however, it will now focus on the movement in risk scoring and action plans, to delve into further examination on the management of these risks.

5.2 As part of this change in focus, the Risk Management Committee has been presented with a drill down into each Care Group over the last quarter with a full list of risks and risk details. A summary of results are as follows:

Groups	**Number of Risks Identified**	**Movement in Risk Scoring (number of risks)**		
		Update recorded within the last year to date	No change in 1-2 years	No change in more than 2 years
Care Group 1	9	3	3	3
Care Group 2	6	2	2	2
Care Group 3	7	0	1	4
Care Group 4	2	0	1	1
Corporate Services	13	3	3	3

5.3 The purpose of this review is to highlight to Senior Leaders the risks that have remained static for some time, prompting consideration to the review of these risks to reduce or horizon scanning for risks escalating in future.

5.4 Identification of those risks with little or no movement has led to a series of meetings with the risk owners in order to review the risks with a view to increase scrutiny on whether or

not the risk is still relevant after nearly two years of being open, whether the actions are suitable to mitigate the risk, that the action plans are SMART and still appropriate. This has led to a number of these risks being closed as not now applicable or merged into newer more up to date risks.

6. Risk Management Committee

6.1 The Risk Management Committee continues to meet on a monthly basis, however the Committee was stood down in December 2024 due to operational pressures.

6.2 All meetings have been quorate with good attendance and engagement from Care Groups

7 Emerging Risks

7.1 The emerging risks have been identified by the Care Groups at the Risk Management Committee and also during Assurance Committees. None of these risks have been registered on the risk management database as at 17th October 2024. Those identified were as follows:

- Second medical opinion – Martha's Rule. It was reported in August RMC that the Trust is doing joint working with pilot sites and the Trust is already compliant with Levels 1 and 2.
- Advanced Clinical Practitioners (ACPs) roles – the Lead ACP reported that the emerging risk is in regard to a number of ACPs that can retire in the next 3-4 years. The training pathway is 3 years and recruiting qualified ACPs is extremely difficult. The other difficulty is that staff can partially retire and remain in the service so it is not easy to plan; it is likely the Trust will have unexpected service delivery gaps due to this.
- UK Covid-19 public inquiry and the likelihood of claims against the NHS. As the report has not yet been finalised and published the risk remains uncertain, however it may potentially lead to increased financial claims against the Trust from patients, families and staff.
- Visa changes for salary thresholds for international staff. It was reported at August RMC that this may only effect a small number of colleagues, but changes should be considered system wide especially when navigating complex immigration issues.

7.2 This is not a limited or completed list and the Board of Directors is asked to discuss and submit further examples to the Corporate Affairs department or at the meeting.

8 Next Steps

8.1 Risk Management training and support continues with the Care Groups, led by the Corporate Affairs Team. This quarter included individual meetings with Estates and Facilities team members, attendance at Radiology Governance Meeting, Risk Review meeting with UECC and ad-hoc support meetings with risk owners.

8.2 The Risk Management Committee has continued to monitor and provide scrutiny to all risks and action plans as well as increased focus on risks rated at 15 or above. The attention on action plans for all risks rated 8 and above has levelled up to include scrutiny over non-active action plans to address stagnation of risks and ensure reviews consider the work completed or still required.

8.3 Details of risks rated 15 and above are provided to Executives for Care Group Performance Meetings each month. The focus on action plans has also been disseminated here.

8.4 As detailed throughout the report, there is progressive risk management across the Trust, allowing for the development to an even higher level.

8.5 This report is presented to provide assurance that the Trust continues to develop and strengthen its Risk Management function. The Care Groups are encouraged to actively horizon scan for future activity and potential risk rating increases. The aim is for these risks to be identified early at the care group level, taken forward for increased scrutiny and monitoring, with the associated action plans in place before it is raised through the Risk Management Committee, Executive Team Meeting, the Audit & Risk Committee and ultimately the Board of Directors.

9 Recommendations

The Board is asked to:

- Note the content of the report;
- Note the ongoing work carried out to further strengthen the risk register.

Alan Wolfe
Deputy Director of Corporate Affairs
January 2025

Corporate Risk Register (15+ Risks)

ID	Opened	Handler	Care Group / Division	Title	Description	Risk level (initial)	Risk level (current)	Risk level (Target)	Date REVIEWED	Review date	Progress notes	Approval status	Description	Start date	Due date	Done date	Responsibility ('To')
6166	26/05/2020	Ramsden, Daniel	Corporate Services	Absence of a Isolated Power Supply (IPS) within All Theatres	Lack of protection to vulnerable patients in Group 2 medical locations, from the risks associated with electrical leakage currents. It is also a requirement of the standards that Group 2 Medical Locations shall have an automatic electrical supply available within 15 seconds in the event of power failure. Consequently it is usual for an IPS unit to be backed-up by an on-line UPS (uninterruptible power supply) as this will provide a 'no-break' supply source.	High 16	High 16	Low 4	09/12/2024	09/01/2025	[Ramsden, Daniel 09/12/24 11:04:31] Site meeting planned for 11/12/2024 with trust and design engineers. This meeting will be to show design engineers the chosen locations on site of the system to be installed. Once the locations of the system have been approved the design engineers employed will start to design the system. Electrical Supplies on the trusts network for the systems have been decided.	Approved Risk	Theatres require UPS/IPS systems installing - Possible locations	06/09/2023	31/01/2025		Ramsden, Daniel
													Theatres require UPS/IPS systems installing - develop plan of works to install	06/09/2023	31/01/2025		Ramsden, Daniel
6888	23/03/2023	Hazeldine, Victoria	Corporate Services	Lack of clinical psychology support for all services for which it is required	Not meeting national recommendations for the use of psychology support for patients receiving clinical care. Currently the workforce is not reflective of the demand for psychological support therefore creating gaps in service. This is caused by lack of funding which sits across SY ICB which then relates to staff required at each organisation, as well as, lack of clinical psychology support and availability. This results in the risk to patients' physical and phycological health and the Trust being non-compliant with national recommendations.	High 15	High 15	Moderate 9	08/10/2024	07/11/2024	[Rimmer, Claire 08/10/24 11:58:45] Risk reviewed by VH 08/10/24: Risk remains static. Not compliant across some requirements within services. Mitigations in place to provide some psychology interventions however this is limited due to capacity. No appetite for business case currently across TRFT or the ICB.	Approved Risk	Escalate Lack of Psychological support for the breast cancer patients	31/08/2023	23/12/2024	14/08/2024	Timms, Mrs. Deborah
													Review of all services which currently require psychology support	14/08/2024	14/02/2025		Hazeldine, Victoria
													Identify gaps in the provision (following the review) and escalate to ICB level	14/08/2024	14/05/2025		Hazeldine, Victoria
6906	04/05/2023	Perry, Stuart	Corporate Services	Theatre 5&6 Ventilation	There is a danger to life and/or infection for patients due to the poor ventilation air flows within the theatre complex. The theatre ventilation has been modified at some point by removing the bottom of some doors to prevent them being blown open or noise. The Theatres require a complete refurbishment to install air transfer grilles to enable the ventilation strategy to be compliant. Also to include new UCV canopy in Th5 which is excessively noisy, install UPS/IPS and redesign the Sterile pack store in the middle of the theatres. This risk is linked with the Fire Doors in Theatres risk and UPS Risk.	High 16	High 16	Low 4	29/11/2024	27/12/2024	[Perry, Stuart 29/11/24 14:12:12] Added to the 25/26 Capital bids for funding	Approved Risk	Refurbishment of Theatre 5&6 Ventilation (large capital funding required)	12/09/2023	31/03/2025		Perry, Stuart
6912	11/05/2023	Cross, Gemma	Corporate Services	Long waits within UECC for mental health patients being admitted for detention under the Mental health act	Patients with mental health conditions presenting to UECC are experiencing long waits following assessment under the Mental health act which identifies them as requiring admission to RDASH (Mental health bed)	High 15	High 15	Moderate 9	03/01/2025	31/01/2025	03/01/2025 13:54:13 Discussed risk with GC. Action plan updated and will be added to following change over of risk from CG1 to Corporate. Risk to be reviewed at MHSG (December meeting stood down due to Operational pressures). GC arrange task and finish group for January to move forward. Senior input will be required to make decisions on care pathways and point of escalations.	Approved Risk	meet with stakeholders to discuss problems	01/11/2023	02/11/2023	20/11/2023	Hammond, Lesley
													arrange task and finish group	02/11/2023	31/01/2025		Cross, Gemma
													Working with RDASH around escalations (now closed and linked to action 855)	02/07/2024	20/12/2024	03/01/2025	Hammond, Lesley
7130	22/05/2024	Hackett, Steve	Corporate Services	Ability to deliver 2024/25 Financial Plan	Non delivery of the financial plan which is currently a £6.0m deficit. Caused by inability to deliver a £12.2m cost improvement programme or under recovery of elective recovery income (current target 103% of 2019/20 activity)or cost pressures exceed amounts set in reserve. Resulting in cash deficiencies limiting ability to pay suppliers and potential regulatory actions for failure to live within financial resources made available.	High 25	High 20	Low 5	10/12/2024	09/01/2025	[Rimmer, Claire 10/12/24 10:48:39] Update from SH: The Trust has received £5.7m additional income as part of South Yorkshire agreed £49m deficit plan. This means the Trust has Improved its cash position. The Trust will now likely have to borrow cash in Qtr 1 or Qtr 2 of 2025/26 depending on the financial settlement in that year.	Approved Risk	Development of Winter plan.	01/04/2024	01/10/2024	23/10/2024	Hackett, Steve
													Cost improvement Efficiency Board.	01/05/2024	01/10/2024	23/10/2024	Hackett, Steve
													Development of robust capacity plans.	01/06/2024	01/11/2024		Kilgariff, Mrs. Sally
													Theatre improvement programme.	03/03/2023	31/03/2025		Kilgariff, Mrs. Sally
													Outpatient utilisation programme.	23/03/2023	31/03/2025		Kilgariff, Mrs. Sally

Corporate Risk Register (15+ Risks)

ID	Opened	Handler	Care Group / Division	Title	Description	Risk level (initial)	Risk level (current)	Risk level (Target)	Date REVIEWED	Review date	Progress notes	Approval status	Description	Start date	Due date	Done date	Responsibility ('To')
7166	18/07/2024	Stewart, Paul	Care Group 1 (UECC and Medicine)	Care Group 1, General Medicine, risk to meeting financial control total	There is a risk of Care Group 1, General Medicine being unable to meet the financial control total in place at the start of the 2024/25 financial year.	High 20	High 20	Moderate 12	05/12/2024	03/01/2025	[Stewart, Paul 05/12/24 08:37:50] Our forecast at month 8 has improved by 762k however despite this we are still significantly away from achieving our original and revised control total and targets respectively. As such, despite the positive movement, we cannot reduce the risk scoring at this stage.	Approved Risk	Financial Recovery Plan - Care Group Level	01/07/2024	31/03/2025		Stewart, Paul
6969	18/08/2023	Staunton, Eamon	Care Group 1 (UECC and Medicine)	Lack of integration of IT services and lack of procedures/protocols against IT requests	Key Issue 1: Imaging, not being seen or delay to be seen by correct speciality /consultant. Significant increased work to sort imaging and redirect Imaging to correct Consultant and speciality. With subsequent SI and incidents arising from specialities not seeing own imaging. 2 PAs of EM Consultant time a week sorting this, and 2 hrs a day of secretarial time used. Key Cause 2: lack of electronic speciality referrals	High 15	High 15	Low 6	29/10/2024	26/11/2024	[McAuley, Heather 01/11/24 15:44:06] concerns remain around inability to access guidelines and leaflets - meeting arranged in 1 week with comms use of ZZ consultant needs rewording to be clearer on the risks. meeting to be arranged.	Approved Risk	escalate to deputy medical director	05/09/2023	05/09/2023	05/09/2023	Staunton, Eamon
													Results Acknowledgement Group	02/02/2024	02/07/2024	02/07/2024	Reynard, Jeremy
													Consultant Awareness of Issue	02/02/2024	29/11/2024	02/01/2025	Reynard, Jeremy
													progression of electronic referrals across care groups and specialities.	01/07/2024	30/12/2024		Staunton, Eamon
7001	12/10/2023	Reynard, Jeremy	Care Group 1 (UECC and Medicine)	In ability to get patients to CT in a timely manner	Delay to CT for patients in the UECC. 30% of majors and resus patients undergo a CT from the UECC, half of which are subsequently discharged. Only 50% of patients get a CT result within 2 hours of request. At 3hours 25% of patients who are discharged are still waiting for a result.	High 20	High 15	Low 4	29/10/2024	26/11/2024	[McAuley, Heather 01/11/24 15:47:08] ongoing concerns with escorts, needs revisiting, need list of appropriate presentations which require CT scans. believe still requesting too many.	Approved Risk	QI Project	16/11/2023	31/12/2024		Staunton, Eamon
													Portering (see action below on Transfer for ongoing actions)	01/10/2023	31/03/2025		Maton, Lynsey
													2nd CT scanner for Trust	01/11/2023	30/08/2024	28/08/2024	Reynard, Jeremy
													Transfer team and transfer policy	01/11/2023	31/03/2025		Maton, Lynsey
													discussions across divisions.	16/11/2023	14/06/2024	27/06/2024	Stephenson, Daniel
													Safer care nursing tool	01/01/2023	31/12/2024		Maton, Lynsey
													Teletracking	17/04/2024	31/07/2024	24/07/2024	Farrow, Lindsay
													Review appropriateness of scans requested in the UECC	02/09/2024	23/12/2024	02/01/2025	Reynard, Jeremy
7027	29/11/2023	Reynard, Jeremy	Care Group 1 (UECC and Medicine)	Inability to provide analgesia and other time critical medications in UECC in a timely manner	Delays to pain relief, less appropriate pain relief been given. Delay to review. Delay to antibiotics. Delay to other time critical medications. Delay to ADREQ and therefore transfer and the 4 hour target.	High 15	High 15	Moderate 8	29/10/2024	26/11/2024	[McAuley, Heather 01/11/24 15:49:41] concerns that there aren't datix to support this risk at this level, but consultants support the current rating. is there an underreporting.	Approved Risk	review available PGDs	20/12/2023	24/07/2024	28/08/2024	Maton, Lynsey
													Improve access to other services	01/02/2024	31/03/2025		Maton, Lynsey
													Improve flow	01/02/2024	30/04/2025		Hammond, Lesley
													Nursing capacity to meet demand	01/02/2024	31/03/2025		Maton, Lynsey
													explore Sepia function to show patients who require time critical medicines	22/04/2024	29/11/2024		Farrow, Lindsay
7084	13/03/2024	Benton, Jennifer	Care Group 1 (UECC and Medicine)	Operational pressures, opening additional beds impact on patient safety, experience	Additional capacity beds opened within the Division. Caused by an increase in patients requiring a medical inpatient admission. Increased infection resulting in funded beds being closed from an IPC requirement. Increase in LOS and a requirement of IDT involvement. Resulting in adverse impact on patient safety, quality and experience - Increase noted in patient incidents, harm to patients (severity), judicial enquiries, concerns and complaints. Negative impact on Trust reputation/credibility.	High 16	High 20	Moderate 9	03/01/2025	05/02/2025	[Stewart, Paul 03/01/25 10:34:19] PS reviewed, no current change to risk score. B4 is now operating as a winter ward at 27. B5 is at 33, Stroke unit at 27. At the time of writing we have 12 additional patients on B6 which were opened on 01/01/2025. Escalation beds impact on patient experience, patient safety and staff experience. . However, we are currently installing a substantive nursing model in B4 including Ward Manager and Clinical Sisters to ensure that there is a more planned approach to the additional beds on B4. This is set in the context of a more general pause to the bed reconfiguration work which will be picked up in the latter part of January 2024 with a focussed QI event to identify a suitable and sustainable model.	Approved Risk	Completion of the SOP for opening a decommissioned area	13/03/2024	01/05/2024	13/06/2024	Benton, Jennifer
													Identification of Golden patients	13/03/2024	01/06/2024	13/06/2024	Benton, Jennifer
													Divisional representation at LLoS review	13/03/2024	01/06/2024	13/06/2024	Benton, Jennifer
													Nurse staffing huddle	13/03/2024	01/06/2024	13/06/2024	Benton, Jennifer
													SHOP Ward round principles	13/03/2024	28/02/2025		Reynard, Jeremy
													Bed Reconfiguration Work	12/07/2024	03/03/2025		Stewart, Paul
													Utilise Perfect Week to enact de-escalation	18/07/2024	24/07/2024	22/08/2024	Stewart, Paul

Corporate Risk Register (15+ Risks)

ID	Opened	Handler	Care Group / Division	Title	Description	Risk level (initial)	Risk level (current)	Risk level (Target)	Date REVIEWED	Review date	Progress notes	Approval status	Description	Start date	Due date	Done date	Responsibility ('To')
5967	27/10/2019	Hammond, Lesley	Care Group 1 (UECC and Medicine)	Insufficient provision of medical cover within the UECC and GP out of hours service	Updated 11.03.24 to link with Risk 6131 and 5238. Lack of staffing in the GP Out of Hours Service. Unable to fill the MG rota, especially at night (within UECC). Not achieving the new 4 hour target. Delay to be seen by a clinician.	High 15	High 15	Moderate 9	29/10/2024	26/11/2024	[Rimmer, Claire 19/11/24 13:45:38] 19.11.24 - RMC Approved for a rating of 15. Medical cover in ED overnight has significantly reduced however, there is temporary element due to staff on pat/mat leave. The longer term underlying issue is in terms of having ST4 appropriate cover overnight - for example, there is a significant issue in December with 10 days of no middle grade cover. This will also have a financial impact due to filling these gaps. It was noted that regarding GP OOH, the department have employed 3 new GPs which is positive - risk should be updated to reflect these changes and the above update at RMC.	Approved Risk	ACT programme	04/04/2022	31/03/2025		Hammond, Lesley
													Recruitment	04/04/2022	03/04/2023	18/05/2023	Hammond, Lesley
													Winter plan	01/11/2023	31/03/2024	25/04/2024	Reynard, Jeremy
													Review of rota	01/02/2023	31/08/2024	02/07/2024	Reynard, Jeremy
													Workforce plan from ACT work	01/02/2023	30/04/2024	30/04/2024	Reynard, Jeremy
													Senior clinical fellows	04/12/2023	30/08/2024	02/01/2025	Reynard, Jeremy
6691	28/04/2022	Reynard, Jeremy	Care Group 1 (UECC and Medicine)	Effect of un-embedded 4 hour and Acute Care Standards on Emergency Department	The lack of ACS compliance across the trust has a detrimental effect on Medical capacity in the UECC Nursing capacity in the UECC Not achieving 4 hour standard Resulting in the department being: 1. Unable to see patients. 2. Unable to offload ambulances 3. at risk of overcrowding in the Main Waiting Room. 4. have delays to time critical treatment 5. have delays to time critical medication.	High 20	High 16	Moderate 12	29/10/2024	26/11/2024	[Rimmer, Claire 20/11/24 12:11:49] Discussed at RMC and with DCOO - Risk of overcrowding has reduced due to pilot of using pilot of fracture clinic OOH. Risk remains around embedding of the 4h standard however work is ongoing through the ACT programme. Risk remains due to increased activity through UECC prior to winter. Risk score reduced to 16 due to reduction in overcrowding and sustained improvements in 4h performance and other performance measures, such as ambulance handover measures.	Approved Risk	Work with Executive team on embedding the standards and engagement with the Trust	01/11/2023	05/02/2025		Reynard, Jeremy
													Transformational work, Task and finish group (ACT Programme)	01/02/2024	31/10/2024		Beahan, Dr Jo
													New staffing tool to be implemented	05/06/2023	15/07/2024	19/08/2024	Maton, Lynsey
													Escalation SOP for Paediatrics for busy periods	13/09/2024	27/12/2024		McAuley, Heather
													Cross-Care Group and cross-specialty working to develop pathways to move to a hospital-wide 4h approach.	13/09/2024	31/03/2025		McAuley, Heather
6723	10/06/2022	Agger, Joanne	Care Group 2 (Surgery)	Anaesthetic Medical Staffing Availability	Unavailability of Anaesthetists due to long and short term sickness. Caused by long and short term sickness. Resulting in lack of availability of Anaesthetists results: Gaps in the on call rota Loss of operating lists in theatres potential burn out for staff picking up on call shifts.	Moderate 12	High 15	Low 6	16/12/2024	31/03/2025	[Howlett, Darren 17/12/24 12:57:25] Further recruitments made, further recruitment still required. Anaes staffing meeting ongoing, tweaks with rota and exra sessions , payback discussions ongoing, Some small changes made to provision, meetings booked and wholesale amendments will be a wider bigger piece of work. Currently have NHSE advisors in to give an indication on improvement work. Still a challenged areas, sickness high in December	Approved Risk	Phase two - Specification and Commissioning	08/01/2024	30/09/2024	17/07/2024	Agger, Joanne
													Phase Two - Resource agreed/appointed to undertake Phase Two work, starting late summer	01/07/2024	31/03/2025		Agger, Joanne
													Phase two - External review, comparing to national standards and benchmarking practice against other peer trusts	30/09/2024	31/03/2025		Agger, Joanne
6762	23/07/2022	Short, Mrs. Sally	Care Group 2 (Surgery)	Inpatient beds in the trolley area ASU	ASU trolley area not operating as surgical SDEC due to unfunded inpatient beds in both bays. Preventing flow from UECC for non ambuatory surgical patients to be managed in ASU. Caused by preventing SDEC operating due to inpatients in 10 non funded beds. Medical and surgical patients in ward surgical beds. Resulting in Increased admissions to hospital due to all patients managed in waiting area sometimes for long periods. Preventing streaming/flow of non ambulatory patients from UECC. Poor patient experience and increased length of stay in department. Preventing good early flow through the unit as previously 10 trollies were available at the start of the day to ensure adequate capacity until patients were discharged from short stay beds.	Low 6	High 15	Low 6	14/11/2024	31/01/2025	[Short, Sally Mrs. 11/12/24 16:30:02] No change to risk	Approved Risk	Surgica SDEC Task and Finish Group	01/11/2022	31/03/2024	29/04/2024	Timms, Mrs. Deborah
													unfunded beds to trolleys (covered in earlier action)	14/06/2024	31/10/2024	11/10/2024	Cresswell, Mr Andrew
													unfunded beds to trolleys	17/06/2024	17/09/2024	13/05/2024	Cresswell, Mr Andrew
													Care Group to review impact on patient safety and quality of care	19/07/2024	21/10/2024		Timms, Mrs. Deborah
													Review bed modelling to understand bed capacity needs - Care Group 2	19/07/2024	19/12/2024		Howlett, Darren
													Care Group to review increase in long length of stay	19/07/2024	19/10/2024	11/10/2024	Howlett, Darren
													SDEC Working Group established - look at options to run SDEC models throughout winter	02/09/2024	31/03/2025		Howlett, Darren

Corporate Risk Register (15+ Risks)

ID	Opened	Handler	Care Group / Division	Title	Description	Risk level (initial)	Risk level (current)	Risk level (Target)	Date REVIEWED	Review date	Progress notes	Approval status	Description	Start date	Due date	Done date	Responsibility ('To')
6809	20/10/2022	Oliver, Lauren	Care Group 2 (Surgery)	Lack of Local Safety Standards for Invasive Procedures (LocSSIPs)	Risk of patient safety incidents and reduced delivery of safe care during invasive procedures.	High 15	High 15	Low 6	28/10/2024	28/11/2024	[Oliver, Lauren 28/10/24 14:50:09] Still no change, no updates from CSUs regarding any LocSSIPS. Advised that there is going to be a Trust meeting shortly regarding LocSSIPS so advised by DHON not to action anything else for now.	Approved Risk	Lack of Local Safety Standards for Invasive Procedures (LocSSIPs)	13/04/2023	31/01/2025		Oliver, Lauren
													To establish Trust wide required LocSSIPs	13/06/2024	01/01/2025		Oliver, Lauren
6630	28/01/2022	Windsor, Claire	Care Group 2 (Surgery)	Lack of Critical Care Follow Up Clinic	Critical illness leaves patients at highly significant risk of long term physical, cognitive and psychological problems. This has the potential for considerable residual impact on patients morbidity and longevity. Caused by no Critical Care follow up service. Resulting in failure to provide vital support following discharge resulting in the inability to identify any complications relating to critical illness which require effective management and ongoing treatment or onward referral including significant mental health / psychological sequalae and physical disability. Failure to meet GPIC's V2 standards.	High 15	High 15	Low 6	12/12/2024	13/01/2025	[Windsor, Claire 12/12/24 10:24:03] Continues with Business Case sat with SLT, ongoing discussions	Approved Risk	Lack of Critical care Follow-Up - Business Case brief for Rehabilitation and Follow-up Service for Critical Care submitted to service manager on the above date.	01/08/2022	10/02/2025		Timms, Mrs. Deborah
7204	18/09/2024	White, Mr. Lee	Care Group 2 (Surgery)	Risk of Theatre Cancellations (incurring 65 week breaches)	65 week breach patients	High 15	High 15	Low 6	18/11/2024	31/01/2025	[Rimmer, Claire 21/10/24 16:17:49] RMC approved 15.10.24 at a rating of 15. It was reported that there is a plan in place for each patient and the Care Group is optimistic but here is considerable risk due to the high cancellation rate as a result of sickness and bed availability. It was suggested that after October, the risk could be reduced.	Approved Risk	Twice Daily Theatre Staffing Meetings	02/09/2024	31/12/2024		Howlett, Darren
													MEOC activity increase	02/09/2024	31/03/2025		Howlett, Darren
													Theatre weekend activity - to run initiatives for 3 months (Oct-Dec) as a trial to increase activity	01/10/2024	31/01/2025		Howlett, Darren
7140	10/06/2024	Howlett, Darren	Care Group 2 (Surgery)	Ability to Achieve Financial Control Total	There is a risk of the Care Group not achieving it's agreed financial control total for the financial year 24/25.	High 20	High 20	Moderate 12	14/11/2024	31/03/2025	[Howlett, Darren 17/12/24 12:48:11] No change in the level of risk but extra scrutiny and grip and control introduced. Monthly improvement meetings, weekly activity and improvement meetings. Exec sign off for business cases and extra spend. internal measures for spend and bank and agency. Improvements and monthly CIP meetings, Finance training given to staff. Run rate reduction required and assurances via Performance require, Some improvement in coding activity had a favourable Month 8, activity was improved. A slightly improved run rate position, would need sustained improvements to warrant any change in score.	Approved Risk	Cost improvement plans (full list in synopsis)	10/06/2024	31/03/2025		Howlett, Darren
6421	31/03/2021	Whitfield, Vicky	Care Group 3 (Family Health)	Backlog of children waiting to be seen for assessment Child Development Centre (CDC)	Delay in assessment and formulation of a care plan for children aged 0-5yrs with additional needs. This will impact on long term outcomes including health and fulfilling educational/developmental potential	High 15	High 15	Low 6	13/12/2024	31/01/2025	[Roper-Bowen, Beth 13/12/24 12:29:11] Funding has been approved by ICB to clear backlog of children waiting to be seen by CDC. Once this funding has been allocated and waiting list is reduced this risk can be reduced.	Approved Risk	Support without referral Pathway	18/09/2023	30/09/2024	30/08/2024	Wilkinson, Jo
													Funding for further staff	18/09/2023	30/11/2023	02/01/2024	Wilman, Mrs. Johanna
													Psycology Funding	18/09/2023	28/06/2024	03/06/2024	Wilman, Mrs. Johanna
													Joint working with RDASH	18/09/2023	30/07/2024	25/07/2024	Wilman, Mrs. Johanna
													Letter to ICB highlighting backlog and current demand versus funded capacity.	24/10/2024	24/10/2024	24/10/2024	Cowie, Alison
													Outcome from SEND inspection (inspection took place w/c 30th Sept)	30/09/2024	31/12/2024	29/11/2024	Cowie, Alison
													Meeting with ICB re recurrent funding	08/11/2024	03/12/2024	03/12/2024	Cowie, Alison
													Service delivery modelling	08/11/2024	01/01/2025	29/11/2024	Whitfield, Vicky

Corporate Risk Register (15+ Risks)

ID	Opened	Handler	Care Group / Division	Title	Description	Risk level (initial)	Risk level (current)	Risk level (Target)	Date REVIEWED	Review date	Progress notes	Approval status	Description	Start date	Due date	Done date	Responsibility ('To')
6284	16/09/2020	Broadhurst, Miss Lucy	Care Group 4 (Community, Therapies, Dietetics & Medical Imaging)	Cardiac Physiology Staffing Levels	Cardiac Physiology Staffing Levels consistently unable to meet all the needs of the service. This includes performance against waiting list targets, staff wellbeing, training of students and governance responsibilities. The staffing challenges affect all sections of Cardiac Physiology (Echo, Devices, Non-Invasive Cardiology, Reception). The current establishment of the department is 36.17 WTE (June 2023).	High 15	High 15	Moderate 9	24/12/2024	23/01/2025	[Broadhurst, Lucy Miss 24/12/24 15:38:03] Updated 24/12/24 - Risk & Action plan reviewed. Unable to reduce the risk because staffing levels remain inadequate. There are 2 main issues: • Ongoing absences/staff turnover across the department • Incorrect establishment due to increasing workload – awaiting business case Current issues: * Cardiac Device Lead due to step down - awaiting advert * LTS of B3 Cardiographer * Planned staff absence (3.52 WTE) has now commenced Nov 24 (affects B7 staff in both Echo and Devices). * 1.0 WTE locum cover (Devices) started 18/11/24 and trying to catch up with device appointments. See risks 6578 and 6576 * Insourcing cover ongoing to cover the Echo absences * ERF funding for extra Cardiology Clinics but we still have vacancies to cover this work (B2 Admin). B3 Cardiographer started 16/12/24 but having xmas and new year off. * Reception team under pressure due to DM01 work, vacancies, sickness and new starters * Ongoing project to recoup tariff income for services. * Meetings planned to progress business case, demand and capacity work ongoing across the dept in preparation. Current vacancies: * 0.6 WTE Band 4 vacancy and 0.8 WTE B6 vacancy now combined into 1.0 WTE Band 6 for ease of recruitment (Non-Invasive) - to be advertised * Some b4 hours remain vacant * 1.0 WTE B3 cardiographer on LTS * 0.91 WTE B4 vacancy - start date 30/12/24 (non invasive) * 1.0 WTE B3 Cardiographer on maternity leave until at least Jan 2025 (non-invasive) * 2 x 0.51 WTE B2 receptionist vacancies now combined to 37.5 hours position to aid recruitment - going to advert * 1.0 WTE B2 receptionist 12 month fixed term contract - currently vacant whilst candidate going through recruitment but post holder leaving in Jan 2025 * 1.0 WTE B6 rebanded to B7 (Echo) in Jan 2025 * 1.0 WTE B5 trainee in an established B6 post (non-invasive) * 1.0 WTE B2 cardiographer in an established B3 post (non-invasive) * Ongoing echo support from Inhealth (longterm contract) * 1.0 WTE B6 expected to hand notice in within next 2months * 1.0 WTE B7 Clinical Practice Educator (6mth fixed term contract funded by ICS) - being worked up for advert * Concerns over retaining current students due to qualify summer 2025. * Concerns over reception cover due to vacancies, staff turnover & training. Working with CG4 validation team. In summary - Echo and Devices have longterm staff absence and being maintained by high cost locum cover/ insourcing. Concerns have shifted towards the Non-invasive team who have significant vacancies/sickness without adequate cover. LTP form approved by ECF for non-invasive cover demanding on locum cost and availability. LB	Approved Risk	Source Locum Support for Non-Invasive Team	28/11/2024	31/01/2025		Barsby, Melvina
													Support Admin/ Reception Team	02/12/2024	31/01/2025		Barsby, Melvina
													Business case to increase staffing	01/07/2022	29/01/2025		Broadhurst, Miss Lucy
5599	04/07/2018	Taylor (Cardiac SNP), Ms. Katie	Care Group 4 (Community, Therapies, Dietetics & Medical Imaging)	Community Cardiac Team capacity resulting in possible clinical risk for heart failure patients	1.Risk of patients not receiving care/ review of investigations in a timely manger and resulting in clinical risk 2. Risk of patients admitting to acute setting due to not being reviewed within recommended timescales or waiting list targets 3. Unable to support and facilitate early hospital discharge 4. Increased risk of complaints/litigations from increase in patient dissatisfaction 5. Increase staff stress sickness, burnout and turnover 6. Not meeting NICE HF guidance of patients reviewed by specialist within 2 weeks of referral/discharge	Moderate 9	High 15	Low 6	23/10/2024	20/11/2024	Taylor (Cardiac SNP), Ms. Katie 23/10/2024 11:56:12 1.Wait now down to 29 weeks, 2. 151 under GP HF champion project- avoided referral and accessing HF disease modifying therapy to improve patient outcome 3. New titration/HF specialist initiation medication clinic for long stable amber waiters to start with B6 prescriber	Approved Risk	Completion of all amber referrals back to GP HF champions	11/03/2024	29/11/2024		Taylor (Cardiac SNP), Ms. Katie
													Increase in nurse prescribers by two staff.	08/01/2024	08/01/2025		Taylor (Cardiac SNP), Ms. Katie
													increase capacity by nurses	23/08/2024	31/01/2025		Taylor (Cardiac SNP), Ms. Katie
													Mortality on waiting list	28/08/2024	25/08/2025		Taylor (Cardiac SNP), Ms. Katie
													Monitoring and reducing waiting times using recovery plans	03/10/2024	31/03/2025		Taylor (Cardiac SNP), Ms. Katie
													Review referral and pathways within the service	14/10/2024	31/03/2025		Taylor (Cardiac SNP), Ms. Katie
													To review current workforce	01/12/2024	31/03/2025		Taylor (Cardiac SNP), Ms. Katie
													To Monitor Patient Experience	01/12/2024	31/03/2025		Taylor (Cardiac SNP), Ms. Katie

Board of Directors' Meeting
10 January 2025

The Rotherham NHS Foundation Trust

Agenda item	P12/25
Report	**Chief Executive Report**
Executive Lead	Dr Richard Jenkins, Chief Executive
Link with the BAF	The Chief Executive's report reflects various elements of the BAF
How does this paper support Trust Values	The contents of the report have bearing on all three Trust values.
Purpose	**For decision ☐ For assurance ☐ For information ☒**
Executive Summary (including reason for the report, background, key issues and risks)	This report is intended to give a brief outline of some of the key activities undertaken as Chief Executive since the last meeting and highlight a number of items of interest. It focuses on the following key areas: • Operational Matters • Performance • Integrated Care Board (ICB), Acute Federation and Rotherham Place Development and Partnership Working • People
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	This paper reports directly to the Board of Directors.
Board powers to make this decision	No decision is required.
Who, What and When	No action is required.
Recommendations	It is recommended that the Board note the contents of the report.
Appendices	1. Chief Executive of NHS South Yorkshire update report for November 2024

1.0 Operational Matters

1.1 In November 2024, the Trust continued to achieve the national target of zero patients waiting over 65 weeks, demonstrating sustained success in this critical area. The focus has now shifted to reducing the number of patients waiting over 52 weeks. The waiting list size has remained stable at 31,925.

1.2 The Referral to Treatment (RTT) 18 weeks standard was met in Geriatric Medicine, Rheumatology, and Stroke, while Respiratory achieved 91%, narrowly missing the 92% target. ENT, OMFS, and Orthopaedics remain areas of challenge however slight improvements have been noted across all three specialties during November 2024. Care Groups are continuing their efforts to enhance RTT performance and are actively developing demand and capacity plans for the next financial year.

1.3 The Trust's engagement with the national GIRFT Further Faster 20 (FF20) initiative is progressing well. The onboarding process commenced in mid-November, with the programme expected to significantly support elective recovery efforts. External support through the programme commences in December and will focus on driving improvements across key areas, including Theatres, Anaesthetics, ENT, Trauma & Orthopaedics, and OMFS. The Trust maintained Diagnostic (DM01) performance at 0.95% in November 2024, aligning with our ambition to sustain this position throughout 2024/25.

1.4 The Trust achieved two of three national cancer standards in November 2024, with the stretch targets for 28-Day Faster Diagnosis Standard and 62-Day Treatment Standard also being met. Performance against the 31-Day Standard fell just short of the national standard due to operational pressures leading to limited HDU capacity to support the Lower GI pathway and workforce issues in Dermatology impacting on Skin pathways. Improvement plans are actively being implemented to sustain achievements against both national and internal stretch targets, with a focus on March 2025 for full compliance.

1.5 **Urgent and Emergency Care Activity:** In November, the Trust achieved 62.1% for the 4-hour access standard and it continued to see high attendances at UECC, with the number of attendances in November peaking at 8946 for the month compared to 8185 in November 2023. The Trust also saw a higher demand for paediatrics services, with respiratory conditions being the main factor in the rise in attendances.

1.6 The overall year to date position for UECC attendances remains high and the Trust has seen 69,154 attendances compared to 63,297 this time last year. This represents 9.3% above 2023/24 and 7.9% above the contract plan for the year with the additional demand having an impact on flow and bed capacity.

1.7 I am pleased to report that the Trust’s bid for £7M capital funding via the Acute Care Transformation and Innovation Fund (ACTIF) scheme was successful and has now been formally approved. The programme mandate has been clearly defined, with objectives focused on enhancing facilities to meet patient care standards and organisational goals. There has been comprehensive stakeholder engagement and a risks and issues log has been maintained, enabling proactive management of potential delays and budget pressures. Progress updates and escalations are routinely reported to the weekly Capital Scheme Executives Group for strategic

oversight and assurance.

1.8 The impact of Winter on urgent and emergency care services has become significant through December and into the New Year. Our Winter plan has been implemented. The Respiratory Syncitial Virus caused considerable illness in children but has now largely subsided. There have been some low levels of Covid-19 and Norovirus but influenza has been the main viral challenge over recent weeks with high numbers of patients and staff affected.

2.0 GP Collective Action

2.1 General Practitioners continue to take collective action across Rotherham Place. The Trust is working with the ICB to understand the impact that this is having on demand through secondary care. There has been an increase of GP referrals through UECC in comparison to last year with a YTD number of 2626 referrals compared to this time last year where there were 1346 referrals. As always, patient care and patient safety is our priority during any such action.

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

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

3.2 I attach (Appendix 1) the November 2024 update report from the Chief Executive of NHS South Yorkshire, which highlights the work of the ICB and system partners since the last update.

3.3 The SYBAF continues to meet regularly to coordinate work between the five member Trusts. I have recently taken on leadership of the new Diagnostic Oversight Group which has emerged from the former Diagnostic and Elective Oversight Group; Kirsten Major, Chief Executive at Sheffield Teaching Hospitals NHS FT will lead the new Elective Oversight Group. I have also agreed to lead the development of the SYBAF Imaging Network.

3.4 The Barnsley and Rotherham partnership continues to collaborate with a number of events taking place to provide an opportunity for colleagues to make connections, focus on shared learning, support and best practice. A work programme for 2025-26 will be developed for approval as part of the Trust's overall operational plan.

3.5 **Mexborough Elective Orthopaedic Centre of Excellence:** Rotherham utilisation is at 74% currently and although not at 85% capped, notable improvements have been made over the past several months through several different improvement initiatives. This includes digitisation of notes transfer, quick access pre assessment, increased scheduling capacity and increased number of surgeons operating at MEOC from TRFT. Further initiatives include the purchase of additional equipment to enhance the scope of operations that can be performed at MEOC and exploration in how the facility can be used for other procedures.

Outcomes for patients have been positive with most patients being discharged on

the day of surgery, feedback from patients is extremely high with FFT at 95%. Quality and safety is performing well with limited number of incidents reported with any harm.

3.6 I am delighted to inform you that the Trust has been awarded a National Joint Registry (NJR) Silver Quality Data Provider for 2024. The 'NJR Quality Data Provider' scheme has been devised to offer hospitals public recognition for Achieving excellence in supporting the promotion of patient safety standards through their compliance with the mandatory NJR data submission quality audit process and by awarding certificates the scheme rewards those hospitals who have met the targets. To gain Quality Data Provider (QDP) status, hospitals were required to meet the targets for best practice; increase engagement and awareness of the importance of quality data collection and embed the ethos that thorough and accurate data enables the NJR to develop improved patient outcomes.

4.0 People

4.1 The annual NHS Staff Survey closed on 29th November 2024. The Trust has received its management report and Picker are now processing the remaining standard reports with the formal publication expected sometime in February 2025. As such the results are currently under embargo.

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

October 2024

INDIVIDUAL AWARD:	Megan Parker, Sitwell Ward Manager
TEAM AWARD:	Children's Ward
PUBLIC AWARD:	Community Occupational Therapy Service

November 2024

INDIVIDUAL AWARD:	Joseph Henson, First Contact Physiotherapy
TEAM AWARD:	MSK Physiotherapy team involved in the Community Assessment Day
PUBLIC AWARD:	Acute Medical Unit

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

- Mr B Alwash, Ophthalmology (13.01.25)
- Dr J Khalil, Anaesthetics (03.03.35)

4.4 I am pleased to report that following a formal recruitment process, Dr Mario Shekar has been successful in appointment to the role of Divisional Director of Care Group 2. He will commence in post from 6th January 2025.

4.5 The Care Quality Commissions (CQC) 2024 Maternity Survey has now been published and looked at the experience of women who gave birth in February 2024. The Trust results were very positive with further detail available in the maternity report to the Board of Directors.

4.6 The CQC's Urgent and Emergency Care Survey 2024 has also been published and asked patients receiving urgent and emergency care during February 2024 about their experience. A total of 120 trusts were surveyed and the Trust had over 300

patients respond to the survey. There were a few key areas in which the Trust scored particularly well in comparison to others. These included communicating with patients and families about test results, information upon arrival, information about support and care after leaving UECC, and privacy during examination and treatment. An improvement plan is already in place to focus on those areas identified as requiring improvement.

4.7 I, along with other Executive Team colleagues attended the 2024 NHS Providers Conference in Liverpool in November. The new Secretary of State for Health spoke about funding, reform, performance management of underperforming Trusts and a new Very Senior Manager Pay Framework that would be shared in the new year. The Chief Executive of the NHS was also in attendance and spoke about the challenges faced by the NHS, as well as the development of an Executive Academy.

Dr Richard Jenkins
Chief Executive
January 2025

Chief Executive Report

Integrated Care Board Meeting

6 November 2024

Author(s)	Gavin Boyle, SY ICB Chief Executive
Sponsor Director	Gavin Boyle, SY ICB Chief Executive
This report provides assurance against the following risk(s) on the ICB's Board Assurance Framework, Risk Register or Issues Log:	N/a

Purpose of Paper

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

Key Issues / Points to Note

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

Is your report for Approval / Consideration / Noting

To note

Recommendations / Action Required by the Committee

The Board is asked to note the content of the report

Board Assurance Framework

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

Priority 1 - Improving outcomes in	✓	Priority 2 - Tackling inequalities in	✓

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

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

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

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

Chief Executive Report

Integrated Care Board Meeting

6 November 2024

1. Purpose

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

2. Integrated Care System Update

2.1 NHS Change and Darzi Independent Investigation

In July following the General Election, Professor Lord Ara Darzi was appointed by the Government to establish the state of the nation's health service. Lord Darzi who is a surgeon and former Labour health minister reported his conclusions in September.

You can read the full Darzi Investigation report here.

The priorities identified through the investigation are expected to inform the spending review this autumn and NHS planning requirements for 2025/26, which are normally issued at the end of the calendar year.

Lord Darzi's findings will also contribute to the development of the Government's 10-year health plan which will be published in Spring 2025. There will be an opportunity for the public and organisations to share their views as part of its development. In October the Government opened the change.nhs.uk on-line platform to allow everyone to share their thoughts.

NHS South Yorkshire submitted evidence to the initial investigation and is now in the process of contributing to the 10-year health plan. We will work with our communities and partners over the next few months to help support engagement and ensure that South Yorkshire's voice is heard in this process.

2.2 Integrated Care Partnership Board

The Integrated Care Partnership Board met on 15 October 2024, focussing particularly on the prevention of ill health, which is a key contributor to achieving the bold ambitions of the Integrated Care Strategy.

During the meeting we heard how cardiovascular disease (CVD) causes a quarter of all deaths in the UK and is the largest cause of premature mortality in deprived areas. In South Yorkshire circulatory diseases have the highest impact on inequalities in life expectancy for men and second highest impact on inequalities in life expectancy for women behind cancer. We received an update on the measures being taken to raise awareness of cardiovascular disease, to encourage lifestyle changes to reduce risk and programmes to identify and manage high blood pressure in the community more

effectively.

We also heard from Yorkshire Sport Foundation on the work being done to strengthen our support for increased activity to improve health. Only 64% of South Yorkshire residents are physically active and 1 in 4 do less than 30 minutes of physical activity a week.

We received an update on our aim to reduce smoking to 5% of the adult population by 2030. Since 2016 smoking has fallen from 18% to lower than 14% in South Yorkshire. Nearly 3,000 people have been supported by the SY QUIT programme to stop smoking. However, to meet our aim further action is required and the ICP is supporting the Government's proposals to prevent those under 16 from becoming smokers.

Since the ICP meeting the Government has announced it is planning new legislation to ban the sale of single-use vapes from 1 June 2025. The Government expects this will curb the rise of young people taking up vaping. Vape usage in England grew by more than 400% between 2012 and 2023, with 9.1% of the British public now buying and using these products. The long-term health impacts of vaping are unknown, and the nicotine contained within them can be highly addictive, which is why NHS South Yorkshire welcomes this latest proposal.

2.3 Financial Plan 2024/25

The NHS in South Yorkshire agreed a plan with NHS England for a deficit end of year position of £49m. The deficit funding has now been received from NHSE, so we are now monitoring against a break even plan.

Delivering this plan requires the ICB to breakeven, and now for the provider trusts to breakeven. The total efficiency requirement for the system is £258.5m and within that that are system efficiencies, held by the ICB, but not yet fully attributed to providers or the ICB, of £48.7m, which still require further firm plans for delivery.

At the end of September, the South Yorkshire system reported a deficit of £47m, (after the receipt of 36.3m, the first half of the year phased element of the £49m). The variance against plan was £28.8m and is split £19.1m with the ICB and £9.7m with the provider NHS trusts.

The South Yorkshire system is progressing plans to save the additional £48.7m as required. We are working with external consultants as part of the NHSE investigation and intervention process. This includes improving efficiency in elective and non-elective care, workforce, estates and non-pay spend. The Acute Federation, MHLDA Alliance and our four place partnerships will continue to play an important role in identifying and implementing schemes, with the expectation that some of these will also deliver savings in future financial years.

2.4 Primary Care Network (PCN) Pilots

NHS South Yorkshire is one of seven participating ICBs in the National PCN Test Site Programme. The Programme's overall objective is to support the sustainability of general practice by better understanding how current resources can be used to meet

demand, the nature of any demand gap and how this demand can be met.

Four of the 21 participating PCNs, which are GPA1, Townships 1 and Sevenhills in Sheffield and Rother Valley South in Rotherham, are based in South Yorkshire. The PCNs are currently undertaking a series of Audit weeks to ensure a baseline before testing a series of additional interventions throughout 2025. These will include additional capacity designed to address issues such as on the day demand, continuity of care and the primary/secondary care interface. The PCNs will then re-audit to analyse and evaluate the impact of these interventions to inform future General Practice contract reform.

South Yorkshire has had good support from our Local Medical Committees for the programme and will ensure learning is spread across all 36 Primary Care Networks in South Yorkshire.

2.5 Audiology services at Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Temporary changes have been made to the Adult and Children Audiology services delivered by Doncaster and Bassetlaw Teaching Hospitals (DBTH).

A National Paediatric Audiology Improvement programme was commenced in 2023, which had followed an NHS Lothian Paediatric Audiology Service Review in 2021. The programmes aim was to establish the scale of issues in paediatric hearing services across the NHS in England and oversee the development of strategic interventions and solutions that improve quality of care, patient safety, and clinical outcomes for those with hearing difficulties.

A South Yorkshire quality oversight group, working with NHS England regional colleagues, has overseen reviews of trusts identified through an initial self-assessment with follow-up visits by subject matter experts. It was this programme that identified further action was required at DBTH. Partners across South Yorkshire have since been working with the Trust, including NHS Nottingham and Nottinghamshire ICB, and a decision was made in October 2024 to temporarily limit some of its diagnostic activities and hearing aid services for both adults and children as part of a broader improvement plan.

This will enable the Trust to make the necessary improvements to its service. During this period, urgent cases will be prioritised, and mutual aid from partner hospitals will be sought as required.

DBTH will continue to provide some hearing aid repairs, counselling for tinnitus clinics, and certain diagnostic tests, such as Auditory Brainstem Response. It is anticipated, if the improvements proceed as planned, that the service will resume in 2025.

At the time of writing no patient harm has been identified. DBTH in line with their duty of candour have spoken and written to all families to seek consent for their child to be recalled for a follow up appointment at another provider in South Yorkshire. The Trust has apologised for the long waiting times, cancellation of appointments and other disruptions faced by patients and families recently and historically. A full report has

been taken to the Board of Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust this month.

2.6 Cheswold Park Hospital

On 1 October adult secure mental health services provided at Cheswold Park Hospital in Doncaster transferred to South West Yorkshire Partnership NHS Foundation Trust. The hospital, a 112-bed unit, was rated as inadequate by the Care Quality Commission and this led to the service becoming clinically and financially unsustainable.

Riverside Healthcare Ltd, the previous provider, shared its intention to leave the adult secure mental health sector. NHS England subsequently asked the Trust to take over the services provided from the hospital. Following a due diligence process this was completed and the Trust will now be running the hospital and its services. This will ensure the continuity of these adult secure mental health services in South Yorkshire, and that service user care in the local area will be maintained.

The Trust's main priority is to ensure the continuity of quality care for the current service users at Cheswold Park Hospital and supporting the wellbeing of its staff. The Trust are working collaboratively and with compassion to ensure that service users, families and carers feel safe, supported, and involved. There is still a large programme of work needed to support the hospital, with many challenges remaining, but brining the hospital into the NHS is the first step into securing the future of the service.

2.7 Winter and Flu and Covid Vaccination Campaigns

Our winter plans were approved at the South Yorkshire Urgent and Emergency Care Board on Monday 14 October. Our plans include oversight of quality and safety of the system through the System Coordination centre, which is staffed seven days per week and has in place Opel frameworks/dashboards to ensure the system has oversight of the pressure points in the system and can then act accordingly. We also have operational and surge planning to prepare for different winter scenarios, ensuring that the Joint Escalation Action Plan, divert policy and full capacity protocols are up to date.

We are ensuring high-impact interventions are in place where required, such as respiratory hubs, same day emergency care centres, Virtual wards, community beds and crisis response teams. In addition, partners are working together across all parts of the system, especially through care co-ordination hubs and system wide discharge plans. We're also supporting our workforce to address staff fatigue caused by ongoing pressures from winter demand and to ensure adequate staffing levels across all care settings.

Providers across South Yorkshire have made a strong start to the Autumn and Winter Flu and Covid Vaccination campaigns. Over 300,000 Flu vaccinations have taken place so far, which is 35% of the eligible population, and performance is particularly strong in some of the most vulnerable groups. These include residents over the age of 65, of which 60% are now vaccinated, and care homes residents, of which 64%are now vaccinated. The rates of children and young people being vaccinated in schools is also higher than this time last year.

Over 140,000 covid vaccinations have taken place since the programme began on 3 October 2024, which is 32% of eligible population. The programme is again targeting the most at risk residents in care homes and immunosuppressed patients as well as frontline health and care workers. Both programmes are using access and inequalities projects including vaccinations from respiratory hubs and pop-up walk-in clinics across our places. All eligible groups are encouraged to take up the opportunity of vaccination to project themselves and others during the winter months.

2.8 General Practice Collective Action

A contractual dispute between the Government and the British Medical Association, representing GPs, continues and the ICB is working hard to plan for disruption and to mitigate this where possible. The nature of the collective action means that the impacts will vary at different GP practices and area by area. The BMA are asking GP partners to take at least one of nine possible actions. None of the options breach the GP contract and actions range from withdrawing from data-sharing agreements, to writing referral letters in place of preferred hospital referral form.

The ICB is in regular dialogue with our Local Medical Committees and is collating all known impact of the action in order to mitigate wherever possible. We are also ensuring regular updates are reviewed with secondary care providers in the area. The NHS is asking the public to come forward as usual for care during collective action. Patients with an appointment at a GP practice, should attend as usual unless told otherwise.

3. NHS South Yorkshire

3.1 Freedom to Speak Up

NHS South Yorkshire is using November 2024 to have a specific focus on Freedom to Speak Up. The NHS People Promise commits to ensuring that “we each have a voice that counts, that we all feel safe and confident to speak up and take the time to really listen to understand the hopes and fears that lie behind the words”. All NHS organisations and others providing NHS healthcare services in primary and secondary care in England are required to adopt this national policy as a minimum standard to help normalise speaking up for the benefit of patients and workers. Its aim is to ensure all matters raised are captured and considered appropriately.

At NHS South Yorkshire we welcome speaking up and we listen. By speaking up at work our staff are playing a vital role in helping us to keep improving our services for all patients and the working environment for them.

3.2 NHS Oversight Framework Support Segment

The NHS Oversight Framework sets out how NHS England segments integrated care boards based on the level of support needed across the themes of quality of care, access and outcomes, preventing ill-health and reducing inequalities, people, finance and use of resources and use of resources, and leadership and capability. The segmentation reflects the complexity of the issues each ICB faces.

NHS South Yorkshire has recently been moved from segment 2 to segment 3, which has primarily been driven by the financial challenge the system currently faces. As has previously been reported, the ICB is receiving support from NHS England's Investigation and Intervention programme to support this.

In addition, we need to make further improvements in elective waiting times, ambulance handovers and mental health out of area placements. We will continue to work with NHS England, using this additional oversight and support, to work towards returning to segment 2.

4. NHS South Yorkshire Place Updates

4.1 Sheffield

Opt-out blood borne virus testing has started at Sheffield Teaching Hospitals' A&E Department. People aged 16 and over who receive routine blood tests when they attend Sheffield's Northern General Hospital A&E department are being tested for HIV, hepatitis B and hepatitis C, regardless of symptoms, as part of a new Government scheme, unless they choose to opt out. More than 56,000 blood tests are carried out in Sheffield's A&E department a year. Thousands of people in England are thought to be living with an undiagnosed blood borne virus without being aware. The routine testing will support earlier detection and diagnosis of the blood borne viruses, saving lives and giving people access to the latest and most effective.

4.2 Doncaster

Doncaster and Bassetlaw Teaching Hospitals has made significant progress in midwifery recruitment and retention over the past three years. The Trust introduced a structured midwifery preceptorship programme, along with support from the pastoral team and practice development midwives, which has seen its largest intake of new midwives to date, with 68 recruits since 2022. The preceptorship programme is designed to help newly qualified midwives transition into practice, provides mentorship and training, helping them build confidence and develop their skills in a supportive environment. Since 2021, the number of midwives at DBTH has grown from 169 to 221.

4.3 Rotherham

A ground-breaking pilot scheme has been launched on the Children's Ward of Rotherham Hospital to support young patients managing chronic conditions such as diabetes, epilepsy, and asthma. This initiative is a collaboration between The Rotherham NHS Foundation Trust, the Children and Young People Consortium, and Rotherham United Community Trust. It aims to significantly enhance quality of life through holistic support beyond medical treatments. Personalised support is provided by trained youth workers who act as mentors and advocates. These professionals guide patients through their diagnosis journey, offering practical advice and connecting them with essential resources, while recognising the challenges faced by young people managing chronic conditions.

4.4 Barnsley

Progress on creating a Health and Wellbeing Hub continued with Barnsley Council agreeing several recommendations to develop the Alhambra Shopping Centre. The Health and Wellbeing Hub will transform parts of the Centre to provide a variety of health and wellbeing services in one convenient town centre location. It will expand the services available at the centre, alongside the retail and leisure businesses. It's estimated more than 100,000 visits a year could be made to the Alhambra instead of Barnsley Hospital. The next step will see planners develop the proposals further over the next 12 months. If the plans proceed as intended, Phase 1 of the development will focus on eye services.

5. General Updates

5.1 Targeted Lung Health Checks

The Targeted Lung Health Checks screening programme started as a pilot in Doncaster in 2021 and then expanded across Rotherham and Barnsley. The programme has recently launched in Sheffield and is expected to significantly expand beyond the 140,000 people in South Yorkshire who have been invited to take part so far.

A Targeted Lung Health Check is a two-stage process in which lung health is assessed. A quick, initial phone call will take place to confirm programme eligibility, and then a respiratory nurse will conduct an assessment with the person over the phone. If the person is deemed to be at a higher risk of developing lung cancer, they will be invited to have a scan that will take a detailed image of their chest and, if a problem is found, they will be referred for treatment.

Since its launch more than 500 cases of cancer have been found to date, with more than 20% being non-lung cancer. Importantly, 75% of cancers were detected at an early stage and three in four of these patients were suitable for curative treatment.

5.2 Work Well

The new South Yorkshire Work Well service to get people with a long term mental health condition or a musculoskeletal condition back into employment, or to keep them in work, has started. South Yorkshire Mayoral Combined Authority (SYMCA), in partnership with NHS South Yorkshire, was awarded more than £3.5m as one of 15 pilot areas across England earlier in the year to deliver a new work and health service. SYMCA will be providing the service in partnership with the South Yorkshire Housing Association.

The new service provides a referral mechanism for employees and employers to ask for the support they need. It provides a health support and assessment service and a single gateway to other support services.

South Yorkshire was selected by the Department for Work and Pensions (DWP) and the Department for Health and Social Care (DHSC) to deliver the WorkWell partnership, as part of the Government’s Back to Work Plan. WorkWell builds on the

successes of SYMCA's Working Win programme that has supported over 6,500 people with a disability or physical and or mental health condition to either start, stay, or succeed in employment since 2018.

5.3 Awards

The Nursing Times Awards were held on 23 October 2024. South Yorkshire colleagues were successful in four of the 25 categories. The South Yorkshire winners were:

- Ann Shuttleworth Rising Star Award: Elaine Blow - Rotherham Doncaster and South Humber NHS Foundation Trust – for a commitment to evidence-based practice, service improvement and the development of care pathways for children with neurodiversity.
- Nurse of the Year: Catherine Harrison - Sheffield Teaching Hospitals NHS Foundation Trust – for the creation of a national course for nurses and allied health professionals, to enable them to deliver care to patients with bleeding disorder and other examples of her commitment to enhancing her specialty.
- Ingrid Fuchs Cancer Nursing Award - Sheffield Teaching Hospitals NHS Foundation Trust – for nurse-led late effects screening service
- Public Health Nursing Award - Sheffield Children's NHS Foundation Trust and Rotherham Doncaster and South Humber NHS Foundation Trust – for the 0-19 research network two-year project to boost research engagement and capacity among specialist community public health nurses and the communities they serve.

In addition, NHS South Yorkshire launched its own Star Awards earlier this year. The recent winners were:

- Danny Bailey, Corporate Services Facilities Manager, September's winner, for his work during the recent office relocations and refurbishments.
- The Medicines Optimisation Rotherham Place Team, October's winner, for the 'Care Home Hydration Project'.

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

Board of Directors' Meeting
10th January 2025

The Rotherham NHS Foundation Trust

Agenda item	P14/25
Report	**Medical Education Report and GMC Training Survey**
Executive Lead	Dr Jo Beahan, Medical Director
Link with the BAF	**U4** We will be proud to work in a compassionate and inclusive organisation that delivers excellent healthcare. **P3** Supporting our people **P2** Improving engagement with our medical colleagues
How does this paper support Trust Values	Paper describes the workplace experiences our Resident Doctors, current report on Education and future plans.
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	NHSE is currently overseeing initiatives to improve the working lives of Doctors in training. Trust Boards are asked to take action and improve the experience of trainees by ensuring the National Training Education Survey and the GMC National Training Survey are treated in the same way as the National Staff Survey with clear action plans and review by Trust Boards. At a recent Educational Quality Interventions visit there was also a recommendation of enhanced board oversight. The Trust has recently appointed Mr Alex Kocheta as Director of Medical Education and along with Debbie Harrison Medical Education manager has produced TRFT 2024 Education Report. The Trust currently ranks top in South Yorkshire for Undergraduate Education. The Education Quality Intervention report is positive with a number of areas of good practice identified. This report encompasses all learners not just medical undergraduates. The GMC National Training Survey ranks the experience of Doctors in Training as 143/230 Trusts Nationwide. The Trust ranks 10th out of 21 Local Providers an improvement from 12th in 2023.Areas of concern and areas of success are identified. The Committee are asked to note concerns relating to sexual safety and undermining. The Trust ranks in the lower quartile for sexual safety. This is a new measure for 2024. There are comments relating to undermining although this score has improved from 70.45% in 2023 to 79.2% in 2024. The National Education Training Survey has recently been running and results will be reported to people committee in due course.

Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	The Quality Intervention Report and Education Report have been presented at ETM and People Committee Action plans and progress against these from the GMC results will be overseen at the Medical Education Committee.
Board powers to make this decision	
Who, What and When (what action is required, who is the lead and when should it be completed?)	Papers presented for information and board oversight.
Recommendations	It is recommended that People Committee review the reports and discusses reporting in future.
Appendices	1. TRFT Education Report 2024 2. Education Quality Interventions Review Report 3. GMC NTS 2024 overview 4. GMC NTS 2024 scores and ranks (published in the Review Room)

The Rotherham NHS Foundation Trust

Medical Education Report 2024

Author: A Kocheta, AMD Medical Education

Date: 17th Sept 2024. Updated 2nd January 2024

For: The Board Meeting 10th Jan 2025.

Introduction

The medical education department at The Rotherham NHS Foundation Trust (TRFT) has a strong, long standing reputation for delivering high quality education at all levels. It is located within the medical education centre at Rotherham General Hospital on level D. The centre comprises several shared offices for the leadership staff, undergraduate team, clinical education team and the Foundation / PeP team. The medical appraisal, medical human resources (HR), research and clinical effectiveness team offices are in close proximity on the same corridor, with a recent expansion of the medical HR team presence. The reception desk at the entrance is fully staffed in office hours each day. Teaching space is provided by the Bardhan simulation suite, clinical education room, three teaching / meeting rooms of various sizes, the Cooper appraisal room and the main lecture theatre. There is a newer undergraduate area at the end of the centre in close proximity to the undergraduate office with seating and computer facilities.

The team is stable with relatively low staff turnover, providing a wealth of experience and knowledge with contacts across the region, deanery and outside. Leadership is provided by the Associate Medical Director for Medical Education and the Medical Education Manager. Each of the main teams has a lead, particularly the undergraduate, clinical education, foundation and library. Each has support staff to assist in the day to day running of the services.

There are changes in medical workforce and educational requirements on the horizon, as will be discussed later. There is a national plan [1] to ‘train, retain and reform’, including an increase in medical student numbers from a current base of 7,500 to 15,000 annually by 2030/31. In 2024, an extra 205 medical students were accepted to undergraduate courses nationally and there is an ambition to expand the number to 10,000 by 2028/29. All three aspects of the plan will have impacts on the medical education department, which will be fundamental in assisting the delivery of these objectives.

[1] NHS Long Term Workforce Plan June 2023
https://www.england.nhs.uk/wp-content/uploads/2023/06/nhs-long-term-workforce-plan-v1.21.pdf

Undergraduate medical education

Undergraduate medical education is headed by Mr Stuart Richards as the Director of undergraduate education and Sam Duke as the Medical Undergraduate Manager. Two administrators support these roles and further support is from an Education & Training Pharmacist and a recently introduced Clinical Education Fellow post, which currently has its second yearly incumbent. The senior clinical educator (Consultant) role in the department very much supports medical student education generally and in the emergency department.
The number of medical students present at TRFT at any one time varies between a minimum of 26 for a fortnight in June and a maximum of over 75 at busier times of the year.

University Quality Assurance visit

The last University of Sheffield Quality Assurance (QA) visit was on 30th July 2024. This was led by the Dean of the medical school, Prof. Mark Strong. Dr. Richard Jenkins, the Trust CEO was in attendance for the feedback session. The formal report is awaited but the verbal feedback on the day was outstanding with Prof. Strong and his team complementing the delivery of undergraduate teaching at the Trust, which compared favourably with other hospitals associated with the medical school. Outcomes were verbally similar to the 2023 student placement evaluation report from which the following is drawn:

- The vast majority of quantitative responses were in the range 8-10 (on a 0-10 scale, with 10 being the maximum score)
    - This was across all domains for phase 3b students (17 responses).
    - Across all domains except 'I was expected by the ward team/staff' (7/10) for phase 4, final year, students (56 responses).
- For the 45 responses from phase 2b LICP1 students, the average score was lower at 7.3 / 10 across all domains. There were no marks below 6/10.
    - Lower marks were given for domains of organisation of the ward for students, learning environment and support, bedside tuition and opportunities for students to see unselected cases and present findings.

The feedback for 2024 seems to have improved for the earlier phase students, helped by the introduction of a clinical teaching fellow and a specific bed-side teaching quality improvement innovation aimed at addressing these student concerns specifically.

Postgraduate medical and dental education

The Foundation Year doctors are looked after by the Foundation Training Programme Director, Dr Amar Joshi and a foundation administrator. Currently we have 28 Foundation year 1 posts and 21 Foundation year 2. The Consultant Senior Clinical Educator role supports education of the Foundation Years doctors in particular as well as providing educational, simulation and pastoral support across the board.

There are a number of Core trainee (CT) posts across medical and surgical specialties and Specialty trainee (ST) posts at the next tier. A recent ESR query [2] revealed 34 core trainees and 67 Specialty trainees with a further 88 recorded as GP STs rotating through the Trust. Seven dental core trainees were recorded with a further 19 other dental officers and Trust dental staff. 113 locally employed doctors, specialists and associate specialists were also recorded on ESR.

Specialty college tutors within the Trust are responsible for the initial point of contact with the CTs and STs but are also responsible for educational and pastoral matters across their domains, which may include more than one department or specialty, e.g. the surgical college tutor. The tutors work in conjunction with the PGME department as well as the specialist training rotations on educational matters.

Quality measures lie mainly with the GMC training survey for doctors only and the NHS England National Education and Training Survey, which takes data from all healthcare professionals.

GMC national training survey

For those specialties where less than three respondents, no data are recorded.
In general there has been an improvement over the last three years (Table 1) in the overall satisfaction score for the Trust, although this peaked at 78% in 2023 from a low of 52.5% in 2021 during the pandemic. There has been a drop in 2024 but this remains in the interquartile range.

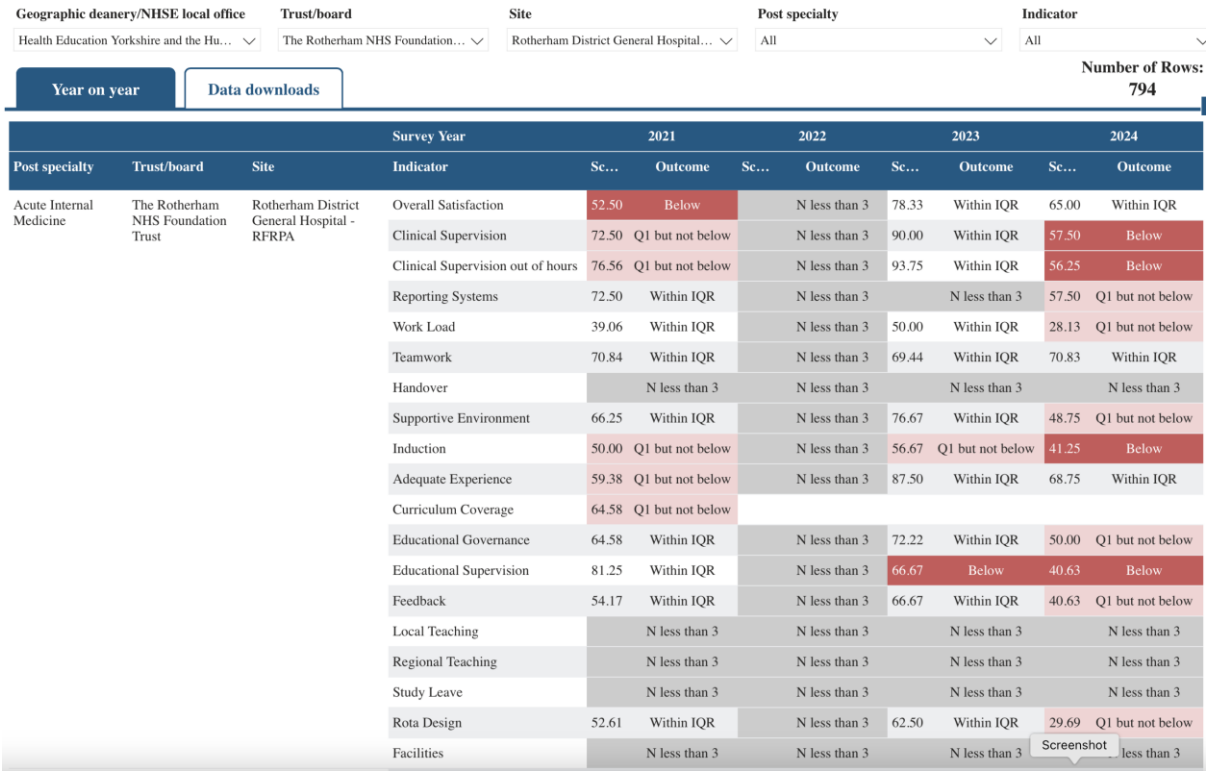
Domains of clinical supervision and educational supervision at TRFT have dropped to levels below the interquartile range for Trusts with a particular drop in educational supervision. This drop is concentrated in a few of the medical subspecialties, particularly: acute internal medicine. Cardiology remains below the range. Geriatric medicine has improved from below to within Q1 in supervision since 2021.
Induction has shown a general decline in performance. This appears to be at a departmental level, rather than the generic Trust induction and is particularly in the surgical specialties. Medicine induction has been improved and induction in emergency medicine and anaesthetics is very good.

The craft specialties have generally shown an improvement in supervision rates and where there is data available, all now at least within the IQR. Paediatrics has shown improvement to within the IQR from being below range in 2022.

Two areas of specific concern were raised to the GMC: one of junior tier understaffing on the acute medicine wards and one of undermining behaviour of nursing staff towards foundation doctors on general surgery wards. Both of these have been addressed with the departments and comments sent back to the GMC.
There are areas of excellence:

[2] Acknowledgement: Thank you to Joanne Freeman for her assistance.

- Trauma & Orthopaedic surgery is marked as an upper outlier in feedback and rota design. The department is in the upper quartile for handover.
- Paediatrics is in the upper quartile for educational governance.
- Obstetrics & gynaecology is an upper outlier in teamwork and educational governance.
- General surgery is an upper outlier in facilities.



Geographic deanery/NHSE local office: Health Education Yorkshire and the Hu…
Trust/board: The Rotherham NHS Foundation…
Site: Rotherham District General Hospital…
Post specialty: All
Indicator: All

Year on year | Data downloads

Number of Rows: 794

			Survey Year	2021		2022		2023		2024	
Post specialty	Trust/board	Site	Indicator	Sc…	Outcome	Sc…	Outcome	Sc…	Outcome	Sc…	Outcome
Acute Internal Medicine	The Rotherham NHS Foundation Trust	Rotherham District General Hospital - RFRPA	Overall Satisfaction	52.50	Below		N less than 3	78.33	Within IQR	65.00	Within IQR
			Clinical Supervision	72.50	Q1 but not below		N less than 3	90.00	Within IQR	57.50	Below
			Clinical Supervision out of hours	76.56	Q1 but not below		N less than 3	93.75	Within IQR	56.25	Below
			Reporting Systems	72.50	Within IQR		N less than 3		N less than 3	57.50	Q1 but not below
			Work Load	39.06	Within IQR		N less than 3	50.00	Within IQR	28.13	Q1 but not below
			Teamwork	70.84	Within IQR		N less than 3	69.44	Within IQR	70.83	Within IQR
			Handover		N less than 3		N less than 3		N less than 3		N less than 3
			Supportive Environment	66.25	Within IQR		N less than 3	76.67	Within IQR	48.75	Q1 but not below
			Induction	50.00	Q1 but not below		N less than 3	56.67	Q1 but not below	41.25	Below
			Adequate Experience	59.38	Q1 but not below		N less than 3	87.50	Within IQR	68.75	Within IQR
			Curriculum Coverage	64.58	Q1 but not below						
			Educational Governance	64.58	Within IQR		N less than 3	72.22	Within IQR	50.00	Q1 but not below
			Educational Supervision	81.25	Within IQR		N less than 3	66.67	Below	40.63	Below
			Feedback	54.17	Within IQR		N less than 3	66.67	Within IQR	40.63	Q1 but not below
			Local Teaching		N less than 3		N less than 3		N less than 3		N less than 3
			Regional Teaching		N less than 3		N less than 3		N less than 3		N less than 3
			Study Leave		N less than 3		N less than 3		N less than 3		N less than 3
			Rota Design	52.61	Within IQR		N less than 3	62.50	Within IQR	29.69	Q1 but not below
			Facilities		N less than 3		N less than 3		N less than 3		less than 3

Screenshot

Table 1: Overall Trust-level GMC NTS data

NHSE National Education and Training Survey

There were a reasonable number of responses from TRFT at 75 [3] for a Trust of our size, but clearly this is only a proportion of all of those who could respond. The overall experience mark is good (see table 2). Where lower aggregate marks are found (e.g. facilities, teaching and learning and workload, these tend to be lower across all Trusts but would clearly benefit from more work generally.
There are a few areas where the Trust is in the lower quartile but there are no low-scoring outliners:

- Delivering curricula and assessments (*60.58% vs benchmark of 62.29%)*
- Bullying in foundation years trainees
- Sexual safety in foundation and anaesthetic trainees

[3] NHSE National Education and Training Survey. 2024.

It is not clear from the survey how curricula and assessments are not being fully delivered but this triangulates with the GMC survey results of a reduction in satisfaction with clinical supervision and workload.

There are several responses relating to undermining behaviours (bullying) and sexual safety. These are separate matters but may have some overlap. Sexual safety is a new domain in the survey, so there is no previous trend data but TRFT is in the lower quartile in this domain. Issues in this area are recorded in two specialty areas but particularly in foundation doctors. It is not clear from the data who is undermining sexual safety and could be medical colleagues at various levels, non-medical colleagues, patients, relatives, etc. The same issues and questions relate to undermining behaviour although this has been surveyed previously. The TRFT score has actually improved from 70.45% in 2021 to 79.27% in 2023, where a higher score is less undermining behaviour.

Education quality indicators

Total selected respondents: 3108

Organisation	N	Overall Experience	Bullying and Undermining	Facilities	Induction	Quality of Care	Sexual Safety	Supervision	Teaching and Learning	Teamworking	Workload
Trust											
Mid Yorkshire Teaching NHS Trust	219	66.73%	80.37%	57.59%	80.99%	68.25%	93.61%	67.48%	62.58%	72.77%	54.57%
North Cumbria Integrated Care NHS Foundation Trust	58	69.22%	69.54%	61.11%	81.03%	69.21%	86.21%	65.19%	60.17%	72.41%	60.34%
North Tees and Hartlepool NHS Foundation Trust	75	75.27%	89.33%	70.33%	84.17%	78.27%	96.67%	74.50%	69.83%	78.72%	68.00%
Northern Lincolnshire and Goole NHS Foundation Trust	65	60.48%	76.41%	54.69%	73.08%	68.53%	92.31%	65.29%	55.79%	68.08%	59.23%
Northumbria Healthcare NHS Foundation Trust	90	82.18%	91.11%	75.28%	86.53%	79.34%	93.89%	79.90%	71.96%	83.85%	77.22%
Sheffield Teaching Hospitals NHS Foundation Trust	393	72.48%	80.32%	55.48%	82.73%	74.22%	91.60%	70.50%	61.52%	75.42%	64.25%
South Tees Hospitals NHS Foundation Trust	124	75.32%	84.41%	63.84%	83.37%	76.16%	97.18%	74.78%	67.51%	77.13%	70.16%
South Tyneside and Sunderland NHS Foundation Trust	114	81.20%	86.26%	71.24%	85.20%	79.67%	92.98%	80.61%	72.66%	81.91%	80.26%
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	245	78.82%	82.45%	66.25%	85.36%	77.73%	94.69%	76.10%	69.64%	78.62%	72.04%
The Rotherham NHS Foundation Trust	75	75.78%	84.89%	68.33%	86.17%	76.49%	92.67%	75.67%	64.56%	77.33%	67.33%
York and Scarborough Teaching Hospitals NHS Foundation Trust	162	69.64%	77.57%	57.92%	78.24%	72.92%	93.21%	66.80%	58.92%	73.23%	66.36%

Table 2: Overall GMC NTS outcomes.

On the positive side, TRFT is a high outlier in four areas. Induction in emergency medicine and obstetrics & gynaecology is excellent. Quality of care rated by more junior trainees in anaesthetics and facilities in anaesthetics are rated very highly.

Doctors mess

The doctors mess is well utilised and regarded by doctors in training. Areas for rest and recuperation through the day and night are provided. Services & refreshments including a supply of out of hours meals and snacks are provided from Fatigue & Facilities funding which sits within the PGME budget.

Ongoing professional education and development

Several innovations have been made in recent years to improve ongoing professional development. These include the appointment of a Future Leadership Fellow (FLF) and a Clinical Teaching Fellow. The Trust's education department has been successful again in being granted an FLF fellow at the national commissioning for 2025-26. An excellent appointment to that post had been made recently from 26 applicants. These are one-year posts, which have allowed various innovations, most recently improved bed-side teaching sessions and in the area of neurodiversity. The Consultant senior clinical educator role in the department has been an excellent innovation over the last few years. This role has been crucial in supporting medical student education, simulation and postgraduate teaching and in my view has been crucial in supporting much of the good medical student feedback as well as supporting the leadership and clinical teaching fellows. The role has impacts on faculty development and an important pastoral support role.

Ongoing Consultant and SAS doctor education is crucial for patient and professional safety. The majority of permanent medical staff are trainers and educators of other medical and non-medical staff. There is a specific 'supervisor' role associated with doctors' GMC registration. This certification requires regular top-up training to maintain presence on the register.

Simulation & clinical teaching

The simulation team includes a Consultant / SAS lead and a specialist simulation-trained simulation practitioner. Simulation has become an increasingly important method of delivering education for multiprofessional groups as well as doctors and medical students. The clinical teaching faculty are important supports for the simulation team.

South Yorkshire's only Advanced Trauma Life Support course started in the department in May 2024 with the next scheduled for November 2024. There is a plan to initiate a basic surgical skills course.

Approximately 1,000 learners have been through the Bardhan simulation suite and 1,100 through the clinical skills area [4].

Advanced practice & medically associated practitioners

The postgraduate medical education centre and Bardhan Suite is used extensively for non-medical training and education including nursing, allied health professional, multiprofessional and advanced practice.

The Practitioner's e-Portfolio (PeP), a nationally available advanced practice and non-training doctors' electronic portfolio is administered from the TRFT PGME department. PeP is used by practitioners in primary care, acute Trusts and mental health Trusts. Users are spread around the country and even internationally, including at several of England's largest teaching hospital Trusts.

[4] Education quality intervention review report. Senior leadership engagement visit. NHSE. May 2024.

There is one Physician Associate (PA) working in the Trust but PA students continue to rotate through the Trust with three being currently present. This group is supported by the PGME department.

Library

The medical library has won awards over the years. It is headed by the Library & Knowledge Service Manager, Daniel Park with a team of librarians working with him. The TRFT library is one of two centres in England holding a national collection of clinical librarianship materials. The library team are working hard to increase their support of clinical teams through clinical librarianship and aim to increase their involvement with evidential support for future policies and procedures.
NHSE have recently been through a series of Quality and Improvement Outcomes Framework (QUIOF) meetings. The report is expected by December 2024.

Welfare
The PGME department is a first port of call for all medical students, doctors in training, SAS and locally employed doctors as well as Consultants with welfare issues. The senior clinical educator is a very important role in support and advocacy for those in difficulty. The foundation team and the AMD for medical education and medical education manager are also crucial in supporting doctors in difficulty and liaising with NHSE WTE, training programme directors and college tutors.

Challenges

NHSE staffing
There has been a reduction in support to training programmes from NHSE due to a recruitment freeze. Yorkshire and the Humber Workforce, Training & Education (previously known as the deanery) is running with an approximately 30% vacancy rate. This has placed an increased workload onto Trust PGME services as well as training programmes.

Space / rooms
There is significant pressure on room availability across the Trust and very much so in the primary PGME department training rooms. Rooms are booked via the Bookwise system and are often booked many months in advance. The education rooms are frequently booked out for non-educational meetings. One office has been given over to medical HR, requiring PGME leaders to share an office with a challenge to finding a location for confidential meetings.

Job planning for educational activities
Job plans for senior doctors should include 0.25PA for educational supervision. College tutors usually have 1PA. Other formal educational roles are renumerated through the job plan at agreed levels. Clinical supervisors are not normally separately renumerated at this time.

Maintaining educational supervision status for senior clinicians
A blended course for educational supervisors at the GMC recommended level is made available and expected to be undertaken by educational and clinical

supervisors every five years to maintain their accreditation. This is offered face to face by senior educators in conjunction with the NHSE online material.

Supporting international medical graduates
International medical graduates (IMGs) are becoming an increasingly important part of the workforce who may have individual training needs. A handbook for IMGs has been produced with input from medical education to assist in onboarding IMGs. PeP is offered free of charge to TRFT employees to support educational development and the evidencing of foundation competencies.

Growth in training numbers.
For the academic year 2024/25, there were a total of 12,000 applicants for 7,705 course places with places appearing at university clearing for the first time. There is an aspiration in the 2023 NHS workforce plan to increase medical student places to 10,000 by 2028/29 and 15,000 by 2030/31. Accommodating this huge increase will require a significant change in the way we train and educate as well as a significant resource injection.

Solutions

Healthcare toolbox
Work is ongoing in association with the Information Technology department, information governance colleagues and the library to institute the 'Healthcare Toolbox' app at TRFT. It is expected this will improve departmental induction, IMG on-boarding, communication, access to and use of guidelines, standardisation of practice and engagement across the medical workforce.

Educational appraisal
The trainer faculty requires support and development with refreshing of skills and knowledge at intervals. There are a number of courses offered by the deanery as well as the in-house educational supervision courses to support trainer faculty. The seven professional standard domains set out by the Academy of Medical Educators is included on the new medical appraisal system. This will allow better tracking of educational supervision skills and performance, allowing support to be offered where gaps are noted.

Clinical and Educational Supervision
Recognition of clinical supervision as well as educational supervision in job plans will need to be seriously considered in due course as the administrative burden upon lead clinical supervisors is increasing. A settlement such as a maximum 0.75PAs for educational supervisors in a department with any PA over this being distributed amongst led clinical supervisors where there are more than three trainees in a department may be such a solution.
A regularly repeated supervision training course is made available through the educational centre.

New clinically relevant courses
The clinical education / simulation team are currently in the process of starting a basic surgical skills course in 2025. Along with the ATLS course, this will both be a fundamental in-house provision for craft specialty trainees but also a reputational draw for the Trust and an increase in the nationally recognised course we offer at TRFT. There are no other centres in South Yorkshire offering either of these foundational courses.

GP-engagement courses
With the NHSE focus on a move from hospital to community care, a wider range of courses for general practitioners run by colleagues in the Trust will be critical to both help to maintain and increase community skills and knowledge as well as foster cooperation between the groups as they meet and discuss issues at such events.

Encourage GMC NTS & NHSE NETS survey completion.
Quality feedback as discussed above is crucial in grounding decisions and strategy. These are also part of the reporting system. I note not all of our trainees in the Trust have responded to either survey, which are approximately six months apart each year. It is important that we communicate more with trainees to encourage them to submit responses to gauge our success in improving experience and effectiveness in medical education at TRFT.

The future

Professionalisation of medical educators
There is a definite trend towards professionalisation of medical educators, rather than assuming an educational component in senior doctor's roles. An increasing number of doctors in training are undertaking formal educational qualifications, whether this be a postgraduate certificate in education as part of a future leader fellowship or an individually studied diploma or master's degree. Societies such as the Association for the Study of Medical Education, the royal colleges, trainee representative bodies, etc. are highlighting the importance of educators. The 2023 educator workforce strategy [5], lays the groundwork for this and runs in conjunction with the long-term workforce plan 2023. We will need to consider a strategy for implementation of these along with the projected increase in training numbers at all levels projected over the next 6 years.

New PGME centre / education hub building
The estate of the medical education centre has become inadequate for the number of events being held there. Whilst there was development of the simulation suite and medical student facilities some years ago, since there has been an increased demand, which is difficult to fulfil in our current accommodation. This is also being encroached by other departments. The pivotal role of medical education, recognised in both the NHSE long-term workforce plan and NHSE educator workforce strategy along with the projected doubling in numbers of medical trainees, which will then feed though the training pipeline for 15 or more years, will require not only changes in methods and modes of education but also real estate in which to educate and

[5] Educator Workforce Strategy. NHSE. 2023
https://www.england.nhs.uk/long-read/educator-workforce-strategy/

train. This expanded workforce will require facilities in which to maintain their skills in the long term. A new education centre with expanded space and facilities fit for the middle decades of the 21st century is required.

Increased technical simulation
With the advent of new education and training methods including increased technical simulation before undertaking real-world procedures, virtual reality, augmented reality, low and high-fidelity technical simulation, non-technical skills training, multiprofessional group training, etc. will require dedicated facilities. This newer type of simulation-based training is akin to pilots training in flight simulators before taking the controls of an airliner, with the real prospect of better patient safety along with improved patient outcomes and shorter learning curves in the costly real world. Simulation of procedures and pathways has been shown to reduce implementation time, reduce the real-world learning curve and reduce the expense of implementation.

Teaching hospital status
The undergraduate feedback for the Trust has been consistently excellent over a number of years, thanks to management by the Medical Education Manager, the team in the undergraduate office and clinical education faculty across the Trust. This along with a solid post-graduate education performance and a strong track-record of clinical research within the Trust, gives a springboard from which a very viable application for teaching hospital status should be made [6]. This will require work and the final bestowal of the title is in the hands of the Secretary of State for Health but is, in my view, attainable. The status will improve the ability of the Trust to attract high-performing colleagues across healthcare professions and build further on its reputation for education and research. Putting 'teaching' in the very name of the institution will bring the aspiration for excellence in patient care, staff development, research and a view to the future into sharp focus.

Summary

In summary, the status of medical education at TRFT is in good health. Undergraduate education is exceptionally good and recognised as such by the University of Sheffield. Postgraduate education is recovering from the pandemic but there is some work to do in certain areas to improve the offering further.

The medical education centre staff are stable and highly competent, supporting educational and training faculty across the Trust and across healthcare professions. New nationally recognised courses are coming on line, utilising local and external faculty, increasing the profile and connections of the department and Trust.

Recent NHSE plans to both double the medical training pipeline alongside other healthcare professional education and training will require a strong long-term strategy combined with an increased education real estate resource and professionalisation of the educational faculty.

[6] University Hospital Status. The University Hospital Association https://www.universityhospitals.org.uk/wp-content/uploads/2021/09/University-Hospital-Status-2021.pdf

Acknowledgement

I would like to thank Debbie Harrison, Medical Education Manager, for her assistance in compiling this report.

Education Quality Interventions Review Report

Provider(s) Reviewed: The Rotherham NHS Foundation Trust

Review Type: Senior Leader Engagement Visit

Regional Office: Yorkshire and the Humber
Date of Review: 14 May 2024
Date of Final Report: 30 September 2024

Review Overview

Background to the review

Senior Leader Engagement (SLE) meetings aim to strengthen working relationships with senior leaders, to develop an understanding around the commitment to the education and training quality agenda.

Who we met with

Name	Role
Joanne Beahan	Medical Director
Susan Douglas	Deputy Medical Director
Jon Clark	Director of Medical & Dental Education
Helen Dobson	Chief Nurse/Director of Nursing
Cindy Storer	Deputy Chief Nurse
Nicola Boulding	Associate Director – Medical Directorate
Donna West	Deputy Head of Learning & Development
Debbie Harrison	Medical Education Manager
Sam Duke	Undergraduate Manager
Gerry Lynch	Guardian of Safe Working Hours (GOSWH)
Harjot Khaira	Freedom to Speak Up Guardian
Munazza Shah	Equality, Diversity & Inclusion Lead

Senior Team Feedback Session

Name	Role
Richard Jenkins	Chief Executive Officer
Steve Hackett	Director of Finance
Daniel Hartley	Director of People (HR)

Evidence utilised

2023 National Education and Training Survey (NETS) Highlights
2023 General Medical Council National Training Survey (GMC NTS) Scores and Ranks
2023/24 Placement Tariff Summary
2024 Guardian of Safe Working Hours (GOSWH) Annual Report
2023/24 GOSWH Q3 Report
2023 National Deans' Equality, Diversity & Inclusion (EDI) Report

Review Panel

Role	Name, Job Title
Education Quality Review Lead	Adam Burns, Quality Associate Dean (NHS England Yorkshire and the Humber chair)
Specialty Expert	Lesley Young, Senior Workforce Lead, Nursing & Midwifery Anthony Hann, Education and Contracts Lead Benjamin Chico, Integrated Care Board Link Lyndsay Murden, Nursing & Midwifery Lead (shadowing)
NHSE Education Quality Representative(s)	Sandra Furniss, Quality Coordinator
Supporting roles	Michele Hannon, Quality Administrator Dawn Crowther, Lay Representative

Executive Summary

NHS England Workforce Training and Education Yorkshire and the Humber (NHS England WT&E YH) would like to thank the education and senior leadership team representatives for attending this SLE meeting. The main findings are:

- NHS England WT&E provided an overview of the purpose of the Senior Leader Engagement meeting.

- The trust was commended for its inclusive projects of excellence including engagement from the senior team in addressing bullying and a vision for the organisation to increase numbers and retain quality at a strategic level.

- The trust ranks top in South Yorkshire for undergraduates and the team has worked well to manage an increase in student numbers.

- In line with the NHS workforce plan, the trust will need to take a multiprofessional approach to workforce development. Building stronger educational leadership links between different learner groups was felt to be one area of focus for Rotherham. (Section 1.1)

- The trust was commended for being awarded the Quality Mark for its preceptorship programme and for the work put into 'growing your own' in midwifery. (Section 1.12).

- Informal professional relationships between the Board and the Medical Education Team are excellent and the open-door policy is positive. NHS England WT&E YH would like assurance that there is a formal mechanism for communication to reach the Board as well as the People Committee and recommend that this be further developed. (Sections 1.12, 2.2)

- It was pleasing to see data to support improvements and these link with the NHS staff survey suggesting people are always learning. (Section 2.7)

- The chief nurse is supporting the nurse leadership in health and wellbeing and will continue to work together with Workforce Transformation. (Section 2.7)

Review findings

NHSE Education Quality Domains and Standards for Quality Reviews

Quality Standard	Education Quality Domain 1 Learning Environment and Culture	Requirement Reference Number
1.1	The learning environment is one in which education and training is valued and championed. • The trust is proud to have responded to the difficulties of the last few years and has continued to deliver quality of education. • The trust employed its first teaching fellow and had a positive Quality Assurance visit in 2023. • The trust has overhauled its specialty and specialist (SAS) support and introduced a new Certificate of Eligibility for Specialist Registration (CESR) Lead, a new SAS Advocate, study days, and improved support. • The trust has had approximately 1,000 learners through the simulation centre and 1,100 learners through the clinical skills laboratory. • The trust was accepted as an Advanced Trauma Life Support (ATLS) course centre, which has been a success. • There are ongoing challenges in releasing staff for training, and availability of training rooms and faculty is a challenge. However, the trust has developed an innovative strategy which involves paying registrars as faculty. • Building a sustainable medical workforce and clinical supervision is a priority for the trust particularly in elderly and respiratory areas. The GMC NTS data is improving in medicine, but this area will continue to be monitored. The trust is to receive 4 additional registrar level PDiT in August in medicine. • A future leader specialist trainee 6 (ST6) in psychiatry with an interest in neurodiversity has been working with NHS England on providing resource banks online and has had a poster accepted at the future leader conference and has developed the following: • Medical PDiT raised concerns about not meeting curriculum criteria with regards to attendance at clinics. A system has been introduced for PDiT to book themselves onto clinics to improve attendance. • Working with advanced nurse practitioners (ANP) and advanced clinical practitioners (ACP) to improve training and development and a recent study day will be in the journal for advanced practice (AP).	

	• The clinical fellow and future leader posts are positive for both the trust and the individual and it is hoped this will continue and buying faculty time which eases the burden. • Doctors in difficulty (DiD) is a valued bespoke service and an ongoing challenge which takes time to work through. • The trust needs an associate medical director (AMD) for medical education. A deputy is in post and the job advert will go out at the end of June. • The relationship between PDiT and ACP is a cause for concern, and external comments in the media have not helped. This issue relates to the regulation of Physician Associates (PA) under the GMC causing concerns from PDiT around access to training opportunities.	
1.2	The learning environment is inclusive and supportive for learners of all backgrounds and from all professional groups. **<u>Safe Learning Environment Charter (SLEC)</u>** • NHS England WT&E YH outlined phase 1 of the SLEC project was initially undertaken for midwifery but was launched multi-professionally to include doctors and dentists. Phases 2 and 3 will include: (phase 2) supporting the embedding of the Nursing & Midwifery Council (NMC) Standards of Student Supervision & assessment (SSSA) and (phase 3) coaching models in clinical practice. Both phases will be across all NMC registrants. • The trust has discussed the SLEC and will give it more capacity when an appointment has been made to the combined Nursing/Equality Diversity & Inclusion (EDI) role. • NHS England WT&E YH are keen to know how the trust will embed the Safe Learning Environment Charter (SLEC) and offer support to the trust if needed.	
1.7	All staff, including learners, are able to speak up if they have any concerns, without fear of negative consequences. **<u>Freedom to Speak Up (FTSU)</u>** • The trust was able to increase the hours for the FTSU guardian role. A clinical lead is now in place who has a safety background, providing good triangulation. • Reporting decreased but was triangulated against the staff survey and national data showing that reporting at the trust is still higher than the national average. • Reports are mainly about attitudes and behaviours. It is hoped the new guardian will increase the number of reports in clinical concerns. • NHS England WT&E YH stated that the reduction in reporting is a slight concern even though it was triangulated. • The trust has other routes to raise concerns, including an open-door policy.	

- The FTSU policy and processes are being renewed to fit in with national guidance.
- There is a new preceptorship lead for nurses providing a visible leadership approach, with both the guardian and clinical lead attending the board.
- NHS England advised that regionally there is a lack of NETS data on bullying and harassment, racism and sexual safety. This is due to the data on patient and staff inappropriate behaviours not being separated in NETS.
- The trust has signed up to the Sexual Safety Charter and is making good progress on its implementation.
- Trust executives are involved in the Violence and Aggression Charter and there is a feedback loop. There have been 4 cases in 6 months of staff being physically abused. Following such incidents the executive team meets with individuals concerned to offer support and listen to their views.
- The trust has a zero tolerance to physical, verbal, and racist abuse, and some staff have body cameras which act as a deterrent to abusive behaviour and help them to feel safer.
- The trust has 3 networks: black, Asian, minority ethnic (BAME), lesbian, gay, bisexual, trans, queer+ (LGBTQ+) and a disability network which the FTSU guardian attends.

PARE feedback

- NHS England WT&E YH advised that overall feedback was positive and has improved.
- Most submissions were green and positive with a small number of reds (6.5%).
- Positives included good examples of patient care, not experiencing bullying and harassment by other staff, not being expected to do tasks unsupervised, not witnessing bullying and harassment and staff being friendly and supportive.
- The bottom 5 were common themes with other trusts and included: feedback, access to groups and forums, and IT which are not unfamiliar.
- There were a couple of comments about students being used in the numbers. NHS England reminded the trust that, as students are now consumers and paying for their roles, it is about being mindful that they are there for a learning experience.

NETS/GMC NTS feedback

- NHS England stated that with regards to NETS for medical learners, the main issues are around medicine which has been mentioned previously. It was acknowledged that feedback did improve in the last survey.
- NETS had low submission rates and NHS England asked that when NETS comes out in autumn if the trust could

	promote it as an opportunity for learners to voice their feedback in an anonymous way.	
1.11	The learning environment provides suitable educational facilities for both learners and supervisors, including space and IT facilities, and access to library and knowledge services and specialists. • In May 2023 the trust lost both the library and knowledge head of services and £100,000 of funding. The new head of services has worked hard on staffing and value-added services to counteract this and, although reduced, it is a sharper and more focused tool than previously.	
1.12	The learning environment promotes multi-professional learning opportunities. • The trust has gone from strength to strength with its links with universities and the postgraduate programme. • There is a robust education workforce team which has put in some temporary bedside education posts and 1:1 support for individuals. • The trust has been awarded the Quality Mark for its preceptorship programme. • There is multidisciplinary training and simulation training in midwifery which includes skills and drills etc. • The trust is heavily invested in local leadership and links with the Royal College of Nursing (RCN) Nightingale leadership programme. • This is the only trust in the region where the medical director's office and chief of nursing have been awarded Generic Instructor Course (GIC) accreditation. • The trust has a Quality paper linked to safe staffing which goes to the Quality Committee and wider board, and the information is triangulated back to outcomes. • The trust has e-portfolios in place and is working to maintain national links to maintain awareness of any national issues that should be addressed. • NHS England queried what the trust's overall strategy was with regards to feedback from any profession and how this was escalated to board level. The trust advised it has an open-door policy with the medical director who takes feedback seriously and attends most Junior Doctor Forums (JDF). For nursing, there is a similar arrangement with the deputy chief nurse leading on the education and training portfolio and a new AHP Forum was put in place in April 2024. • NHS England queried if the trust had thought about how to bring these groups together to share best practice and learning. The trust advised it has a new lead ACP who works	

	with the medical side. The Deputy DME supports the forum in the background and other consultants are also involved.	

Quality Standard	Education Quality Domain 2 Educational Governance and Commitment to Quality	Requirement Reference Number
2.1	There is clear, visible and inclusive senior educational leadership, with responsibility for all relevant learner groups, which is joined up and promotes team-working and both a multi-professional and, where appropriate, inter-professional approach to education and training. **<u>Guardian of Safe Working Hours (GOSWH)</u>** • The trust lost 33 PDiT days to industrial action in 2023. • Over 400 exception reports were received in 2023; 333 from medicine. 23 reports related to education and the others for hours or connected to hours (e.g. service support, missed breaks). • The trust has a focus on medicine as work intensity is high and foundation often flag up that it is 'unsafe'. • The seniors in orthopaedics are in grievance with the trust, but rotas are being reviewed and should be resolved. • In 2022 there were 23 reports around missed opportunities which flag on the system immediately as a safety concern and are discussed with the DME or MD and at the JDF. Triangulation with the Datix system showed 7 related to lack of staff but all were graded as 'no harm' incidents. • The trust is pleased with how the medical division has engaged with concerns and meets with trainees where issues can be addressed immediately. • The trust has had to flag up fines in the medical division. • The rota is 47.25 hours so if PDiT work an hour a week later, they will be in breach but a reduction of hours of rota to 47 should resolve this. • There was a hotspot on one ward, but a floating trainee and consultant presence has improved things. • Job adverts are out for acute medicine and elderly medicine and a higher speciality PDiT from August. • The JDF has excellent attendance with between 10 and 30 attendees. Discussions are typically around rotas, operational opportunities, IT and equipment issues, induction of locums and access to systems.	
2.2	There is active engagement and ownership of equality, diversity and inclusion in education and training at a senior level. **<u>Equality Diversity and Inclusion</u>**	

	• In nursing, the EDI lead left their post in 2023 and the structure has changed into a new combined role. • The NHS Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) reports are monitored through the People Committee, which reports to the executive board. • For International Medical Graduates (IMG) the medical director has developed a specific induction and wraparound pastoral care, providing support about accommodation, local banks etc. and the welcome pack is well received. • There is a new head of organisation, inclusion and wellbeing which has strengthened the EDI offering. • The launch of the new People and Culture Strategy includes the EDI agenda, creating a more joined-up approach. • Staff networks feed into the Educational Operational Group for triangulation and alignment. • The trust drives teams to come together on EDI and emphasises this across all teams for protected groups. • NHS England advised that there is a golden thread of EDI running through the SLEC and it includes a great tool to benchmark which is very useful.	
2.5	The placement provider can demonstrate how educational resources (including financial) are allocated and used. **NHS Education Contract/Tariff Allocation** • NHS England advised that we are expecting the tariff document for 2024/25 but budgets are not yet approved. The Education Funding Agreement is also due out shortly. • Contracts were terminated at the end of March with transition and the financial rules and regulations changed and were split into commercial and non-commercial. • The tuition elements will go out to tender. • NHS England advised that there was concern that a large proportion would be under commercial law, but the Education Funding Agreement will cover this. • A small number of areas will need business cases, but a transitional plan will be in place for the first year. • NHS England queried if the trust has a vision for using tariff and if there is education time in job plans. The trust advised that it has a very close relationship with the finance team and a good understanding of money for postgraduate medical education (PGME). • The trust has medics on the PGME books as faculty, college tutors etc. and is constantly providing feedback to universities via the Self-Assessment (SA). • The trust has become income-generating with the ATLS course and other courses. The income goes towards buying new kit, such as surgical specimens and simulation.	

	• For nursing there is a robust process between learning development and workforce, linking to a training needs analysis so it is allocated appropriately. The trust is looking at a policy on study leave so that it is mandated on service needs rather than personal needs. • NHS England queried how the tariff was utilised from a nursing, midwifery and AHP perspective. The trust advised it has 2 practice learning facilitators, one for nursing and one for AHP, who are responsible for running the training programme. There is a good number of Practice Assessors, Practice Supervisors and a network of people who support this. • Following an NMC inspection, the trust developed a Standard Operating Procedure (SOP) to support students in practice and how the tariff goes into that structure. • NHS England would like to see greater links between finance and education teams. There should be strong oversight of the educational funding agreement.	
2.7	There is a clear strategy, involving working with partners, to ensure sufficient practice placement capacity and capability, including appropriately supported supervisors. **Workforce Transformation** • The NHS staff survey shows the trust is performing well across all domains and it is particularly good to see the "we are always learning" domain showing improvement in every aspect. • The trust is within the regional average for leaver rates. • The South Yorkshire Education Delivery Group is co-chaired by the strategic lead for education, learning and staff development at Sheffield Teaching Hospitals and NHS England WT&E YH and is about how upskilling can be enabled, with the agenda and priorities identified by trusts. • There is difficulty in the funding stream shifts and it is hoped to get announcement on continual professional development (CPD) soon, considering the workforce development funding is coming to end. • Rotherham has the second highest number of apprentices and support for the levy transfer. • NHS England advised that the trust is fully engaged with ACP training and the Learning Environment Placement Group. • The chief nurse is supporting the nurse leadership in health and wellbeing and will continue to work together with Workforce Transformation. NHS England are keen to receive feedback as to where this can be improved.	

Quality Standard	Education Quality Domain 3 Developing and Supporting Learners	Requirement Reference Number
3.2	There is parity of access to learning opportunities for all learners, with providers making reasonable adjustments where required. • The trust works closely with the HR team, has notification of students with additional needs and looks at placements to understand where adaptations can be made. • Risk assessments are undertaken for each student.	

Good Practice

Learning Environment/Professional Group/Department/Team	Good Practice	Related Education Quality Framework Domain(s) and Standard(s)
Senior Executive Team	Trust executives are involved in the Violence and Aggression Charter and there is a feedback loop. The trust has a zero tolerance to physical, verbal, and racist abuse and some staff now have body cameras which act as a deterrent and help them to feel safer. Following incidents of this type, the executive team meets with individuals concerned to offer support and listen to their views.	Learning Environment & Culture
Medical Education Team	The trust works with doctors in difficulty (DiD) on an individual basis, either with the DME or with individual departments. It is a valued bespoke service.	Learning Environment & Culture
Medical Education Team	For International Medical Graduates (IMG) the medical director has developed a specific induction and wraparound pastoral care, providing support about accommodation, local banks etc. and the welcome pack is well received.	Educational Governance and Commitment to Quality

Glossary

ACP	Advanced Clinical Practitioner
AHP	Allied Health Professional
ANP	Advanced Nurse Practitioner
AMD	Associate Medical Director
AP	Advanced Practice
ATLS	Advanced Trauma Life Support
BMA	British Medical Association
CESR	Certificate for Eligibility for Specialist Registration
CPD	Continuing Professional Development
DiD	Doctors in Difficulty
DME	Director of Medical Education
ECC	Early Childhood Centre
EDI	Equality, Diversity and Inclusion
ER	Exception reporting
FTSU	Freedom to Speak Up
GIC	Generic Instructor Course
GMC	General Medical Council
GOSWH	Guardian of Safe Working Hours
IMG	International Medical Graduate
JDF	Junior Doctor Forum
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer+
NETS	National Education and Training Survey
NHS	National Health Service
NHS England WT&E YH	National Health Service England Workforce Training and Education Yorkshire and the Humber
NMC	Nursing & Midwifery Council
NTS	National Training Survey
PA	Physician Associate
PARE	Practice Assessment Record and Evaluation
PDiT	Postgraduate Doctors in Training
PGME	Postgraduate Medical Education
RCN	Royal College of Nursing
SA	Self-Assessment
SAS	Specialist, associate specialist and speciality
SLEC	Safe Learning Environment Charter

SOP	Standard Operating Procedure
SSSA	Standards for Student Supervision and Assessment
ST6	Specialty Trainee 6
SY	South Yorkshire
WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard
WT&E	Workforce, Training and Education
YH	Yorkshire and the Humber

Report Approval

Report Completed by	Sandra Furniss, Quality Coordinator
Review Lead	Adam Burns, Quality Associate Dean
Date signed	16 July 2024

NHSE Authorised Signature	Jon Hossain, Deputy Postgraduate Dean and Director of Quality
Date signed	13 August 2024

Final Report submitted to organisation	30 September 2024

2024 GMC National Training Survey results

115 trainees responded.

143 out of 230 UK wide Trusts. Improved from 146 in 2023.

Highest ranking indicator – facilities 35th. Lowest ranking indicator – Induction 209th

10th out of 21 local trusts. Improved from 12th in 2023

This is an improvement from 2023, where adequate experience was an outlier.

The survey asks questions in 4 domains with 19 indicators

Domain	Indicator
Learning environment & culture	Handover Rota design Supportive environment Team work workload
Educational governance & leadership	Clinical supervision Clinical supervision out of hours Educational governance Educational supervision Induction Reporting systems
Developing & Supporting learners	Facilities Local teaching Regional teaching Study leave
Delivering curricula & assessments	Adequate experience Curriculum coverage Feedback Overall satisfaction

Areas of concern (combined grades)

Red outliers	
Acute Medicine	Clinical supervision, clinical supervision out of hours, educational supervision, induction
Diabetes	Clinical supervision, team work
Cardiology	Clinical supervision, clinical supervision out of hours, supportive environment
O&G	Induction
Pink outliers	
Acute Medicine	Feedback, educational governance, reporting systems, rota design, supportive environment, workload
Cardiology	Overall satisfaction, local teaching, educational supervision, reporting systems, handover, rota design
Diabetes	Clinical supervision out of hours, reporting systems, handover
Geriatrics	Clinical supervision, educational supervision
General Surgery	Induction
O&G	Feedback, regional teaching
Paediatrics	Induction

Areas of success (combined grades)

Light green outliers	
Paediatrics	Educational Governance

Areas of concern by programme

Red outliers	
Anaesthetics	Adequate experience, overall satisfaction
F1 in Medicine	Clinical supervision, clinical supervision our of hours, work load
F2 in Medicine	Adequate Experience, overall satisfaction, clinical supervision, reporting systems, handover, rota design, team work
GP in Emergency Medicine	Team work
Internal Medicine Training 1	Clinical supervision out of hours
O&G	Regional teaching
Paediatrics	Local teaching, rota design
Orthopaedics	Induction, supportive environment
Pink outliers	
Anaesthetics	Local teaching, regional teaching, clinical supervision, educational supervision
Core Anaesthetics	Team work
Emergency Medicine	Handover
F1 in Medicine	Feedback, educational supervision, induction
F2 in Medicine	Feedback, clinical supervision out of hours, induction

GP in Emergency Medicine	Clinical supervision
GP in Medicine	Clinical supervision out of hours, handover
GP in O&G	Adequate experience, feedback, local teaching, induction
O&G	Feedback, clinical supervision out of hours, induction
Paediatrics	Adequate experience, induction
Orthopaedics	Educational governance

Areas of success by programme

Dark green outliers	
Core Anaesthetics	Work load
ACCS	Study leave, educational governance, rota design, supportive environment
F1 in Medicine	Facilities
GP in Emergency Medicine	Induction, handover
GP in O&G	Educational governance, team work
O&G	Facilities
Orthopaedics	Handover
Light green outliers	
Core Anaesthetics	Handover
ACCS	Reporting systems
F1 in Surgery	Facilities, educational governance

Debbie Harrison, Medical Education Manager, November 2024

Board of Directors' Meeting
10 January 2025

The Rotherham NHS Foundation Trust

Agenda item	P15/25
Report	**National, Integrated Care Board and Rotherham Place Update**
Executive Lead	Michael Wright, Managing Director
Link with the BAF	R2: There is a risk we will not establish ourselves as leaders in improving the lives of the population we serve because of insufficient influence at PLACE leading to increased ill health and increased health inequalities. OP3: There is a risk robust service configuration across the system will not progress and deliver seamless end to end patient care across the system because of a of lack of appetite for developing strong working relationships and mature governance processes leading to poor patient outcomes.
How does this paper support Trust Values	Together: This paper demonstrates how the Trust and partners across both Rotherham Place and the wider system work together in providing patient care and providing mutual support.
Purpose	**For decision** ☐ **For assurance** ☐ **For information** ☒
Executive Summary (including reason for the report, background, key issues and risks)	The purpose of this report is to provide the Board of Directors with an update on national developments, developments across the South Yorkshire Integrated Care Board (SYB ICB) and Rotherham Place. Key points to note from the report are: • The Trust continues to work with South Yorkshire Police (SYP) to tackle violent and aggressive behaviour against colleagues working on the front line at the Trust. SYP continue to attend the Trust on a weekly basis offering advice and guidance in addition to taking forward cases of violent and aggressive behaviour. It is essential that colleagues report violent and aggressive behaviour from service users so that appropriate action can be taken. This is one of the key questions within the NHS Staff Survey, for which the results will be available in early 2025. • NHS England reported on the 19 December that Flu cases in hospital have already surpassed last year's peak as winter infections result in hospital admissions early this winter. Weekly figures published on the 19 December show one in 20 hospital beds are being taken up or closed by a winter bug, with 2,504 general and acute beds alone being taken up by flu patients. This is an increase of almost 40% on the previous week (1,795).

	• Following a three-week inspection in early October 2024, Ofsted and CQC inspectors assessed children's services across Rotherham, looking at arrangements for education, health and social care services for children and young people with special educational needs and disability (SEND) across the borough. There are three possible inspection outcomes in the SEND framework with Rotherham's children's services receiving the highest outcome of: 'the local area partnership's SEND arrangements typically lead to positive experiences and outcomes for children and young people with SEND.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	The Executive Team receives a weekly verbal update covering key Place and South Yorkshire Integrated Care Board (SYICB) level activities in addition to specific papers periodically, as and when required.
Board powers to make this decision	N/A
Who, What and When (what action is required, who is the lead and when should it be completed?)	N/A
Recommendations	It is recommended that the Board note the content of this paper.
Appendices	1. Rotherham Place Partnership Update November and December 2024.

1.0 Introduction

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

2.0 National Update

2.1 NHS England reported on 19th December that Flu cases in hospital have already surpassed last year's peak as patients with winter infections being admitted to hospitals early this winter. Weekly figures published on 19th December show one in 20 hospital beds are being taken up or closed by a winter bug, with 2,504 general and acute beds alone being taken up by flu patients, which is an increase of almost 40% on the previous week (1,795). The weekly figures published on the 19th of December showed that there were a total of 2,629 patients with flu in hospital, including 125 in critical care beds, which was up 90% on the week before.

Staff continue their efforts to protect those most at risk of becoming seriously ill from flu, Covid-19 and RSV this winter with fears around the quad-demic continuing, having now delivered a total of 28.5 million vaccines since the start of September (28,465,824 w/e 15 December).

2.2 Hundreds of thousands of older and frail patients will receive urgent treatment from home this winter, as part of NHS plans to manage additional pressure this winter. Rapid teams based in local neighbourhoods will attend less clinically urgent calls within two hours and treat patients for a range of conditions and issues at home. From falls to diabetes support or people who are suffering from confusion, the nationwide teams ensure that patients are managed quickly and effectively in their home, avoiding a hospital stay but also preventing hospital admissions.

The NHS has been putting plans in place to prepare for the busy winter period, from same day emergency care, live data centres open 24 hours a day and huge vaccination efforts.

More than two fifths (86%) of all Urgent Community Response team referrals are for patients aged 65 or over with the latest data showing that more than two thirds of people (67%) who received an urgent community response team response, was able to get treatment at home, without the need for a hospital attendance.

Hardworking NHS teams have consistently delivered well above the target to respond to 70% of patients within two hours, prioritising patients that require a speedy response, with 85% of patients seen within just two hours in September.

3.0 South Yorkshire Integrated Care Board (SYICB)

3.1 Health and care partners in South Yorkshire are working to improve care experiences for people with eating disorders. The overarching vision is:

- To have a South Yorkshire wide approach which supports individuals who have an eating disorder by bringing hope and belief to their recovery journey
- To provide help and support to them, their carers, family, and friends so they can help their loved ones recover whilst also looking after their own mental health

- To do this by providing a timely and equitable approach that is evidence based, clinically led and patient informed

Preliminary engagement and involvement has been conducted by South Yorkshire Integrated Care System (ICS) from June 2023 to July 2024 to inform the development of eating disorders services and pathways in Barnsley, Doncaster, Rotherham and Sheffield.

Through these initial engagement activities with people who have experiences of eating disorders, a number of key themes have emerged for where improvements could be made. These themes are:

- Access
- Person-centred care
- Service location
- Adult service provision
- Transitions
- Family and/or carer support
- Workforce

Now the SYICB are looking to build on these by collecting wider feedback and experiences by asking people to complete a brief survey. The survey, which closes on 31st January 2025 is open to anyone who has experience of an eating disorder, whether they have accessed NHS services for support or not, and responses are also welcome from family or friends of those with these experiences.

3.2 The Trust's work with the SYB Pathology Partnership is progressing and the relationship is maturing. The Trust has had a key focus on the governance arrangements between the Pathology Partnership, with the Head of Nursing & Governance (Corporate Operations) taking a lead for the Trust. The governance arrangements are becoming embedded and cross-partnership working is progressing. The Head of Nursing and Governance (Corporate Operations) is holding monthly Operational and Governance meetings with senior members of the SYB Pathology Partnership Team.

4.0 Rotherham Place

4.1 The Rotherham Place Board met in November and December and received several updates including a report covering the new Strategic Plan for Rotherham Hospice. This Strategic Plan "Living Life's Wishes" will run from 2024 to 2030. The strategy is about ensuring the continued provision of the very best care and support for patients, their families, and the Rotherham community.

The Chief executive of the Charity also provided an update on the current work of the Hospice including:

- The 2024 staff survey showed a significant improvement in all areas compared to 2020.
- Rotherham Hospice cares for approximately 1700 patients and their loved ones every year.
- The new superstore had opened and a new store and café in Swinton are due for opening in January.
- Around 70% of hospice care in the UK is provided in patients' own homes or care homes.

- At Rotherham Hospice there are 220 dedicated volunteers, a number they aim to significantly grow over their strategic period.
- The Hospice was awarded the best Not for Profit organisation at the un-limited business awards for 2024/25.

It was also noted that further investment was required and there were discussions regarding a funding model and financial challenges going forwards.

4.2 Place Board members received a presentation outlining the details from the independent investigation of the NHS by Professor Lord Darzi. The report focussed on performance of the NHS and the key drivers of performance. In response to the report a National 10-year health plan is expected to be published in May 2025. It is anticipated to outline three shifts which are broadly aligned to Rotherham's current approach. These are:

- Hospital to Home
- Analogue to Digital
- Treatment to Prevention

There are also expected to be a number of areas of focus asked of Places including:

- Vision and actions to deliver governments manifesto
- Public confidence and staff morale
- Shared ownership
- Public/staff/leadership
- Future facing plan
- Local implementation to suit context

It was acknowledged that implementing change with the current challenges around funding will be difficult. However, it is important to bring together a Rotherham plan early. Members agreed to set time aside for a development session to build the new Rotherham plan from January to April with a pause in May to reflect on the national report and discuss any necessary adjustments.

4.3 Rotherham Place Board noted that the Darzi Report specifically mentioned palliative and end of life care (PEoLC), stating that society needs to restart the conversation about how to die well, with dignity, compassion, and preferences respected. In Rotherham work is already taking place on a number of these areas. Rotherham Place Board received an update in relation to the PEoLC transformation programme across Rotherham, there are several initiatives that are ongoing as described below:

- Review of the Fast Track process (workshop Dec 2024)
- Faith Deaths Event (Aug 2024) Main themes being worked on - information, process, communication and education
- YAS / Care Homes Team (TRFT) joint review of ambulance call outs/conveyances etc.
- The Rotherham Hospice Strategy Launched (and new branding)

- TRFT producing an update report twice a year
- New Bereavement Book for families and new staff guide
- ReSPECT Inpatient Audit completed

The Assisted Dying Bill was discussed in Government and passed to committee stage on 29 November 2024. Further decisions are awaited but NHS England (NHSE) have produced a position statement, and also statements and guidance for doctors, nurses and pharmacists.

4.4 Following a three-week inspection in early October 2024, Ofsted and CQC inspectors assessed children's services in Rotherham, looking at arrangements for education, health and social care services for children and young people with SEND across the borough. There are three possible inspection outcomes in the SEND framework with Rotherham's children's services receiving the highest outcome of: 'the local area partnership's SEND arrangements typically lead to positive experiences and outcomes for children and young people with SEND. The local area partnership is taking action where improvements are needed. This means the services will not need to be inspected again for five years. They found 'most children's and young people's needs are identified and assessed quickly and accurately' and they 'enjoy attending a range of mainstream schools and specialist provisions'. The report also highlighted that children and young people are valued and visible in their communities. Praise from the inspectors comes from the collaborative way partners work together to provide support for children and young people with SEND. Partners include Rotherham Council, Rotherham's Integrated Care Board (ICB) and Rotherham Parent Carers Forum. Rotherham Parent Carers Forum was particularly praised for their compassionate approach in advocating for children and young people, working in partnership with services through the Four Cornerstones, Welcome and Care, Value and Include, Communication and Partnership, to influence the culture of how services for children and young people with SEND are delivered and developed in Rotherham.

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

- A process has been established for extracting demographic information including ethnicity information to the reporting layer of the data warehouse. Once this work is complete, we will be able to draw the most updated demographic information from across our Meditech and SystmOne to a reporting table, which will allow us to report most of our performance information by ethnicity and other demographics. Work is also continuing through the contact centre to identify gaps in ethnicity record and ensure that patients who are booked in to our services are approached for this information. The Trust's Business Intelligence team have produced a fully working demographics table now which draws from our latest knowledge across multiple systems to provide the best and most up to date information about patients. This information currently covers ethnicity, deprivation, age and sex, but the plan is to widen to include other characteristics such as language, veteran status and disability status. The data can be matched and

applied to key outcome metrics and will be used to inform development of new dashboards around missed appointments and waiting list management initially

- The Healthy Hospitals team continue to perform well in delivering the QUIT programme alongside other preventative interventions. Over the course of the year, 4,000 patients have had a conversation with our staff about smoking cessation; 1,300 inpatients have been prescribed Nicotine Replacement Therapy and over a thousand have been referred on to community stop smoking services. Now that the QUIT programme has been evaluated and has been demonstrated to be effective in supporting smoking cessation in high-risk groups, the research funding from Yorkshire Cancer Research has been fully allocated. While the SYICB will continue to fund most of our service, there is an ask of all Trusts to contribute around a quarter of the current Trust budget to support the existing programme and to further develop local preventative initiatives from April 2025.

4.6 The Trust continues to work with South Yorkshire Police (SYP) to tackle violent and aggressive behaviour against colleagues working on the front line at the Trust. SYP continue to attend the Trust on a weekly basis offering advice and guidance in addition to taking forward cases of violent and aggressive behaviour. It is essential that colleagues report violent and aggressive behaviour from service users so that appropriate action can be taken. This is one of the key questions within the NHS Staff Survey, for which the results will be available in early 2025.

4.7 Further information in relation to Rotherham Place activity can be seen at appendix 1

Michael Wright
Managing Director
January 2025

Rotherham Place Partnership Update: November/December 2024

Rotherham Care Home Hydration Project takes top prize at 2024 HSJ Awards

A collaborative effort to improve hydration for care home residents in South Yorkshire has received top honours at the 2024 HSJ awards.

NHS South Yorkshire ICB (Rotherham Place) Medicines Management Team and The Rotherham NHS Foundation Trust, Nutrition and Dietetics Team were winners in the **Place-based Partnership and Integrated Care Award** category for their Care Homes Hydration Project.

The Rotherham Care Homes Hydration Project was launched in 2022 to address rising rates of urinary tract infections (UTIs) and antibiotic use in local care homes, after it was discovered that care home residents were 10 times more likely to be dehydrated than residents from their own homes, showing the need for training and support.

By providing education and training to care home staff on hydration interventions, the project successfully improved the hydration in older people, which decreased the number of UTIs, decreased the unnecessary use of antibiotics and even reduced the number of times ambulances were called.

Over 1000 care home staff received face to face training as part of the project which is now expanding across South Yorkshire.

Rotherham Area Partnership is awarded highest rating by Ofsted

Independent inspectors have praised Rotherham's services for children and young people with special educational needs and disabilities (SEND) for their ***'genuine determination across the partnership that all children and young people with SEND are happy, successful and thrive'*** and awarded them the highest rating in their inspection report.

Following the three-week inspection in early October 2024, Ofsted and CQC inspectors assessed children's services, looking at arrangements for education, health and social care services for children and young people with SEND across the borough.

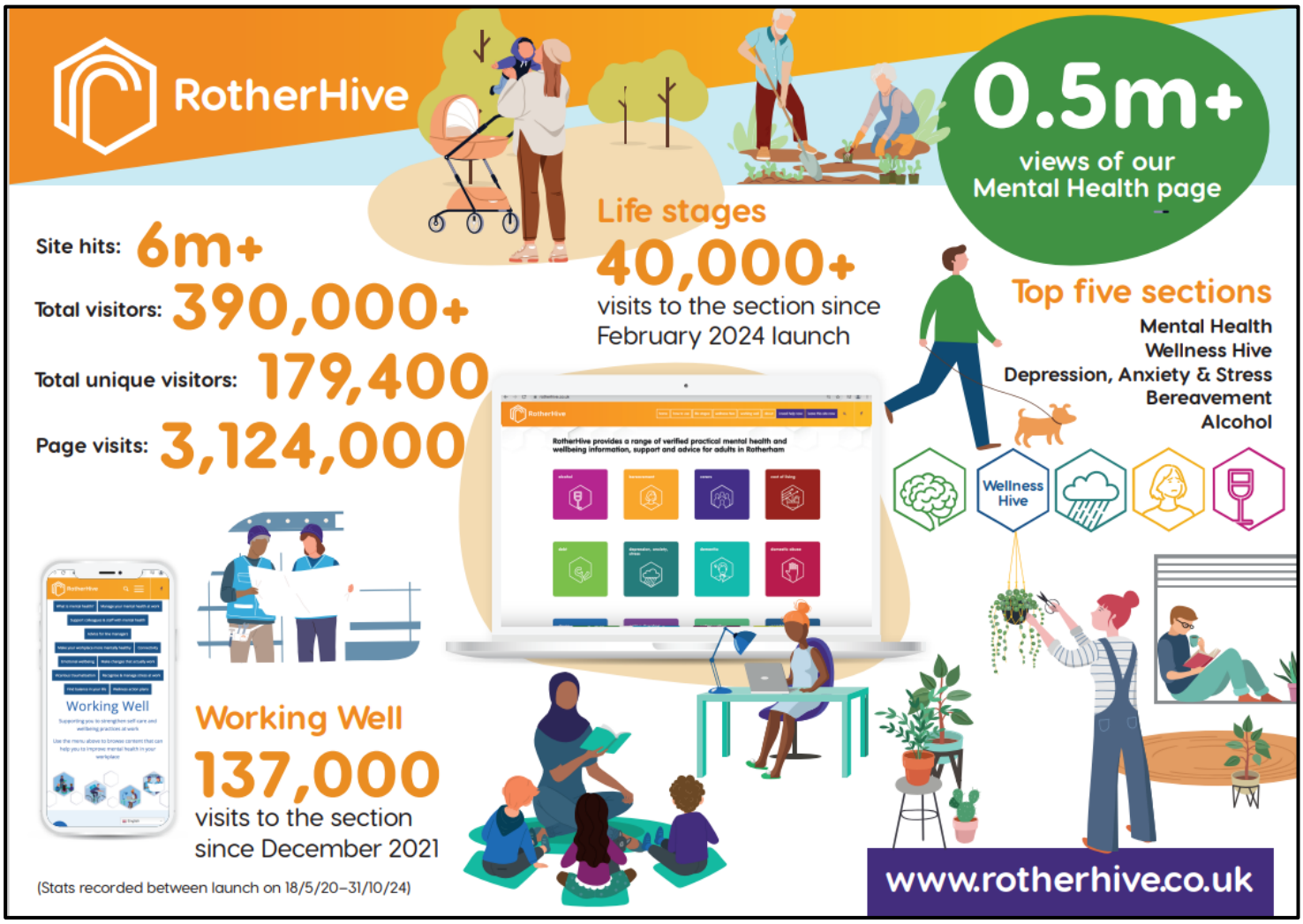
There are three possible inspection outcomes in the SEND framework with Rotherham's children's services receiving the highest outcome of: '*the local area partnership's SEND arrangements typically lead to positive experiences and outcomes for children and young people with SEND. The local area partnership is taking action where improvements are needed*'. This means the services won't need to be inspected again for five years.

They found '*most children's and young people's needs are identified and assessed quickly and accurately'* and they '*enjoy attending a range of mainstream schools and specialist provisions'*. The report also highlighted that children and young people are valued and visible in their communities.

Praise from the inspectors comes from the collaborative way partners work together to provide support for children and young people with SEND. Partners include Rotherham Council, Rotherham's Integrated Care Board (ICB) and Rotherham Parent Carers Forum.

Rotherham Parent Carers Forum was particularly praised for their compassionate approach in advocating for children and young people, working in partnership with services through the Four Cornerstones, Welcome and Care, Value and Include, Communication and Partnership, to influence the culture of how services for children and young people with SEND are delivered and developed in Rotherham.

For further information about services available for children and young people with SEND can be found on the Rotherham SEND Local Offer website.



RotherHive was launched in 2020 originally as a mental health resource, it has since significantly expanded and now provides a range of verified practical mental health and wellbeing information, support and advice for adults in Rotherham.

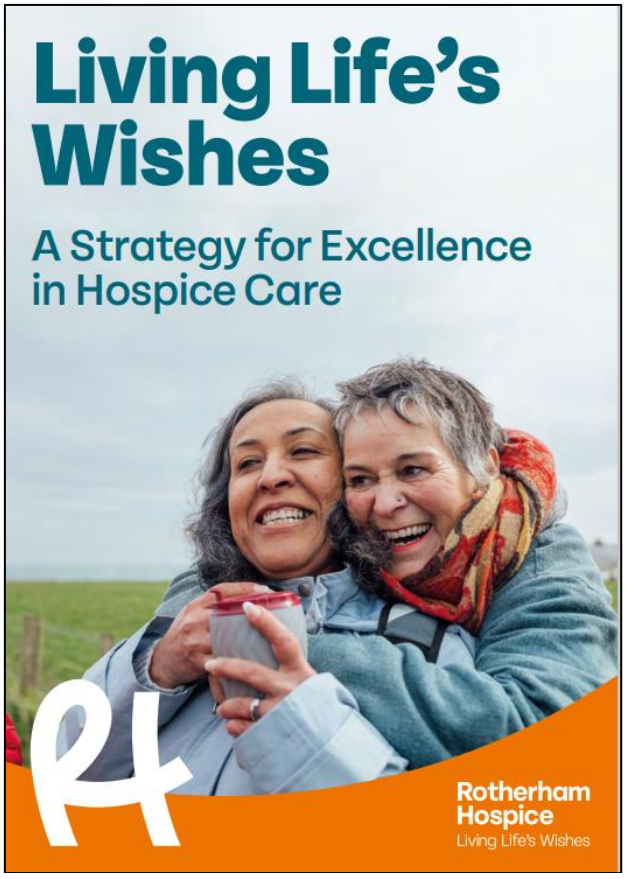
Alcohol	Bereavement	Carers	Cost of Living	Debt	Depression, Anxiety, Stress	Dementia
Domestic Abuse	Drugs	Eating Disorders	Eating Well	Gambling	Homelessness	Mental Health
Moving More	Pain Management	Perinatal	Self-harm/ self-neglect	Sleep	Smoking	Suicide Prevention

The **Rotherhive facebook** page has launched its 2024 Christmas advent calendar. In the lead up to christmas this social media campaign will cover a wide range of topics, such as debt, mental wellbeing, alcohol, self-care, gambling, sleep and coping with christmas.

Why not follow this campaign on the Rotherhive facebook https://www.facebook.com/rotherhive/ and help us share this information as we approch the christmas period.

- **Public Health Peer Review** – positive feedback from the October review included comments on:
  - strengthened partnerships, fully embedded public health intelligence in local health systems at all levels
  - integration of the local public health team with Rotherham health partners as good as seen anywhere
  - JSNA genuinely shaping specific priorities and service development across the local health system and NHS are full partners in the delivery of the H&WB strategy
  - RODA a good illustration of the strength of partnership working and the real trust between partners
  - Good progress in the last year in integrating the public health and planning agenda
- **The Rotherham NHS Foundation Trust were successful in their bid** for funding to support digital developments as part of elective recovery. The bid was for implementation and roll out of Patient Engagement Platform (PEP) and NHS App inpatient and day case appointment management with call agent integration. Well done!
- Congratulations to the **Product Support Team and all Place Primary Care teams** who combined brilliantly to help get all 170 practices enabled with the national service to allow patients to register with their practice online. This enabled South Yorkshire to achieve the 100% target ahead of the December deadline.

- **Vaccination Position**
  - 44.9% of the eligible Rotherham population have been vaccinated
  - 100% Rotherham Care homes visited
  - November Breathing Space session vaccinated 30 chronic respiratory patients
  - TRFT Staff vaccinations – community pharmacy have delivered a number of sessions at the trust alongside their flu team
  - Public vaccination session planned Saturday 11 Jan 10am-12pm at the Good Measure Pharmacy
  - RDASH have vaccinated 2700 staff (2800 target of by the end of the year)



Rotherham Hospice launch their New Strategy: Living Life's Wishes

The brand-new Strategic Plan for 2024-2030: "Living Life's Wishes." is all about ensuring the continued provision of the very best care and support for patients, their families, and the Rotherham community.

Rotherham Hospice opened in 1988 and has been a place of comfort and support for those facing the toughest times. The Hospice has come a long way since then, caring for over 1,700 patients each year and reaching even more through their community services.

Recognising there's always more that can be done they have listened to what the community have to say and used the feedback to shape the strategy.

- Truly personalised care focused on what matters most to each patient.
- Support earlier, right from the point of diagnosis.
- More services that can be delivered at home, so families can stay together in familiar surroundings.
- Inclusivity, be there for everyone in Rotherham community, making sure care is accessible and welcoming to all.

The **seven aims** are:

1. Personalised and Compassionate Care: *creating care plans that are tailored just for the individual.*
2. Early Support and Intervention: *easier access support as soon as you need it.*
3. Inclusivity and Equity: *committed to making services open to everyone*.
4. Strengthening Our Finances: *new ways to raise funds, to keep providing the best possible care.*
5. Innovation and Growth: *looking for better ways to care for patients.*
6. Supporting Our Amazing Team: *investing in staff and volunteers who are at the heart of everything we do.*
7. Raising Awareness: *everyone in Rotherham to know what the hospice can do and how they can help.*

The National Academy for Social Prescribing

published a new report highlighting the measurable benefits of social prescribing. The **Rotherham Social Prescribing Service** is one of the services profiled in the report and mentioned in the press release:

In Kirklees and Rotherham, frequent users of healthcare services saw GP visits and A&E attendances reduce substantially following social prescribing interventions.

The report also suggested that social prescribing can have a positive economic impact. In Newcastle, secondary care costs were 9.4% lower compared to a matched control group where social prescribing was not available. In Rotherham, a pre and post analysis on frequent users reported a reduction in costs up to 39% for A&E attendances.

The full report can be found at this link, Rotherham features on page 16.

https://socialprescribingacademy.org.uk/resources/new-report-shows-impact-of-social-prescribing-on-health-service-use-and-costs/

Academics at Sheffield Hallam University have been evaluating the impact of Rotherham Social Prescribing service since 2013, focusing on the long-term conditions component of the service. The NASP report details the services and impact.

Headline impact on frequent users of health services were identified as:
33%-40% reduction in non-elective inpatient spells
39%-43% reduction in A&E attendances

The Mental Health Community Connectors

service was established in April 2024 as a response to NHS England guidance to improve the physical health care of adults living with severe mental illness (SMI) through improved physical health checks and supported follow-up interventions. The new service was developed with VCS delivering multi-disciplinary approach for people living with SMI and based on social prescribing model.

A key aspect was increasing uptake of SMI physical health checks in primary care, checks include: height and weight measurements, blood tests, medication review, alcohol consumption and smoking status, diet and exercise review, access to screening and vaccinations.

A number of patient voice workshops were held, some of the feedback highlighted:

- A lack of prior information and advice, leading to anxiety and lack of motivation to take up appointments
- Experiences in difficulty making contact and using appointment systems
- On-going mental and physical illness impacting attendance and follow up
- The need for a slow, steady approach to physical health improvements with ongoing support.

The service adapts to individual need, it is not a linear pathway but reacts to peoples needs. It aims to build trusting relationships, raise awareness of different aspects of health and wellbeing, upskill to embed healthy lifestyle behaviour into everyday life, raise feelings of wellbeing, through fostering connections with others, provide a welcoming environment and peer support and enable individuals to attend and complete their physical health checks and follow up interventions.

There have been **218 referrals** into the service from primary care and after three months **100% of service users have improved their ReQol score**. *The Recovering Quality of Life (ReQoL) score is a measurement of quality of life for people with mental health conditions.*

Going forward the service intends to:

- Co-produce physical health check resources
- Map practice level approaches and challenges to physical health checks
- Plan new collaborative approaches between PCNs and Rotherham voluntary sector

National Programme - RCN cadets were hosted for their placement by Rotherham care group - college students with an interest in Health Care were invited via the RCN cadet programme to spend 3 days learning about services, staff and patient stories and have experiential learning opportunities including venepuncture and psychological formulation.

Potential employment opportunities including apprenticeships shared with the cadets as well as practical guidance on completing job applications and interview preparation.

The evaluation from the cadets and NHSE was fantastic, a programme RDASH would like to support again to encourage young people into health care and share the amazing input that RDaSH provides for patients, carers, and staff.

Recognition for the Trauma and Resilience Service (TRS) and the work they have done in partnership across Rotherham Place. To recognise the work done by the Trauma and Resilience Service and their contribution to Operation Stovewood, Julie Godbehere (social worker), Sue Byrne (Mental Health nurse) and Kate Oldfield (Clinical Psychologist) were all awarded individual outstanding contribution awards by the National Crime Agency at the end of November in Sheffield.

They were invited to attend a formal lunch and award ceremony where the trauma informed approach and their multi-disciplinary contribution to Operation Stovewood was spoken about. The Deputy Director of the overall National Crime Agency commended the work of the Trauma and Resilience Service, also suggesting that this should be a national model.

Woodlands you are amazing!!!!! - 1 in 5 children in the country may not receive a Christmas present this year, due to poverty, abuse or being in the care system, many families can't afford gifts without getting into debt. Kind-hearted staff at The Woodlands reached out to the Rotherham Morrisons community champion.

Staff from inpatient wards Glades & Brambles, Crisis Team, Home Treatment Team, Mental Health Hospital Liaison Team, and Admin Team were asked to kindly donate a Christmas gift for a child from the age of 0-18 years so that a child can open at least 1 present this year.

The target of 50 gifts was exceeded with 82 gift bags stuffed with toys and chocolate being donated. Jenny Exley the community champion was overwhelmed when she collected the gifts and couldn't thank staff enough for their generosity. The gifts will be split between Rotherham Social Services and the Rotherham Women's Refuge.

Board of Directors' Meeting
10 January 2025

Agenda item	P16/24
Report	**Finance Report**
Executive Lead	Steve Hackett, Director of Finance
Link with the BAF	D8: We will not be able to sustain services in line with national and system requirements because of a potential deficit in 2024/25 leading to further financial instability.
How does this paper support Trust Values	This report supports the Trust's vision to always ACT the right way and be PROUD to provide exceptional healthcare to the communities of Rotherham by adhering to the core values – (A)mbitious, (C)aring and (T)ogether and focussing on our strategic ambitions: (a) (P)atients - We will be proud that the quality of care we provide is exceptional, tailored to people's needs and delivered in the most appropriate setting for them; (b) (R)otherham - We will be proud to act as a leader within Rotherham, building healthier communities and improving the life chances of the population we serve; (c) (O)ur partners - We will be proud to collaborate with local organisations to build strong and resilient partnerships that deliver exceptional, seamless patient care; (d) (U)s - We will be proud to be colleagues in an inclusive, diverse and welcoming organisation that is simply a great place to work; (e) (D)elivery - We will be proud to deliver our best every day, providing high quality, timely and equitable access to care in an efficient and sustainable organisation. Exercising strong financial management, control and governance is a key component element in the Trust achieving these ambitions.
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	This detailed report provides the Board of Directors with an update on: • Section 1 – Financial Summary for November 2024 (Month 8 2024/25): ○ A summary of the key performance metrics linked to income and expenditure, capital expenditure and cash management. ○ The Trust was notified in September that it would receive £5,718K of national deficit funding. The overall impact is the requirement to improve the 2024/25 planned deficit from £6,302K to £584K

	• Section 2 – Income & Expenditure Account for November 2024 (Month 8 2024/25: o Financial results for November 2024. - A control total surplus to plan of £788K in month and £1,915K deficit to plan 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 £523K). • Section 3 – Income and Expenditure Account Forecast Out-Turn o A forecast out-turn deficit to the planned control total, for the year ending 31st March 2025, of £9,490K. o At this point the Trust will be reporting externally to the ICB and NHSE that it will be delivering its planned deficit as actions are being taken to recover this position, and the use of reserves will enable the Trust to deliver its plan. • Section 4 – Capital Expenditure for November 2024 (Month 8 2024/25) o Results for November 2024 show expenditure of £815K in month and £4,315K year to date against a budget of £5,999K, an under-spend of £1,684K (28%). Schemes are progressing and it is expected that the Trust will spend its full capital allocation. • Section 5 – Cash Flow 2024/25 o A cash flow graph showing actual cash movements between April 2023 and November 2024. A month-end cash value as at 30th November 2024 of £10,145K, which is £4,159K favourable to plan.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	This report to the Board of Directors has been prepared directly from information contained in the Trust's ledgers and is consistent with information reported externally to NHS England. o The overall financial position for I&E has been reviewed collectively by and agreed with the senior Finance Team together with the Director of Finance. o CIP performance has been discussed with the Efficiency Board chaired by the Managing Director. o The capital expenditure position has been discussed and reviewed by the Capital Monitoring Group, chaired by the Director of Finance.

	○ More comprehensive and detailed reports of the financial results have been presented to Finance & Performance Committee and the Executive Team.
Board powers to make this decision	Within Section 4.5 of Standing Financial Instructions – Budgetary Control and Reporting – paragraph 4.5.1 states that *"The Director of Finance will devise and maintain systems of budgetary control. These will include:* *(a) Financial reports to the Board, in a form approved by Finance & Performance Committee on behalf of the Board."*
Who, What and When (What action is required, who is the lead and when should it be completed?)	• Overall financial performance was discussed at the monthly performance meetings on 17th December 2024. • CIP performance was discussed at the Efficiency Board meeting held on 11th December 2024 and it was discussed at the Improvement Group Meeting on 12th December 2024. • Capital expenditure was reviewed at the Capital Monitoring Group held on 16th December 2024. • Detailed discussions have also taken place at the meeting of Finance & Performance Committee on 18th December 2024, including feedback from all of the above. Any issues for escalation from the Committee will be reported at the meeting of the Board.
Recommendations	It is recommended that the Board of Directors note the content of the report.
Appendices	None.

1. Key Financial Headlines

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

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

Key Headlines	Month			Year to date			Forecast	Prior Month
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Variance £000s	FV £000s
I&E Performance (Actual)	(284)	500	784	(715)	(2,661)	(1,946)	(9,522)	(12,372)
I&E Performance (Control Total)	(223)	565	788	(223)	(2,138)	(1,915)	(9,490)	(12,343)
Capital Expenditure	1,060	815	245	5,999	4,315	1,684	0	0
Cash Balance	(671)	(3,491)	(2,820)	5,986	10,145	4,159	0	0

1.2 The Trust has under-spent against its I&E control total in November 2024 by £788K and year to date it has over-spent by £1,915K. 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 £1,358K year to date, it is expected that this will be recovered through additional targeted schemes and from a review to provide assurance that the activity is appropriately recorded and captured.

1.4 The Trust was notified of deficit funding of £5,718K in September 2024, which improves the overall planned deficit for 2024/25 from £6,302K to £584K. Deficit funding has been phased into the plan from September 2024.

1.5 Capital expenditure is behind plan in month and year to date, with cumulative spend of £4,315K against a budget of £5,999K. 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.

1.6 The cash position at the end of November 2024 is £10,145K and is favourable to plan by £4,159K. This is due to the receipts (year to date) for deficit funding, and incremental capital funding.

2. Income & Expenditure Account for November 2024 (Month 8 2024/25)

2.1 The table below shows the financial results subjectively (by type of expenditure). The Trust has delivered a surplus to plan in November 2024 of £788K and a deficit to plan of £1,915K year to date.

Summary Income and Expenditure Position	Annual plan	Month			Year to date			2024/2025
		Plan	Actual	Variance	Plan	Actual	Variance	Monthly Trend /
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	Variance
Clinical Income	347,420	29,719	31,634	1,915	233,293	236,529	3,236	
Other Operating Income	24,984	2,237	2,634	398	16,826	18,596	1,770	
Pay	(243,715)	(21,994)	(23,272)	(1,278)	(163,558)	(173,930)	(10,372)	
Non Pay	(101,538)	(8,920)	(10,338)	(1,417)	(72,111)	(77,992)	(5,881)	
Non Operating Costs	(4,995)	(338)	(323)	14	(2,912)	(2,554)	358	
Reserves	(24,104)	(988)	164	1,153	(12,253)	(3,311)	8,941	
Retained Surplus/ (Deficit)	(1,949)	(284)	500	784	(715)	(2,661)	(1,946)	
Adjustments	1,365	61	65	3	492	523	31	
Control Total Surplus/ (Deficit)	(584)	(223)	565	788	(223)	(2,138)	(1,915)	

2.2 Clinical Income is ahead of plan year to date largely due to the true up position on the 2023/24 ERF of £1,250K, consultants pay reform £800K, Industrial Action funding £604K and Community Diagnostic Centre (CDC) income of £890K. These figures include an adverse year to date position on ERF in 2024/25 of £1,358K. 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 (£803K), which will be an offset to the pay over-spend, and increased research, education and training income (£1,027K).

2.4 Pay costs are over-spending by £10,372K year to date. Bank and agency expenditure is not currently being maintained within the gross establishment budget, and contributing to this is £2,541K under-delivery against the planned cost improvements.

2.5 Non Pay costs are over-spending by £5,881K year to date. The overspend is largely related to Drugs and Clinical Supplies £3,965K, Premises £531K, and under-delivery against cost improvement plans of £1,101K which are offset by under-spends for clinical negligence £306K.

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

2.7 £8,941K has already been released from Reserves year to date, this is to cover the under-delivery of CIP, additional capacity over and above funded bed capacity and Industrial Action impact on ERF.

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 £9,490K deficit to plan.

Summary Income and Expenditure Position	Annual plan	Forecast outturn (Full Year)	Forecast Variance (Full Year)	Actual Variance (YTD)	Forecast Variance	Total Variance	2024/2025 Monthly Trend /
	£000s	£000s	£000s	£000s	£000s	£000s	Variance
Clinical Income	347,420	351,424	4,005	3,236	768	4,005	
Other Operating Income	24,984	27,753	2,769	1,770	999	2,769	
Pay	(243,715)	(260,284)	(16,569)	(10,372)	(6,197)	(16,569)	
Non Pay	(101,538)	(110,752)	(9,214)	(5,881)	(3,324)	(9,205)	
Non Operating Costs	(4,995)	(4,450)	545	358	178	536	
Reserves	(24,104)	(15,162)	8,941	8,941	0	8,941	
Retained Surplus/ (Deficit)	(1,949)	(11,471)	(9,522)	(1,946)	(7,576)	(9,522)	
Adjustments	1,365	1,397	32	31	(1)	32	
Control Total Surplus/ (Deficit)	(584)	(10,074)	(9,490)	(1,915)	(7,576)	(9,490)	

3.2 Within Clinical Income, the estimated ERF YTD under delivery against divisional targets is reflected of £1,358K. No further under or over delivery of ERF is forecast. It also includes the true up of 2023/24's ERF £1,250K, variable income, and income relating to the consultants pay reform which was notified of post plan submission and CDC income of £890K.

3.3 Other Operating Income is forecasting increases in income from research, development, education & training (£1,601K) and staff recharges (£1,404K). 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 £4,238K and premium agency cost FOT variance of £4,505K. Pay is not being managed within budgeted establishment.

3.5 Non Pay costs are similarly showing a significant deterioration in performance linked to continued increasing costs most notably within premises £987K, undelivered CIPs £2,330K, and drugs and clinical supplies £5,885K, which are partly offset by forecast underspends in clinical negligence £452K.

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 £584K. This position assumes that the Elective Recovery Fund and Efficiency targets will be met, 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. Financial recovery meetings are being held monthly with Senior Leaders and Executive Directors to address the financial and operational challenges, and to identify solutions.

4. Capital Programme

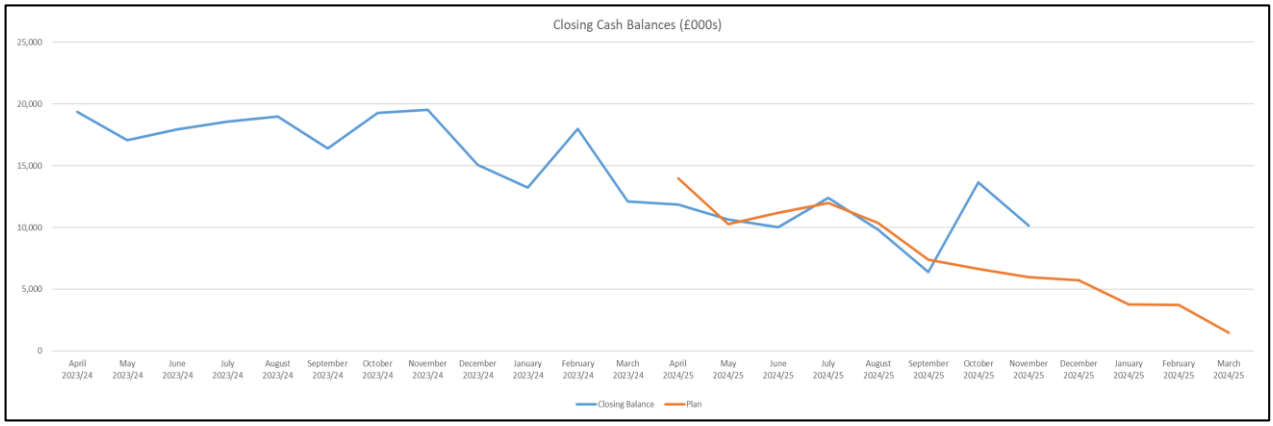
4.1 During November 2024 the Trust incurred capital expenditure of £815K, and year to date it is £4,315K. Schemes are progressing and it is expected that the Trust will spend its full capital allocation.

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	368	195	173	1,977	1,470	507	0	0
Estates Maintenance	474	519	(45)	2,287	1,147	1,140	0	0
Information Technology	171	11	160	1,327	991	336	0	0
Medical & Other Equipment	88	89	(1)	582	707	(125)	0	0
Other	(41)	0	(41)	(174)	0	(174)	0	0
TOTAL	1,060	815	245	5,999	4,315	1,684	**0**	**0**

4.2 The planned capital spend for the year is £11,180K. This includes an additional £30K of capital PDC which has been agreed since the plan submission.

5. Cash Management

5.1 The cash position at the end of November is £10,145K and is favourable to plan by £4,159K. This has allowed the Trust to earn interest on its daily cash balances of £574K year to date.



Steve Hackett
Director of Finance
10 December 2024

Board of Directors Meeting
10th January 2025

Agenda item	P17/25
Report	**Integrated Performance Report**
Executive Lead	Bob Kirton, Managing Director
Link with the BAF	D5, D6, P1, R2
How does this paper support Trust Values	The Integrated Performance Report supports the Trust's *Ambitious* value in ensuring we are constantly striving to deliver stronger performance across all of the core domains.
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	The Integrated Performance Report (IPR) provides a monthly overview of the Trust's performance across four key areas: Operational Delivery, Quality, Finance, and Workforce. This report covers data from November 2024, where available, and outlines performance in relation to established national, local, or benchmarked targets. Statistical Process Control (SPC) charts are used throughout this report. A brief explanation of the main features of these charts is provided at the back for your reference.
Due Diligence	The Finance and Performance, Quality Committee Committees and People Committee have received the relevant elements of the Integrated Performance Report or identical information, with the Executive Directors approving the content for their domain.
Board powers to make this decision	In order to be assured of the performance of the organisation, the Board needs to have visibility of the Trust's performance against core metrics.
Who, What and When	The Managing Director is the Lead Executive for reporting on the performance of the organisation through the Integrated Performance Report on a monthly basis.
Recommendations	It is recommended that the Board of Directors note the Trust's performance against the metrics presented in the Integrated Performance Report and receive assurance on the basis of this report.
Appendices	Integrated Performance Report – November 2024

Board of Directors Meeting

Integrated Performance Report - November 2024

Trust Dashboard

The Rotherham NHS Foundation Trust

Strategic Update

Providing high quality care improving the experience of our patients	• Ward accreditation process complete for all Adult ward, plans in place for Maternity and Paediatrics. • Engagement has started on developing our Quality Priorities for 25/26 • Actions plans have commenced for those areas that show room for improvement in our most recent CQC surveys
Engaging with our people & improving the organisational culture	• The Trust has received its Staff Survey management report and Picker are now processing the remaining reports. National reports remain embargoed until mid-February 2025. • Occupational health services are vital for supporting staff and reducing sickness absence; the trust is currently re-tendering this contract.
Becoming a financially sustainable & productive organisation	• Significant new development approved for UECC £5.5m with MOU due to be signed imminently • While National planning guidance has been delayed, internal service level Demand & Capacity Planning continues to be progressed for 2025/26.
Focus on our operational delivery and improving access to care	• Improvement noted in the RRT position, and the Trust continues to have 0 waits over 65 weeks. • Full review of the existing transformation programme, enabling us to go further faster with a key focus on ENT paediatrics, orthopaedics, gynaecology specialties from January 2025

Patient and Staff Experience

- CQC's 2024 inpatient surveys for Urgent & Emergency Care, and Maternity Service have been published, with positive results.
- Areas in the UECC survey where the Trust scores well in comparison to others; include communicating with patients & families about results, information upon arrival; support after leaving UECC. Maternity Service results were also positive
- Comments from FFT and Complaints are informing future actions plans in those areas where there is room for improvement.

Combined Positivity Score (95.0%)

93.8 ☒

Complaints Rate (8.0)

10.1 ☒

Quality and Safety

SHMI (*As Expected*/100.0)

As Expected ☑

Care Hours per Patient Day (7.3)

6.6 ☒

Patient Falls per 1k Bed Days (0.19)

0.16 ☑

People and Culture

Sickness Absence (4.8%)

6.5 ☒

MAST (85.0%)

90.0 ☑

Appraisal Season Rate (90%)

79.8 ☒

Turnover (8.0-9.5%)

8.6 ☑

Capital Investments

Capital Expenditure (YTD)

£4.3m (plan £5.9m)

- Current spend is £1.6m behind plan but forecast to spend all capital allocation by year end
- Significant new development approved for UECC £5.5m with MOU due to be signed imminently

Finance (YTD, £000s)

Indicator	Plan	Actual
I&E	(223)	(2,138)
CIP	7,201	3,571
Cash balance	5,986	10,145

Operational Performance

A&E 4 Hour Standard (78%)

62.1 ☒

RTT 18 Week Standard (92%)

62.6 ☒

65 Week Waits (0)

0 ☑

DM01 6-Week Standard (1%)

1.0 ☑

Cancer Faster Diagnosis (77%)

80.2 ☑

Cancer 62 Day Standard (70%)

74.6 ☑

For more information on how to interpret SPC summary icons click here.

Performance Matrix Summary

The Rotherham NHS Foundation Trust

Variation	Assurance: Pass	Assurance: Hit or Miss	Assurance: Fail
Special Cause: Improvement	**VERY GOOD: LEARN AND CELEBRATE** • Urgent 2 Hour Response • Mean LoS (Elective) • Turnover (12 month rolling)	**GOOD: CELEBRATE AND UNDERSTAND** • Readmissions • OP to PIFU • 31 Day Treatment Standard	**CONCERNING: CELEBRATE BUT TAKE ACTION** • 1:1 Care in Labour • 65+ weeks • RTT • Appraisal Rates
Common Cause	**GOOD: CELEBRATE AND UNDERSTAND** • SHMI • MAST – Job Specific • Vacancy Rate (total)	**STATIC: INVESTIGATE AND UNDERSTAND** • Care Hours per Patient Day • Complaints (per 10k contacts) • Patient Safety Incident Investigations • Patient Falls (Moderate and above) • Medication Incidents (Moderate and above) – Acute and Community • C. diff infections • Waiting List Size • OP to PIFU • Overdue Followups • DM01 • FDS • 62 Day Treatment Standard • >12 hours in A&E • 12 hour Trolley Waits • Bed Occupancy • LoS >21 Days • Date of Discharge = Discharge Ready Date • Patients on Virtual Ward • First Outpatients (%Plan) • Inpatients (%Plan) • Daycases (%Plan) • LoS >7 Days • Mean LoS (Non-Elective) • A&E Attendances from Care Homes	**CONCERNING: INVESTIGATE & TAKE ACTION** • Breast milk first feed • 4 Hour Performance • Ambulance Handovers >30min • Average time to be Seen • Criteria to Reside is No • Admissions from Care Homes • Clinic Utilisation • Capped Theatres Utilisation • Did Not Attend • Discharged <5pm • Sickness Rates (12 month rolling) • Sickness Rates • Appraisal Rates (12 month rolling)
Special Cause: Concern	**CONCERNING: INVESTIGATE AND UNDERSTAND** • Stillbirth rate • MAST - Core	**CONCERNING:INVESTIGATE & TAKE ACTION** • VTE Risk Assessments • Combined Positivity Score • Pressure Ulcers (Cat 3 and above) – Acute and Community	**VERY CONCERNING: INVESTIGATE & TAKE ACTION** • 52+ weeks

Performance Matrix Summary - Quality

The Rotherham NHS Foundation Trust

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

How to read the ICONs in this report:

Have we achieved in month?

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

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

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

Quality

Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
SHMI	"As expected"	"As expected" (104.0)	**Jun-24**	N/A	P		-	G
Readmissions (%)	-	6.2	Oct-24	-	-	L		GI
VTE Risk Assessments (%)	95.0	94.0	Nov-24	☒	?	L		C
Care Hours per Patient Day	7.3	6.6	Nov-24	☒	?			S
Combined Positivity Score (%)	95.0	93.8	Nov-24	☒	?	L	-	C
Complaints (per 10k Contacts)	8.0	10.1	Nov-24	☒	?		-	S
Patient Safety Incident Investigations	3	4	**Oct-24**	☒	?		-	S
Patients Falls (Moderate and Above per 1000 bed days)	0.19	0.16	Nov-24	☑	?		-	S
Pressure Ulcers Cat 3/4/STDI and Unstageable per 1000 bed days - Acute	0.77	1.32	Nov-24	☒	?	H	-	C
Pressure Ulcers Cat 3/4/STDI and Unstageable per 100 contacts - Community	0.06	0.13	Nov-24	☒	?	H	-	C
Medication Incidents - Moderate and Above per 1000 bed days – Acute	0.05	0.16	Nov-24	☒	?		-	S
Medication Incidents - Moderate and Above per 100 contacts - Community	0.00	0.00	Nov-24	☑	?		-	S
C. difficile Infections	<4	5	**Oct-24**	☒	?			S

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

SHMI: Summary Hospital-Level Mortality Indicator

Data, Context and Explanation

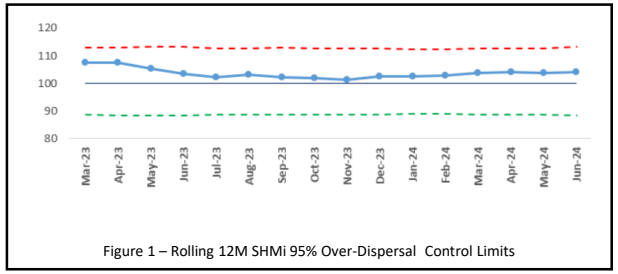


Figure 1 – Rolling 12M SHMi 95% Over-Dispersal Control Limits

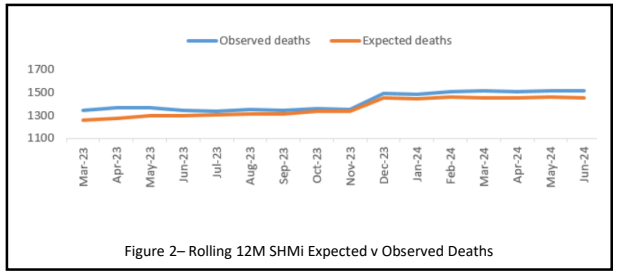


Figure 2– Rolling 12M SHMi Expected v Observed Deaths

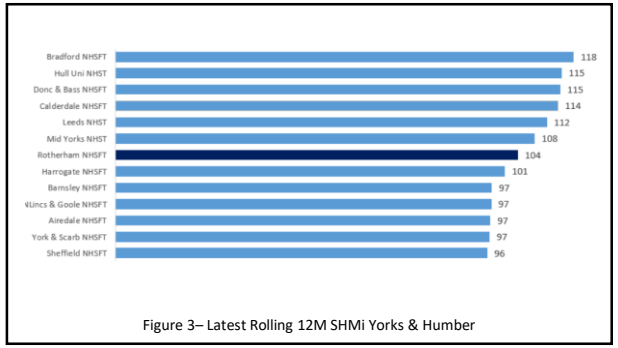


Figure 3– Latest Rolling 12M SHMi Yorks & Humber

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

Covid activity was added back into the SHMI data Dec 2023

- The SHMI reports on mortality at trust level across the NHS in England using a standard methodology. It is produced and published monthly as a National Statistic by NHS Digital
- The SHMI is the ratio between the observed number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated
- 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
- Approximately 50% of England's Trusts will be above 100 and 50% below
- There are 3 SHMI banding, As Expected, Higher or Lower. TRFT's SHMI has consistently been As Expected, since July 2021
- SHMI Bandings are calculated for the Trust overall and 10 diagnostic groups

Metric	Current	Target	Exec Owner	Organisational Lead
Latest Rolling 12 Month SHMI -Jun 24	104.0	-	Jo Beahan	John Taylor
Expected Deaths	1455	-		
Observed Deaths	1515	-		
Trust Banding	Expected	-		

What actions are planned?

- To highlight when SHMI values are in the higher than expected band (95% Over-dispersion Control Limit)
- The Trust Mortality Group will decide on any required investigations/reviews based on the Investigation Pyramid
- This may lead to changes/improvements in practice

What is the expected impact?

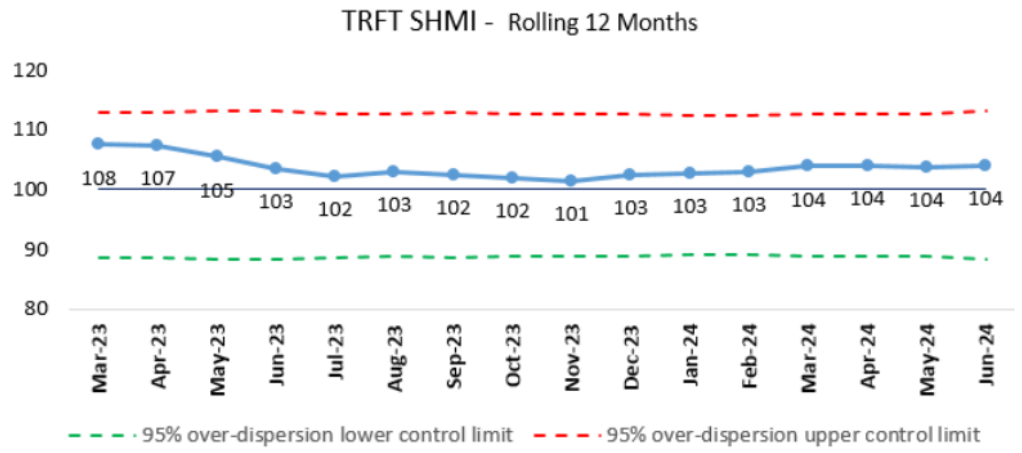
- Investigations or reviews resulting from SHMI investigations will give the Trust Assurance when there are significantly more deaths observed than expected
- Intelligence from SHMi investigations/reviews may lead to changes/improvements in practice

Potential risks to improvement?

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

SHMI: Summary Hospital-Level Mortality Indicator

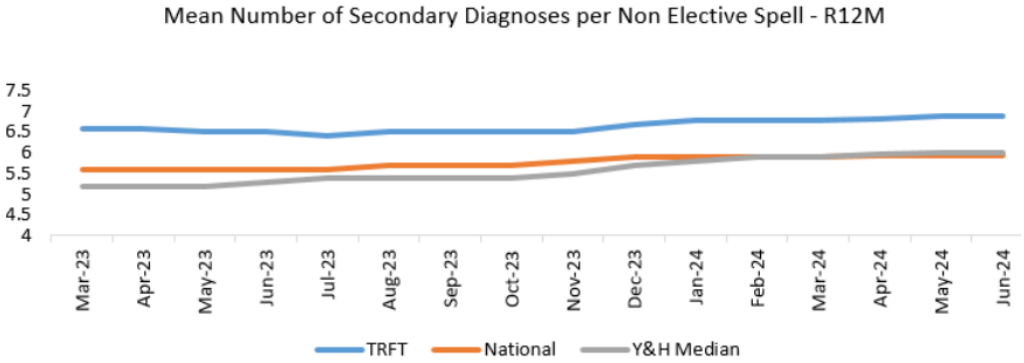
SHMI Update



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 because its effects the calculated expected risk of death % for each inpatient admission.

This chart shows that TRFT's depth of coding for non elective spells has been consistently higher than the National figure and the Yorkshire & Humber median.

TRFT's higher rate is either down to TRFT's casemix having a higher prevalence of co-morbidities or better capture of these co-morbidities.

SHMI: Coding & Alerts

SHMI - Diagnostic Group Alerts

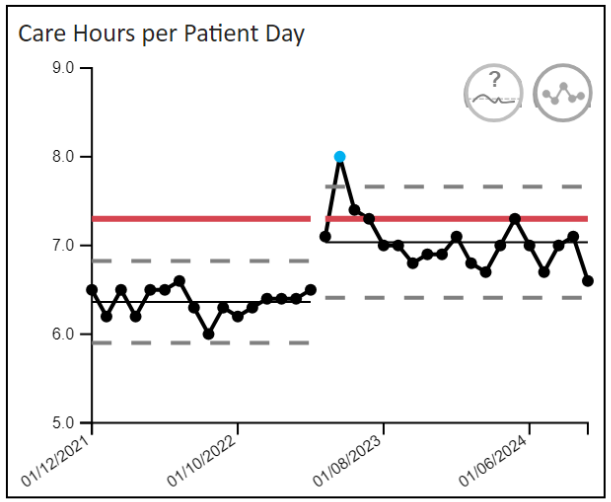
TRFT currently has no alerts for its diagnostic groups.

SHMI Changes – Methodology, Process or Specification

No new changes

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.
- Focus on percentage of fill rate against funded establishment.
- CHPPD for November was 6.8 against planned 7.1
- Fill rates for nights is good and for HCSW 113% above planned
- Fill rates for days RN is the lowest but there are more members of the multi-professional team to support patient safety and experience.

Metric	Value	Target	Exec Lead	Ops Lead
Care Hours per Patient Day	6.6	7.3	Helen Dobson	Cindy Storer

What actions are planned?

- Continued roll out of the Exemplar Accreditation programme. This programme is underpinned by monthly Quality dashboards
- All the September/October NRN are in post and most have ended their supernumerary period.
- Recruitment of 24 NRN for January-March has started with offer letters sent.

What is the expected impact?

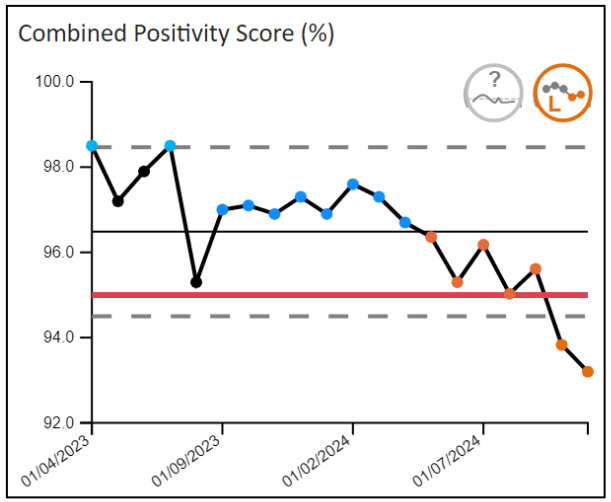
- CHPPD planned versus actual within 5% range
- Clinical quality and safety outcomes are maintained and unwarranted variation reduced across ward areas.

Potential risks to improvement?

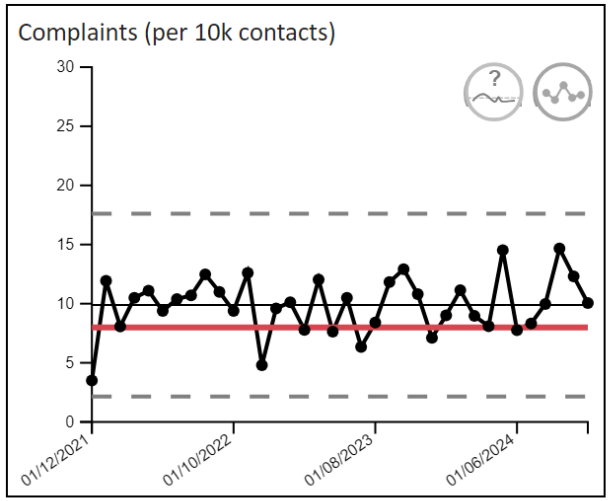
- Needing to open additional beds using existing establishments and temporary NHS staff
- Roster KPI not being met
- Turnover of Nurses, Midwives and HCSW

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 dipped in October to 93.8% with an increase in negative responses in UECC and IP wards.



- 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, despite the rising numbers of patients being seen.
- Deterioration in FFT in UECC is impacting on the overall Trust score. Actions are planned to meet the team to understand the change in feedback scores.

Metric	Value	Target	Exec Lead	Ops Lead
Combined Positivity Score (%)	93.2	95.0	Helen Dobson	Cindy Storer
Complaints (per 10k contacts)	10.1	8.0	Helen Dobson	Cindy Storer

What actions are planned?

- Meeting with UECC teams to discuss deterioration in position.
- Front line resolution through the new PALS resulting in positive compliments
- Training through new Monopoly board continues and is well received
- Patient experience improvement plan for 2024/5 delivered

What is the expected impact?

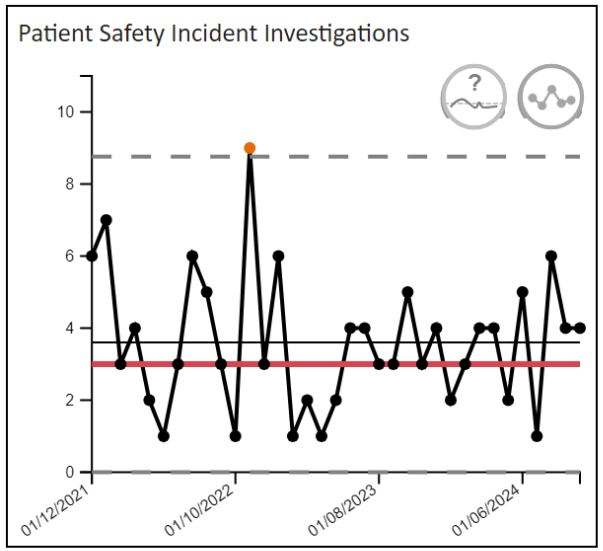
- FFT Positivity score above 95
- The PALS service aims to promote local resolutions to concerns earlier in the process leading to a reduction in concerns being raised. Themes from PALS are around outpatient appointments and discharge.

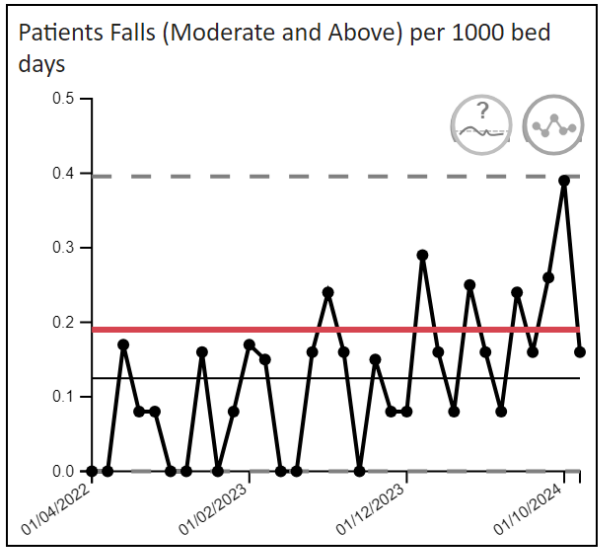
Potential risks to improvement?

- None – all patient experience improvement plans now delivered for 2024/5

Subtheme: Care Incidents (1)

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.
- The number of patient falls at moderate harm is remaining consistent at present, at times achieving the 0.19 per 1000 bed days target, and has achieved in month

Metric	Value	Target	Exec Lead	Ops Lead
Patient Safety Incident Investigations	4	3	Helen Dobson	Victoria Hazeldine
Patients Falls (Moderate and Above) per 1000 bed days	0.31	0.19	Helen Dobson	Victoria Hazeldine

What actions are planned?

- 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
- The Patient Safety Incident Response Plan has been updated and will be published by December 2024

What is the expected impact?

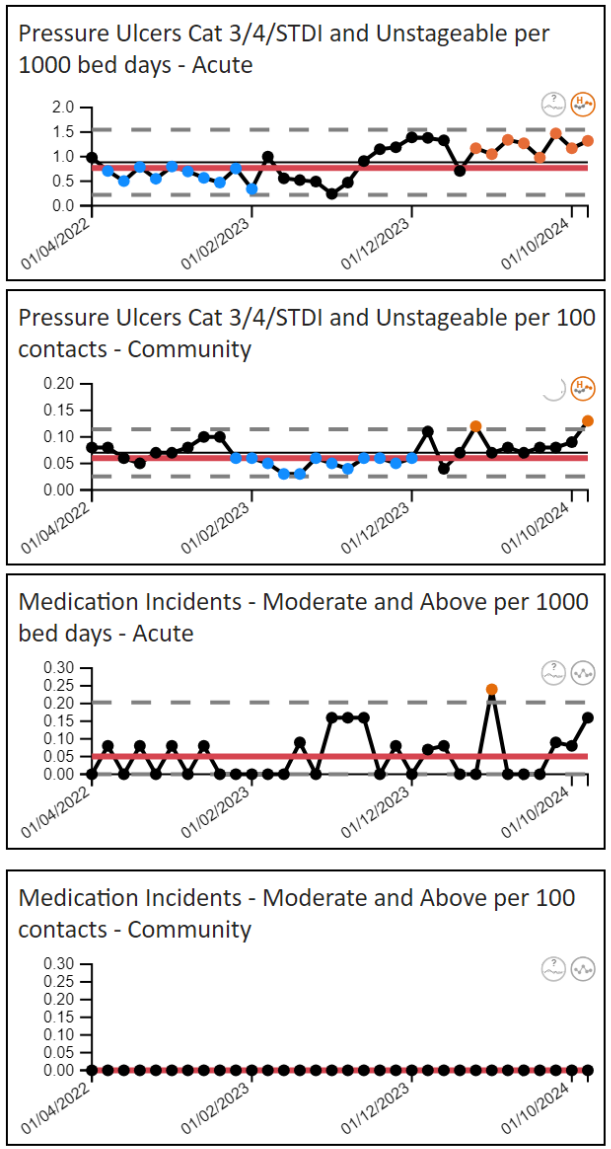
- Stabilisation of PSII's with adequate evidence of shared learning
- Reduction in the total number of falls
- Clear guidance on the use of PSII's against alternative investigation methodology

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: Care Incidents (2)

Data, Context and Explanation



- Pressure ulcers (PU) remain a concern and are considered, the main, an avoidable harm associated with healthcare delivery. The rate of PU in Acute remains in common cause, however in Community the PU rate has shown a deterioration with an increased rate of PU. This equates to 0.8% increase on previous months. September's figure is 0.53%. there are no themes/trends identified for this increase.
- The reported Cat 3 and 4, SDTI's and unstageable damage are all reviewed and graded by Tissue Viability, some are downgraded when assessed even though this assessment work has shown an improvement in initial grading by the community staff.
- Medication incidents in both Community and Acute remain in common cause, although Community the rate persists at 0 whilst in Acute it fluctuates with a mean of 0.05.

Metric	Value	Target	Exec Lead	Ops Lead
Pressure Ulcers Cat 3/4/STDI and Unstagea...	1.48	0.77	Helen Dobson	Victoria Hazeldine
Pressure Ulcers Cat 3/4/STDI and Unstagea...	0.11	0.06	Helen Dobson	Victoria Hazeldine
Medication Incidents - Moderate and Abov...	0.16	0.05	Jo Beahan	Victoria Hazeldine
Medication Incidents - Moderate and Abov...	0.00	0.00	Jo Beahan	Victoria Hazeldine

What actions are planned?

- The metric for medication incidents has now been set for moderate harms and above. This has taken into account the past 2 years data to provide a reasonable target score.
- Pressure Ulcer Investigation Tool completion and presentation at Harm Free panel is working well with action plans developed and worked through where further learning has been identified. Staff report that the process is helpful to them.

What is the expected impact?

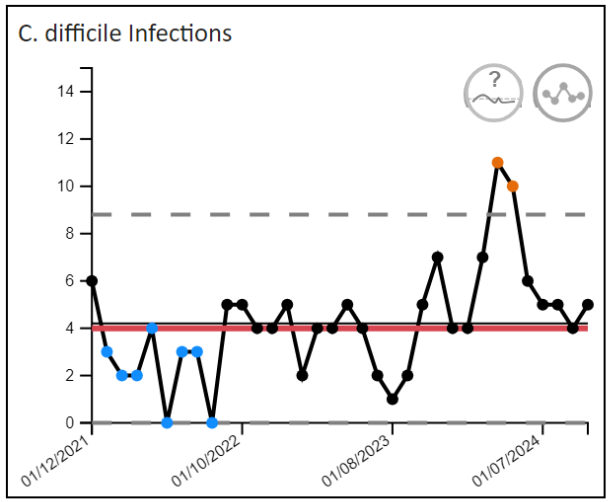
- Reduction in the number of moderate and above medication incidents.
- Reduction in the number of CAT 3/4/SDTI and unstageable pressure ulcers
- Clearer understanding of where the highest area of risk in between community and acute

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

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 showed significantly higher than expected rates. This is also in line with increased national rates of C. diff.
- Learning from harm 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 been published for Q1 highlighting the Trust as an outlier for that period.

Metric	Value	Target	Exec Lead	Ops Lead
C. difficile Infections	5	4	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 microbiologist appointed and started 18 November
- Antimicrobial pharmacist to consider using EPMA to set a stop date for antibiotics and introduce a process where antibiotics have permission codes issued to allow prescribing

What is the expected impact?

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

Potential risks to improvement?

- Heavy promotion of Sepsis pathway and common prescribing of co-amoxiclav within the pathway resulting in use of antibiotics without proven bacterial infection

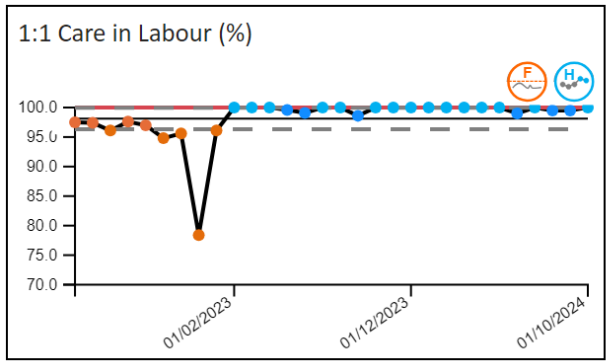
Maternity

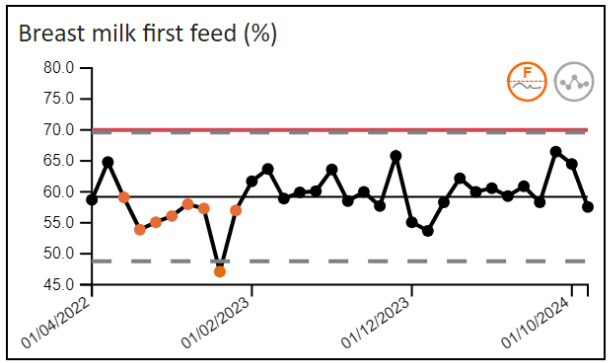
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
1:1 Care in Labour (%)	100.0	100	Sep-24	✗			-	CI
Breast milk first feed (%)	70.0	57.6	**Oct-24**	✗				C
Stillbirth rate (per 1000 births)	4.66	4.0	**Oct-24**	✓			-	C

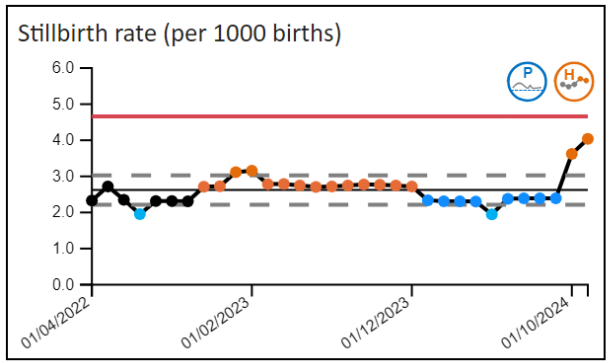
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

Subtheme: Maternity

Data, Context and Explanation







- 1:1 care in labour remains at a high performance level, This data is monitored through the Maternity Birth Rate plus Acuity tool to provide assurance for Maternity incentive scheme. Performance on the tool is 100% for August.
- Breast Milk First Feed % continues to be below the Trust target, with an average of 59.9 % against a Trust target of 66%.
- 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.
- In September/ October and November the Maternity service reported 5 stillbirths over a 5 week period. This has increased the adjusted stillbirth rate to 3.62 per 1000.

Metric	Value	Target	Exec Lead	Ops Lead
1:1 Care in Labour (%)	100.0	100.0	Helen Dobson	Sarah Petty
Breast milk first feed (%)	57.6	70.0	Helen Dobson	Sarah Petty
Stillbirth rate (per 1000 births)	4.0	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. This is to ensure that all women in labour on labour ward receive 1:1 care.
- 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: Due to the cluster of stillbirths seen over a 5 week period a thematic review has been undertaken. The Local Maternity and Neonatal System have been invited to undertake an independent review of the stillbirths. This is scheduled for the 29th November 2024.

What is the expected impact?

- Performance to be maintained supporting safe staffing as detailed in the bi annual staffing paper/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 thematic review undertaken by TRFT did not identify any immediate learning, the themes identified were deprivation and mental health, we are awaiting the LMNS external review for further assurance .

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 cluster of 5 stillbirths together will impact on the rolling stillbirth figure for the next 12 months.

Performance Matrix Summary – Finance and Performance

The Rotherham NHS Foundation Trust

Variation	Assurance: Pass	Assurance: Hit or Miss	Assurance: Fail
Special Cause: Improvement	**VERY GOOD: LEARN AND CELEBRATE** • Urgent 2 Hour Response • Mean LoS (Elective)	**GOOD: CELEBRATE AND UNDERSTAND** • OP to PIFU • 31 Day Treatment Standard	**CONCERNING: CELEBRATE BUT TAKE ACTION** • 65+ weeks • RTT
Common Cause	**GOOD: CELEBRATE AND UNDERSTAND**	**STATIC: INVESTIGATE AND UNDERSTAND** • Waiting List Size • OP to PIFU • Overdue Followups • DM01 • FDS • 62 Day Treatment Standard • >12 hours in A&E • 12 hour Trolley Waits • Bed Occupancy • LoS >21 Days • Date of Discharge = Discharge Ready Date • Patients on Virtual Ward • First Outpatients (%Plan) • Inpatients (%Plan) • Daycases (%Plan) • LoS >7 Days • Mean LoS (Non-Elective) • A&E Attendances from Care Homes	**CONCERNING: INVESTIGATE & TAKE ACTION** • 4 Hour Performance • Ambulance Handovers >30min • Average time to be Seen • Criteria to Reside is No • Admissions from Care Homes • Clinic Utilisation • Capped Theatres Utilisation • Did Not Attend • Discharged <5pm
Special Cause: Concern	**CONCERNING: INVESTIGATE AND UNDERSTAND**	**CONCERNING:INVESTIGATE & TAKE ACTION**	**VERY CONCERNING: INVESTIGATE & TAKE ACTION** • 52+ weeks

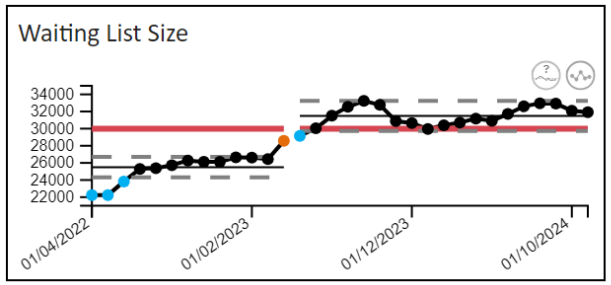
Elective Care and Cancer

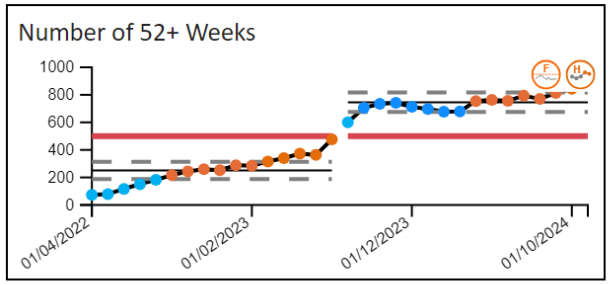
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
Waiting List Size	30,000	31,925	Nov-24	✗	?			S
Number of 52+ Weeks	500	890	Nov-24	✗	F	H		VC
Number of 65+ Weeks	0	0	Nov-24	✓	F	L		CI
Referral To Treatment (%)	92.0	62.6	Nov-24	✗	F	H		CI
OP Activity moved or Discharged to PIFU (%)	2.5	2.8	**Oct-24**	✓	?			S
Overdue Follow-ups	-	16,308	Nov-24	-	-		-	S
DM01 (%)	1.0	1.0	**Oct-24**	✓	?			S
Faster Diagnosis Standard (%)	77.0	80.2	Oct-24	✓	?			S
31 Day Treatment Standard (%)	96.0	99.1	Oct-24	✓	?	H		G
62 Day Treatment Standard (%)	70.0	74.6	Oct-24	✓	?			S

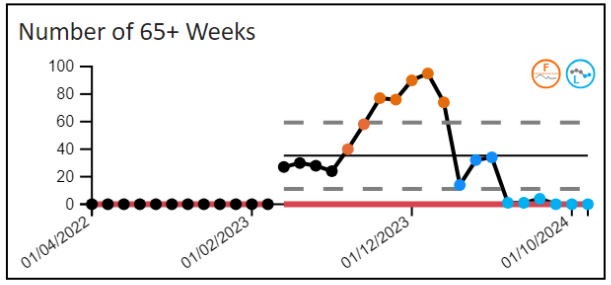
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

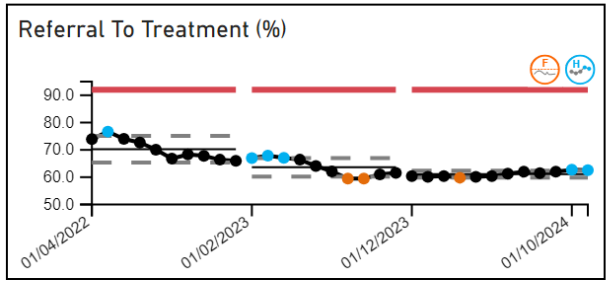
Subtheme: Long Waiters

Data, Context and Explanation









- The number of patients on our RRT waiting list continues to be within normal variation, with a slight in month reduction being seen.
- The Trust had committed to reducing the number of patients waiting over 52 weeks by 50% by March from 755 to 500. We are currently seeing an impact on elective orthopaedic capacity due to an increase trauma, and delivery of this ambition remains challenging.
- For 2024/25, the national planning guidance set an objective for 0 patients to still be waiting over 65 weeks for their treatment by the end of Sept-24. We achieved 0 breaches in Sept-24 and have maintained this through to Nov-24. We continue to focus on sustaining this position.
- A review of the existing transformation programme, supported by GIRFT Further Faster 20 is progressing at pace. This work aims to see us reach our Trust ambition to achieve RTT performance of 92% in a minimum of 5 specialties. Rheumatology, Stroke, and Geriatric Medicine are now achieving compliance with the RTT standard, however, Respiratory were just short at 91% in Nov-24.
- The last 5 months have begun to show increased performance levels, with November's RTT performance being significantly better than the preceding months.

Metric	Value	Target	Exec Lead	Ops Lead
Waiting List Size	31,925	30,000	Sally Kilgariff	Andrea Squires
Number of 52+ Weeks	890	500	Sally Kilgariff	Andrea Squires
Number of 65+ Weeks	0	0	Sally Kilgariff	Andrea Squires
Referral To Treatment (%)	62.6	92.0	Sally Kilgariff	Andrea Squires

What actions are planned?

•Roll out light-touch electronic triage for low-risk patients, improve processes for shutting down underutilised lists, and develop clear booking guidelines for theatres
•Conduct validation of booked theatre lists using PowerBI, finalise theatre SOPs, and install TVs in theatre reception to display real-time flow data
•External reviews planned in December as part of the FF20 programme to review Theatre/Anaesthetic processes

What is the expected impact?

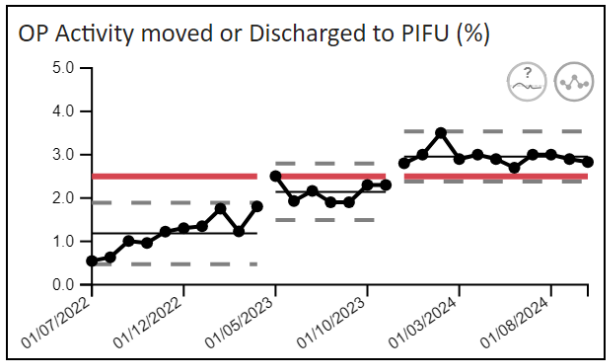
•Optimised booking and triage workflows to reduce delays and improve patient outcomes, with full impact anticipated by March 2025
•Increased theatre efficiency and reduced cancellations, with visible improvements by January 2025
•Full review of the existing transformation programme, enabling us to go further faster with a key focus on ENT paediatrics, orthopaedics, gynaecology specialties from January 2025

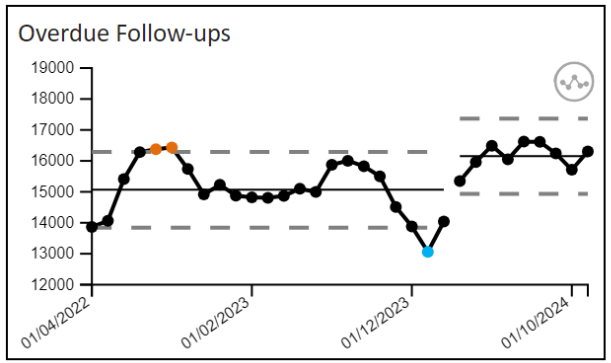
Potential risks to improvement?

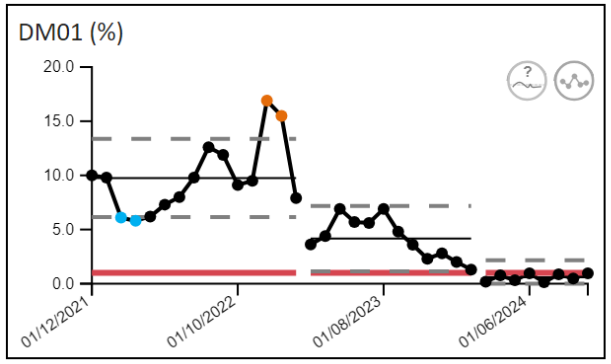
- Operational pressures could divert resources and delay the implementation of planned actions i.e. HDU capacity, elective activity
- Limited staff availability, high sickness rates, and change fatigue may impact the adoption of new processes and technologies
- Availability of financial resource to support additional activity
- Risk of identification of long waits through enhanced validation of waiting list.

Subtheme: Diagnostics & Follow-ups

Data, Context and Explanation







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

•The Trust set the objective to ensure 1.5% of patients waiting for an outpatient follow-up appointment is moved or discharged to PIFU, by Mar-25. We have seen significant improvement in this area from Dec-23, which is currently holding steady around 2.5%

• The last 8 months have seen a step change in the average number of overdue follow ups, with notable increases seen in Ophthalmology, Respiratory, Dermatology, ENT and Rheumatology. This does look to be reducing in recent months.

•The 2024/25 national planning guidance also set an objective to increase the % of patients that receive a diagnostic test within 6 weeks to 95%. The Trust consistently met this standard, so set an internal ambition to maintain performance at 99% for 24/25. The Trust has maintained this achievement since Mar-24.

Metric	Value	Target	Exec Lead	Ops Lead
OP Activity moved or Discharged to PIFU (%)	2.8	2.5	Sally Kilgariff	Andrea Squires
Overdue Follow-ups	16,308	-	Sally Kilgariff	Andrea Squires
DM01 (%)	1.0	1.0	Sally Kilgariff	Andrea Squires

What actions are planned?

•Roll out PIFU SOP across all services, incorporating specialty-specific clinical protocols
•Train healthcare assistants in additional tasks, review outpatient clinic utilisation data to identify opportunities, and ensure consistent room booking practices across outpatient areas
•Demand & Capacity Planning continues to be progressed for 2025/26
•Mutual aid continues to be accessed to support Endoscopy capacity following the addition of surveillance patients to the active DM01 wait list in September 2024

What is the expected impact?

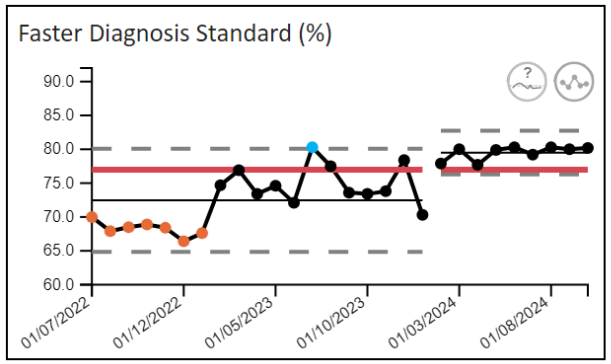
Streamlined follow-up processes and improved patient engagement, with measurable outcomes expected by January 2025
• Better clinic utilisation and expanded service capacity, with progress expected by February 2025
•Services will identify gaps in service provision and develop 'closing the gap' plans to support 2025/26 planning cycle for submission on 16 December 2024
•Sustainability of DM01 performance through to March 2025

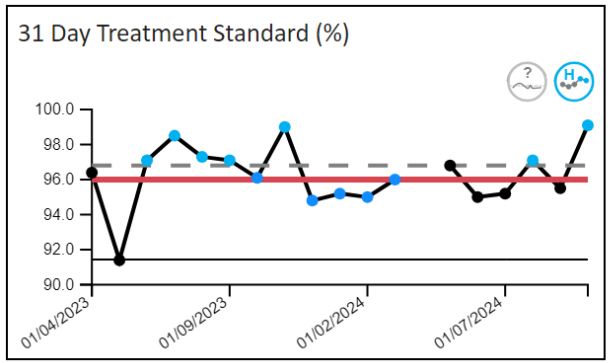
Potential risks to improvement?

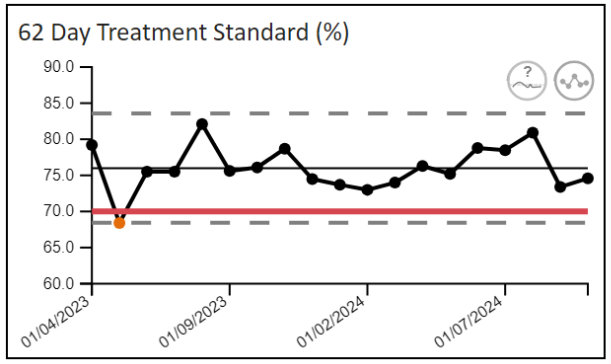
- Addition of overdue surveillance patients in endoscopy to DM01 from September 2024 requiring additional capacity may impact on DM01 performance
- Availability of financial resource to support additional activity.
- Impact of the transfer of long waits in DM01 as part of any mutual aid agreements across the system.
- Limited staff availability, high sickness rates, and change fatigue may impact the adoption of new processes and technologies

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. 8 out of the last 9 months have achieved the national target, with average performance at 79% since Feb 24. We continue to work towards consistently achieving this standard and have set a further ambition to improve performance to 80% by March 2025.

•The 31-day standard continues to show normal variation patterns. The Cancer Improvement Team are focusing support in Skin to improve this standard.

•The national planning guidance also sets the objective to improve the 62-day Referral-to-Treatment performance to 70% by Mar-25.

• As the Trust is consistently achieving this standard, we have set a further ambition to improve performance to 77% by March 2025. The trust continues to meet this target, and current variation/process indicates that it is extremely unlikely that performance will fall below target levels, however it is not impossible.

Metric	Value	Target	Exec Lead	Ops Lead
Faster Diagnosis Standard (%)	80.2	77.0	Sally Kilgariff	Andrea Squires
31 Day Treatment Standard (%)	99.1	96.0	Sally Kilgariff	Andrea Squires
62 Day Treatment Standard (%)	74.6	70.0	Sally Kilgariff	Andrea Squires

What actions are planned?

•Implement targeted interventions to improve performance and reduce breaches in urology.
•Ensure sustained delivery of the 77% national 62 Day target through focused operational improvements
•Investigate deviations around the 96% 31 Day target to identify root causes and develop corrective actions
•Continue monitoring the impact of previous interventions and refine strategies to sustain the local FDS stretch target of 80%

What is the expected impact?

•Reduce urology breaches through enhanced scheduling and capacity improvements, with initial impact expected by February 2025
•Ensure timely diagnostics and treatments to sustain compliance with the 77% 62 Day target, with improvements visible by February 2025
•Address root causes of variability in 31 Day pathway to achieve more consistent performance, with significant progress by February 2025
•Sustain the 80% FDS stretch target by March 2025

Potential risks to improvement?

•Lack of capacity in key areas such as diagnostics, clinics, or staffing to accommodate additional workload for targeted interventions, particularly in urology
•Ongoing operational demands and emergency cases could divert resources and delay the implementation of planned actions i.e. HDU capacity for LGI
Resistance from clinical and operational teams to adopt new processes or prioritise changes due to change fatigue or competing priorities

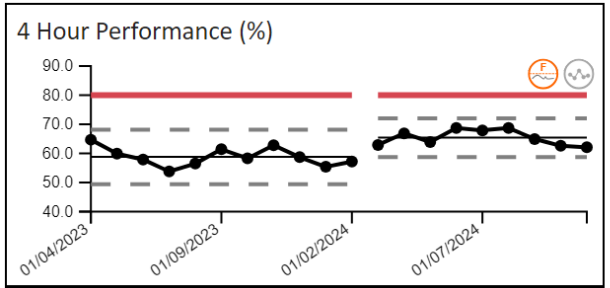
Non-elective and Flow

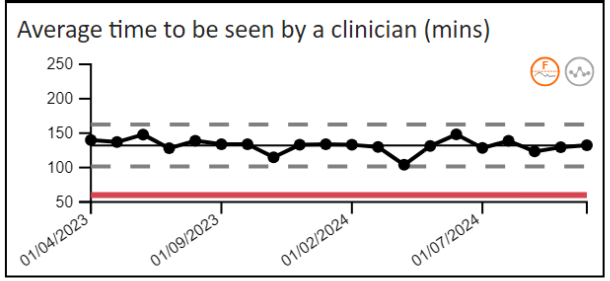
Metric	Trust Target	Latest Data	Period	Achieved (in Month)	Assurance	Variation	Quartile	Grid*
4 Hour Performance (%)	80.0	62.1	Nov-24	☒	F			C
Ambulance Handover Times >30 mins (%)	0.0	18.9	Nov-24	☒	F			C
Average time to be seen by a clinician (mins)	60.0	132.3	Nov-24	☒	F		-	C
Patients spending >12 hours in A&E from time of arrival (%)	2.0	4.6	Nov-24	☒	?			S
12hr Trolley Waits	0	16	Nov-24	☒	?		-	S
Bed Occupancy (%)	92.0	90.4	Nov-24	☑	?			S
Length of Stay over 21 Days	64	49	Nov-24	☑	?		-	S
Patients where Date of Discharge = Discharge Ready Date (%)	85.0	83.1	Aug-24	☒	?		-	S
Criteria to Reside is No (%)	10.0	20.4	Nov-24	☒	F		-	C

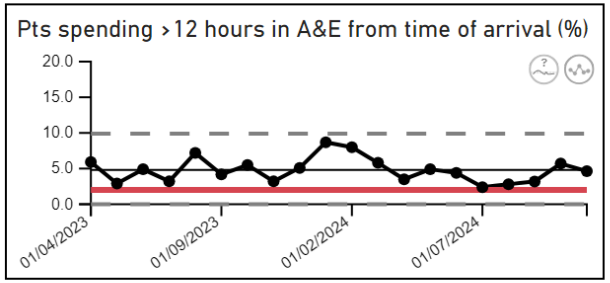
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

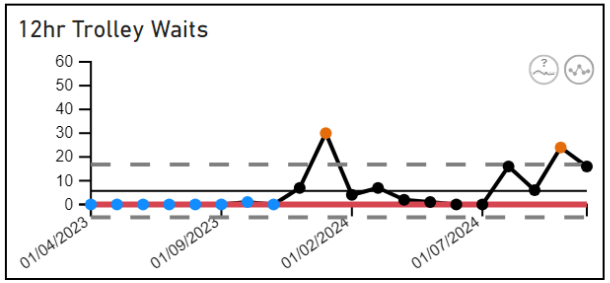
Subtheme: Emergency Care - Waiting Times

Data, Context and Explanation









- National guidance set an objective for all Trusts to achieve the 4 hour performance standard of 78% by March 2025. While performance falls below this standard, there is sustained improvement in this area, which is now performing at a stable average of 67%.
- Average time to see a clinician remains in a natural variation pattern. The consistent increase in demand continues to challenge further improvements.
- The number of patients spending more than 12 hours in the department is a key national focus. This is increasing month on month which is further compounded by the increase in UECC attendances and increased waits for admission.
- The Trust has set a standard to achieve zero trolley waits in line with national guidance, this had been seen recently but hard to maintain over the last few month due to ongoing challenges with patient flow across the trust footprint. The ringfencing and protecting of SDEC from inpatients has resulted in some trolley waits in the short term, but improved patient flow overall.

Metric	Value	Target	Exec Lead	Ops Lead
4 Hour Performance (%)	62.1	80.0	Sally Kilgariff	Lesley Hammond
Average time to be seen by a clinician (mins)	132.3	60.0	Sally Kilgariff	Lesley Hammond
Pts spending >12 hours in A&E from time of arrival (%)	4.6	2.0	Sally Kilgariff	Lesley Hammond
12hr Trolley Waits	16	0	Sally Kilgariff	Lesley Hammond

What actions are planned?

- Work continues to develop SDEC Pathways and improve efficiency within SDEC's
- Continued focus on 'live' SDEC dashboard
- Expansion of Radiology tracker to improve visibility of reporting (CT/MRIs)
- Additional validation by senior operational team of 4 hour breaches
- Recruitment to Clinical Vacancies (medical/ENP)
- Escalation SOP to be approved for Paediatrics although is currently in use

What is the expected impact?

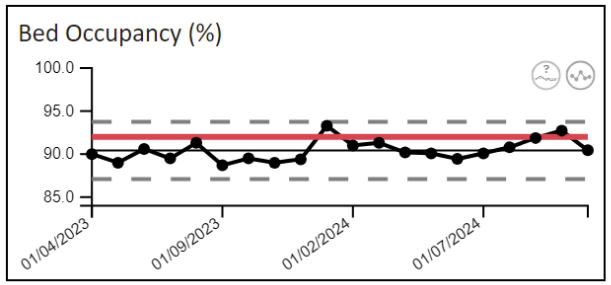
•Non-admitted performance for Primary Care, Minor Injuries will improve by March 2025
•Visibility of all SDEC area via the new dashboard, to improve flow and support SDECs to remain open even at times of high demand by January 2025
•Improvement in the total time patients spend in the department by March 2025
•Improved time to be seen by a clinician by January 2025

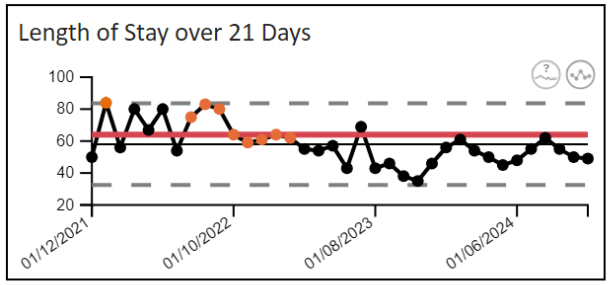
Potential risks to improvement?

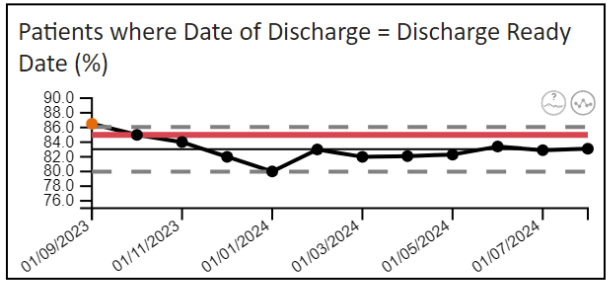
- Significant increases in demand will significantly impact the Trust ability to achieve the 4 hour performance standards.
- Medical workforce staffing through December into January particularly at Tier 4 level

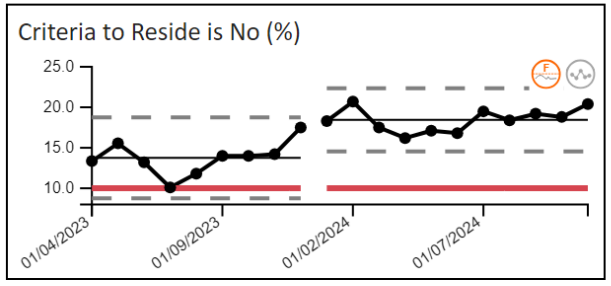
Subtheme: Inpatient Flow

Data, Context and Explanation









- Bed Occupancy for November was 90.4% this includes both core bed capacity as well as escalation capacity in line with national definition. 90.4% for Adult G&A. If we were to exclude the “escalation beds” on B5, Rockingham and SU we would be at 92.6% for Adult G&A. (B5 would be 101.7%, Rockingham would be 90.3% and SU would be 111.3%.)
- 92% is recognised as optimum bed occupancy. It should be expected that we would see values fluctuate between 87% and 94% based on current patterns and Winter pressures.
- Length of stay >21 days remains in line with natural variation and achieving the target for the month
- Date of Discharge = Discharge Ready holds steady below target at around 83%.
- Criteria to Reside continues to fluctuate, showing natural variation between 22% and 14%, consistently not achieving the target of below 10%. 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 (%)	90.4	92.0	Sally Kilgariff	Lesley Hammond
Length of Stay over 21 Days	49	64	Sally Kilgariff	Lesley Hammond
Patients where Date of Discharge = Discharge Ready Date (%)	83.1	85.0	Sally Kilgariff	Lesley Hammond
Criteria to Reside is No (%)	20.4	10.0	Sally Kilgariff	Lesley Hammond

What actions are planned?

- Roll out of discharge tracker across the trust
- Length of Stay meetings changed and more focus on patients not known to IDT
- Focus on criteria to reside and internal delays
- Clear repatriation policy at place and in the trust
- Board round standardisation across medical wards

What is the expected impact?

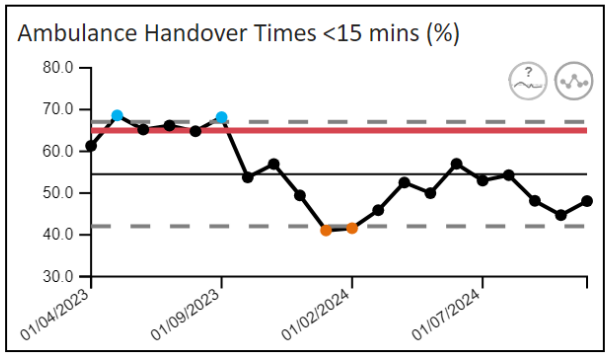
- Patients discharged on discharge ready date to reach target by March 2025
- Continued reduction in patients in hospital over 21 days by January 2025
- Reduction in those patients that have been an inpatient over 7 days by January 2025
- Reduction in numbers of patients that are Out of Areas and an increased LOS by January 2025
- Reduction in internal delays for patients waiting discharge by January 2025

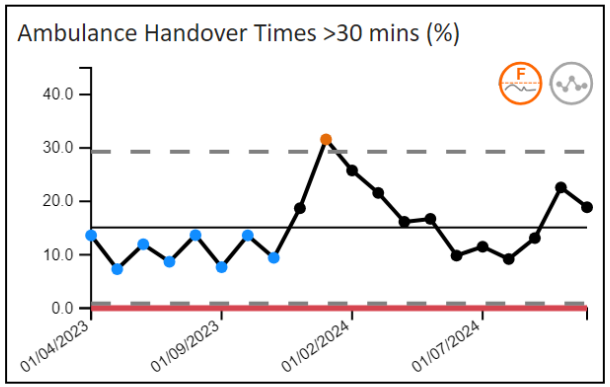
Potential risks to improvement?

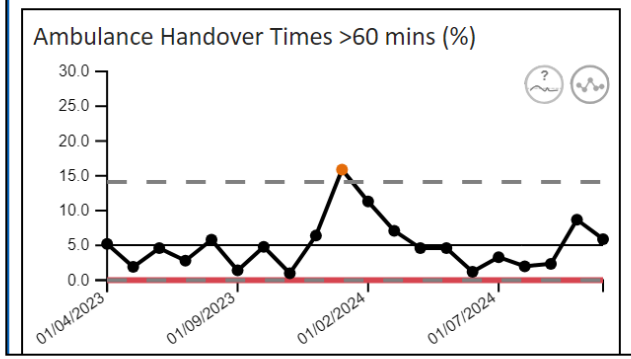
•Increase demand through UECC sustained
•De-escalation of inpatient beds not possible due to ongoing pressures
• Increased demand fails to reduce bed occupancy and additional beds will need to remain open

Subtheme: Emergency Care - Ambulance

Data, Context and Explanation







- The Operational Planning Guidance set an objective to achieve an average of 30 minutes to handover by March 2025.
- Achievement of this standard is dependent on compliance with two other standards; patients wait less than 15 minutes for handover and patients must not wait over 60 minutes for handover.
- The Trust compliance with Ambulance handover times <15 minutes remains below the standard of 65%. There is a month on month deterioration in the ability to handover within 15mins due to capacity restraints.
- For handover times >30mins, average times appeared to be falling but recent months have seen continued growth in this area due to capacity restraints within UECC at times of peak demand.
- Ambulance handover times >60 did not meet the standard of 0%. Performance levels indicate that we should expect an average of 5%, while some months may achieve 0%, the data indicates the process is not currently sustainable.
- YAS has identified the Trust as benchmarking positively.

Metric	Value	Target	Exec Lead	Ops Lead
Ambulance Handover Times <15 mins (%)	48.1	65.0	Sally Kilgariff	Lesley Hammond
Ambulance Handover Times >30 mins (%)	18.9	0.0	Sally Kilgariff	Lesley Hammond
Ambulance Handover Times >60 mins (%)	5.9	0.0	Sally Kilgariff	Lesley Hammond

What actions are planned?

- YAS and CHAT colleagues piloting new approach to support patients who have fallen and utilising community UCR
- Key focus on ambulance handover by Operational managers and Nursing workforce
- Text Messages will alert Operational Managers and Clinical Site Managers to delays with Ambulance Handovers as well as alerts on MS Teams

What is the expected impact?

•There will be an improvement in ambulance handover times and TRFT sustained high levels of performance by January 2025
•Pilots will support reduction in conveyance to ensure all pathways in and out of hospital are utilised by March 2025

Potential risks to improvement?

•High demand resulting in possible increase in ambulance attendances or batching of ambulances
•Ongoing demands for UEC services
•Peaks in demands for services
•Flow within the Trust/organisation and Place
• Potential increase in IPC during the winter which will require off load direct to cubicles

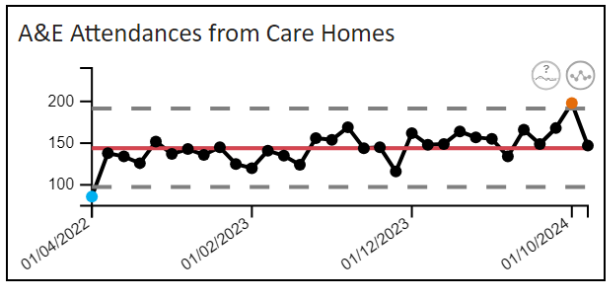
Community

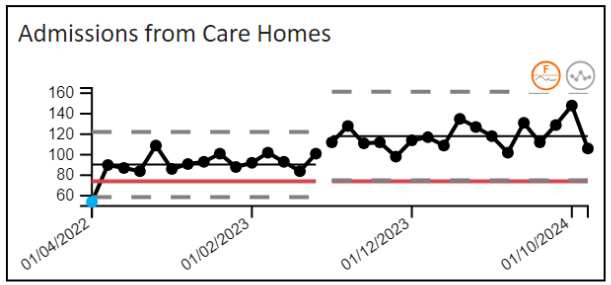
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
A&E Attendances from Care Homes	144	147	Nov-24	✗	?		-	S
Admissions from Care Homes	74	106	Nov-24	✗	F		-	C
Number of Patients on Virtual Ward	80	72	Nov-24	✗	?		-	S
Urgent 2 Hour Community Response (%)	70.0	79.0	Sep-24	✓	P	H	-	VG

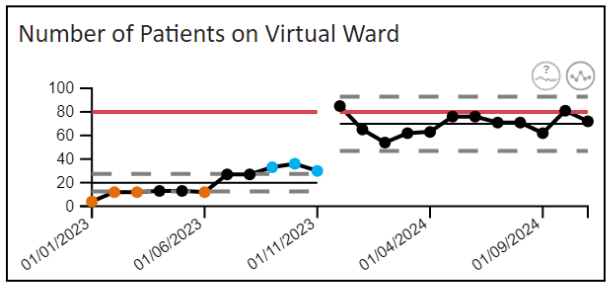
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

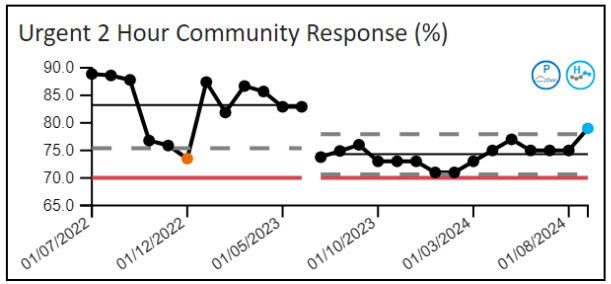
Subtheme: Community

Data, Context and Explanation









- The Community Teams, including the Trusted Assessors, continue to in reach into the Acute setting to facilitate early supported discharges for care homes residents. The Trusted Assessors also continue to build relationships with Care Home staff to ensure community pathways are considered prior to calling 999.
- Community Teams continue to work with YAS regarding the support community colleagues can provide.
- All care homes attendances and admissions are analysis each month to highlights any potential training requirements or concerns within care homes

- The number of patients on Virtual Ward has decreased in month. In November there was an average of 63 patients being cared for against a Trust standard of 80. Occupancy reached a peak of 78 on the 1 November and 73 on 30 November. Capacity was impacted by sickness in month.

- The National standard for the 2 hour urgent community response is 70% of appropriate referrals. The trust is consistently meeting this target, and recent performance indicated this is now at a level where is can sustainably met the standard. The forecast position for October 77%, November 78%

Metric	Value	Target	Exec Lead	Ops Lead
A&E Attendances from Care Homes	147	144	Sally Kilgariff	Penny Fisher
Admissions from Care Homes	106	74	Sally Kilgariff	Penny Fisher
Number of Patients on Virtual Ward	72	80	Sally Kilgariff	Penny Fisher
Urgent 2 Hour Community Response (%)	79.0	70.0	Sally Kilgariff	Penny Fisher

What actions are planned?

- Continue to embed the role of Trusted Assessors and monitor impact.
- Monitor the Virtual Ward Heart Failure pathway.
- Test remote technology with a small number of heart failure patients
- Ongoing review of specialist planned nursing activity to identify any UCR activity, including a review of the Directory of Service and Data quality.

What is the expected impact?

- Reduce conveyance from Care Homes to UECC and admission from Care Homes
- Increased offer to patients and increased referrals to Virtual Ward, thereby increasing our Virtual Ward bed utilisation.
- Improved categorisation of patients into three general acuity levels
- 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

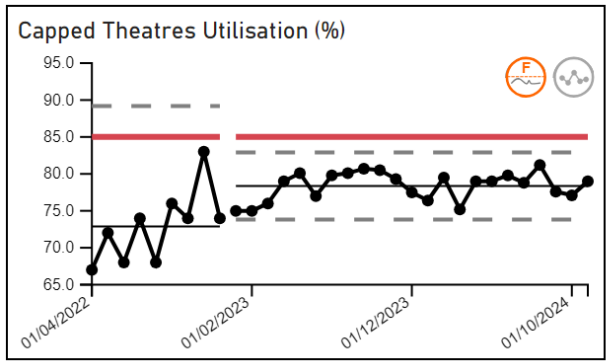
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
Clinic Utilisation (%)	85.0	78.2	Nov-24	✗	F		-	C
Capped Theatres Utilisation (%)	85.0	79.0	Nov-24	✗	F			C
Did Not Attend (%)	7.0	7.4	Nov-24	✗	F			C
First Outpatients (% of Plan)	100.0	102.0	Nov-24	✓	?			S
Inpatients (% of Plan)	100.0	101.0	Nov-24	✓	?		-	S
Daycases (% of Plan)	100.0	107.0	Nov-24	✓	?		-	S
Length of Stay over 7 days	-	187	Nov-24	-	-		-	S
Mean Length of Stay (Non-elective)	-	5.2	Nov-24	-	-			S
Mean Length of Stay (Elective excluding Daycases)	-	2.2	Nov-24	-	-	L		GI
Discharged before 5pm (%)	70.0	62.9	Nov-24	✗	F			C

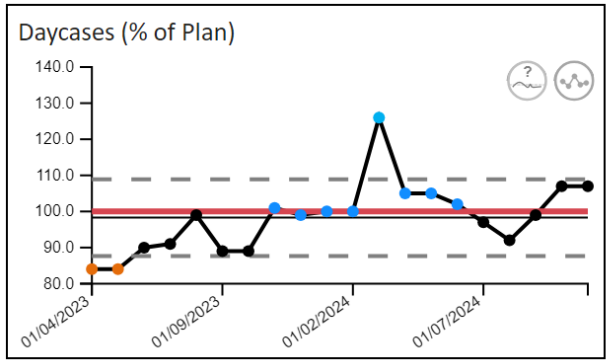
Plan is 19/20 + 3% i.e. *103% of 19/20*, therefore 100% achievement against Plan is 103% of 19/20

*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 consistent, with current utilisation at 79% against the 85% standard.
- Day case activity had been achieving plan for a number of months. Work continues across a variety of targeted specialties.

Metric	Value	Target	Exec Lead	Ops Lead
Capped Theatres Utilisation (%)	79.0	85.0	Sally Kilgariff	Jodie Roberts
Daycases (% of Plan)	107.0	100.0	Sally Kilgariff	Jodie Roberts

What actions are planned?

- Increased pre-op assessment sessions have been agreed to support scheduling
- Increased focus on T&O day cases
- Enhanced analysis of work that has been transferred to MEOC
- Improved utilisation of MEOC for simple cases
- Roll out of increased cases per list in Ophthalmology
- Validation of patients that are not fit for surgery

What is the expected impact?

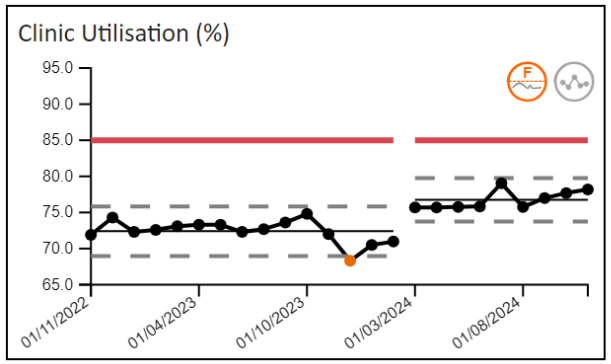
- Improvement in theatre utilisation
- Improved overall scheduling
- Increase in use of day cases theatres from T&O
- Increased day case rate in Ophthalmology
- Improvement in forward view and reducing on the day cancellations.
- Positive impact on data quality

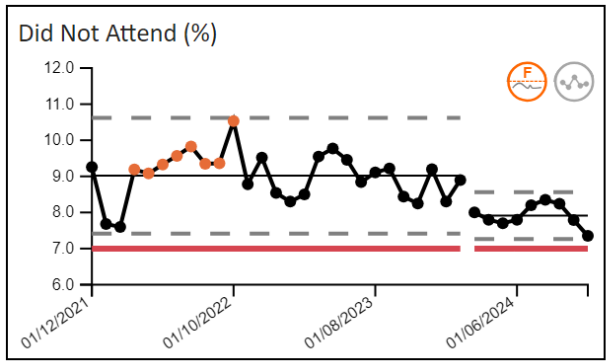
Potential risks to improvement?

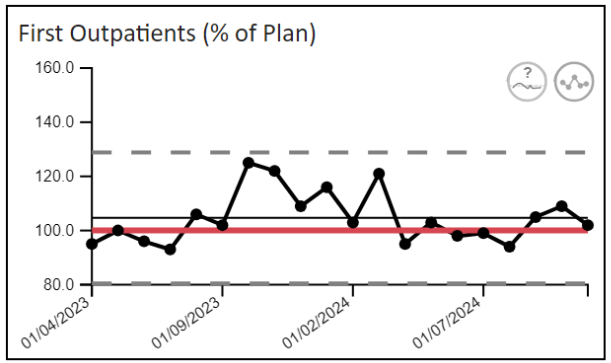
- Anaesthetic rotas may continue to impact on the ability to run theatre activity which significantly impacts on T&O in particular
- Capacity to deliver pre-op assessment may impact on patients available and fit for surgery
- High levels of theatre staff absence impacting on lists been used
- Theatre staffing remains a concern

Subtheme: Outpatients

Data, Context and Explanation







- Clinic Utilisation is key to productivity and underutilised clinics is a key focus for the Trust this year. A 4% improvement step change has been noted since Mar 24, and further incremental improvements with further work still to do to achieve the standard of 85%.
- Trust DNA rates have shown sustained reductions, holding steady around 8%, with more to do to get to the 7% target. Work is focused on meeting the needs of our local population when attending for outpatient appointments to improve attendance via digital reminders and targeted patient engagement.
- Outpatient productivity provides the organisation with the opportunity to increase activity levels and improve outcomes for patients. The last two months have performed in excess to plan, although sustained change is not yet seen.
- The Further Faster programme (GIRFT) supports each speciality in addressing their own specific productivity challenges in relation to outpatients in line with the GIRFT handbooks.

Metric	Value	Target	Exec Lead	Ops Lead
Clinic Utilisation (%)	78.2	85.0	Sally Kilgariff	Jodie Roberts
Did Not Attend (%)	7.4	7.0	Sally Kilgariff	Jodie Roberts
First Outpatients (% of Plan)	102.0	100.0	Sally Kilgariff	Jodie Roberts

What actions are planned?

- Increased capacity to deliver first outpatient appointments across numerous specialities to support activity levels are on-going. Funded via ERF.
- Development of PIFU module on Patient Hub to support management of patients in PIFU.
- Review Utilisation capacity and understand un-booked slots.
- Review data on discharged at first appointment to understand where triage may have biggest impact.
- Triage process being improved to enable clinicians to discharge with Advice and Guidance
- Clinic templates review on going to standardise in line with GIRFT action

What is the expected impact?

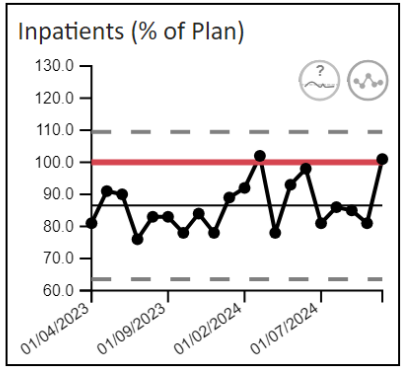
- Increase in clinic utilisation by 5% by Q3 2024/25.
- Reduction in patients that DNA to 7% by Q4 2024/25
- Increase in outpatient activity by 2% by Q3 2024/25

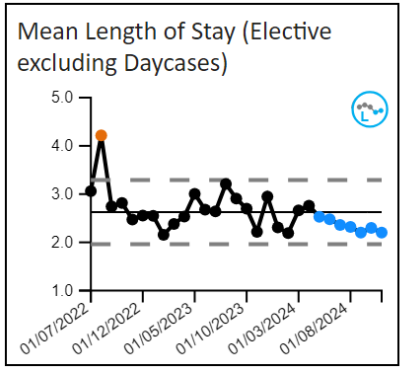
Potential risks to improvement?

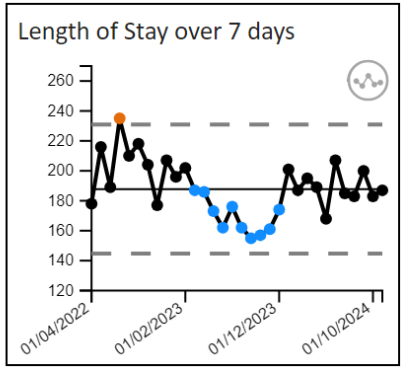
- Capacity in the contact centre to ensure that clinics are fully utilised, and any cancellations are back filled.
- Patient availability may impact on the ability to improve clinic utilisation, particularly short notice backfilled appointments.
- GP collective action and impact on referrals to specialities and use of advice and guidance

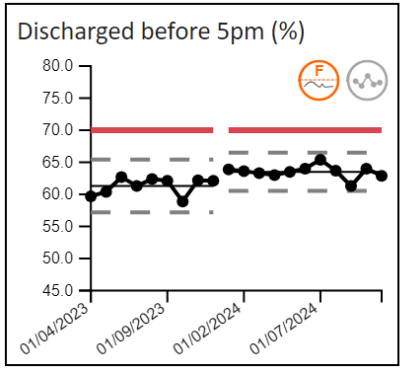
Subtheme: Inpatients

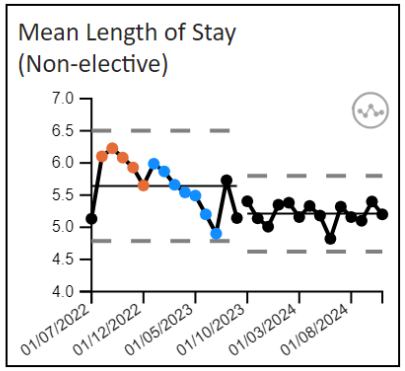
Data, Context and Explanation











- Inpatient have performed to plan for the first time in 7 months, while this remains in normal variation it is a marked in month improvement.
- Mean length of stay for **elective** patients is showing a continued downward trend over the last 6 months. Focused work to decreasing length of stay on surgical wards is imperative to support the elective recovery programme.
- Mean length of stay for **Non-elective** patients has remained stable under 5.5 days over the last 12-18 months.
- The number of patients with a LoS of 7+ days has remained static . Work continues to focus on getting patients to the right place and follow the home first approach.
- Patients discharged before 5pm has showed sustained improvement since Jan 24, although dips in current months have been noted. Work continues to focus on improving discharge rates earlier in the day. With a new discharge tracker implemented across the trust.

Metric	Value	Target	Exec Lead	Ops Lead
Inpatients (% of Plan)	101.0	100.0	Sally Kilgariff	Jodie Roberts
Length of Stay over 7 days	187	-	Sally Kilgariff	Jodie Roberts
Mean Length of Stay (Non-elective)	5.2	-	Sally Kilgariff	Jodie Roberts
Mean Length of Stay (Elective excluding Daycases)	2.2	-	Sally Kilgariff	Jodie Roberts
Discharged before 5pm (%)	62.9	70.0	Sally Kilgariff	Jodie Roberts

What actions are planned?

- Increase daily numbers through the discharge lounge by 5 further patients.
- Ongoing LLOS reviews focusing on patients not known to IDT
- Focus on Internal delays to reduce patients with no criteria to reside
- Focus on LOS in surgical specialities
- Focus on patients waiting over 7 days to reduce LOS overall
- Opening of Community Ready Unit on Sundays through Winter to support earlier discharges

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%
- Continued reduction in average LOS for elective inpatients
- Increased number of discharges earlier in the day supported by CRU opening on a Sunday

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, with no additional resource to support both internally and externally
- Ability for the CRU to manage significant increase in numbers and transport to support earlier discharge (peaks and troughs in demand)
- Additional beds and demand on medical and nursing workforce

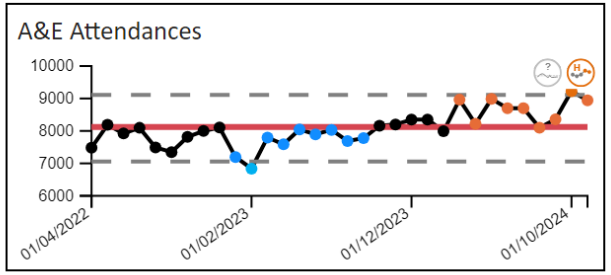
Activity

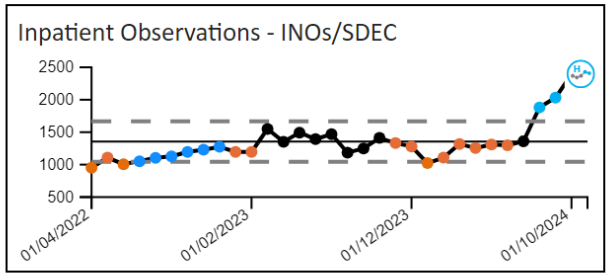
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
A&E Attendances [Block]	8,124	8,946	Nov-24	☒	?	H	-	C
Inpatient Observations – INOs/SDEC [Block]	-	2,262	Nov-24	-	-	H	-	G
Non-Elective Inpatients [Block]	-	2,554	Nov-24	-	-	H	-	C
Outpatients Follow Up - Attendances [Block]	14,699	15,545	Nov-24	☒	?		-	S
Daycases [ERF]	1,999	2,139	Nov-24	☑	?		-	S
Inpatients - Electives [ERF]	352	354	Nov-24	☑	?		-	S
Outpatients New - Attendances [ERF]	6,049	6,170	Nov-24	☑	?		-	S
Outpatient Procedures - New and Follow Up [ERF]	4,767	4,817	Nov-24	☑	?		-	S
Referrals [Outpatient Demand]	-	8,203	Nov-24	-	-		-	S
2ww Referrals [Outpatient Demand]	-	1,166	Nov-24	-	-		-	S

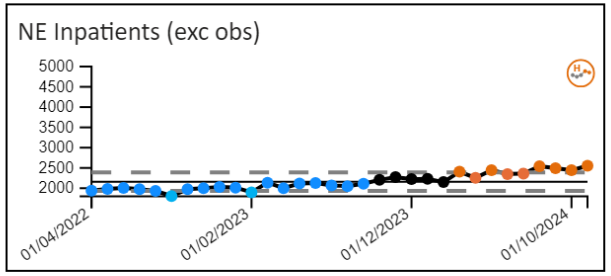
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

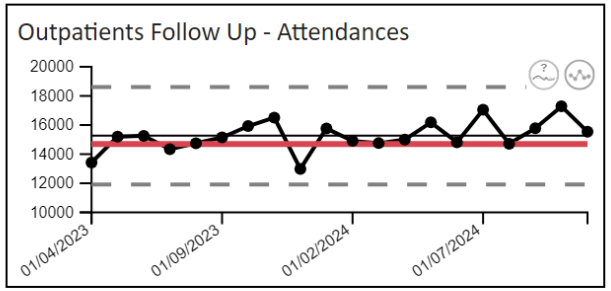
Subtheme: Block

Data, Context and Explanation









- Key activity lines on block contract are based on 23/24 M10 forecast outturn (block funding will not directly reflect activity)
- Block contracts do not allow additional income generation where activity lines are over performing
- A&E attendances are above plan both in-month (+13%) and year-to-date (10%).
- Non-Elective admissions (excluding obs/SDEC) have been increasing month on month.
- Outpatient Follow-ups continue to significantly over perform both in-month (and year-to-date) however some of these are expected to convert to Procedures when the activity recording issues are resolved. It is anticipated there will be a reduction in follow-up activity as a consequence.
- The Trust has significant follow-up backlogs therefore over performance is expect to continue/increase whilst we look to clear these.

Metric	Value	Target	Exec Lead	Ops Lead
A&E Attendances	8,946	8,124	Sally Kilgariff	Jodie Roberts
Inpatient Observations - INOs/SDEC	2,262	-	Sally Kilgariff	Jodie Roberts
NE Inpatients (exc obs)	2,554	-	Sally Kilgariff	Jodie Roberts
Outpatients Follow Up - Attendances	15,545	14,699	Sally Kilgariff	Jodie Roberts

What actions are planned?

- Reconciliation of SDEC activity against Non-Elective under performance
- Review of un-coded A&E attendances – work underway to review documentation and recording in MT
- Continue to monitor follow-up performance and benchmark new to follow-up ratios at specialty level
- Identify any areas of correlation between non-elective pressures and reduction in elective procedures (impacting ERF)

What is the expected impact?

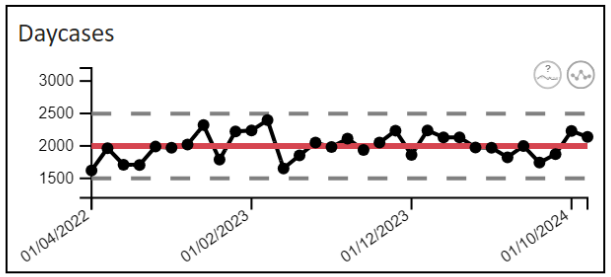
- Confirm SDEC/NEL activity is accurately being reflect in the data submission/contract monitoring. Fully understand the impact of EDS4.
- Ensure accurate record keeping for A&E attendances (should the contract mechanism change in the future this could potentially impact any re-basing)
- Identify areas of above national/peer average new to follow-up ratios and initiate further review to understand why

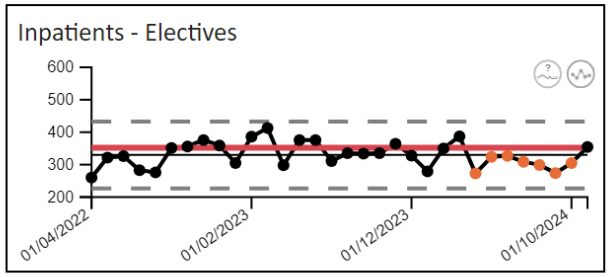
Potential risks to improvement?

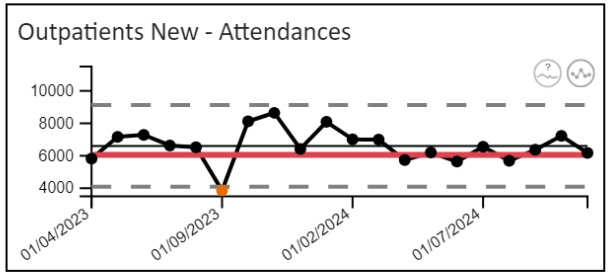
- Despite being on block, all key lines require scrutiny to ensure the Trust a) understands how this is impacting on financial performance b) we maintain an accurate position to safeguard changes to future contracting models
- Continuing increase in non elective demand, which is unfunded due to block contract.
- Switches of activity to SDEC could impact on any future re-basing (contract team aware)

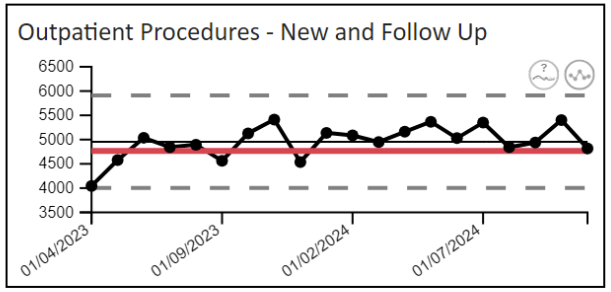
Subtheme: ERF

Data, Context and Explanation









- ERF contracted activity targets are based on 19/20 actuals + 3% (24/25 plans include the 3% increase)
- ERF lines operate on a cost and volume basis as per National Planning Guidance
- In October the new tariff price uplifts for the pay award have been transacted on both plan and actuals
- In-month Daycase activity is 264 above planned activity levels. Casemix has seen a significantly improvement at October flex position and in-month 8 is only £13k below plan. Ophthalmology, General Surgery, T&O, OMFS are the biggest contributors to the year-to-date under performance but improvements are being made
- In-month Elective is 3 above activity plan and £29k above income plan. General Surgery, T&O, Urology are the biggest contributors to the year-to-date under performance but improvements are being made
- In-month Outpatient New Attendances are 121 above planned levels with income at £59k above plan.
- In-month Outpatient Procedures are 50 above activity plan and £59k above income plan.

Metric	Value	Target	Exec Lead	Ops Lead
Daycases	2,139	1,999	Sally Kilgariff	Jodie Roberts
Inpatients - Electives	354	352	Sally Kilgariff	Jodie Roberts
Outpatients New - Attendances	6,170	6,049	Sally Kilgariff	Jodie Roberts
Outpatient Procedures - New and Follow Up	4,817	4,767	Sally Kilgariff	Jodie Roberts

What actions are planned?

- Additional sessions to increase Elective, Day case and Outpatient first activity from September 2024
- Outsourcing of T&O EL/DC activity has been agreed
- Activity recording issues continue to be addressed and corrected
- Issues with an external/internal system synchronisation continue to be identified and urgently addressed
- Analysis of Day Case activity by HRG

What is the expected impact?

- Internal additional sessions and insourcing/outsourcing schemes will support delivery against the 24/25 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.
- Agreement of waiting list initiative payments is likely to increase uptake of additional sessions by internal staff therefore reducing the need for ongoing external resource and reducing costs associated with theatre staff insourcing

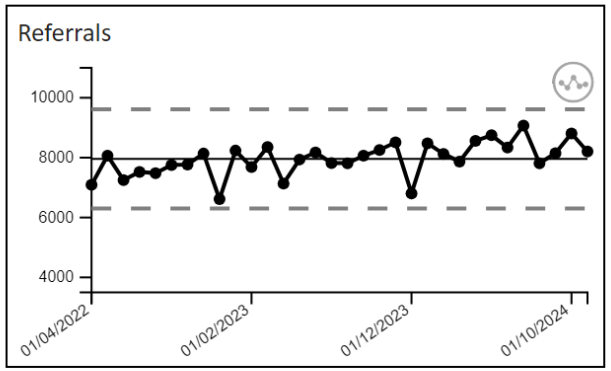
Potential risks to improvement?

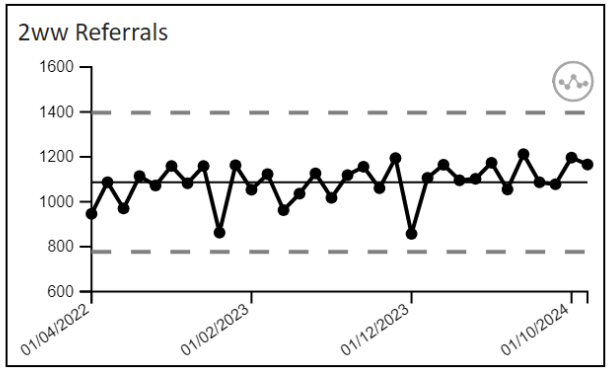
- Internal workforce (consultant and wider) to support additional sessions
- Efficient utilisation of core capacity (e.g. if core lists are stood-down or consistently underutilised, any additional sessions/insourcing will be replacing that loss of activity as opposed to delivering additional capacity)
- Work to correct the Outpatient procedure recording is much more complex than originally anticipated – however there remains a significant income opportunity
- Timely rectification of IT system data mapping issues

Subtheme: OP Demand

Metric	Value	Target	Exec Lead	Ops Lead
Referrals	8,203	-	Sally Kilgariff	Jodie Roberts
2ww Referrals	1,166	-	Sally Kilgariff	Jodie Roberts

Data





- Changes in referral patterns are key drivers affecting our ability to deliver waiting time and waiting list metrics
- Even small changes in specific specialties can generate significant increases in waits
- Referral patterns and trends are available in the Contract Monitoring Power BI data
- Significant changes generate discussion with Commissioners to identify what is driving the variation

What actions are planned?

- A more detailed review of referrals by specialty will be introduced into monthly Contract Compliance meetings held with Care Groups
- Identify whether duplicate referrals are being made to a range of services (often due to long waits)
- Identify appropriateness of 2WW referrals
- Review of capacity and demand to support 25/26 planning
- Increasing use of Advice & Guidance by GPs
- Capacity and Demand planning

What is the expected impact?

- Greater understanding of referral patterns internally
- Determine what discussions to have with Commissioners to identify potential solutions and work with Primary Care to ensure clinical referral protocols are being adhered to
- Agree approaches for Demand Management with Commissioners
- Communicate any new systems/processes
- Greater visibility on gaps to meet demand / activity plans based on Capacity and Demand planning

Potential risks to improvement?

- Analysis does not identify any inappropriate referrals (i.e. demand has genuinely increased)
- Analysis demonstrates sustained decreases in demand with no impact on waiting times or waiting list reductions
- Lack of engagement from Commissioners/Primary Care
- Nationally mandated targets which are non negotiable

Finance

Apr 24 to Nov 24

Key Headlines	Month			YTD			Forecast Variance £000s	Prior Month Forecast variance £000s
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s		
I&E Performance (Actual)	(284)	500	784	(715)	(2,661)	(1,946)	(9,522)	(12,372)
I&E Performance (Control Total)	(223)	565	788	(223)	(2,138)	(1,915)	(9,490)	(12,343)
Efficiency Programme (CIP)	1,193	688	(505)	7,201	3,571	(3,630)	(4,063)	(4,957)
Capital Expenditure	1,060	815	245	5,999	4,315	1,684	0	0
Cash Balance	(671)	(3,491)	(2,820)	5,986	10,145	4,159	0	0

Performance Matrix Summary – People and Culture

NHS The Rotherham NHS Foundation Trust

Variation	Assurance: Pass	Assurance: Hit or Miss	Assurance: Fail
Special Cause: Improvement	**EXCELLENT: LEARN AND CELEBRATE** • Turnover (12 month rolling)	**GOOD: CELEBRATE AND UNDERSTAND**	**CONCERNING: CELEBRATE BUT TAKE ACTION** • Appraisal Rates
Common Cause	**GOOD: CELEBRATE AND UNDERSTAND** • MAST – Job Specific • Vacancy Rate (total)	**STATIC: INVESTIGATE AND UNDERSTAND**	**CONCERNING: INVESTIGATE & TAKE ACTION** • Sickness Rates (12 month rolling) • Sickness Rates • Appraisal Rates (12 month rolling)
Special Cause: Concern	**CONCERNING: INVESTIGATE AND UNDERSTAND** • MAST - Core	**CONCERNING:INVESTIGATE & TAKE ACTION**	**VERY CONCERNING: INVESTIGATE & TAKE ACTION**

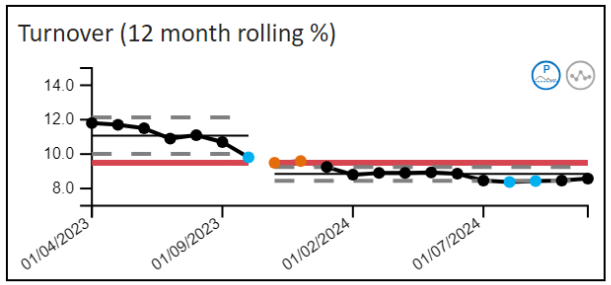
People and Culture

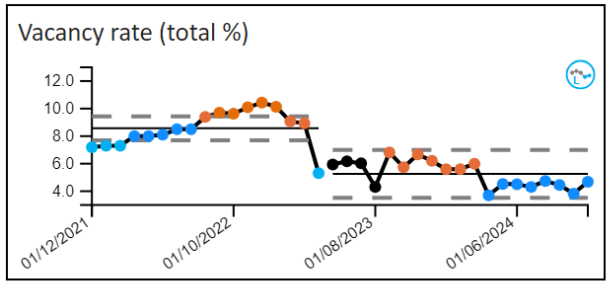
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
Turnover (12 month rolling %)	8.0-9.5	8.6	Nov-24	☑	P	L		VG
Vacancy Rate (total %)	-	4.7	Nov-24	-	-	L	-	G
Sickness Rates (12 month rolling %)	4.8	5.9	Nov-24	☒	F		-	C
Sickness Rates (%)	4.8	6.5	Nov-24	☒	F			C
Appraisal Rates (12 month rolling %)	90.0	80.9	Nov-24	☒	F		-	C
Appraisals Season Rates (%)	90.0	79.8	Nov-24	☒	F	H	-	CI
MAST – Core (%)	85.0	90.0	Nov-24	☑	P	L	-	C
MAST – Job Specific (%)	85.0	87.6	Nov-24	☑	P		-	G

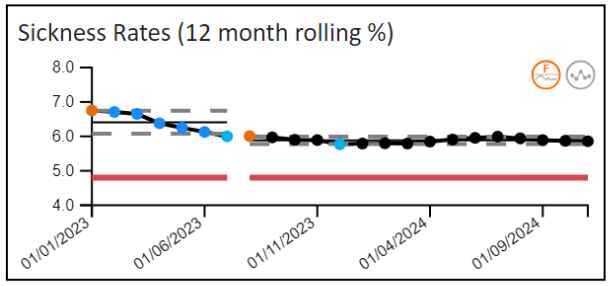
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

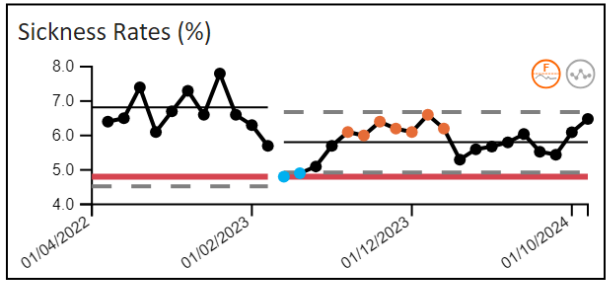
Subtheme: People

Data, Context and Explanation









- Retention performance continues to be strong and in within our target range for 2024/25 of 8-9.5%. Care Groups are all within a healthy range with more detailed breakdowns provided as part of operational management information for action where appropriate.
- Vacancy rate is in a strong position with strong recruitment campaigns for newly qualified nurses and midwives attracting success.
- Sickness absence rate performance, especially the rolling 12 month measure 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 %)	8.6	9.5	Daniel Hartley	Paul Ferrie
Vacancy rate (total %)	4.7	-	Daniel Hartley	Paul Ferrie
Sickness Rates (12 month rolling %)	5.9	4.8	Daniel Hartley	Paul Ferrie
Sickness Rates (%)	6.5	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
- Currently out to tender for Occupational Health Service with an emphasis in specification for more support to operational managers

What is the expected impact?

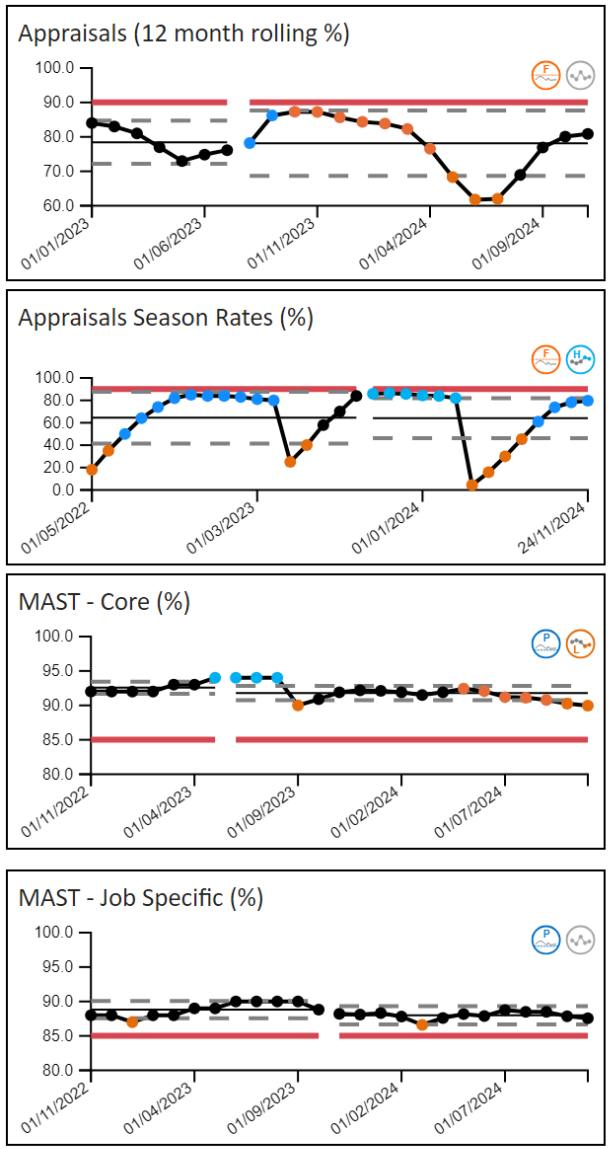
- Continued strong performance on retention and vacancy rates
- Improvement in sickness absence rates

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 begun to show an improvement as the appraisal season comes to a conclusion.
- New seasons appraisal completion rate performance is 79.8%, rolling 12 months 80.9% and is expected to improve further over the coming weeks as final appraisals are recorded onto ESR.
- This is a 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 %)	80.9	90.0	Daniel Hartley	Paul Ferrie
Appraisals Season Rates (%)	79.8	90.0	Daniel Hartley	Paul Ferrie
MAST - Core (%)	90.0	85.0	Daniel Hartley	Paul Ferrie
MAST - Job Specific (%)	87.6	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
- Review of new national guidance around MAST, expected during 2025/26

What is the expected impact?

- Improvement in appraisal completion rates both in month and rolling 12 months
- Improvement in MAST Core and Job Specific completion rates

Potential risks to improvement?

- Operational pressures resulting in reduced time for proactive people management and time for Appraisals and MAST completion

APPENDIX Assurance

Variation/Performance

	PASS	HIT OR MISS	FAIL
H	**VERY GOOD: CELEBRATE AND LEARN** • This metric is improving. • Your aim is high numbers and you have some. • You are consistently achieving the target because the current range of performance is above the target.	**GOOD: CELEBRATE AND UNDERSTAND** • This metric is improving. • Your aim is high numbers and you have some. • Your target lies within the process limits so we know that the target may or may not be achieved.	**CONCERNING: CELEBRATE BUT TAKE ACTION** • This metric is improving. • Your aim is high numbers and you have some. • HOWEVER your target lies above the current process limits so we know that the target will not be achieved without change.
L	This metric is improving. • Your aim is low numbers and you have some. • You are consistently achieving the target because the current range of performance is below the target.	• This metric is improving. • Your aim is low numbers and you have some. • Your target lies within the process limits so we know that the target may or may not be achieved.	• This metric is improving. • Your aim is low numbers and you have some. • HOWEVER your target lies below the current process limits so we know that the target will not be achieved without change.
	GOOD: CELEBRATE AND UNDERSTAND • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • HOWEVER you are consistently achieving the target because the current range of performance exceeds the target.	**STATIC: INVESTIGATE AND UNDERSTAND** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • Your target lies within the process limits so we know that the target may or may not be achieved.	**CONCERNING: INVESTIGATE AND TAKE ACTION** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • HOWEVER your target lies outside the current process limits and the target will not be achieved without change.
H	**CONCERNING: INVESTIGATE AND UNDERSTAND** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • HOWEVER you are consistently achieving the target because the current range of performance is below the target.	**CONCERNING: INVESTIGATE AND TAKE ACTION** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • Your target lies within the process limits so we know that the target may or may not be missed.	**VERY CONCERNING: INVESTIGATE AND TAKE ACTION** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • Your target lies below the current process limits so we know that the target will not be achieved without change
L	• This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • HOWEVER you are consistently achieving the target because the current range of performance is above the target.	• This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • Your target lies within the process limits so we know that the target may or may not be missed.	• This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • Your target lies above the current process limits so we know that the target will not be achieved without change

APPENDIX: SPC Summary Icons Key

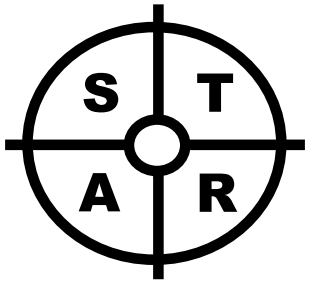
Assurance Icons

Icon	Technical Description	What does this mean?	What should we do?
	This process will consistently HIT AND MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **within** those limits then we know that the target will not be consistently achieved.	**Consider** whether this is acceptable and if not, you will need to change something in the system or process.
	This process is not capable and will consistently FAIL to meet the target if nothing changes.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the wrong direction** then you know that the target cannot be achieved.	**You need to change something in the system or process** if you want to meet the target.
	This process is capable and will consistently PASS the target if nothing changes.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the right direction** then you know that the target can be consistently achieved.	**Celebrate** the achievement. **Understand** whether this is by design and **consider** if the target is still appropriate.

Variation Icons

Icon	Technical Description	What does this mean?	What should we do?
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.	**Consider if the level/range of variation is acceptable.** If the process limits are far apart you may want to change something to reduce the variation in performance
	Special cause variation of a **CONCERNING** nature where the measure is significantly HIGHER.	**Something is going on!** Your aim is to have LOW numbers but you have some high numbers – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what is going on. Is it a one-off event that can be explained or do you need to change something?
	Special cause variation of a **CONCERNING** nature where the measure is significantly LOWER.	**Something is going on!** Your aim is to have HIGH numbers but you have some low numbers – something one-off, or a continued trend or shift of low numbers.	**Investigate** to find out what is going on. Is it a one-off event that can be explained or do you need to change something?
	Special cause variation of a **IMPROVING** nature where the measure is significantly HIGHER.	**Something good is happening!** Your aim is to have HIGH numbers and you have some – either something one-off, or a continued trend or shift of high numbers.	Find out what is going on. **Celebrate** the improvement and **share learning** with other areas.
	Special cause variation of a **IMPROVING** nature where the measure is significantly LOWER.	**Something good is happening!** Your aim is to have LOW numbers and you have some – either something one-off, or a continued trend or shift of low numbers.	Find out what is going on. **Celebrate** the improvement and **share learning** with other areas.

Data Quality STAR Key



Domain	Definition
Sign Off and Validation	Is there a named responsible person apart from the person who produced the report who can sign off the data as a true reflection of the activity? Has the data been checked for validity and consistency?
Timely and Complete	Is the data available and up to date at the time someone is attempting to use it to understand the data? Are all elements of information need present in the designated data source and no elements of need information are missing?
Audit and Accuracy	Are there processes in place for either external or internal audits of the data and how often do these occur?
Robust Systems and Data Capture	Are there robust systems which have been documented according to data dictionary standards for data capture such that it is at a sufficient granular level?

Metric Log

Metric	Definition	Target Type	Target Value	DQ STAR
SHMI	Ratio between the actual number of patients who die following hospitalisation and the number expected to die based on population average.	Benchmark	As Expected	
Readmissions (%)	Proportion of readmissions within 30 days from the same Treatment Function specialty back to same Treatment Function specialty.	-	-	
VTE Risk Assessments (%)	Proportion of patients eligible for VTE Screening who have had a VTE screen completed electronically as per DH and NICE guidance.	National	95.0	
Care Hours per Patient Day	The Number of Care Hours per patient day.	National	7.3	
Combined Positivity Score (%)	The Positivity Rate of all the Friends and Family tests done combined - includes IP/DC/OP/UECC/Community/Maternity/Paeds/Long Covid	National	95.0	
Complaints	The number of formal complaints received.	Local	-	
Patient Safety Incident Investigations	The number of Patient Safety Incident Investigations that take place.	Local	0	

Metric Log

Metric	Definition	Target Type	Target Value	DQ STAR
Medication Incidents	The number of recorded medication incidents	Local	-	
Pressure Ulcers (Cat 3/4/STDI and Unstageable) per 1000 bed days	The number of Pressure Ulcers (Cat 3/4/STDI and Unstageable) per 1000 bed days	Local	-	
Patient Falls	The number of Patients Falls (Moderate and Above) per 1000 bed days	Local	0	
C. difficile Infections	The number of recorded C. difficile infections	Local	0	
1:1 Care in Labour (%)	Proportion of women in established labour who receive one-to-one care from an assigned midwife.	Local	75.0	
Breast milk first feed (%)	The percentage of babies born that receive maternal or donor breast milk as their first feed	National	70.0	
Stillbirth rate (per 1000 births)	The number of still births per 1000 live births	Local	4.66	

Metric Log

Metric	Definition	Target Type	Target Value	DQ STAR
Waiting List Size	Number of patients waiting to receive a consultative, assessment, diagnosis, care or treatment activity	Local	-	
Number of 52+ Weeks	Number of patients on the incompletes waiting list for more than 65 weeks	Local	200	
Number of 65+ Weeks	Number of patients on the incompletes waiting list for more than 65 weeks	Local	37	
Referral To Treatment (%)	Proportion of patients that receive treatment in less than 18 weeks from referral	National	92.0	
OP Activity moved or Discharged to PIFU (%)	Proportion of patients moved to a Patient Initiated Follow-up Pathway following an outpatient appointment	National	3.0	
Overdue Follow-ups	Number of patients who are overdue their follow-up appointment, based on the requested time-period for the appointment made by the clinician	Local	-	
DM01 (%)	Proportion of diagnostics completed within 6 weeks of referral for 15 Key Tests	National	1.0	

Metric Log

Metric	Definition	Target Type	Target Value	DQ STAR
Faster Diagnosis Standard (%)	Proportion of patients diagnosed with cancer or informed cancer is excluded within 28 days from receipt of urgent GP referral for suspected cancer, breast symptomatic referral or urgent screening referral	National	75.0	
31 Day Treatment Standard (%)	Proportion of Patients receiving first definitive treatment for cancer within 31 days following an urgent referral for suspected cancer	National	96.0	
62 Day Treatment Standard (%)	Proportion of Patients receiving first definitive treatment for cancer within 62 days following an urgent referral for suspected cancer	National	85.0	
4 Hour Performance (%)	Proportion of Patients that have been seen and treated and left dept within 4hrs (admitted or discharged) based on Dept date.	Local	70.0	
Ambulance Handover Times <15 mins (%)	Proportion of Ambulance Handovers where the time recorded was as waiting less than 15 mins for handover.	-	-	
Ambulance Handover Times >60 mins (%)	Proportion of Ambulance Handovers where the time recorded was as waiting over 60 mins for handover.	National	0.0	
Average time to be seen by a clinician (mins)	The average time a patient waits from Arrival to being seen by a clinician in ED.	Local	60	

Metric Log

Metric	Definition	Target Type	Target Value	DQ STAR
Patients spending >12 hours in A&E from time of arrival (%)	Proportion of Patients who are in ED for longer than 12hrs from Arrival to Departure/Admission	Local	2.0	
12hr Trolley Waits	Number of patients waiting more than 12 hours after a decision to admit	National	0	
Bed Occupancy (%)	Proportion of Adult G&A beds occupied as at midnight snapshots daily as per KH03 guidance.	Local	91.6	
Criteria to Reside is No (%)	Proportion of inpatients where Criteria to Reside is no	Local	9.9	
Length of Stay over 21 Days	Snapshot of number of Inpatients with a current LOS of 21 days or more as at month end.	Local	70	
Patients where Date of Discharge = Discharge Ready Date (%)	Proportion of patients where date of discharge is same as the recorded Discharge Ready Date	Local	85.0	
A&E Attendances from Care Homes	Number of care home residents attending A&E (based on postcode)	Local	144	

Metric Log

Metric	Definition	Target Type	Target Value	DQ STAR
Admissions from Care Homes	Number of care home residents admitted (based on postcode)	Local	74	
Number of Patients on Virtual Ward	Number of patients on a virtual ward in the month	Local	80	
Urgent 2 Hour Community Response (%)	Proportion of standard Urgent 2 Hour Community Response (UCR) referrals seen within 2hrs.	Local	70.0	
Clinic Utilisation (%)	Proportion of Outpatient clinic slots that are utilised	Local	85.0	
Capped Theatres Utilisation (%)	Proportion of time spent operating in theatres, within the planned session time only.	National	85.0	
Model Hospital Daycase Rate (%)	The total number of Day Cases done on patients over 17 where the admission method is elective and the episode is "pre-planned with day surgery intent"	Local	85.0	
Did Not Attend (%)	Proportion of Outpatient clinic slots where the outcome was Did Not Attend	Local	7.0	

Metric Log

Metric	Definition	Target Type	Target Value	DQ STAR
First Outpatients (% of Plan)	In month activity compared to plan, defined as 103% of 19/20 activity for same month on a working day basis.	National	103.0	
Inpatients (% of Plan)	In month activity compared to plan, defined as 103% of 19/20 activity for same month on a working day basis.	National	103.0	
Daycases (% of Plan)	In month activity compared to plan, defined as 103% of 19/20 activity for same month on a working day basis.	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	

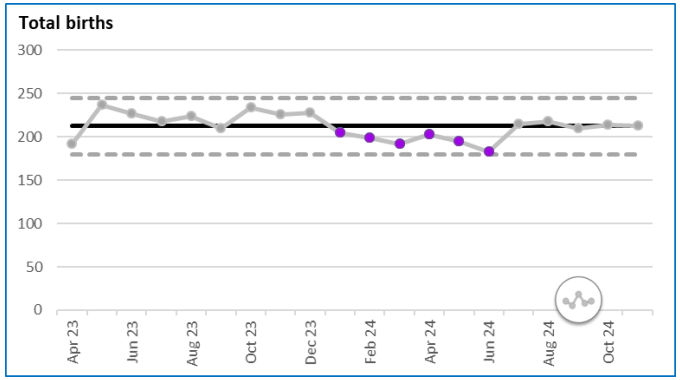
Board of Directors
10th January 2025

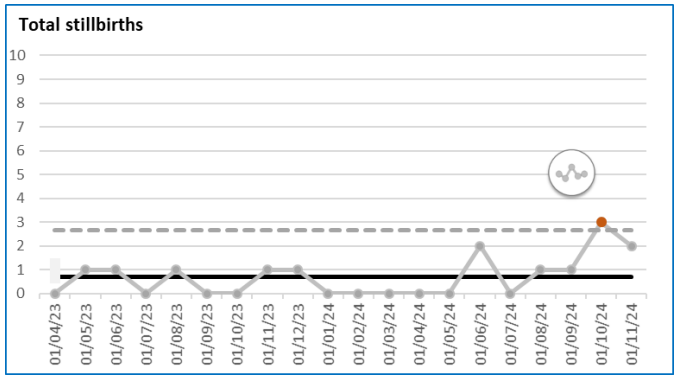
The Rotherham NHS Foundation Trust

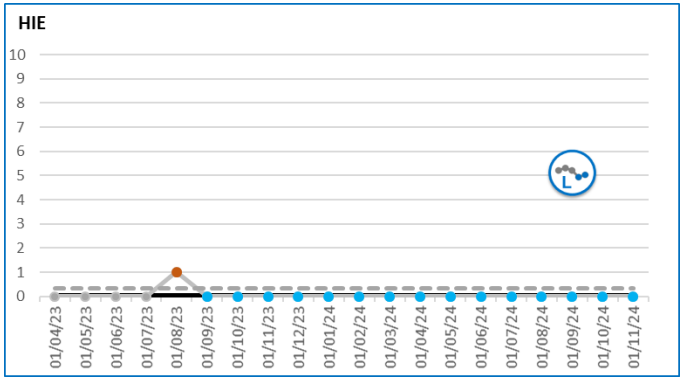
Agenda item	P18/25
Report	**Maternity and Neonatal Safety**
Executive Lead	Helen Dobson, Chief Nurse
Link with the BAF	P1: There is a risk that we will not embed quality care within the 5-year plan because of lack of resource, capacity and capability leading to poor clinical outcomes and patient experience for our patients.
How does this paper support Trust Values	High Standards for the services we deliver, aim to be outstanding, delivering excellent and safe healthcare.
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary	It is a national requirement for The Board of Directors to receive a monthly update on Maternity Safety, which goes through Quality Committee. This month's paper is a full maternity and neonatal safety report. • The Perinatal oversight maternity dashboard data is represented below in the Safety Statistical Process Control charts (SPC). The stillbirth data represents an increase over the last 3 months. • The Perinatal Mortality data for November represents an adjusted total Perinatal death rate of 4.85 per 1000, for stillbirth 4.04 per 1000. This is a consequence of the cluster of stillbirths reported in September, October and November 2024. A thematic review has been undertaken and the Local Maternity and Neonatal System (LMNS) have been invited to undertake an independent review of all cases for 2024. Three cases have met the criteria for Maternity and Newborn Safety investigation (MNSI) referral. • The data for the Perinatal Mortality Review Tool (PMRT is presented for TRFT, sharing the updates on the cases reviewed and learning from PMRT review meetings. • The Maternity safety data is presented, there were 13 cases reviewed as moderate harm in November 2024 with x1 case remaining as a moderate harm following MDT review. This case was referred for MNSI investigation. • The Published CQC Maternity inpatient results are shared with the benchmarking position of TRFT nationally. The Maternity service have invited the maternity and Neonatal Voices lead to co design an improvement plan following the findings from the survey. • The compliance for the Maternity Incentive Scheme (MIS) Year 6 is shared in the paper with a presentation to reflect full compliance with all ten safety actions. Safety action 4 required an action for Neonatal Nursing staffing to meet the safety action recommendations and this has been approved by the LMNS. (Appendix 2) • The Avoiding Term Admission to the Neonatal Unit rate (ATAIN) in

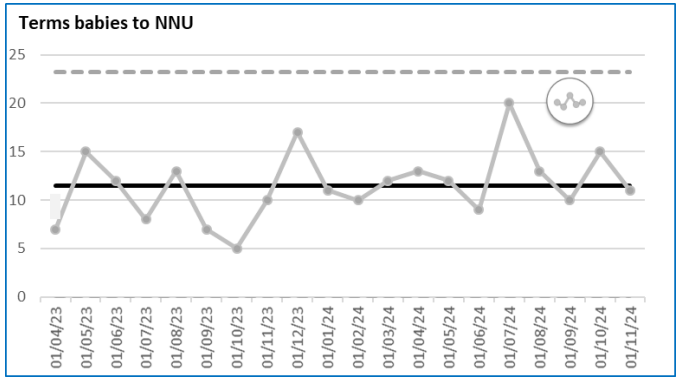
	November 2024 had decreased from the previous month but remains above the 5% regional target as seen in Table 14.1. Of the term admissions, following MDT review, 1 case was noted to have been avoidable.
Due Diligence	This paper has been prepared by the Head of Midwifery and shared through Maternity and Care Group 3 Business and Governance meetings, the Maternity and Neonatal Safety Champions and Quality Committee
Board powers to make this decision	The Trust Board are required to have oversight on the maternity and neonatal safety work streams.
Who, What and When	Helen Dobson, Chief Nurse, is the Board Executive Lead. The Head of Midwifery attends Quality Committee and Trust Board bi-monthly to discuss the Maternity and Neonatal Safety agenda.
Recommendations	It is recommended that Quality Committee are assured by Maternity and neonatal outcome data and update provided.
Appendices	Appendix 1 is included in the report as a reference guide for reporting criteria and Key of categories. The Appendices below are in the reading room: 1. Appendix 2 BAPM Nursing action plan 2. Appendix 3 Maternity incentive scheme presentation 3. Appendix 4 Maternity incentive scheme Tracker 4. Appendix 5 CNST board sign off 5. Appendix 6 Perinatal Mortality Review Tool data

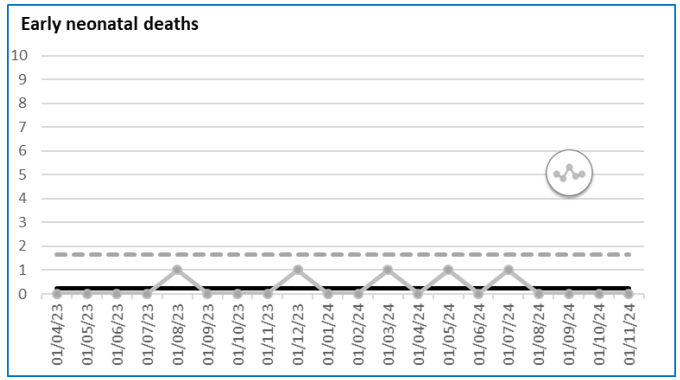
Maternity Safety Statistical Process Control charts (SPC)

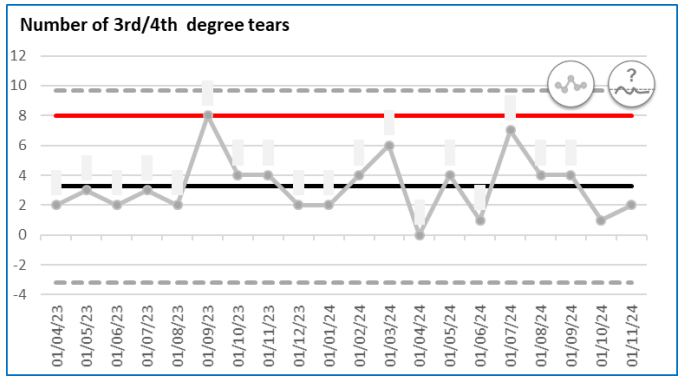


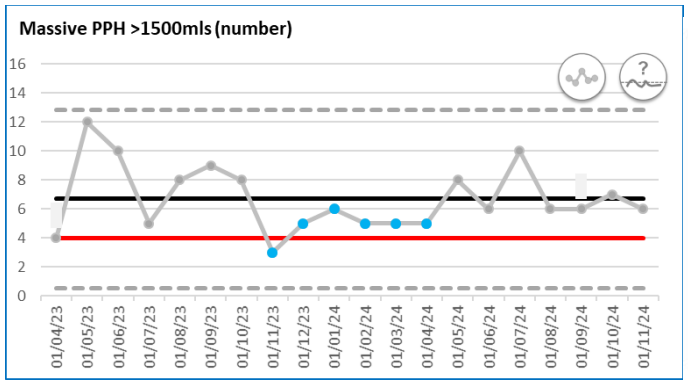


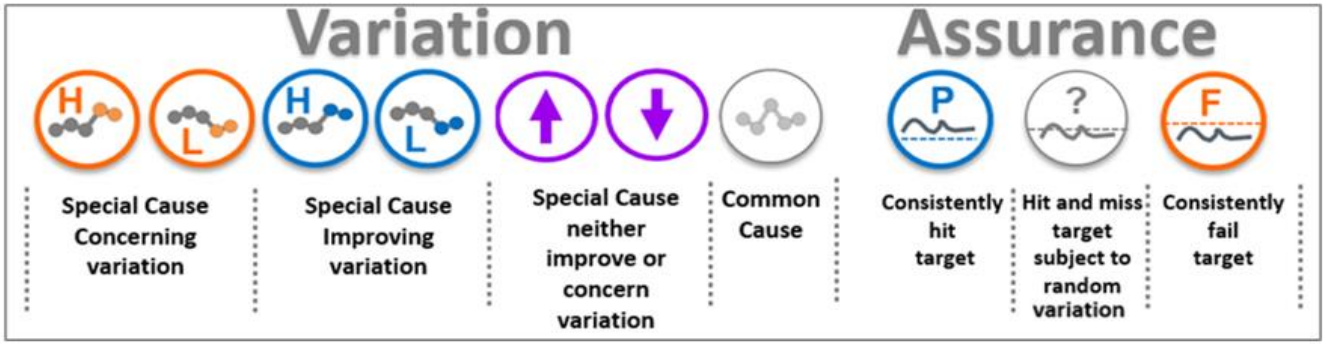












TRFT Maternity Dashboard: General

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Smoking at booking %	Nov 24	10.6%	6.0%			10.8%	4.8%	16.8%
Smoking at birth %	Nov 24	13.7%	6.0%			10.4%	5.8%	15.0%
Number of bookings	Nov 24	263	-			250	187	312
Booking < 13 weeks	Nov 24	90.9%	90.0%			90.2%	84.8%	95.7%
Booking < 10 weeks	Nov 24	67.7%	90.0%			71.0%	61.2%	80.8%
Personalised Care Plan	Nov 24	97.7%	95.0%			97.7%	94.7%	100.7%
Total Induction rate	Nov 24	35.0%	32.8%			37.9%	29.0%	46.8%
Augmentation IOL	Nov 24	42	-			42	23	61
Augmentation 1st Stage	Nov 24	21	-			14	0	28
Augmentation 2nd stage	Nov 24	3	-			3	-1	6
Shoulder dystocia	Nov 24	3	2			3	-3	8
Massive PPH >1500mls (number)	Nov 24	6	4			7	1	13
Massive PPH >1500mls (%)	Nov 24	2.8%	2.0%			3.1%	0.3%	6.0%
Number of 3rd/4th degree tears	Nov 24	2	8			3	-3	10
3rd/4th degree tears in spontaneous vaginal birth	Nov 24	2	-			2	-3	7
3rd/4th degree tears in spontaneous vaginal birth (%)	Nov 24	1.7%	2.8%			1.7%	-2.9%	6.4%
3rd/4th degree tears assisted birth	Nov 24	0	-			1	-3	5
3rd/4th degree tears assisted birth (%)	Nov 24	0.0%	6.0%			6.9%	-19.5%	33.3%
Number of eclamptic fits	Nov 24	0	-			0	0	0
Pressure ulcers	Nov 24	0	-			0	0	1
Optimal Cord Clamping	Nov 24	96.7%	-			90.6%	84.6%	96.6%
APGARS 0-6 @ 1 minute	Nov 24	12	-			11	-2	24
APGARS 7-10 @ 1 minute	Nov 24	199	-			200	171	229
Skin to skin	Nov 24	84.0%	80.0%			82.5%	73.6%	91.4%
Breastfeeding	Nov 24	58.0%	72.7%			60.2%	51.4%	69.0%

DATA MEASURES – REVISED PERINATAL QUALITY SURVEILLANCE TOOL Nic

Trust:

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

Maternity Safety Support Programme	Select	No

	Jan	Feb	March	April	May	June	July	Aug	Sep	Oct	Nov
1.Findings of review of all perinatal deaths using the real time data monitoring tool	No immediate learning identified at the January 2024 perinatal Meeting. Cases to be closed still.	Questions raised at the review meeting, the cases are to be presented again for further discussion and review.	No perinatal mortality meeting held March 2024	Issues raised with 1 case. Thematic review of processes in triage to be undertaken	No immediate learning identified for cases presented at May perinatal mortality meeting. Some learning to be disseminated to staff via learning points.	June 2024 perinatal mortality meeting (PMRT) cancelled due to Dr's industrial action.	Review of Neonatal death, learning identified and an action plan has been formulated. See Narrative in point 4	Minutes and details pending	No perinatal mortality meeting was held Sept 2024. Cases on the Sept agenda will be reviewed at the meeting to be held 25/10/2024.	No immediate learning was identified from the 4 cases that were reviewed and graded using PMRT.	No immediate learning identified. 1 case graded as a C and has already been investigated as a PSII following the rapid review that was undertaken. Overview of the most recent 6 stillbirths with LMNS support.
2. Findings of review of all cases eligible for referral to HSIB	1 case in progress. Draft report received with no safety recommendations	1 case completed. Final report shared with staff involved. Tripartite meeting to be held with family in April. No safety recommendations	No cases reported to MNSI in March	1 case referred to MNSI in April. Cat 1 section for pathological CTG. Baby has HIE.	1 case ongoing with MNSI. No new referrals in May.	2 cases referred in June. 1 case referred to MNSI for baby requiring cooling. MRI shows no signs of HIE, therefore case rejected by MNSI. 1 case referred for a maternal death, 1 case remains ongoing.	2 cases ongoing, same as previous months finding, still attempting to gain consent for MNSI to investigate recent maternal death.	1 ongoing case reported in April, report anticipated next month. Unable to gain consent for maternal death. Working with South Yorkshire advocate to continue to gain consent.	1 case ongoing, draft report due October to Trust. 1 case rejected for lack of consent following maternal death. Approaching NoK for consent and will refer again. 1 new case referred for an intrapartum stillbirth at 39+6/40	2 MNSI cases ongoing. 1 draft report being shared with family following Trust review. 1 new case referred for a woman who presented in labour with no fetal heart detected. Meeting the criteria as a Intrapartum stillbirth 39+3/40 in October.	1 case completed. Final report shared with staff. 2 cases ongoing for intrapartum stillbirths. 2 new cases referred for an intrapartum still births at 39+/40. Attended in spontaneous labour but no fetal heart on admission. 1 case initially referred in October but rejected as no family consent. Consent now gained and case progressing.

Report on: 2a. The number of incidents logged graded as moderate or above and what actions are being taken	16 recorded as moderate harm. Following MDT review 0 remained moderate harm	15 recorded as moderate harm. Following MDT review 0 remained at moderate harm	20 recorded as moderate harm. Following MDT review 0 remained at moderate harm	14 recorded as moderate harm. Following MDT review 1 remained at moderate harm	15 recorded as moderate harm. Following MDT review all were graded as low or no harm.	17 recorded as moderate. Following MDT X1 remained moderate and for further investigation x1 level of harm death for further investigation by MNSI.	In July there were 109 incidents logged of which 25 cases graded as Moderate – following review, only one remained moderate.	In August there was 111 incidents reported of which 15 were graded as moderate. Following MDT review all were graded as low or no harm.	In September there were 100 incidents reported of which 18 incidents were graded as moderate. Following MDT review all but one were graded as low or no harm. One incident remained at moderate, case referred to MNSI	In October there were 128 incidents reported. 15 incidents were graded as moderate. Following MDT review all but one were graded as low or no harm. One incident remained moderate which was referred to MNSI.	In November there were 103 incidence, 13 were recorded as moderate but following review 12 were downgraded to low harm, 1 incident remained at moderate harm which is an MNSI referral.
2b. Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training	All staff groups are over the required 90% compliance range.	Training compliance of Obstetric trainees has declined to below 90% due to new rotation of trainees. Training for all other disciplines is >90%	See section 12.2	90% for all disciplines with the exception of junior Doctors.	90% for all disciplines with the exception of junior Doctors. The new programme for obstetric Anaesthetists requires a full day MDT training from April 24	90% of all disciplines with the exception of junior doctors (89%) and anaesthetics. (28%). Plan in place.	90 % for all disciplines with the exception of Anaesthetic colleagues see section 11.1	No training in August 24	See section 11.1	CNST & Maternity MAST ongoing.	See section 12.2 for training updates and compliance.
2c. Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively	See point 12 within this report for a full break down.	No issues for escalation	See section 19	No staffing issues for escalation see Appendix 2 for Bi annual staffing report	No staffing issues for escalation see Appendix 2 for Bi annual staffing report	Doctor strike managed well with senior cover. No issues to escalate.	No staffing issues to escalate for the month of July 24.	August report in next month's paper	See section and 9.1 Appendix 2	Staffing remains stable and in line with Birthrate+	See section 10 for overview of staffing levels.
3.Service User Voice Feedback	NHS CQC Maternity Survey 2024 Result, see point 5.1 within	MNVP role to change over to the MNVP engagement	MNVP 15 Steps NNU	Feedback shared from MNVP Facebook	Interim MNVP lead supporting TRFT,	New MNVP substantive role recruited to.	Parents and carer panel focus group	New MNVP lead now in post – to	CQC picker survey results received,	Work ongoing for the new MNVP chair	CQC picker survey results now published, to share with MNVP for

	this report.	officer from April 2024.		page for TRFT	chairing local MNVP meeting and sharing user feedback.	To start in Aug 24. Work plan reviewed with LMNS.	feedback received from MNVPs. Narrative in report for August.	explore resources from Sand's and Tommy's to support Equality and Equality plan.	embargoed until December 2024	creating new diverse networks.	action plan development.
4. Staff feedback from frontline champion and walk-abouts. Executive / NED meeting with the perinatal leadership team	Walk-about and meeting feedback, see point 13 within this report.	Visit to NNU to support the team. No escalations.	No walk around meeting in March 2024	No walk around meeting in April 2024	Visit to NNU	No walk around in June. Planned for community 2nd July 24.	Community walk around with Board level safety champion – Narrative within Sept report.	Escalations to safety champion around the lack of theatre space for planned LSCS and around the ongoing NND case that will be heard by the Coroner	See Section 10.1	No walk around this month, planned for Wharncliffe ward next	See section 13.1
5.HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
6.Coroner Reg 28 made directly to Trust	0	0		0	0	0	0	0	0	0	0
7.Progress in achievement of CNST 10	Achieved	Achieved	Achieved	Achieved New standards began for 24/25	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing

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

1. Report Overview

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

2. Perinatal Mortality Rate

2.1 Within Q2 and Q3 of 2024, TRFT have seen a cluster of 6 stillbirths in September, October and November which is demonstrated within the SPC charts above on page 3 of this report. Below in table 2.1 is a brief overview of the 6 cases which occurred in the last 2 quarters.

Date of stillbirth	Gestation	Ethnicity	Deprivation rank	PSII or MNSI referral
28/09/2024	39+6/40	White British	2	MNSI referral as in labour at attendance to unit. + PMRT
28/09/2024	35+6/40	White British	3	Rapid review + PMRT
07/10/2024	T+6/40	White British	7	Rapid review + PMRT
14/10/2024	39+3/40	White British	2	MNSI referral as in labour at attendance to the unit. +PMRT
30/10/2024	37+5/40	White British	1	Rapid review + PMRT
16/11/2024	39+2/40	White British	5	MNSI referral as in labour at attendance to the unit. + PMRT

Table 2.1 Overview of Q2 and Q3 cases

2.2 All cases have been individually reviewed by the MDT team and will follow the systematic, MDT Perinatal Mortality Review Tool (PMRT) process. 3 cases were found to meet the MNSI criteria for referral as the women were deemed to be intrapartum at the time of the stillbirth diagnosis. All referred cases have received a Duty of Candour letter and all three families have given consent to be contacted by MNSI.

2.3 In the ethos of Patient Safety Incident Response Framework (PSIRF) and to gain the maximum learning for the maternity unit, a thematic review has been undertaken by the in-house MDT. From this, whilst there has been incidental learning, overall, the pathways and guidelines have been followed for each case. One focus of the developed action plan from the thematic review is to look at current pathways and acuity of women requiring an induction of labour, whilst current national and local guidelines were followed, 4 of the 6 women had a scheduled date for admission for an induction of labour at the time of the stillbirth diagnosis, however, the thematic

review has concluded that there were no delays with induction of labour which may have contributed to the outcome.

2.4 To add further rigour into the investigation of the rise of TRFT stillbirths, the Local Maternity and Neonatal System (LMNS) have been invited to undertake an external thematic review of the above cases. The team consisted of a senior Obstetric Consultant and a Senior Midwife who have been supported by our team to access information to undertake their independent review. At the time of submitting this report, the LMNS are in the process of compiling their feedback.

2.5 The impact on the staff who have cared for and continue to care for the families who have suffered a stillbirth has been acknowledged by the senior team. Supportive meetings have been arranged by the Governance Midwife, the Bereavement Midwife and Professional Midwifery Advocates (PMAs) with the focus of not only offering a space to debrief but to share the findings of the initial rapid review. Our Bereavement Midwife also has regular supervision from an external psychologist to support her in her challenging role.

3. Perinatal Mortality Summary for month of November 2024

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

	2022 Total:	2023 Total:	01/01/2024 – 31/10/2024	In Month: Nov 2024
Total Stillbirths (All)	7	6	7	2
Stillbirths >37 weeks	1	1	3	2
Stillbirths 24 - 36+6 weeks	6	5	4	
Intrapartum Stillbirths	1	-	1	1
MTOP Anomaly >24 weeks	0	2	-	-
Adjusted Stillbirths	7	6	7	2
Total Neo-Natal Deaths (NND)	8	4	4	-
ENND >24 weeks up to 7 days of life	7	2	1	-
LNND 7-28 days	1	1	1	-
Adjusted Neonatal Deaths – All gestation (EXCL MTOP)	2	2	1	0
Total Adjusted Perinatal (24 wk – 28 days)	9	8	7	2
MTOP ENND	1	-	-	-
Stillbirth Elsewhere (booked at RFT)	0	-	-	-
Neo-Natal Deaths Elsewhere (outside of TRFT)	2	2	4	-
Maternal Deaths	0	1	1	-
NVF <24 weeks	12	10	12	1
NPMRT entered	12	10	10	2
NPMRT Closed	14	10	8	0

Table 3.1 TRFT perinatal deaths (See appendix 1 for key)

3.2 The rolling figure of stillbirths and neonatal deaths from Dec 2023 to Nov 2024 are as demonstrated within Table 3.5 below. The TRFT rate has increased to 4.40 per 1000 births for stillbirths. The current South Yorkshire stillbirth rate is 3.29 per 1000 births. In the October 2024 paper, TRFT rates were 1.99 per 1000 births.

Adjusted Perinatal Mortality (excludes deaths due to congenital anomalies and MTOP) Adjusted Total Perinatal **4.85/1000 births**		
Type of death	Number	Rate per 1000 births
Stillbirth	10	4.04
Neonatal Death	2	0.81

Table 3.5 Adjusted perinatal deaths

4. PMRT real time data monitoring tool

4.1 In Oct 2024 – November 2024, 2 PMRT cases were closed and the reports published. Details were also inputted into 1 PMRT case that is held by another trust. Table 4.1 represents the PMRT meeting outcomes from December 2023 – 10th December 2024.

4.2 Following the review of a neonatal death via the PMRT process, a new LMNS Standard Operating Procedure (SOP) is being created to support Trusts where parents have requested that a PMRT should be re-opened. The SoP is currently within the LMNS Governance process and is expected to be shared in the new year.

4.3 Whilst there have been no themes or trends identified from the timeframe of this reporting period, learning from a PMRT case of a 28-week neonatal death included, gaining an impact statement from the family to be used within the maternity MAST training to improve bereavement communication with families. A more detailed action plan from this case has been created and has been shared via the Maternity and Neonatal Safety Champions meeting.

4.4 Appendix 6 represents the requirements of CNST standard 1 – reporting all eligible cases to MBRRACE and reviewing cases using PMRT.

CNST standard 1 requirements	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	July 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24
Percentage of eligible perinatal deaths reviewed using PMRT as an MDT (100%)	No cases	No cases	No cases	No cases	No cases	100%	No cases	100%	100%	100%	100%	
Percentage of eligible perinatal deaths notified to MBRRACE – UK within 7 working days (100%)						100%		100%	100%	100%	100%	
Surveillance information completed within 1 calendar month.						100%		100%	100%	100%	100%	
Percentage of parents that have had their perspective of care and any questions sought following baby's death (95%)						100%		100%	100%	100%	100%	
Percentage of PMRT reviews started within 2 months (95%)						100%		100%	100%	100%	100%	
Percentage of PMRT reports published within 6 months (60%)												

All cases are post qualifying date for publication of final report.
The requirement for the draft report has been removed from CNST requirements.

Table 4.1

5. Maternity and New-born Safety Investigation (MNSI) formally known as Healthcare Safety Investigation Branch (HSIB) and Maternity Patient Safety Investigations (PSII) (Criteria Appendix 1)

5.1 Since the commencement of MNSI (formally HSIB) maternity investigations in 2018, TRFT have reported 26 cases for external review. Of the 26 cases, 10 were rejected, leaving 16 cases progressing to a full external investigation, three of the 16 cases are ongoing. Table 5.1 demonstrates the level of safety recommendations for all cases that have been completed.

Case number	Category	Date completed	Recommendations
1901-319	HIE/Cooling	20/12/2019	2 Safety recommendations
1902-430	HIE/Cooling	13/03/2020	No safety recommendations
1903-555	Maternal death	03/02/2020	No safety recommendations
1909-1185	HIE/Cooling	30/06/2020	2 Safety recommendations
1912-1509	HIE/Cooling	18/08/2020	4 Safety recommendations
2007-2295	HIE/Cooling	18/01/2021	No safety recommendations
2009-2470	Neonatal Death	01/04/2021	3 safety recommendations
2101-2893	HIE/Cooling	20/07/2021	6 safety recommendations
MI- 03385	HIE/Cooling	18/10/2021	No safety recommendations
MI-03662	Neonatal Death	22/11/2021	No safety recommendations
MI-05238	Stillbirth	24/05/2022	1 Safety recommendation
MI-028038	HIE/Cooling	22/02/2024	No safety recommendations
MI-037282	HIE/Cooling	29/11/2024	3 Safety recommendations, 8 safety prompts

Table 5.1, MNSI completed cases.

5.2 Case MI-037282 (the final case within Table 5.1) has now been completed and the final report shared with staff and the family for a baby having seizures at 36 hours of age and abnormal head CT which occurred in March 2024. MNSI will approach the family to offer a tripartite meeting. An improvement plan meeting is taking place to develop an action plan for the final report which has the following 3 safety recommendations.

1. It is recommended that the Trust develops latent phase guidance to support staff to develop an individualised and holistic plan of care for mothers in the latent phase of labour that considers both maternal and fetal wellbeing. This to include timescales for fetal monitoring, support for mothers and thresholds for escalation to ensure the safety and wellbeing of mothers and babies.
2. It is recommended that the Trust develops guidance to support clinicians to recognise, appropriately categorise and escalate an abnormal cardiotocograph when labour is not established and reinforce this through regular multi-disciplinary training.

3. It is recommended that staff are supported to recognise and appropriately categorise a CTG when a mother is not in established labour and that an abnormal CTG is immediately escalated using a structured communication tool.

5.3 In June 2024 the maternity service reported a maternal death which took place at 5 weeks postnatally following her birth at TRFT, this case was referred to MNSI. MNSI have stood down the case due to lack of consent from the family. The Next of Kin have been approached for consent on several occasions via several routes, however we have received no response. Consequently, this case will now become a PSII for Maternity to lead as an internal investigation.

5.4 In September 2024 one of the 6 stillbirths discussed in 2.1 of this paper was referred to the MNSI. The case to be investigated is a woman who presented in the latent phase of labour where an intrapartum stillbirth at 39 weeks and 4 days gestation was found on admission. Staff involved in the case are to be interviewed. Invitations have been sent out with the offer of PMA support.

5.5 In October 2024, an intrapartum stillbirth identified on admission to labour ward at 39 weeks and 3 days gestation was initially rejected by MNSI as the family did not wish to give consent. Following further discussion with the TRFT maternity governance team, family consent was gained, and the case was re-referred in November 2024.

5.6 A further case was referred in November 2024 of a woman presenting in the latent phase of labour where an intrapartum stillbirth at 39 weeks and 2 days gestation was identified on admission.

5.7

Ref	Case Ref	Type	Start date	Overview	Progress
167978	MI-037282	MNSI	22/04/2024	Pathological CTG. Seizures at 36 hours old with abnormal head CT and MRI.	Report completed and final November 2024. (Safety recommendations explained in 5.2).
170988	N/A	MNSI	Rejected	Maternal death following a cardiac arrest. Woman brought to UECC 5 weeks postnatal.	MNSI unable to gain consent from family. MNSI to archive at this time. Case returned to Trust Incident review panel, now declared Trust PSII
175352	MI-038575	MNSI	30/09/2024	Intrapartum stillbirth. Attended in latent phase of labour and sadly no fetal heartbeat on admission.	Family consent gained, record sharing in progress

176026	MI-039030 (Initially MI-038697)	MNSI	13/11/2024	Intrapartum stillbirth at 39 weeks and 3 days gestation. Initially	Family declined consent initially. Following further conversation consent gained and case now in progress
177379	MI-039073	MNSI	19/11/2024	Intrapartum stillbirth at 39 weeks and 2 days gestation	Family consent gained. Record sharing in progress

Table 6.1. MNSI ongoing cases and progress

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

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

Table 5.8 Ongoing current PSII cases.

6. Coroner Regulation 28 made directly to Trust

6.1 TRFT Maternity have no Coroner Regulation 28 orders.

7. Learning from recent closed investigations cases and moderate harms

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

Ref	Type	Overview	Learning
168816	PSII	29-day old death of a baby – overlay at home	All processes and guidelines were followed however, learning identified for improvements in documentation

			and communication between services.
164265	PSII (joint with CYPS)	28/40 preterm birth requiring extensive resuscitation.	Communication, triage calls, equipment. Coroners' case to be heard in May 2025.

Table 7.1

7.2 Table 7.2 highlights the number of women who suffered a moderate harm in the month of November 2024. In November there were 13 incidents reported as a moderate harm. 12 cases have been examined at the Maternity Weekly Datix meeting by a senior MDT and reduced to low or no harm. 1 incident - intrapartum stillbirth - remains at moderate harm and has been referred to the MNSI for external investigation. Deprivation and ethnicity scores have been collected for this group (Table 7.2, 7.3, 7.4 and 7.5) and highlights that for November 2024, poorer outcomes were sustained by the women who live in the poorest areas of Rotherham. The ethnic demographic is representative of the diversity of women who birth at Rotherham.

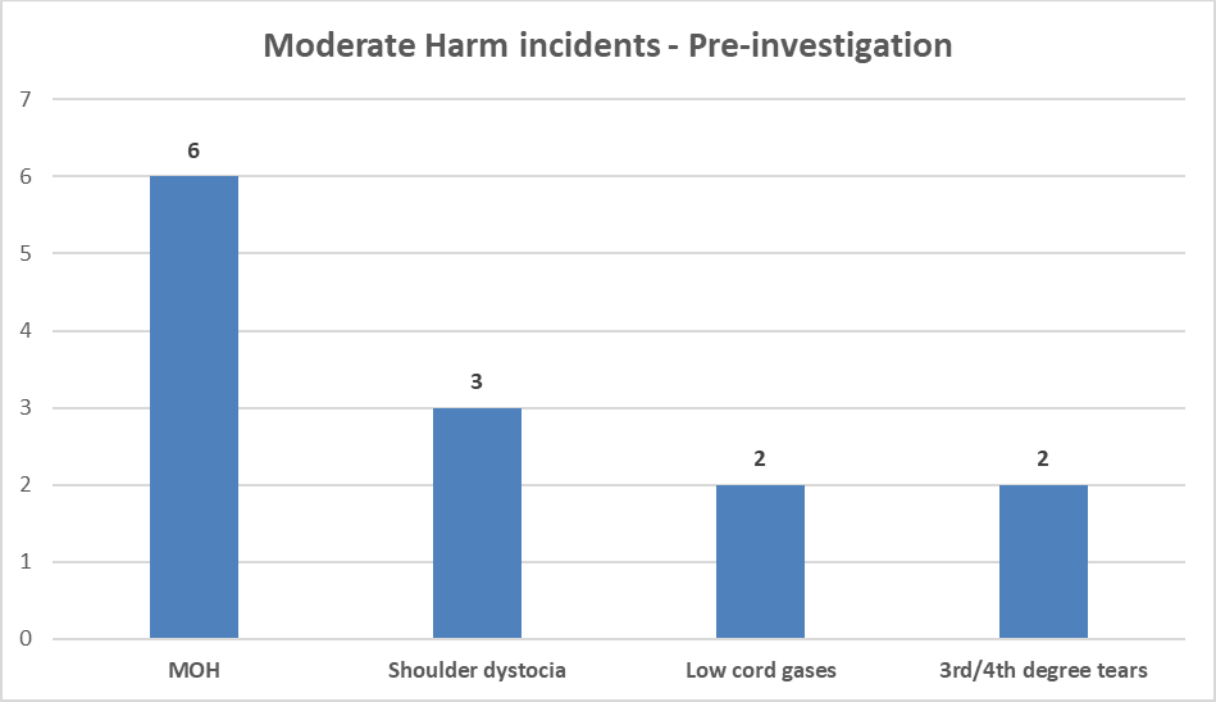


Table 7.2 Moderate harms in maternity

7.3 The highest number of reported harms remains massive obstetric haemorrhage (MoH). Previously each case has been reviewed in isolation, moving forward and in line with the Trust PSIRF plan, a thematic review will be used to analyse the cases with the hope that broader actions can be devised to reduce the number of MoH.

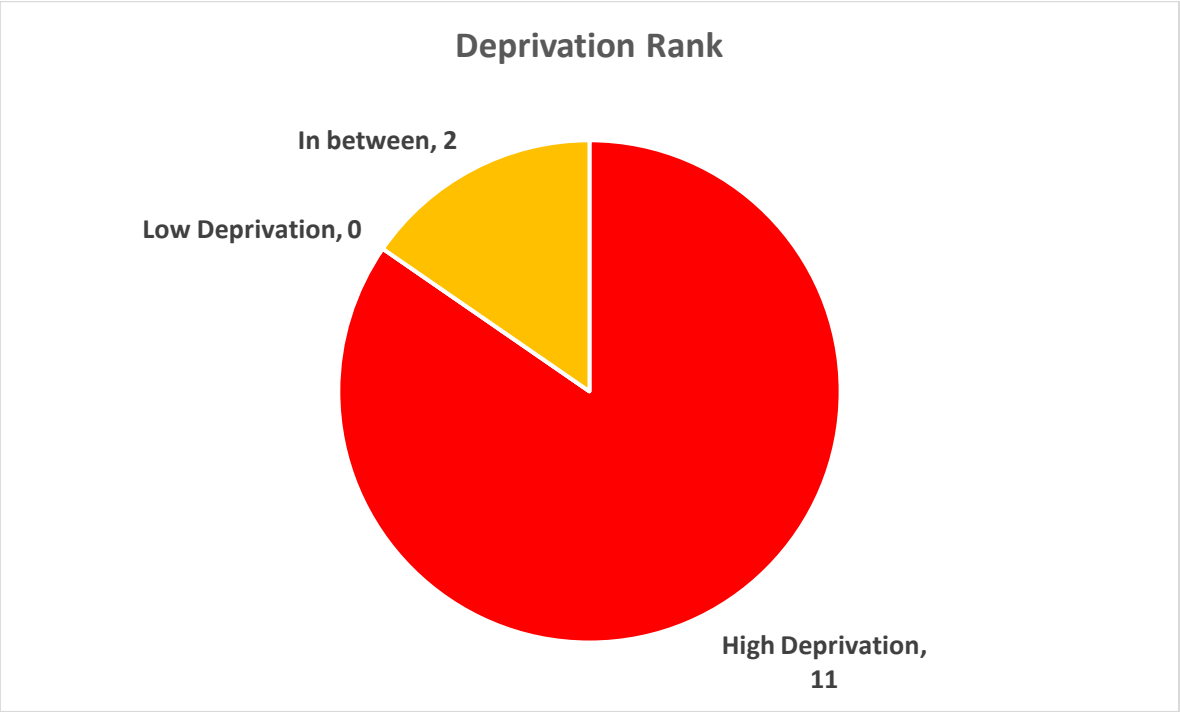


Table 7.3 Women's deprivation of moderate harms suffered

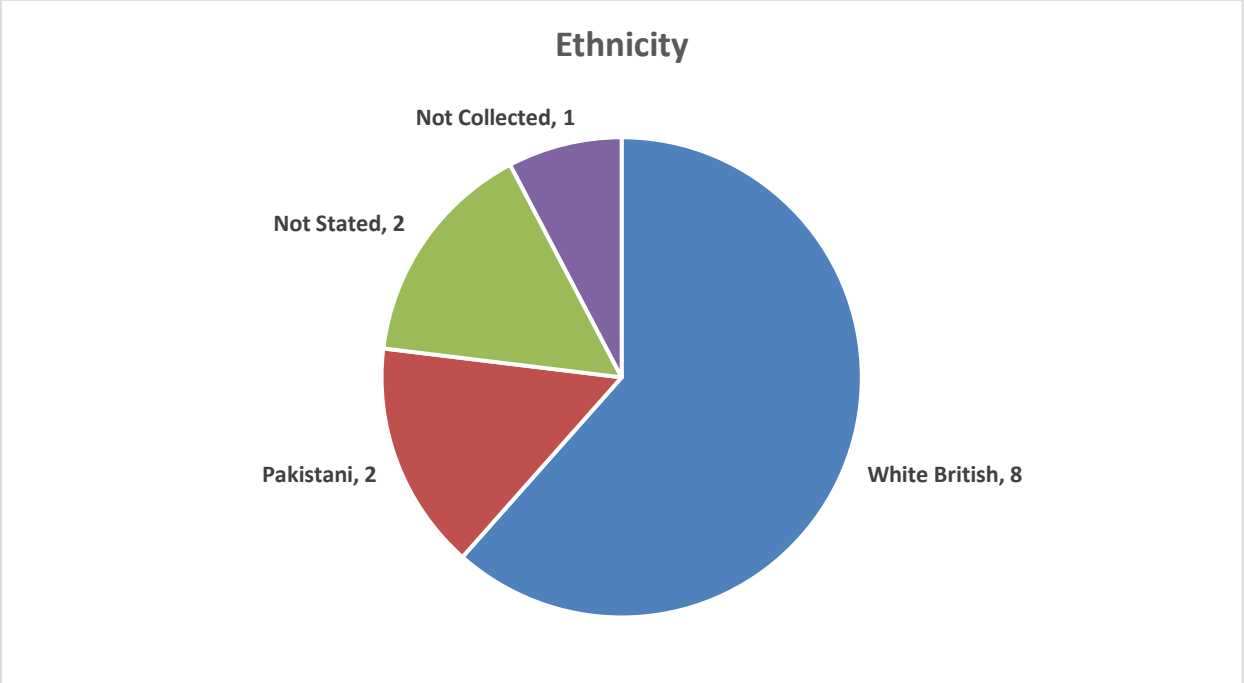


Table 7.4 Ethnicity of women who suffered moderate harms

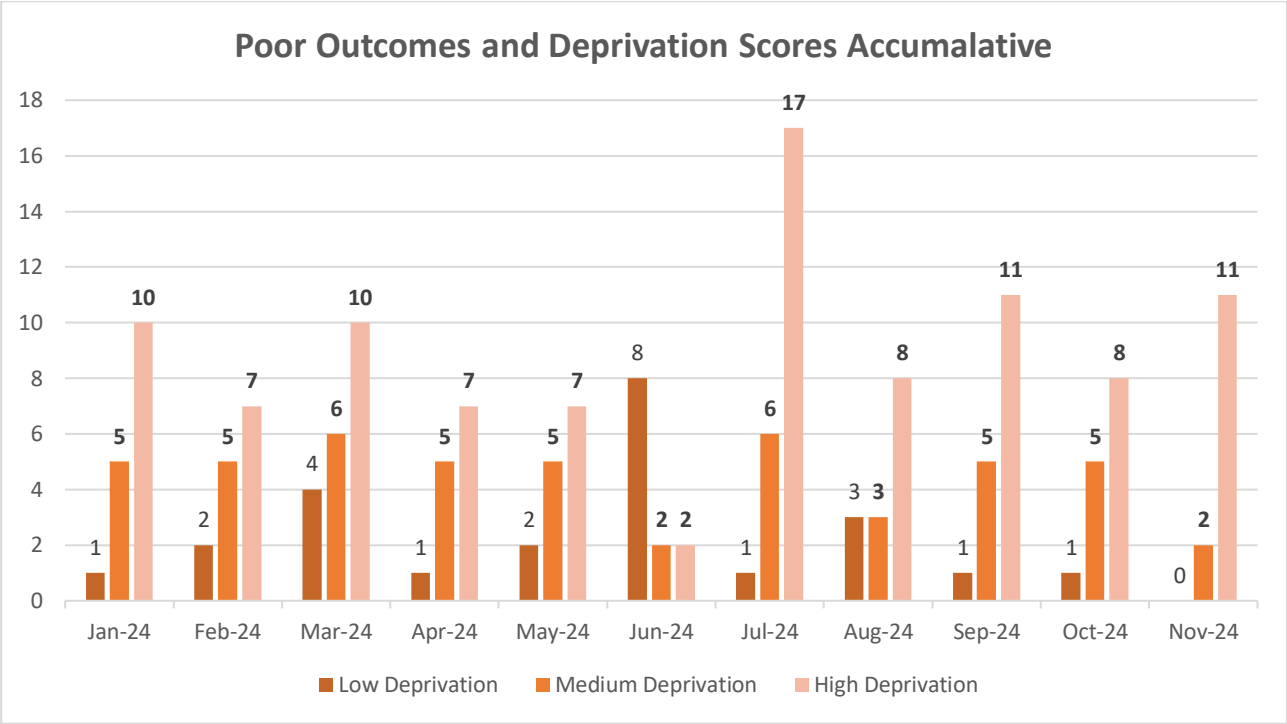
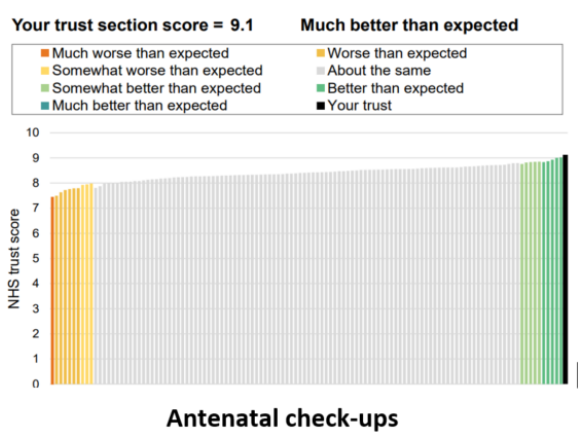


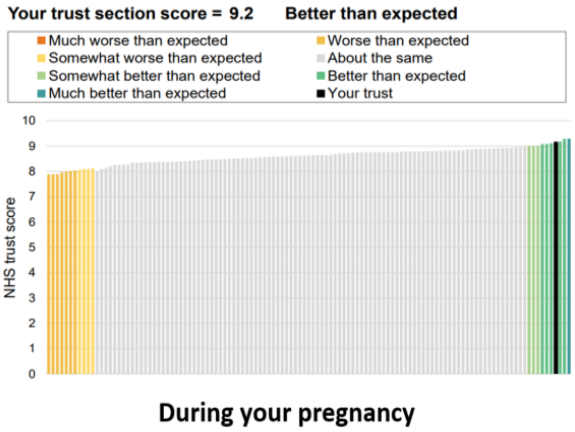
Table 7.5 Ongoing surveillance of deprivation scores and moderate harms

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

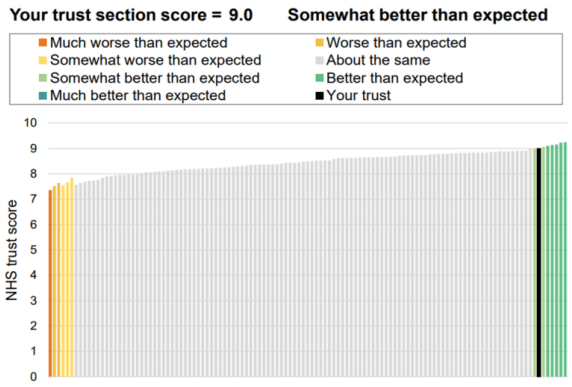
8.1 The Maternity CQC annual in-patient survey has been published for 2024 with comparisons for each Trust who has taken part. The results are positive and recognised the progress and investment made in TRFT maternity services over recent years. In the tables below, the black line represents TRFT in comparison with other organisations.



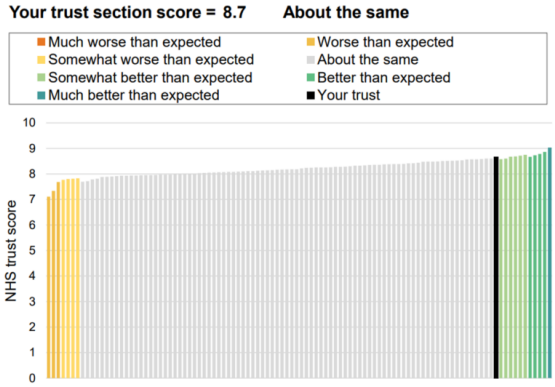
Antenatal check-ups



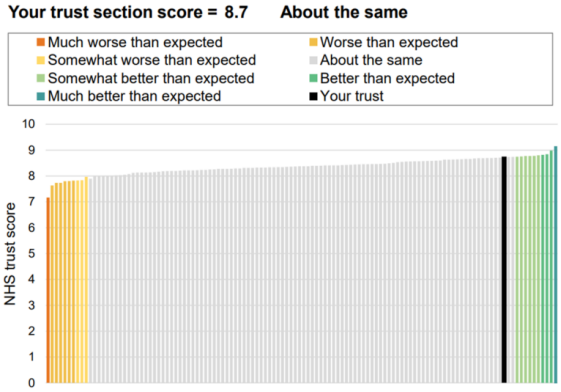
During your pregnancy



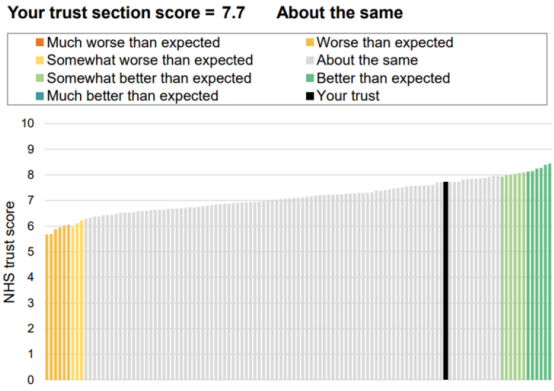
Triage: Assessment and Evaluation



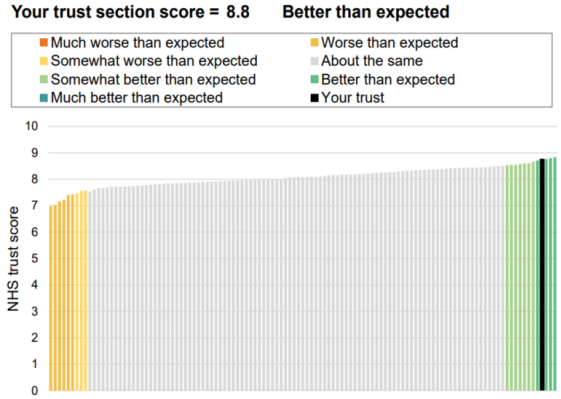
Your labour and birth



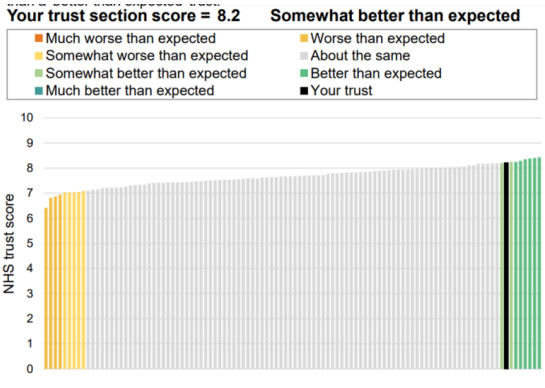
Staff caring for you



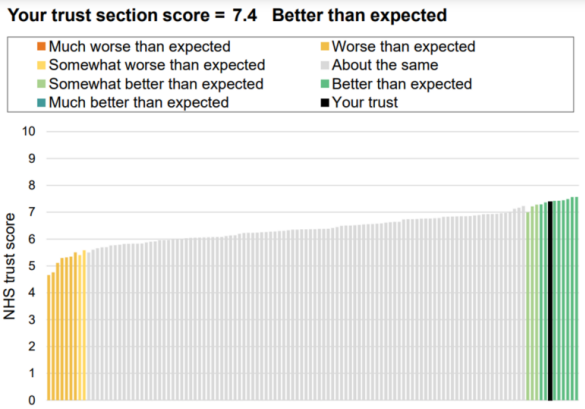
Care in the ward after birth



Feeding your baby



Care at home after birth



Complaints

Table 8.1 newly published CQC Picker In-patient survey.

8.2 The next steps following the publication of the results will be to go through the survey with the Maternity and Neonatal voice partnership to co-develop an action plan for sustained and continued improvement of Maternity services at TRFT.

9 BFI re-accreditation

9.1 On the 27th of November, TRFT maternity services were assessed by the UNICEF Baby Friendly Initiative (BFI) for re-accreditation of stage 3. Following the removal of our BFI status in January 2020, investment has been made within the infant feeding team and with the training provided to the wider MDT. Whilst formal acknowledgement of the current accreditation level is pending, the feedback from the assessing team was positive. The initial feedback was that TRFT maternity had a positive view towards infant feeding with staff being knowledgeable, kind and informative. Formal feedback is expected in the New Year.

10. Developing our workforce

10.1 The Maternity, neonatal and medical workforce requirements, continues to be monitored closely. Maternity and neonatal services undertake daily staffing huddles to assess acuity, flow and staffing gaps on the day and a weekly forward view.

10.2 Current midwifery staffing can be seen in Table 10.1 The maternity leave, long term sickness and planned leavers result in the total gaps of 8.73 WTE for November 2024, which is a decrease from last month following the recruitment of the early career midwives. NHSP is being used only when the gaps equate to above the designated headroom for sickness to maintain grip and control. The current budgeted establishment, which is in line with Birthrate+ shows a deficit of 0.29 with some vacancy and reduction on hours following maternity leave. Maternity leave continues to be the highest contributing reason for workforce gaps.

Maternity Staffing live nominal roll as at :												
30/09/2024												
	2024/25											
Trajectory	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Contracted Vacancies	-3.24	-1.64	-0.96	-0.48	0.29	0.29	0.29	0.29	0.29	0.29	0.29	0.29
Maternity leave	7.28	7.28	8.08	6.12	5.76	5.12	7.92	8.12	8.76	8.12	7.48	6.84
Long term sickness	2.64	3.80	4.12	8.88	7.00	2.36	1.56	1.56	0.00	0.00	0.00	0.00
Upcoming Leavers	0.00	0.20	0.00	0.00	0.00	0.00	4.85	5.17	5.65	5.17	5.17	5.17
Other - see detail	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20
Total Gaps	**6.88**	**9.84**	**11.44**	**14.72**	**13.25**	**7.97**	**14.82**	**15.34**	**14.90**	**13.78**	**13.14**	**12.50**
New Starters (reducing gaps)	0.00	-0.09	0.00	0.00	0.00	-0.64	-0.64	-1.44	-1.44	-1.44	-2.44	-2.44
New Starters - students/NQM's	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-5.17	-6.08	-6.08	-6.08	-6.08
Trajectory - for planning	**6.88**	**9.75**	**11.44**	**14.72**	**13.25**	**7.33**	**14.18**	**8.73**	**7.38**	**6.26**	**4.62**	**3.98**
% Workforce Gaps	**7.0%**	**9.9%**	**11.6%**	**14.9%**	**13.4%**	**7.4%**	**14.3%**	**8.8%**	**7.5%**	**6.3%**	**4.7%**	**4.0%**

Table 10.1 Midwifery establishment

9.3 Table 10.2 highlights the acuity data for labour ward for November 2024 and demonstrates that midwifery staffing met acuity 85% of the time, with 15% showing that the unit was short by up to 2 Midwives actions taken to reduce the acuity gaps included, lead midwives and specialist midwives being re-deployed to assist and maintain safety and one to one care for the mothers in labour. Compliance in data entry dropped slightly from the previous month but remained above the 80% compliance required for accurate data.

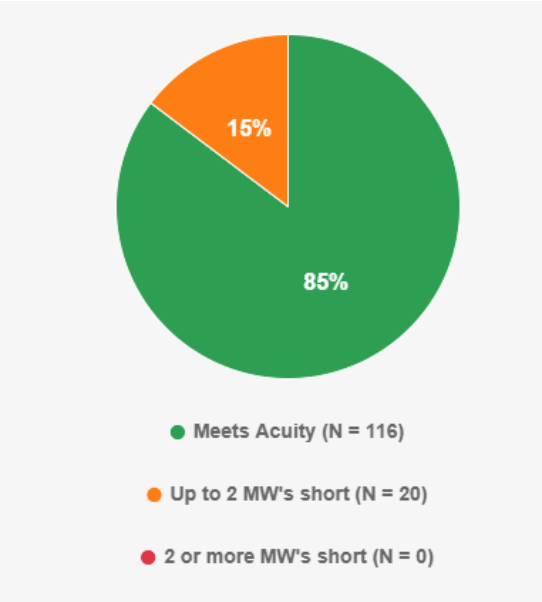


Table 10.2 Midwifery acuity for the month of November 2024

9.4 Medical workforce locum covers can be seen in Table 9.4 for November 2024 including the reasons for the requirement. The Neonatal British Association of Perinatal Medicine (BAPM) standards for Medical workforce standards are currently met by TRFT. For Nurse staffing the Trust meets the Qualified in speciality standards however, following the LMNS review and challenge meeting the standard for the Supernumerary status of the shift co-ordinator role as detailed in the BAPM service and quality standards is not currently implemented therefore an action has been completed to meet Maternity Incentive Scheme safety action 4 standards. This will be shared with the LMNS and ODN. (Appendix 2).

Grade	No of Shifts	Reason	Internal / External
ST1/2	4	3 Vacancies 1 x sickness absence	4 x Internal
ST3/7	15	4 x Compassionate Leave 6 x Additional Weekend Theatres 5 x Vacancies	15 x Internal
CONSULTANT	48	6 x Annual/Study Leave 21 x Additional clinics 8 X Additional Theatres 12 x Vacancies	48 x Internal

		1 X Compassionate leave	

Table 9.4 Medical vacancies

10.5 Table 10.4 below represents November 2024 workforce data. Sickness rates increased in November overall short- and long-term sickness is above the Trust target. Absence is managed in line with the sickness and absence policy. No themes or trends have been identified.

Maternity unit closures	**0**	**Datix / Birth-rate Plus®**
Utilisation of on call midwife to staff labour ward (Night Duty)	**2**	**Birth-rate Plus® data/ Datix**
1-1 care in labour	**100%**	**Data from Birth-rate Plus® acuity tool / Maternity Dashboard**
Redeploy staff internally	**5**	**Birth rate plus Acuity (Occasions)**
Redeploy staff from Community	**2**	**Birth rate plus Acuity (Occasions)**
Matron Working Clinically	**1**	**Birth rate plus Acuity**
Delay in Induction of Labour, women awaiting artificial rupture of membranes (ARM)	**14**	**Birth rate plus Data and Datix**
Supernumerary labour ward co-ordinator	**100%**	**Data from Birth-rate Plus® acuity tool/Maternity Dashboard/Datix**
Staff absence 1	**6.48%**	**November 24 data, 2.30 %short term 4.18% long term**
Obstetric compliance at mandatory consultant escalation	**100%**	**No Datix incidents reported**
Compliance with twice daily face to face ward round	**100%**	**Datix**

Table 10.6

11. Developing a Safety Culture

Safety Champions meetings:

11.1 In November 2024 the safety champions meeting was used to provide strategic infant feeding training which is a stipulation of the BFI re-accreditation process. The importance of the senior TRFT team and the involvement of the Safety Champions to address the inequalities of infant feeding was shared.

11.2 Concerns Raised by service users

During October 2024 the service had x 4 formal complaints, 2 were around care in labour and 1 was around care on the postnatal ward, a further complaint was raised following the release of some patient information in regard to a safeguarding data request. A local resolution meeting has been offered to all families involved in complaints apart from the data request complaint. It was agreed that a formal letter for this last complaint would be safer for staff responding to the complaint.

A reopened complaint In November 2024, following a homebirth, included the service user being invited to meet with the Clinical Educator Team and co-develop a scenario for the 2025 MAST training for the MDT.

11.3 Concerns raised by staff via safety champions walk around

No new concerns have been raised in November 2024, previous issues including concerns around interpretation services at TRFT are continuing to be monitored and reported via Datix. An action plan is monitored via the Safety Champion meetings and feedback to the staff will take place via an annual newsletter.

12.1 Year 6, CNST 10 standards (current status)

Table 12.1 represents the current compliance for TRFT. A confirm and challenge meeting was held on 3rd December 2024 with the LMNS, and meetings with The Executive Team are currently taking place to review the final evidence in preparation for the final presentation at Trust board in January 2025 for Chief Executive sign off to be submitted by 12 noon 3rd March 2025 (Appendix 5). On the 11th of December 2024, all evidence for Year 6 CNST was presented to the Safety Champions for assurance, this included the Head of Midwifery and the Divisional Director and Consultant Obstetrician, Appendix 3 shares the presentation for Quality Committee.

12.2 The LMNS review on the 3rd December 2024 of all the final evidence was positive. The CNST action tracker presentation (Appendix 4) was agreed to be updated to blue (passed) except for Standard 4, Clinical Workforce (see table 12.1 for further detail and actions).

No	Safety Action	Compliance via LMNS	Progress / challenges	Sing off via Executive Oversight
1	PMRT		Fully complaint by deadline.	Medical Director
2	Digital		Achieved full compliance – all 10 data quality requirements passed.	Director of Health Informatics

3	Transitional Care		QI reviewed by LMNS – Positive feedback noted.	Chief Nurse
4	Clinical workforce		Action plan to achieve full compliance with the BAPM standards for NNU nursing approved at the December 2024 LMNS Board This fulfils the CNST compliance. (Appendix 2)	Medical Director
5	Midwifery workforce		Fully compliant, Board papers and six monthly staffing papers.	Deputy Chief Executive
6	Saving Babies Lives V3		Progress has been demonstrated to the LMNS each quarter. Review December 2024 97% compliance. Outstanding; VBA training and pre-term job plans to be updated. This fulfils the compliance for year 6 as TRFT are progressing towards full compliance.	Medical Director
7	MNVP – working with families		LMNS agree with current level of assurance for ongoing work with the MNVP.	Director of Operations
8	Training		Full compliance met for training standards. (See table 12.2)	Deputy Chief Executive
9	Board assurance		All processes in place	Director of Corporate affairs
10	HSIB compliance		Compliant up to deadline	Chief Nurse

Table 12.1 CNST current compliance

12.3 Training requirements for CNST Year 6 have been achieved, Table 12.2 highlights the various elements of this standard along with the percentage of staff who have undertaken the training, and all elements were required to be above 90%. In addition to this training, a live drill has taken place on labour ward in this reporting period.

Staff Group	Training undertaken	% of staff attended
Midwife (Including NHS P)	Fetal Monitoring	96%
Obstetric Trainees & Registrars	Fetal Monitoring	100%
Ob's Consultants	Fetal Monitoring	91%

Midwives and Neonatal Nurses and Support staff.	New-born Life Support	94% (Individual groups all above 90%)
Neonatal Medical Team	New-born Life Support	100%
Ob's Consultants and all other Ob's Doctors	PROMPT MDT training	100%
Midwives including NHSP	PROMPT MDT training	96.5%
Support workers (Maternity)	PROMPT MDT training	94%
Obstetric anaesthetists	PROMPT MDT training	91%

Table 12.2 CNST Standard 6 training percentages

13. Saving Babies Lives V3 (SBLV3)

12.1 A further external review of our Q2 progress with SBLV3 took place on the 3rd of December 2024. The LMNS reviewed ongoing assurance audits for previously acquired achievements and discussed the outstanding two elements. TRFT were congratulated for the work involved in the maintaining standards that have previously been reported and discussions actions for the final aspects to be achieved.

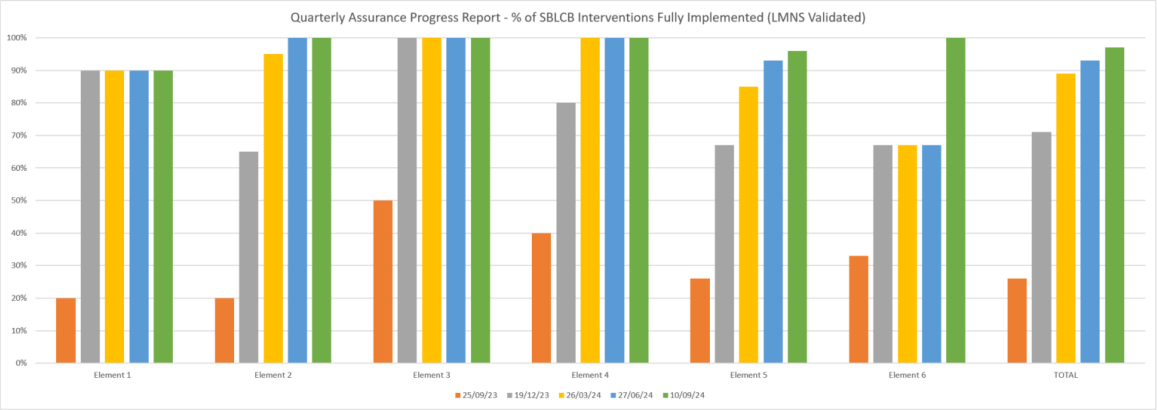


Table 12.1 TRFT progress for SBLV3

12.2 Remaining challenges for the outstanding actions include:

- Element 1 (Reducing smoking) Fully implementing the Very Brief Advice training to all women facing practitioners.
- Element 5 (Pre-term) Medical job plans still required funding and operationalising. Since the review in Q4, the funding has been identified and job plans are being updated.

12.3 Evidence of progression with SBLV3 is part of the CNST safety standard 6 (see Table 10.3). In order for TRFT to achieve this, the LMNS is required to review progress on a quarterly basis (as above). Following the December 2024 LMNS check and challenge

meeting, it was agreed that the Trust had progressed to the desired requirement to achieve compliance with CNST safety standard 6. The current compliance rate for SBLV3 is 97%.

14. Avoidable Admission into the Neonatal Unit (ATAIN)

14.1

SYB ATAIN - QI Dashboard v4.0

Unit/Trust: Rotherham **Person completing data:** Verity Gough & Jamie Dodd

Month	Live Births All Gestations	Term babies Inborn (>37/40)	Inborn admissions: (all gestations) excl transfers	Inborn TERM admissions (>37/40) excl transfers	Term Admissions as % of Live Births	5% Local Ambition	6% National Target	Avoidable Admissions (Enter Below)	% Avoidable Admissions
Apr-24	203	190	21	13	6.4%	5.0%	6.0%	0	0.0%
May-24	195	182	25	12	6.2%	5.0%	6.0%	0	0.0%
Jun-24	181	168	20	9	5.0%	5.0%	6.0%	2	22.2%
Jul-24	215	202	30	20	9.3%	5.0%	6.0%	2	10.0%
Aug-24	217	207	22	12	5.5%	5.0%	6.0%	1	8.3%
Sep-24	209	189	27	10	4.8%	5.0%	6.0%	0	0.0%
Oct-24	211	205	29	15	7.1%	5.0%	6.0%	0	0.0%
Nov-24	211	201	23	11	5.2%	5.0%	6.0%	1	9.1%
Dec-24					0.0%	5.0%	6.0%	0	#DIV/0!
Jan-25					0.0%	5.0%	6.0%	0	#DIV/0!
Feb-25					0.0%	5.0%	6.0%	0	#DIV/0!
Mar-25					0.0%	5.0%	6.0%	0	#DIV/0!

Table 14.1 Term admissions to the NNU

14.1 Term admissions for November 2024 had decreased from the previous month but remain above the 5% regional target as seen in Table 14.1. Of the term admissions, following MDT review, 1 case was noted to have been avoidable (see Table 14.2). The ongoing rolling action plan for the QI project is shared with the LMNS for shared learning. This work contributes to CNST Year 6, standard 3.

Select PRIMARY Reason (only 1 entry per admission)		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Total
R1	Management of a respiratory problem								1					1
R2	Hypothermia or need for temperature monitoring				1	1								2
R3	Hypoglycaemia/intervention to maintain blood glucose – BAPM pathway not followed			1										1
R5	Administration of antibiotics with no additional requirement for care.													0
R6	Requires period of observation including Observation following resuscitation													0
R8	Suspected sepsis													0
R9	Jaundice (After 24h)													0
A11	Admission for single procedure													0
R12	Management of seizures including HIE where clinical concerns were identified													0
R13	Management of NAS													0
A15	Other: (Well baby admitted for social reasons or mother in ITU)													0
A16	Other: (Admitted for congenital anomaly that could have been managed on PNW)													0
A17	Other: (could have been cared for in an NTC setting it this had been available)				1									1
A18	Other Not included above: (Enter number)													0
A18-reason	Other (enter reason)			1										1
	Total	0	0	1	2	1	0	0	1	0	0	0	0	5

15. Staff Survey

Annually	Report on: Proportion of midwives responding with 'Agree' or 'Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (Reported annually)

Update: 2023 survey results The most available data is for "*I would recommend my organisation as a place to work*" – 77% (Trust average 63%) This is an increase from the 2022 staff survey results which were 59%) "*I would recommend my organisation for care/treatment* "-. 78% (Trust average 58%) This is an increase from 66% from the 2022 result.	
Annually	Report on: Proportion of speciality trainees in Obstetrics & Gynaecology responding with 'excellent' or 'good' on how they would rate the quality of clinical supervision out of hours (Reported annually)
Update: 91.67% of trainees surveyed felt that the support they received out of hours was good or excellent.	

15. Red Risks/Risk register highlights

There are currently no Obstetric risks graded over **Moderate 12.**

16. Recommendation

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

Appendix 1 Reference guide for reporting criteria and Key of categories.

MNSI Criteria

The Maternity and Newborn Safety Investigations (MNSI) programme investigates certain cases of:

Early neonatal deaths,
Intrapartum stillbirths
Severe brain injury in babies born at term following labour in England
Maternal deaths in England.

PMRT review Criteria

Which perinatal deaths can we review using the PMRT?

- Late fetal losses where the baby is born between 22^{+0} and 23^{+6} weeks of pregnancy showing no signs of life, irrespective of when the death occurred, or if the gestation is not known, where the baby is over 500g;
- All stillbirths where the baby is born from 24+0 weeks gestation showing no signs of life, or if the gestation is not known, where the baby is over 500g;
- All neonatal deaths where the baby is born alive from 22^{+0} but dies up to 28 days after birth, or if the gestation is not known, where the baby is over 500g;
- Post-neonatal deaths where the baby is born alive from 22^{+0} but dies after 28 days following neonatal care; the baby may be receiving planned palliative care elsewhere (including at home) when they die.

Perinatal Bereavement Table Key of Abbreviations

Key:

SB – Stillbirths >24 weeks

SB Adjusted – excludes anomalies

MTOP – Medical Termination of pregnancy

ENND – Early Neo Natal Deaths (within first 7 days from birth)

LNND – Late Neo Natal Death (between 7 – 28 days Birth)

PLNND >28 days but under 1 year.

Total Perinatal – (All stillbirths and Neo Natal Deaths),

Total Adjusted Perinatal – excludes MTOPS / suspected Deaths. NVF – non-viable fetus

Maternal Deaths – Any woman whose death occurs during or within a year of completion of a pregnancy

PMRT – Perinatal Mortality Review Tool

Board of Directors
10 January 2025

Agenda item	P19/25
Report	**Safe Staffing and Establishment**
Executive Lead	Helen Dobson – Chief Nurse
Link with the BAF	P1: There is a risk that we will not embed quality care within the 5 year plan because of lack of resource, capacity and capability leading to poor clinical outcomes and patient experience for our patients.
How does this paper support Trust Values	Ambitious – aiming to achieve full compliance against national standards for safe staffing Caring - supporting health and wellbeing of staff to improve retention and providing a set of metrics to ensure patients are safe and have a positive experience Together – the actions and recommendations are Trust wide to support all areas employing clinical staff
Purpose	**For decision** ☒ **For assurance** ☐ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	The National Quality Board (NQB) publication: Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: Safe, Sustainable and Productive Staffing (2016) outlines expectations and the framework. In addition improvement resources have been published to support and underpin this approach in 2018 for adult inpatient wards in an acute hospital, community nursing services, children and young people, neonatal units and maternity services. This paper has used the Safer Nursing Care Tool (SNCT) to thoroughly review the acuity and dependency of adult inpatients, adult assessment areas, children's ward and emergency department. Due to a national pause in the use of the Community Nursing Safe Staffing Tool (CNSST) to review the acuity and dependency of community nursing services, this paper has not been able to provide any updated guidance for community nursing teams. The tool is expected to relaunch in January 2025 so the tool will be used following this. After the data is collected and analysed, all the ward managers add professional judgement to the SNCT data and are asked if their wards are safe. They confirmed planed establishments would be safe. These professional judgement to the current establishments has assured the Chief Nurse the areas have safe establishments. There is ongoing work on a bed reconfiguration for the medical ward areas. The increased acuity and dependency on the medical wards will

	be reviewed in the SNCT data collection for 2025 to inform decisions on safe establishments. Work to agree an establishment for the expanded Haematology ward has progressed with a proposal being presented at the Haematology programme board for discussion. Acuity and dependency will be tested in 2025 when this is established and the new establishment included in the next paper for Board approval. The Board of Directors should note the remaining risks: • Skill mix of RNs across all adult inpatient and assessment areas not at the recommended 65% RN for IP areas and 70% RN for assessment areas. • Increasing acuity and dependency across medical inpatient areas now demonstrating a variance of -24.4 WTE • Opening additional winter beds in autumn created additional risk by having to use temporary staffing and daily deployment as there is no ward roster for this area. The Trust Board are asked to support the recommendations of the establishment review as led by the Deputy Chief Nurse (nursing workforce) and agreed with the Chief Nurse.
Due Diligence (include the process the paper has gone through prior to presentation to the meeting)	This paper was presented to People Committee in December 2024.
Powers to make this decision	
Who, What and When (what action is required, who is the lead and when should it be completed?)	
Recommendations	The Board of Directors are assured by the process of collecting the SNCT data and using professional judgement to collate proposed establishments
Appendices	None

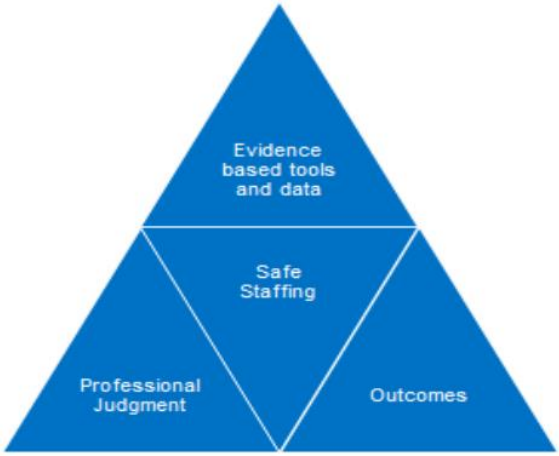
1. Introduction

1.1 The National Quality Board (NQB) publication: Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: Safe, Sustainable and Productive Staffing (2016) outlines expectations and the framework. In addition improvement resources have been published to support and underpin this approach in 2018 for adult inpatient wards in an acute hospital, children and young people, neonatal units and maternity services.

1.2 These resources have been used to support establishment setting, approval and deployment from the ward sisters and charge nurses through to the Chief Nurse.

1.3 There has been a refreshed approach to setting the Nursing establishments in the Trust since November 2022, to ensure compliance with the National Quality Board Standards and Developing Workforce Safeguards. This included the implementation of the Safer Nursing Care Tool (SNCT), an evidence based tool which will support and inform the establishment setting process. SNCT is an objective tool which utilises acuity and dependency scoring to support workforce planning. The tool had been recognised for supporting safe staffing on in-patient wards, and received NICE endorsement in 2014.

Figure 1: Principles of safe staffing



1.4 Four cycles of acuity and dependency data collection using SNCT were completed in 2023, and two cycles have taken place in 2024, the results from the last 4 cycles of data collection are included in this report.

1.5 Intensive care and high dependency were excluded as staffing is in line with the Guidelines for the Provision of Intensive Care Services (GPICS, 2019).

1.6 Hard Truths commitments regarding the publishing of staffing data (Care Quality Commission, March 2014) states ‘data alone cannot assure anyone that safe care is being delivered’. However research demonstrates that staffing levels are linked to the safety of care and that fewer staff increase the risk of patient safety incidents occurring’.

1.7 In order to assure the Board of Directors of safe staffing on our wards, this paper sets out the outcome of the strategic staffing review which has been undertaken in line with national guidance. The review has been a comprehensive assessment of each ward, with the ward manager, matron, head of nursing and management accountant, to take into account the following;

- Ensuring professional judgement is applied to staffing and is representative of activity requirements whilst ensuring the appropriate skill mix of staff.
- Benchmarking ward level CHPPD data from peer organisations is incorporated into each review.
- Nurse/midwifery sensitive indicators are aligned to each review such as pressure ulcers, falls, medication incidents and complaints relating to nursing care.
- The financial impact to setting of budgets is considered.

1.8 With each staffing review our compliance against the SNCT guidelines is reviewed to ensure validity of the data.

2. Compliance Against National Standards

2.1 A gap analysis on the Trust compliance with the workforce safeguards was presented to the Board of Directors in January 2023. There were recommendations within the paper to further improve full compliance with NQB guidance and workforce safeguards.

2.2 To support full compliance with the workforce safeguards, work has been completed in the following areas;

- Training 70 staff on the use of the SNCT to ensure inter-rater reliability. All have received further training for the updated SNCT tool which was released December 2023 and we have used in this year's data collections
- The roll out of the community nursing safe staffing tool (CNSST), which has included training all Registered Nurses and HCSWs
- Formal reporting of safe staffing and quality to the Quality Committee from April 2023.
- Progression of a Trust wide safety and quality dashboard.
- Implementation of a clear Retention of Nurses plan across TRFT

2.3 The Safe Staffing and Quality Paper, reported every other month to the Quality Committee, includes a detailed analysis of the Care Hours Per Patient Day (CHPPD), triangulated with patient outcomes, reported incidents and the progress on the plan to retain the whole nursing workforce.

2.4 The report is grounded in the need to ensure safe nurse and midwifery staffing levels and has been underpinned by the following publications/resources:

- NHS improvement – developing workforce safeguards, supporting providers to deliver high quality care through safe and effective staffing, October 2018.
- National Quality Board – Safe, sustainable and productive staffing - An improvement resource for Urgent and Emergency Care, 2018
- National Quality Board – Safe, sustainable and productive staffing - An improvement resource for adult inpatient wards in acute hospitals Edition 1, January 2018.
- National Quality Board – Safe, sustainable and productive staffing - An improvement resource for neonatal care, Edition 1, June 2018.
- National Quality Board – Safe, sustainable and productive staffing - An improvement resource for children and young people's inpatient wards in acute hospitals, Edition 1, January 2018.
- National Quality Board – Safe, sustainable and productive staffing - An improvement resource for Maternity, Edition 1, January 2018.
- National Quality Board – Safe, sustainable and productive staffing (SSPS). An improvement resource for adult inpatient wards in acute hospitals 2016 (2017 approved).

- Hard Truths – The Journey to Putting Patients First 'Hear the patient, speak the truth and act with compassion'. Published by the Department of Health 2014.
- National Quality Board report – How to ensure the right people, with the right skills, are in the right place at the right time. Published by NHS England 2013.
- The Model Hospital Portal - a new digital information service provided by NHS Improvement to support the NHS to identify and realise productivity opportunities; key nursing information is contained within the portal. https://improvement.nhs.uk/news-alerts/updates-model-hospital/

3. Feedback to Care Groups

3.1 The Heads of Nursing and Midwifery received their SNCT data, once collected and verified. A detailed feedback session was then arranged with every ward manager, matron, head of nursing/ midwifery and management accountant in September 2024.

3.2 The Deputy Chief Nurse (Nursing Workforce) and Matron for Safe Staffing led the feedback. During the session, the funded establishment was confirmed, the current funded skill mix, the average of the latest four SNCT data collections and ward manager supervisory time of 0.8 wte per inpatient ward also confirmed.

3.3 Adding in the professional judgement of each Ward Manager, Matron and Head of Nursing a proposed establishment was then agreed.

4. Analysis

4.1 Following the addition of professional judgement to the SNCT average data results, the explanation was given to care groups that establishments shouldn't stay static and should be amended and updated, subject to the rigour of the SNCT process.

4.2 The purpose of the feedback sessions in some instances, this meant an increase in the funded establishment and in some instances this meant a decrease in funded establishments.

4.3 Assessment Units

	Funded Bed Number	Funded Establishment updated April 2024	SNCT Average	Establishment Variance	RN skill mix (planned actual)
AMU	27	50.77 (exc SDEC)	52.7	-1.93	58%
ASU	23+10	48.93 (inc SDEC)	46.3	2.43	55%
Totals	50 +10	99.7	99	0.7	56.5%

4.3.1 Work completed on 9 September 2024 to separate out AMU and medical SDEC. The SNCT is averaging on 52.7 WTE for AMU with a funded establishment of 50.77 WTE. This is a variance of -1.93 WTE

4.3.2 The Acute Surgical Unit and surgical SDEC are a combined establishment. The inpatient area is recommending an establishment of 46.3 WTE which leaves 2.43 WTE to staff the surgical SDEC. This includes a 22% headroom on average across all the areas as the SNCT tool will not allow a recommended establishment below this head room.

4.3.3 The current funded Registered Nurse (RN) and Registered Nursing Associate (RNA) skill mix (column 6 above) is variable with an average of 56.5% across the assessment areas. The evidence base for assessment areas is 70% RN skill mix. Current establishments will not allow the changes needed to work towards the 70% skill mix, but as the Trust have agreed to a temporary over-establishment of Newly Registered Nurses from September 2024, this will allow some establishment restructuring to take place and enable a change to alter the skill mix.

4.3.4 At the establishment reviews with ward managers, matrons and heads of nursing, medicine and surgery confirmed their funded establishments (where the planned staffing matches the actual) is safe.

4.4 Medical wards

Medicine	Funded Bed Number	Funded Establishment updated April 2024	SNCT Average	Establishment Variance	RN skill mix (planned actual)
A1	33	39.68	40.5	-1.02	50%
A2	24	35.07	37.2	-2.5	52%
A3	33	39.52	47.2	-7.9	49%
A4	33	40.36	46	-5.8	49%
A5	33	39.48	41.7	-2.42	49%
A7	12	20.87	14.6	5.1	63%
CCU	8	20.91	14.3	6.6	80%
Stroke Unit	24	33.83	40.2	-6.6	55%
Short Stay	28	34.74	37.0	-2.26	54%
B5	24	33.22	40.6	-7.6	50%
Totals	251	337.68	361.3	-24.4	55.1%

4.4.1 The current funded establishment for medicine including the ward managers is 337.68 WTE for the inpatient wards. The recommended establishments from the last four SNCT data collections is 361.3 WTE. This includes a 22% headroom on average across all the areas as the SNCT tool will not allow a recommended establishment below this head room. This is a variable of -24.4 WTE nursing staff.

4.4.2 The current funded Registered Nurse (RN) and Registered Nursing Associate (RNA) skill mix (column 6 above) is variable with an average of 55.1% across all areas. The evidence base for Inpatient wards should be a 65% RN skill mix. Current establishments will not allow the changes needed to work towards the 65% skill mix, but as the Trust agreed to a temporary over-establishment of Newly Registered Nurses from September 2024 this will allow some establishment restructuring to take place and enable a change to alter the skill mix.

4.4.3 At the establishment reviews with ward managers, matrons and heads of nursing, medicine confirmed their funded establishments (where the planned staffing matches the actual) are safe.

4.5 Surgical wards

Surgery (Excluding ASU)	Funded Bed Number	Funded Establishment updated April 2024 Excluding 2.75 quality roles	SNCT Average	Establishment Variance	RN skill mix
Sitwell	14	20.94	19.4	1.34	59%
B10	22	29.73	26.7	2.83	54%
Rockingham	22+6flex	31.61	28.6	2.81	51%
Fitzwilliam	27+PBR	39.68	39.8	-0.32	49%
B11	14	18.63	13.2	5.43	63%
Totals	99+7	140.59	127.7	12.09	55.2%

4.5.1 The current funded establishment for Surgery is 140.59 WTE for the inpatient wards and the recommended establishments from the last four SNCT data collections is 127.7 WTE. This would give a 22% headroom on average across all the areas but is only an average. This is a variance of + 12.09 WTE nursing staff.

4.5.2 Professional judgement was applied in addition to the data. As the surgical wards are smaller than the medical wards but safety still needs to be maintained and as such some wards with smaller bed base have an SNCT average which would not give the minimum of 2 Registered Nurses per shift as is needed to maintain patient safety. No changes to the establishments were proposed when professional judgement applied.

4.5.3 The current funded Registered Nurse (RN) skill mix is variable with an average of 55.2% across all areas. The evidence base for Inpatient wards should be a 65% RN skill mix. Current establishments won't allow the changes needed to work towards the 65% skill mix, but as the Trust agreed to a temporary over-establishment of Newly Registered Nurses from September 2024 this will allow some establishment restructuring to take place and enable a change to alter the skill mix

4.5.4 At the establishment reviews with ward managers, matrons and heads of nursing, surgery confirmed their funded establishments (where the planned staffing matches the actual) is safe

4.6 <u>Paediatrics</u>

	Funded Bed Number	Funded Establishment	SNCT Average	Establishment Variance	RN skill mix
Childrens ward	22-25	39.4	30.65	8.75	73%

4.6.1 There is not currently a SNCT tool for Children's assessment areas, which would be calculated differently. The results of the SNCT are for the Children's Ward, which shows a positive variance of 8.75 WTE. Taking into account professional judgement and the higher acuity of nursing an assessment area, it was felt the Children's ward was safely staffed on the funded establishment. The current funded establishment for Children's wards is 39.4 WTE, the recommended establishment from the last four SNCT data collections is 30.65 WTE. This would give a 22% headroom. This is a variance of + 8.75 WTE nursing staff.

4.6.2 The current funded Registered Nurse (RN) skill mix is 73% for Children's ward. The evidence base for Children's wards should be a 67% RN skill mix but this area is also an assessment area so the 73% funded skill mix is appropriate. The Head of Nursing also covers Paediatric UECC and Neonatal Unit so daily redeployment takes place across these areas dependant on acuity in each area

4.6.3 At the establishment reviews with ward manager, matron and head of nursing, children's ward confirmed their funded establishments (where the planned staffing matches the actual) is safe.

4.6.4 When using professional judgement with the Children's Wards, there are no proposed changes to the funded establishments.

4.6.5 Acuity and dependency on the Neonatal Unit is measured using the Badger Net tool and actual activity on the unit. This data is included in the maternity safety paper but will also be included in this paper for next year.

4.7 <u>UECC</u>

UECC Acuity and Dependence data ADULTS	Average attendees 2023-2024	Funded Establishment	SNCT Average	Establishment Variance	RN skill mix
UECC Adults 22% headroom	76883	84.08	81.24	2.84	68%
UECC Adults 25% headroom	76883	84.08	83.55	0.53	68%

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UECC Acuity and Dependence data Paediatrics	Average attendees 2023-2024	Funded Establishment	SNCT average	Establishment variance	RN skill mix
UECC Paediatrics 22% headroom	21088	19.49	20.95	-1.46	73%
UECC Paediatrics 25% headroom	21088	19.49	21.5	-2.01	73%

4.7.1 A headroom of 25% is recommended in the NQB 2018 guidance (safe, sustainable and productive staffing: An improvement resource for urgent and emergency care). This supports the amount of regulatory training for Registered Nurses within the UECC. The Trust headroom is currently 21% but the SNCT tool does not allow for below 22% headroom, therefore the establishment review included 22% and 25% headroom percentages.

4.7.2 For adult UECC, adding professional judgement – there was still concern that staffing numbers are not meeting patient needs. The planned establishment is higher than the recommended establishment by either 2.84 WTE or 0.53 WTE, but the layout of the department means that these staffing numbers are required to maintain patient safety.

4.7.3 The UECC has the Rapid Assessment and Treatment (RAT) funded to open from 08.00 – 19.00. This model was implemented as part of the new build in 2017, due to current operational pressures RAT operates 24 hours a day seven days a week with no option to close, this takes up a Registered Nurse to ensure the space can be staffed and some pressure taken off the rest of the department.

4.7.4 UECC has 12 RNs in the day and 10 RNs at night. Additional winter funding has been approved for an additional RN at night and a twilight shift is also in place (at cost pressure) as part of the fracture clinic pilot.

4.7.5 Paediatrics UECC had a SNCT negative variance of -1.46WTE. To support the peak in activity over winter months, funding had been agreed for a band 6 Registered Nurse to cover the twilight shift. Professional judgement will be used to deploy the RN to the area with the highest acuity and dependency

4.7.6 Previous reports have used national average data based in the Trust's annual attendance only and uses the national average percentage distribution of patients at each level of acuity and dependency.

5. Community Nursing

5.1 Unfortunately, the National Team have paused the use of the Community Nurse Safe Staffing Tool (CNSST) due to some concerns about the efficacy of the tool. NHS England have announced a planned relaunch date of 22 January 2025.
Because of this, no updates on predicted establishments can be provided in this paper, as no data collections have taken place this year. Establishment reviews were planned but did not take place.

5.2 As soon as the refreshed tool is released four data collections will be planned and updated training will take place with all community based nursing staff

6. Recommendations

6.1 While all the ward managers added professional judgement to the SNCT results and confirmed if the planned staffing always met the actual staffing – the areas would be safe. These professional judgement to the current establishments has assured the Chief Nurse the areas have safe establishments.

6.2 The Board of Directors should note the remaining risks:

- Skill mix of RNs across all adult inpatient and assessment areas not at the recommended 65% RN for IP areas and 70% RN for assessment areas.
- Increasing acuity and dependency across medical inpatient areas now demonstrating a variance of -24.4 WTE
- Opening additional winter beds and using temporary staffing and daily deployment to staff the area.

6.3 There is ongoing work on a bed reconfiguration for the medical ward areas. The increased acuity and dependency on the medical wards will be reviewed in the SNCT data collection for 2025 to inform decisions on safe establishments.

6.4 Work to agree an establishment for the expanded Haematology ward has progressed with a proposal being presented at the Haematology programme board for discussion.

Acuity and dependency will be tested in 2025 when this is established and the new establishment included in the next paper for Board approval.

6.5 Next years SNCT will include planned CHPPD and a gap analysis will be undertaken for areas under the recommended RN skill mix.

6.6 The next paper will also include the acuity data from the neonatal unit, currently collected using badger net and included in the Maternity safety paper.

6.7 The Board of Directors are asked to support the recommendation of the establishment review as led by the Deputy Chief Nurse (nursing workforce) and agreed with the Chief Nurse.

Board of Directors' Meeting
10th January 2025

The Rotherham NHS Foundation Trust

Agenda item	P20/25
Report	**Learning From Deaths & Mortality: Quarterly Report 2024/25 Q2**
Executive Lead	Dr Jo Beahan, Medical Director
Link with the BAF	**P1:** There is a risk that we will not embed quality care within the 5 year plan. **OP3**: There is a risk that robust service configuration across the system will not progress and deliver seamless end-to-end patient care across the system. **D5:** There is a risk that we will not deliver safe and excellent performance.
How does this paper support Trust Values	**Ambitious** – demonstrates that the Trust strives to deliver the highest standards and quality of care possible. **Caring** – demonstrates that the Trust strives to give outstanding, compassionate care, including around end of life care. **Together** – demonstrates that the Trust strives to ensure that quality improvement and the learning from deaths is achieved through a multidisciplinary approach.
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☒
Executive Summary	**LFD** 21% of deaths had an SJR requested in Q2 24/25. 64% were reviewed in 60 days (compared to 45% in Q1) with a 93% completion rate. 95% of deaths were felt to not be preventable and poor care identified in 5%. A thematic review of deaths will take place in January and will inform Quality Improvement work in themes identified as suitable. As continued monitoring of 360 audit findings care group meetings have been reviewed and there continues to be evidence of discussion of findings from mortality reviews and actions. **Mortality Indicators** The latest **SHMI** Score (latest Month June 2024) is **104.0**. TRFT remain in the 'As Expected' Band. Trusts are placed in the 'As Expected'. This means that any variation from the number of expected deaths is not statistically significant. An alert for deaths from Acute Myocardial Infarction has led to the 7 deaths being reviewed with some areas of care to be improved but overall was not concerning.

	SHMI may be impacted by the required changes of coding to ECDS. Pilot trusts showed a small increase in SHMI. We are likely to see the impact of this starting in January. Although all Trusts are required to change to ECDS there are currently differing adoptions. Work is ongoing to accurately capture comorbidities which if improved could reduce SHMI.
Due Diligence	This report is produced by the Learning from Deaths and Mortality Manager with a final review by the Medical Director.
Powers to make this decision	N/A
Who, What and When	The Trust has established a robust Learning from Deaths process, based on national guidance and best practice. Its aim is to provide intelligence, to be used by the Trust to enhance care for future patients. The major component of the Learning from Deaths process is the case note review of selected deaths, using the Structured Judgement Review (SJR) method. The objective of the review method is to look for strengths and weaknesses in the caring process, to provide information about what can be learnt about hospital systems where care goes well, and to identify points where there may be gaps, problems or difficulties in the care process. The Trust completes SJRs for around 25% of Trust deaths. The majority are selected after recommendation by a Medical Examiner following a scrutiny, identified from Trust data or recommended by a Trust clinician. The Trust's SJRs are completed by a Team of 7 reviewers who are trained and have protected time to complete. This delivers good quality and timely SJRs. The ultimate objective is for the Trust to use this intelligence to drive improvement. This can be achieved by the sharing of good practice or devising changes to reduce or eliminate the occurrences of poor care. Intelligence from SJRs is disseminated to Trust Groups/Individuals, who have the expertise to devise and implement changes to care processes and procedures. Intelligence from SJRs, either comes from information from an individual review, or more beneficially from the Thematic Analysis of cohorts of SJRs. Thematic Analysis identifies repeated similar occurrences of poor or good care. Learning from Deaths is managed by the Learning from Deaths & Mortality Manager. It is co-ordinated by the Trust Mortality Group, chaired by the Deputy Medical Director. The program has oversight and assurance through the Trust's Patient Safety Committee and the Quality Committee.

Recommendations	It is recommended that the Committee notes the progress/updates on the Learning from Deaths program and the latest SHMI values.
Appendices	1. SHMI Report – Latest Month's Data June 2024

John Taylor
Learning from Deaths & Mortality Manager
December 2024

1.0 Learning from Deaths Quarterly Report: 2024/25 Q2

	Due Date	SJR Data	SHMI Latest Month
This Report	-	2024/25 Q2	01/06/2024
Next Report	07/03/2025	2024/25 Q3	01/09/2024

*SJR data is grouped & reported by the date of death

2.0 SJR Requests

				Source of SJR Request		
Discharge Date	**Adult Inpatient & UECC Deaths**	**SJR Requested**	**SJR Requested %**	**Medical Examiner**	**Trust Data**	**Other**
2024/25 YTD	453	105	23%	60	37	8
2024/25 Q1	243	60	25%	34	20	6
2024/25 Q2	210	45	21%	26	17	2
2023/24	1070	224	21%	111	105	8

3.0 SJR Completion & Timeliness Figures - % SJR Completed within 60 Days of Death

Target 75%

Month of Discharge	Completed	Outstanding	% Completed	% Completed < 60 Days	Overall Care Score < 3	Preventa-bility Score < 4
2024/25 YTD	97	8	92%	53%	10	0
2024/25 Q1	55	5	92%	45%	6	0
2024/25 Q2	42	3	93%	64%	4	0
2023/24	224	5	100%	56%	40	3

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

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

At Year End	SJRs Completed	< 60 days after death
2022/23	45%	24%
2023/24	90%	57%

3.1 The Learning from Deaths process is described as a rapid cycle of learning, where good or poor practice is identified close to the time when care was delivered. Timely SJR completion and intelligence dissemination is crucial for this.

3.2 This is dependent on timely recommendation by the Medical Examiner Service, timely distribution to the SJR Reviewers and timely completion by the Reviewers themselves. Some SJRs such as those requested after a SHMI alert won't be requested close to the time of death and be able to be completed within target.

3.3 Comments from all SJRs are themed and categorised in quarterly Thematic Analysis Reports

Update

3.4 Timeliness figures are monitored by the Trust Mortality Group.

3.5 For deaths in 2024/25 Q1&2 92% of SJRs have been completed. 53% have been completed within 60 days of death, which is below the 75% target.

3.6 There are 49 breaches, which have either been completed >60 days after death, or are yet to be completed. For 26 of these breaches the Reviewers were given at least 28 days to complete.

3.7 Measure to improve timelines: SJR Reviewers are sent reminders of incomplete SJRs and the importance of timeliness, which will be achieved if they complete their 3 SJR allocations within the 4 week cycle.

3.8 Some of the breaches resulted from having to reallocate a number of SJRs (deaths in Apr 24 – July 24) within the team due to a SJR Reviewer leaving this role.

3.9 The timeliness rate for deaths in September 2024 is **93%.** There is no reason this can't be maintained and the 75% target met for 2024/25 Q3.

4.0 Summary & Distribution 2024/25 Q2 SJR Thematic Analysis

4.1 Learning from SJRs comes in the form of free text judgment statements which support the scores given to Phases of Care and to problems identified. These free text comments are allocated to categories based on the element of health care they refer to and whether they are positive or negative.

4.2 The Thematic Analysis reports are distributed to various groups, individuals and teams within the Trust. The purpose is for these groups to review the reports and then to design and implement new/changes to health care processes that will prevent the reoccurrence of these problems or promote good practice.

4.3 These two tables detail the categories to which comments are allocated to and the groups/teams who receive the report.

Category of Problem
Medication or Treatment
Escalation
Assessment/Opinion/Review
Tests/Results/Monitoring
Location of Care/Bed Availability/Inappr
End of Life/Palliative Care/DNACPR
Communication

Groups Distributed to
Deteriorating Patient Group
Medicine Safety Committee
Patient Safety Committee
Results Flagging & Notification
Safeguarding Operational Group
Clinical Governance - Medicine & its CSUs
Clinical Governance - Surgery & its CSUs
End of Life Group
Sepsis QI Group
Parenteral Nutrition & NG Feed T&F
Quality Governance & Assurance Group
Divisional Mortality Meeting - Medicine
Divisional Mortality Meeting - Surgery
Trust Mortality Group

Update:

4.4 The Thematic Analysis report for 2024/25 Q2 has been produced and distributed. The report should be read and themes relating to objectives of Trust meeting be put on the agenda and discussed.

4.5 A feedback questionnaire, to determine how intelligence from Thematic Analysis is being used in the Trust was sent out on 04/09/2024. This had a requested return date of 30/09/2024. The questionnaire was sent to 9 Trust Meetings Groups. Only 1 was returned. This will be re-sent in January 2025. Discussions are being had with regards to increasing the return rate.

5.0 SJR Themes to QI Project (Quality Improvement)

5.1 A twice yearly discussion group is commencing in January 2025. At this meeting SJRs themes will be reviewed for 2 quarters. The purpose of the meeting is to select themes suitable for QI projects, and to decide which team/person will lead the project. Membership will include the Deputy Medical Director, the Learning from Deaths Manager and there will be representation from the QI Team, Care Group and a SJR Reviewer.

Next Report:

5.2 The next Thematic Analysis Report will be completed in March 2025 for 2024/25 Q3 SJRs.

6.0 Learning from Deaths – Learning Disabilities, Autism & Serious Mental Illness

6.1 As recommended TRFT completes SJRs for Trust deaths for those with a Learning Disability, Autism or a Serious Mental illness.

6.2 These deaths are identified by the Medical Examiner during scrutiny, from Trust data or from a request by the Matron for Learning Disabilities and Autism. In addition some SJR requests for patients with a Learning Disability or Autism will come from an ICB LeDer Team.

6.3 The LeDer Programme is a Commissioner-led review of deaths for patients with Learning Disabilities and Autism, regardless of the place of death. Provider Trusts are frequency asked to assist with LeDer reviews when they have been involved in the care provision for that patient. SJRs are requested if the patient died within 14 of a TRFT discharge or longer, if appropriate.

6.4 Completed SJRs are distributed to the Matron for Learning Disabilities and Autism, the Head of Safeguarding, the Mental Capacity Act Lead Nurse and to the requesting ICB LeDer Team.

SJR Figures for Adults with a Learning Disability, Autism or Serious Mental Illness

Discharge Month	SJR Requested	SJR Completed	SJR Outstanding	Overall Care Score < 3	Preventability Score < 4
2024/25 YTD	15	15	0	1	0
2024/25 Q1	8	8	0	1	0
2024/25 Q2	7	7	0	0	0
2023/24	33	33	0	7	0

	Requested SJRs	Learning Disability or Autism	Serious Mental Illness
2024/25 YTD	15	6	9

Update

6.5 All 2024/25 Q1&2 deaths for those with an identified Learning Disability, Autism or a Serious Mental illness have has an SJR requested. Zero SJRs are outstanding.

6.6 All completed SJR have been distributed to the Matron for Learning Disabilities and Autism, the Head of Safeguarding, the Mental Capacity Act Lead Nurse and to the requesting ICB LeDer Team.

7.0 Learning from Deaths: Incidents & the Patient Safety Incident Response Framework

7.1 All SJRs with an Overall Poor Care Score or judged to be more than likely preventable are entered as Incidents on Datix. As with other logged incidents, these are reviewed/investigated by the appropriate Care Group and clinical team/s.

7.2 Although infrequent it is mandated that deaths judged to have been more than likely preventable have a Patient Safety Incident Investigation.

Update

7.3 The 10 reportable SJRs for deaths in 2024/25 Q1&2 have been logged as incidents for review and possible investigation on Datix. Nine of these have been concluded in Datix.

7.4 All resulting outcomes (Lessons Learnt & Actions) are reported for discussion at the Trust Mortality Group.

8.0 Learning from Deaths in the Care Groups & Respective Clinical Support Units

8.1 Every four weeks completed SJRs are distributed to the Care Group Mortality leads. Typically 15 to CG1- Medicine, 5 to CG2 – Surgery and 1 to CG1 – UECC.

8.2 Each care group is asked to complete a 1-2 minute review of each SJR and determine which ones have learning points, both positive and negative. These SJRs should be disseminated to the relevant CSU for discussion at their Clinical Governance or separate Mortality meeting. All those with an Overall Poor Care Score or judged to be more than likely preventable should be disseminated and discussed.

8.3 The suggested format for CSU discussion is a brief presentation of the SJR, followed by a presentation of a local review. This may:

- support findings in the SJR
- refute findings in the SJR
- identify new issues

8.4 Each discussion should end in a documented summary with an action plan, if appropriate.

8.5 CSUs are invited to present reviews at their respective Care Group Mortality Meeting, held monthly in CG1 – Medicine and bi-monthly in CG2 – Surgery. Where appropriate the CG Mortality leads escalate issues and cases to the Trust Mortality Group, particularly when it has been determined that the problem and solution is system/trust wide.

8.6 Due to the small volume, all UECC deaths are discussed at the bi-monthly held CG1-UECC Mortality Meetings.

Update

8.7 The Learning from Deaths & Mortality Manager completed a review of Care Group 1 Mortality Review discussions in their CG Mortality meeting and in their CSU Clinical Governance or separate Mortality meetings. This was completed for meetings held between April and Sept 2024. The purpose of this review was to determine if TRFT are continuing to meet the requirement for the final 360 Assurance Action Point, which it passed in April 2024.

8.8 We did not find evidence that suitable arrangements are in place within Medicines CSUs for discussion on the outcomes of mortality reviews/SJRs – Governance finding from 360 Assurance Audit June 2023 (passed in April 2024)

8.9 There were 24 minuted Mortality Review Discussions. This number is likely to be larger because some CSUs are unable to produce or provide minutes for their meetings. This is an issue that has been discussed at CG1 Mortality meeting.

8.10 The CG and Divisions have been asked to follow a format where the issues raised in the SJRs are discussed prior to the local clinical review. It is evident that this is now starting to happen.

8.11 A similar review of meetings held between October 2024 & March 2025 will be untaken in May 2025. The aim to give the Trust assurance that TRFT would pass the 360 Action Point, if the Trust is audited again.

9.0 SHMI Alert Investigations

9.1 The SHMI has two methods which prompt Trusts to investigate potential areas of concerns. Alerts should not be immediately interpreted as indicating good or bad performance and should prompt the Trust to investigate further.

9.2 The first method uses upper and lower control limits banding system to indicate that the number of deaths is statistically significantly different from the number of expected deaths. This method is used for the Trust overall mortality numbers and completed for 10 Diagnosis Groups.

9.3 The second method is the production of Variable Life Adjusted Display (VLAD) charts for 10 Diagnosis Groups to demonstrate the difference between observed and expected mortality over a period of time in. The VLAD is sometimes called the expected-observed cumulative sum. The VLAD will highlight runs of more deaths than expected over shorter time period than the 1st method.

Last Alerts & Investigations:

9.4 SHMI Alerts are presented and discussed at the Trust Mortality Group meeting. Responses are decided and requested at these group meetings.

10.0 Acute Myocardial Infarction VLAD Alert –

10.1 This alert was triggered by a higher than usual amount of deaths in March 2024. There were 7 deaths. The Trust usually has between 1 and 4 each month.

Response:

10.2 This alert was discussed at the September Trust Mortality Group meeting. A decision was made to ask Cardiology to complete a brief review of the deaths and to request SJRs for 5 of the 7 deaths.

10.3 A Cardiology Consultant has looked at the 7 cases and determined that none of the deaths were preventable. The 5 SJRs have been completed. Although issues were identified with care, all of the deaths was judged to have been 'Definitely Not Preventable'.

11.0 Coding Changes Affecting the SHMI:

11.1 It's now mandatory for Same Day Emergency Care activity to be submitted in the Emergency Care Data Set (ECDS), rather than the Inpatient Commissioning Data set (IPCDS). At TRFT, August 2024 is the first month that will include this change.

11.2 The SHMI only uses data from the IPCDS and therefore the SHMI may be affected. The SHMI showed a small increase for early pilot NHS Trusts. However once most Trusts have made the change, the expected values will reflect this, and adjust accordingly.

11.3 Data for August 2024, will be included in the January 2025 SHMI release and will be reviewed to determine any effect. Data is isn't being retrospectively changed, therefore the change will be gradual, 1 month at a time.

11.4 Clinical Coding and Data Quality continue to work with the MediTech team and Clinician Teams to maximise the capture of co-morbidities. A new co-morbidity capture form is being worked on, which should be piloted in 2025.

John Taylor
Learning From Deaths & Mortality Manager
Medical Directorate
The Rotherham NHS Foundation Trust

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Phone: MS Teams/07833 634440

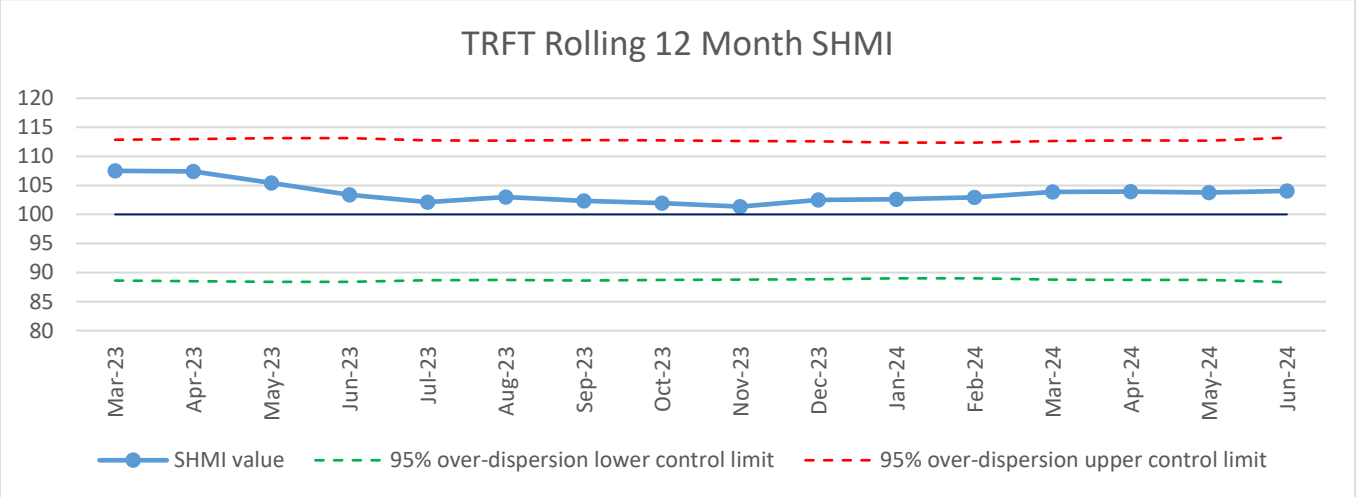
Latest Publication Date: 14/11/2024
Latest Data Month: Jun-24

TRFT SHMI Report

Summary

TRFTs latest Rolling 12 Month SHMI Value is 104.0. TRFT remain in the Band 2 'As Expected' band. The previous value was 103.7

TRFT has 0 Diagnosis Group in the Higher than Expected Band.

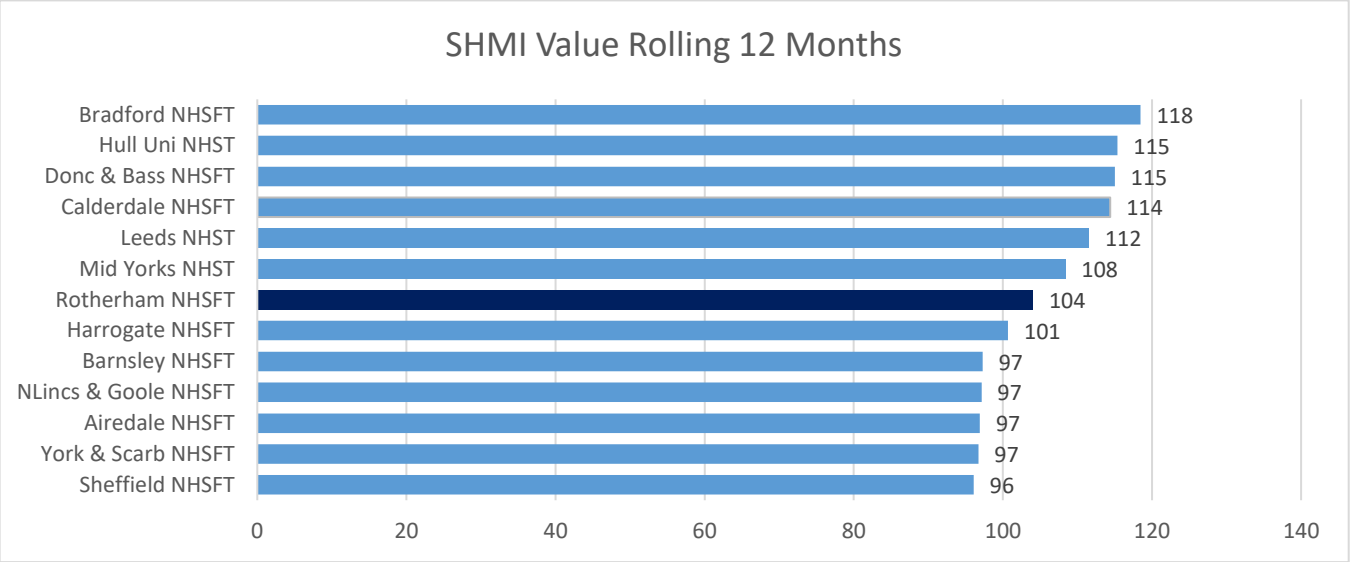


TRFT Latest SHMI Value

End Month	SHMI value	SHMI banding	Number of spells*	Observed deaths	Expected deaths
Jun-24	104.0	2	51405	1515	1455

* Excluded Day Cases and Regular Attendances

Region Comparator - Yorkshire & Humber Non Specialist Trusts



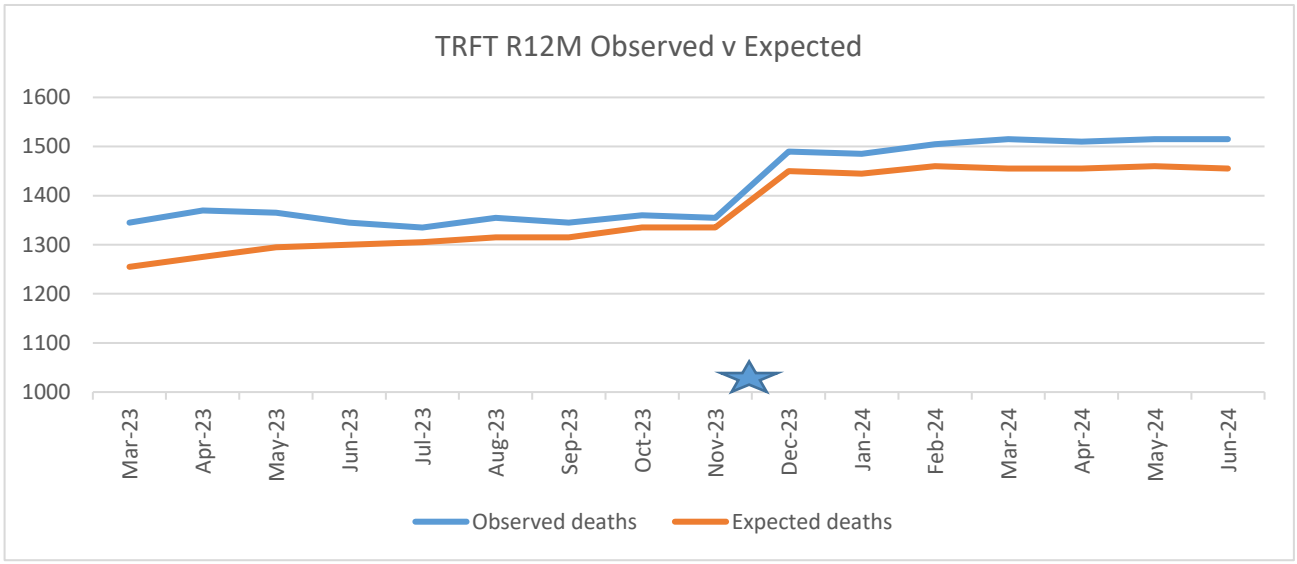
SHMI Diagnostic Group Breakdown

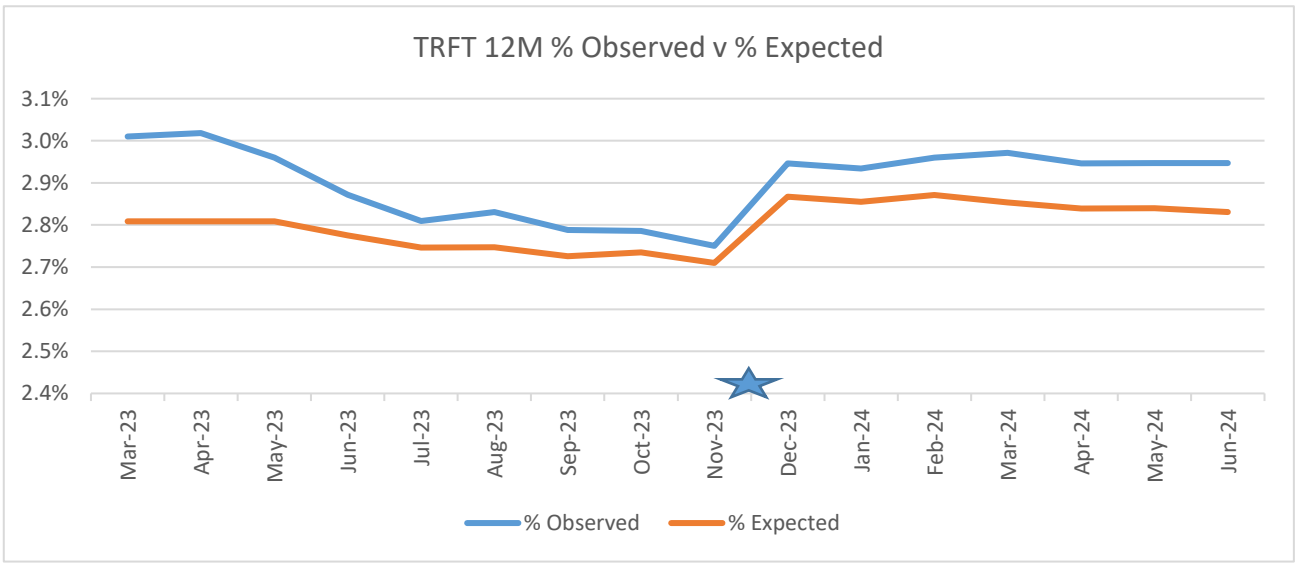
Diagnosis Group	Number of spells	Observed deaths	Expected deaths	SHMI Value	SHMI banding
Fluid and electrolyte disorders	380	35	20	153.2	2
Acute myocardial infarction	395	40	30	135.7	2
Fracture of neck of femur (hip)	345	35	30	121.1	2
Acute bronchitis	1325	30	25	112.1	2
Septicaemia (except in labour), Shock	560	125	115	111.1	2
Cancer of bronchus; lung	55	25	20	109.6	2
Pneumonia (excluding TB/STD)	1725	240	225	107.2	2
Gastrointestinal hemorrhage	395	15	20	96.7	2
Secondary malignancies	125	25	25	92.4	2
Urinary tract infections	945	30	35	83.3	2

Coding Metrics

TRFT Rank of 13	3rd Highest	3rd Highest	2nd Highest	7th Highest	2nd Highest
Yorks & Humber Region Non Spec Provider Trusts	**% of Spells: Primary Diagnosis is a Sign & Symptom**	**% of Spells: Invalid primary diagnosis code**	**MEAN Secondary Diagnoses per Spell Non Elective**	**% of Spells with palliative care**	**% of deaths with palliative care**
Harrogate NHSFT	31.2	18.4	4.0	1.3	27
NLincs & Goole NHSFT	17.6	0.1	4.9	1.3	29
Rotherham NHSFT	17.1	2.9	6.9	1.9	48
Barnsley NHSFT	14.3	0.0	7.5	2.4	43
Airedale NHSFT	14.3	0.0	4.7	1.2	26
York & Scarb NHSFT	13.5	0.0	6.1	1.2	27
Donc & Bass NHSFT	12.0	0.1	4.9	2.2	51
Bradford NHSFT	11.9	3.5	3.7	1.1	36
Sheffield NHSFT	9.8	0.0	5.1	1.7	37
Mid Yorks NHST	9.0	0.5	6.8	2.1	40
Hull Uni NHST	7.8	0.0	6.0	2.2	37
Calderdale NHSFT	7.4	0.0	6.7	2.8	46
Leeds NHST	5.5	*	6.3	2.1	36
England	14.0	1.8	6.0	2.1	44

Comparison of the SHMI Observed and Expected Deaths





SHMI Methodology Change Dec 2023 (May 2024 release):

Covid Activity was included in the SHMI after being excluded. This increased spell, expected and observed death numbers.

Board of Directors
10th January 2025

The Rotherham NHS Foundation Trust

Agenda item	P21/25
Report	**Guardian of Safe Working Quarterly report Q2 2024**
Executive Lead	Dr Jo Beahan, Medical Director
Link with the BAF	
How does this paper support Trust Values	Ambitious- for improvement in working conditions and patient safety. Caring- for colleagues and patients. Together- solutions are proposed after discussion has identified problems.
Purpose	**For decision** ☐ **For assurance** ☐ **For information** ☒
Executive Summary (including reason for the report, background, key issues and risks)	Under the 2016 Junior doctor contract a quarterly and annual report from the Guardian of Safe Working is required to provide assurance to the Board that working in the trust is safe. The contract specifies maximal shift durations, total hours per week and hours worked without breaks. A dispute over national pay and conditions for junior doctors has been resolved. The junior doctor forum will be known in future as the resident doctor forum, recognising the recent change in designation. Exception reports rose to highest quarterly numbers since 2021 as the August intake of residents began reporting. As always, the most junior doctors in medicine account for the largest proportion. Overall hours worked are not unsafe, although the rising trajectory will need monitoring. The intensity of working, however, is always high, particularly in Medicine. Workload and staffing are sometimes felt to be unsafe, especially by the most junior trainees.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	The Report collates information from the Allocate system for exception reporting, the Junior Doctors' forum monthly meetings, the Datix system, personal communication and assorted email correspondence. It has been prepared by Dr G Lynch, RFT Guardian for Safe Working, and sponsored by Dr J Beahan, Executive Medical Director.

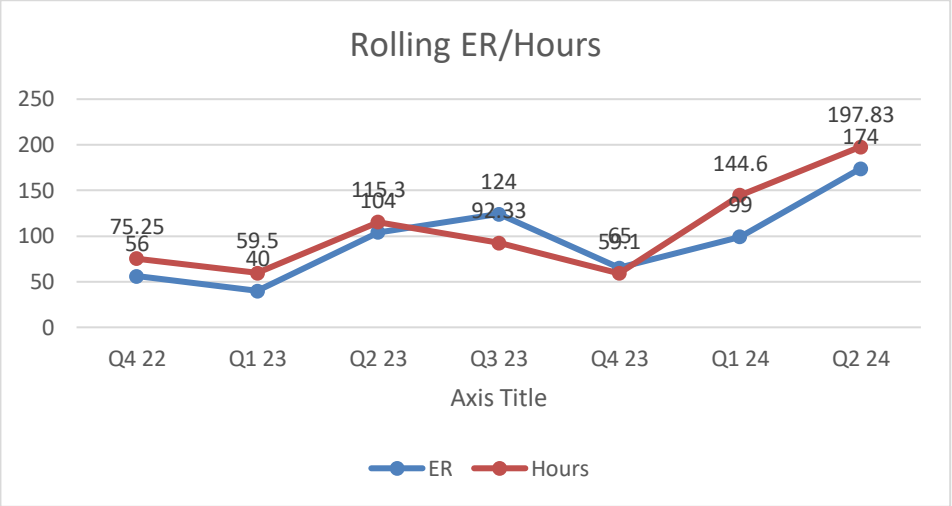
<table>
<tr><td></td><td>This report was presented to People and Culture Committee on 13th December 2024.</td></tr>
<tr><td>Board powers to make this decision</td><td></td></tr>
<tr><td>Who, What and When
(what action is required, who is the lead and when should it be completed?)</td><td>Dealing with the issues raised in junior doctor forum which takes place monthly-JDF attendees including medical staffing, MD, DME and GSW.</td></tr>
<tr><td>Recommendations</td><td>The Board is asked to note this report.</td></tr>
<tr><td>Appendices</td><td>
In Q2, between 28/6/24 and 28/9/24, 47 Doctors- 26 FY1, 5 FY2, 7 CT1, 2 ST1, 2 ST2, 2 ST3, 1 ST4, 1 ST7 and 1 ST 8 submitted 174 ER related to hours worked
6 ER related to pattern and 5 related to service support were also submitted.

Working hours:

<table>
<tr><th>(Sub) Specialty</th><th>Exceptions</th><th>Daytime Hours</th><th>Nightime hours</th></tr>
<tr><td>A1 Cardiology</td><td>7</td><td>12.5</td><td></td></tr>
<tr><td>A1 HCOP</td><td>3</td><td>3.16</td><td></td></tr>
<tr><td>A2 HCOP</td><td>1</td><td>1</td><td></td></tr>
<tr><td>A3 Respiratory</td><td>25</td><td>35.92</td><td></td></tr>
<tr><td>A4 HCOP</td><td>42</td><td>24.5</td><td></td></tr>
<tr><td>A5 Diabetes</td><td>0</td><td>0</td><td></td></tr>
<tr><td>A5 Gastro</td><td>1</td><td>2</td><td></td></tr>
<tr><td>AMU</td><td>24</td><td>25.84</td><td>0.75</td></tr>
<tr><td>Medical Division total</td><td>103</td><td>104.92</td><td>0.75</td></tr>
<tr><td>Orthopaedics</td><td>17</td><td>24.25</td><td></td></tr>
<tr><td>General Practice</td><td>8</td><td>9.5</td><td>6.5</td></tr>
<tr><td>Obs and Gynae</td><td>3</td><td>8.5</td><td></td></tr>
<tr><td>Gen Surgery ASU</td><td>19</td><td>22.16</td><td>4.12</td></tr>
<tr><td>Gen Surg B10</td><td>21</td><td>20</td><td>5.33</td></tr>
<tr><td>Paediatrics</td><td>3</td><td>8.5</td><td></td></tr>
<tr><td>Total</td><td>174</td><td>197.83.</td><td>16.7</td></tr>
</table>

<u>Exception reports for missed educational opportunities</u>

8 exception reports for missed educational opportunities were filed from Medicine- these are dealt with by the DME
</td></tr>
</table>



Immediate safety concerns

3 ISCs were logged from surgery relating to workload from a single weekend and a FY1 de facto acting up due to lack of staff.
This was discussed with the care group SLT who undertook to look at consultant job plans to improve available support and there have been no recurrences.

Triangulation with Datix system

Search of the Datix system revealed no incidents in this quarter where lack of trainee staff was mentioned.

Guardian fines

No fines have been levied this quarter for > 25% missed breaks or persistent hours in excess of 48/week. Doctors on the medical FY2/CT rotas whose work schedules average 47.25 hours per week have little margin for overstays and this is being monitored.

Qualitative examples from Exception reports

“18 outliers and 3 junior doctors”

“1 hour. Lack of lunch break and overtime from expected hours”

“There was no SHO on the rota for the day. So I carried the SHO bleep and phone for the entire 12 hour shift”

	Actions to mitigate issues The new Junior clinical fellows in medicine have been deployed to areas where intensity is high with some evidence of success from exception report trends in busy areas. Divisional managers and medical workforce manage rota gaps and source locums to the best of their ability, moving trainee doctors to where need is greatest on a daily basis, factoring in absences and patient numbers. The GSW, DME, and foundation director have raised any serious problems highlighted in Exception reports as soon as possible to the divisional leadership in medicine, as well as to medical workforce where appropriate; in particular any which might pose genuine immediate threats to safety. **Issues for Resident doctor forum** The GSW and DME will co-chair the Junior or Resident doctor forum and alternate weekday meetings to help attendance. This forum is the vehicle for trainees to raise concerns and issues and for management and medical workforce to respond. As well as doctors in training, it is attended by representatives from medical workforce, the care groups, MD, DME and GSW. Live issues for the current trainee cohort are- Adequacy of Ward A4 minimum staffing. Medical on call workload and taskboard management. Rota access from home. Monitoring of recent changes to AMU rotas to reduce reliance on locum and agency staff. Immediate risks to safety and any departures from contract will be flagged up as soon as possible to the divisions by the GSW and DME. NHSE have mandated measures to improve working lives: including timely rotas, increased availability of self-rostering improved payroll accuracy and reduced burden of Statmand training, amongst others and the JDF will discuss implementation of these.

Board Planner

Event/Issue

Action	TRUST BOARD MEETINGS		2024								2025	
			Jan	March		May	June	July	Sept	Nov	Jan	March
			12	8		3	11	7	8	1	10	
			M10	M12		M2		M4	M6	M8	M10	M12
	PROCEDURAL ITEMS											
	Welcome and Apologies	Chair	●	●		●		●	●	●	●	●
	Quoracy Check	Chair	●	●		●		●	●	●	●	●
	Declaration of Conflicts of Interest	Chair	●	●		●		●	●	●	●	●
	Minutes of the previous Meeting	Chair	●	●		●		●	●	●	●	●
	Action Log	Chair	●	●		●		●	●	●	●	●
	Matters arising (not covered elsewhere on the agenda)	Chair	●	●		●		●	●	●	●	●
	Chairman's Report (part 1 and part 2)	Chair	●	●		●		●	●	●	●	●
	Chief Executive's Report (part 1 and part 2)	CEO	●	●		●		●	●	●	●	●
	STRATEGY & PLANNING											
	TRFT Five Year Strategy 6 month Review	CEO				●				●		
	Operational Plan: 6 Month Review	DCEO				●				●		
	Annual Operational Planning Guidance	COO										●
	Winter Plan	COO								●		
	Digital Strategy	CEO						●dfd		●		
	Estates Strategy	DoF	●					●dfd				●
	People and Culture Strategy	DoW				●						
	Quality Improvement Strategy.	CN								●		
	Fire Safety Strategy (via ETM)	DOE				●						●
	Public and Patient Involvement Strategy	CN										
	SYSTEM WORKING											
	SYB ICS and ICP report	DCEO	●	●		●		●	●	●	●	●
	SYB ICS CEO Report (included as part of CEO report)	CEO	●	●		●		●	●	●	●	●
	Partnership Working	NED				●			●			
	SYB ICS - Wider Needs of Rotherham Community	Public Health		●					●			
	CULTURE											
	Patient Story	CN		●				●		●		●
	Staff Story	DoW	●			●			●		●	
	Annual Staff Survey	DoW		●								
	Staff Survey Action Plans	DoW				●						
	Freedom to Speak Up Quarterly Report	CN	●			●			●dfd	●		
	Gender Pay Gap Report and Action Plan	DoW		●								●
	Integrated EDI Plan - WRES, WDES, PSED	DoW							●			
	Patient Experience and Inclusion Annual Report	CN						●				
	End of Life Annual Report	DCN						●				
	PERFORMANCE											
	Integrated Performance Report:	COO	●	●		●		●	●	●	●	●
	Maternity including Ockenden	CN	●	●		●		●	●	●	●	●
	Safe Staffing & Establishment Nurse review (6 monthly)	CN	●					●			●	
	Safe Staffing & Establishment Nurse review	CN		●								
	Reports from Board Assurance Committees	NEDs	●	●		●		●	●	●	●	●
	Finance Report	DoF	●	●		●		●	●	●	●	●
	Car Parking Review (via ETM)	DOE				●		●				
	Summary of review on Laboratory safety prior to TUPE of staff	MD		●								
	ASSURANCE FRAMEWORK											
	Governance Report	DoCA	●	●		●		●				●
	Board Assurance Framework	DoCA	●	●		●		●	●	●	●	●
	Quarterly Risk Management Report	DoCA		●		●			●		●	
	Corporate Risk Register	DoCA	●	●		●		●	●	●	●	●
	Annual Review of risk appetite	DoCA						●	●			
	Assurance Board Committee ToRs - Audit & Risk Committee	DoCA								●		
	Assurance Board Committee ToRs - FPC, QC, PC	DoCA		●								
	Health and Safety Annual Report	DoE										●
	Quality Assurance Quarterly Report	CN		●		●			●	●		●

	SIRO Annual Report	DCEO						●dfd	●			
	Safeguarding Annual Report	CN							●			
	Infected Blood Inquiry	MD							● dfd			
	Organ Donation Annual Report	HC						●				
	POLICIES											
	Health and Safety Policy (review date August 2026)	DoE										
	Freedom to Speak Up Policy (Updated when National Policy available)	CN										
	Management of Complaints and Concerns Policy (review due 2025)	CN										
	Procurement Policy (due for renewal February 2026)	DoF										
	Risk Management Policy (due April 2026)	DoCA										
	REGULATORY AND STATUTORY REPORTING											
	Annual Report and Audited Accounts	DoF					●					
	Audit & Risk Committee Annual Report	Com Chair					●					
	People & Culture Committee Annual Report	Com Chair					●					
	Finance and Performance Committee Annual Report	Com Chair					●					
	Quality Committee Annual Report	Com Chair					●					
	Nomination and Remuneration Committee Annual Report	Com Chair					●					
	Annual Quality Account (approval)	CN					●					
	Data Security and Protection Toolkit Recommendation Report	SIRO						●dfd	●			
	Quarterly Report from the Responsible Officer Report (Validation)	MD	●			●			●			●
	ANNUAL Responsible Officer report (Validation)	MD							●			
	Quarterly Report from the Guardian of Safe Working	MD	Q4 ●			●			●	●	●	
	ANNUAL Report from the Guardian of Safe Working	MD				●						
	Learning from Deaths Quarterly Report	MD		●		●		●		●	●	
	Learning from Deaths Annual Report	MD							●			
	Emergency preparedness, resilience and response (EPRR) assurance process sign off/Annual Report	COO						●				
	Controlled Drugs Annual Report	MD							●			●
	NHSE Self-Assessment for Placement Providers 2024	MD								●		
	BOARD GOVERNANCE											
	Executive Team Meetings report	CEO	●	●		●		●	●	●	●	●
	Assurance Committee Chairs Logs	NEDs	●	●		●		●	●	●	●	●
	Register of Sealing (bi-annual review)	DoCA						●				●
	Register of Interests (bi-annual review)	DoCA				●						●
	Review of Board Feedback	DoCA										●
	Review of Board Assurance Terms of Reference	DoCA										
	Review of Standing Financial Instructions	DoF								●		
	Review of Scheme of Delegation	DoF								●		
	Review of Standing Orders	DoCA								●		
	Review of Matters Reserved to the Board (ad hoc)	DoCA								●		
	Constitution	DoCA										●
	Annual (re)appointment of Senior Independent Director	Chair							●			
	Annual (re)appointment of Board Vice Chair	Chair							●			
	Annual Board Meeting dates - approval	DoCA							●			
	Fit and Proper Person	DoCA							●			
	Escalations from Governors	Chair							●	●	●	●
	Nomination & Remuneration Committee Chair Assurance Report	Chair										●
	Annual Planner	Chair	●	●		●		●	●	●	●	●
	Annual Refresh of Committee membership (part of Chairs Report)	Chair				●						
	Audit & Risk Committee minutes	Chair	●			●		●				●
	Quality Committee minutes	Chair	●	●		●		●	●	●	●	●
	People & Culture Committee	Chair	●	●		●		●	●	●	●	●
	Finance & Performance Committee minutes	Chair	●	●		●		●	●	●	●	●
	Nomination Committee minutes (ad hoc)	Chair				●		●	●	●		
	Remuneration Committee Annual Report	Chair										●
	Remuneration Committee minutes (ad hoc)	Chair							●	●		

	Going Concern	DoF		•								•
	Segmental Reporting	DoF		•								•
	Accounting Policies	DoF		•								•
	Ad Hoc Business Cases for consideration by Board value in excess of £1m											
	Out-patient Pharmaceutical Dispensing Services	COO				•						
	Board feedback		RS	SH		HW		JBe	MT	MW	JB	JR
	NED Review of complaints files (Quarterly)		KM			JB		HW		MT	New NED	
	CORPORATE TRUSTEE (AD HOC)											
	Approved Minutes (Oct 23, Jan, 24, Mar 24 plus confidential)							•				
	Chair's Logs (Oct 23, Jan 24, Mar 24, May 24)							•				
	Terms of Reference							•				
	Summary of Performance Against Objectives							•				
	Objectives to f24/25							•				
	Financial plan and budget 24/25							•				
	Cancer Appeal							•				
	Legacy Giving							•				
	Annual CFC Report							•				