Board of Directors (Public)

The Rotherham NHS Foundation Trust

Schedule	Friday 7 March 2025, 9:00 AM — 12:30 PM GMT
Venue	Boardroom, Level D
Organiser	Alan Wolfe

Agenda

9:00 AM	PROCEDURAL ITEMS	
	P27/25.	Chairman's welcome and apologies for absence For Information - Presented by Dr Mike Richmond
	P28/25.	Quoracy Check For Assurance - Presented by Dr Mike Richmond
	P29/25.	Declaration of interest For Assurance - Presented by Dr Mike Richmond
	P30/25.	Minutes of the previous meeting held on 10 January 2025 For Approval - Presented by Dr Mike Richmond
	P31/25.	Matters arising from the previous minutes (not covered elsewhere in the agenda) For Assurance - Presented by Dr Mike Richmond
	P32/25.	Action Log For Decision - Presented by Dr Mike Richmond
	OVERVIEW AND CONTEXT	

9:10 AM	P33/25.	Board Committees Chairs Reports - Committee Chairs i. Quality Committee - Chair's Log - Julia Burrows ii. People & Culture Committee Chair's Log - Rumit Shah iii. Finance & Performance Committee - Chair's Log - Martin Temple iv. Audit & Risk Committee - Chair's Log - Kamran Malik For Assurance
9:40 AM	P34/25.	Board Assurance Framework For Decision - Presented by Angela Wendzicha
	P35/25.	Corporate Risk Register Report For Discussion - Presented by Angela Wendzicha
9:50 AM	P36/25.	Report from the Chairman - Verbal For Information - Presented by Dr Mike Richmond
9:55 AM	P37/25.	Report from the Chief Executive For Information - Presented by Dr Richard Jenkins
10:00 AM	STRATEGY & PLANNING	
	P38/25.	Draft Annual Operational Plan - Verbal For Approval - Presented by Steve Hackett and Bob Kirton
	P39/25.	Fire Safety Strategy For Approval - Presented by Scott Dickinson
	CULTURE	
10:20 AM	P40/25.	Patient Story For Information - Presented by Helen Dobson
10:40 AM	P41/25.	Freedom to Speak Up Quarter 3 Report For Assurance - Presented by Helen Dobson

	P42/25.	Freedom to Speak Up Annual Report 2023/24 For Assurance - Presented by Helen Dobson
10:50 AM	P43/25.	Gender Pay Gap Report and Action Plan For Approval - Presented by Daniel Hartley
11:00 AM	SYSTEM WORKING	
	P44/25.	South Yorkshire Bassetlaw Integrated Care System and Integrated Care Partnership report For Information - Presented by Bob Kirton
11:05 AM	BREAK	
11:10 AM	PERFORMANCE	
	P45/25.	Finance Report For Assurance - Presented by Steve Hackett
	P46/25.	Integrated Performance Report For Assurance - Presented by Helen Dobson, Sally Kilgariff, Steve Hackett and Jo Beahan
11:40 AM	ASSURANCE	
	P47/25.	Maternity and Neonatal Safety Report Presented by Sarah Petty For Assurance
	P48/25.	Health & Safety Annual Report For Assurance - Presented by Scott Dickinson
	REGULATORY AND STATUTORY REPORTING	

12:00 PM	P49/25.	Controlled Drugs Annual Report 2024 For Assurance - Presented by Jo Beahan
12:05 PM	P50/25.	Guardian of Safe Working Hours Quarter 3 Report: Gerry Lynch in attendance For Assurance - Presented by Jo Beahan
12:15 PM	BOARD GOVERNANCE	
	P51/25.	Register of Sealing For Assurance - Presented by Angela Wendzicha
	P52/25.	Register of Interests (Bi-annual review) For Assurance - Presented by Angela Wendzicha
	P53/25.	Escalations from Governors - No Escalations For Discussion - Presented by Dr Mike Richmond
	P54/25.	Board Annual plan For Noting - Presented by Dr Mike Richmond
	P55/25.	Any Other Business For Discussion - Presented by Dr Mike Richmond
	P56/25.	Questions from Members of the Public on the Business of the Meeting For Discussion - Presented by Dr Mike Richmond
	P57/25.	Date of next meeting - Friday 02 May 2025
	CLOSE OF MEETING	
	Untitled agenda	

Draft until approved at the 7th March 2025 meeting

The Rotherham NHS Foundation Trust

MINUTES OF THE BOARD OF DIRECTORS MEETING
Friday 10th January 2025, 09:00 – 12:00 pm
Boardroom

Present:
Dr M Richmond, Chairman
Dr R Jenkins, Chief Executive
Mrs H Craven, Non-Executive Director
Mrs H Dobson, Chief Nurse
Dr J Beahan, Medical Director
Mr S Hackett, Director of Finance
Mrs S Kilgariff, Chief Operating Officer
Mr M Temple, Non-Executive Director
Mr B Kirton, Managing Director
Ms J Burrows, Non-Executive Director
Ms H Watson, Non-Executive Director
Professor S Congdon, Non-Executive Director

In attendance:
Mr A Mondon, Associate Non-Executive Director
Mrs J Roberts, Director of Operations/Deputy COO
Mrs E Parkes, Director of Communications (from 9.20am)
Mr J Rawlinson, Director of Health Informatics
Mr P Ferrie, Deputy Director of People
Mr A Wolfe, Deputy Director of Corporate Affairs
Ms C Rimmer, Corporate Governance and Risk Manager (minutes)
Mr H Dim, Head of OD and Inclusion (for item P13/25)
Ms K Richards, Registered Midwife (for item P13/25)
Mrs S Petty, Head of Midwifery (for item P18/25)

Observers:
Ms L Brookshaw, 360 Assurance
Mr J Edwards, Acacium Group
Ms L Mumby, Deputy Director of Digital and Tech Services
Ms C Hill, Aqua (Well-led Review)

Apologies:
Mr D Hartley, Director of People
Dr R Shah, Non-Executive Director
Mr K Malik, Non-Executive Director
Ms A Wendzicha, Director of Corporate Affairs

Item	Procedural Items	Action
P1/25	**CHAIRMAN'S WELCOME & APOLOGIES FOR ABSENCE** Dr Richmond welcomed Mr Kirton to his first Board meeting at Rotherham as Managing Director and introduced Ms Hill who would be observing the meeting as part of the ongoing well-led review.	
P2/25	**QUORACY CHECK**	

	The meeting was confirmed to be quorate.	
P3/25	**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. 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.	
P4/25	**MINUTES OF PREVIOUS MEETING HELD ON FRIDAY 8th NOVEMBER 2024** The minutes were approved as a correct record, subject to amendments outlined and agreed by Board members.	
P5/25	**MATTERS ARISING** There were no matters arising which were not covered by either the action log or agenda items.	
P6/25	**ACTION LOG** The Action Log was received and Log numbers 16, 18, 21, 22, 23, 24 and 25 were agreed to be closed. Regarding Log no. 17, Dr Jenkins updated the Board that a report had been collated by the Deputy Director of Communications and there was focus on publicising the positives. The Board agreed for the action to be closed.	
	OVERVIEW AND CONTEXT	
P7/25	**Board Committees Chairs Reports** i. Quality Committee (QC) Ms Burrows updated the Board on the decision and recommendation for BAF risk P1 to remain at a score of 8. Ms Burrows reported that the committee received the full presentation on the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) to continue to support the delivery of safer maternity care and recommended to Board for final sign off. Lastly, Ms Burrows advised the Board of the Learning from Deaths report received, noting some decline in compliance in quarter one but that improvements were reported in quarter two. Further discussions were held during the agenda item P20/25. ii. People & Culture Committee (P&CC) Ms Watson presented the chairs report on behalf of Dr Shah and highlighted the following:	

- The committee commended the Achievements of Our People report, detailing various awards and achievements and Ms Watson linked back to discussions on action log no. 17. Feedback had been given to develop the report further by looking forward and horizon scanning, as well as reflecting on the past successes
- The positive reduction in agency spend that had been hard won by teams
- The continued focus by the committee on Job Planning and the vast improvements in this space
- First presentation of the Medical Education Report and GMC Training Survey, noting the connection to the Trust objective around Teaching Hospital Status
- Guardian of Safe Working Hours report flagged issues in a particular area however the committee were assured by the proactive steps in place.

Regarding job planning, Dr Richmond was encouraged by the progress and put forward that good compliance should be the norm rather than the exception. Dr Beahan raised that job planning is going to be an area of national scrutiny and once the target of 95% has been achieved, the next stage will be to track job plan delivery and map against capacity and demand. Mrs Craven concurred that the demand and capacity work will be a key driver for Elective Recovery as well as other services.

Mrs Dobson reflected on the Medical Education Report connection to teaching hospital status and queried how the Board had likewise oversight and information on Research. This sparked consideration on the assurance committee reporting for such items to feed through to Board, to be determined outside the meeting. Dr Jenkins posed a holistic approach when looking at teaching hospital status and highlighted the concept to make education more central to the work of the Trust.

Dr Jenkins

Prof. Congdon noted the research funding outlined in the financial report and also that it would be beneficial to see evidence-based practices in future reporting for education.

On the agency spend reductions, Mr Mondon queried whether the savings had then been spent on substantive staff and Mr Hackett clarified the inflated costs for agency staff for which there is a direct saving and the benefits of substantive staff from a quality perspective as well as a financial perspective. Financial reporting and coding are used to analyse and monitor agency spend to backfill and to meet additional capacity. Dr Jenkins added that, in regard to doctors in particular, it is a complicated area and there is a large amount of focus regionally and nationally.

iii. Finance and Performance Committee (FPC)

Mr Temple introduced the reports and raised that a key theme at the meetings had been volume, and the consequence of the volume, recognising the dynamic change. Despite all the pressures, Mr Temple highlighted that the trust is often in, or near to, the top quartile for performance metrics. The committee were still challenging, learning and supporting colleagues and Mr Temple updated the Board on the decision to reduce the agenda for the next meeting, reflecting on the need for attendees to be elsewhere to support operational pressures.

	Mr Temple noted the recommendations in relation to the BAF risks aligned to the committee, the EPRR core standards and the recent update on Mexborough Elective Orthopaedic Centre of Excellence (MEOC) with an advisory to the Board that there is to be a further review of overhead costs. Dr Richmond queried whether there were any constraints at MEOC to improve utilisation, such as equipment or diagnostics. Mrs Kilgariff explained that a key challenge is to deliver case mix and that a recent equipment purchase would enable a broader range of procedures to help improve the position. Dr Richmond noted that general reporting is positive on the quality of care, patient experience and clinician experience.	
P8/25	**TRFT Strategic Risk Appetite Review 2024/25:** Mr Wolfe introduced the report, drawing attention to the outstanding risk appetite for approval on the People and Culture element. Ms Watson reflected on previous Board and People and Culture Committee discussions on separating and defining into two sub categories as the correct approach with appropriate wording. The Board of Directors approved the risk appetite for People and Culture.	
P9/25	**Board Assurance Framework (BAF)** Mr Wolfe presented the report, highlighting the increase to D5 which was discussed at November and December FPC, and the regular reviews of P1 considering the increasing pressure on resources and the impact on quality of care. On BAF Risk D5, Mrs Kilgariff explained that the increase from 4 to 5 was due to fluctuations noted in the paper and the increase in demand. Although not all services had been impacted, there had been detailed discussions on the breadth of metrics involved and there was need to recognise the substantial impact on urgent care. Various mitigations are in place to address the areas of concern. Dr Richmond acknowledged the self-evident nature of the increase but stressed that the increase requires enhanced mitigating actions and inquired about the timeline for bringing the risk back to acceptable levels. Mrs Kilgariff detailed that a recovery plan is in place, focusing on actions for this year. Discussions are ongoing with the ICB regarding the current model, addressing both short-term and broader issues with urgent care services. Dr Richmond reiterated that the increase in risk score necessitates revisiting the risk and discussions at board and executive team levels and Mrs Kilgariff confirmed that the recovery plan was agreed at FPC and would bring back a deep dive on urgent care at FPC to ensure conversations and oversight continue. On BAF Risk P1, Mrs Dobson reported that the position of the risk had been reviewed in terms of acuity and would monitor pressures, but justified maintaining the score due to the lack of adverse incident or harm. Dr Jenkins clarified the system of monitoring harm, not waiting for harm to occur, and that good processes are embedded.	

	Mrs Dobson updated the Board that the Exemplar Accreditation Programme had commenced in Paediatrics and Maternity and in reference to C2, the PSIRF Plan and Policy would need to be updated on an annual basis. Mrs Craven raised that the risk level for Risk R2 had remained static for a long period of time, prompting further consideration into the actions and outcomes as the controlled mitigations included various meetings and reference to the strategy. There had been various conversations about the Board's role at Place, and Mrs Craven observed that the controls and risk level do not align with the discussions. Dr Jenkins highlighted the extensive involvement at Place, noting that the current description underplays this. The Managing Director would continue to play a crucial role here and Dr Jenkins emphasized the Trust's strong advocacy role within this for the local population. The 10-year health plan will naturally bring more focus on neighbourhood operations, which could be reviewed and incorporated into in Q2 reporting. Mrs Burrows suggested that if a deep dive is conducted, there is analysis of the inward as well as outward influence of Place. Mr Kirton commented that there are good mechanisms in place and, although there is complexity of relationships, there is a clear vision expressed in a local way. Dr Richmond summarised that the national picture is looking at further unification and with many moving parts, the BAF needs to be succinct with this movement to inform discussion and decisions. Mrs Craven posed that there is a disconnect between discussions on the future and the BAF here and it was agreed to review to recognise the position to give further clarity on gaps, actions and outcomes. Prof. Congdon queried the gap on the inequalities data and Mr Rawlinson explained the central suppository and increased focus here with the Public Health consultant. Missed opportunities to record data on protected characteristics had been identified and work is ongoing to ensure this is embedded to provide data to inform decisions. The wording was agreed to be reviewed to be clearer. The Board approved the recommendations from the Board Committees in relation to the risk scores Quarter 3 2024/25.	**Mr Wolfe**
P10/25	**<u>Corporate Risk Register Report</u>** Mr Wolfe presented the report and updated the Board that the January Risk Management Committee had been stood down due to operational pressures. Mr Wolfe highlighted the improved risk management function and ongoing work evidenced within the report, and the increased challenge and scrutiny that had followed at Assurance Committees. Mrs Kilgariff considered risks that require further Executive Team oversight, such as Risk 7084 regarding additional beds and pressures, and how to triangulate with other risks and information to balance the scoring. Although Care Groups have full ownership of their risks, Mrs Kilgariff raised that further development would be to recognise the Trust position alongside this to give	

	further breadth to risk management. Dr Jenkins concurred that risks need to be robustly reviewed by Executives, particularly risks that have remained static, and ensure there is consistency across the Care Groups. Mr Hackett detailed that Care Group engagement and development in risk management had been evidenced at recent Performance meetings and also through capital resource requests. With the work by the Corporate Affairs department, Mr Hackett summarised that the risk register had become a live tool to support taking services and clinic areas forward. Mrs Dobson considered the next stage of development, which could be to enable ownership of risks by multiple Care Groups rather than working in silo. The Board noted the content of the report and the ongoing work to further strengthen the risk register.	
P11/25	**Report form the Chairman - Verbal** Dr Richmond noted the anniversary of commencing in post and that it had been a profound privilege to serve as Chairman of TRFT, working with a dedicated board and executive team. Dr Richmond stated that the Trust must remain grounded whilst collectively and individually striving for excellence to deliver the highest standard of healthcare. Dr Richmond detailed that in all forums, the aim is to engage with integrity and a positive attitude, striving to be effective collaborators and that the primary mission is to serve the people of Rotherham. The opportunities ahead are substantial, and by pushing ourselves, the Trust is confidently moving in the right direction.	
P12/25	**Report from the Chief Executive** Dr Jenkins introduced the report, noting the significant operational pressures. Dr Jenkins highlighted that RSV cases had been decreasing, while flu levels are similar to those seen two years ago, making it difficult to predict the peak. Operational performance had been further compounded by significant staff sickness. Despite these challenges, the Trust is maintaining elective capacity through the winter, and performing well. Dr Jenkins raised that the national Elective Recovery Plan had been published and the wide-ranging set of tasks will be addressed in collaboration with the Executive Team. Dr Jenkins provided a brief update on the accommodation blocks and the timeline for closure. Dr Jenkins gave details of the work to support residents including capital works to convert houses into multiple occupancy units to provide alternative spaces and other contingencies in place to support those affected. Regarding Flu cases, Ms Burrows queried whether there was any correlation with the uptake on the Flu vaccine. Dr Jenkins detailed that, in general, the uptake for the vaccine had been lower post-covid. Mr Ferrie commented that the People Team had made the staff vaccination programme more mobile this year and the outturn for the Trust had been one of the highest in the patch.	

	Mrs Craven highlighted that the ICB are still reporting a significant deficit and queried that impact on the Trust before year end. Dr Jenkins explained that the Trust needs to deliver the agreed plan and posed that the deficit could have impact next year with cost savings measures. Ms Watson commended the Trust's approach to staff communications, particularly the timeliness of the appreciation messages and highlighted that it is important in the context of engaging with and supporting staff. Mr Temple queried the impact of the capital works for A&E and Mrs Roberts reassured that the teams have managed incredibly well and taken on the challenge to move around services. Ms Burrows questioned the value of the ICB report without corresponding evidence or attendance from the CEO to give further context and clarity. Dr Jenkins reflected that it was added to ensure Board oversight of different workstreams and suggested that consideration be given to how to capture and connect the various activities within different networks in a way that contextualizes their efforts. Dr Jenkins linked back to the earlier discussions on the BAF. Dr Richmond highlighted the achievements regarding 65-week waits but cautioned that there remains a large number of patients waiting a long time for medical care. On the prevalence of winter illnesses, discussions were held on mask wearing in the hospital and the Trust's approach. Mrs Dobson outlined the communications and expectations set, the setup of a Flu Ward and the use of PPE and other initiatives put in place to protect patients and staff.	
	CULTURE	
P13/25	**Staff Story** Mr Ferrie introduced Ms Richards and Mr Dim to present the staff story centred on neurodiversity for staff and patients, aligning with the EDI plan approved and in progress. Ms Richards shared with the Board her achievements as RCM Student Midwife of the Year and her co-created Neurodivergence Acceptance Toolkit to help support students in placement and university by making adjustments that are reasonable and realistic. Ms Richards talked about her early career, diagnosis of combined ADHD at University and shared her challenges and experiences since the diagnosis. Ms Richards detailed various initiatives she set up, such as a Midwifery Society and her work to bridge the gaps in her education, working with the University Teams and calling out for change. These were very successful and led Ms Richards to present at conferences, Council of Deans and she joined the RCM forum to have a voice there. Ms Richards raised that adjustments can enable neurodiverse staff to thrive and detailed the thought processes and extra efforts someone such as herself puts	

	in to understand things and to get tasks completed. The next steps for Ms Richards was to continue her work from the Toolkit and was meeting with the Chief Midwifery Officer for England. Ms Burrows congratulated Ms Richards on her achievements and raised that diversity can often be referred to as a deficit, but she had demonstrated it can be an asset. Ms Richards highlighted that neurodiversity can often be masked and so even getting the basics right, such as adjustable lighting, quiet spaces and more time can help people thrive. Ms Richards talked about the stigma attached and how this can create barriers to people speaking up and gave example of ways to overcome this. Ms Richards posed that it is important to ensure things that are put in place are actually being used and this comes with more awareness and mutual support. Mrs Dobson thanked Ms Richards for sharing her lived experience and how this will feed into the work under the Health and Wellbeing programme on staff spaces. Ms Richards summarised that, in the university setting, there is more work to be done to review and implement assessments, and for the clinical environment, there is still a lot of stigma attached and that lack of awareness can be really detrimental. Ms Parkes offered support in her role as Communications Director to help raise awareness and understanding, both internally and externally. Mr Dim requested that the Board consider a Neurodiversity campaign as a key focus for the EDI Plan next year and Dr Richmond commented that the Board would give favourable consideration when the full information is presented. Dr Richmond summarised that it was an uplifting and thought-provoking presentation, and encouraged Ms Richards to continue her valuable advocacy work.	
P14/25	**<u>Medical Education Report and GMC Training Survey</u>** Dr Beahan introduced the new report to the Board, prompted by the NHSE initiative to improve the lives of doctors and training and the Board visibility the subject requires; the request is that the survey has the same platform as the national staff survey and the subsequent appropriate action plans. Dr Beahan highlighted that the report was positive and gave good quality assurance, alongside recent visits from universities and feedback from Medical students; the Medical Education team continue to strive for improvements. The National Training survey results gave aspiration to do better and Dr Beahan drew attention to the concerns around sexual safety, which correlated with the national staff survey. Dr Beahan noted the challenges outlined in the report, such as staffing and adequate space in the Education Centre, as well as support for International Medical students.	

	Mr Temple queried the negative behaviour reported and whether it could be pinpointed or there was further information. Dr Beahan explained that there is some narrative that can give more detail but in terms of the Trust data, no added narrative was given. The Trust is proactive in addressing poor behaviour and ensures awareness of the Freedom to Speak Up guardians. Referring to Teaching Hospital status aspirations and the national increase in the number of trainees, Mrs Craven questioned the constraints of the estate and equipment and how, at an Executive Level, this was being planned for to accommodate increase in numbers as well as different methods of teaching. Dr Beahan detailed that it is an area of opportunity for income generation and highlighted the concerns outlined in the report by the Medical Director for Education, particularly around training for surgeons. Ms Burrows queried the level of concern given to the results on sexual safety. Dr Beahan explained that it was the first time this question was posed so it was difficult to benchmark this time, and highlighted the work already in train in the Trust such as posters, communications campaigns and being clear that concerns are taken seriously and robust actions are taken. On education, Prof. Congdon questioned the plan or bespoke/ring-fenced budget, and for sexual safety, the reporting tools. Dr Jenkins raised that the Executive Team are aware of the estates constraints in education and were looking to build into the estates plan. There is ring-fenced funding for under graduates and other groups of training however capital funding for training is still a challenge. For Sexual Safety, Dr Jenkins clarified that there are a number of avenues for doctors to raise concerns, both at the Trust and also at their university. Dr Richmond highlighted the reporting on professionalising medical educators as a development opportunity for the organisation and making this part of the Trust operations. Dr Richmond summarised this report as an important part of the Board agenda moving forward, bringing into core business. There is clear ambition to become a teaching hospital and it is therefore key to have a plan to move forward to avoid significant constraints.	
	SYSTEM WORKING	
P15/25	**National, Integrated Care Board and Rotherham Place Update** Mr Kirton presented the report, highlighting the updates on the work with South Yorkshire Police, positive outcome from the SEND inspections which had only been possible with partners working together, and the Place updates. Mr Temple raised that there had been increased media coverage recently on the child exploitation cases in Rotherham yet the reporting did not comment. Mr Temple queried whether the organisation needs to have further input here and what systems are in place. Dr Jenkins detailed that there should be no complacency here and that there had been profound learning at the council. For the Trust, safeguarding had vastly improved and there are good processes in place. Mrs Dobson commented that the Safeguarding team are very active and	

	working closely with Place, reporting on a regular basis. There was also awareness that those affected will now be women and may be presenting with further needs such as for mental health, and the teams are mindful of this. Dr Beahan echoed the comments, seeing this in action with daily safeguarding discussions whilst working in UECC. There has been a step change and the awareness around sexual exploitation has increased and there are much better processes in place.	
	PERFORMANCE	
P16/25	**Finance Report** The Finance report was presented by Mr Hackett, who was pleased to report a positive performance for Month 8, a clear outcome from actions put in place. Mr Hackett confirmed that there was still a lot of work to do but the performance had reduced the deficit. The Cost Improvement Board continues to focus on improving the run rate and there are plans and contingencies in place. Mr Hackett updated the Board on some legacy issues and the due cash now received, and that the risk around system adjustments from ICB had not come to fruition. Mr Hackett summarised that the Trust was still in the midst of winter pressures which carries risk on delivery. The cost containments and CIP delivery were ongoing and the financial plan was still achievable but with significant challenges. Mr Hackett also noted the challenges that will continue into next year and the increased CIP demand placed nationally. Ms Burrows queried the position on bank and agency spend reflecting on the achievements presented in the P&CC chairs log. Mr Hackett explained that the expenditure would have been significantly higher if actions had not been put in place to achieve reductions and clarified the CIP allocation to Care Groups to pay and non-pay areas. Furthermore, there had been increased pressure primarily in pay due to the amount of patients coming through the door and meeting those demands. Mrs Craven posed that there was still a significant gap to deliver this year's plan and will require everyone to pull in the same direction. Mr Hackett concurred and detailed that the right plans are in place with the right engagement and that it is still achievable as long as there is no external influence. Mrs Craven raised that CIP had been discussed over a number of meetings and reiterated the need for truly transformational schemes and for the Board to be aware of the gaps. A full report of CIP is presented to FPC and Mr Temple concurred that it should be more than stretching the current resource. Dr Richmond endorsed the request for the next Board report to include further information on this aspect. Members discussed further the areas that could be viewed as beneficiaries and areas that require less targeting. Attention was drawn to the transformational workstreams in train which feed into CIP and Back to Balance, as well as horizon scanning for collaborative services and partnership links.	**Mr Hackett**
P17/25	**Integrated Performance Report**	

For further context to the report, Mrs Kilgariff and Mrs Roberts gave a thorough update to the Board on the current site position. This included details on the increased number of attendances, impact of Flu, escalation levels, partnership working, increased capacity on virtual ward and escalation beds.

Dr Beahan was conscious that longer waits can lead to patient harm however, was assured by the lack of incidents and from UECC feedback that they have felt supported and have the right escalations in place. The next steps are to continuing to gather the lessons learnt and Dr Beahan updated that there had been some early hints of regional recognition as the Trust had been asked to present their different ways of working to manage in excess pressures.

Ms Burrows queried the impact on staff well-being and whether there were any days of despite from the increased demands. Mrs Kilgariff explained that there are some fluctuations but was a rarity. The Health and Wellbeing team had been very supportive and a useful tool to gather staff feedback. Their support had not only been in clinical areas, visiting areas such as pharmacy and imaging.

Ms Watson referred to the known challenges in staff sickness and whether there had been correlation in the peaks of demand with peaks in staff sickness. Mrs Roberts detailed that the peaks had been evident and also impacted by snow, on the day sickness and flu. Dr Beahan added that staff planning had been proactive and strategic, particularly on known busier days.

Mr Temple reflected on comments heard from members of the public and whether there needs to be more awareness of the pressures and demands on the services. Ms Parkes explained that comments and expectations can depend on people's perspectives at their time of need and that there is significant media coverage on the NHS challenges. At Place and the Trust, there are constant updates but there is debate on the reach and engagement.

Dr Richmond commended all the teams involved to manage the pressures and that it was clear that the processes had been effective and delivered a standard others have not been able to meet.

On the IPR report, Mrs Kilgariff drew attention to achievements on 65 week waits, and the increased focus on 52 week waits; the numbers had stabilised and were starting to decrease. Growth could be seen in three key areas and Mrs Kilgarff confirmed that all had robust plans and insourcing to improve positioning.

Mrs Craven referred to the data quality scoring of the report, highlighting that a number of metrics were red and that it needed to be addressed. There were also still gaps in the data and Mrs Craven requested more progress here. Dr Richmond concurred and requested that there was also further clarification on the growth and maximisation of virtual ward.

Mr Kirton

Ms Burrows noted the deteriorating combined positivity scores to consider the impact on inpatient surveys. Mrs Dobson posed that this does not always correlate and that the Patient Experience team are in the process of updating

	the improvement plan. A key theme from feedback was regarding waiting times and could be seen through non-elective and elective services.	
	ASSURANCE	
P18/25	**Maternity and Neonatal Safety Report** The Board welcomed Mrs Petty to the meeting and congratulated her on her new appointment as Joint Director of Midwifery for TRFT and Barnsley from 3rd February. Mrs Petty provided the key headlines from the report as follows: • SPC Charts detailed a spike in still birth rates over the last 3 months and an increase in perinatal death rate. Mrs Petty explained that this was due to a cluster of still births. A thematic review had been conducted with input from Public Health colleagues and LMNS had conducted their own thematic review for further rigour, with themes detailed in the report. Three cases had also been reported to LMNS for investigation due to their stage in labour. • Published CQC survey results showing a positive position for Rotherham. The next steps are to co-design an improvement plan. • Maternity Incentive Scheme CNST and the evidence, challenge and due diligence conducted to demonstrate compliance with all safety actions. Ms Burrows queried staffing levels, following staff feedback and Mrs Petty confirmed that safe staffing tools are used to assess and ensure appropriate levels and an escalation process followed to ensure all women have 1:1 care in labour. Dr Jenkins congratulated Mrs Petty and her team on the survey results and achieving all CNST standards. On the analysis by deprivation and adverse outcomes, Dr Jenkins posed whether there needed to be further triangulation with population data to give more context. Dr Richmond questioned the peak in still births and whether, alongside the underpinning assurance, there was anything else the Board should be sighted on here due to the peak. Mrs Petty detailed that the external reviews had not highlighted anything contrary or further to the Trust's reviews. There had been suggestions of improvements, but nothing that would have caused harm. The Board approved delegated authority for Dr Jenkins as Chief Executive to sign off the evidence for CNST Maternity Incentive Scheme.	
P19/25	**Safe Staffing and Establishment Nurse Review** Mrs Dobson presented the paper and reminded the Board that it is a national requirement to publish this document on the Trust website every 6 months, detailing the nationally validated tools to assess the funded establishment against the acuity of patients. Mrs Dobson highlighted that there were no proposals to change the establishment but that in line with upcoming bed reconfigurations, this may be subject to change.	

	Mrs Kilgariff raised that there are planned temporary staff for additional beds and highlighted that the demand is planned for and reported here, however, the actual demands can fluctuate. Mrs. Dobson commented that the Safer Nursing Staffing Tool is used nationally for business planning purposes, and there is ongoing collaboration with the national team to assess its effectiveness. The Board of Directors supported the recommendation of the establishment review.	
	REGULATORY AND STATUTORY REPORTING	
P20/25	**Learning from Deaths & Mortality Quarterly Report** Dr Beahan introduced the report for Quarter 2 and highlighted the following: • SHMI remains as expected • Structure Judgement Reviews (SJRs) are well embedded. Quarter 1 had some challenges here due to staff sickness and non-completion of reviews, however, this had been rectified and compliance had improved • Focus had turned to conditions flagging as of concern and retrospective SJRs • The Learning From Deaths Manager maintains scrutiny at Care Group and Ward level to ensure discussions of findings from mortality and actions, as part of 360 Assurance feedback • Twice yearly discussion group looks at thematic analysis and QI projects. Coding changes are being monitored and Dr Beahan raised that the move to Emergency Care Data Set (ECDS) could affect the SHMI data in future. The Board noted the report.	
P21/25	**Guardian of Safe Working Hours Quarterly Report** Dr Beahan presented the report on behalf of Gerry Lynch, Guardian of Safe Working Hours. Dr Beahan reported that exception reports rose to the highest quarterly numbers since 2021 but that overall, working hours are not unsafe; this will continue to be monitored. Particular concerns fit with additional demands such as areas with additional beds and not additional staffing, and this was reiterated at a listening event that problems are caused by the high number of beds.	
	BOARD GOVERNANCE	
P22/25	**Escalations from Governors - No Escalations** There were no escalations from the Council of Governors.	
P23/25	**Board Annual plan** The Board noted the annual planner.	
P24/25	**Any other business**	

	There were no other items of business.	
P25/25	**Questions from Members of the Public** No questions were received.	
P26/25	**Date of next meeting** Friday 7th March 2025	
	CLOSE OF MEETING	

Chair:

Date:

Board Meeting; Public action log

Log No	Meeting	Report/Agenda title	Minute Ref	Agenda item and Action	Lead Officer	Timescale/ Deadline	Comment/ Feedback from Lead Officer(s)	Open /Close
2024								
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	May-25	Not due until May 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	On agenda	**Recommend to close**
2025								
1	10.01.25	Board Committees Chairs Reports	P7/25	Consider how the Board has oversight of Research, as well as Medical Education, in the context of the objective around Teaching Hospital Status.	RJ	May-25		**Open**
2	10.01.25	Board Assurance Framework	P9/25	Review and clarify wording in regard to data collection gap.	AMW	Apr-25	To be included in annual review of BAF 2025/26	**Open**
3	10.01.25	Finance Report	P16/25	In regards to CIP, include further details of the gaps for Board oversight.	SH	Mar-25	Information included within Finance Report and discussed in full at Finance & Performance Committee 26.02.2025	**Recommend to close**
4	10.01.25	IPR	P17/25	To address concerns over number of metrics presenting red and ensure all data sets are included. A request was also made to include further clarification on the growth and maximisation of virtual ward.	BK	May-25	To include in annual review	**Open**

Open
Recommend to Close
Complete

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

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

Committee / Group: Quality Committee	**Date: 29th January and 26th February 2025**	**Chair: Ms Julia Burrows**

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
1	IPR	The Committee noted the decrease in combined positivity scores with additional information to be provided by the Chief Nurse. The committee also requested further specificity on the actions to be taken for the quality elements.	Board of Directors
2	Care Group 4 Presentation	The Committee welcomed the positive presentation from Care Group 4, noting the need for more promotion of services to the Rotherham people and also scope for community to do more with a shift of resource approach rather than a stretch.	Board of Directors
3	Draft Quality Priorities 2025/26	The Committee noted the Quality Priorities 2025/26 recommendations, and the Antimicrobial Stewardship which would be linked to IPC reporting around C Difficile.	Board of Directors
4	Patient Safety Committee Report	The Committee were informed of a never event reported and wished to alert the Board. This was regarding a complex patient and a piece of equipment that failed. Due process and investigations would be followed.	Board of Directors
5	Clinical Effectiveness Committee (CEC) Quarterly Report	The Committee agreed that it might be worthwhile to hold a development session for Board on Clinical Effectiveness as it would be an opportunity to develop engagement as a pillar of the Quality Strategy.	Board of Directors

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
6	Patient Experience Committee Report	Volunteering was raised as a potential opportunity for expansion and that it was worth re-evaluating the model and resources, alongside the benefits and outcomes.	Board of Directors
7	Future Award Opportunities	From the Patient Safety and Patient Experience Committee reporting, the committee raised that there were opportunities to put successful projects and work forward for awards. This included the work on AKI, Decaffeinated drinks and Acute Pain Management.	Board of Directors
8	Health and Safety Annual Report 2023/24	The Committee received the Annual Report and supported the updates agreed and addendum included, for recommendation to Board of Directors.	Board of Directors
9	Board Assurance Framework	Whilst acknowledgement was given to operational pressures and the potential risk to patient safety, triangulating with data and reporting and the overall picture, the Committee agreed for the score of P1 to remain at 8.	Board of Directors
10	Risk Management Report	The Committee welcomed the intention that moving forwards, there would be further triangulation throughout all committee reports with the high level risks. Committee reports should provide further detail on relevant high level risks which would then link back to the main Risk Register Report. Risk details should be acknowledged in each report's Executive Summaries to ensure the triangulation has been considered and included. The Committee agreed that there is need to develop from good papers, to papers that can make a difference, which can change the focus, decisions and possibly the resources of the Trust based on the mature risk information provided to the Committees and Board.	Board of Directors
11	The Medicines and Healthcare products Regulatory Agency (MHRA) Inspection	The committee wished to advise the Board of a recent MHRA inspection at the new Radio-Pharmacy facilities and that there were a significant number of non-conformances noted.	Board of Directors

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
		There are 3 Major and 7 Other non-conformances. A Major is a significant deviation from Good Manufacturing Practice (GMP) that has a good chance of impacting patient safety, while an Other is a deviation from GMP that isn't as immediately significant to patient safety. There has been a formal letter detailing the non-conformances and assessment and a Trust response will be delivered by the 6th March. This was a pre-inspection and there are currently no patient safety risks. The team are working through the actions and a paper will be submitted to ETM.	
12	Quality Strategy Development Session	A proportion of the meeting was reserved for a strategic session to develop the new Quality Strategy. The outcome was good triangulation of overarching themes from the key areas of patient safety, patient experience, clinical effectiveness and quality improvement. The committee will continue to have input on the formulation of the new strategy, linking with the Trust Strategy, as well as the underpinning quality sub-strategies in place.	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	Director of People Report	The Committee acknowledged and recognised he excellent work carried out across the Trust on the band 2 and 3 healthcare assistant review which has now concluded with a number of positive outcomes evident for the colleagues involved, the Trust and for patient care. The Committee also were sighted on the positive impact of the Health and Wellbeing trolleys with sees staff receiving a hot drink and nutritious breakfast pots whilst on the ward. This initiative seeks to give staff 5 mins to have a drink made for them and provides further opportunity for staff to open up about any issues they might be having and the opportunity for them then to be guided to appropriate help and advice. Executives and other senior managers reported that this feedback has been beneficial. This offering will be extended to support Muslim colleagues breaking their fast for Ramadan and to include trolley rounds during out of hours shifts. An open invitation to committee/Board members was made to take part in a wellbeing trolley round via the Director of People.	Board of Directors
2	Board Assurance Framework	The Committee agreed that the rating should remain at 12.	Board of Directors

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
3	Risk Register	The Committee welcomed the intention that moving forwards, there would be further triangulation throughout all committee reports with the high level risks. Committee reports should provide further detail on relevant high level risks which would then link back to the main Risk Register Report. Risk details should be acknowledged in each report's Executive Summaries to ensure the triangulation has been considered and included. The Committee agreed that there is need to develop from good papers, to papers that can make a difference, which can change the focus, decisions and possibly the resources of the Trust based on the mature risk information provided to the Committees and Board.	Board of Directors
4	Care Group 1 (UECC and Medicine) Presentation	The Committee received the presentation from Care Group 1 and agreed to advise the Board as to their concerns relating to the current staff sickness rates in line with the increased pressures and demands on the service. There were also concerns over the decrease in MaST compliance, particularly for medical staffing and that the Care Group do not have any Freedom to Speak up Guardians, although they are the highest reporting Care Group into the FTSU lead. The Committee agreed that this would be followed up in a Confidential People & Culture Committee with the Care Group at the 20th June 2025 Committee.	Board of Directors

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
5	Trust wide People Performance report	The Committee shared their concerns as to the rolling 12 months sickness absence rate of 6.0% which is a deterioration from 23/24 (5.8%), and significantly above target (4.8%). As part of the wider Health, Wellbeing and Attendance programme which is taking forward a number of actions, a retendered Occupational Health contract is designed to contribute to addressing this which is currently being finalised. The committee agreed a deep dive into Health, Wellbeing and Attendance at its next meeting.	Board of Directors
6	Gender Pay Gap	The Committee received the Gender Pay Gap report and recommended it to the Board for approval.	Board of Directors
7	Staff Survey Report	The Committee received the embargoed staff survey report which is presented in Confidential Board and will come to Public Board in May 2025.	Board of Directors

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

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

Committee / Group: Finance & Performance Committee	**Date:** 29th January and 26th February 2025	**Chair: Mr Martin Temple**

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
1	Risk Register Report	The Committee welcomed the intention that moving forwards, there would be further triangulation throughout all committee reports with the high level risks. Committee reports should provide further detail on relevant high level risks which would then link back to the main Risk Register Report. Risk details should be acknowledged in each report's Executive Summaries to ensure the triangulation has been considered and included. The Committee agreed that there is need to develop from good papers, to papers that can make a difference, which can change the focus, decisions and possibly the resources of the Trust based on the mature risk information provided to the Committees and Board.	Board of Directors
2	Integrated Performance Report (IRP)	Under some pressured circumstances the IPR measurement parameters are potentially misleading with data appearing to show some poor performance. The Committee however agreed that quality can be seen to still be high and the financial position. The Committee noted the improved performance position with the report RAG rating quadrants indicating sustained and stable improvement trajectories. Although did also note concerns related to specific areas such as ambulance hand-over delays, with	Board of Directors

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
		partnership working with the Yorkshire Ambulance Service underway.	
3	Integrated Financial Performance Report	The Committee noted the current Trust financial position and the positive work completed regarding clinical coding, continued grip and control and the belief that the trust was on course to deliver at year end, whilst also advising the Board that the next Financial Year 2025/26 would be a very challenging one financially.	Board of Directors
4	Operational Update	There is continuing demand on services, Care Group and Corporate Services action plans are in train.	Board of Directors
5	Agency Collaborative Tender - Award to Holt Doctors	The Committee commended the regional collaborative work undertaken related to the procurement process and agreed to recommend the paper to the Board for approval.	Board of Directors

Subject:	AUDIT & RISK COMMITTEE CHAIR'S ASSURANCE LOG Quorate: Yes	Ref:	Board of Directors:

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

Committee / Group: Audit & Risk Committee	Date: 24 January 2025	Chair: Kamran Malik

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
1	Risk Management Report	The Committee recognise the increased focus and work and improvement of the risk management process. They agreed that consideration was now required as to the next step for risk management to take it to the next level, with dynamic risk assessments, joined up actions across different risks and the importance of consistency when grading risk ratings across the different Care Groups and Corporate Services. The Committee welcomed the advice from 360 Assure and Forvis Mazars that they have started using elements of the Trust's risk management process as a good example to other trust in the region.	Board of Directors
2	Board Assurance Framework	The Committee noted that risks R2 and OP3 are now owned by the new Managing Director who is undertaking a full review of the risks. The risks are also to be aligned to one of the Assurance Committees for strategic oversight.	Board of Directors
3	Risk Management Strategy	The Committee welcomed the Risk Management Strategy and recommended it for approval to the Trust Board.	Board of Directors
4	Standards of Business Conduct:	The Committee agreed to advise the Board of the improving compliance of staff with the annual declaration of conflicts of interest	Board of Directors

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
		to the December 2024 position of 67.85% compared to the November 2024 position of 56.23%. The Committee noted the work undertaken in order to provide the data for this item and the further actions being taken in conjunction with the Medical Director's office and Communications to further improve compliance The Committee also agreed to alert the Board of Directors of the limitations of the current form of Trust Communications which often leads to important messages being lost amongst other Trust news.	
5	Internal Audit Progress Report	The Committee agreed to advise the Board of Directors of the audit opinion on the following audits: Budget setting, reporting and monitoring: Significant Assurance Bank and agency spend: Spilt significant/moderate (23/24 plan) Board Assurance Framework (BAF): Significant Assurance	Board of Directors
6	Losses and Special Payments Report	The Committee approved the paper.	Board of Directors
7	2024/2025 Accounts: Accounting Policies	The Committee approved the paper.	Board of Directors
8	2024/2025 Annual Accounts: Operating Segments	The Committee approved the paper.	Board of Directors

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
9	2024/2025 Annual Accounts: Going Concern	The Committee approved the paper.	Board of Directors

BOARD OF DIRECTOR'S MEETING
7th March 2025

The Rotherham NHS Foundation Trust

Agenda item	P34/25
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 risk appetite position of Seek was discussed and agreed at the January 2025 Board of Directors. **Finance and Performance Committee:** Discussed and approved the position in relation Strategic Risk D5 and D8 relating to future financial risk at the January and February 2025 meetings. **Quality Committee:** Discussed and approved the position in relation to Strategic Risk P1 at the January and February 2025 meetings. The Board will continue to review and approve the recommended scores for Strategic Risks R2 and O3 which is currently subject to a full review by the Managing Director. The attached report illustrates the position in relation to the Board Assurance Framework for months 1 and 2 of Quarter 4 2024/25.

Due Diligence	Since presentation at the last Board in January 2025, the relevant sections of the Board Assurance Framework have been discussed at the relevant Board Committees during January and February 2025 .
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 remain at 15; and ➢ The rating for BAF Risk D8 to remain at 20.
Appendices	Board Assurance Framework for Quarter 4 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 is now nearing the end of its third year in 2024/25 and continues to be monitored on a monthly basis at the Board Committees and at every full Board of Directors 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 1 and 2 of Quarter 4 2024/25.

1.4 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 on a monthly basis during 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

1.5 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 1 and 2 of Quarter 4.**

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 Controls C1 to C7 dates of assurance have been updated following the January Assurance Committees and Board of Directors and clarity on dates for the release of national surveys included in C5.

Gap G7, the development of an antimicrobial action plan has now been added as a Trust Quality Priority for 2025/26. Three new Gaps have been identified and added to the report, Gap G8 relates to a proposed new Quality Committee report, G9 is the 360 Assure audit on governance, with a focus on PSIRF, and G10 is the further development of the final Quality Priorities for 2025/26.

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.

2.5.1 It had been agreed at the July 2024 Board of Directors that the Likelihood of the risk should be reduced from 3 (Possible) to 2 (Unlikely) and rating for BAF P1 decreased from 12 to 8. This was due to the strengthening of the control measures laid out in the BAF report, at the review in February 2025 the progress relating to a number of the Gaps was noted and as such it is recommended that the rating should remain at 8.

2.7 Taking the above into consideration, it was recommended the risk score remains at **8** at Quarter 4, therefore at target score**.**

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 BAF risk R2 is currently subject to a full review and there will be a meeting to discuss this, including the Managing Director, the Director of Corporate Affairs and the Deputy Director of Corporate Affairs, on Tuesday 1st April 2025.

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 following full review by the Managing Director will still be subject to monthly review.

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 The BAF risk O3 is currently subject to a full review and there will be a meeting to discuss this, including the Managing Director, the Director of Corporate Affairs and the Deputy Director of Corporate Affairs, on Tuesday 1st April 2025.

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 and following full review by the Managing Director will still be reviewed on a monthly basis.

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 Deputy Director of People in Quarter 4 with the last review being in February 2025.

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 February 2025 it is recommended that BAF Risk U4 remains at **12.**

4.6 The Board 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.

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 4.

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 March 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

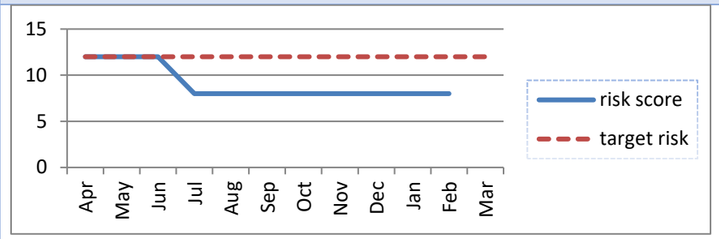
- Approve the recommendations from the Board Committees in relation to the risk scores Quarter 4 2024/25.

Alan Wolfe

Deputy Director of Corporate Affairs

March 2025

Ambition	Strategic Risk			Origin al 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 resour ce, capacit y and capability	..poor clinical outcomes and patient experience	4(L)x 4(C)=16	12	8	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	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	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	12	2(L)x4(C) =8	⟺	Seek
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 insuffici ent resourc e and increas ed 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	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	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**	**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 Dec24 - QC requested a replacement for the QA paper as it remained CQC based. An overarching quarterly update from QC to Board to be developed, see Gap G9.	November 2024 Board January 2025	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.	February 2025 Monthly	QC	L1				Chief Nurse	

		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.							
		Exemplar Accreditation Programme established for adult inpatient areas. Completed adults, paediatrics and maternity. The update on progress made at QC Jan25 and ETM Feb25; also shared with CQC Jan 25	January 2025	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. Subject specific presentation shared with CQC on a monthly basis providing assurance around key areas - Dec24 = falls, Jan25 = Accreditation and Feb25 = Tissue Viability, will also be presented to QC.	January 2025	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.	February 2025	PSC QC ETM					Chief Nurse

		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						
C3	Mortality and Learning from Deaths	All actions in the 360 Learning from Deaths Audit have been completed. Work continues to further improve the program and to ensure there is no slippage for implemented improvements. Reports detailing the completion rates and timeliness of SJRs 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. QI review to thematic analysis to identify quality improvement priorities 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	January 2025 November2024 ~~January 25~~ - delayed January 2025 QC - December 2024 January 2025	CEC QC Board					Medical Director

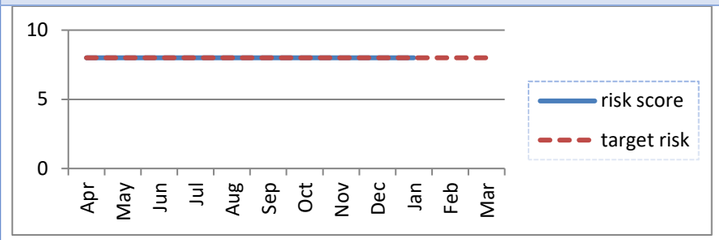
C4	Ongoing monitoring of the effectiveness of the newly implemented Clinical Effectiveness Strategy by the Clinical Effectiveness Committee.	The Care Groups report details of their Clinical Audits, Getting it Right First Time Programme (GIRFT), National Clinical Audits - Quality Accounts (NCAPOP & Other) 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 national inpatient and UECC surveys	Monthly text surveys to a proportion of discharged patients asking questions related to lowest scores on most recent national survey. Results and actions will be presented to Quality Committee in quarterly Patient Experience Report All on track	November 2024 QC January 2024	QC					Chief Nurse
		Friends and Family Test offered to all patients. Results shared with Care Groups on a monthly basis and reported at Patient Experience Committee and Quality Committee quarterly	February 2025	QC	L1				Chief Nurse
		Report on Complaints including volume, themes and learning reported at Patient Experience Committee and Quality Committee quarterly	February 2025	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	February 2025 November 2024 - public - Inpatients Q1 25/26, UECC Nov24, Maternity Nov24. CYPS Currently under embargo	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,	January 2025	QC	L1				Chief Nurse

		supported by Qi, Effectiveness and Data Analysis teams							
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	QC - February 2025	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	February 2025	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	February 2025	QC	L2				Chief Nurse
		Annual audit reports commissioned within the Quality domain following agreement of Audit & Risk Committee received at both ARC and Quality Committee with action plans monitored to completion. Audits include Internal Audit of Clinical Audit and Nice Implementation, Safeguarding and Medication Safety. Safeguarding and Medication 360 audits completed	January 2025 ARC January 2025	QC	L3				Chief Nurse

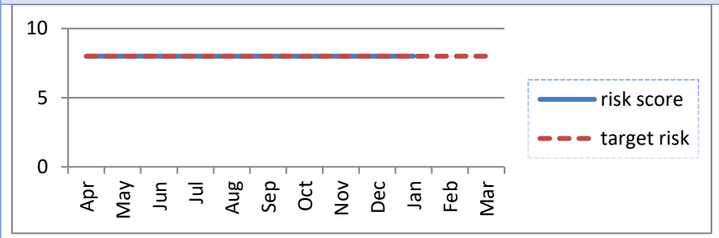
Gaps in Controls or Assurance Quarter 1 2023-24		**Actions Required**	**Action Owner**	**Date Action Commenced**	**Date Action Due**			**Progress Update**	
G1	Lack of assurance regards quality of end of life care	Completion of action plan that has been created in response to 360 assurance report and NACEL 2022 alarm outlier status report Strategy went to May 2023 Quality Committee and Board of Directors September 2023 Recruit additional palliative care consultant	Medical Director and Chief Nurse Medical Director	January 2023 September 2023 July 2024	~~May 2023~~ September 2023 May 2023 February 2025			Action plan created and shared internally and with external organisations Awaiting completion of NACEL and 360 audit action plan. NACEL to be four times per annum from 2024 NACEL 2024 has commenced, new Lead Nurse for End of Life now in post Paper to ETM regards restructure of team approved and End of Life will now sit Corporately - December 2023 NACEL to change to a rolling programme of audit All actions Completed - not archived as rolling programme The situation is ongoing and improving, awaiting a full year of improvement work and full report. Consultant Post recruited into, awaiting commencement into role.	

								Exec Team to Exec Team meeting TRFT and Rotherham Hospice held in January 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. 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 industrial action meetings to mitigate impact.	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. Care Group asked to escalate to Execs prior to cancelling any patients requiring a HDU bed.	
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**	May 2025				
G5	Development of Trust Quality Strategy	Development and publication of Trust Quality Strategy	Chief Nurse/Head of Quality Improvement	**November 2024**	April 2025			To include as agenda item at QC February 25 and 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. New Chief Pharmacist started 20 January 2025. CQC visit to Pharmacy November 2024, awaiting formal report and development of associated action plan.	
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.	

								Identified as a Quality Priority for 25/26. Meeting arranged with external partners for Feb 25 to expand key actions for 2025/26.	
G8	QC report for Board	Development of report to cover areas including Patient Safety, Patient Experience and Clinical Effectiveness	Chief Nurse/Medical Director	**Bi-monthly April 2025**					
G9	360 Audit Care Group governance with a focus on PSIRF governance	Just agreed ToR for 360 Audit, to commence Q4	Chief Nurse/Medical Director	**Monthly QC April 2025**					
G10	Quality Priorities 2025/26	Agreed 3 priorities, metrics and key objectives, currently being discussed and agreed	Chief Nurse	**Monthly QC March 2026**					
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**	**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		**January 25**	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		**January 25**		Level 1				**Control remains ongoing**	
C3	Trust is a member of the Health and Wellbeing Board			**January 25**		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.		**January 25**		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		**Actions Required**		**Action Owner**		**Date Action Commenced**	**Date Action Due**			**Progress Update**	

Quarter 1 2022-23									
G1	Ethnicity details not on all electronic systems	Public Health Consultant identifying and working on solution. A working group has been established including the Public Health Consultant and the Director of Health Informatics	Managing Director	Ongoing	~~End of Quarter 1~~ End Quarter 4			Work ongoing with Managing Director	
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**	**8**

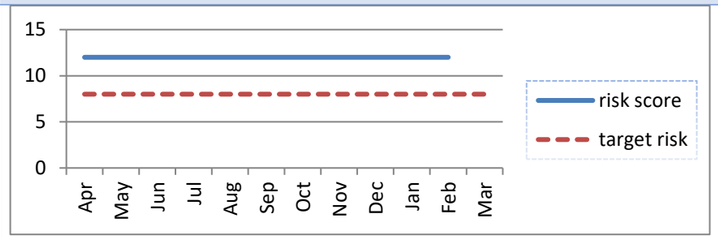
BAF Risk Description	Linked Risks on the Risk Register & BAF Risks				Assurance Committee
O3: There is a risk that robust service configuration across the system will not progress and deliver seamless end to end patient care across the system because of lack of appetite for developing strong working 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	**January 25**		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.	**January 25**	**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. SYPB Management meeting January 2025 - There has been engagement with medical directors and chief nurses who have agreed that a cohesive approach is required and SYPB are now in the process of creating a new POCT policy across the network and agreeing SLA's to reduce risk and strengthen governance relating to procurement/ training/QA and IQA. Going forward, the POCT will eventually be managed by SYPB. UKAS inspection – TRFT Pathology services. UKAS inspectors will be on site from the 20/1/25 and will undertake the elements of their assessment over a number of days until approximately 3rd week in February. There are no expectations of any problems but should any concern arise, SYPB will inform the Trust. With respect to the Fuller enquiry (mortuaries), as the HTA are now undertaking unannounced inspections of mortuaries, the SYPB will be rolling out a peer review process across the region from April 2025 to support partners to prepare for such inspections happening. Dates to follow.	
	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 Orthopaedic Centre (MEOC) - Not filling capacity	Director of Operations and COO meeting regularly with colleagues internally to increase fill rate	Managing Director		April 2024	~~July 2024~~ Ongoing until satisfactory capacity sustained.			Activity reviewed on weekly basis at ETM with full updated report. In an improving position, activity reviewed weekly at ETM and now past 70%		

	leading to increased reputational and financial risk to TRFT								
Archived Controls within month – Completed									
Archived Gaps within month – Completed									

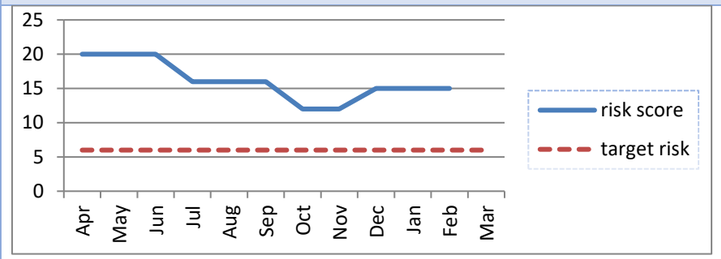
BAF Risk U4

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)**~~ **Seek**		**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 Oct24 12 month review at April 25		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 2024/27 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. July 24 launched trust wide 'we said, we did' 2024/25.	October 2024 and March 2025 At Care Group P&CC presentations	P&CC Oct 24 Ongoing confirmation from Care Groups		Level 1					

		NHS Staff survey outcomes and scores to be presented at People Committee and then the March 2025 Board of Directors.	P&CC February 2025 P&CC Board Mar25		Level 3				
C4	Health wellbeing and attendance work	Went 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 Feb25 and Apr25 updates	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. Formal Leadership Programme completed update to Feb25 P&CC

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 Group 3 Care Group 4 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	

G3	Development of the Trust Workforce Plan	Development of Plan for introduction in April 2025	Director of People						
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 ↓	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	**Feb25** **Feb25 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	**Feb 25**	**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	**Feb 25**	**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	**Feb25 IPR** **Feb25 IPR** **Feb25 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)	**Feb25**	**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	**Feb25**	**Monthly** **Weekly** **Weekly**	**Level 1** **Level 3 - 360 Assurance audit report - July24**				COO Ass Director of Operations

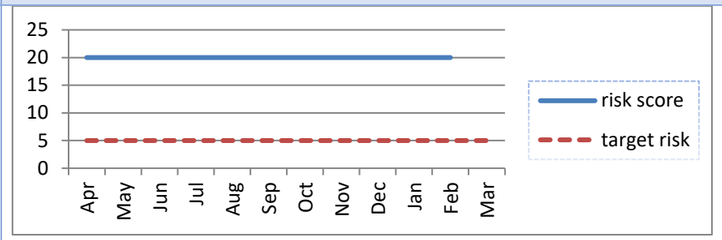
	for elective recovery schemes	To include financial allocation from ERF reserve. New weekly PTL for Elective and Cancer week commenced 27/11/2023. Outpatient, Theatre & Endoscopy Transformation Programmes External review of Trust PH processes via FF20 Programme - feedback report received		**Weekly** **Monthly 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	**Feb25**	**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
C6	**CYBER**	Monthly / Quarterly/Yearly Updates to F&PC Internal Audit programmes with finding to audit and risk Information Governance Committee with minutes chaired by SIRO DSPTK national submissions Monthly IT Security Group, with minutes 24x7 Carecert alert monitoring by NHS England Cyber teams	**Feb25** **Dec25** **Feb25**	**Minutes** **Audit** **Minutes** **Minutes** **tbc**					Director of Health Informatics

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 ***January attendances remain high, 10.7% above 2023/24 and 7.9% above the contract plan for the year. Escalation bed capacity has remained open at peak times.***	
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-fence trolleys in surgical and gynae SDEC	COO	Q1	Q3			Trolley capacity currently impacted by increased demand on inpatient beds – medicine relocated to B6. Surgery reviewing Los and bed requirements and ASU/SDEC requirements. Gynae dependent on reduction in surgical outliers. Gynae to review how SDEC delivered within existing footprint. Further trust-wide bed modelling being undertaken to review current capacity vs demand on beds. Capital bid submitted to provide increase capacity 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 B6 and ring-fenced from inpatients. Funding for capital scheme approved. Jan SDEC capacity impacted by inpatients. Capital scheme for new SDEC progressing well. February capacity continues to be impacted by inpatients due to increased demand. Capital scheme continues to progress. Work on new SDEC pathways is in train. 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	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	

		Training of existing staff to support validation of waiting list Ensure oversight through regular audits and performance monitoring						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. Review of validation resource within the Trust has been undertaken with proposal to strengthen arrangements and increase capacity being developed. Currently mobilising options for increased validation capacity. Support to cleanse waiting list as part of an initial diagnostic from external; provider is underway and due to be completed in Feb25	
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. Initial review undertaken in Dec 24 with verbal feedback (awaiting report). Dates for clinical leads to review workforce and processes with anaesthetic team scheduled in January 2025. Initial meetings with national clinical leads have been undertaken with some early feedback received and dates for on-site reviews in February 25 progressing.	
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. Q4 activity expected to be in line with forecast at month 8.	
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**	**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**	

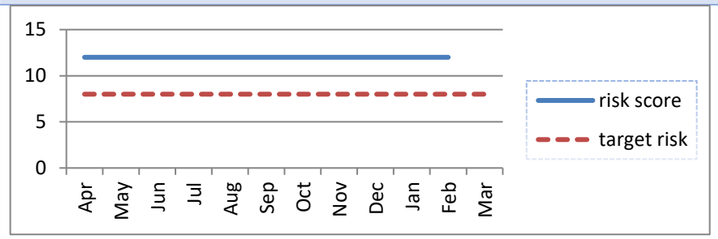
Controls and Mitigations ***(what have we in place to assist in securing delivery of our ambition)***		**Assurance Received** *(what evidence have we received to support the control)*	**Date Assurance Received**	**Confirmed By:**	**Assurance Level** *Level 1 = Operational* *Level 2 = Internal* *Level 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	**Feb25 Board**		Level 1				
C2	CIP Track and Challenge in place		**Feb25 Board**		Level 1				
C3	Contingency of £3m in place.		**Feb25 Board**		Level 1				
C4	Winter funding allocated in reserves of £1.2m.		**Feb25 Board**		Level 1				
C5	Elective recovery fund £6.0m		**Feb25 Board**		Level 1				
C6	Financial plan submitted to NHSE by 08/05/2024	Submitted on time, still awaiting sign off by NHSE	**Feb25 Board**						
C7	Finance and Performance Committee oversee budget reports	Budget reports presented to Finance and Performance Committee	**Feb25 Board**		Level 1				
C8	System wide delivery of Recovery	Director of Finance attends South Yorkshire DoF Group	**Feb25 Board**		Level 1				

	On plan with mitigations in place to manage winter pressures.	Monthly Finance Report to CEO Delivery Group	**Feb25 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 10 - Trust is £1.0m 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									

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)~~** **Seek**		**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 Oct24 12 month review at April 25		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 2024/27 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. July 24 launched trust wide 'we said, we did' 2024/25.	October 2024 and March 2025 At Care Group P&CC presentations	P&CC Oct 24 Ongoing confirmation from Care Groups		Level 1					

		NHS Staff survey outcomes and scores to be presented at People Committee and then the March 2025 Board of Directors.	P&CC February 2025 P&CC Board Mar25		Level 3					
C4	Health wellbeing and attendance work	Went 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 Feb25 and Apr25 updates	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. Formal Leadership Programme completed update to Feb25 P&CC

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 Group 3 Care Group 4 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	

G3	Development of the Trust Workforce Plan	Development of Plan for introduction in April 2025	Director of People						
Archived Controls within month - Completed									
Archived Gaps within month - Completed									

Corporate Risk Register Report

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')
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	19/02/2025	[Gibbons, Melanie 07/01/25 13:48:09] Update on Risk 5599. Continued Long waits for patients assessed as requiring routine review (Amber patients) current waits are as follows: Red patients seen as an urgent community response with step up to Virtual Ward if needed for acutely unwell patients. 35 week wait for Amber patients 35 week wait for High Amber patients (2 outlying patients that are being seen and treated by the Community Matron and District Nursing Teams. The the true wait then is 15 weeks) Both Lead nurse and Clinical lead are currently not in work. Assistance from Community Matron team for clinical intervention. Team have held Quality Improvement sessions that have developed into further actions as the service is remodelled to meet the needs of the patients.	Approved Risk	Completion of all amber referrals back to GP HF champions	11/03/2024	31/03/2025		Taylor (Cardiac SNP), Ms. Katie
													Increase in nurse prescribers by two staff.	08/01/2024	31/03/2025		Taylor (Cardiac SNP), Ms. Katie
													increase capacity by nurses	23/08/2024	30/05/2025		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
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	24/02/2025	24/03/2025	[Broadhurst, Lucy Miss 24/02/25 13:49:50] Updated 24/02/25 - 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: * Device team under pressure due to longterm absence & vacancies. * 1.0 WTE cardiac Device B7 leaving this week. Obtained approval last week for locum cover and awaiting NHSP to suggest potential candidates * Change in Cardiac Device Lead, new in post and getting up to speed * 1.0 WTE B5/B6 leaving in March * LTS of B3 Cardiographer ongoing - no cover * Mat leave Cardiographer due to return March 25 but had submitted request to go part-time * Planned staff absence (3.52 WTE) commenced in Nov 24 (affects B7 staff in both Echo and Devices) - career break/mat leave * 1.0 WTE locum cover (Devices) started 18/11/24 to cover longterm absence. See risks 6578 and 6576 * Insourcing cover ongoing to cover the Echo absences. * ERF funding for Echo (for extra Cardiology clinics) due to expire March 25 but will leave a shortfall before 1.0 WTE returns from career break in May 25. Still awaiting approval to extend this extra work (3 day post) because there has been less cardiology referrals than expected so this post has been addressing general shortfall in capacity. * ERF funding for extra Cardiology Clinics in Non-Invasive but we still have vacancies to cover this work (B2 Admin). B3 Cardiographer started 16/12/24. * Reception team under pressure due to DM01 work, sickness and new starters. 2.0 WTE new starters in February - in training * Increasing work in Pre-Op Assessment (ECG). Their move to Greenoaks creates challenges delivering cover - discussions ongoing * Increased activity across the department * Ongoing project to recoup tariff income for services. * Business case now split into a phased process to align with demand and capacity work. Echo business case submitted to Radiology Professional Lead/ Deputy Professional lead for comments. * Demand and capacity work ongoing across other areas of department Current vacancies: * 1.0 WTE Band 6 (Non-Invasive) - ready to go to advert * 1.0 WTE 6moth fixed term - Clinical Practice Educator -out to advert * 1.0 WTE B7 Devices - out to advert * Some b4 hours remain vacant * 1.0 WTE B2 cardiographer in an established B3 post (non-invasive) * Some vacant locum hours in Non-Invasive cardiology - no suitable candidates * Ongoing echo support from Inhealth (longterm contract) Staff absence/vacancies persist and being maintained by high cost locum cover/ insourcing. Awaiting approval to continue additional echo capacity. LB	Approved Risk	Business case to increase staffing	01/07/2022	31/03/2025		Broadhurst, Miss Lucy
													Source Locum Support for Non-Invasive Team	28/11/2024	30/04/2025		Barsby, Melvina
													Support Admin/ Reception Team	02/12/2024	31/03/2025		Barsby, Melvina
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	24/02/2025	26/05/2025	[Hazeldine, Victoria 24/02/25 12:20:06] Currently no appetite for a business case. No change to the risk. Patients psychological harm is difficult to assess and therefore unable to provide safety level details without individual patients contacted and formal psychology impact assessments being completed. Remain non-compliant with national guidance and requirements.	Approved Risk	Review of all services which currently require psychology support	14/08/2024	31/03/2025		Hazeldine, Victoria
													Identify gaps in the provision (following the review) and escalate to ICB level	14/08/2024	14/05/2025		Hazeldine, Victoria

Corporate Risk Register Report

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')
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	22/01/2025	20/02/2025	[Perry, Stuart 22/01/25 14:38:26] Added to the capital 25/26 for funding	Approved Risk	Refurbishment of Theatre 5&6 Ventilation (large capital funding required)	12/09/2023	31/03/2025		Dickinson, Scott
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	28/02/2025	28/03/2025	28/02/25: Risk discussed with GC: lots of conversations ongoing internally and externally and was felt that the partnership level work required with partners to mitigate the risk sits at executive level. At operational level, everyone keen to be involved, but there are discrepancies in escalation and timescales between partners. GC looked at other trusts' arrangements and some have policies in place, however, it was acknowledged that the reality can be different. Risk remains static as mitigations outside of the Trust control. Action plan includes working group however, more high-level discussions with partners are required.	Approved Risk	Arrange task and finish group with stakeholders, including RDASH, to discuss and work through pathways and escalations for patients	02/11/2023	28/03/2025		Cross, Gemma
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	04/02/2025	04/03/2025	Reviewed at RMC 04.02.25: SD updated that from an investigation on Datix, there was no recorded harm or incidents in relation to this risk. A design is in place, equipment purchased and planning for a start in April. SD reported that the team will look to reduce to a score of 12 through the Health and Safety Committee, and bring back here for final approval for reduction.	Approved Risk	Theatres require UPS/IPS systems installing - Possible locations	06/09/2023	31/01/2025	04/02/2025	Ramsden, Daniel
													Theatres require UPS/IPS systems installing - planning of works to start install in April	06/09/2023	31/03/2025		Ramsden, Daniel
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	22/01/2025	21/02/2025	[Wolfe, Alan 22/01/25 10:36:09] 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. Planning guidance has been delayed to 28/01/2025 and financial settlements to the NHs have not been agreed with Treasury for 2025/26.	Approved Risk	Development of robust capacity plans.	01/06/2024	28/02/2025		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
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	03/02/2025	03/02/2025	[McAuley, Heather 21/01/25 09:01:48] rewording of risk still required. meeting to be arranged. ongoing work with the hub functionality	Approved Risk	progression of electronic referrals across care groups and specialities.	01/07/2024	30/04/2025		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 20	Moderate 8	03/02/2025	03/03/2025	[McAuley, Heather 03/02/25 16:07:30] feel CT scanning is worse, delays in having patient scanned. recent AAR relating to patient scan being delayed for eGRF and pregnancy tests. not able to override.	Approved Risk	QI Project	16/11/2023	28/02/2025		Staunton, Eamon
													Portering (see action below on Transfer for ongoing actions)	01/10/2023	31/03/2025		Maton, Lynsey
													Transfer team and transfer policy	01/11/2023	31/03/2025		Maton, Lynsey
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	03/02/2025	03/03/2025	[McAuley, Heather 03/02/25 16:21:31] auditing in progress for time critical medications. tendable audit now on pain management. remains a concern.	Approved Risk	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	28/02/2025		Farrow, Lindsay

Corporate Risk Register Report

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')
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	07/02/2025	07/03/2025	[Stewart, Paul 07/02/25 10:16:51] Discussed at RMC on 04/02/2025, agreed with the committee that this risk should be reduced at the point that B6 is de-escalated, however whilst patients remain on B6 this risk remains at the current risk score	Approved Risk	SHOP Ward round principles	13/03/2024	28/02/2025		Reynard, Jeremy
													Bed Reconfiguration Work	12/07/2024	31/03/2025		Stewart, Paul
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	03/02/2025	03/03/2025	[McAuley, Heather 03/02/25 16:02:43] staffing review paper to increase staffing to match attendances. to review in 3/12	Approved Risk	ACT programme	04/04/2022	31/03/2025		Hammond, Lesley
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 20	Moderate 12	03/02/2025	03/03/2025	[McAuley, Heather 03/02/25 15:37:20] discussed with clinical lead and HoN. unable to meet targets on a daily basis. risk level increased.	Approved Risk	Work with Executive team on embedding the standards and engagement with the Trust	01/11/2023	30/05/2025		Reynard, Jeremy
													Transformational work, Task and finish group (ACT Programme)	01/02/2024	30/04/2025		Beahan, Dr Jo
													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
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	13/02/2025	13/03/2025	[Stewart, Paul 13/02/25 20:25:11] Forecast at Month 10 has improved to 7.1 million overspend against a control total of 6.7 million, however despite this we are still significantly away from our original control total target and so the risk remains unchanged.	Approved Risk	Financial Recovery Plan - Care Group Level	01/07/2024	31/03/2025		Stewart, Paul
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	19/02/2025	18/03/2025	[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	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	31/03/2025		Howlett, Darren
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 - 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	30/03/2025	[Short, Sally Mrs. 06/02/25 16:10:56] Remains the same. No further update re request for surgical space in progress. Limited estate footprint.	Approved Risk	Review bed modelling to understand bed capacity needs - Care Group 2	19/07/2024	31/10/2025		Howlett, Darren
													SDEC Working Group established - look at options to run SDEC models throughout winter	02/09/2024	31/03/2025		Howlett, Darren
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	20/02/2025	30/04/2025	[Oliver, Lauren 20/02/25 12:56:37] Discussed as previous update, for HC/LO to explore what areas are using LOCSSIPS within Surgery and SD to explore other areas such as Endoscopy and Cardiology.	Approved Risk	Lack of Local Safety Standards for Invasive Procedures (LocSSIPs)	13/04/2023	30/04/2025		Oliver, Lauren
													To establish Trust wide required LocSSIPs	13/06/2024	30/04/2025		Oliver, Lauren

Corporate Risk Register Report

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')
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	14/02/2025	[Howlett, Darren 23/01/25 08:10:46] No change in the level of risk but some progress on levels of spend. activity in December took a hit due to bed closures, list cancellations. Monthly improvement meetings, weekly activity and improvement meetings. Run rate reduction required and assurances via Performance require. CIP identifies for 25/26 and LTS staff returning to reduce agency spend totals. Coding scrutiny now finished and expected to be BAU.	Approved Risk	Cost improvement plans (full list in synopsis)	10/06/2024	31/03/2025		Howlett, Darren
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	28/01/2025	28/02/2025	[Windsor, Claire 28/01/25 09:25:22] Business case ongoing. Added to SYBCCN Peer Review Action Plan for ongoing review	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
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	14/02/2025	31/03/2025	[Roper-Bowen, Beth 14/02/25 10:56:33] 14/02/2025 requested that action plan is added to datix risk action plan.	Approved Risk	To introduce the new streamlined assessment pathway	01/01/2025	31/03/2025		Cowie, Alison
													To keep parents and partners informed about the changes	01/02/2025	31/07/2025		Cowie, Alison
													To reduce the overall number of children waiting for neurodevelomental assessment through a 2 yr backlog project funded by commissioners	01/04/2025	31/03/2027		Cowie, Alison

Board of Directors
7th March 2025

The Rotherham NHS Foundation Trust

Agenda item	P35/25
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 10th February 2025 there are 21 risks out of a total of 265 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 4).
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 Committees, Executive Team Meeting and finally the Board of Directors.
Board powers to make this decision	The Trust Board of Directors are required to have oversight of the Trust's risk management processes.
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 This report to the Board of Directors is to provide assurance that the Care Groups are considering their risks, issues and emerging risks. The following information provides an update to the Board for the review of all Approved risks rated at 8 or above, there is also Appendix 1 which details all risks rated at 15 and above. The data analysed within this report was exported from Datix on 10th February 2025; any updates or changes subsequently within the database, will not be recorded in this report. Please note, regarding the data and graphs found relating to 'All Trust Risks', these risks have been approved at Care Group level not all have been considered or approved at the Risk Management Committee (RMC). This data includes all risks rated between 8 and 12 which are discussed and approved at Care Group Governance meetings.

1.2 As at 10th February 2025 the Trust had a total of 265 Approved risks recorded on Datix, these are risks rated between 8 and 25, as follows:

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

This report does not contain any details to risks rated at 12 or below, apart from the three graphs indicating review date and action plan compliance. These are as follows:

Moderate Risks rated 8 - 12 and Care Group Approved = 244

Low Risks: Controlled/Managed Risks: rated 1 - 6 = 430

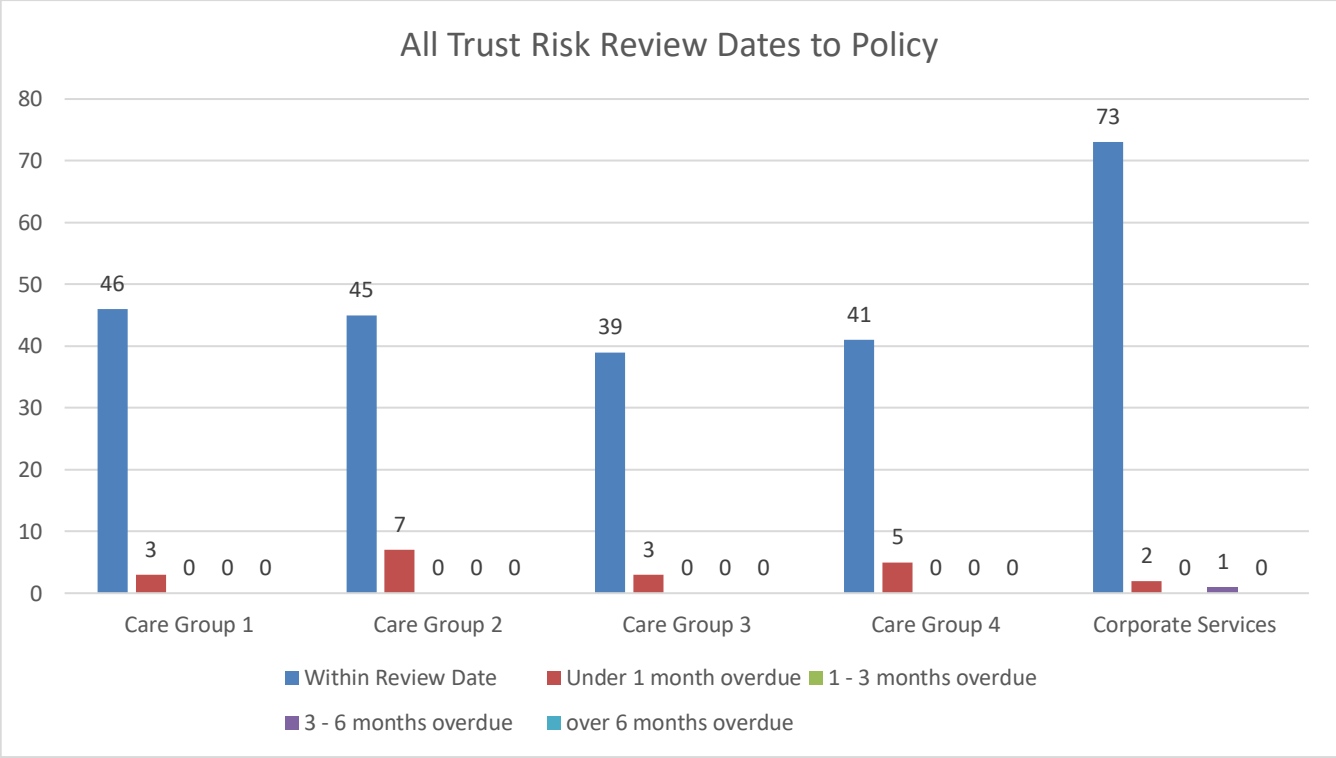
1.3 The following report illustrates the overview and analysis of the risks by review dates, action plans, Emerging Risks and the Issues Log.

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 achieved 92%, which is an improved position compared to 83% that was reported to Audit and Risk Committee in January 2025. This demonstrates the efforts of Care Groups to re-establish best practice following intense winter pressures and periods of annual leave. Care Group 2 have the lowest individual compliance at 87%, and Corporate Services have the highest at 96%.

2.3 There was one risk that was out of date for review between three and six months, no risks that were out of date for review for between one and three months, and twenty risks overdue by less than one month. Of these risks out of date for review by less than one month, there was one that was a high risk as detailed below:

- Risk 6969 - Lack of integration of IT services and lack of procedures/protocols against IT requests - Care Group 1

2.4 All Care Group management and governance teams are provided with monthly information on risks that require further 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 directly.

3. Further consideration of the Trust High Level Risks

3.1 Detailed discussion has taken place at the Board Committees held during February with a commitment to redefine the report for the May 2025 Board to include more detailed analysis of the high level risks.

3.2 For February 2025 reporting to the Board Committees, further detail was provided on specific risks to bring to the attention of the committee for focused discussions and scrutiny of the risks, actions to mitigate and the future trajectory of the risk.

4. Risk Action Plans

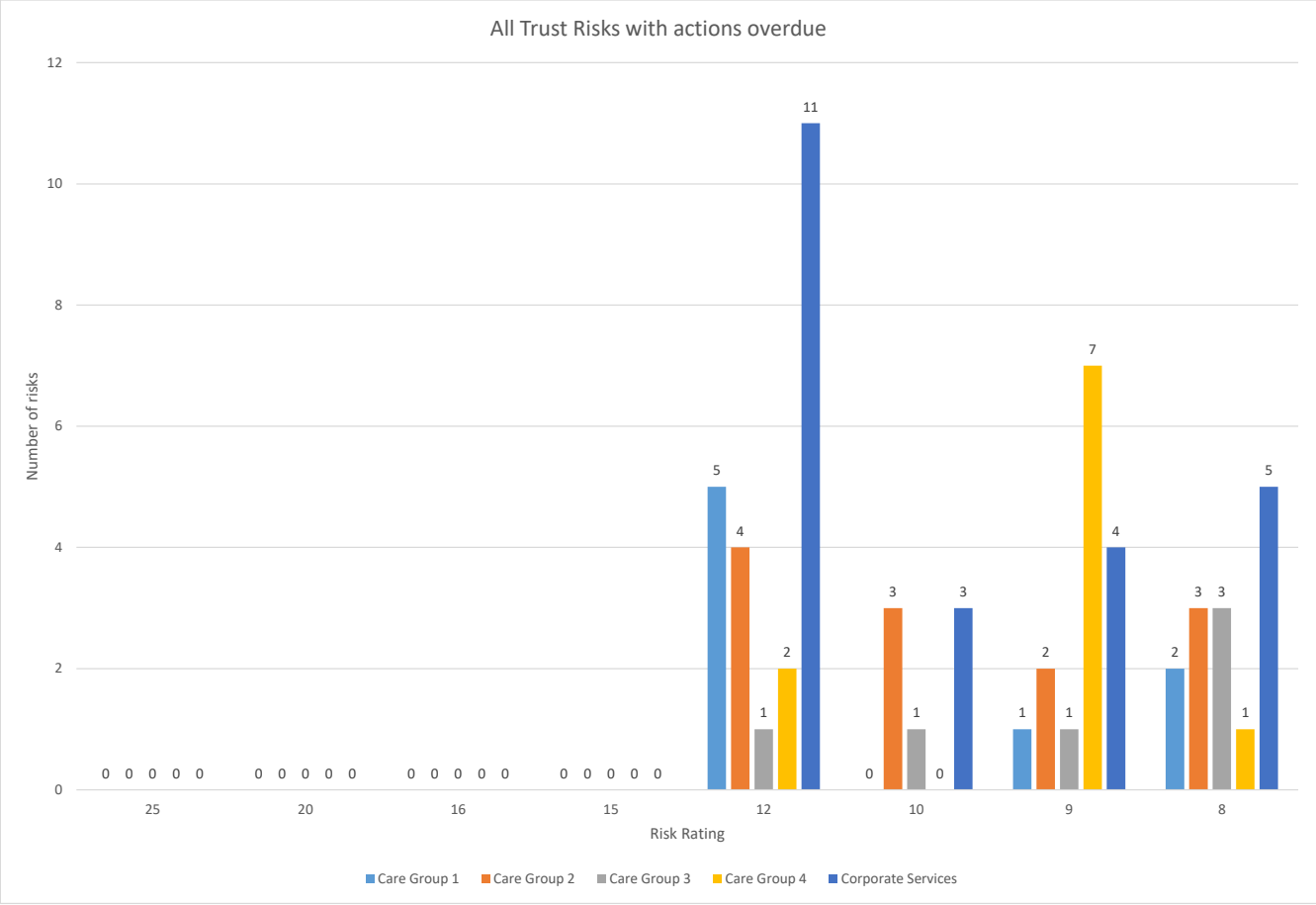
4.1 The scrutiny of action plans now includes focus on action plans in place that have all actions marked as completed, action plans that are out of date, as well as risks with no action plan in place.

4.2 Work continues to strengthen this aspect of risk management with further scrutiny on areas of action plans that need to be addressed:

- 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

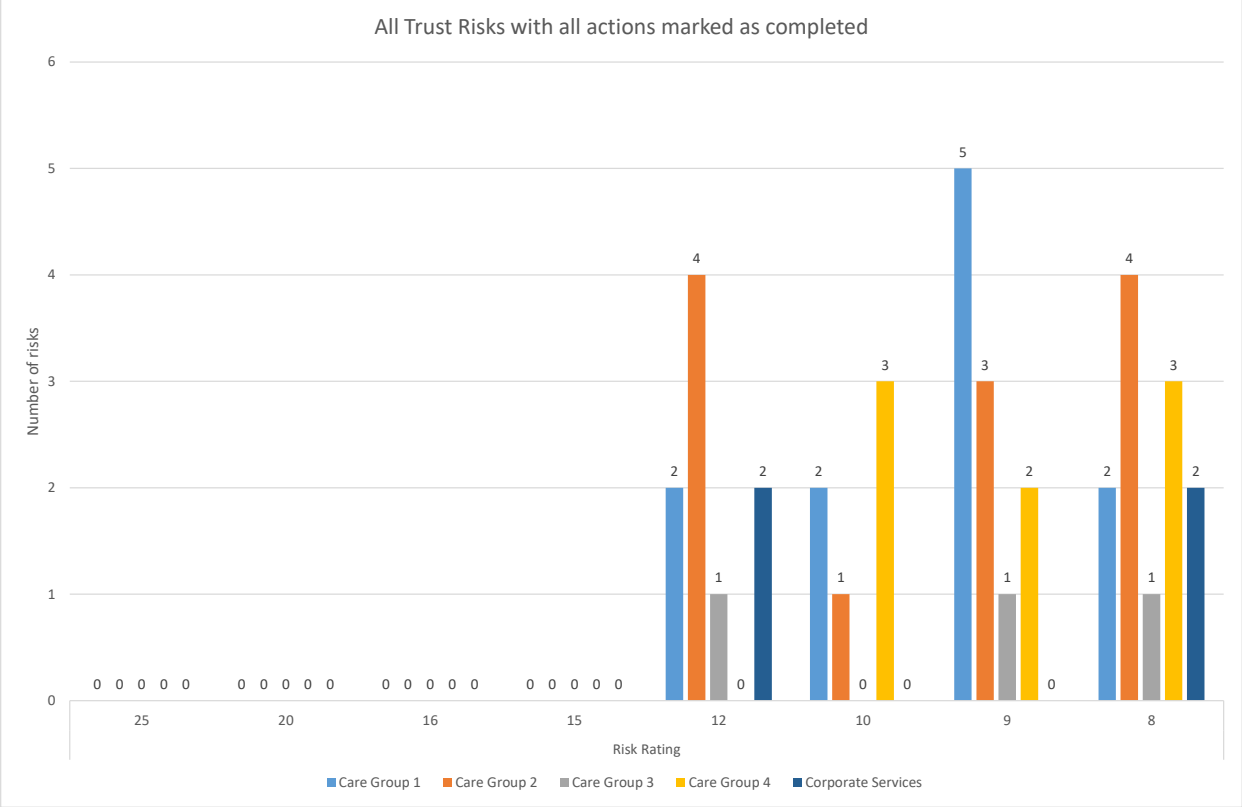
4.3 The graph below includes the data on risks with action plans only. All of these risks have action plans, however one or more individual action has been found to be out of date.

4.4 There are currently no High Rated risks across the four Care Groups that have individual actions that are overdue for review as per policy.



4.5 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 were no high risks marked as actions complete for the month, as Care Group 3 added more actions to Risk 6421, relating to the backlog of children waiting to be seen for assessment Child Development Centre (CDC).



5. Risk Management Committee

5.1 The Risk Management Committee continues to meet on a monthly basis, with both the January and February 2025 Committees taking place.

5.2 Both meetings were quorate with good attendance and engagement from the Care Groups and Corporate Services.

6. Emerging Risks

6.1 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 February 2025 due to insufficient detail at this point. Those identified were as follows:

- 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. This emerging risk was discussed at the January 2025 Quality Committee where is was explained that the risk is not to all groups of ACPs, but only three distinct lowered the potential risk to the Trust. This is also a national risk and one that sits outside of the control of the Trust.
- 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. The government changes came into force on 4 April 2024 so it no longer an emerging risk. Work will continue with the People Team to monitor the impact through workforce risks.
- The Assisted Dying Bill could significantly impact the NHS by potentially causing resource strain due to the need for additional assessments, complex ethical decision-making processes, and potential staff concerns, while also raising questions about whether it would lead to improved or diminished access to quality palliative care, depending on how it's implemented and funded.

6.2 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.

7. Next Steps

7.1 Risk Management training and support continues with the Care Groups, led by the Corporate Affairs Team. This quarter included ad-hoc support meetings with Corporate Functions, Pharmacy and Estates.

7.2 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.

7.3 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.

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

7.5 This report is presented to provide assurance that the Trust continues to develop and strengthen its Risk Management function.

8. 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
March 2025

Board of Directors' Meeting
7 March 2025

The Rotherham NHS Foundation Trust

Agenda item	P37/25
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 • Other News
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 January 2025

1.0 Operational Matters

1.1 The **recovery of elective waiting times** remains a key focus. The Referral to Treatment (RTT) 18 weeks standard has been achieved in Geriatric Medicine, Stroke, Paediatrics and Respiratory, with Rheumatology narrowly missing the target at 86.1%. ENT has seen a positive impact of insourcing and pathway review work with the service achieving 60.9% for the first time. OMFS and Orthopaedics continue to face challenges, however, progress continues with incremental improvements recorded in both specialties throughout January. Due to workforce challenges within the service and the size of the waiting list, Dermatology and Gastroenterology are unlikely to meet the RTT standard this financial year. Unfortunately, two patients waited over 65 weeks for orthopaedic. Efforts continue to reduce the number of patients waiting over 52 weeks. The waiting list size has shown a slight reduction to 31,231, which is a decrease of 702.

1.2 The Trust maintained its **Diagnostic (DM01) performance** in January 2025, aligning with our ambition to sustain this position throughout 2024/25. The Trust remains amongst very few that are delivering the constitutional standard.

1.3 In December 2024, the Trust successfully met all three national **cancer targets**, along with achieving the stretch targets for the 28-Day Faster Diagnosis Standard and the 62-Day Treatment Standard. Plans are in place to build on these successes, with improvement on track to deliver sustained compliance with both national and internal stretch targets by March 2025. The new national cancer delivery plan has now been confirmed and sets ambitious targets to improve cancer outcome and streamline care pathways.

1.4 **Urgent and Emergency Care Activity:** January has been a challenging month in relation to urgent and emergency care, with the Trust achieving 58.7% for the 4-hour access standard in January with February's performance at around 64% with two days of the month to go. The Trust has continued to see high attendances at UECC, with the number of attendances in November peaking at 8708 for the month compared to 8315 in January 2024. Plans are in place with the aim of delivering 78% in March although with considerable risk relating to occupancy and flow.

1.5 The overall year to date position for UECC attendances remains high and the Trust has seen 87,084 attendances compared to 79,941 this time last year. This represents 7.9% above the contract plan for the year with the additional demand having an impact on flow and bed capacity with the Trust experiencing a high number of 12-hour trolley breaches (above the national average for the month).

2.0 Operational Planning

2.1 The NHS England Priorities and Operational Planning Guidance for 2025/26 has been published and the Trust was required to submit its initial response to the ICB by 17th February 2025 with full submission of plans required in late March 2025.

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 January 2025 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 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 including a Joint Executive Team meeting and a Joint Senior Leaders Team meeting.

4.0 People

4.1 As reported previously, the annual NHS Staff Survey closed on 29th November 2024. The results are still embargoed with the embargo due to be lifted on Thursday 13th March 2025, pending the publication of the national reports from NHSE. Further information on the results will be provided once the embargo has been lifted.

4.2 The monthly staff Excellence Awards winners for the months of December and January are as follows:

December 2024

INDIVIDUAL AWARD:	Kirsty Wright, Clerical Assistant, Kimberworth Place
TEAM AWARD:	Ward A3
TEAM AWARD:	Stroke Unit
PUBLIC AWARD:	Sexual Health
PUBLIC AWARD:	UECC

January 2025

INDIVIDUAL AWARD:	Claire Martin, Waiting List Coordinator and Validation Manager
TEAM AWARD:	Healthcare Support Worker and Admin team: Respiratory Services, Breathing Space
PUBLIC AWARD:	Ward A1
PUBLIC AWARD:	Breast Clinict

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

- Dr D Lim, Gastroenterology (03.03.25)
- Dr P Hurlstone, Gastroenterology (03.03.25)

4.4 It is with sadness that I inform you of the retirement of our Director of Finance, Steve Hackett. Steve will be leaving the Trust on 1st July 2025 and a recruitment process will follow. Steve has been in Rotherham since 2001 and since then, his contribution to addressing the financial governance issues and leading the delivery

of each year's financial plan has been enormous and led to the good financial standing of the Trust currently. More widely, he has worked in the NHS for 35 years, 24 of those as a Director of Finance. I am sure the Board would wish to thank Steve for such a dedicated commitment not only to the Trust but also to the wider NHS.

5.0 Other News

5.1 In response to feedback from both staff and members of the public, the Trust has now started the changes and improvements to car parking across our sites. Automatic Number Plate Recognition (ANPR) is being installed and the first phase went live on Wednesday 19th February (for public car parks on the hospital site). ANPR at Woodside and the Rotherham Community Health Centre went live on Friday 28th February 2025. The second phase will involve staff car parks and the installation of ANPR in these areas.

Dr Richard Jenkins
Chief Executive
March 2025

Public Board of Directors' Meeting

The Rotherham NHS Foundation Trust

Agenda item	P39/25
Report	Fire Safety Strategy
Executive Lead	Scott Dickinson, Director of Estates and Facilities
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	The contents of the Strategy 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)	Fire Safety Strategy Initially presented to the ETM in June 2024 and the Finance and Performance Committee in September 2024 where it was recommended for approval by the Board pending minor amendments. The updated final Strategy is included for approval.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	The Fire Safety Strategy has been approved at Health & Safety Committee, the Executive Team Meeting and at the Finance and Performance Committee
Board powers to make this decision	For assurance that the Trust has processes in place to manage Fire Safety
Who, What and When (what action is required, who is the lead and when should it be completed?)	Approval of the Fire Strategy by the Board.
Recommendations	It is recommended that the Board approve the Strategy.
Appendices	Fire Safety Strategy

THE ROTHERHAM NHS FOUNDATION TRUST

FIRE SAFETY STRATEGY

2024

Version:	3
Ratified by:	Health & Safety Committee
Date ratified	6 December 2023
Title/Name of Sponsor	Director of Estates and Facilities
Title/Name of originator/author	Fire Safety Advisor
Date issued	TBD
Review date	TBD
Target Audience	Trust Wide

CONTENTS

Document History Summary

Version	Date	Author	Status	Comment
1a	Oct 17	Trust Fire Safety Advisor	Initial Draft	
1	Feb 18	Trust Fire Safety Advisor	Final	
2a	Mar 20	Trust Fire Safety Advisor	Draft	Forwarded to Topic Lead for Triennial Review
2b	Oct 20	Trust Fire Safety Advisor	Draft	Document circulated for Health & Safety Committee review
2	Oct 20	Trust Fire Safety Advisor	Final	Document approved by Health & Safety Committee
3a	Jul 23	Trust Fire Safety Advisor	Draft	Forwarded to Topic Lead for Triennial Review
3b	Oct 23	Trust Fire Safety Advisor	Draft	Document circulated for Health & Safety Committee review
3	Nov 23	Trust Fire Safety Advisor	Approved	Document approved by Health & Safety Committee
3	June 24	Trust Fire Safety Advisor		Document submitted to the Executive Team Meeting for review.

1. INTRODUCTION

1.1 Purpose Statement

The purpose of this document is to set down the fire safety objectives and how these objectives for life safety and property protection are delivered at The Rotherham NHS Foundation Trust. A fire safety approach has been adopted in developing this fire strategy recognising the inter-relationship between treatment and non-treatment facilities, retail units, customer cafe area support services and community premises.

This document will provide a high-level overview of the fire safety aspects of the fire engineering design that were and are incorporated into the buildings in its original and subsequent construction phases and the management fire safety procedures implemented with the day to day operation of the Trust.

It is recognised that fire safety plays an important role in influencing building design. The development of fire safety objectives at an early stage of the design process and progressing throughout the project phases is to ensure the continuity of cohesion of fire safety design.

The fire safety strategy and design of The Rotherham NHS Foundation Trust reflects a multi-occupancy scenario. This document should be read in conjunction with the latest Fire Risk Assessments and Fire Safety Policy issued to all departments.

1.2 Description of Buildings

The Rotherham NHS Foundation Trust was originally constructed in 1977, the site consists of:

1.2.1 The Main Hospital

The Main Hospital phase 1, 2, 3 & 3b. This is a concrete framed building with concrete beam floors consisting of 5 levels with a central corridor on Levels A, B, C, and D the wards and departments lead off this central corridor. There are 4 junctions along the corridor Junction numbers 2 and 4 house the main lifts for the premises. Phase 1 of the building incorporates the main part of the Trust including outpatients and a large amount of the wards, phase 2 has more wards located with phase 3 having maternity, endoscopy and dermatology located within it. Phase 3b is a further extension which has wards and the urology outpatients located within it. The 5 levels are broken down as follows with departments and wards entrances at one of 4 junctions along the main corridor.

Level A

Junction 1: Wards A1, 2, 3, 4, Angiography & Cardiac Suites, Coronary Care & Clinical Engineering.

Junction 2: Sterile Services, Pharmacy Manufacturing, Pathology Clinical Chemistry, Medical Physics, Stores, Portering, Linen, Rooftop Restaurant. & Cardiac Device Suite.

Junction 3: Ward A5, A6 & A7, Photopheresis, Haematology & Immunology. Nutrition & Dietetics.

Junction 4: Children's Wards 1, 2 & 3, High Dependency Unit (Paediatrics) Children's Assessment Unit.

Level B

Junction 1: Urgent & Emergency Care Centre, Fracture Clinic, Orthopaedic, Clinical Decision Unit, Medical Admissions Ward B1, 2, & 3, Clinical Radiology, (X-Ray, Ultrasound, CT & MRI), AMU, ASU & SDEC.

Junction 2: Theatre Admissions Unit, Intensive Care Unit (ICU), High Dependency Unit (HDU) & Theatre Treatment Suite

Junction 3: Wards 4 5 & 6 Short Stay Unit, Surgical Assessment Unit, Delivery Suite, Operating Theatres.

Junction 4: Alternative Level of Care Wharncliffe Ward, Sitwell Ward, Ward B10 &11, Gynaecology, Pregnancy Advisory Service, Early Pregnancy Advisory Unit (EPAU), Special Care Baby Unit (SCBU).

Level C

Junction 1: Main Entrance, Main Outpatients, Pre-admission Centre, Orthodontic, Whiston Suite.

Junction 2: Medical Illustration, Breast Screening & Assessment Unit, Chatham Suite & Oral Maxillofacial Department.

Junction 3: Earl of Scarborough, Macmillan Suite, Physiotherapy, Occupational Therapy, Orthotics, Pharmacy Dispensary, Chaplain's Office, Chapel, Prayer Room, Sexual Health Services.

Junction 4: Endoscopy, Colposcopy, Fitzwilliam Ward, Children's Clinic & Day Surgery, Dermatology, Early Pregnancy Assessment Unit.

Level D

Junction 1: Medical Secretaries, Education Centre, Library & Diabetes Education and Resource Centre.

Junction 2: Volunteer Office, Cancer Services Dept., Community Ready Unit (Discharge lounge).

Junction 3: Earl of Scarborough Suite MDT Room, General Management, NHS Professionals, Estates & Facilities Department & Clinical Operations Hub.

Junction 4: Administration offices, Medical Secretaries, Darshane Unit Urology Outpatients, Mortuary, Stroke Unit & Moorgate Wing.

Level E

Administration offices

The main Hospital is served by 4 internal core escape staircases, one at junctions 1, 2, 3 and 4 with a further number of external escape staircases all of which are suitably protected, all staircases are numbered. The main use of the building is primarily for healthcare as defined within HTM 05-03 Part K, however there are also support services and offices within the building, these other occupancies also include, a retail outlet and cafe, a public and staff restaurant.

1.2.2 Well Being & Integrated Neurological Conditions Unit

This is a single storey building, brick built with a traditional tiled roof. It has a fire alarm system fitted which is part of the main Hospital system. This unit operates Monday to Friday 08:00 – 16:00. The fire alarm system is part of the Hospital main system.

1.2.3 New Greenoaks

A single storey brick built building with internal breeze blockwork and concrete floor with a traditional tiled roof. The use of this building is the Antenatal/Gynaecology Clinic. It is a day unit and operates between the hours of 08:00 – 18:00 Monday to Sunday. The fire alarm system is part of the Hospital main system.

1.2.4 Diaverum Renal Dialysis Unit

This is a single storey building constructed of brickwork with exterior grain effect insulated cladding & sloped insulated roof. It is a day unit that operates between 07:30 – 17:30 Monday to Friday. The fire alarm system is part of the main Hospital system.

1.2.5 Computer Centre

This is a single storey brick building with a tiled ridged roof. It is staffed 24 hours, seven days a week, 365 days a year for the provision of the hospital IT functions and equipment.

1.2.6 The Lodge

This is a two-storey building that is stone built with a traditional tiled roof. It houses the Security Department and has a stand-alone fire alarm system fitted. The building is manned 24 hours, seven days a week.

1.2.7 Residential Accommodation.

These are three separate residential blocks built in the 1970s consisting of three floors with a small basement plant room where the gas heating boilers are located – Derwent Court (56 flats), Loxley Court (41 flats) & Swale Court (50 flats).

Each building is constructed of external brickwork with internal blockwork and concrete floor separation with timber supported apex tiled roofs.

The fire alarm systems have recently been upgraded to comply with the current BS 5839 standards and have been connected to the main Hospital system.

1.2.8 Community Buildings.

The Rotherham NHS Foundation Trust have agreements with numerous landlords and partners including RMBC and NHS PS for the use of accommodating TRFT & clinics in their premises. Such premises include RCHC, Breathing Space and many other medical centres.

Where Trust staff are located in such premises they must familiarise themselves with the Fire Safety requirements of their place of work including the fire action plan and relevant fire assembly point. The duty of care around fire and emergencies is a collective responsibility involving all tenants, including the Rotherham NHS Foundation Trust (TRFT), landlords, and other occupants. The key aspects of this duty of care includes coordination, communication, compliance with regulations, and active participation in fire safety measures.

Duty of Care in a Shared Occupancy Building

1. **Coordination and Collaboration:**
    - **Joint Planning:** Collaborate with all occupants and the building management to develop a comprehensive fire safety plan that addresses the specific needs of a shared occupancy building.
    - **Shared Responsibilities**: Clearly define and distribute fire safety responsibilities among all parties, ensuring everyone knows their role in an emergency.
2. **Compliance with Regulations:**
    - **Adherence to Laws:** Ensure compliance with all relevant fire safety regulations and standards, including local fire codes and health and safety legislation.
    - **Building-Wide Policies**: Implement consistent fire safety policies and procedures across the entire building, encompassing all tenants and common areas.
3. **Communication:**
    - **Information Sharing**: Maintain open lines of communication between all tenants and the building management regarding fire safety measures, changes, and updates.
    - **Clear Signage:** Ensure that fire exits, evacuation routes, and assembly points are clearly marked and visible to everyone in the building.
4. **Training and Drills:**
    - **Regular Training**: Provide regular fire safety training for all staff, emphasising the unique challenges and procedures in a shared occupancy building.
    - **Joint Drills:** Conduct fire drills involving all tenants to practice coordinated evacuation procedures and identify potential issues.
5. **Fire Safety Equipment:**
    - **Regular Maintenance:** Ensure that fire safety equipment, such as alarms, extinguishers, sprinklers, and emergency lighting, is regularly inspected, maintained, and accessible.

- **Shared Resources:** Coordinate the maintenance and use of shared fire safety resources and equipment with other tenants and building management.

6. **Emergency Response Plan:**
   - **Evacuation Procedures:** Develop and communicate clear evacuation procedures that take into account the needs of all occupants, including those with disabilities or special requirements.
   - **Assembly Points**: Designate and communicate specific fire assembly points for all tenants, ensuring they are safely away from the building.
7. **Risk Assessment:**
   - **Regular Assessments**: Conduct regular fire risk assessments to identify potential hazards and implement measures to mitigate them.
   - **Shared Responsibility**: Collaborate with other tenants to address shared risks and ensure a coordinated approach to fire safety.

Practical Steps for TRFT in a Shared Occupancy Building

- **Induction Training**: Include specific fire safety procedures for the shared building in the induction training for new staff.
- **Fire Response Team:** coordinate with other tenants and building management.
- **Regular Meetings**: Participate in regular fire safety meetings with other occupants to review and update fire safety plans.
- **Information Accessibility**: Make fire safety information readily accessible to all staff, including maps of evacuation routes and locations of fire safety equipment.

Examples of Specific Actions

- Coordinate with other tenants to ensure that all fire exits are unobstructed and that shared fire drills are conducted regularly.
- Work with building management to maintain clear signage for evacuation routes and ensure that all staff are familiar with the shared emergency procedures.
- Collaborate with landlords and other tenants to conduct joint fire risk assessments and implement shared fire safety improvements.

By fulfilling these duties of care, TRFT can contribute to a safer environment for all occupants of the shared building, ensuring effective response and coordination in the event of a fire or other emergencies.

1.3 Design Parameters

The fire safety provisions incorporated into the design are in accordance with the Building Regulations Requirements, Health Technical Memorandums and relevant British Standards as approved at each construction phase of the works. Any modifications that have been made to the property have continued to have these standards implemented as an integral part of the design specification requirements and statutory approval.

The fire safety of the complex is based on Fire Engineering principles and due to the size of the building some are unique to this facility. It is for this reason that plans for alterations or modifications are strictly controlled to ensure design principles are not breached.

2. COMPARTMENTATION & INTERNAL FIRE SPREAD

2.1 Compartmentation Strategy

The Health Technical Memorandum recommends that a building of this type and size needs to be compartmented using fire resisting construction to floors and walls.

The objectives of this are to:

- Prevent rapid fire spread which could trap occupants
- Reduce the chances of a fire becoming large
- Large fires represent a greater hazard to building occupants
- Reduce the fire threat to fire fighters and other persons in the immediate vicinity. To ensure that life safety and assets can be protected fire compartments have been constructed to limit the spread of fire within the building to separate the higher occupancy risk areas from the lower risks and contain any potential high fire loads. The compartmentation is designed to allow people to stay within the building should a fire break out by providing adequate fire separation between each designated area which will always have a safe route away from the fire and terminate to a place of ultimate safety.

2.2 Methods of Fire Rating

The fire resistance periods for compartmentation are based on complying with the requirements of the Health Technical Memorandums and Building Regulations as appropriate at each construction phase and subsequently other newer versions of the regulations have and are being applied where modifications have been made to the structure in recent times. Compliance with the recommendations of British Standards relating to structural fire precautions and fire safety installations are also applied. The compartment strategy is made up of two key elements: passive and active fire protection measures implemented by passive means of firewalls, fire doors, fire shutters, fire stopping, fire dampers and active by suppression systems, as follows:

- An in-situ concrete floor slab at floor levels with fire stopping at wall junctions.
- Fire resisting block work and stud partitions enclosing the wards and Hospital streets and sub-dividing it internally when required.
- Fire resisting timber doors in the compartment walls, fitted with either closers or electromagnetic hold-open devices as appropriate.
- Fire stopping is provided to all compartment wall junctions with external walls compartment floors, and also at opening reveals in fire-resisting partitions.
- Fire dampers are provided in ventilation ducts, where penetrations occur through fire rated partitions.

Minimum ratings for structure and fire doors to key areas are:

Area	Time (minutes)
Hospital Streets	60
Plant Areas	60
Electrical Rooms	60
Electrical Cupboards	30
Compartment Floors	60
Compartment Doors	60
Kitchens	30
Fire Fighting Shafts	60
Fire Fighting Stairs	60
Fire Doors Protected Lobby	30
Fire Doors Corridors	30
Glazing in fire structure	30/60

2.3 Internal Spread of Fire Linings

The interior wall and ceiling surfaces in a building can have a major influence on how fast a fire may develop. The restrictions contained in Health Technical Memorandums and Building Regulations are intended to prevent the spread of fire across such internal surfaces. It is recommended that where combustible wall and ceiling linings are proposed they satisfy the following classifications given in the relevant Health Technical Memorandum and Building Regulations, rooms - Class 1 Circulation spaces - Class 0. It is considered good fire safety practice to ensure that, where ever possible, all furniture, fixtures and fittings have low ignitability, are of limited combustibility, and do not give off noxious fumes if ignited. This is particularly applicable to circulation areas/spaces of the building.

3. STRUCTURAL FIRE PROTECTION

3.1 Statutory Requirements

The Trust is subject to control under the Regulatory Reform (Fire Safety) Order 2005 with the Chief Executive Officer for the Trust having the ultimate responsibility for compliance.

3.2 Fire Safety Design

The principle design is to protect the life risk within the building fire safety design which is organised around the fire growth and its resulting products of combustion, for example flame/heat and smoke/gas. The ease of generation and movement of these products is influenced by the counter-measures provided by the building structure. The effectiveness of the building fire safety systems determines the speed, quality, and paths of movement of those products of combustion.

3.3 Fire Growth

The simplest description of the fire growth process is to divide it into three fire regimes:

- pre-combustion
- smouldering combustion
- flaming combustion

Pre-combustion is considered the process of heating fuels to their ignition point, during which time vapours and particulates are released from the fuel.

Smouldering combustion is defined as glowing on the fuel surface and may or may not be related to the oxygen content in the vicinity of the smouldering process.

Flaming combustion is almost self-explanatory, in that the production of sufficient energy and fuel vapours in the combustible range is the condition that underlines and supports the presence of flame.

3.4 Fire Safety Objectives

The fire safety objectives are to determine the degree to which the property and its associated facilities protect the occupants, the structure, contents, continuity of operations and impact on the community. It is impossible to completely prevent the ignition of a fire in a building, therefore, the overall fire safety objective is when a building is designed to a standard it needs to be maintained to that benchmark, and any subsequent alterations, modifications or refurbishments are approved in a similar manner.

Structural fire protection measures to the Trust have been designed in accordance with the relevant Health Technical Memorandums and Building Regulations B1. This includes both passive and active fire protection measures. The building has been provided with the relevant level of fire rating to the structure during its construction and fit out phases. More detailed information can be obtained by referring to building plans and operating and maintenance manuals.

4. FIRE SAFETY SYSTEMS

4.1 Fire Alarm

FIRE ALARM SYSTEM (L1)

All of the Trust buildings have an automatic fire alarm system, smoke and heat detectors as required, with a series of break glass call points. The system is a Gent Vigilon analogue addressable with 17 main panels situated within the building. There are repeater panels and links from other fire alarm systems attached to the system also situated within the building. The repeater panels are only for information and the system cannot be silenced or reset from these panels. An actuation of the fire alarm system will also activate some of the smoke dampers within the affected zones in Phases 1, 2 & 3 along with shutting down relevant plant and air handling units as laid down within the Hospital's cause and effect fire alarm strategy. All external buildings apart from the Security Lodge are interfaced to the Trust fire alarm system, when these systems are operated it activates the panels within the Trust and also a red indication light within the switchboard department. There are Vigilon panels in both 4 loop and 6 loop versions. The 4 loop Vigilon has a self-contained power supply and battery standby for at least 24 hours and the 6 loop with external batteries will support a system for 72 hours in the event of mains and stand by generator power failure. The fire alarm when in "operational" mode is currently two stage alarm fire alarm system. The two stage alarm principle is approved by South Yorkshire Fire & Rescue Service and complies with Article 14 of the Regulatory Reform (Fire Safety) Order 2005.

Operation of the Fire Alarm System

The fire alarm system provided in the Trust will operate upon the actuation of a single automatic fire detector or upon the operation of a break glass call point device. The fire alarm will sound a continuous alarm within the zone where a device has activated and sound intermittently within all other areas within the main building to facilitate the phased evacuation procedure.

When the system is activated by either a heat, smoke or manual call point the message is shown on all the panels within the Trust including the repeater panels. On this activation the Switchboard team send a message out on the emergency bleep system to inform the Fire Response Team the location of the call. The subsequent activation of an automatic fire detector or manual call point within the building will result in the fire alarm returning to full fire mode. The fire alarm system can be reset when the stand down has been given by the Fire Safety Advisor or Clinical Site Manager (221 bleep) who is in charge of the Fire Response Team.

Example
A fire detector actuates on Level B within the x-ray department of the Trust. The fire alarm system operates immediately sounding continually within this department and intermittently in the remainder of the Trust. The occupants of the x-ray department first look for the fire, or if need be, begin to evacuate the department. All other departments send a member of staff to their nearest fire alarm panel then the panel closest to the incident send 4 members of staff to assist the department that has the continual alarm.

The fire alarm system is tested weekly, every Thursday morning 08:00 – 12:00 with the results of the test recorded within the Estates Department. The fire alarm contractor, Professional Fire Systems, carry out maintenance, repairs, commissioning and annual testing which is completed every week on a Wednesday between 08:00 – 16:30. Annual certificates are kept with the Estates Department.

4.2 Automatic Smoke Detection

The vast majority of the property is protected by an automatic fire detection system. All the devices are constantly monitored by the main fire alarm panel. The system is designed currently to operate the evacuation process and alert all Trust staff, patients and visitors that there is a possible fire within the building. The system is not connected to a call centre as there is 24-hour cover from the Fire Response Team and the Switchboard staff. Designers need to be aware that it is important to achieve an L1 standard as outlined in BS5839 on building design and refurbishment projects.

4.3 Automatic Suppression Systems

The main concourse area and all commercial premises on Level C are covered by a sprinkler deluge system, with associated tanks and pumps located off corridor at rear of commercial premises.

There are automatic FM200 fire suppression systems within the Computer Centre located near the staff car park, D Level Computer Server Room and the Telecommunication Switch Room within Switchboard. Access to these areas is controlled by the I.T. and Estates Departments.

4.4 Dry Risers and Wet Risers

There are dry and wet risers fitted within the Hospital at strategic areas in compliance with BS5306, the locations of the risers can be found on the fire strategy drawing.

4.5 Hose Reels

First aid fire-fighting hose reels throughout the Trust and any of the Trust premises have been removed. This is due to the legionella risk, and a view has been taken that the members of staff are not sufficiently trained or adequately equipped to use a hose reel as it is considered that this type of equipment should be used by fully trained fire fighters and not Trust staff. It is recommended by most UK fire services to remove hose reels and provide sufficient portable fire-fighting appliances.

4.6 First Aid Hand Operated Portable Fire Equipment

The majority of hand operated portable fire equipment provided are made up of water/ foam or CO_2, there should be no dry powder extinguishers within the main parts of the Trust or ancillary buildings other than plant room and workshop areas.

4.7 Smoke Control and Ventilation

Smoke control within the building is achieved by the means of fitting smoke seals to all fire doors which will also be an aid for fire-fighting activities; this will maintain clear smoke free zones outside of the area that is affected by fire. The primary objective of smoke control is to preserve the continuity of treatment and delay final evacuation, whilst providing an aid to Fire Service personnel in their fire-fighting activities. Controlled Fire Growth – each fire compartment is kept within the limits of those stated within the Health Technical Memorandum. Throughout all phases of the Trust there are some automatic smoke dampers within the air handling units. There are different types of dampers including fusible link and automatic ones that are connected to the fire alarm system. The fire alarm strategy incorporates the shutdown of some of the air supply systems for each area in the event of the fire alarm being activated. Details of all the damper systems and air handling units can be found within the Estates Department on Level B. Smoke Ventilation – smoke ventilation can only be achieved by means of natural ventilation. It should be noted that all of the staircases are provided with manually operated vents.

4.8 Lifts

There are a number of lifts in the Trust which are for patients, visitors and staff, these are not fire lifts. When the fire alarm operates in the lift junction areas all lifts stop on Level C. They are reset by the fire alarm being reset. There are also a number of goods lifts which are used for equipment, these lifts are not fire lifts.

5. MEANS OF ESCAPE

5.1 General Principles

A concrete framed building with fire doors protecting the escape routes and providing compartmentation as required within the Health Technical Memorandums.

5.2 Evacuation Strategy

There has been little change made to the fire escape strategy since it was constructed. However, as each new development has taken place the evacuation strategy for life safety has been key part of the approvals process.

5.3 Full Building Evacuation

In the unlikely event that the building requires a full evacuation this will be covered within the Rotherham NHS Foundation Trust Major Incident Procedures facilitated by a joint collaboration of all the emergency services and senior Trust officials.

5.4 Emergency Power Supplies

Primary and secondary power supplies are installed to serve life safety systems within the building. Secondary power for the Trust will emanate from backup generators located around the Trust in electrical sub-stations.

The locations for the electrical sub-stations and backup generators are as follows:

- Electrical sub-station A, opposite Moorgate entrance.
- Electrical sub-station B, next to Swale Court.
- Electrical sub-station C, near RDASH Woodlands.
- Electrical sub-station D and G, Estates yard B Level and staff red car park.
- Electrical sub-station E, main public car park.

The secondary power supply is tested and maintained on a regular basis by the Estates Department.

5.5 Emergency Lighting

The emergency lighting currently conforms to British Standard 5266 Part 1 and is currently under review with new emergency lights being fitted under a rolling programme carried out by the Estates Department. Whilst there are backup generators that will provide power to the lighting circuits should the primary power source fail, it should be understood that should the distribution panel fail or the electrical wiring fail then a battery backup system is essential to provide adequate lighting for the purposes of means of escape. The emergency lighting circuits should have a suitable means for testing as per British Standard 5266 Part 1 2005 paragraph 9.3.3. This is currently undertaken by the Estates Department who are adapting certificate type paperwork along with the testing. Also the Trust is placing self-testing

emergency lighting systems in departments which are linked to the building maintenance system.

5.6 Escape Route Signage

Fire exit signage is provided throughout the Trust showing the escape routes and fire exits. These are mounted over doors, ceilings and hung at strategic positions within the building and other escape routes from various locations within the Trust. Signage has generally been sized according to the predicted viewing distance and sited conspicuously in accordance with the Health Technical Memorandum recommendations. All signs meet the recommendations of BS 5499-4 Safety Signs.

5.7 Fire Doors Emergency Exits

Manually operated fire exit doors are either provided with break-glass emergency release devices, push pads, or crash bars. Some doors are also integrated with the Trust security systems which are designed to fail safe, where necessary, on the actuation of the fire alarm systems. Green emergency door release boxes are also fitted where required to enable the doors to be opened in the event of any technical failure of the systems.

5.8 Persons with disabilities/additional needs

Whilst the building is fully compliant for the evacuation of persons with additional needs, it should be noted that trained personnel are available to assist with their safe evacuation from the building. Where new developments are being carried out suitable safety features and systems are being adopted in line with BS 5588: Part 8, Equality Act 2010 and Building Regulations requirements. This is completed through the capital team within the Estates Department.

6. MANAGEMENT ROLES AND FIRE SAFETY PLAN

6.1 Duty of Care Responsibilities

The Trust has appointed responsible persons (Board of Directors and Chief Executive, supported by the Chief Operations Officer) to take control of such fire precautions and to ensure, as far as is reasonably practicable, the safety of any of their employees; and in relation to relevant persons who are not their employees, take such general fire precautions as may be reasonably required in the circumstances of the case to ensure the premises are safe. The responsible person as designated within the Trust's fire policy will make and give effect to such arrangements as are appropriate, having regards to the size of their undertaking and the nature of their activities, for the effective planning, organisation, control monitoring and review of the preventive and protective measures for life safety, property protection and duty of care that needs to be delivered for a safe and secure operation.

6.2 Responsible Persons (Board of Directors and Chief Executive)

The Responsible Person means a person who has control of the premises (as occupier or otherwise) in connection with the carrying on by their trade, business or other undertaking (for profit or not). This control may be delegated to the Fire Safety Manager (Director of Estates and Facilities).

The Fire Safety Manager and wider Estates team are responsible for the following:

- Obtain expert advice on fire legislation;
- An awareness of all fire safety features in their buildings;
- Obtain expert technical advice;
- Fire safety risks particular to the organisation;
- Requirements for mobility impaired patients, staff and visitors with regard fire procedures;
- Compliance with legislation, taking into account advice from the Fire Safety
- Advisor or instruction from the Fire Authority;
- Co-operation between employers where two or more share the premises;
- Monitoring and the mitigation of unwanted fire incidents;
- Liaison with enforcing authorities;
- Liaison with other managers and provide a link to Trust committees;
- Monitoring the inspection and maintenance of fire safety systems and equipment to ensure it is compliant;
- Review of identified risks in fire risk assessments and if necessary place on the Trust risk register;
- Ensure the day to day implementation of the fire safety policy;
- Provide support for the Fire Safety advisor.

6.3 Competent Person (Fire Safety Advisor)

The Responsible Person has appointed a Competent Person/s to assist them in undertaking the preventive and protective measures for the Trust. The competent person appointed is to comply with Article 18 of the Regulatory (Fire Safety) Order 2005. “This is a person deemed to be competent where having regard to the task they are required to perform and taking into account of the size of the hazards if the undertaking or establishment in which they undertake the work, possess sufficient training, experience and knowledge appropriate to the work undertaken”.

6.4 Fire Risk Assessment

It is a requirement under Article 9 of the Regulatory Reform (Fire Safety) Order 2005 that the Trust carries out a Fire Risk Assessment of the premise and record any significant findings. The process of risk assessment is an on-going task that is constantly monitored and reviewed. This process is carried out by the Trust Fire Safety Advisor who works with all the department managers. The overall fire risk is covered within the Trust’s Fire Policy and this document. Each individual area/department has a fire risk assessment carried out by the Fire Safety Advisor which is passed over to each manager. This is an on-going process which is monitored and audited by the Trust’s Fire Safety Advisor.

6.5 Management Fire Safety Policy

The Fire Safety Policy sets out the approach to life safety and property fire protection and incident management planning within The Rotherham NHS Foundation Trust and has been prepared in accordance with the guidelines of the Regulatory Reform (Fire Safety) Order 2005 and the Health Technical Memorandums. The Trust presents many special problems in respect of life safety because of the large numbers of patients with various levels of ability and consciousness in a single building and the critical need to protect the operational function of the building against possible disruption. The primary purpose of the policy is the protection of life safety and also to protect the Trust and its contents against fire, to ensure compliance with all relevant statutory controls, and establish effective liaison with the local Fire and Rescue Service. To ensure that measures provided for fire safety are compatible with the operational needs of The Rotherham NHS Foundation Trust, so far as is practicable to make all staff aware of the importance of fire safety and ensure that they receive appropriate training at different levels, along with their duties, so that they can discharge their responsibilities effectively. To ensure that the required standards of fire safety in the buildings are regularly audited and inspected in line with the Fire Safety Policy so that it can be effectively managed to reduce the danger from fire to be as low as is reasonably practicable.

6.6 Maintenance of Fire Safety Equipment and Provisions

Estates and Procurement in conjunction with the Fire Safety Advisor via their preferred Service Partners have in place a planned inspection, maintenance and testing programme to ensure all fire protection systems are fit for service

and can operate effectively when required in an emergency situation. Arrangements and contracts are in place for competent staff and specialist contractors for maintenance to be carried out on all life safety and fire protection systems with records retained on site with the Estates Department.

6.7 Contractors and Service Partners on the Premises and Hot Works

Specialist contractors and service partners can present additional fire risk, as they may be unfamiliar with the premises and with the associated fire risks and fire precautions to be observed. This risk can be increased when they are carrying out hazardous tasks such as hot works and using substances that give off flammable vapours. The Estates Officers based on Level B have a process in place for the control of this function with a Permit to Work and hazardous risk assessment plan in place to safely control the operation. This comes in different types of Permits to Work including the Hot Works Permit. At times the Security Department will inspect areas which are being worked on out of normal hours or when a 7-day permit is issued. The Health & Safety Advisor and/or Estates & Facilities Health & Safety Co-ordinator audit these permits to ensure the standards are being followed.

6.8 Training

Staff are an integral part of the fire risk management process and the Trust has an excellent fire-training package in place for the training of all staff. This training is delivered by trainers who are employed by the Trust working for Estates and Facilities. The trainers make it clear at the start of every presentation that they are not fire safety advisors and cannot answer any technical questions regarding fire safety. Any questions are passed to the Fire Safety Advisor who returns the answer to the staff member who asked it. Training sessions are arranged by the trainers who carry out mandatory fire training to all staff twice a month and departments as and when required. The Fire Safety Advisor carries out training with Main Theatres, Intensive Care and High Dependency Units. All members of staff sign in on attendance and this paper work is sent to the Learning and Development Department. They place the information on to the ESR system and keep the training records up to date. Fire training is given to all members of staff on an annual basis.

6.9 Statutory Records

One of the essential elements that the Estates management need to be in control of is the holding of statutory records, keeping them up to date, (can be in manual or electronic form) and having them preferably readily available to any of the statutory enforcing bodies on request. These records should include:

- Fire Alarm System
- Automatic Detection
- Wet and Dry Risers
- Fire Fighting Equipment
- Emergency Lighting

- Emergency Generators
- Smoke Control Systems
- Fire Suppression Systems

Where changes are made to the building as a result of refurbishment or new projects floor plans will be reviewed and updated by the Estates Capital team.

6.10 Control of Substances Hazardous to Health (COSHH)

Substances hazardous to health have become a major importance to emergency response teams and need to be carefully controlled and managed to mitigate the risk to patients, visitors, employees, and Fire Service personnel who may have to deal with such an incident. Regardless of its size or nature, each COSHH incident can present a potential hostile environment. All COSHH substances are readily identified within the area stored and are satisfactorily controlled. Copies of the COSHH registers are held within the department and electronically – centrally on Alcumus SypoCMS which can be made quickly available to the Fire Service when they have to deal with an incident.

7. ACCESS AND FACILITIES FOR THE FIRE SERVICE

7.1 General

In a building of such size and complexity it is essential that means are provided and maintained to ensure the safe and unimpeded access for the Fire Service personnel at all levels with the building. In general, access facilities for the fire service are as recommended in HTM 05-02 Chapter 7.

7.2 Access

There are 6 main entrances to the Trust and each level has an exit to ground floor. These are:

- Level A – Entrance leading onto Oakwood Hall Drive.
- Level B – A&E
- Level C – Main Entrance & Maternity Entrance
- Level D – PGME & at Management/Executive Entrance
- Level E – Entrance to the Moorgate Wing

There are also a number of fire escape stairwells that can be used for access via the Security Department. These also house the dry risers that are located around the Trust. Upon arrival of the Fire Service, information relating to the fire location will be passed on initially by the Security team who will take the Fire Service Commander to the department that has the incident. On their arrival at the department a more detailed brief will be carried out by the Clinical Site Manager (221 Bleep) who is the responsible person for the incident. An assessment will then be made by the Fire Service Commander of the most suitable method of dealing with the incident. The corridors and staircases are fully fire protected in accordance with HTM 05-02.

7.3 Water Supplies

There is a 155mm main situated within the service roadways and strategically around the site. The meter point is near the bus stop on Baker Street. The main is a ring main with spurs coming off at points around the Trust. There are 31 dedicated hydrants around the site which are tested by the fire extinguisher contractor.

7.4 Fire Service Predetermined – Attendance

On receipt of an emergency call from the Hospital, the Fire Service have an agreed predetermined attendance to this Hospital which has been given a Class ‘A’ Category. The number of fire appliances to respond is 3 Fire Appliance Pumps.

8. COMMAND AND CONTROL

8.1 Contingency Planning

Contingency plans need to include preparation and response to a wide range of unusual events. This can include possible emergencies and incidents that include fire, communications, water, power supplies, weather, time of day, time of week, time of year, traffic issues and other unexpected/unplanned events. It is essential that when management prepare their contingency plans that these key elements are discussed and incorporated into the final plans as necessary. For this to be successful this needs buy in from service partners and concessionaires and they need to be kept up to date on each review of the plan and if any table top exercises are performed they need to be involved. This will be carried out in conjunction with the Emergency Planning & Business Resilience Manager for the Trust.

8.2 Incident Management Systems Operations

The Incident Management System Operations should be considered as the basic command control process to be used to deal with any size or kind of incident that may occur at the Trust. This process is covered in the Trust Major Incident Plan which members of the Trust Silver Command team operate from the Incident Control Centre within PGME. The Executive team would operate from the Board room (assuming neither of those locations were affected by the incident).

8.3 Command Organisation

For this management to be successful it is important to appoint a senior position from the management team as the Emergency Co-ordinator to set up Command and Control and liaise with the Fire Service. This person should report to the Senior Management Team. Ensure the Control Centre is available to the Emergency Services and is properly briefed and trained and coordinates the activities of the company and it service partners.

8.4 Fire Response Team

The building is served by a 24 hour, 7 day a week Fire Response Team; consisting of porters, Estates engineer, Security staff and a Clinical Site Manager (221 Bleep) who are all involved within the evacuation procedure should an actuation of the fire alarm take place, this is detailed within the Trust's Fire Safety Policy.

8.5 Re-entry into the Rotherham NHS Foundation Trust

Once the incident has been professionally acted upon and closed and the life safety and fire protection systems have been restored to their operational status, the Fire Response Team will stand down the incident and get people back to normality and into the building when designated safe by the Fire Service.

Board of Directors' Meeting
7 March 2025

Agenda item	P41/25
Report	**Freedom to Speak up Guardian Quarter 3 Update**
Executive Lead	Helen Dobson, Chief Nurse
Link with the BAF	U4: There is a risk that we do not develop and maintain a positive culture because of insufficient resources and the lack of compassionate leadership leading to an inability to recruit, retain and motivate staff.
How does this paper support Trust Values	Promoting a culture of Speaking up within TRFT supports all three of the Trust values of Ambitious, Caring and Together
Purpose	**For decision** ☐ **For assurance** ☐ **For information** x
Executive Summary (including reason for the report, background, key issues and risks)	This paper provides the Board of Directors with an update of the concerns which have been raised through the Freedom to Speak up Guardian and the themes which have been raised through the Freedom to Speak up Champions To provide an update of how the profile of the Speaking up agenda is being raised and embedded within The Rotherham NHS Foundation Trust. **<u>Summary of Key Points:</u>** The key points arising from the report are • Increase in number of staff raising concerns • Increase in number of concerns raised across all staff groups • Themes arising from champions • Increase in Champion representation across care groups and staff groups • Positive feedback received from concerns closed in Q3
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	This report was presented to People Committee on 28 February 2025
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?)	No further action required from the Trust Board
Recommendations	It is recommended that the Board note the Q3 report.
Appendices	

1. Introduction

1.1 The National Guardian's Office and the role of the Freedom to Speak Up (FTSU) Guardian were created in response to recommendations made in Sir Robert Francis QC's report "The Freedom to Speak Up" (2015). The aim of FTSU Guardian (FTSUG) is to help create a culture of openness within the NHS, where staff are encouraged to speak up, their voices heard, lessons are learnt and care improves as a result. The FTSUG's responsibility is to ensure workers can speak up about any issues impacting on their ability to do their job.

1.2 The Trust introduced FTSUG in 2015, with a Lead FTSU Guardian appointed in October 2016.

2. Background

2.1 The report aims to provide the Board with a high-level overview of the activity undertaken by the FTSUG during quarter three, highlighting the number of concerns raised, the themes that underpin the concerns and resultant learning**.**

2.2 FTSU will help our organisation deliver on the People Promise for workers, by ensuring they have a voice that counts and that our staff to feel 'safe and confident to speak up', the FTSUG and Champions take the time to really listen to understand to the concerns that are raised. By developing a speaking up culture in which leaders and managers value the voice of their staff FTSU is a vital driver of learning and improvement.

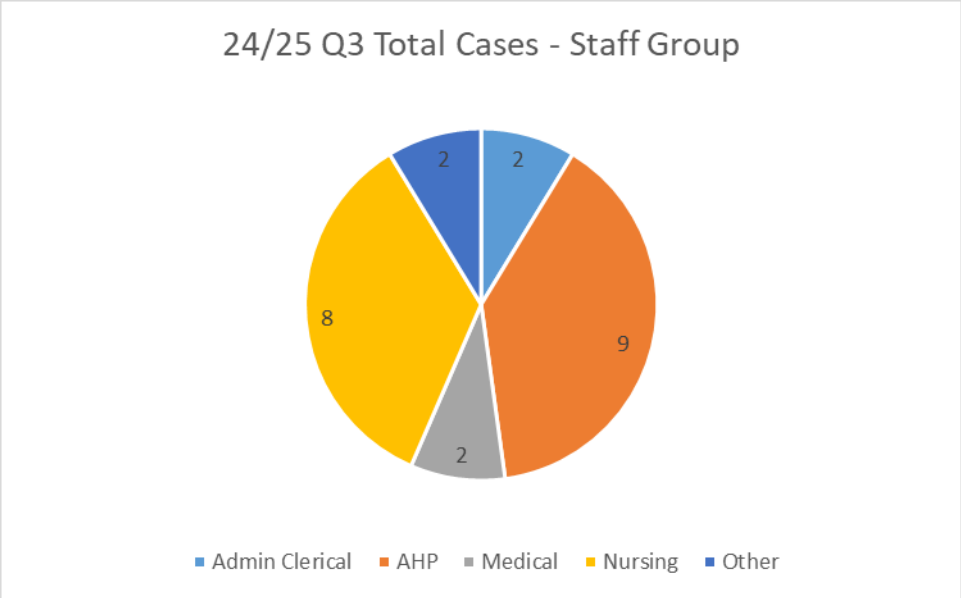
3. Policy, Reporting and Governance

3.1 The NGO in collaboration with NHSE developed a National FTSU policy template. All NHS organisations are required to adopt the national policy as a minimum standard to help normalise speaking up for the benefit of patients and workers. The Policy was approved at Operational Workforce Group and Joint Partnership Forum in July prior to being ratified at the Trust's Document Ratification Group in August 2024. The National Policy is available on TRFT's internal and external web page.

3.2 The Lead FTSUG has remained the responsibility of the Chief Nurse. The lead role with increased hours to 0.6 WTE has been in post since March 2024. In line with recommendations from the National Guardian's Office (NGO) the FTSU Lead role is a standalone role.

3.3 During this reporting period 23 individuals have raised concerns directly with the FTSUG. A number of the concerns raised related to the same issue within specific clinical areas. These concerns have been grouped together, to constitute 14 separate FTSU cases in Q3 (Figure 2). The two cases where the individual concerns are being managed as grouped concerns, both required intervention from the Senior Leadership Team (SLT) with support from the HR team. These cases are on-going and involve multiple staff groups across the Care Group.

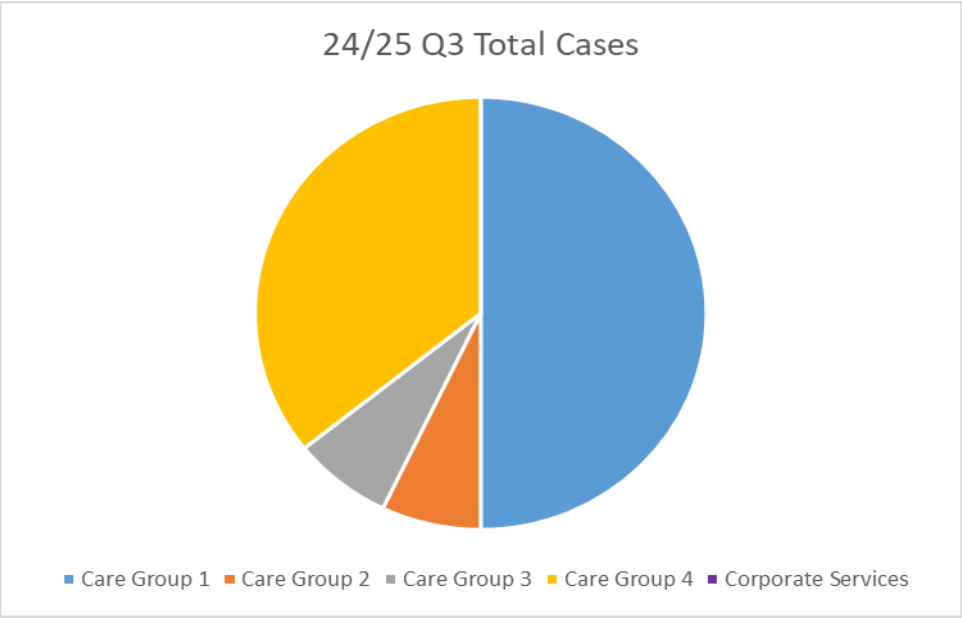
Figure 1: Total number of individual concerns across staff groups Q3 24/25



3.4 Figure 1 represents the 23 individual concerns raised across staff groups within the Trust in Q3. Q3 data indicates that concerns have been raised across a variety of the staff groups, this can be seen as a reflection of the awareness of the FTSU route for speaking up across staff groups. The variety of staff groups speaking up was also identified in Q2 data. Q3 data demonstrates concerns being raised from the medical workforce (2) with a slight increase from Q2 (1). Both concerns from the medical staff group related to patient safety and quality in care. The largest number of concerns raised in this reporting period were in the AHP (9) and Nursing (8) staff groups.

3.5 For the purpose of this report the figures represented in Figure 2 reference the 14 FTSU cases raised split across the Care Groups.

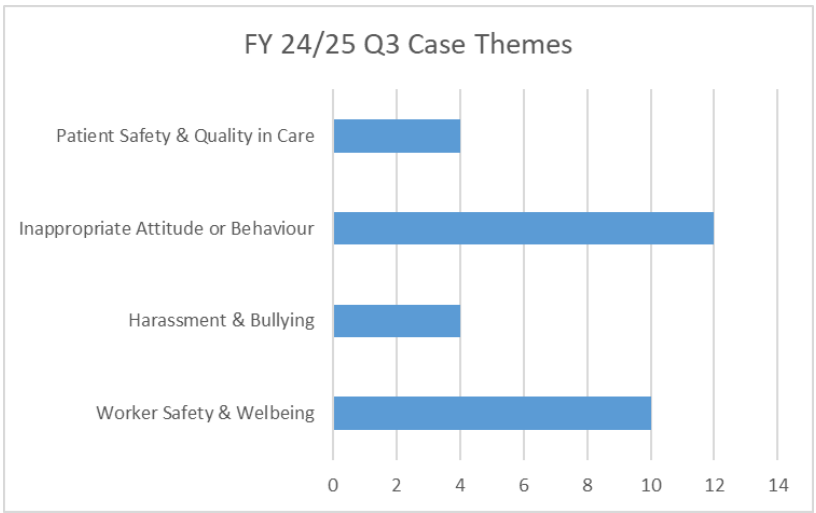
Figure 2: Total cases raised across care groups



3.6 For this reporting period 7 of the 14 cases raised with the FTSU occurred within Care Group 1. Although this represents half of all total cases, Care Group 1 incorporates services where there are challenging operational environments. The staff survey results are a key indicator of staff confidence in speaking up and being listened to by the organisation and by managers locally. The FTSUG awaits the latest results to help steer the focus for speaking up within the care groups.

3.7 A breakdown of the themes underpinning the concerns can be seen in Figure 3. Each concern raised with The FTSUG may have multiple themes associated with that concern, therefore the number of themes will exceed the total number of cases reported. For the purpose of this report the figures in figure 3 reference the 14 FTSU cases.

Figure 3: Number of Cases with associated theme Q3 24/25



3.8 Inappropriate attitudes and behaviours was the most common theme found in 12 of the 14 cases reported. Worker Safety and Wellbeing was a theme found for 10 of the 14 cases. The FTSUG found that for a number of the individuals raising concerns, inappropriate attitudes and behaviours experienced by individuals had a direct link with their wellbeing. The FTSUG found worker wellbeing to be present in both the grouped concerns and experienced by all the individuals involved in those concerns. For the grouped concerns, the FTSUG, supported by the Chief Nurse have worked closely with the SLT to strengthen leadership visibility and promote active listening events in relation to the themes that underpin the concerns.

3.9 Of the 14 cases raised, 6 of them have now been closed and resolution has been achieved for the individuals that have raised the concerns. None of the 6 cases closed in this quarter required formal investigation, resolution was achieved via informal routes.

3.10 The FTSUG meets regularly with the Chief Nurse, Chief Executive and Head of OD&I, which provides an opportunity for discussion regarding concerns raised, and potential for learning and improvement opportunities. The FTSUG lead has regular support from the Non-Executive Director responsible for FSTU regarding issues and themes.

3.11 Figure 4 represents the Trust's overall compliance rating of 85.62% which is a slight increase from Q2 of 83.03% for FTSU MaST e-learning training. Corporate being the only Care Group below the Trust target of 85%, with performance of 65.14%. This is a focus for the FTSUG, who has raised the recent fall in compliance with the SLT's for the Corporate Care Group.

Figure 4: FTSU MaST compliance

	Freedom to Speak Up - for all workers MAST
Care Group	**Sum of % Compliance**
Care Group 1	**88.12%**
Care Group 2	**93.08%**
Care Group 3	**90.36%**
Care Group 4	**90.49**
Corporate	**65.14%**
Grand Total	**85.62%**

4 Summary of FTSU Concerns for TRFT

4.1 It remains difficult to identify common themes and trends across the quarterly concerns, the number of FTSU cases is low despite an increase from Q2 and Q1. Inappropriate attitudes and behaviours has been identified in 12 of the 14 FTSU cases raised in Q3, and present in 6 of the 7 cases reported in Care Group 1. This is a targeted areas of focus for the FTSUG, in collaboration with the OD&I team to emphasise the right culture and behaviour.

4.2 FTSUG is encouraged that 23 individuals have accessed the FTSU route to raise concerns, in order for these to be addressed through follow up and investigation where appropriate.

5. Feedback following Raising a FTSU concern

5.1 It continues to be a challenge to get feedback from staff who have raised concerns via the questionnaires, there is a reluctance to respond once the concerns have been addressed. Feedback forms were sent to 4 of the 6 cases resolved in Q3, 3 questionnaires were returned by the time this report was completed.

5.2 The feedback received was positive with all 3 individuals stating that they would speak up again. The response to the question 'based on your experience of raising a concern, would you do it again?' is part of the data set required by the National Guardian's Office provided by all FTSUG's. The feedback stated that all 3 individuals felt that their concern had been taken seriously and that they were treated with confidence. One feedback stating '*I hope that more people would raise concerns as it was a benficial expereince for me personally and professionally*'.

6. Raising the Profile of FTSU within TRFT and Champion Network

6.1 Work has continued to increase the visibility of FTSU within the Trust. This has included development of promotional information on the role of the guardian and champion network.

6.2 The activities undertaken by the FTSUG relating to increasing FTSU visibility can be seen in the table below:

Date	Area	Method of delivery	Participants	Staff Group	Quarter
01/10/2024	CYPS Therapy services	Face to face	15	Occupational therapists & Physiotherapists	3
16/10/2024	Apprentice ACP induction	Face to face	6	ACP	3
17/10/2024	Orthopaedic's team meeting	Face to face	15	Consultants, Registrar's, Foundation Trainee, Nursing, AHP, Therapist	3
25/10/2024	Professional Nurse Advocate's	Face to face	8	Nursing	3
12/11/2024	Theatre Audit Day	Face to face	25	Nursing, HCSW, AHP, Medical	3
12/11/2024	Lunchtime Lecture	Face to face	25	Staff workforce	3

6.3 In addition to the lead guardian, there are 11 Freedom to Speak Up Champions within the Trust. The Champions provide representation across the staff groups, with Champions from the Medical, Nursing, AHP, Admin and Clerical workforce. The recruitment process for Champions and raising the profile of FTSU is on-going with interest in the role continuing to increase as the profile raises across the Trust. The FTSUG wishes to increase the number of Champions to 20 which is aligned to other local and similar sized organisations. Although there is Champions representation across the main staff groups, the FTSUG would like to increase the champion profile to provide a more reflective representation of TRFT staff demographics, ensuring that Champions represent the workforce population and staff groups with protected characteristics.

6.4 The FTSUG currently has Champion representation across the Care Groups with the exception of Care Group 1. The recruitment of a Champion within Care Group 1 is a priority for the FTSUG for Q4.

6.5 The FTSU Champions' have highlighted the role and associated agenda through various forums and local area staff meetings. The FTSUG has at the request of a number of Champion's attended local area meetings to assist in raising the FTSU profile and to address local concerns. The FTSUG lead is continuing to work with the OD&I Lead to increase awareness amongst all staff groups and embed a FTSU culture across the organisation.

7. National Guardian Office Data

7.1 The Trust has submitted data on a quarterly basis to the National Guardians Office. Quarter 1, 2 and 3 data has been submitted for 24/25.

8. TRFT Comparison with National Data

8.1 The value of comparison between Trusts is difficult to determine as a high or low number of concerns does not necessarily provide assurance regarding the speaking up culture of the Trust. The NGO remains keen for Trusts to avoid comparison.
The staff survey results remains an indicator of staff confidence in speaking up, the data for the recent staff survey is not currently available.

8.2 The key performance indicator for organisation is that the NGO receive a data return each quarter.

9. National Guardian Office Case Reviews

9.1 There have been no case reviews published during quarter three.

10. Conclusion

10.1 The number of cases for Q3 (14) have increased in comparison to Q2 (9), the FTSUG considers it is worth noting that the increase in concerns raised is reflective of a positive reporting culture. The increase in cases is aligned with the work undertaken by the FTSUG and Champions in raising awareness of the FTSU. The profile raising of FTSU can be reflected in the 23 individuals across the care groups and staff groups that spoke up during Q3. This is a signal of a positive FTSU culture and an increasing

awareness of how to speak up, promoting an environment where staff feel encouraged to raise concerns. The FTSUG and Champions will continue to promote a positive speaking-up culture, to prevent harm and improve outcomes for both colleagues and patients.

10.2 It is vital, not only to encourage colleagues to raise issues, but to foster an environment where staff are truly supported to speak up. Managers have an important role to play in supporting a culture within their teams so that speaking up becomes business as usual.

10.3 Our aim remains to be a Trust where everyone from front line care to Board level is committed to supporting a transparent and open culture, where all staff including: agency workers, temporary workers, contractors, students, volunteers, governors and other stakeholders are encouraged and confident that they are able to 'Speak Up'.

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Board of Directors' Meeting
7 March 2025

The Rotherham NHS Foundation Trust

Agenda item	P42/25
Report	**Freedom to Speak up Guardian Annual Report 2023/24**
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	Promoting a culture of Speaking up within TRFT supports all three of the Trust values of ambitious, Caring and Together
Purpose	**For decision** ☐ **For assurance** ☐ **For information** x
Executive Summary (including reason for the report, background, key issues and risks)	To provide the Board of Directors with a retrospective annual update of the concerns which have been raised through the Freedom to Speak up Guardian in 2023-2024 To provide an update of how the profile of the Speaking up agenda is being raised and embedded within The Rotherham NHS Foundation Trust. **<u>Summary of Key Points:</u>** The key points arising from the report are • The appointment of a new Freedom to Speak Up Guardian in March 2024 • Increase from 0.4 to 0.6 WTE for New FTSUG Lead role appointed
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	This is retrospective report on the concerns raised in 2023-2024. This report was presented to the Audit and Risk Committee on 24 January 2025.
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?)	No further action required from the Trust Board

Recommendations	It is recommended that the Board note the 2023-2024 annual report.
Appendices	None

1. Introduction

1.1 The Freedom To Speak Up Guardian (FTSUG) initiative was implemented following the Francis report (2015). The aim of the FTSUG is to help create a culture of openness within the NHS, where staff are encouraged to speak up, lessons are learnt and care improves as a result.

1.2 The Trust introduced FTSU in 2015, with a FTSUG lead appointed in October 2016.

2. Background

2.1 The report aims to provide the Board of Directors with a retrospective high-level overview of the activity undertaken by the FTSUG during 2023-24, highlighting the number of concerns raised, actions taken and resultant learning**.**

3. Reporting and Governance

3.1 The FTSUG lead has remained the responsibility of the Chief Nurse. The FTSUG lead during this reporting period was Tony Bennett who covered the role on a 0.4 WTE. The lead role was advertised in December 2023 and the successful candidate appointed to the role in March 2024 on an increased 0.6 WTE.

3.2 During this reporting period eight concerns were raised that relate to bullying & harassment/attitudes and behaviours. Due to the low numbers of concerns raised there were no identifiable trends across departments, Care Groups or staff groups.

3.3 All of the concerns were escalated to line managers/HR and are now closed and the individual's who raised the concern informed of the outcome.

3.4 The FTSUG lead meets regularly with the Chief Executive, Chief Nurse and Director of People, which provides an opportunity for discussion regarding issues raised, and potential learning opportunities. The FTSUG lead has also had regular support from the Non-Executive Director for FSTU regarding issues and themes.

3.5 The Trust has an overall compliance rating of 93.51% for FTSU Mast e-learning training with every division being above the target of 85%.

Division	Conflict Resolution
Clinical Support Services	95.67%
Community Services	96.42%
Corporate Operations	87.07%
Corporate Services	89.77%
Emergency Care	92.35%
Family Health	93.55%
Medicine	92.44%
Surgery	95.67%
Grand Total	93.51%

3.6 In addition to the lead guardian, there were for this reporting period 8 Freedom to Speak Up Champions within the Trust. During 2023/2024 there were two changes

to the Champions Network, one due to a Champion stepping down and the other due to a Champion leaving the Trust.

3.7 A further review of the FTSU Champion structure and FTSU strategy will take place once the new FTSUG lead has started.

4. Retrospective Summary of FTSU Concerns for TRFT

Table 1: FTSU Concerns 2023/24

Quarter	Number of concerns	Nature of concern	Investigations completed	Detriment
1	4	Attitudes and behaviours 3 Bullying & harassment 1	4	0
2	3	Attitudes and behaviours 3	2	0
3 & 4	1	Attitudes and behaviours Bullying & harassment	0	0
Total	8		6	0

4.1 There was no pattern to the Care Group (formerly Division) or reporting due to the small number of concerns raised during 2023/2024. All the concerns raised were in relation to attitudes and behaviours with elements of bullying. There were no concerns raised in relation to patient safety.

5. Feedback following Raising a FTSU concern

5.1 It remains difficult to get feedback from staff who have raised concerns via the questionnaires, as there is a reluctance to respond once the concerns have been addressed.

6. Raising the Profile of FTSU within TRFT

6.1 Work has continued to increase the visibility of FTSU within the Trust. This has included development of promotional information on the role of the guardians. Promotion of FTSU profile within TRFT and the role of the FTSUG is a key priority and focus for the new Guardian for 2024/2025.

6.2 The FTSU Champions' highlighted the role and associated agenda through various forms. The FTSUG lead continued to work with the equality and diversity lead to increase awareness amongst all staff groups.

7. National Guardian Office Data

7.1 The Trust has submitted data on a quarterly basis to the National Guardian's office.

8. TRFT Comparison with National Data

8.1 The value of comparison between Trusts is difficult to determine as a high or low number of concerns does not necessarily provide assurance regarding the speaking up culture of the Trust. The NGO remains keen for Trusts to avoid comparison.

The staff survey results remain the best indicator of staff confidence in speaking up, the provisional data for the recent staff survey for this reporting period (Nov 2023) shows significant increase in staff confidence.

8.2 The key performance indicator for organisation is that the NGO receive a data return each quarter.

9. National Guardian Office Case Reviews

9.1 There have been no case reviews published during 2023/2024.

10. Conclusion

10.1 There was a decrease in the number of concerns raised during the reporting period 2023/24 with only one concern being raised in Q3&4. The initial responses to the staff survey are extremely encouraging and the Champions will continue to promote a positive speaking-up culture, to prevent harm and improve outcomes for both colleagues and patients. The appointment of a new Guardian with standalone ring-fenced time to focus on the FTSU profile is aligned with the guidance released by the NGO in November 2024.

10.2 It is vital, not only to encourage colleagues to raise issues, but to foster an environment where staff are truly supported to speak up. Managers have an important role to play in supporting a culture within their teams so that speaking up becomes business as usual.

10.3 Our aim remains to be a Trust where everyone from front line care to Board level is committed to supporting a transparent and open culture, where all staff including: agency workers, temporary workers, contractors, students, volunteers, governors and other stakeholders are encouraged and confident that they are able to ‘Speak Up’ their voices are heard and concerns followed up appropriately.

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Board of Directors' Meeting
7th March 2025

The Rotherham NHS Foundation Trust

Agenda item	P43/25
Report	**Gender Pay Gap Report**
Executive Lead	Daniel Hartley, Director of People
Link with the BAF	Us - there is a risk that we do not develop and maintain a compassionate and inclusive culture leading to an inability to retain and recruit staff and deliver excellent healthcare to patients.
How does this paper support Trust Values	This paper is presented to fulfil a statutory responsibility and support our values of Ambitious, Caring and Together.
Purpose	**For decision** ☒ **For assurance** ☒ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	This report (once published) will fulfil the Trust's statutory duty to publish information regarding its gender pay gap as of 31st March 2024 by 31st March 2025. According to the Trust's 2024 data, the mean pay gap remains broadly the same as the previous year 27.69% (27.72% in 2023). The median pay gap has, however, declined from 17.24% in 2023 to 21.47% in 2024. This change is attributed to the Trust's gender split at consultant-level. Despite recruiting more female resident doctors than male, more male consultants were recruited than female during the period. Further analysis has shown, however, that the probability of appointment from shortlisting demonstrates parity between men and women. This suggests that bias in the appointment stage is not a factor, and that the focus to seek to address this is around pipeline and attraction. Both the mean and median gender pay gap in the Trust's non-medical workforce has improved in 2024 compared to 2023. The mean gender pay gap is 7.28% (8.39% 2023) and the median is 6.77% (7.4% in 2023) The next steps, in line with our EDI plan work for 2025/26 is to investigate other potential solutions to this in terms of pipeline of all roles and the attractiveness of consultant roles at TRFT to women in terms of working patterns, flexibility etc.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	This paper has been shared with ETM and presented to the People & Culture Committee on Friday 28th February ahead of submission to the Board on 7th March.

Board powers to make this decision	Approval of the Gender Pay Gap submission is a matter reserved for Board as it forms part of the Board Assurance Framework and forms part of our statutory reporting requirements.
Who, What and When (what action is required, who is the lead and when should it be completed?)	Once approved the report will be published on the Trust website, with data also submitted via the government portal by 31 March 2025.
Recommendations	It is recommended that the report and submission are approved for publication. Actions designed to improve the gender pay gap will be delivered through the EDI plan and led by the People team and Medical Director team in respect of medical workforce.
Appendices	Appendix 1 - Gender Pay Gap Report Appendix 2 – Content to be uploaded to the Government portal site

The Rotherham NHS Foundation Trust

ANNUAL GENDER PAY GAP REPORT

REPORTING PERIOD: 2023/2024

PUBLICATION: 31ST MARCH 2025

Contents

Introduction

The gender pay gap report shows the difference between the average (mean or median) earnings of men and women. This is expressed as a percentage of men's earnings e.g. women earn x% less than men.

The mean and median are different ways of expressing an average. Mean hourly pay for a group of ten people would be calculated by adding together the hourly rates of all ten people, and then dividing the result by 10. To find the median hourly rate for the same ten people, you would put the hourly rates in order, from lowest to highest, and the median would be a value halfway between the 5th and 6th rate. When used in relation to pay, the mean can be significantly affected by a small number of very high earning staff.

The gender pay gap differs from equal pay. Equal pay deals with the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value. It is unlawful to pay people unequally because they are a man or a woman. The gender pay gap shows the differences in the average pay between men and women. If a workplace has a particularly high gender pay gap, this can indicate there may be a number of issues to deal with, and the individual calculations may help to identify what those issues are.

As a public body employing over 250 staff the Trust is required to publish the following gender pay gap information:

a) Mean gender pay gap
b) Median gender pay gap
c) Mean bonus gender pay gap
d) Median bonus gender pay gap
e) Proportion of males receiving a bonus payment
f) Proportion of females receiving a bonus payment
g) Proportion of males and females in each quartile pay band

Gender Pay Gap Reporting

Data and statistics provided for this report have been created using the national Electronic Staff Records System (ESR) Business Intelligence (BI) reporting tool, specifically designed to allow NHS Trusts to meet the statutory reporting requirements.

As at 31st March 2024, the Trust employed 4763 full-pay relevant employees (112 more than the previous year). Of these, 3901 (+80 on last year) were women and 862 (+32 on last year) were men. Employees who are on maternity, maternity support, adoption, or sick leave, or on a career break are not full-pay relevant employees. The national NHS Electronic Staff Record system does not facilitate the recording of genders other than male or female.

(A & B) - Mean Gender Pay Gap and Median Gender Pay Gap

All Staff Average & Median Hourly Rates

Gender	Mean Hourly Rate	Median Hourly Rate
Female	£18.47	£16.45
Male	£25.55	£20.94
Difference	£7.07	£4.50
Pay Gap %	27.69%	21.47%

The Trust's Gender Pay Gap (mean and median) as of 31st March 2023 is 27.69% & 21.47%, the mean hourly gap has improved slightly compared to last year's 27.72%, however the median gap has declined from 17.24% in 2023. Some of the reasons are explored further in this report.

(C & D) - Mean Bonus Gender Pay Gap and Median Bonus Gender Pay Gap

All Staff Average & Median Bonus Pay

Gender	*Mean Bonus Pay	*Median Bonus Pay
Female	£5,558.24	£4,079.83
Male	£8,105.35	£4,079.83
Difference	£2,547.11	£0.00
Pay Gap %	31.43%	0.00%

* This data excludes Long Service Awards

Bonus pay consists of Clinical Excellence Awards (CEAs) which are paid to consultants (subject to certain eligibility criteria) in a discretionary and non-discretionary award. During Covid temporary arrangements were introduced involving paying new CEAs between all eligible consultants. Pre-existing CEAs continued to be paid, although there is an inevitable reduction in the number of staff receiving them due to leavers e.g. consultant retirements.

In 2024, the Median GPG was 0% and there are 139 employees (including both male and female) who received £4,079.83. As an element of the award is non-discretionary and males make up a larger proportion of the consultant population, the mean bonus pay gap is 31.43%. This includes National clinical excellence awards.

(E & F) - Proportion of Males Receiving a Bonus Payment and Proportion of Females Receiving a Bonus Payment

All Staff Bonus Payment Ratio

Gender	Employees Paid Bonus	Total Relevant Employees	%
Female	45	4193	1.07%
Male	96	949	10.12%

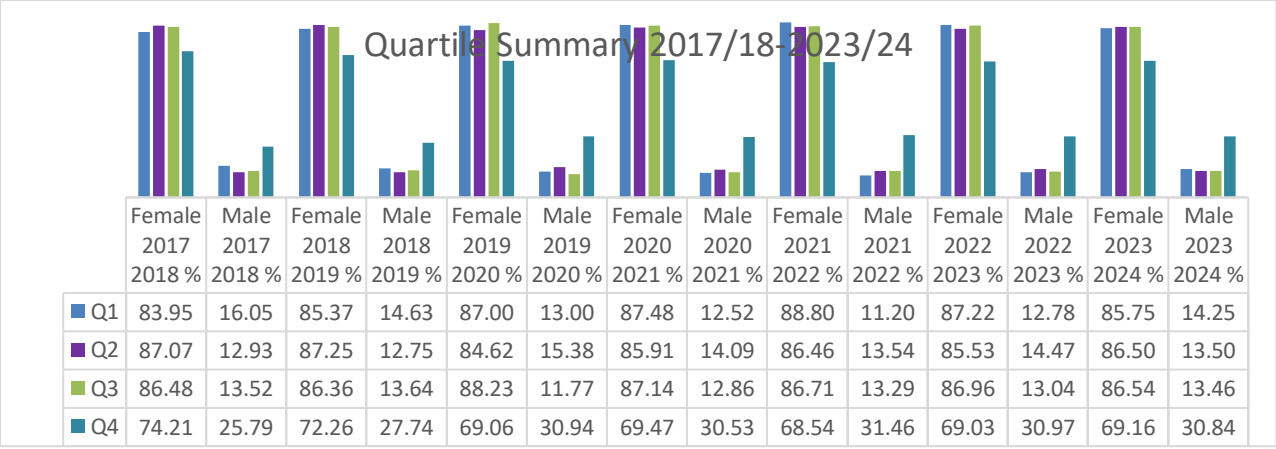
These payments relate exclusively to CEAs.

(G) - Proportion of Males and Females in each Quartile Pay Band

Quartile 1 - lowest paid and quartile 4 - highest paid employees.

Quartile	Female	Male	Female %	Male %
1	987	164	85.75%	14.25%
2	1064	166	86.50%	13.50%
3	1009	157	86.54%	13.46%
4	841	375	69.16%	30.84%

The graph below shows data on the proportion of male and female staff in each pay quartile over the last 5 years.

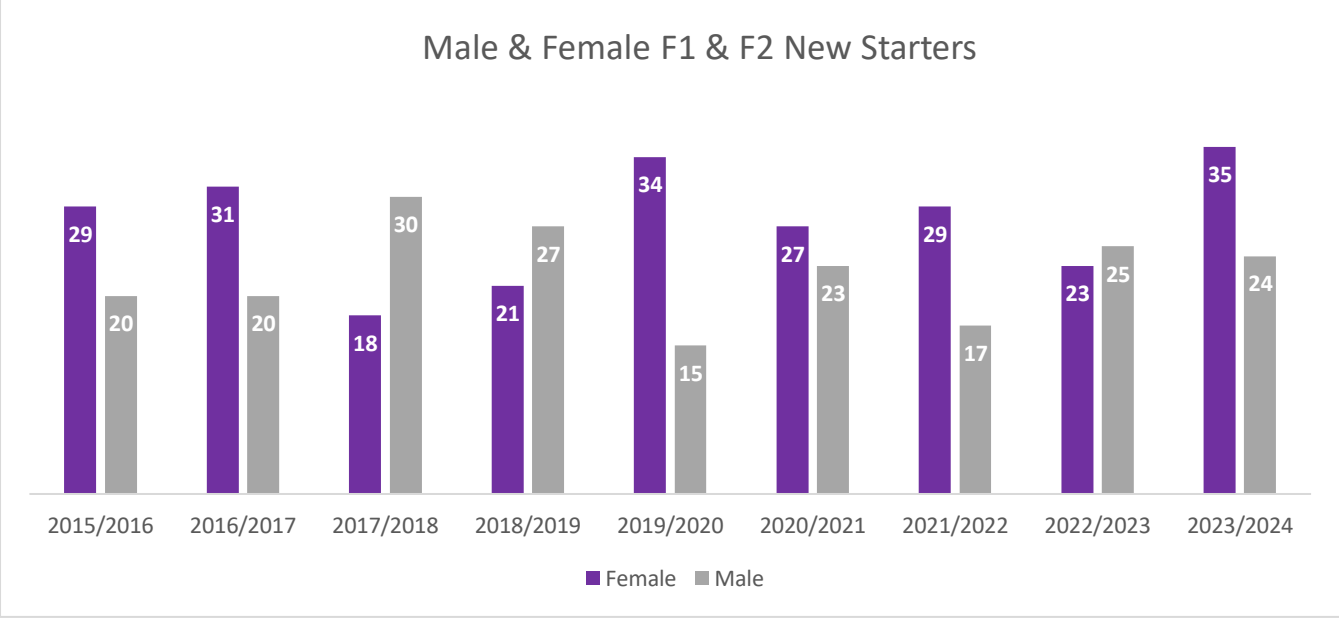


	Female 2017 2018 %	Male 2017 2018 %	Female 2018 2019 %	Male 2018 2019 %	Female 2019 2020 %	Male 2019 2020 %	Female 2020 2021 %	Male 2020 2021 %	Female 2021 2022 %	Male 2021 2022 %	Female 2022 2023 %	Male 2022 2023 %	Female 2023 2024 %	Male 2023 2024 %
Q1	83.95	16.05	85.37	14.63	87.00	13.00	87.48	12.52	88.80	11.20	87.22	12.78	85.75	14.25
Q2	87.07	12.93	87.25	12.75	84.62	15.38	85.91	14.09	86.46	13.54	85.53	14.47	86.50	13.50
Q3	86.48	13.52	86.36	13.64	88.23	11.77	87.14	12.86	86.71	13.29	86.96	13.04	86.54	13.46
Q4	74.21	25.79	72.26	27.74	69.06	30.94	69.47	30.53	68.54	31.46	69.03	30.97	69.16	30.84

This data indicates a mixed picture with the number of males in Q1 increasing by 1.47%, but decreasing in Q2 by 0.97, and very small changes in Q3 and Q4 +0.42 and -0.13 respectively.

1. Trainee Comparison (FY 1&2)

The table below shows number of female and male trainee Foundation Years 1 and 2 new starters for all years since 2015 - 16. Over the period, there have been 247 female new starters within this group, compared to 201 male new starters. Coupled with long-term trends showing increased numbers of female medical students, it is likely that the gender balance of the medical workforce will shift over time, however this may be significantly influenced by the availability or otherwise of flexible working opportunities within hospital medical posts, and no significant shift in gender balance has been seen at consultant level in the Trust as yet.



2. Comparison of hourly pay rates amongst non-medical and medical staff groups

2.1 Non-medical

Gender	Mean Hourly Rate	*Median Hourly Rate
Female	£17.39	£15.88
Male	£18.75	£17.03
Difference	£1.37	£1.15
Pay Gap %	7.28%	6.77%

The gender pay gap amongst non-medical staff is relatively small compared to the Trust's overall gender pay gap, and both the mean and median hourly rates have improved from last year (8.39% and 7.4%), representing a continued trend from 2022-2023.

2.2 Medical and dental

Gender	Mean Hourly Rate	*Median Hourly Rate
Female	£39.18	£36.07
Male	£43.78	£46.29
Difference	£4.60	£10.22
Pay Gap %	10.50%	22.07%

There remains a significant pay gap within the medical and dental workforce. In 2023, there was significant improvement where the mean and median fell to an improved position of 5.51% and 15.96% respectively. However, this has worsened in 2024, and although still better than prior years, the gap now stands at 10.5% and 22.07% respectively. Some of this change is resultant from hiring more male medical and dental consultants 16 versus hiring 6 female consultants.

3. Comparison of proportion of non-medical and medical staff in each pay quartile

3.1 Non-medical

Quartile	Female	Male	Female %	Male %
1	987	164	85.75%	14.25%
2	1057	159	86.92%	13.08%
3	982	142	87.37%	12.63%
4	681	163	80.69%	19.31%

Quartile 1 - lowest paid and quartile 4 - highest paid employees.

There continues to be a slight decrease in the proportion of men within the highest pay quartile; and an increase in men in the lower quartile 1.

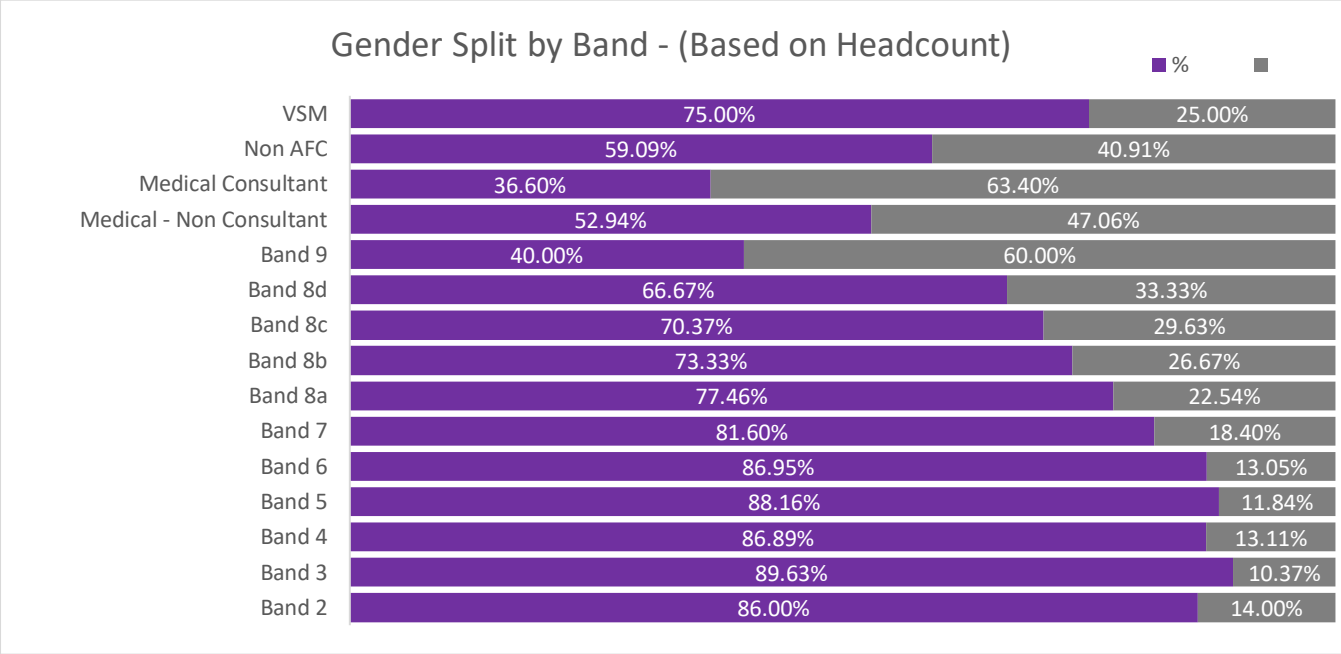
3.2 Medical

Quartile	Female	Male	Female %	Male %
1	0	0	0	0
2	7	7	50.00%	50.00%
3	27	15	64.29%	35.71%
4	160	212	43.01%	56.99%

Quartile 1 - lowest paid and quartile 4 - highest paid employees.

The overwhelming majority of medical staff continue to be in the highest-paid quartile of Trust staff with the majority being male (57.18%).

4. Gender split by pay band



5. Gender pay gap by staff group

Staff Group	**Headcount		Pay Gap
	Female	Male	
Add Prof Scientific and Technic	70	22	23.60%
Additional Clinical Services	909	116	6.74%
Administrative and Clerical	789	166	37.66%
Allied Health Professionals	355	100	13.30%
Estates and Ancillary	202	100	43.05%
Healthcare Scientists	78	38	15.27%
Medical and Dental	194	234	21.73%
Nursing and Midwifery Registered	1297	86	12.63%
Students	7	0	0

The largest pay gaps are within the administrative and clerical and estates and ancillary staff groups, although these have fallen by 3.56% and 1.29% respectively, year on year.

6. Conclusion

As most staff groups and employees are part of the Agenda for Change framework then this negates a large element of gender pay gap variance; however, the Trust needs to ensure that recruitment processes and career opportunities remain fair and transparent to avoid any potential longer-term problems. Historical and societal occupational role division e.g. females in admin and nursing roles also plays a part in contributing to gender pay gaps. The main contributing factor to the pay gap differential remains with the medical & dental workforce.

There is a need to highlight and promote female leadership within the Trust and also the wider community – actively encourage colleagues to participate in International Women's Day and be part of the ICS Women in Leadership Network (which TRFT participate). In 2024, the ICB launched its South Yorkshire Women's Network which is being actively promoted across the Trust. There are commitments in the new Integrated EDI Plan for 2024-2027 to consider what more needs to be done to support women into leadership, including whether to set up an internal Women's Staff Network. Further wok on attraction and flexibility will be taken forward during 2025/26 particularly in relation to the medical and dental workforce.

There is no statutory requirement for either recommendations or an action plan in relation to gender pay gap; however, actions designed to improve the gender pay gap will be delivered through the EDI plan and led by the People team and Medical Director team in respect of medical workforce.

Hashim Din

February 2025

Hourly pay

Gender pay gap

If women in your organisation are paid more than men, enter a negative percentage figure – for example -12%.

Enter the **mean (average)** gender pay gap for hourly pay
27.69 %

Enter the **median** gender pay gap for hourly pay
21.47 %

Upper hourly pay quarter

Women
69.16 %

Men
30.84 %

Upper middle hourly pay quarter

Women
86.54 %

Men
13.46 %

Lower middle hourly pay quarter

Women
86.50 %

Men
13.50 %

Lower hourly pay quarter

Women
85.75 %

Men
14.25 %

Bonus pay

Gender pay gap

If women in your organisation are paid more than men, enter a negative percentage figure – for example -12%.

Enter the **mean (average)** gender pay gap for bonus pay
31.43 %

Enter the **median** gender pay gap for bonus pay
0.00 %

Percentage who received bonus pay

Women
1.07 %

Men
10.12 %

Board of Directors' Meeting
7 March 2025

The Rotherham NHS Foundation Trust

Agenda item	P44/25
Report	**National, Integrated Care Board and Rotherham Place Update**
Executive Lead	Bob Kirton, 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: • Latest Place Plan Performance • Update on SY Pathways to Work • Rotherham Together Partnership Social Value Action Plan
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. Q3 Rotherham Plan Performance 2. Pathways to Work Update 3. Rotherham Together Partnership Social Value Action Plan

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 **Amanda Pritchard has today formally notified the NHS England Board of her decision to stand down as Chief Executive at the end of this financial year.**

Amanda has been Chief Executive since August 2021 and Chief Operating Officer since 2019, leading the NHS through the most challenging period in its 76-year history.

Having discussed this with the Secretary of State for Health and Social Care over recent months – now that the NHS has turned a corner on recovery from the pandemic and the foundations are in place to make the necessary changes to the centre to best support the wider NHS – Amanda has decided now is the right time to stand down.

Sir James Mackey will be taking over as transition Chief Executive Officer of NHS England, working closely with Amanda for the next month before taking up post formally on the 1st April 2025.

2.2 Data published by the NHS shows that 961 patients a day were in hospital with norovirus in the first week of February, up 7% on the week before and 69% higher than the same period last year (570 for the week ending 4 February 2024). There was an average of 98,101 patients in hospital each day for the week – higher than at any point so far this winter. Around 96% of adult hospital beds were occupied, also a record for this winter. Almost 1 in 7 beds (13,776) were taken up by patients who did not need to be in hospital and were well enough to be discharged – a record high for this winter.

Flu rates have dropped since last month's peak, but more than 2,462 patients were still hospitalised with the illness on average each day last week, including 122 in critical care. Other winter viruses are also continuing to circulate with almost 1,000 patients on average (952) in hospital with COVID-19 every day last week, a slight decrease on the previous 7 days (995); while 18 children on average were in hospital with RSV each day – a decrease from the previous week (28).

The data comes as new analysis set to be presented at NHS England's board meeting this afternoon shows NHS acute productivity has grown by 2.4% in the first 7 months of this financial year. NHS staff have delivered a 6.3% increase in acute activity this financial year, while spending adjusted for growth increased by just 3.9%. This has been driven by a range of improvements, including hospitals delivering more same day surgeries, and the slashing of agency staff costs by £500 million to its lowest ever level. NHS services have also managed to make a further £5.7 billion of savings this year through reduced staffing costs.

3.0 South Yorkshire Integrated Care Board (SYICB)

3.1 South Yorkshire and Bassetlaw ICB's draft commissioning intentions have been shared for feedback and the Trust have responded. This work will progress aligned to the planning process.

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 At the latest Board Strategic Workshop a presentation was given on place covering: what does place mean to people, Joint Strategic Needs Assessment headlines, current place plan and governance structure, and finally what are the risks and opportunities for TRFT within the place perspective. In the discussion around this subject it was agreed a report would follow to Board in May including the latest plans, their intended impact and recommendations on how TRFT can continue to play a partnership and leadership role at place in improving the lives of the population.

4.2 The Place Board has received a quarterly performance report to show delivery against the Rotherham Place Plan since 2018. The report covers both metrics, milestones and timescales against priorities for each of the transformation work streams. An action for the year 2 report was to address the number of milestones and metrics with either no baseline, no data captured or still to be confirmed. The update has addressed that issue and there are now significantly less metrics still to be confirmed, those missing are due to reporting timescales impacting on the availability of data. There are no milestones to be confirmed. *The full report is attached as Appendix 1.*

- Milestones: The quarter 3 position represents performance towards the end of the 2nd year of delivering on the 2023-25 Plan. The position in Q3 is 66% of milestones either complete or on track, which is a 16% deterioration compared to Q2 in terms of milestones slightly off track.
- Metrics: The quarter 3 position represents performance towards the end of the 2nd year of delivering on the 2023-25 Plan, this shows 62% of metrics are on track, slightly above the Q2 position of 55%.

4.3 The latest Health and Wellbeing Board was held on 22nd January at the Town Hall. Key highlights included: an update on the carers strategy, the foetal alcohol spectrum disorder project and the latest housing strategy. Following the public meeting there was a workshop to develop a new Health and Wellbeing Strategy with the final version expected in April 2025.

4.4 At the February Place Board an update was given on pathways to work. Pathways to Work will combine the new funding sources (the NHSE Growth Accelerator and DWP Trailblazer funding) with existing ones (such as WorkWell) to create a unified employment support system. The reforms will align strategies and operations, enhance personalised support, and work with employers to make sustainable workplace changes. The system will become more flexible and innovative through data integration and will introduce new interventions across health, skills, and employment sectors to prevent economic inactivity, especially for those at higher risk due to long-term sickness or health conditions. We anticipate that these changes will help 2,000 more people in South Yorkshire find jobs and prevent 950 people from becoming economically inactive next year. This effort aims to create a more inclusive and prosperous economy in South Yorkshire, serving as a model for other regions. *A set of slides are attached in Appendix 2.*

4.5 At the February Rotherham Together Partnership Partners were asked to sign up to the Social Value Action Plan. This Social Value Action Plan sets out a bold shared ambition to maximise Social Value outcomes for Rotherham. In simple terms, Social Value is the added social, economic and environmental value delivered as part of a contract.

The Rotherham Social Value Vision has been co-created by the Rotherham Together Partnership to bring to life this opportunity. The Vision sets out how coordinated action from partners to embed Social Value across the commercial lifecycle can unlock an additional £53,500,000 of added social, economic and environmental benefits for Rotherham each year through Social Value commitments from suppliers and providers.

To realise this potential, partners have come together to develop a joint set of implementation actions. The actions, set across three phases, will be crucial in translating the Vision into reality. *The plan is attached as Appendix 3.*

Bob Kirton
Managing Director
March 2025

Chief Executive Report

Integrated Care Board Meeting

8 January 2025

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

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

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

Are there any 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

8 January 2025

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 November and December 2024.

2. Integrated Care System Update

2.1 NHS Change and Darzi Independent Investigation

NHS South Yorkshire has submitted its response to the 10-Year Health Plan. This followed the release of the Darzi independent investigation, which was published in September. We are also working through our community networks to support people whose voice often goes unheard to have their say.

Our response reflects the four aims of the ICB and the bold ambitions of our integrated care strategy. Our emphasis is on children and young people and how to give them the best start in life; a focus on prevention, health inequalities and the wider determinants of health; the relationship between good jobs and good health, and our role as an anchor institution supporting the wider social and economic development of SY.

We also highlighted the issue of the importance of investment in primary and community health and social care. As part of this, we need to support the workforce capacity and capability in primary care to deliver multidisciplinary models and integrate neighbourhood teams. The response included the need for parity in mental health, emphasising the need to take a personalised approach encompassing mental health and wellbeing as well as physical health.

We raised how a change in the financial arrangements in the NHS could see a greater focus on prevention and the shift of care from secondary to primary and community settings, as well as the capital to help transform our physical estate and invest in longer-term solutions such as digital. Our full response is published in these Board papers.

2.2 Government’s white paper on English devolution.

The UK government's recent white paper on English devolution, titled "Power and Partnership: Foundations for Growth," outlines several key initiatives aimed at enhancing health and wellbeing across the country. The white paper introduces a bespoke duty focused on health improvement and reducing health inequalities which includes the mayoral Combined Authorities. This duty is designed to complement the existing health improvement responsibilities held by upper-tier local authorities. The government plans to collaborate with combined authorities, local councils, and the NHS to implement this approach.

A central goal of the white paper is to tackle regional disparities in health outcomes. By granting local authorities greater control over areas such as economic development, skills training, and transport infrastructure, the government seeks to address the underlying determinants of health and promote equitable health improvements across regions.

The government emphasizes the importance of collaboration between combined authorities and health institutions. Strategic authorities are encouraged to work closely with the NHS and public health bodies to ensure that devolved powers lead to tangible health benefits for local populations.

SY Yorkshire is identified as a leader in adopting this approach through our Integrated Partnership whose Board is chaired by the South Yorkshire mayor. We will continue to work with our four local authorities, SYMCA and wider partners to develop this way of working as the government's Bill is formed.

2.3 Economic inactivity investment

NHS South Yorkshire, together with SYMCA and local authorities are pioneering an approach to tackle economic inactivity. As part of the Government's Get Britain Working White Paper, South Yorkshire will receive up to £10m of funding for a trailblazer programme, focussed on improving the support available to people who are economically inactive due to ill health, helping them return to work.

As part of the trailblazer, the South Yorkshire Integrated Care System will also become an NHS England Health and Growth Accelerator area, receiving up to £8m. This will help develop evidence of the impact of targeted action on the top health conditions driving economic inactivity. SYMCA and the South Yorkshire ICS will work together to integrate the support to tackle economic inactivity.

These programmes will build on the recommendations of the Pathways to Work Commission, which was led by Barnsley Council in partnership with the South Yorkshire Mayoral Combined Authority. The report outlined the need for a proof-of-concept model that brings together work, health and skills support in a radical new approach to help people overcome barriers to employment. Pathways to Work Commission suggested that 10,000 South Yorkshire residents could get back into work over the next four years.

2.3 Integrated Care Partnership Board

The Integrated Care Partnership met in Doncaster on 28 November 2024. This included a focus on work and health as part of the investment into economic inactivity. There is a close relationship between having a good job and being in good health so funding mentioned in the previous item will help towards our ambition of making SY the healthiest place to live.

The ICP heard about the work being done in the housing sector. Nick Atkin, CEO of South Yorkshire Housing Association, shared the work being done to try to keep people living in their own homes and reduce the need for temporary housing. This followed the recent SY Housing & Health Summit. The discussion included how housing has a big impact on the lives of children, and whilst it might not be as evident as adult homelessness, child homelessness is every bit as real. The ICP supported

the further work recommended following the Summit.

In addition, the Board discussed the VCSE Alliance plan and introducing opportunity to explore shared investment funds, and the Cancer Alliance progress on the South Yorkshire ‘Shows up Campaign’ and Cancer Strategy.

2.4 Financial Plan 2024/25

The NHS in South Yorkshire agreed a plan with NHS England for a deficit end of year position of £49m. This required the ICB to breakeven, the providers to have a deficit no greater than £49m and the delivery of a further £48m system savings target. The total efficiency requirement for the system is £258.5m, which is greater than delivered previously.

At the end of September, the system received £49m funding from NHSE to offset the provider’s deficit plans. Consequently, the system is now working towards a breakeven plan.

At the end of November, the system deficit was £47.3m which was a variance against plan of £35.1m. This was a small improvement on the previous month. Of this variance £16.2m relates to the ICB due to excess continuing healthcare and prescribing costs, £8m to provider Trusts reflecting increased demand for emergency care, and £10.9m due to under-delivery of the additional system savings requirement.

A System Efficiency Board has been established to improve performance against the plan and specifically to identify programmes of work to address the additional system efficiency target of £48m. This includes improving efficiency in elective and nonelective care, workforce, estates, and non-pay spend. The Acute Federation, MHLDA Alliance and our four place partnerships are engaged in this work, and we are also receiving additional support from NHSE and Deloitte.

2.4 Winter and Flu and Covid Vaccination Campaigns

Demand for urgent and emergency care services has started to increase and this saw performance reduce towards the end of 2024, although still above 70%. Throughout winter we’re encouraging our communities to stay well and be prepared, including promoting the Pharmacy First campaign, where pharmacists can now manage a further seven conditions ranging from Sinusitis to uncomplicated urinary tract infections.

In addition, we have now vaccinated 230,000 people for a Covid booster, which is 42% of those eligible, and 450,000 people for their flu vaccination, 50% of all those eligible. The highest uptake is amongst those in care homes and over 65s. As part of this we have also vaccinated more than 11,000 housebound patients, who although not part of the priority groups, can often be vulnerable. The vaccination programme continued ahead of the festive period. During that time we continued to do everything possible to ensure those that want to be vaccinated are able to.

2.5 General Practice Collective Action

The contractual dispute between the Government and the British Medical Association, representing GPs, continues. The BMA are asking GP partners to take at least one of nine possible actions, none of which breach the GP contract. We are continuing with regular dialogue with our Local Medical Committees and making appropriate mitigations wherever possible to support patients. 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, especially during the critical winter months when many in our community are vulnerable, during collective action. Patients with an appointment at a GP practice, should attend as usual unless told otherwise.

3. NHS South Yorkshire

3.1 Primary Care update

Across South Yorkshire the NHS has a contract with 170 General Practices, 152 Dentists, 151 Opticians and 309 Community Pharmacies, which comprise 90% of all healthcare appointments. A large majority still rate their experience as Good (76% General Practice, 87% Community Pharmacy, 75% Dentistry) and 87% of people feel they are treated with care and concern by professionals. However, 42% of people In SY still report difficulties in contacting their GP. To meet this challenge all of our practices now have cloud-based telephony systems in place.

The South Yorkshire Primary Care Alliance recently held a time out to firm up our plans for the next 12 months aligned to the priorities of access, workforce, digital and integrated neighbourhood teams. Our Community Pharmacies continue to be at the heart of transformation on our patch. They have delivered 77,000 minor ailment appointments since the launch of Pharmacy first.

3.2 Board changes

Wendy Lowder, Executive Director for Barnsley Place and the Director of Adult Social Services at Barnsley Council, retires in February 2025. Katy Calvin-Thomas has been appointment into this joint role. Katy has extensive experience and an impressive track record in health and social care leadership, bringing together priorities across health and social care. She has served as Chief Executive of the Manchester and Trafford Local Care Organisation since 2017, following her role as Director of Strategy.

Katy has overseen the development and delivery of one of the largest integrated community health and social care organisations. With a deep commitment to place-based, integrated services, Katy is known for her dedication to joint commissioning, empowering communities, and championing health and social care initiatives that drive positive outcomes.

4. NHS South Yorkshire Place Updates

4.1 Sheffield

Sheffield Children's NHS Foundation Trust has approved the full business case for the National Centre for Child Health Technology. This will be on the site of the Olympic Legacy Park and building will start this year using funds from various partners, including Sheffield City Council, SYMCA and The Children's Hospital Charity. It's

anticipated that the centre will open for the Children's Hospital's 150th anniversary. The final pledge of funding came from Sheffield City Council, which approved an £8.8m investment.

4.2 Doncaster

Doncaster and Bassetlaw Teaching Hospitals are investing in a Robotic Rehabilitation Suite, believed to be one of the first of its kind in the NHS, to support stroke recovery. The suite will aid those treated with mobility, limb functionality, and cognitive recovery. Among the devices is an advanced functional electrical stimulation tool that enhances hand motor recovery through high-tech electrodes linked to a tablet for precise and rapid therapy.

The suite will support Montagu Hospital towards providing rehabilitation services seven days a week, addressing growing demand. Over time, the enhanced service is expected to support patients from a wider area, establishing the hospital as a hub of excellence in South Yorkshire for stroke care.

4.3 Rotherham

Independent inspectors have praised Rotherham's services for children and young people with special educational needs and disabilities (SEND). Following a 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.

4.4 Barnsley

Barnsley Hospital NHS Foundation Trust has had recent significant success in recruiting newly-qualified nurses. Nearly 50 new nurses will also take up roles in medical and surgical wards, intensive care, outpatients, short stay unit, acute medical unit, endoscopy and respiratory care unit. The Trust's Workforce Development and Student Support Team has launched a new 'Prepare to Nurse' week. The nurses will undertake the 'Preceptorship' programme which helps new nurses to be supported during their first year in their new roles as Registered Nurses. The Trust has previously been recognised for its Preceptorship programme with the National Preceptorship Interim Quality Mark.

5. General Updates

5.1 South Yorkshire Innovation Showcase

More than 100 leaders and experts from across health, care, research and innovation came together for the South Yorkshire Innovation Showcase. More than 70 applications were received for the event and judges eventually selected 10 teams to speak to the audience, which included Oliver Coppard, Mayor of South Yorkshire. The five categories of initiatives aligning with the strategy bold ambitions:

- Focus on development in early years so that every child in South Yorkshire is school ready.
- Act differently together to strengthen & accelerate our focus on prevention and early identification.
- Work together to increase economic participation and support a fair, inclusive and sustainable economy.
- Collaborate to value & support our entire workforce across health, care, VCSE, carers, paid, unpaid. Developing a diverse workforce that reflects our communities.
- Open category for other cross-cutting themes.

A range of presenters have been nominated to speak at this year's NHS Expo in Manchester to share best practice. We will know when these have been accepted in Spring.

5.2 Anti-racist Assembly

A South Yorkshire Anti-Racist Assembly took place in November 2024 bringing together partners from across the region, particularly those working in EDI, organisation leaders, staff network leads and allies. Becoming an actively anti-anti-racist health and care system is one of our joint commitments through the Integrated Care Strategy.

All NHS organisations have all adopted the North West Race Equality Framework – as systematic programme of work for organisations. Speakers at the event included colleagues from Sheffield Health and Social Care and Rotherham, Doncaster and South Humber, who provided an update on their own progress in pursuing the standards set out in the framework. The discussion included the long-term cultural change that is needed, but that there are practical actions that organisations can take now. As the largest employer in South Yorkshire the NHS has a responsibility to set the standard in anti-racist employment practices for others to follow.

5.3 Baton of Hope

NHS South Yorkshire has signed up to the Baton of Hope Workplace Pledge. This pledge is designed to eradicate the stigma around mental health in the workplace and increasing awareness of suicide. In the UK there are 6,000 deaths by suicide annually and acute mental health conditions account for over 55% of all lost working days annually in the UK. By supporting the pledge NHS South Yorkshire is committed to open conversations to increase awareness, improve and do our best to save lives and make support and prevention in the workplace a priority.

5.4 Awards

NHS South Yorkshire ICB 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 at the HSJ Awards.

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.

For older people living in care homes, staying hydrated can help reduce UTIs which can sometimes lead to more serious complications requiring unnecessary antibiotics or an avoidable hospital admission. 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 1,000 care home staff received face-to-face training as part of the project which is now expanding across South Yorkshire.

In addition, the Local Maternity & Neonatal System team were nominated for the HSJ Workforce Initiative of the Year for the Centralised recruitment for newly qualified midwives.

The NHS South Yorkshire Star Awards recent winners were:

- Kate Woods, Project Implementation Officer from SYB Cancer Alliance, won the Star Award in November 2024. Kate has led work around the Cancer Alliance's 'Psychosocial Support' priorities that has been inclusive and helped the Alliance to underpin onward improvement actions.
- Sam Humphries, Secondary Care Project Lead in the Medicines Optimisation Team, won the Star Award in December 2024. Sam was nominated for his outstanding work on the DAISY (Delivering Asthma Improvement in South Yorkshire) project, which will see thousands of asthma patients across South Yorkshire having their asthma care optimised, improving asthma outcomes and reducing asthma deaths.

Gavin Boyle
Chief Executive NHS South Yorkshire Integrated Care Board
Date: 8 January 2025

Rotherham Public Place Board – 19 February 2025

2023-25 Health and Care Place Plan Performance Report

Q3 2024/25

Lead Executive:	Claire Smith, Deputy Place Director – NHS South Yorkshire ICB (Rotherham)
Lead Officer:	Lydia George, Strategy & Delivery Lead – NHS South Yorkshire ICB (Rotherham)

Purpose:

To provide members with a performance report for the 2023-25 Health and Care Place Plan as at quarter 3 2024/25 (end December) reporting period.

Background:

The Place Board has received a quarterly performance report to show delivery against the Rotherham Place Plan since 2018. The report covers both metrics, milestones and timescales against priorities for each of the transformation workstreams.

The impact of the covid pandemic on metrics meant that it was either not possible or that the reporting was very skewed as performance had been severely impacted, therefore the reporting of metrics was stalled over that period.

The 4th Rotherham Health and Care Place Plan was agreed in July 2023. The attached Performance Report was produced to provide an overview of delivery against the plan and represents the position as at end Q3, end December 2024.

Analysis of key issues and of risks

The Q4 2023/24 report received at Place Board in July 2024 has been subject to review by lead officers. The review particularly looked at milestones, metrics and timescales to ensure they were fit for purpose. Milestones complete as at Q4 2023/24 report have been removed.

Officers also reviewed priorities to ensure they remained relevant, following this the priorities within the Urgent and Community workstream have been updated; partly as a result of year one delivery and also to bring them in line with the High Impact Priorities identified as a key focus this year.

An action for the year 2 report was to address the number of milestones and metrics with either no baseline, no data captured or still to be confirmed. The update has addressed that issue and there are now significantly less metrics still to be confirmed, those missing are due to reporting timescales impacting on the availability of data. There are no milestones to be confirmed.

Milestones: The quarter 3 position represents performance towards the end of the 2nd year of delivering on the 2023-25 Plan. The position in Q3 is 66% of milestones either complete or on track, which is a 16% deterioration compared to Q2 in terms of milestones slightly off track.

Metrics: The quarter 3 position represents performance towards the end of the 2nd year of delivering on the 2023-25 Plan, this shows 62% of metrics are on track, slightly above the Q2 position of 55%.

Further analysis can be seen at the beginning of the report. The report will be received quarterly.

Approval history:

Rotherham Place Leadership Team – 19 February 2025

Recommendations:

Members are asked to receive and comment on the Place Plan Performance Report, noting the report provides a position as at Q3, end December 2025.

Place Plan Performance Report for the period 2024-2025

Rotherham Place Partnership Public Board: 19 February 2025

Reporting Period: Quarter 3, end December 2024

Key for Milestones

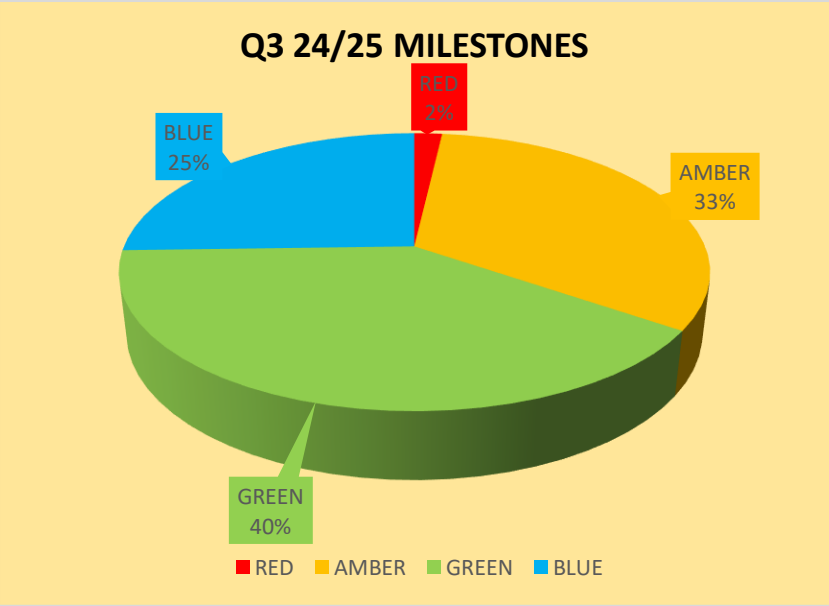
Red	Milestone significantly off target
Amber	Milestone slightly off target
Green	Milestone on target
Blue	Milestone complete
Grey	Milestone not due/ not commenced

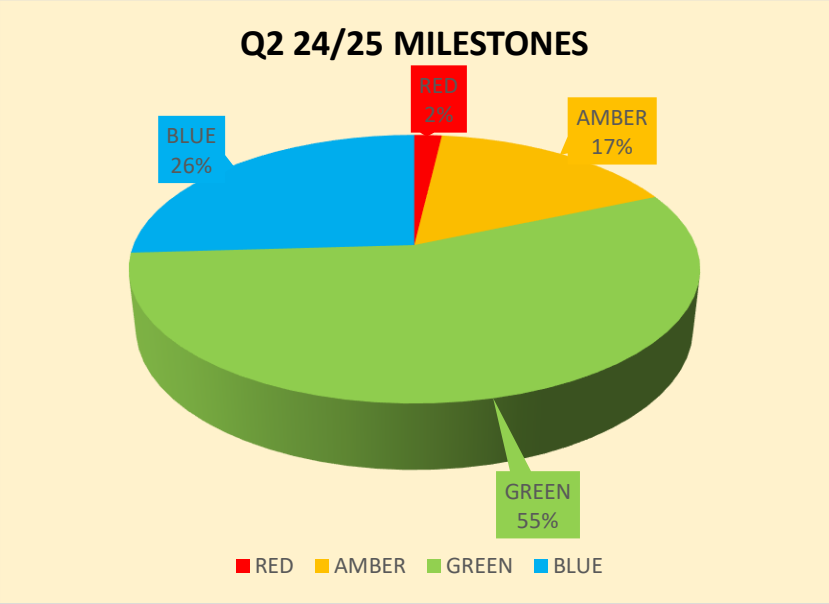
Key for Metrics

Red	Metric significantly off target
Amber	Metric slightly off target
Green	Metric on target
Grey	Metric to be confirmed/established

Contents

1 Overall Position for Milestones





All priorities and milestones have been reviewed for the 2024/25. The priorities in Urgent and Emergency have been updated, partly as a result of positive delivery in 2023/24 and also to align to the chosen high impact priorities that have been identified in year.

Milestones that were complete as at Q4 2023/24 have been removed. Some new milestones have been added and existing milestones rolled over. In reviewing the milestones some of the timescales have been amended to reflect the current position.

In the revised report for 2024/25 there are 55 milestones used to form part of the Performance Report. These are key milestones that have been identified that enable members to gain an understanding of overall progress in delivery of the Place Plan. As at Q3, of the 55 milestones, there are:

RAG	Q2 Position		Q3 Position		Definition
	Number	%	Number	%	
TBC	0	0%	0	0%	Milestone not due/ not commenced
RED	1	2%	1	2%	Milestone significantly off target
AMBER	9	16%	18	32%	Milestone slightly off target
GREEN	30	55%	22	39%	Milestone on target
BLUE	14	27%	14	27%	Milestone complete

Overall the number of milestones complete is the same as Q2, but there has been a 16% shift from milestones on track to milestones slightly off track. The milestones that have deteriorated from **Green** to **Amber** are:

CYP 5	Re-develop, implement, and embed a tiered sleep pathway
CYP 9	Implement and embed preparation for adulthood guidance
MH 4	Finalise outcomes and performance metrics for the Rotherham CMHT
MH 15	Dementia Partnership Plan to be developed and approved
UEC 2	Community frailty model - review and streamline the current frailty and falls offer
UEC 4	Develop an integrated MDT offer to support acute frailty
UEC 9	Agree and implement escalation process for place and out of area
UEC 13	Develop and embed the TOCH D2A model

There is one **Red** milestone which was also red in Q1 and Q2:

CYP MS 7: Actively engage in recruitment activity to increase the number of foster carers:
Actions: The Fostering Action Plan continues to progress to support the recruitment of more foster carers and retain existing foster carers.

Summary of Performance against milestones

Workstream	Priority Area	No. of Milestones	Red	Amber	Green	Blue	TBC/Not started
Best start in Life - Maternity, Children & Young People	Best Start for Life	3	0	1	0	2	0
	Children and young people's mental health and emotional wellbeing	2	0	2	0	0	0
	Looked After Children	3	1	2	0	0	0
	Children and Young People with Special Educational Needs and/ or Disabilities	0	0	0	0	0	0
	Preparation for Adulthood	2	0	1	1	0	0
		10	1	6	1	2	0
Enjoying the best possible mental health and wellbeing	Delivery of the Adult Severe Mental Illness in Community Health Transformation Plan	6	0	1	2	3	0
	Delivery of the Mental Health Crisis & Liaison	6	0	0	1	5	0
	Suicide Prevention Programme	2	0	0	2	0	0
	Dementia pathway transformation	3	0	1	1	1	0
	Delivery of the Better Mental Health for all Plan, also includes the loneliness delivery plan	2	0	0	2	0	0
		19	0	2	8	9	0
Supporting People with Learning Disability and Autism	Increase the uptake of enhanced health checks for people with a learning disability aged 14 upwards	2	0	1	1	0	0
	Support development of SY Pathways to reduce the need for inappropriate admissions into mental health services	1	0	0	1	0	0
	Ensure people with a learning disability and autistic people have better access to employment opportunities	1	0	0	1	0	0
	To further develop accommodation with support options	1	0	0	1	0	0
	Refresh the Vision and Strategy for people with a learning disability through coproduction and codesign	1	0	0	1	0	0
	Develop a new service model for day opportunities for people with high support needs	0	0	0	0	0	0
		6	0	1	5	0	0
Urgent, Emergency and Community Care	Frailty	4	0	2	1	1	0
	Ambulatory Care	3	0	2	0	1	0
	Integrated Discharge to Assess	5	0	2	3	0	0
	Cross cutting workstreams	3	0	2	0	1	0
		15	0	8	4	3	0
Palliative and End of Life Care	• Enhance personalised palliative and end of life care • Implementation of ReSPECT across Rotherham • Benchmark against the Ambitions Framework • Inform future commissioning through patient and Carer experience	5	0	1	4	0	0
		5	0	1	4	0	0
Overall Totals		55	1	18	22	14	0

2 Overall position for KPIs for Q4

The position for the 46 KPIs is very similar to that in Q2:

RAG	Q2 Position		Q3 Position		Definition
	Number	%	Number	%	
TBC	7	15%	7	15%	Metric not due/ not commenced
RED	2	4%	2	4%	Metric significantly off target
AMBER	12	26%	9	19%	Metric slightly off target
GREEN	22	48%	25	55%	Metric on target
BLUE	3	7%	3	7%	*NOTE, target was for 23/24 and was achieved

Red Metrics: there are two **red** metrics in Q1, Q2 and Q3:

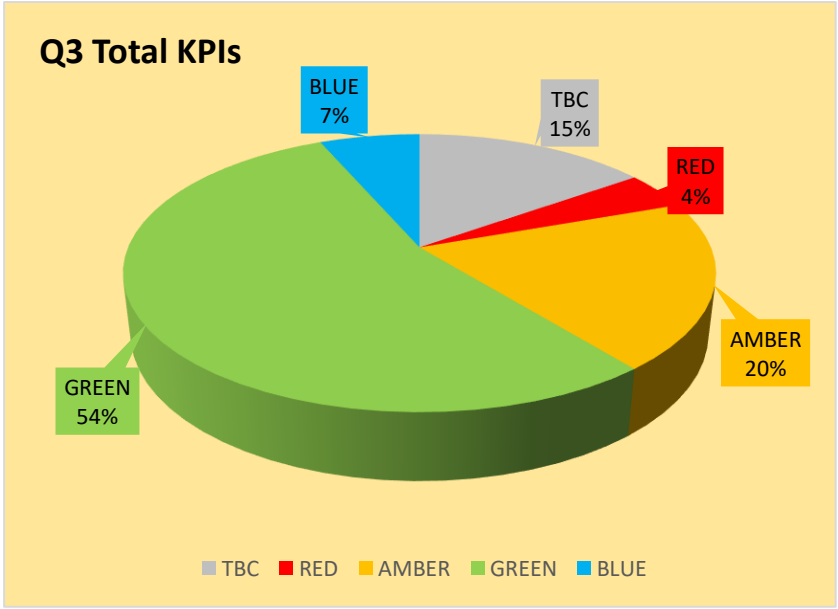
- **CYP KPI 7*: Increase the % of Children in Care living in a family-based setting*** – 74% as at end December 2024 against a target of 85%, This remains a key area of focus for the service and will throughout 2024-2025.
- **CYP KPI 9: Increase the number of CYP in a Rotherham fostering placement by March 2025 (to reach 151 by year end)** - Continue to progress the Fostering Action Plan to support the recruitment of more foster carers and to retain existing foster carers

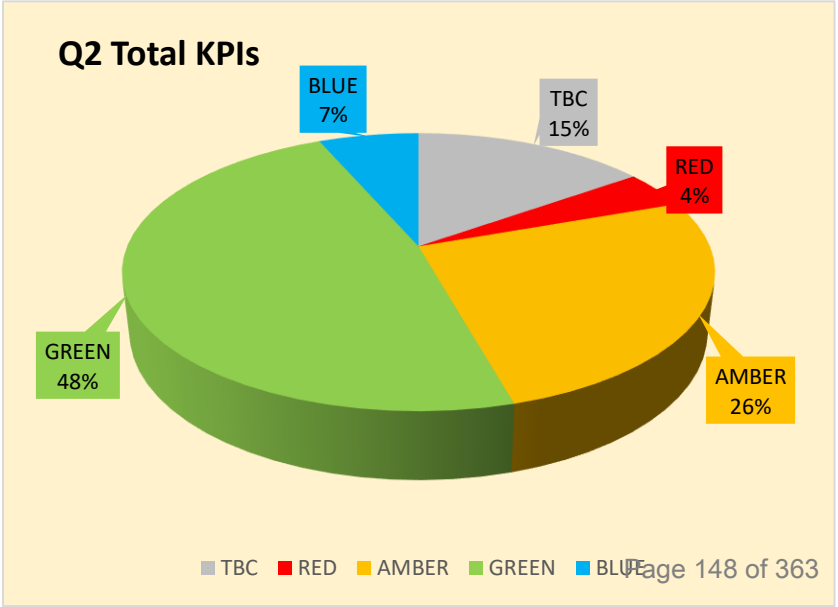
There has been **deterioration** in the following 2 metrics from **Green** to **Amber**:

MH 5	Increase in number of mental health ARRS workers in Primary Care
UEC 4	Improve ambulance response times

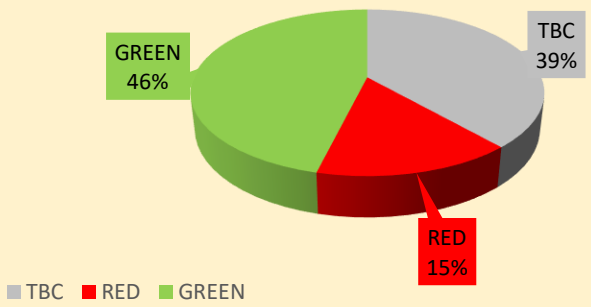
There has been an **improvement** in the following 5 metrics **Amber** to **Green**:

CYP 1	% of children aged 0-5 living in the 30% most deprived SOA's in Rotherham who are registered with a Children's Centre
CYP 5	Increase the number of early help assessments completed by partners
LD 2	75% of people with a learning disability in Rotherham will have access to GP enhanced health check
LD 3	Reduction in the numbers of people needing to be detained in mental health services
UEC 9	Reduction in long lengths of stay in Acute bed base 21 days % of acute bed occupancy for NCTR by LOS

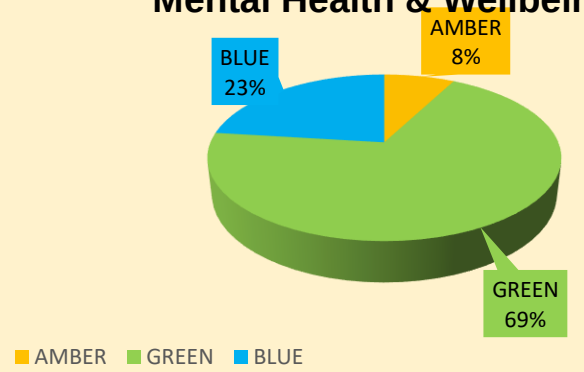




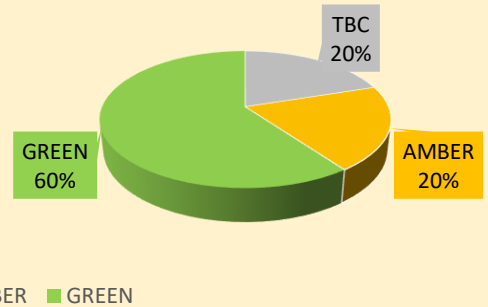
Children and Young People



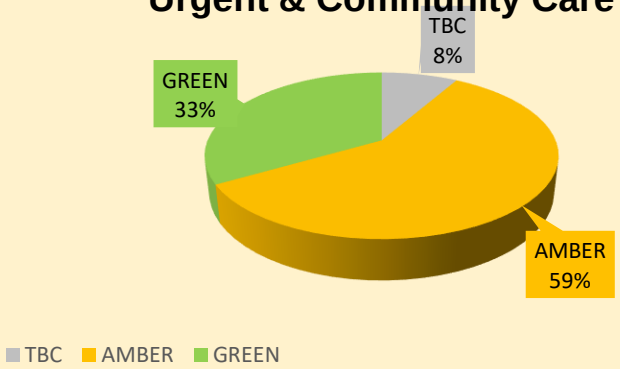
Mental Health & Wellbeing



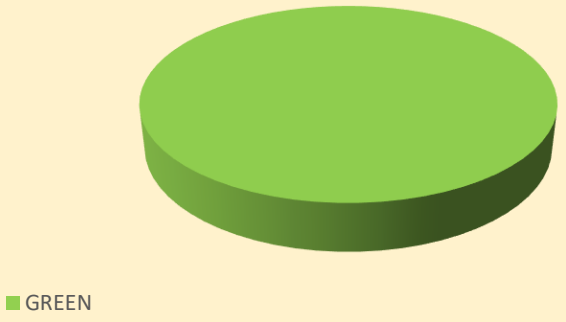
Supporting People with Learning Disabilities and/or Autism



Urgent & Community Care



Palliative & End of Life Care



3 Transformation Workstream: Best start in Life - Maternity, Children & Young People

Priority 1: Best Start for Life	Lead Officer: Helen Sweaton

Milestone		Target for Delivery	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Key actions from the last period / identify achievements	Any risk, including mitigation
CYP MS 1	Develop and implement the "Start for Life Pack" for all families taking a proportionate universalism approach to targeted engagement.	Q2 2024/25						Q2: The hard copy of the Family Hubs guide has been produced and is now being provided in 'The personal child health record' (red book). There has been a targeted launch event celebrating this with the Parent Carer Panel.	
CYP MS 2	Embed the Breastfeeding friendly Borough Declaration through the delivery of Breastfeeding Friendly initiatives.	Q4 2023/24	16 breastfeeding peer support workers trained	20	30			Q2: The training courses in September took place with a further 10 peer support workers trained. Children's centres are working towards stage 1 of BFI accreditation and are hoping to have this by the end of Q4 24/25.	
CYP MS 3	Review the Child Development Centre to ensure children in Rotherham will have timely access to an assessment and intervention when developmental needs are identified.	Q3 24/25						Q2 - A task and finish group is now working on an improved cross agency graduated response for pre-school children with SEND and their families. A cross agency CPD offer for practitioners is also being developed to support this. Work on waiting time trajectories at the CDC has been completed and discussions about the additional resource required to clear the backlog at the CDC, and ensure future sustainability, will need to be undertaken. Q3: Work on the CPD offer and graduated response is progressing well. Agreed children are in the process of transferring to RDASH for assessment. A new, streamlined neurodevelopmental assessment pathway is being introduced at the CDC. A recovery plan to address the CDC backlog has been developed and non-recurrent funding has been agreed to support this.	Children are waiting for assessment. Additional non-recurrent funding identified to create capacity to meet pandemic related (and the notable year on year increased) demand on service. The transfer of older children from the CDC to the CAMHS assessment waiting list has still not happened. This is because CAMHS are waiting to sign a contract with Healios to support with screening of the transferred cases. There is no planned transfer date currently, pending the contract being signed.

Priority 2: Children and young people's mental health and emotional wellbeing	Lead Officer: Helen Sweaton

Milestone		Target for Delivery	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Key actions from the last period / identify achievements	Any risk, including mitigation
CYP MS 4	Children in Rotherham will have timely access to an assessment and intervention for neurodevelopment disorders when a need has been identified. (Transforming health care)	Q2 2024/25						Q2 – The streamlined assessment process has now been embedded including a standardised report template which has reduced the time spent on report writing and more concise for families to read. Q2 has seen the longest waits continued to reduce and more completed assessments month on month. Q3 – Longest waits have continued to reduce with higher number of completed assessments and discharges, currently meeting the trajectory.	Children are waiting for assessment. The trajectory does not reflect increased demand previously. RDaSH are revising the trajectory and awaiting sign off by the CEO. Q3 The trajectory has been reviewed to reflect increased demand and awaiting sign off by RDaSH CEO.
CYP MS 5	Re-develop, implement, and embed a tiered sleep pathway.	Q3 2024/25						Q1 - The ICB has identified £45k funding and is working with TRFT to mobilise the service with an expected launch date in Q3. Q2 - The Q1 update still stands as TRFT is still working with the ICB to mobilise the service with an expected launch date in Q3. Q3 - TRFT is still working with the ICB to mobilise the service with an expected launch date now in Q4.	Gap analysis has identified a lack of capacity to deliver targeted interventions. An invest to save business case is being prepared. Q1 - It should be noted that there is currently a shortfall of £23k in the budget. ICB is aware of the shortfall and will review it in month 6 of service delivery.

Priority 3: Looked After Children	Lead Officer: Helen Sweaton

Milestone		Target for Delivery	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Key actions from the last period / identify achievements	Any risk, including mitigation
CYP MS 6	Re-development and implementation of our therapeutic offer to looked after children, in-house foster carers/ residential care providers.	Q2 2024/25						Consultation with the Support for Change staff team ended 17/01/25. The review and restructure implementation is underway, with a projected completion and transition date of 28th April. The proposals are linked directly to the therapeutic offer of intervention and support for children who are being supported to return home to family, or where there are concerns around placement stability. The proposals include a reduction in the length of intervention to ensure that the service can	Delayed due to requirement to end contracted agreement with Sheffield Health and Social Care and establish new arrangements with Rotherham CAMHs to inform the development of the new offer inclusive of CAMHs delivery. Rotherham CAMHs now engaged ensuring children in care and carers access appropriate support.

								capture a wider audience and reduce drift and delay. CAMHS are as yet to be consulted with regarding the changes, and this will be undertaken once the formal and final restructure has been confirmed with RMBC staff due to posts being at risk within the service.	Some challenge in CAMHS not accepting referrals due to RMBC having an in-house therapeutic team. Clinical Psychologist will continue to liaise with CAMHS, as employed by RDASH, attend meetings and provide an interim between the services. An escalation process alongside CAMHS to be completed.
CYP MS 7	Actively engage in recruitment activity to increase the number of foster carers.	25 new foster families during 2024/25	17	2	2 (4 ytd)	3 (7 ytd)		Two foster families were recruited in both Q1 and Q2, with a further three in Q3, equating to seven in total during the 2024/25 financial year to date. There were ten prospective foster families active in the recruitment process at the end of December 2024.	We continue to progress the Fostering Action Plan to support the recruitment of more foster carers and retain existing foster carers. We regularly review and strengthen the BrightSparks and Place Based marketing and recruitment campaign at the Fostering Operational and Strategic Board. The recruitment and retention strategy has been updated by the Communications Team and the Marketing Manager.

Priority 4:	**Children and Young People with Special Educational Needs and/ or Disabilities**	**Lead Officer: Helen Sweaton**

All milestones were complete this remains a priority and will be assured via the metrics

Priority 5: Preparation for Adulthood	Lead Officer: Helen Sweaton

Milestone		Target for Delivery	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Key actions from the last period / identify achievements	Any risk, including mitigation
CYP MS 8	Work to provide a 'health passport' to support transition from paediatric to adult services.	Q4 2024/25						Q2 – Rotherham Health Record has been developed to provide summary information to GPs. Further development of the summary information agreed to include key flagged indicators from system one (in addition to those already included from meditech). Engagement with GPs planned to promote the use of Rotherham health record. Engagement with parent carers and young people to be planned to raise awareness of summary information available on Rotherham health record. Work underway to consider whether summary pdf document can be provided to young people and parent/ carers. A range of health passports (to suit individual need) are now being promoted. There is a section on health passports in the draft transition to adulthood guide. Further work is needed to raise awareness with practitioners and young people to further spread use. Q3 – Development work underway. Engagement activity planned once protocol developed.	
CYP MS 9	Implement and embed preparation for adulthood guidance, including involving families in transition planning.	Q3 2024/25						Q1 - First draft of the Transitions/ Preparation for Adulthood guidance was shared at the PfA strategic Board on 17th June 24. Further work is planned based on feedback from the multi-agency group and parent/ carers, young people and young adults. Q2 - Further workshop held 4th October 2024 to agree final content and structure. Q3 – Successful Futures Fair held at New York Stadium to share preparation for adulthood guidance with young people and families. Publication of parent guidance delayed, final draft being developed with comms.	

Metric		2024/25 target	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Comments if off track	Any risk, including mitigation
CYP KPI 1	% of children aged 0-5 living in the 30% most deprived SOA's in Rotherham who are registered with a Children's Centre (within the Family Hub.)	95%	94.5%	92.0%	93.4%	96.0%		N.B. this data currently relates to children's centres (0-5) and not the wider Family Hub. Work is ongoing to develop reporting as part of the Family Hub programme. Q3 – performance is now above target with an increase from 93.4% at end of September 2024, to 96.0% at end of December 2024.	There is a risk that this target won't be achieved. The continued development of Family Hubs will help with registration rates moving forwards as well as the universal roll-out of baby packs over the next 2 years.
CYP KPI 2	% of children aged 0-5 living in the 30% most deprived SOA's in Rotherham who have accessed Children's Centre (within the Family Hub) activities.	65%	80.6%	48.6%	68.7%	75.1%		NB this data currently relates to children's centres (0-5) and not the wider Family Hub. Work is ongoing to develop reporting as part of the Family Hub programme. Q3 – performance well above target at 75.1%.	The target of 65% is for the full year (Apr-24 to Mar-25), therefore the percentage gradually increases throughout the quarters.
CYP KPI 3	Increase breastfeeding continuation status at 6-8 weeks.	62%	78%	78%	78%	Not currently available		Q3 update: Data for Q2 24/25 show 78% for breastfeeding continuation. Q1 has been updated to 78% following validation. Q3 position is expected February 2025.	
CYP KPI 4	Increase the proportion of births that receive a face-to-face New Birth Visit within 14 days by a Health Visitor.	89% by 2024/25 (by Mar-25)	84%	83%	85%	Not currently available		Q3 update: Data for Q2 show that 85% of births received a face-to-face New Birth Visit within 14 days by a Health Visitor (Adjusted data - long stay hospital patients removed). Q3 position is expected February 2025.	
CYP KPI 5	Increase the number of early help assessments completed by partners.	Last year outturn (23/24) was 27.5%	27.5%	37.9%	27.2%	29.2%		The ambition is to increase Early help assessments completed by partners. Q3 – outturn confirmed an increase on the previous quarter and last year's outturn of 27.5%.	
CYP KPI 6	Percentage of eligible children accessing their 2-2.5yr health visitor checks.	84% contractual target (93% RMBC Council Plan target)	88%	92%	92%	Not currently available		Q3 update: Data for Q2 24/25 shows 92% of children received a 2-2.5 year review. Please note that the RMBC Council Plan has an ambition to overperform on the contractual 84% due to the importance of checks for child development, achieving school readiness and reducing inequalities. Q3 position is expected February.	
CYP KPI 7	Increase the % of Children in Care living in a family-based setting to 85% by March 2025 (CYPS scorecard measure).	8 5% by March 2025	75.3%	73.6%	74.0%	74.0%		Q3 – Q1 data has been updated from 74.6% to 73.6% and Q2 data has been updated from 75.0% to 74.0% following validation.	This remains a key area of focus for the service and will throughout 2024-2025.

Metric		2024/25 target	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Comments if off track	Any risk, including mitigation
CYP KPI 8	Ensure the number of Children in Care (rate per 10k population 0-17) remains better than or in line with statistical neighbours (sn).	In line or better than stat neighbour average	88.4	88.0	87.3	86.6		Q3 – target remains well above statistical neighbour average, which is currently 100.9. Q2 data has been updated from 87.1% to 87.3% following validation.	
CYP KPI 9	Increase the number of CYP in a Rotherham fostering placement by March 2025. (to surpass the net gain of 23 new placements in 2023/24)	Increase **by 6 per quarter** to reach a total of 151 by year end.	127	118	112	113		There were 113 children in care (CiC) placed in an in-house foster placement at the end of Q3.	We continue to progress the Fostering Action Plan to support the recruitment of more foster carers and to retain existing foster carers.
CYP KPI 10	Increase the number of overall visitors to the Local Offer website.	Launched in May 2023. Baseline to be set during 23/24. Target increase to be agreed for 24/25	Baseline being established Q1 May-June only – TBC Q2 - 5643 Q4 5300	5100	5500	7215		Number of overall visitors have increased over the quarter. This probably reflects the increase in interest in the Local Offer following the Ofsted SEND inspection. Numbers increased significantly in September and have largely been maintained.	Increase in spam/bot activity on the website which may artificially inflate figures. Stand Out Media are investigating possible mitigation. Periods of time when the website is down. This happened over the Christmas period for up to 6 days in total. Reasons for this have been investigated and a plan is place to avoid a repeat.
CYP KPI 11	Number of requests for corrections (contacts/broken links etc) resolved within a 4 week timescale from the date the request was received.	100%	100%	~~17~~ ***100%**	~~100%~~ ***91%**	100%		100% has been restored now that the team is back to full strength *Figures for the previous quarters have been corrected. The number of requests resolved within the timescale fell slightly in Q2 during a period of staff absences after 2 out of 22 requests were not resolved within 4 weeks. The issues were resolved in November when staff were available.	
CYP KPI 12	Increase % of young people aged 14 or over with learning disabilities offered enhanced GP Annual Health Checks (this info runs over a Financial Year - April to March and is cumulative over this time).	In line with national – 68% March 24	69.7%	14.1%	26.3%	Not currently available		This is a cumulative measure per financial year, so the % is always going to be lower in Q1, increasing throughout the year to Q4.	

Metric		2024/25 target	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Comments if off track	Any risk, including mitigation
CYP KPI 13	Increase % of Adults Transitions cases aged 17 and a half and over, who were referred to transitions prior to turning 18, who have a Care Act Assessment in place.	70%	69.9%	76.4%	78.2%	Not currently available			

To note, no routine data for CYP Neuro waits/completed assessments. There is a possibility that reporting is moving to automated, but this has been paused until September for this pathway, the list of draft metrics they will be reporting against are:

- Number of children referred to the Mental Health Pathway
- Number discharged from service Mental Health Pathway
- Number of children referred for the Neuro-Developmental pathway
- Number of Neuro-Developmental assessments Completed
- Number of CYP seen for assessment within 4 Weeks
- Number of CYP discharged from the Neuro-Developmental pathway

New PfA metrics are currently being looked at by Adult Services – this is due for discussion at their PfA Board on 17/10/24. See metrics CYP KPI 12 and CYP KPI 13.

4 Transformation Workstream: Enjoying the best possible mental health and wellbeing

Priority 1: Delivery of the Adult Severe Mental Illness (SMI) in Community Health Transformation Plan	Lead Officer: Kate Tufnell

Milestone		Target for Delivery	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Key actions from the last period / identify achievements	Any risk, including mitigation
MH MS 1	Implementation of Mental health ARRs roles in Primary Care in line with year 3 ambition	Q1 24/25						MH ARRS roles are integrated within the Primary Care - ARRS Mental Health Primary Care Pathway in place.	
MH MS 2	Primary care integrated Mental Health Hubs launched	Q1 24/25						Achieved in 23/24. Primary Care Mental Health Hubs went live 5 December 2023	
MH MS 3	Community Mental Health Transformation pathways in place (targeted work on Community rehab, complex needs/PD & eating disorders)	Q1 24/25						NHSE have established criteria for when services are deemed to be transformed. Rotherham MH services have now met these criteria. A number of milestones on the roadmap have been achieved and the roadmap may be closed down and a new programme plan devised in line with the MH Needs Assessment when available. Eating Disorders continues to be a risk. A Primary Care Education Session planned in Q4 regarding pathways and links between partners.	
MH MS 4	Finalisation of the outcomes and performance metrics for the Rotherham Community Mental Health transformation programme	Q3 24/25						Proposed metrics were considered by the CMHT Steering Group and the MH, LD & ND Transformation Group in September 2024. Feedback on the metrics was shared to RDASH in Sept.	Raised at MH & LDA Transformation Group January 25.
MH MS 5 **New**	Increase access to Adult Community Mental Health Services	Q4 24/25						See CMH Access metric below for positive performance. Over Q3 Rotherham provided assurance to NHS England on progress against the national Community Mental Health Transformation Roadmap (key milestones and deliverables).	
MH MS 6 **New**	Continue to monitor uptake of the SMI Annual Health checks	Q4 24/25						A conversation has commenced with partners to identify what else could be done to support/improve data quality and recording of SMI Annual Health Checks.	

Priority 2: Delivery of the Mental Health Crisis & Liaison programme	Lead Officer: Kate Tufnell

Milestone		Target for Delivery	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Key actions from the last period / identify achievements	Any risk, including mitigation
MH MS 7	Rotherham Crisis Care Concordat established	Q4 23/24						Having reviewed the Crisis Concordat, the key areas of the Concordat around Earlier Support, Alternative to Crisis, Better Integration and Prevention area being progressed at either Place or South Yorkshire level through a variety of workstreams. As such it is proposed that this action is closed. A Crisis MOU across Place Partners has been agreed which will support the principles of working collaboratively across the pathway.	
MH MS 8	Place Crisis pathway Health and Social Care delivery action plan agreed and considered at RMBC Cabinet	Q3 23/24						Achieved in 23/24.	
MH MS 9	Development of a Place Crisis Service specification	Q2 24/25						Achieved. A document to describe the roles and responsibilities of RDaSH and RMBC in relation to the Place Crisis Pathway has been agreed.	
MH MS 10	Expansion of the alternative to crisis offer	Q2 24/25						Achieved. Mental Health Matters is delivering Rotherham Safe Space four nights a week. Rotherham are Samaritans providing follow up calls for RDaSH adult services, Primary Care. The pathway has been expanded to enable the Rotherham Parent Carers Forum and Talking Therapies to be able to refer people.	
MH MS 11	Implementation of a new Health and Social Care Crisis Pathway	Q1 24/25						Achieved. The new pathway went live 1 April 2024	
MH MS 12 **New**	Embed the Rotherham Safe Space offer/service within wider system pathways.	Q3 24/25						The Service is continuing to develop links across Rotherham. Over Q3 the Service has become part of the Rotherham Humanitarian and Community Group and joined the Advice in Rotherham (AIR) partnership. In addition, the Service has presented to the citizens Advice Bureau and were given permission to have a stall at a Rotherham United Football match in November 2024.	

Priority 3: Suicide-prevention programme	Lead Officer: Ruth Fletcher-Brown

Milestone		Target for Delivery	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Key actions from the last period / identify achievements	Any risk, including mitigation
MH MS 13	Procurement for Attempted Suicide Pilot	Q4 2024/25						New provider appointed. In the mobilisation phase with service due to launch on the 1 April	
MH MS 14	Refresh of the suicide prevention and self-harm action plan in line with the National strategy	Q4 2024/2025						• Held symposium on 2 December to shape the refreshed suicide action Plan • A draft is currently in progress with feedback from partners and local data	

Priority 4: Dementia pathway transformation	Lead Officer: Kate Tufnell

Milestone		Target for Delivery	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Key actions from the last period / identify achievements	Any risk, including mitigation
MH MS 15	Dementia Partnership Plan to be developed and approved	~~Q3 2024/25~~ Revised date for delivery Q3 2025/26						A Dementia Conference was held in October 24 (Q3) organised by Crossroads Care Rotherham and the Alzheimer's Society. The conference provided an opportunity to further develop partnership working and improve system understanding of current provision.	The Dementia Partnership continues to be at the development stage and is not yet sufficiently mature to identify and agree the key priorities and actions for a Dementia Partnership plan. In light of this the timescale for delivery of the Dementia Plan/Strategy has been revised.
MH MS 16 **New**	Review Admiral Nurse Service to understand effectiveness, impact and options for future model	Q2 2024/25						Sheffield Hallam have undertaken a review of the Admiral Nurse Service and the findings of the evaluation were presented to the Clinical Director's in August 2024. The GP Federation have considered all findings and agreed next steps for the service.	Possible risk of impact from the end of the pilot, to understand the flow.
MH MS 17 **New**	Dementia system mapping, undertaken jointly with RMBC of commissioned services, non-commissioned, gaps in service and possible duplication	Q4 2024/25						The mapping work continues, and the same timescales apply to this area of work. The initial mapping work has been completed and service reviews will continue to be explored with partners including the Rotherham Dementia Network.	

Priority 5: Delivery of the Better Mental Health for all Plan, also includes the loneliness delivery plan	Lead Officer: Ruth Fletcher-Brown

Milestone		Target for Delivery	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Key actions from the last period / identify achievements	Any risk, including mitigation
MH MS 18	Delivery of Action plan in response to the Prevention Concordat	Q4 24/25						Delivery of Action Plan by Partners of the Better Mental Health for All Group. Last update July 2024. An update went to H&WBB in September. Progress is measured through the BMH for all group but majority of actions are on target	
MH MS 19	Delivery of the Rotherham Loneliness action plan	Q4 24/25						An update went to H&WBB in September. Progress is measured through the BMH for all group but majority of actions are on target	

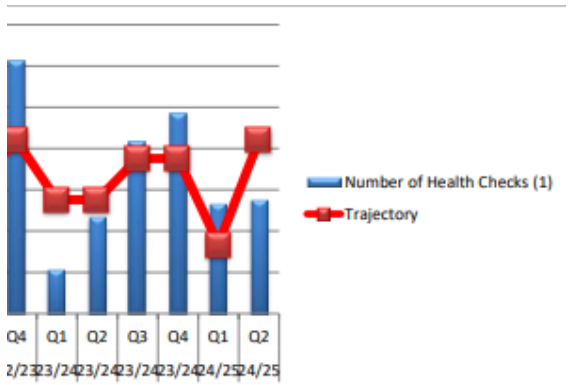
Metric		2024/25 Target	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Comments if off track	Any risk, including mitigation
MH KPI 1	Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services	Rotherham 2900 on a rolling 12-month basis *(NHS National Objective)*						This metric relates to 2023/24. See revised MH KPI 2 below.	
MH KPI 2 Revised Metric	Access to transformed Community Mental Health Services for adults and older adults with SMI	12 month rolling basis. Rotherham target 2470						Data for this metric comes from the National Mental Health Services Standard Data Set (MHSDS). The most recent national data available is for September 2024 (12 months rolling) 3240. RDaSH are reporting a position of 3379 for November 2024. December data not yet available.	
MH KPI 3	People on the GP SMI Registers receiving all six physical Health Checks (in the 12 months to period end) 75% of those living with SMI (LTP ambition/Core20PLU5)	Q4 2023/24 60%						This metric relates to 2023/24. See revised MH KPI 4 below.	

Metric		2024/25 Target	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Comments if off track	Any risk, including mitigation
MH KPI 4 Revised Metric	Reduce inequalities by working towards 75% of people SMI receiving a full annual physical health check with at least 60% receiving one by March 25	Q4 2024/25						For Q1 the actual was 69% For Q2 the actual was 70% For Q3 the actual was 72.5%	
MH KPI 5	Increase in number of mental health ARRS workers in Primary Care (expected 6 per year, a total of 18 in year 3 = is 3 per PCN).	A total of 18 MH ARRS by March 2024						There is a level of instability within the MH ARRS workforce with recruitment and retention challenges being experienced in some but not all PCNs. This has been raised at the CMHT Steering Group in Q3 as an issue that requires further discussion and a partnership response.	A meeting is due to take place in Q4 between partners to identify solutions.
MH KPI 6	Increase in the number of people accessing alternative to Crisis provisions	By end of Q4 200 people						Rotherham Safe Space – the Service transferred to a new provider (Mental Health matters) in Q1 following a procurement exercise. The new provider commenced a 4 night a week service in July 2024. At the end of Q2 49 people accessed the service. 194 support sessions were provided in total (face to face or telephone) At the end of Q3 87 people accessed the service. 242 support sessions were provided in total (face to face or telephone) Rotherham Samaritans mental health wellbeing pathway: Q1 - 71 referrals received. Q2 - 64 referrals Q3 - 63 referrals	
MH KPI 7	Increase in referrals to amparo	*Increase on 23/24 (2023/24 was 37)*						6 referrals in Q1 10 referrals in Q2 19 referrals in Q3. Note: These figures are Rotherham referrals into a South Yorkshire wide service.	

Metric		2024/25 Target	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Comments if off track	Any risk, including mitigation
MH KPI 8	Improve quality of life, effectiveness of treatment and care for people with Dementia by increasing the Dementia diagnosis rate to 66.7% by March 2025	Above 67% *(NHS National Objective)*						NHS England Data for November 24 shows that Rotherham has a Dementia Diagnosis rate of 89.7% https://digital.nhs.uk/data-and-information/publications/statistical/primary-care-dementia-data/november-2024	
MH KPI 9	**New** Improve the timeliness of Dementia diagnosis (Referral to Treatment Time).	Q4 2024/25						Contract reporting from RDaSH shows the Referral to treatment target of 18 weeks has been met consistently from April 24 to Nov 24. RDaSH Contract Performance reporting shows that most people waiting less than 8 weeks for treatment during October and November 24. Data not yet available for December 24.	.
MH KPI 10	Improved access to support for people with dementia and their Carers.	500 per year						This metric relates to 2023/24	
MH KPI 11	Reduction in dementia waiting list	92% seen within 12 weeks						The waiting list has reduced significantly following the transfer of patients to Primary Care for ongoing monitoring. Contract reporting from RDaSH as at November 2024 (latest available data) shows that 98% of people were seen within 12 weeks.	
MH KPI 12	The number of MECC sessions delivered in the quarter	4 sessions per quarter, 12 sessions in total.	*2 courses Feb and March*		4	1		Q3 (Loneliness)	
MH KPI 13	The number of people attending a MECC session in the quarter	Minimum of 120 staff and volunteers trained across Place in 24/25.	*17 sessions held*		60	14		Q3 (Loneliness)	

5 Transformation Workstream: Supporting People with Learning Disability and Autism

Priority 1: Increase the uptake of enhanced health checks for people with a learning disability aged 14 upwards	Lead Officer: Garry Parvin

Milestone		Target for Delivery	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Key actions from the last period / identify achievements	Any risk, including mitigation
LDN MS 1	Additional support will be offered to GP Practices to undertake enhanced health checks	Q4 24/25						276 health checks have been completed in Q2. This puts Rotherham above the planned trajectory – see below 	NHSE have indicated that are wishing to stretch the 75% target. Further guidance is awaited.
LDN MS 2	Focus on increasing the numbers of eligible young people to access GP enhanced health checks	Q4 24/25						Work is ongoing to support GP's to promote the uptake of enhanced health checks in the 14 -17 cohort of young people. Increase in uptake is being reported. SYICB discussions have occurred to increase uptake	NHSE have indicated that are wishing to stretch the 75% target. Further guidance is awaited.

Priority 2: Support of the development of South Yorkshire Pathways to reduce the need for inappropriate admissions into mental health services	Lead Officer: Garry Parvin

Milestone		Target for Delivery	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Key actions from the last period / identify achievements	Any risk, including mitigation
LDN MS 3	SY ICB to source a suitable provider who has the skills, knowledge and values who can provide this Service	Q2 24/25 (SYICB led)						Kelly Glover (SY ICB Lead) has stated that the tender has been awarded to Voyage. Voyage are in the process of finding a suitable property. Preferred option is located in Shefield	Questions

Priority 3: Ensure people with a learning disability and autistic people have better access to employment opportunities	Lead Officer: Garry Parvin

Milestone		Target for Delivery	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Key actions from the last period / identify achievements	Any risk, including mitigation
LDN MS 4	Monitor SEND Supported Internships action plan	Q4 2024/25						This plan has been approved. The Rotherham SEND Employment sub group are tracking the plan.	

Priority 4: To further develop accommodation with support options	Lead Officer: Garry Parvin

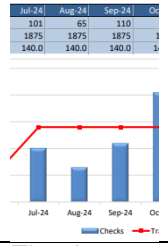
Milestone		Target for Delivery	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Key actions from the last period / identify achievements	Any risk, including mitigation
LDN MS 5	To expand the number of providers on the Rotherham FPS	Q3 24/25						The supported living FPS has increased to now include 12 providers	

Priority 5: Refresh the Vision and Strategy for people with a learning disability through coproduction and codesign	Lead Officer: Garry Parvin

Milestone		Target for Delivery	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Key actions from the last period / identify achievements	Any risk, including mitigation
LDN MS 6	Embed the Vision and Strategy for people with a learning disability and the Autism Strategy.	Q4 24/25						Coproduction has completed. Refreshed strategy presented to cabinet in February 2023 and approved Coproduction to develop an action plan is in train A yr 1 review is being completed	

Priority 6: Develop a new service model for day opportunities for people with high support needs	Lead Officer: Garry Parvin/Debbie Ramskill

Actions completed for this period, building due to be complete 2026

Metric		2024/25 Target	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Comments if off track	Any risk, including mitigation
LDN KPI 1	Rising numbers of young people aged 14-25 accessing enhanced Health checks.	60% Q4 24/25	66.7%					The position is comparable with previous years; Rotherham GPs complete most health checks in the last quarter A task and finish group has been convened to review NHSE diagnostic codes, which may indicate that a young person has a learning disability and eligible for a health check	Not all practices conduct health checks each month for 14 to 17 year olds. If no checks were conducted for a practice the national data excludes that practice's data.
LDN KPI 2	75% of people with a learning disability in Rotherham will have access to GP enhanced health check.	75% Q4 24/25 *(NHS National Objective)*		Apr health checks 83, Trajectory 56	July health checks 101 Trajectory 140	In Oct 205 health checks were completed		 The position is comparable with previous years,	NHSE have indicated that are wishing to stretch the 75% target
LDN KPI 3	Reduction in the numbers of people needing to be detained in mental health services	8 people by Q2		Increase to 9	Maintain at 9	Decrease to 6		The demography of the transforming care cohort has shifted. Most admissions to mental health services are autistic people without a learning disability. This a pattern repeated across the SY ICS footprint.	Proposed SY safe space pilot will offer some mitigation. However, there is an emerging issue of sufficiency. This is being mitigated by a review of the emergency respite bed in Rotherham
LDN KPI 4	An increase in the number of young people accessing supported internships by 2025.	TBC	TBC	TBC	TBC	**36 supported internships have been created this year. This will be the baseline**		• The supported internships delivery plan is being reviewed and Delivery partners are being consulted. Currently 31 young people access supported internships. • The Supported Employment Team further expanded in early 2024, to deliver Council-led Supported Internship Programme which ensures a structured, work-based study programme for 16 to 24-year-olds with SEND, who have an Education, Health and Care plan. • Supported internships are a great opportunity to improve the life chances of young people with SEND by supporting them into sustained, paid employment. • There are also benefits for the economy, employers, families, the local community and wider society.	
LDN KPI 5	12 units of supported living are created every year	12 per year To maintain						New capacity opening in Thrybergh On track	Out of borough providers creating services without appropriate consultation

6 Transformation Workstream: Urgent, Emergency and Community Care

Priority 1: Frailty	Lead Officer: Steph Watt \ SROs: Dr Rod Kersh, Jodie Roberts, Kirsty Littlewood

Milestone		Target for Delivery	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Key actions from the last period / identify achievements	Any risk, including mitigation
UEC MS 1	Review and delivery of a revised falls offer	Q4 23/24						This scope has been expanded to support 2 out of 4 of Rotherham's high impact projects including frailty and ambulatory care. Cross system MDT workshops have been held. Outputs include a directory of services created along with identifying what is working well, challenges, opportunities and risks. To be sessions held to inform 24/25 priorities. Developing and delivering the model has been incorporated into the frailty workstream in order to provide an integrated offer	Risk in developing, delivering and embedding sustainable change due to the size and complexity of the offer. Mitigation: Partnership and programme approach, supported by Frailty being identified as a high impact priority for 2024/25.
UEC MS 2	Community frailty model: Review and streamline the current frailty and falls offer to provide a more holistic and integrated approach within an affordable resource envelope, including enhanced access to physical activity, self help, signposting, and self referral to appropriate pathways	Q4 24/25						A tiered pyramid model has been developed with prevention at the base, progressing to proactive care for those at the highest risk of admission through to acute level care where needed to improve prompt access to the right level of inpatient care, reducing admission waits and length of stay. As part of the prevention agenda a bid for external funding has been submitted to support access to physical activity and assist with signposting and navigating the current offers. The care homes falls pathway developed during Covid is being reviewed and aligned to safeguarding processes and actions to ensure quality standards in care homes and reduce avoidable conveyance/admissions.	
UEC MS 3	Implement proactive care	Q3 24/25						A Primary care led cross system MDT launched in December with community health, social care and VCS to support frail people who have had multiple admissions to develop a care plan to improve quality of life and reduce avoidable admissions. A highly complex frailty pathway has been developed for those in the last year of life which is being piloted Dec – March. The aim of both is to improve the experience of frail people living in the community and reduce avoidable conveyances and admissions.	There is a risk to timescales if collective action impacts on this work.

Milestone		Target for Delivery	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Key actions from the last period / identify achievements	Any risk, including mitigation
UEC MS 4	Develop an integrated MDT offer to support acute frailty	Q4 24/25						Development of an integrated acute frailty pathway to support frailty identification, intervention, admission avoidance and discharge, further strengthening the link between acute and community care. Benchmarked against the national frailty strategy as part of the TRFT quality initiative and ambulatory care workstream. Additional resource to support Comprehensive Geriatric Assessment/ holistic approach in place which has increased the numbers being completed, particularly upstream in the pathway. TRFT have been successful in securing £7m capital funding to expand urgent and emergency capacity to facilitate flow. Service improvement plans and timescales have been aligned to this.	

Priority 2: Ambulatory Care	Lead Officer: Steph Watt \ SROs: Kirsty Littlewood & Jodie Roberts

Milestone		Target for Delivery	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Key actions from the last period / identify achievements	Any risk, including mitigation
UEC MS 5	Ensure signposting and navigation directs to the most appropriate pathway according to need focusing on out of hospital pathways wherever possible	Q2 24/25						111/999 directory of services reviewed and updated as new work streams come on board.	
UEC MS 6	Enhance ambulatory care offer through focussed review of top presenting conditions and implementation of alternative pathways	Q4 24/25						SDEC exclusion criteria (rather than inclusion criteria) under development to enhance access. Development of the Early Pregnancy Assessment Unit pathway underway.	
UEC MS 7	Implementation of hot clinics	Q3 24/25						Scoping and establishing plans for hot clinics delayed to focus on other key developments. Development of virtual fracture clinic underway.	

Priority 3: Integrated Discharge to Assess	Lead Officer: Steph Watt \ SROs: Kirsty Littlewood & Jodie Roberts

Milestone		Target for Delivery	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Key actions from the last period / identify achievements	Any risk, including mitigation
UEC MS 8	Review and recommission community bed base	Q4 24/25						Extension of existing nursing intermediate care community bed base contract in place to enable wider review of the commissioned bed base in 2024-5.	Dependency with the home based pathway review and discharge to assess model.
UEC MS 9	Agree and implement escalation process for place and out of area	Q3 24/25						Revised whole system escalation process established in Rotherham with new national acute, community and mental health OPEL requirements being embedded. Has enabled barriers to be addressed on a case by case basis and learning which has informed new ways of working to improve system flow. Work progressed with SY ICB to agree updated repatriation policy and streamlined out of area process for SY placements and the wider system	
UEC MS 10	Support for care homes: i. to reduce avoidable conveyances ii. support time discharge including Trusted Assessor pilot	Q4 24/25						An information pack for Care Homes concerned about a resident has been circulated to guide escalation to appropriate services and reduce avoidable conveyance/admissions. Care Home Falls pathway under development.	
UEC MS 11	Implement a community patient tracker and enhance visibility and oversight of community pathways	Q4 24/25						Work completed to identify and rationalise existing reporting so information can be accessed by all partners in a single space for operational and strategic management. This will be further developed for enhancing operational and strategic oversight. SY ICB are working with Place partners to identify a community solution for real time patient tracking.	To date there is no evidence that a real time community patient tracker is on the market. This is due to complexities arising from the need to draw on data sources from different record systems across multiple organisations and extracting real time data. Mitigation: reduce scope and build interim solutions that provide core information at snap shot times
UEC MS 12	Update capacity and demand tool	Q2 24/25						Delayed due to recruitment. Demand and Capacity modelling underway to inform future plans with anticipated completion Q4.	

Priority 4. Cross cutting workstreams	Lead Officer: Steph Watt SROs: Kirsty Littlewood & Jodie Roberts

Milestone		Target for Delivery	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Key actions from the last period / identify achievements	Any risk, including mitigation
UEC MS 13	Develop and embed the TOCH D2A model	Q3 24/25						Building work and changes to the IT infrastructure commenced to support expanded physical co-location.	If an alternative space cannot be secured for the expanded team this may impact on the effectiveness of the service/staff morale Mitigation: a space has been identified and is being progressed.
UEC MS 14	Out of Hospital Pathways. Targeted community pathways to reduce avoidable conveyances/ admissions and in-reach to deflect from the front door. Including implementation of Virtual Ward remote monitoring, growing push pathways and reaching 80% virtual ward occupancy.	Q2 2024/25						Virtual ward heart failure pathway developed and is now live. Push pathway to Community Respiratory Exacerbation service developed. This extends the push pathways from two to four, with 258 accepted referrals 1/04/23-29/1/24 and 469 referrals, 1/04/24- 29/1/25, representing an 82% percentage increase.	Remote technology may not be appropriate to support all pathways. Mitigation: The technology will only be applied where appropriate to support care according to the individual's needs.
UEC MS 15	Review Falls offer Delivery of revised model incorporated into frailty work stream	Q4 2023/24						Review of falls offer complete and included in frailty directory of services. Strengths and opportunities of the offer have been identified through whole system workshops. Now incorporated into the wider high impact frailty and ambulatory care workstreams	Risk in developing, delivering and embedding sustainable change due to the size and complexity of the offer. Mitigation: Partnership and programme approach, supported by Frailty /ambulatory care being identified as a high impact priority for 2024/25.

Metric		2024/25 Target	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Comments if off track	Any risk, including mitigation
UEC KPI 1	% of 2-hour UCR referrals that achieved the 2-hour standard *Data from Care Group 4, TRFT*	70%	73% March (Validated position)	75% April	75% July	80% Oct		Project completed and work transitioned into business as usual. Performance continues to be monitored through the UEC meeting for benefits realisation/impact on whole system flow. The service has met or exceeded 70% threshold consistently since launch.	
UEC KPI 2	Virtual Ward trajectory and capacity (occupancy rate) *Data from Care Group 4, TRFT*	Q4 100 beds with 80% occupancy	76% March	76.1% June	69% Sept	73% Dec		Project completed and work transitioned into business as usual. Performance continues to be monitored through the UEC meeting for benefits realisation/impact on whole system flow. The quality of service is high as validated by patient feedback and requests to speak at national conferences and hosting subsequent good practice meetings. Acuity levels are high reflecting genuine admission avoidance and early discharge. Capacity is on track but occupancy has been varied due to increased demand across all unplanned pathways, some staff sickness and vacancies resulting in some resourcing challenge.	
UEC KPI 3	Improve A&E waiting times, compared to 2023/24, with a minimum of 78% of patients seen within 4 hours in March 2025 *Data from 6 key indicators – Source: NHS Digital*	78% of people treated, referred or admitted within 4 hours of arrival	63% March	68.7% June	68.6% August	62.1% Nov		This standard is nationally challenged due to sustained increases in demand. Rotherham moved from a national field site pilot to implementing the now nationally required 4 hour A&E response target. Sustained record numbers of attendances have been seen in UECC which has resulted in not meeting the planned 4 hour trajectory. This has also masked the impact of some of the service improvements made to date. Activity includes streaming at the front door, development of Same Day Emergency Care, alternative pathways to ED including virtual ward and 2 hour urgent response and workforce/cultural change. The four hour standard is measured and reported across all types of A&E department. When broken down by type 1, it is reflective of the performance comparison for services operating 24 hour consultant led care with full resuscitation capability. Rotherham continues to perform well for type 1 attendances when compared nationally. For week ending 25/11/24 Rotherham ranked 50/126 for type 1 performance and 116/126 for all performance.	A rapid action plan has been developed with daily oversight and monitoring.

Metric		2024/25 Target	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Comments if off track	Any risk, including mitigation
UEC KPI 4	Improve ambulance response times *Data from 12 Additional Measures – Source: NHS Digital*	Cat 2 30 mins	29:28 March	30:43 June	26:11 August	37:18 Nov		A new single national target to improve category 2 ambulance response times to an average of 30 minutes across 2024/25 has been set. TRFT, YAS and Place partners are working together to reduce avoidable conveyances including Project Chronos to identify new ways of working.	
UEC KPI 5	Ambulance handover times *Data from UEC Alliance report*	18:50 (SY target)		16:32 June	19:00 YTD to October	22:09 YTD to Dec		Year to date figures from SY Alliance show that the target is just off track, but Rotherham continues to perform well when compared across the region.	
UEC KPI 6	Reduction in people with no criteria to reside *Data from 6 key indicators – Source: NHS Digital*	NCtR % occupancy of ≤10.8% Local target 10%		16.2% June	18% August	17.9% Nov		Unprecedented levels of attendance in UECC/industrial action and impact on admissions has resulted in unplanned escalation beds being used in the acute in addition to planned escalation beds which impacts on demand for discharge pathways. Additional escalation meetings have been held to facilitate de-escalation of the unplanned beds which impacts / exceeds capacity in the discharge pathways.	System pressures may be higher than impact of changes. A new escalation framework and operational /performance reports helped manage resource across pathways to maximise impact.
UEC KPI 7	Reduction in long lengths of stay in Acute bed base at 7, 14 and 21 days % of acute bed occupancy for NCTR by LOS *Data from UEC Performance Report – Source: TRFT*	Acute: 7 days 40%	7 days 55%	45.6% June	46.5% August	45.9% Dec		As above Escalation meetings were increased including daily Executive escalations across Place at peak times.	As above
UEC KPI 8		Acute: 14 days 25%	14 days 27%	22.7% June	24.8% August	22.4% Dec		As above	As above
UEC KPI 9		Acute: 21 days 12%	21 days 16%	12.8% June	14.4% August	11.7% Dec		As above	As above
UEC KPI 10	Reduction in long length of stay for community beds	TBC	TBC	TBC	TBC	TBC		Baseline being established to set target reduction Additional escalation meeting added for commissioned beds and new review meeting for spot purchase beds. Successful go live of the updated Community Daily Discharge SitRep / Intermediate Care Data Collection. Working with business intelligence and applications team to support a system solution to enhance performance monitoring.	

Metric		2024/25 Target	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Comments if off track	Any risk, including mitigation
UEC KPI 11	Proportion Discharged to Usual Place of Residence Data from 12+ indicators, Local data – Source: SUS	94%	95.5% March	96.1% June	94.9% August	95.2% Nov		The target continues to be met despite increased demand and complexity. Better care funding has been used to increase capacity to support more people to remain/return home. However capacity is challenged due to levels of demand, staff sickness and vacancies. Service improvement work continues to grow capacity.	Due to the aging population there is greater complexity of requirements which cannot always be supported at home Mitigation: Rotherham has prioritised and invested in supporting people at home wherever possible. The majority of people receive a period of rehab/recovery before final decisions are made.
UEC KPI 12	Reduce adult general and acute (G&A) bed occupancy to 92% or below. Data from 6 key indicators – Source NHS digital	92% *(NHS National Objective)*	95.3% March	93.2% June	93% August	96.2% Nov		Unprecedented levels of attendance in UECC and impact on admissions has resulted in unplanned escalation beds being used in addition to planned escalation beds which impacts on flow. Additional escalation meetings are stood up to facilitate de-escalation of the unplanned beds.	System pressures may be higher than impact of changes. A new escalation framework and operational /performance reports will help manage resource across pathways to maximise impact.
Any further comments: Operational pressures, including industrial action, and staffing (sickness and vacancies) poses a risk to engagement and successful delivery.									

7 Transformation Workstream: Palliative and End of Life Care

Priorities covered by the milestones and metrics below are:	Lead Officer: Emma Royle
1. Enhance personalised palliative and end of life care 2. Implementation of ReSPECT across Rotherham 3. Benchmark against the Ambitions Framework 4. Inform future commissioning through patient and Carer experience	

Milestone		Target for Delivery	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Key actions from the last period / identify achievements	Any risk, including mitigation
PEOLC MS 1	Undertake work to identify Rotherham patients and carers experience to inform future commissioning	Q3 24/25						Engagement sessions have taken place with Speak-up (Self Advocacy for people with LD and autism), The Rainbow Project (LGBT), and The One Voice & Life Groups (run by and for BAME women). Healthwatch have also carried out SY wide consultation work with patients, families, and carers. Next steps – to undertake engagement sessions focused specifically on Rotherham.	
PEOLC MS 2	Implement ReSPECT across Rotherham, including relevant training	Q4 24/25						ReSPECT went live in Rotherham 1st October 2023. A multi-agency implementations meetings continue every 2 months. Level 1, 2 and 3 training videos, ECHO training sessions etc developed. Positive feedback re use from the Training session to continue. Audit and evaluation is taking place and feedback from this will go to the UK Resuscitation Council.	
PEOLC MS 3	Repeat Benchmark against the ambitions for PEOLC framework annually (by March 2025)	Q4 24/25						The results from Rotherham, Sheffield, Barnsley and Doncaster to form a SY wide action plan. This will be monitored by the SY ICB PEoLC Board. The repeat benchmarking has commenced, starting with Childrens PEoLC.	
PEOLC MS 4	Develop a Rotherham Place Action Plan working with the SY wide Implementation Group to respond to the SY PEoLC Strategy	Q3/4 24/5						This will take into account the actions within the new SY PEoLC Strategy and also the Rotherham Benchmarking against the national ambitions framework. The action plan is in place and the areas relating to Rotherham are to be discussed at the next Rotherham Place Group.	

Milestone		Target for Delivery	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Key actions from the last period / identify achievements	Any risk, including mitigation
PEOLC MS 5	Develop Rotherham PEoLC Dashboard.	Q2 24/25						This has been completed on a SY wide basis and is available on the SY ICB intranet. Information from this is exportable and is shared with Partners at the Rotherham Place PEoLC Group for discussion. Further discussion is taking place regarding SY wide trajectories. Rotherham Dashboard has been completed by Public Health as part of the JSNA work. It will be added to the RMBC website and discussed at the monthly Rotherham Place PEoLC meetings. (NB: Work is taking place with the SYICB Business Intelligence Team to develop a common activity and monitoring process to measure Rotherham performance against the SY PEoLC strategy.)	

Metric		2024/25 Target	Q4 Position (23/24)	Q1 Position (24/25)	Q2 Position (24/25)	Q3 Position (24/25)	Q4 Position (24/25)	Comments if off track	Any risk, including mitigation
PEOLC KPI 1	Maintain the proportion of people on end of life care registers at 0.7%	0.7%	0.72%	0.71%	0.74%	0.77%			
PEOLC KPI 2	Increase the number of ReSPECT plans in place.	1000 by March 25	485	626	792	919			
PEOLC KPI 3	Increase number of people who have completed training in end of life care	250	56	55	56	56			

Any further comments:
The South Yorkshire ICB Palliative and End of Life Care Board has been established and has met three times. There are 3 sub-groups under the Board – Children and Young People, Patient Engagement and Clinical Reference Group. A SY PEoLC Strategy is signed off in principle and is to go to the SY ICP board.

Pathways to Work:
a new system approach

SOUTH YORKSHIRE SYMCA MAYORAL COMBINED AUTHORITY

NHS South Yorkshire Integrated Care Board

Pathways to Work: a new system approach

- **The challenge:** South Yorkshire is severely impacted by a national trend in rising economic inactivity with 172,500 economically inactive residents, 31.4% of whom are inactive due to long term sickness or disability.

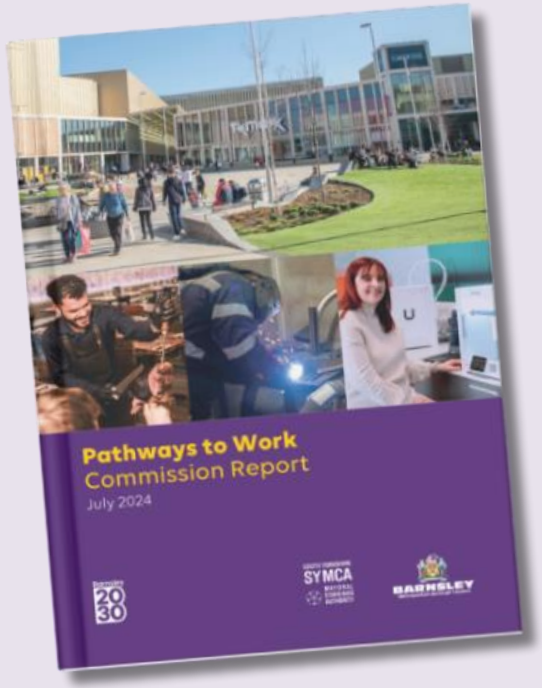
- **The ambition:** to support 10,000 economically inactive people into work over the next four years

- This is our opportunity to **do something different** at system level for our local population

The Barnsley Pathways to Work Commission

- Pathways to Work Commission report published on 23 July 2024.
- Launched in Barnsley at the Town Hall, with partners, Commissioners and participants invite.
- Keynote from the Secretary of State – first major policy speech.
- Launched in Westminster on 24 July 2024 at a private event for MPs, policymakers, and civil servants.
- The findings of this Commission form the basis for our local plans, as well as informing national policy.

Paper copies still available on request.
Read online here: barnsley.gov.uk/PathwaysToWork



National and local context

- The Get Britain Working White Paper outlined the government's mission to kickstart economic growth with good jobs and productivity making everyone, not just a few, better off. The White Paper drew on learning from the work done by the Pathways to Work Commission in Barnsley.

- In the White Paper, South Yorkshire was identified as one of eight **trailblazer** sites chosen to receive funding to reduce economic inactivity, and additionally one of three areas to be given funding to become a **Growth accelerator** to develop evidence of the impact of targeted action on the top health conditions driving economic inactivity.

A simplified, flexible approach to employment support that is tailored to the needs of individuals and businesses

Pathways to Work System Change

- Pathways to Work will combine the new funding sources (the NHSE Growth Accelerator and DWP Trailblazer funding) with existing ones (such as WorkWell) to create a unified employment support system.

- The reforms will align strategies and operations, enhance personalized support, and work with employers to make sustainable workplace changes. The system will become more flexible and innovative through data integration and will introduce new interventions across health, skills, and employment sectors to prevent economic inactivity, especially for those at higher risk due to long-term sickness or health conditions.

- We anticipate that these changes will help 2,000 more people in South Yorkshire find jobs and prevent 950 people from becoming economically inactive next year. This effort aims to create a more inclusive and prosperous economy in South Yorkshire, serving as a model for other regions.

A simplified, flexible approach to employment support that is tailored to the needs of individuals and businesses

P2W Trailblazer

Undertaking ambitious system redesign at South Yorkshire and Local Authority level to move from a fragmented, difficult to navigate system to one which is cohesive, easily navigable and has a single point of access/no wrong front door approach

Priority 1: Ambitious redesign of local systems

Establishing a **System Steward (SS)** function, positioned at the South Yorkshire level, to drive system change, provide system oversight, a shared vision for those that are economically inactive, a governance mechanism to manage the system and a capacity to align with existing infrastructure and partners working across South Yorkshire.

Establishing a System Service Manager (SSM) at Local Authority level to build capacity across service providers to respond to those that are economically inactive; address system barriers to outcomes; manage system level performance against agreed targets and to address gaps in service system operations in conjunction with the System Steward.

Priority 2: Employer engagement and employment activation

Proactive engagement with employers to shift attitudes, change hiring and employment practices, increasing confidence and identify opportunities to support employment of those with potentially complex needs.

The approach will have both an activation layer (made up of SS and SSM input) as well as practical support including design, contract award and ongoing management cost, specialist employer support and development fund allocation for a combination of third-party services and direct delivery (to be further designed), as well as a work simulation pilot and peer support allocation for retention.

Priority 3: Delivery of a Personalised Support Service

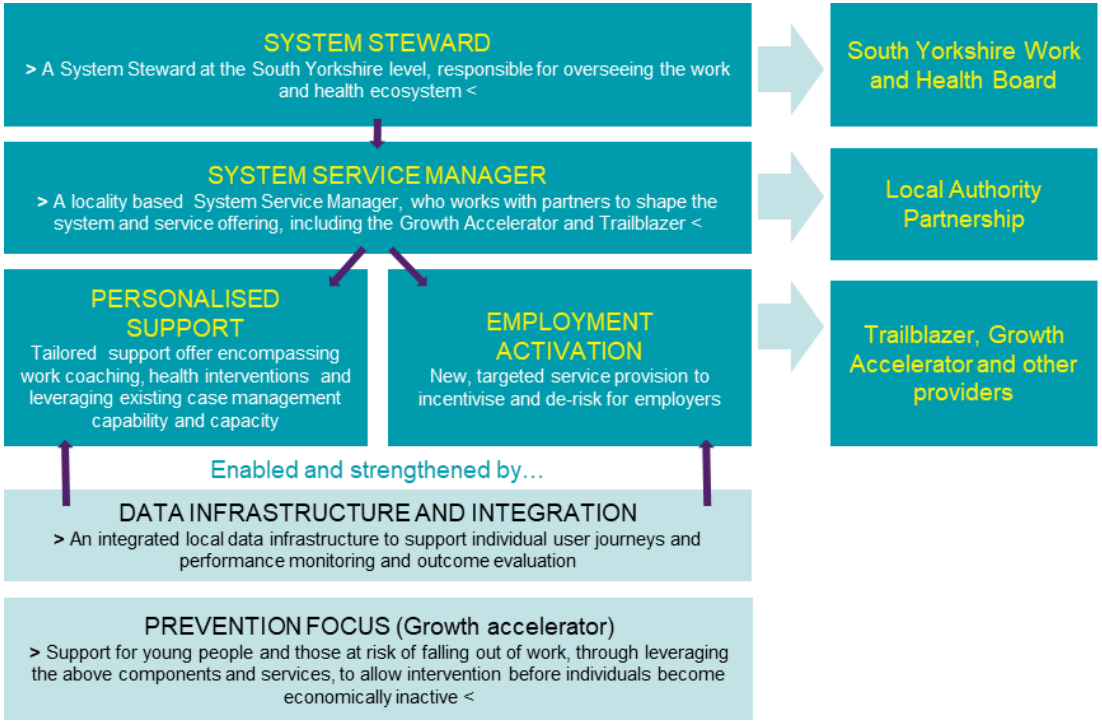
Delivering an individual-centric, strengths based, trauma informed Personalised Support service that places people into work and connects those who are economically inactive to the complex ecosystem of support services in South Yorkshire. Every personalised support journey will be unique, while adhering to specific key stages such as being engaged and attached to the Pathways to Work system, triage support, and ongoing interaction with support services in South Yorkshire, ultimately always working towards sustained employment that aligns with the complex needs of every individual.

Priority 4- Innovation in reducing economic inactivity rates.

There is local appetite to be bold and innovative, both within the trailblazer and Growth Accelerator. We are currently exploring what that might look like, considering novel partnerships, digital solutions and work simulation pilots.

A simplified, flexible approach to employment support that is tailored to the needs of individuals and businesses

P2W Trailblazer



An integrated, systematic approach that focuses on people, not conditions:

P2W Growth Accelerator

The Pathways to Work report recognised that the longer someone is out of work, the more likely they are to see their barriers to work multiply. Timely interventions and support can prevent the 'spiralling' of these barriers; new barriers may be developing while people wait for treatment.

NHS England is providing additional funding to South Yorkshire through the Health and Growth Accelerator to strengthen the system's prevention focus and work with specific sub-cohorts to address their health issues holistically and through a people-centred approach, aligning closely to the personalised support model embedded through the Trailblazer, and utilising an integrated approach to triage. It will also embed different ways of working between health, work and education professionals and strengthen the infrastructure which will allow the combined authority, Integrated Care Board and local authorities to work more closely together in the future.

Following initial work to scope the Health and Growth Accelerator, local partners have identified three priorities for support -

Priority 1: Supporting people in work with repeated or longer-term absences at risk of falling out of work

For the majority of people, health conditions worsen gradually over time, eventually resulting in the person leaving the labour market. There is an opportunity to build on the success of WorkingWin and strong networks with primary care providers as well as those individuals presenting for work capacity assessments to provide enhanced support to facilitate a reduction in absences from work. We also envisage working with GP practices to strengthen alternative pathways which do not require Fit Notes.

Priority 2: Supporting young people struggling to remain in work or education or enter the workplace due to experiencing depression and anxiety

Over the last 5 years, the number of economically inactive people aged 16-24 has been rising at faster rates than in other age groups, with difficulties with mental health and mood disorders and / or additional educational needs a recognised key driver for this. By ensuring that transitions from Child to Adult services are tailored to young people's needs and focus particularly on those with neurodiversity issues, we want to enable more young people to enter the world of work successfully.

Priority 3: Enhanced occupational health and wellbeing support through local employers

Only 45% of workers in Britain have access to some form of occupational health services, with the majority of small and medium-sized enterprises unable or unwilling to provide support. There is an opportunity for South Yorkshire to build on existing offers and hubs to widen access, utilising digital and AI technologies. We also want to to develop more innovative enhanced wellbeing and support offer targeted to those with specific needs, such as MSK-related pain.

Designing successful interventions

Design work is currently underway with key stakeholders and subject matter experts to define what the Growth Accelerator interventions will look like. Current thinking is as follows (though this is subject to change and further refinement):

	Priority 1: Supporting people in work with repeated or longer-term absences at risk of falling out of work	Priority 2: Supporting young people struggling to remain in work or education or enter the workplace due to experiencing depression and anxiety	Priority 3: Enhanced occupational health and wellbeing support through local employers
Cohort	1) Individuals who have a **recent history of absences from work**, either due to frequent (over 3) short term absences relating to the same or related health issues, or prolonged (over 4 weeks) absences due to mild to moderate mental health and mood disorders, musculoskeletal conditions and chronic pain. 2) Individuals with an **existing fit note and a recent work history**, who are submitting a capability for work questionnaire to DWP.	Young people aged 16-24 who are either: 1) in full time work or education with recent experience of significant absences due to depression and/or anxiety. 2) not in full time work or education who are experiencing mild to moderate depression and/or anxiety. 3) or struggling to enter the workplace due to neurodivergence who are experiencing mild to moderate depression and/or anxiety	1) Employers who **do not currently provide occupational health support**, with a particular focus on small and medium sized companies 2) Selected employers who are **willing to provide opportunities for individuals with a history of repeat absences or emerging issues due to MSK conditions**, with a potential future roll out to more employers

Proposed intervention	• Holistic assessment to understand what type of support may enable them to stay in work
	• Integrated clinic / support offer provide personalised, ongoing support which integrates across health and employment
	  ▪ Physio and pain management
	  ▪ Mental health support
	  ▪ Nutrition / weight management
	  ▪ Social prescribing
	• Ongoing follow up to ensure people are managing and not leaving work (including digital and in-person support as appropriate)
		• Holistic assessment to understand what type of support may enable them to stay in work
		• Integrated clinic / support offer provide personalised, ongoing support which is age segmented for younger adults, traditional medicine pathways are not always tailored for young people with neurodiversity
		• integrated into work and careers advice (including reasonable adjustments)
		• focus on transition from child to adult services, providing an enhanced offer for 16-24 year olds
		• Ongoing follow up to ensure people are managing and not leaving work (including digital and in-person support as appropriate)
			• Initially discounted Occupational Health to SMEs, delivered in the most flexible and accessible way (e.g. utilising the government's recent investment in digital platforms and offers)
			• A discounted enhanced wellbeing offer through digital channels, delivering wellbeing and therapeutic solutions for those with MSK conditions through digital or mixed channels

Progress to date and next steps

Progress to date

- ✓ Joint delivery plan submitted Dec 2024 (we were the first region to submit, most submitted in late Jan 2025)
- ✓ Wide ranging stakeholder engagement including design workshops with over 100 participants
- ✓ Core working groups established for both Trailblazer and Growth Accelerator
- ✓ Target cohorts and priority areas identified
- ✓ Outline proposals of interventions scoped
- ✓ Roles and responsibilities within the new structure scoped (with recruitment underway in some areas)
- ✓ We are working with central DWP to develop the process and programme
- ✓ We are leading an Economic Inactivity Trailblazer MCA group with all other MCAs

Next steps

- ❑ Ongoing design work to define what the participant journey through the service will look like, as well as specific delivery elements.
- ❑ Further ecosystem mapping to identify what services already exist and where there are gaps. Particular focus on digital needed
- ❑ Agreement of proposed governance structures to ensure partner alignment at all levels
- ❑ Recruitment and/or commissioning of the required elements
- ❑ Work with delivery partners to ensure alignment to existing employment support services
- ❑ Development of a Work, Health and Skills Strategy
- ❑ Go live – from April 2025

Thank you

If you'd like to be kept up to date with this work, or think you can contribute in some way please contact Helen at SYMCA

Helen Lipinski
Work and Health Integration Lead

W: southyorkshire-ca.gov.uk
E: helen.lipinski@southyorkshire-ca.gov.uk

South Yorkshire Mayoral Combined Authority
11 Broad Street West
Sheffield
United Kingdom
S1 2BQ

Rotherham Together Partnership

Social Value Action Plan

JANUARY 2025

Social Value Portal

ROTHERHAM TOGETHER PARTNERSHIP

Contents

The development of this Action Plan has been supported by Social Value Portal: a B Corp with a mission to make Social Value count in every local community, worldwide.

Executive summary

This Social Value Action Plan sets out a bold shared ambition to maximise Social Value outcomes for Rotherham: **The Rotherham Social Value Vision** (p3).

In simple terms, Social Value is the added social, economic and environmental value delivered as part of a contract. The consideration of these additional benefits within public sector commissioning and procurement award criteria – sparked by the 2012 Public Services Act – and the effective management of their delivery over project lifecycles represents a **major opportunity** in Rotherham.

The Rotherham Social Value Vision has been **co-created** by the Rotherham Together Partnership to bring to life this opportunity.

The Vision sets out how coordinated action from partners to embed Social Value across the commercial lifecycle can unlock an additional **£53,500,000** of added social, economic and environmental benefits for Rotherham each year through Social Value commitments from suppliers and providers.

When effectively targeted at **key local needs** and joined up with existing local initiatives, the potential of Social Value to have a long-term impact on the prosperity of Rotherham and contribute to the ambitions set out in The Rotherham Together Plan is further amplified.

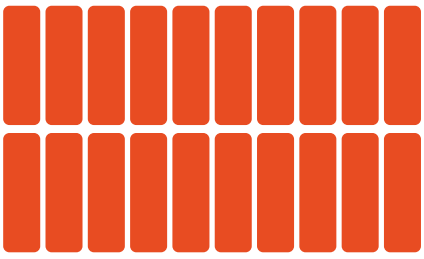
To realise this potential, partners have come together to develop a joint set of **implementation actions** (p6).

The actions, set across three phases, will be crucial in translating the Vision into reality. They are built on the power of collective support and accountability that the Rotherham Together Partnership can foster and represent a **renewed commitment** to achieving the overarching ambitions originally articulated in The Social Value Charter and unlock the power of place-based coordination on Social Value.

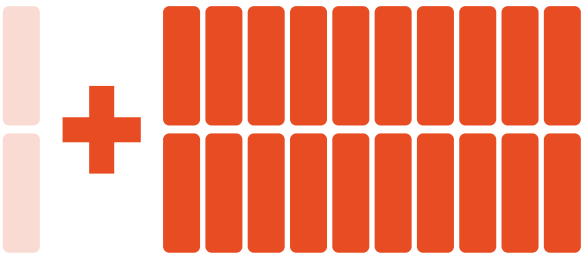
The following pages set out the detail behind the Vision and implementation actions, built on **contributions** from procurement and strategic leads from across partners. Their efforts have produced this Action Plan. It is now time to commit to making it a reality.

The Rotherham Social Value Vision

Rotherham Together Partnership (RTP) has £535,000,000 of collective procurement spend across partners on Rotherham-specific goods, works and services



RTP procurement spend can be used to leverage added **social, economic and environmental** benefits for Rotherham.



By embedding Social Value into all procurement, there is potential for +10% or £53,500,000 added value for Rotherham

Having this objective empowers suppliers and providers to make **targeted** Social Value commitments delivered as part of their contracts.

Providing targeted mentoring and support for local young people	Providing support to build community wellbeing	Increasing local spend and local SME spend
Providing local work placements, apprenticeships, jobs and training	Providing targeted in-kind support to VCSE organisations	Providing decarbonisation support to SMEs

Directing these Social Value commitments towards key **local needs** in Rotherham will make a long-term impact in our local communities.

20.4% of 16-64s are without an RFQ2 **qualification** (compared to 14.9% in Y&H and 13.5% GB)

13,300 16-64 year olds are **economically inactive** due to long-term sickness (36.3% of those economically inactive in Rotherham, compared to around 25% in Y&H and GB)

34.6% of Rotherham children living in **poverty** in 2020, based on End Child Poverty research

99.6% enterprises in Rotherham are **SMEs**, with many struggling with decarbonisation

Measurement Framework

This RTP Social Value Framework sets out the **minimum Social Value measures** that each partner will encourage suppliers and providers to make targeted Social Value commitments against in procurement. The measures have been co-designed by partners based on what will make the biggest difference to key local needs (see 'The Rotherham Social Value Vision'), with a particular focus on **driving local jobs, apprenticeships and skills**.

RTP has adopted the TOM System™ as the basis for the RTP Social Value Measurement Framework. The TOM System is the most used Social Value framework in the UK. It is a flexible, measures-based calculation framework designed to articulate Social Value outcomes in terms that can be objectively measured; usability and transparency are core principles, as well as methodological rigour.

Priority commitments	TOM Ref	Measure	Unit
Providing targeted mentoring and support for local young people	NT8	Support for students at local educational institutions	no. staff volunteering hours
	NT98	Expert curriculum support for universities and colleges	no. staff expert hours
Providing local work placements, apprenticeships, jobs and training	NT13a	Providing targeted work placements paying at the Real Living Wage+	no. weeks
	NT10	Employment of new apprentices	no. weeks
	NT1	Local people employed or retained	no. people FTE
	NT9	Accredited training for new employees	no. weeks
	NT80	Upskilling of existing employees through accredited training	no. weeks
Providing support to build community wellbeing	NT26	Support for community health or wellbeing interventions	£ invested inc. time, materials, equipment
Providing targeted in-kind support to VCSE organisations	NT15	Expert support to VCSEs and SMEs	no. staff expert hours
	NT16	Support for VCSEs through donations	£ invested
Increasing local spend and local SME spend	NT18	Spend with local companies in the supply chain	£
	NT19	Spend with local SMEs in the supply chain	£
Providing decarbonisation support to SMEs	NT15a	Expert support to VCSEs and SMEs to achieve net zero carbon	no. staff expert hours

Other measures can be considered and reported on at the individual partner level as is most relevant for activities and contracts.

The Dual Role of Partners

Partners will each play a dual role in realising the Rotherham Social Value Vision

Catalysts
to drive supplier and provider Social Value commitments

All partners

Particularly partners with annual procurement spend >£1m through embedding Social Value requirements into all procurement and holding suppliers and providers to account through contract delivery.

Connectors
in the delivery of Social Value commitments

All partners

Particularly VAR and The Chamber through connecting suppliers and providers making Social Value commitments to local VCSEs and SMEs as both recipients and delivery partners.

The role of connector will maximise Social Value outcomes for VCSEs and SMEs in two ways...

Recipients of Social Value commitments

- Connecting suppliers and providers looking to provide in-kind resources or expertise to VCSEs and SMEs most in need of support
- Connecting suppliers and providers looking to increase SME and VCSE supply chain spend to local businesses and VCSEs

Providing targeted in-kind support to VCSE organisations	Providing decarbonisation support to SMEs	Increasing local spend and local SME spend

Partners in delivering Social Value commitments

- Connecting suppliers and providers looking to collaborate in the delivery of Social Value commitments to VCSEs best placed to partner, for example, on joint programmes to support local people furthest from the jobs market into work

Providing targeted mentoring and support for local young people	Providing local work placements, apprenticeships, jobs and training	Providing support to build community wellbeing

Implementation Action Plan

A joint Action Plan to operationalise Social Value across partners and achieve the Rotherham Social Value Vision

Build Foundations

1. Establish clear **senior accountability** for Social Value, including the delivery of this Action Plan
2. Assign an organisational **Social Value Champion** responsible for operationalising this action plan
3. Adopt the RTP Social Value **measurement framework** (minimum set of measures)

Develop Capability

4. Deliver RTP Social Value **awareness training** for commissioning, procurement and delivery
5. Provide a **workshop** of RMBC procurement process case studies for Social Value Champions
6. Deliver targeted **implementation training** for commissioning, procurement and delivery
7. Identify a **pilot project** due out to market in the next 3-4 months and test embedding Social Value
8. Co-create guidance on how to connect suppliers and providers to **VCSEs and SMEs** as Social Value recipients and delivery partners

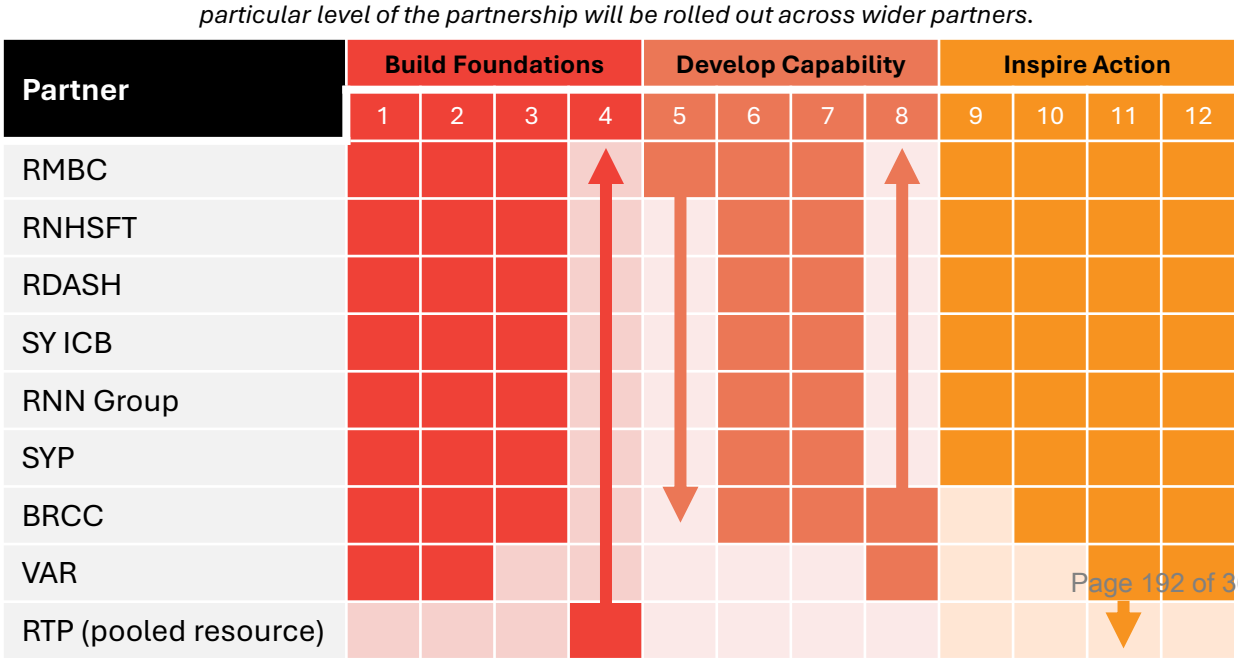
Inspire Action

9. Create a **Social Value Network** of individuals who can lead Social Value across key functions
10. Create a **Social Value Toolkit** to guide how you embed Social Value across project lifecycles
11. **Report** aggregate Social Value delivery annually as the Rotherham Together Partnership

12. Develop (or where appropriate update) and launch an organisational **Social Value Policy** that formalises partners' Social Value approach

Actions will either be led by each **individual partner**, or by a **sub-section of partners** or **RTP collectively** and rolled out across wider partners.

The block colour indicates where each action is led from, and the arrow indicates where actions led at a particular level of the partnership will be rolled out across wider partners.



Build Foundations

Build Foundations

Partners have highlighted the crucial need to **build foundations** to ensure there is the organisational accountability and awareness to deliver on the Rotherham Social Value Vision.

The following targeted actions were co-created by partners to address key gaps in accountability and awareness identified across partners through the joint Social Value maturity diagnostic survey.

1 Establish clear senior accountability for Social Value, including the delivery of this Action Plan

Delivered by	• All partners internally
Requirement	• Appoint a senior accountable officer for Social Value who will be ultimately responsible for overseeing Social Value delivery across the organisation and annual reporting into the Rotherham Together Partnership [11], as well as for the implementation of this Action Plan. • Where a senior accountable officer for Social Value is already in place, ensure accountabilities are updated to incorporate overall responsibility for the implementation of this Action Plan. • The officer should work proactively with their Social Value Champion [2] to understand and unblock operational challenges, including securing the required buy-in and involvement from wider leadership and key functions, cascading information and giving Social Value Champions a clear mandate for implementing the changes in this Action Plan.
RTP-level support	• Partners will access shared learning from RMBC as to how to allocate senior accountable officers and formalise their Social Value accountability within governance structures.
Timescale	• To be determined by RTP CEX Group

2 Assign an organisational Social Value Champion responsible for operationalising this action plan

Delivered by	• All partners internally
Requirement	• Appoint a 'Social Value Champion' responsible for driving effective operationalisation of Social Value across key functions, including delivering key elements of this Action Plan, with support from their senior accountable officer. • The 'Social Value Champion' will also be responsible for actively contributing to the wider network of Social Value Champions from across partners, including proactively sharing learning.
RTP-level support	• RTP will create a regular forum for Social Value Champions to connect and share learning throughout the implementation of this Action Plan, as well as an opportunity to escalate issues at a Rotherham Together Partnership level where appropriate.
Timescale	• To be determined by RTP CEX Group

3 Adopt the RTP Social Value measurement framework (minimum set of measures)

Delivered by	• All partners internally
Requirement	• Review and formally opt in to adopting (as a minimum) the measures set out in the Rotherham Together Partnership Social Value measurement framework (p4) as a common framework for suppliers and providers to make Social Value commitments and measure Social Value delivery. (Integration of the Social Value Measurement Framework across the commercial lifecycle will be delivered in phase 2: Building Capability). • Where appropriate, incorporate additional Social Value measures not included in the Rotherham Together Partnership framework which are of particular relevance to your organisation and/or supply chain.
RTP-level support	• RTP will maintain the 'Rotherham Together Partnership' Social Value Measurement Framework content and assets – a minimum set of Social Value measures partners are expected to encourage suppliers and providers to make commitments against.
Timescale	• To be determined by RTP CEX Group

4 Deliver RTP Social Value awareness training for commissioning, procurement and delivery

Delivered by	• RTP pooled resource followed by roll out across partners
Requirement	• Pool resources as a partnership to develop a bespoke 'Rotherham Social Value Vision' awareness training module, designed to support colleagues across any organisation to understand the Rotherham Social Value Vision and why it matters. • The 'Social Value Champion' from each partner organisation will be responsible for supporting the roll out of the awareness training across commissioning, procurement and delivery functions, with support from the senior accountable officer.
RTP-level support	• RTP will create and maintain the 'Rotherham Social Value Vision' awareness training module content and assets.
Timescale	• To be determined by RTP CEX Group

Develop Capability

Develop Capability

With a strong foundation established, broader teams will need specialist upskilling to **develop capability** in different functions to effectively embed Social Value across the commercial lifecycle in each partner organisation.

The following targeted actions were co-created by partners to address several key capability gaps identified across partners through the joint Social Value maturity diagnostic.

5 Provide a workshop of RMBC procurement process case studies for Social Value Champions

Delivered by	• Led by RMBC, all RTP partners participating
Requirement	• RMBC to select a few past tenders and create a workshop for Social Value Champions from RTP partners to attend. RMBC should determine a programme for the workshop, including seeing a project from start to finish and explaining how Social Value considerations are determined and evaluated for the tender and handed over to contract management. • Social Value Champions will be accountable for identifying and incorporating learnings from the workshop within their own organisational practices across the commercial lifecycle.
RTP-level support	• RTP will use the Social Value Champions forum to discuss learnings and explore ideas for implementation.
Timescale	• To be determined by RTP CEX Group

6 Deliver targeted implementation training for commissioning, procurement and delivery

Delivered by	• All partners internally with procurement spend >£1m
Requirement	• Each organisation to deliver specialist training for different teams across commissioning, procurement and delivery functions focused on equipping colleagues to be able to effectively embed Social Value in their processes. • Social Value Champions should ensure that all relevant team members across the organisation engage with the implementation training materials.
RTP-level support	• Partners will share ideas for useful training modules and successful approaches to team adoption through the Social Value Champions forum.
Timescale	• To be determined by RTP CEX Group

7 Identify a pilot project due out to market in the next 3-4 months and test embedding Social Value

Delivered by	• All partners internally with procurement spend >£1m
Requirement	• Each RTP partner to select a specific project due out to market in the next 3-4 months to be used as a pilot to embed Social Value across its lifecycle. • Social Value Champions should be involved in the pilot project and responsible for supporting colleagues to put learnings into practice from awareness and implementation trainings, along with the RMBC case study workshop. This should include skilfully determining Social Value requirements, effectively evaluating bid responses and supporting the incorporation of Social Value into contract management. • Data for the project should be tracked against the RTP measurement framework [3] and any other relevant measures.
RTP-level support	• RTP members will share learnings and feedback on the effectiveness of their Social Value approach to this pilot project, including the appropriateness of minimum reporting measures, ease of data collection and if additional training is needed.
Timescale	• To be determined by RTP CEX Group

8 Co-create guidance on how to connect suppliers and providers to VCSEs and SMEs as Social Value recipients and delivery partners

Delivered by	• Led by Voluntary Action (VAR) and BRCC, all RTP partners participating

Requirement	• VAR and BRCC to lead engagement with all RTP partners to better understand how to more effectively connect suppliers and providers to local VCSEs and SMEs, including both how to:
	  ○ Ensure offers of in-kind resources or expertise are targeted to most pressing needs in the VCSE sector and for SMEs
	  ○ Ensure suppliers and providers are better able to identify local VCSEs and SMEs with whom to increase flow-down spend where possible
	  ○ Connect suppliers and providers looking to collaborate in the delivery of Social Value commitments to VCSEs best placed to partner
	• VAR and BRCC to collate findings and determine the best way to codify, for example, as guidance which can be shared across RTP partners, and identify any key next steps.

RTP-level support	• Social Value Champions will engage with VAR and BRCC to co-create guidance and identify key actions for rolling out next steps internally.
Timescale	• To be determined by RTP CEX Group

Inspire Action

Inspire Action

Once teams have been upskilled in Social Value and a pilot project has been completed, partners will need to take steps to operationalise Social Value at scale to **inspire action** across their organisations.

The following targeted actions were co-created by partners to address several key operational gaps identified across partners through the joint Social Value maturity diagnostic survey.

9 Create a Social Value Network of individuals who can lead Social Value across key functions

Delivered by	• All partners internally with procurement spend >£1m, led by Social Value Champions
Requirement	• Each partner organisation should identify individuals across key functions to be members of an internal Social Value Network. The purpose of the Network should be to play an active role in driving and embedding Social Value best practice across the organisation. • Network members should be upskilled to act as Social Value subject matter experts within their respective functions, using a train-the-trainer model. • Each partner organisation should establish a clear governance structure for the network, including allocating a chair and setting out a terms of reference which formalises the Network's purpose and ways of working.
RTP-level support	• RMBC will share their learning from having already initiated a cross-functional Social Value Network.
Timescale	• To be determined by RTP CEX Group

10 Create a Social Value Toolkit to guide how you embed Social Value across project lifecycles

Delivered by	• All partners internally with procurement spend >£1m
Requirement	• Each partner to document the process for best practice implementation of Social Value across commissioning, procurement and contract management in a Social Value Toolkit or equivalent resource. • The best practice toolkit should be developed and launched with input from Social Value Network members and support should be provided to key functions to understand how best to use the toolkit.
RTP-level support	• Partners will take inspiration and share learnings from the RMBC Social Value Toolkit. • Partners will share learnings and additional resources through the Social Value Champions forum throughout the drafting and roll out process.
Timescale	• To be determined by RTP CEX Group

11

Report aggregate Social Value delivery annually as the Rotherham Together Partnership

Delivered by	• All partners internally, shared with RTP
Requirement	• Partners to use the RTP Measurement Framework (p4) and any additional, relevant measures to track Social Value delivery across contracts. • Collected data should be shared with RTP partners to create an annual Social Value report and track progress over time.
RTP-level support	• Creation and maintenance of 'Rotherham Together Partnership' Social Value Measurement Framework. • Creation of joint annual Social Value report for the Rotherham Together Partnership.
Timescale	• To be determined by RTP CEX Group

Alongside

Alongside

Building foundations, developing capability and inspiring action on Social Value will represent significant shifts for RTP partners. **Alongside** the three phases**,** partners will need to formalise their approach to Social Value in organistaional policy to give colleagues the mandate to make these shifts.

The following targeted action was co-created by partners to address gaps in organisational policy identified through the joint Social Value maturity diagnostic survey.

12 **Develop (or update) and launch an organisational Social Value Policy that formalises partners' Social Value approach**

Delivered by	• All partners internally

Requirement	• Develop and publish an organisational Social Value Policy. The Policy should set out the organisation's approach to Social Value, including its:
	  ○ Social Value priorities, including how the organisation will support the delivery of the RTP Social Value Vision
	  ○ Approaching to measuring, monitoring and reporting on Social Value delivery, including as a minimum the measures set out in the RTP Social Value Measurement Framework
	  ○ Approach to embedding Social Value within the organistaional governance, operations and culture, including how the roles of Senior Accountable Officer and Social Value Champion will work with key functions
	  ○ Social Value expectations for suppliers and providers across bidding and delivery

RTP-level support	• Share learning from partners who have already developed a Social Value Policy through the Social Value Champions forum. • Maintenance of the RTP Social Value Charter.
Timescale	• To be determined by RTP CEX Group

Appendices

Social Value Portal

ROTHERHAM TOGETHER PARTNERSHIP

Measure Definitions

The table below provides the definitions for the measures in the RTP Social Value Measurement Framework, to support suppliers and providers to make and deliver **high quality Social Value commitments**. Partners are also equipped with a separate spreadsheet with evidence requirements and proxy values for each measure.

TOM Ref	Measure	Unit	Definition
Providing targeted mentoring and support for local young people			
NT8	Support for students at local educational institutions	no. staff volunteering hours	This Measure covers staff volunteering with pupils and students of local educational institutions. Qualifying activities include corporate presentations, preparing and delivering career talks, curriculum support, literacy support, and specific industry talks. They can take place virtually as well as onsite. Recorded hours of staff time can only include time spent preparing and conducting the activities. An employee's volunteering hours can only be recorded if they have been allocated time during paid working hours or time off in lieu.
NT98	Expert curriculum support for universities and colleges	no. staff expert hours	This Measure covers activities to support the curriculums of higher and further educational institutions through activities delivered by a qualified external expert. Examples are guest lectures, specialist workshops, and specific industry talks. They can take place virtually as well as onsite. Recorded hours of staff time can only include time spent preparing and conducting the activities. An employee's expert hours can only be recorded if they have been allocated time during paid working hours or time off in lieu.
Providing local work placements, apprenticeships, jobs and training			
NT13a	Providing targeted work placements paying at the Real Living Wage+	no. weeks	This Measure covers the provision of paid work placements paying the real living wage or higher that make a meaningful contribution to enabling young people to find gainful employment. The placement can last between 2 weeks and 6 months. The Measure can only be used once per person, within a 12-month period. Examples of meaningful work placements include work on junior-level tasks providing industry experience and insight.
NT10	Employment of new apprentices	no. weeks	This Measure covers the employment of new apprentices at level 2 or higher. Qualifying apprenticeships must follow an established path of progression to ensure timely completion and should be supported by the organisation until complete. This Measure can only be used to record opportunities for new employees and not upskilling for existing employees.
NT1	Local people employed or retained	no. people FTE	This Measure covers the employment of local people. Qualifying employees must live in the local area, have an employment contract that reflects the hours they regularly work with a guaranteed minimum working time of 16 hours per week and at least 4 weeks of notice for shifts in the working pattern. The Full Time Equivalent (FTE) calculation must be derived from the length of the employment contract within the reporting period. The Measure requires a definition of the local area.

Measure Definitions (cont.)

NT80	Upskilling of existing employees through accredited training	no. weeks	This Measure covers the upskilling of existing employees through accredited vocational training. Qualifying courses are at level 2 or higher such as: BTEC, City & Guilds, NVQ, HNC, RQF or T-levels. Courses must be completed by the employee and supported by the organisation until qualification is attained.
Providing support to build community wellbeing			
NT26	Support for community health or wellbeing interventions	£ invested inc. time, materials, equipment etc	This Measure covers support for a range of initiatives aimed at promoting and increasing health and wellbeing in a community such as fitness programmes, nutrition support and smoking, alcohol, and drug abuse reduction initiatives, etc. These can be run in partnership with a VCSE or as part of a company programme. Recorded hours of staff time can only include time spent preparing and conducting the activities. Each of the types of support offered should be recorded separately.
Providing targeted in-kind support to VCSE organisations			
NT15	Expert support to VCSEs and SMEs	no. staff expert hours	This Measure covers employees providing their expertise to Voluntary, Community and Social Enterprises (VCSEs) or Small and Medium Enterprises (SMEs). Qualifying activities include a range of expert-led sessions offering specialist business advice that builds the capacity of VCSEs and SMEs. Recorded hours of staff time can only include time spent preparing and conducting the activities. An employee's expert hours can only be recorded if they have been allocated time during paid working hours or time off in lieu.
NT16	Support for VCSEs through donations	£ invested	This Measure covers financial and in-kind contributions to Voluntary, Community and Social Enterprises (VCSEs). This Measure cannot be used for staff donations or donations raised from third parties at fundraising events.
Increasing local spend and local SME spend			
NT18	Spend with local companies in the supply chain	£	This Measure covers spend with local suppliers and reflects the economic and social benefits to the local community. It allows for adjustment by local area and industry. The Measure requires a definition of the local area.
NT19	Spend with local SMEs in the supply chain	£	This Measure covers spend with local suppliers which are Small and Medium Enterprises (SMEs) and reflects the economic and social benefits to the local community. It allows for adjustment by local area and industry. The Measure requires a definition of the local area.

Measure Definitions (cont.)

Providing decarbonisation support to SMEs			
NT15a	Expert support to VCSEs and SMEs to achieve net zero carbon	no. staff expert hours	This Measure covers employees providing their expertise on the circular economy to internal staff, Voluntary, Community and Social Enterprises (VCSEs) or Small and Medium Enterprises (SMEs). Qualifying activities include a range of expert-led sessions offering specialist business advice that builds the capacity of VCSEs and SMEs. Recorded hours of staff time can only include time spent preparing and conducting the activities. An employee's expert hours can only be recorded if they have been allocated time during paid working hours or time off in lieu.

Social Value Model Alignment

Partners within scope of Procurement Policy Note 06/20 may wish to align measures in the RTP Social Value Measurement Framework to the **Social Value Model**. The mapping below demonstrates how the measures align to the Themes set out in the Model. Partners have also been equipped with a separate TOM System-Social Value Model mapping spreadsheet which provides mapping at Model Award Criteria level.

TOM Ref	Measure	COVID-19 Recovery	Tackling economic inequality	Fighting Climate Change	Equal opportunity	Wellbeing
NT8	Support for students at local educational institutions	✓	✓			✓
NT98	Expert curriculum support for universities and colleges	✓	✓			✓
NT13a	Providing targeted work placements paying at the Real Living Wage+	✓	✓		✓	
NT10	Employment of new apprentices	✓	✓		✓	
NT1	Local people employed or retained	✓	✓			
NT9	Accredited training for new employees	✓	✓			
NT80	Upskilling of existing employees through accredited training	✓	✓		✓	
NT26	Support for community health or wellbeing interventions	✓				✓
NT15	Expert support to VCSEs and SMEs	✓	✓			✓
NT16	Support for VCSEs through donations	✓				✓
NT18	Spend with local companies in the supply chain		✓			
NT19	Spend with local SMEs in the supply chain		✓			
NT15a	Expert support to VCSEs and SMEs to achieve net zero carbon		✓	✓		

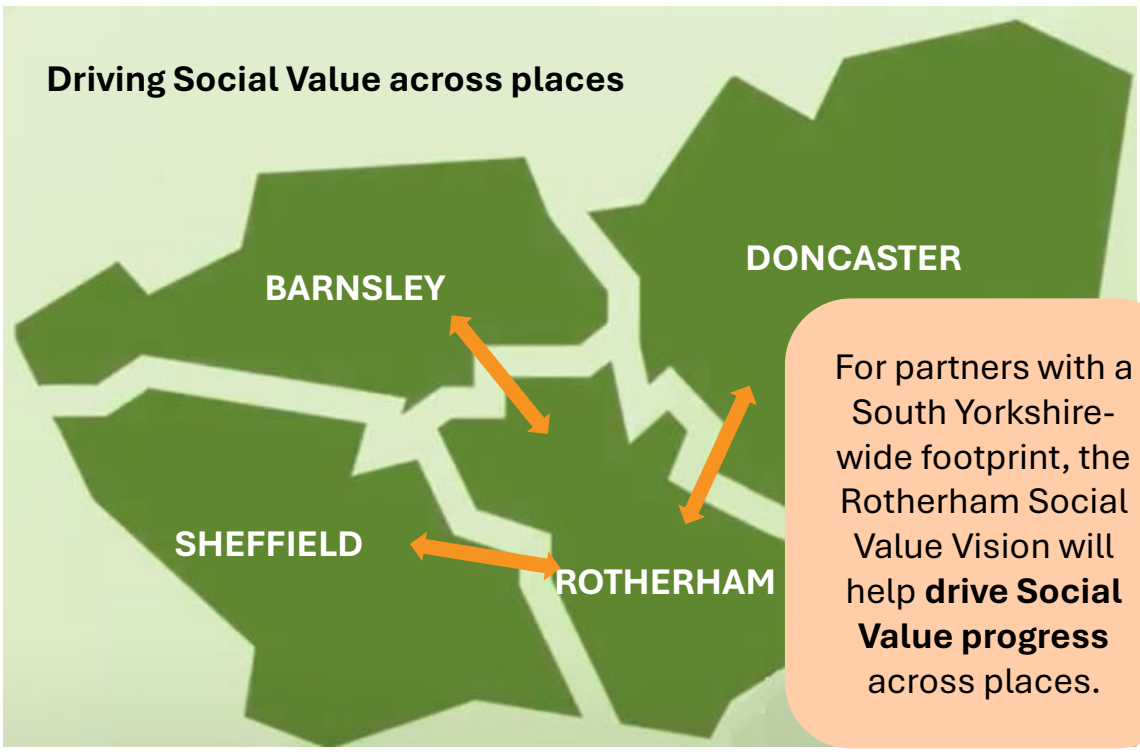
South Yorkshire Progress

The Rotherham Together Partnership recognises that several partners operate across multiple South Yorkshire places. Where this is the case, partners are obliged to drive supplier and provider Social Value commitments across multiple geographical specifications:

a) **Rotherham-specific** procurement spend
b) Procurement spend specific to **another or multiple places** within South Yorkshire
c) **South Yorkshire-wide** procurement spend

The Rotherham Social Value Vision and target of £53,500,000 annual Social Value is calculated from procurement spend on goods and services for Rotherham (across a-c). However, this Action Plan has been designed to support South Yorkshire-wide partners to embed a **consistent Social Value approach across all procurement spend.**

Doing so will support South Yorkshire-wide partners to align their Social Value approach with local anchor institutions in other South Yorkshire places and **increase Social Value across all South Yorkshire** places.



To maximise the opportunity to drive progress across places, Social Value senior officers and Champions from South Yorkshire-wide partners will decide at which of **two levels** each action in this Action Plan will be executed to best suit their context:

i **Actions executed at a South Yorkshire level.**

For example, South Yorkshire-wide partners will likely wish to adopt a single Social Value Measurement Framework (action [3]) to cover procurement spend across all places. To support this, the RTP Measurement Framework has been designed using the TOM System™ , which is already used by multiple Local Authorities across South Yorkshire. Partners are also able to incorporate additional measures should they choose to reflect priorities across different places.

ii **Actions executed at a place level.**

For example, South Yorkshire-wide partners may wish to deliver implementation training (action [6]) at a Rotherham level before to build capability and capacity before rolling out more widely.

Social Value Portal

ROTHERHAM TOGETHER PARTNERSHIP

Board of Directors' Meeting
7 March 2025

Agenda item	P45/25
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 January 2025 (Month 10 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 January 2025 (Month 10 2024/25: o Financial results for January 2025. - A control total surplus to plan of £694K in month and £1,051K 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 £776K). • 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 £5,114K. o 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 January 2025 (Month 10 2024/25) o Results for January 2025 show expenditure of £793K in month and £5,979K year to date against a budget of £8,100K, an under-spend of £2,121K (26%). 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 January 2025. A month-end cash value as at 31st January 2025 of £6,094K, which is £2,315K favourable to plan, in part due to the deficit funding being received.
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 25th February 2025. • CIP performance was discussed at the Efficiency Board meeting held on 12th February 2025 and it was discussed at the Financial Recovery Meeting on 13th February 2025. • Capital expenditure was reviewed at the Capital Monitoring Group held on 17th February 2025. • Detailed discussions have also taken place at the meeting of Finance & Performance Committee on 26th February 2025, 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	Forecast variance £000s
I&E Performance (Actual)	(109)	582	691	(1,735)	(2,320)	(585)	(4,648)	(7,302)
I&E Performance (Control Total)	(48)	646	694	(493)	(1,544)	(1,051)	(5,114)	(7,770)
Capital Expenditure	1,160	793	367	8,100	5,979	2,121	0	0
Cash Balance	(1,964)	(4,459)	(2,495)	3,779	6,094	2,315	4,718	0

1.2 The Trust has under-spent against its I&E control total in January 2025 by £694K and year to date it has over-spent by £1,051K. 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 £1,866K year to date, it is expected that this will be recovered through additional targeted schemes and from a review to provide assurance that the coding 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 £5,979K against a budget of £8,100K. 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 January 2025 is £6,094K and is favourable to plan by £2,315K. This is due to the receipts (year to date) for deficit funding and underspends on the capital schemes year to date.

2. Income & Expenditure Account for January 2025 (Month 10 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 January 2025 of £694K and a deficit to plan of £1,051K 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	348,594	29,422	29,592	170	291,528	295,350	3,822	
Other Operating Income	25,128	2,102	3,606	1,504	21,043	24,936	3,893	
Pay	(245,726)	(20,739)	(22,404)	(1,665)	(205,535)	(218,535)	(13,000)	
Non Pay	(106,235)	(9,664)	(10,967)	(1,303)	(91,486)	(99,233)	(7,746)	
Non Operating Costs	(4,743)	(444)	(340)	104	(3,997)	(3,434)	563	
Reserves	(18,966)	(787)	1,094	1,881	(13,288)	(1,404)	11,884	
Retained Surplus/ (Deficit)	(1,949)	(109)	582	691	(1,735)	(2,320)	(585)	
Adjustments	1,365	61	64	3	1,242	776	(466)	
Control Total Surplus/ (Deficit)	(584)	(48)	646	694	(493)	(1,544)	(1,051)	

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 £1,109K. These figures include an adverse year to date position on ERF in 2024/25 of £1,866K. 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 (£1,073K), which will be an offset to the pay over-spend, and increased research, education and training income (£1,287K) and clinical services SLAs £890K.

2.4 Pay costs are over-spending by £13,000K year to date. Bank and agency expenditure is not currently being maintained within the gross establishment budget, and contributing to this is £3,227K under-delivery against the planned cost improvements.

2.5 Non Pay costs are over-spending by £7,746K year to date. The overspend is largely related to Drugs and Clinical Supplies £5,693K, Premises £953K, and under-delivery against cost improvement plans of £1,160K.

2.6 The positive performance in Non-Operating Costs is due to the inflationary uplift on the Carbon Energy Fund (Service Concession) lease of £426K.

2.7 £11,884K has already been released from Reserves year to date, this is to cover the under-delivery of CIP, and additional capacity over and above funded bed capacity.

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 £5,114K 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	348,594	353,077	4,483	3,822	661	4,483	
Other Operating Income	25,128	29,671	4,543	3,893	650	4,543	
Pay	(245,726)	(262,285)	(16,559)	(13,000)	(3,559)	(16,559)	
Non Pay	(106,235)	(115,902)	(9,667)	(7,746)	(1,921)	(9,667)	
Non Operating Costs	(4,743)	(4,076)	668	563	105	668	
Reserves	(18,966)	(7,082)	11,884	11,884	0	11,884	
Retained Surplus/ (Deficit)	(1,949)	(6,597)	(4,648)	(585)	(4,064)	(4,648)	
Adjustments	1,365	899	(466)	(466)	(0)	(466)	
Control Total Surplus/ (Deficit)	(584)	(5,698)	(5,114)	(1,051)	(4,064)	(5,114)	

3.2 Within Clinical Income, the estimated ERF YTD under delivery against divisional targets is reflected of £1,866K. 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 £1,109K.

3.3 Other Operating Income is forecasting increases in income from research, development, education & training (£1,582K), staff recharges (£1,326K) and clinical SLAs (£1,021K). 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 £4,206K and premium agency cost FOT variance of £4,570K. 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 £1,121K, undelivered CIPs £1,675K, and drugs and clinical supplies £6,833K, 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 and a favourable inflationary uplift to the Carbon Energy Fund (Service Concession) lease compared to plan.

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 recovery plans to continue 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 January 2025 the Trust incurred capital expenditure of £793K, and year to date it is £5,979K. Schemes are progressing and it is expected that the Trust will spend its full capital allocation.

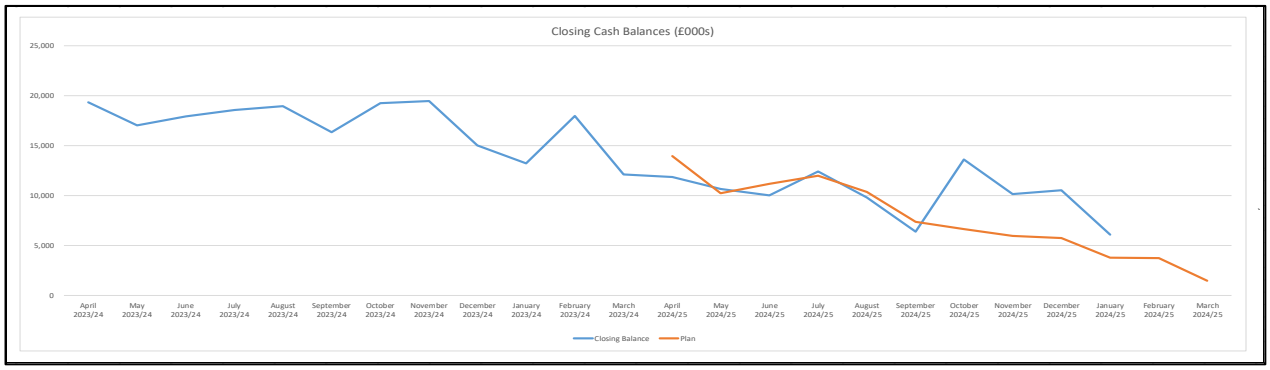
Capital Expenditure	Month			Year to date			Forecast	Prior Month
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Variance £000s	Forecast Variance £000s
Estates Strategy	334	71	263	2,645	1,972	673	0	0
Estates Maintenance	394	152	242	3,025	1,543	1,482	0	0
Information Technology	42	443	(401)	1,530	1,619	(89)	0	0
Medical & Other Equipment	236	126	110	920	845	75	0	0
Other	154	0	154	(20)	0	(20)	0	0
TOTAL	**1,160**	**793**	**367**	**8,100**	**5,979**	**2,121**	**0**	**0**

4.2 The planned capital spend for the year is £17,030K. This includes an additional £5,880K of capital PDC which has been agreed since the plan submission. The Trust is awaiting confirmation from SYICB/NHSE regarding a further capital allocation of £400k, this is not currently included within the £17,030K.

4.3 Additional PDC capital funding was agreed in Dec 2024 of £7m. This will be split over 2024/25 (£5.5m) and 2025/26 (£1.5m). This has been agreed from the Additional Capacity Targeted Investment Fund (ACTIF) to expand our Urgent and Emergency Care Centre (UECC). The funding is to be used to increase our patient capacity for urgent care and minor injuries, medical same day emergency care (SDEC), and to improve our work towards the national four-hour emergency care standard.

5. Cash Management

5.1 The cash position at the end of December is £6,094K and is favourable to plan by £2,315K. This is due to the receipt of deficit funding and underspends year to date on the capital schemes. This has allowed the Trust to earn interest on its daily cash balances of £706K year to date.



Steve Hackett
Director of Finance
10 February 2025

Board of Directors Meeting
February 2025

The Rotherham NHS Foundation Trust

Agenda item	P46/25
Report	**Integrated Performance Report**
Executive Lead	Bob Kirton, Deputy Chief Executive
Link with the BAF	D5, D6, P1, R2
How does this paper support Trust Values	The Integrated Performance Report supports the Trust's *Ambitious* value in ensuring we are constantly striving to deliver stronger performance across all of the core domains.
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	The Integrated Performance Report (IPR) provides a monthly overview of the Trust's performance across four key areas: Operational Delivery, Quality, Finance, and Workforce. This report covers data from January 2025, 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 Deputy CEO 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 – January 2025

Board of Directors Meeting

Integrated Performance Report - January 2024

Performance Matrix Summary

NHS The Rotherham NHS Foundation Trust

Assurance

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

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**	**CONCERNING: CELEBRATE BUT TAKE ACTION** • 1:1 Care in Labour
Common Cause	**GOOD: CELEBRATE AND UNDERSTAND** • SHMI	**STATIC: INVESTIGATE AND UNDERSTAND** • Readmissions • Care Hours per Patient Day • Complaints (per 10k contacts) • Patient Safety Incident Investigations • Patient Falls (Moderate and above) - Community • Medication Incidents (Moderate and above) – Acute and Community • Pressure Ulcers (Cat 3 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 • Patient Falls (Moderate and above) – Acute	**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" (104.8)	Sep-24	N/A	P		-	G
Readmissions (%)	-	6.3	Dec-24	-	-			S
VTE Risk Assessments (%)	95.0	94.0	Dec-24	☒	?	L		C
Care Hours per Patient Day	7.2	6.8	Jan-25	☒	?			S
Combined Positivity Score (%)	95.0	92.8	Dec-24	☒	?	L	-	C
Complaints (per 10k Contacts)	8.0	11.5	Jan-25	☑	?		-	S
Patient Safety Incident Investigations	3	3	Dec-24	☑	?		-	S
Patients Falls (Moderate and Above per 1000 bed days)	0.19	0.23	Jan-25	☒	?	H	-	C
Pressure Ulcers Cat 3/4/STDI and Unstageable per 1000 bed days - Acute	0.77	1.76	Jan-25	☒	?		-	S
Pressure Ulcers Cat 3/4/STDI and Unstageable per 100 contacts - Community	0.06	0.11	Jan-25	☒	?		-	S
Medication Incidents - Moderate and Above per 1000 bed days – Acute	0.06	0.15	Jan-25	☒	?		-	S
Medication Incidents - Moderate and Above per 100 contacts - Community	0.00	0.00	Jan-25	☑	?		-	S
C. difficile Infections	4	7	Jan-25	☒	?			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

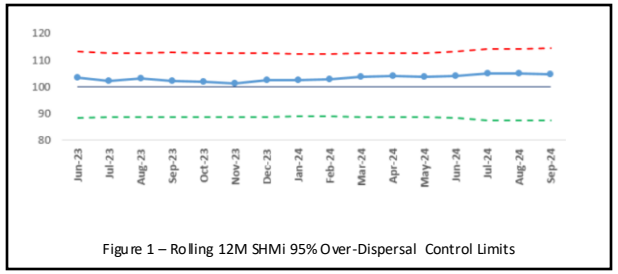


Figure 1 – Rolling 12M SHMi 95% Over-Dispersal Control Limits

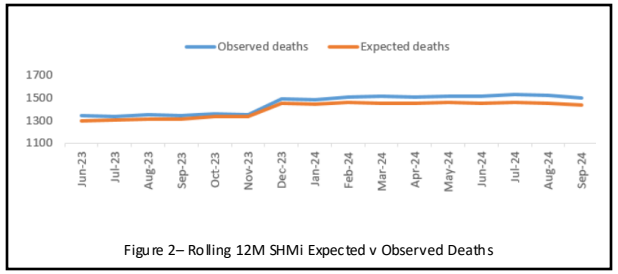


Figure 2– Rolling 12M SHMi Expected v Observed Deaths

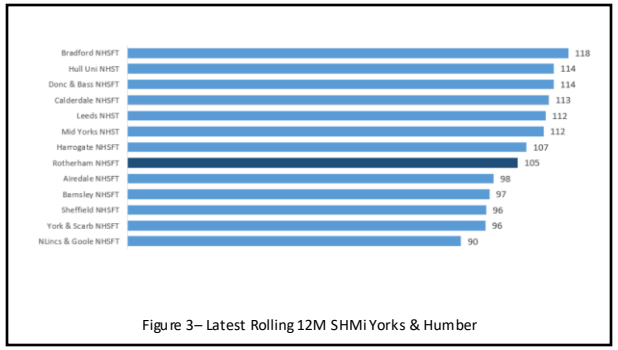


Figure 3– Latest Rolling 12M SHMi Yorks & Humber

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 -Sep 24	104.8	-	Jo Beahan	John Taylor
Expected Deaths	1435	-		
Observed Deaths	1500	-		
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?

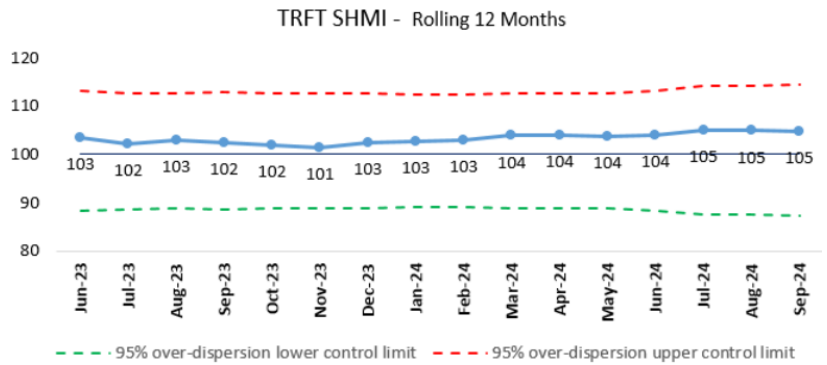
- Investigations or reviews resulting from SHMI investigations will give the Trust Assurance when there are significantly more deaths observed than expected
- Intelligence from SHMI investigations/reviews may lead to changes/improvements in practice

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

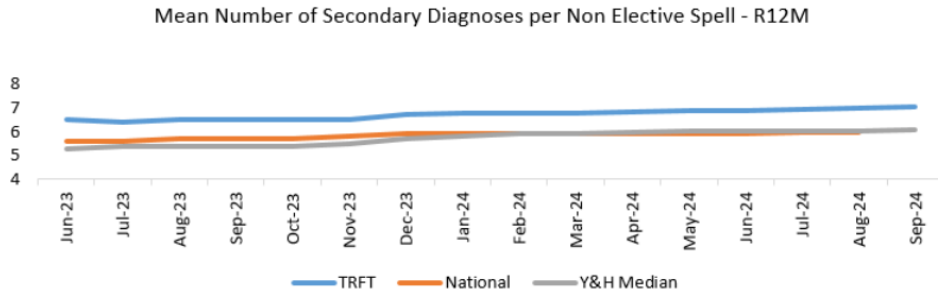
SHMI Update



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: Summary Hospital-Level Mortality Indicator

SHMI: Coding & Alerts

SHMI - Diagnostic Group Alerts

TRFT currently has no alerts for its diagnostic groups.

The last alert was for Fluid & Electrolyte Disorders for the SHMI release in Sept 2024.

Diagnosis Group	SHMI banding
Acute bronchitis	As Expected
Acute myocardial infarction	As Expected
Cancer of bronchus; lung	As Expected
Fluid and electrolyte disorders	As Expected
Fracture of neck of femur (hip)	As Expected
Gastrointestinal hemorrhage	As Expected
Pneumonia (excluding TB/STD)	As Expected
Secondary malignancies	As Expected
Septicaemia (except in labour), Shock	As Expected
Urinary tract infections	As Expected

SHMI Changes – Methodology, Process or Specification

No new changes

SHMI Coding Metrics –

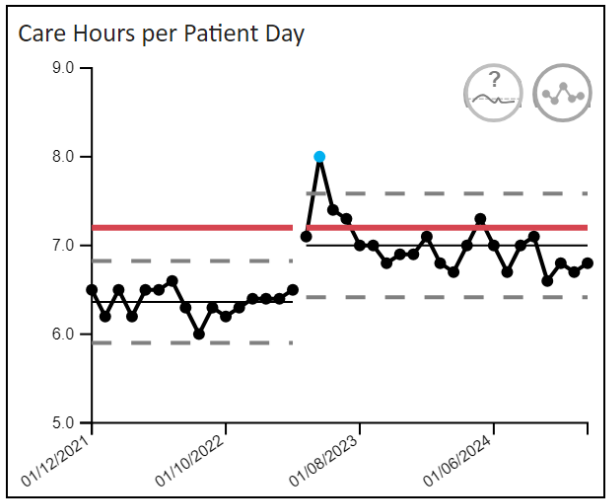
TRFT continue to have a high rate of spells with an Invalid Primary Diagnosis Code and where the code is a Sign or Symptom.

TRFT continue to have a high depth of comorbidity coding for its non elective spells.

TRFT Rank of 13	3rd Highest	3rd Highest	2nd Highest	7th Highest	4th Highest
Yorks & Humber 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	33.0	21.0	4.1	1.3	25
NLincs & Goole NHSFT	17.4	0.1	4.8	1.3	29
Rotherham NHSFT	16.8	3.0	7.1	2.0	47
Barnsley NHSFT	14.5	0.0	7.7	2.6	48
Airedale NHSFT	14.5	0.0	4.7	1.2	25
York & Scarb NHSFT	13.4	0.0	6.1	1.2	27
Donc & Bass NHSFT	12.4	0.1	5.0	2.2	51
Bradford NHSFT	11.2	3.9	3.7	1.2	38
Sheffield NHSFT	9.9	0.0	5.1	1.7	36
Mid Yorks NHST	8.8	0.5	6.8	2.2	42
Hull Uni NHST	8.0	*	6.1	2.3	37
Calderdale NHSFT	7.0	*	6.9	3.1	48
Leeds NHST	5.5	0.0	6.5	2.2	37
England	14.4	2.3	6.0	2.1	44

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 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.
- CHPPD for January was 6.8 against planned 7.2
- Percentage of fill rate against funded establishment is below;
- Fill rates for RN days was 91%
- Fill rates for HCSW days was 85%
- Fill rates for RN nights was 99%
- Fill rates for HCSW nights was 108%
- Twice daily staffing huddles continue and actions fed into bronze operational meeting.
- The safe staffing escalation SOP is used to ensure all areas are safely staffed.
- All staff redeployments, unavailability's and bank and agency use are picked up in roster meetings and weekly bank/agency meeting.

Metric	Value	Target	Exec Lead	Ops Lead
Care Hours per Patient Day	6.8	7.2	Helen Dobson	Cindy Storer

What actions are planned?

- Continued roll out of the Exemplar Accreditation programme.
- 14 NRN are planned to start throughout January 2025
- HCSW/CSW recruitment is re-starting in January now the national job profiles updates have been completed.
- Retention work still sees sustained improvements in leaver rates
- B4 winter ward now on Roster

What is the expected impact?

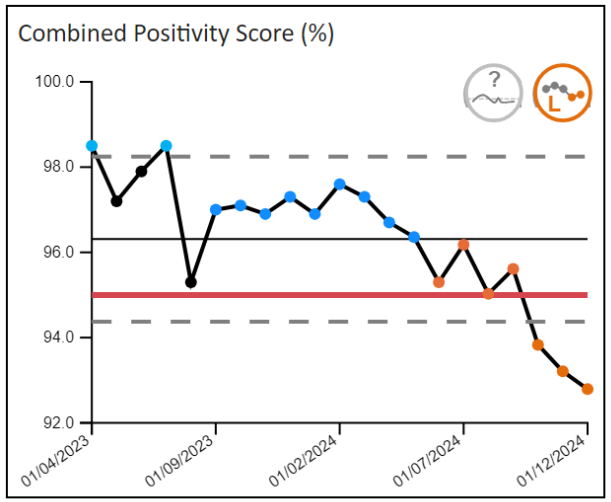
- CHPPD planned versus actual within 5% range
- Clinical quality and safety outcomes are maintained and unwarranted variation reduced across ward areas.

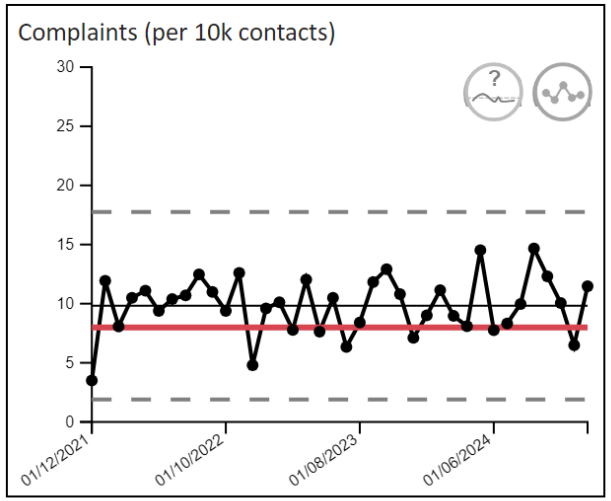
Potential risks to improvement?

- Needing to open additional beds due to operational pressures using existing establishments and temporary NHS staff
- Roster KPI not being met
- Increased sickness of 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 January to 92.8% with an increase in negative responses in UECC and IP wards.
- Deterioration in FFT in UECC is impacting on the overall Trust score. This is likely linked to long waits in UECC during this period of deterioration.
- The number of complaints has been a consistent rate of written complaints per month over the last three years, despite the rising numbers of patients being seen.
- There has been over 1000 contacts through the new PALS since September. All issues have been resolved in real time and no PALS contacts have progressed to a formal complaint. The numbers of concerns have dropped by 35% since the new PALS opened.

Metric	Value	Target	Exec Lead	Ops Lead
Combined Positivity Score (%)	92.8	95.0	Helen Dobson	Cindy Storer
Complaints (per 10k contacts)	11.5	8.0	Helen Dobson	Cindy Storer

What actions are planned?

- Meeting with UECC teams to discuss deterioration in position. Support with long length of stay and flow through the organisation continues.
- Front line resolution through the 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?

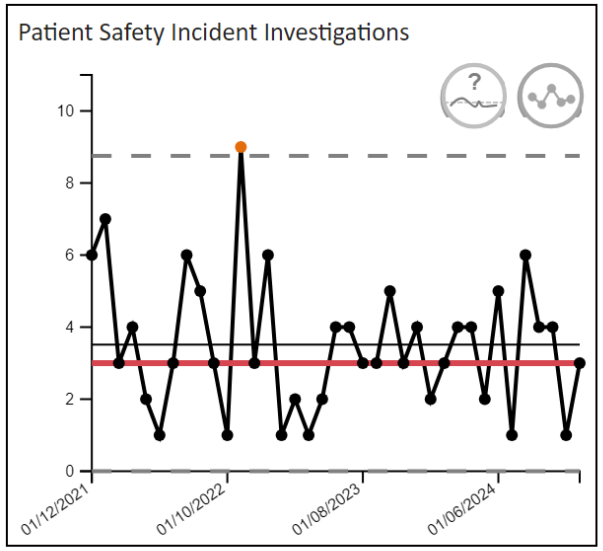
- FFT Positivity score above 95
- The PALS service aims to promote local resolutions to concerns earlier in the process leading to a reduction in concerns being raised.
- Patient flow through the hospital improves and waits in UECC improve

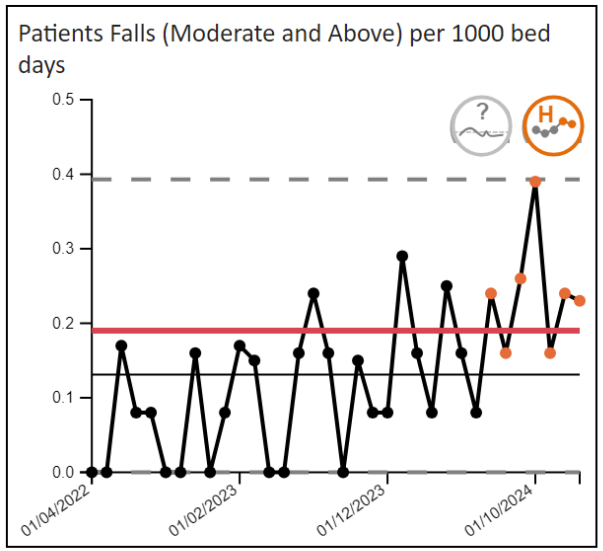
Potential risks to improvement?

- 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 PSII remain consistent per month.
- The updated Patient Safety Incident Response plan now provides clear guidance on what the national criteria is for PSII and the Trust guidance for the type of incident response required when a patient safety incident occurs.
- The number of patient falls at moderate harm has risen over the past two months. This can be triangulated against an increased number of attendances, requirement for additional inpatient capacity and nurse staffing levels.
- The patients who suffered a moderate harm due to a fall were all reviewed and discussed at incident review group. In 1 case there was missed opportunities. In all other cases full interventions and mitigations were in place.

Metric	Value	Target	Exec Lead	Ops Lead
Patient Safety Incident Investigations	3	3	Helen Dobson	Victoria Hazeldine
Patients Falls (Moderate and Above) per 1000 bed days	0.23	0.19	Helen Dobson	Victoria Hazeldine

What actions are planned?

- A Falls Prevention Lead has now been agreed for the Trust to help reduce the total number of all falls and moderate harm falls through Qi projects and education. This post will be recruited to within the next 1 month.
- There has been a focused deep dive into the moderate harms falls.
- The Patient Safety Incident Response Plan has now been published with a clear direction on when a PSII is warranted.

What is the expected impact?

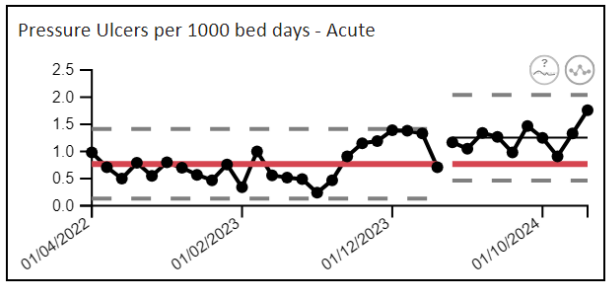
- Stabilisation of PSII's with adequate evidence of shared learning
- There is likely to be an increase in the number of After Action Reviews due to the new categorisation for when a PSII is warranted.
- Reduction in the total number of falls
- Key themes identified from moderate harm falls will drive a Qi initiative

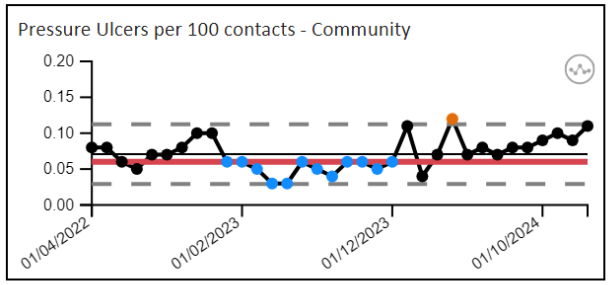
Potential risks to improvement?

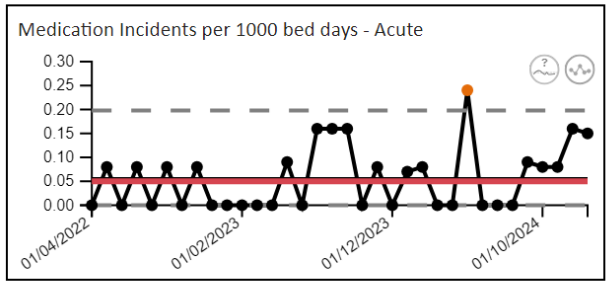
- Increase in the number of patients admitted to acute Trust with complex health problems and additional bed capacity, resulting in reduced nursing and medical ratios
- The lack of a falls lead practitioner to complete work across acute and community to ensure the Trust is compliant with NAIF and Qi initiatives

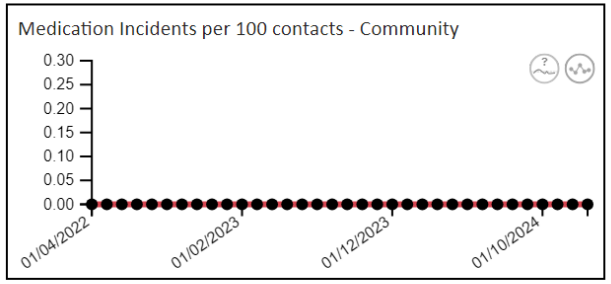
Subtheme: Care Incidents (2)

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.
- 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 per 1000 bed days - Acute	1.76	0.77	Helen Dobson	Victoria Hazeldine
Pressure Ulcers per 100 contacts - Community	0.11	0.06	Helen Dobson	Victoria Hazeldine
Medication Incidents per 1000 bed days - Acute	0.15	0.05	Jo Beahan	Victoria Hazeldine
Medication Incidents per 100 contacts - Comm...	0.00	0.00	Jo Beahan	Victoria Hazeldine

What actions are planned?

- Medication incidents at moderate harm and above remain low, however actions to address those incidents related to critical medication have been identified and will be presented at the next Medication Safety Committee.
- Pressure Ulcer Identification Tool audit has demonstrated improved compliance.
- The Trust will be completing an implementation plan to come into line with the National Guidance of having only Category 1,2,3 and 4.
- Business case currently being completed for a full mattress replacement program.

What is the expected impact?

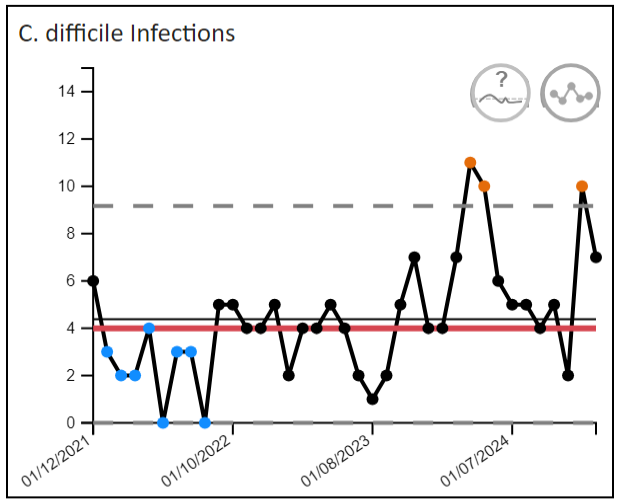
- Reduction in the number of critical medication incidents.
- Removal of the SDTI category.
- There will be an increase in Category 3 PU's as under the new guidance, SDTI will now be Category 3.
- Converting to hybrid mattresses will mean that patients requiring pressure relieving equipment will have it immediately and reduce the incidence of PU's.

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.
- April, May, December and January 24/25 showed higher than expected rates.
- Nationally there is a trend for increasing rates of C. diff with a renewed focus on AMR. The UKHSA safety alert has been shared with clinicians
- Rates per 100,000 bed days from UKHSA have been published for Q2 which shows the Trust having a mean rate for this period. Likely to increase again for Q3
- 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.

Metric	Value	Target	Exec Lead	Ops Lead
C. difficile Infections	7	4	Helen Dobson	Jen Hilton

What actions are planned?

- Monthly Harm Free panel continues with shared learning on timely stool sampling from symptomatic patients on admission
- Grand round performed by consultant microbiologist on antibiotic prescribing
- Meeting with UKHSA took place in February to discussion actions in place with no new recommendations
- Antibiotic guidance in UECC pathways reviewed and updated

What is the expected impact?

- A stabilisation of C. diff cases associated per 100,000 bed day rate

Potential risks to improvement?

- National patterns of increases in rates of C. diff
- Limited availability of single rooms

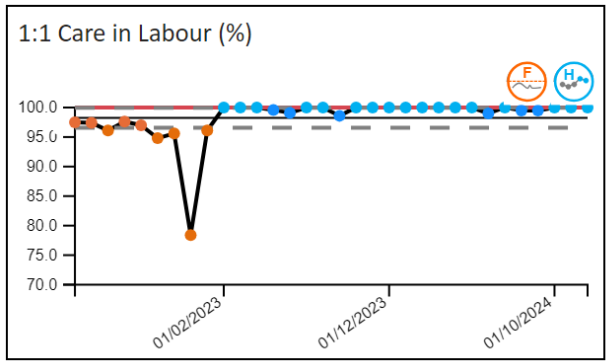
Maternity

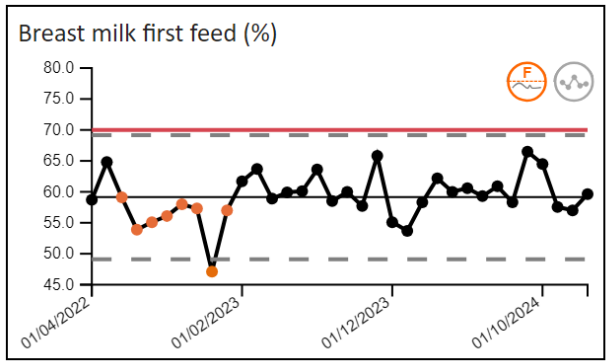
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
1:1 Care in Labour (%)	100.0	100.0	Dec-24	☑			-	CI
Breast milk first feed (%)	70.0	59.6	Jan-24	☒				C
Stillbirth rate (per 1000 births)	4.66	4.1	Jan-24	☑			-	C

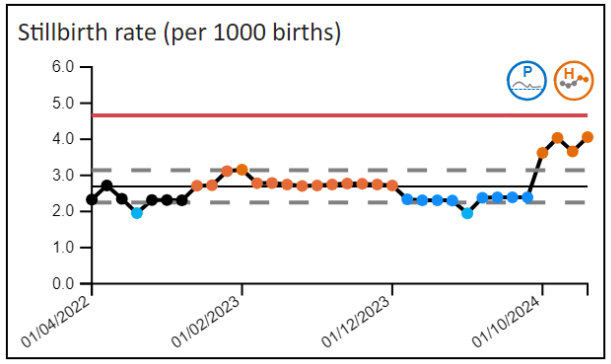
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

Subtheme: Maternity

Data, Context and Explanation







- No concerns currently with 1:1 care in labour.
- Breast Milk First Feed % continues to be below the Trust target, with an average of 59.6% against a Trust target of 70%. This is a slight improvement of the previous month but actions continue to aid improvement.
- In January 2025 we had one stillbirth reported at 37+6 weeks gestation due to placental abruption. Initial finding are that all care was appropriate. The stillbirth rate as a rolling figure in January 2025 has increased from the previous month to 4.1 stillbirth per 1000 births. The current South Yorkshire stillbirth rate is 3.29 per 1000 births. The 2024 stillbirth rate for TRFT was 3.66 stillbirths per 1000 births.

Metric	Value	Target	Exec Lead	Ops Lead
1:1 Care in Labour (%)	100.0	100.0	Helen Dobson	Sarah Petty
Breast milk first feed (%)	59.6	70.0	Helen Dobson	Sarah Petty
Stillbirth rate (per 1000 births)	4.1	4.66	Helen Dobson	Sarah Petty

What actions are planned?

- 1:1 care in labour – continue to monitor for variation.
- Breast milk first feed – continue with action plans to move infant feeding status to BFI gold following reaccreditation at TRFT to level 3 accreditation. Work will consider the inequalities and inequities seen in the Rotherham birthing population to attempt to improve rates.
- Stillbirth rate: - To review current MBRRACE reports for all Trusts Nationally and await new national stillbirth rate target in order to reset the TRFT target. Following a recent SBLV3 progress report (2023) it is evident that the NHS *halving stillbirth and infant deaths (2015) campaign* has fallen short nationally to reach the ambitus targets previously set to reduce stillbirths.

What is the expected impact?

- Safety of women and babies will be maintained on labour ward
- Rates of first feed breastmilk will increase for all women who are cared for at TRFT.
- Learning from recently released reports and pending national recommendations will inform the work undertaken at TRFT to monitor, learn and improve services for woman at risk of suffering a stillbirth.

Potential risks to improvement?

- If staffing levels were not maintained, 1 to 1 care in labour may be impacted.
- Lack of focus on public health work streams for pregnant women. Women are often disadvantage within the Rotherham's birthing population. TRFT maternity need to maintain focus on the health promotional needs of all women to inform of the benefits of breastfeeding.
- Stillbirth thematic reviews have demonstrated a misalignment of outcomes to that of national findings. Data analysis need to continue to find areas of improvement for TRFT.

Performance Matrix Summary – Finance and Performance

NHS 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	**GOOD: CELEBRATE AND UNDERSTAND** • FDS	**CONCERNING: CELEBRATE BUT TAKE ACTION** • RTT
Common Cause	**GOOD: CELEBRATE AND UNDERSTAND**	**STATIC: INVESTIGATE AND UNDERSTAND** • Waiting List Size • 52+ weeks - CYP • 65+ weeks • OP to PIFU • Overdue Followups • DM01 • 31 Day Treatment Standard • 62 Day Treatment Standard • >12 hours in A&E • 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 (Elective) • Mean LoS (Non-Elective) • A&E Attendances from Care Homes	**CONCERNING: INVESTIGATE & TAKE ACTION** • 4 Hour Performance • 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** • 12 hour Trolley Waits	**VERY CONCERNING: INVESTIGATE & TAKE ACTION** • 52+ weeks • Ambulance Handovers >30min

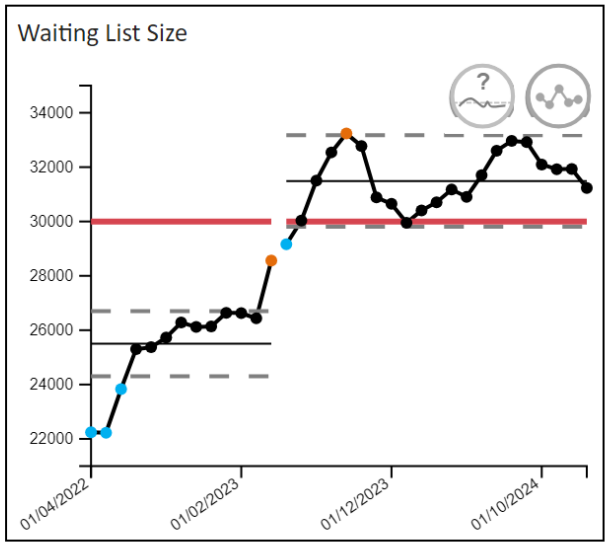
Elective Care and Cancer

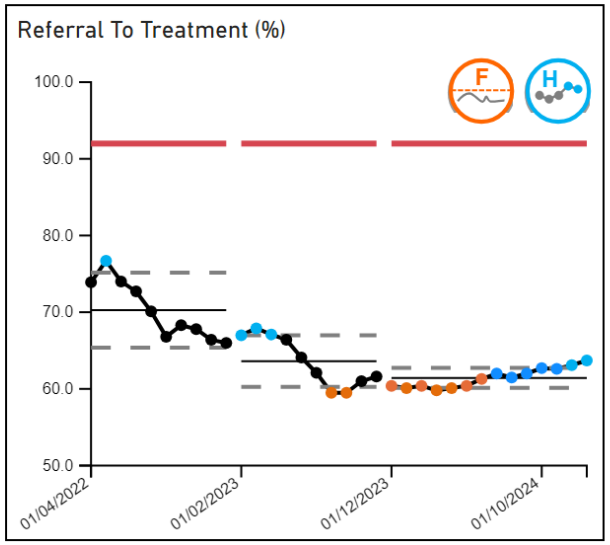
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
Waiting List Size	30,000	31,231	Jan-25	✗	?			S
Referral To Treatment (%)	92.0	63.7	Jan-25	✗	F	H		CI
Number of 52+ Weeks	500	902	Jan-25	✗	F	H		VC
Number of 52+ Weeks - CYP	0	68	Jan-25	✗	F			C
Number of 65+ Weeks	0	2	Jan-25	✗	?			S
OP Activity moved or Discharged to PIFU (%)	2.5	2.5	Jan-25	☑	?			S
Overdue Follow-ups	-	17,538	Jan-25	-	-		-	S
DM01 (%)	1.0	0.4	Jan-25	☑	?			S
Faster Diagnosis Standard (%)	77.0	85.1	Jan-25	☑	?	H		G
31 Day Treatment Standard (%)	96.0	97.3	Dec-24	☑	?			S
62 Day Treatment Standard (%)	70.0	84.0	Dec-24	☑	?			S

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

Subtheme: Waitlist & RTT

Data, Context and Explanation





- The Trust had committed to reducing the number of patients waiting over 52 weeks by 50% by March from 755 to 380. We are currently seeing an impact on elective orthopaedic capacity due to increased 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 submitted 2 breaches in Jan-25 due to patient choice. We expect to achieve 0 breaches in Feb-25.
- The last 5 months have begun to show increased performance levels, with December's RTT performance being significantly better than the preceding months.

Metric	Value	Target	Exec Lead	Ops Lead
Waiting List Size	31,231	30,000	Sally Kilgariff	Andrea Squires
Referral To Treatment (%)	63.7	92.0	Sally Kilgariff	Andrea Squires

What actions are planned?

- On-the-ground improvement support from GIRFT to commence with a focus on delivering Super Clinics and HVLC Theatre Lists
- Review of MSK pathway support by GIRFT to be commenced
- Specialty SLT's to present demand and capacity proposals for 2025/26
- TRFT Priorities and Operational Planning to be submitted to ICB for 2025/26
- Review of existing Elective Transformation Programme to build improvement actions from GIRFT review and planning guidance into the programme

What is the expected impact?

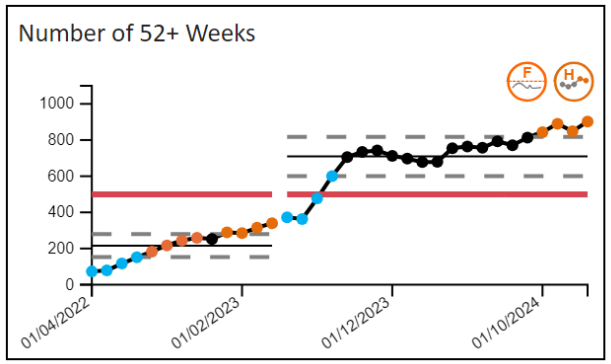
- Increased outpatient capacity and reduction in outpatient waits, with full impact anticipated by March 2025
- Improved MSK pathway releasing pressure on orthopaedics and reducing waits to be agreed by March 2025

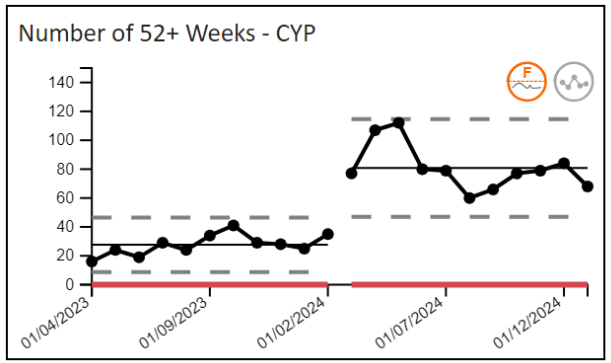
Potential risks to improvement?

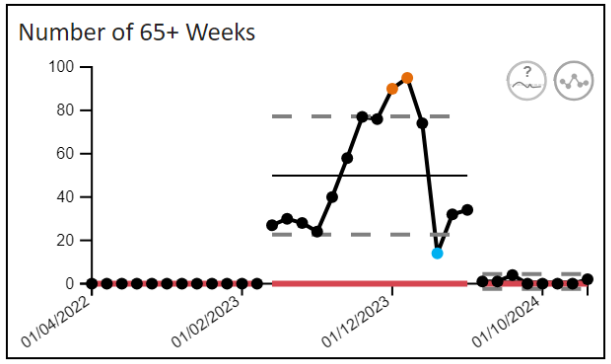
- Operational pressures could divert resources and delay the implementation of planned actions i.e. HDU capacity, elective activity
- Limited staff availability, high sickness rates, and change fatigue may impact the adoption of new processes and technologies
- Availability of financial resource to support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

Subtheme: Long Waiters

Data, Context and Explanation







- The Trust had committed to reducing the number of patients waiting over 52 weeks by 50% by March from 755 to 380. We are currently seeing an impact on elective orthopaedic capacity due to increased trauma, and delivery of this ambition remains challenging.
- Particular growth in patients waiting over 52 weeks has been noted in ENT, General Surgery, Gynaecology, OMFS, orthopaedics and urology. Insourcing and outsourcing options continue to be prioritised for these specialties.
- Similar growth is noted in children and young people waiting over 52 weeks for treatment in orthopaedics, ENT and OMFS; though these are starting to reduce.
- 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 submitted 2 breaches in Jan-25 due to patient choice. We expect to achieve 0 breaches in Feb-25.

Metric	Value	Target	Exec Lead	Ops Lead
Number of 52+ Weeks	902	500	Sally Kilgariff	Andrea Squires
Number of 52+ Weeks - CYP	68	0	Sally Kilgariff	Andrea Squires
Number of 65+ Weeks	2	0	Sally Kilgariff	Andrea Squires

What actions are planned?

- On-the-ground improvement support from GIRFT to commence with a focus on delivering Super Clinics and HVLC Theatre Lists
- Review of MSK pathway support by GRIFT to be commenced
- Continued insourcing provision in ENT and OMFS
- Continued outsourcing provision in orthopaedics

What is the expected impact?

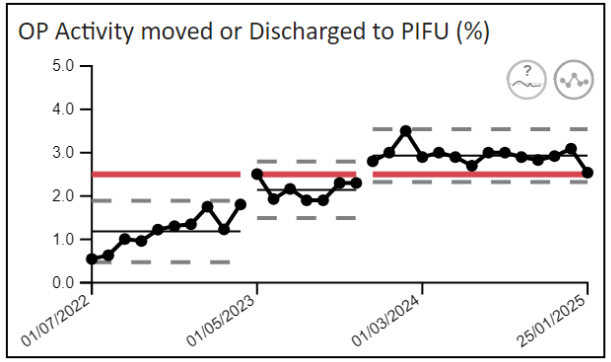
- Increased outpatient capacity and reduction in outpatient waits, with full impact anticipated by March 2025
- Improved MSK pathway releasing pressure on orthopaedics and reducing waits to be agreed by March 2025
- Zero patients breaching 65 week for ENT, OMFS and Orthopaedics

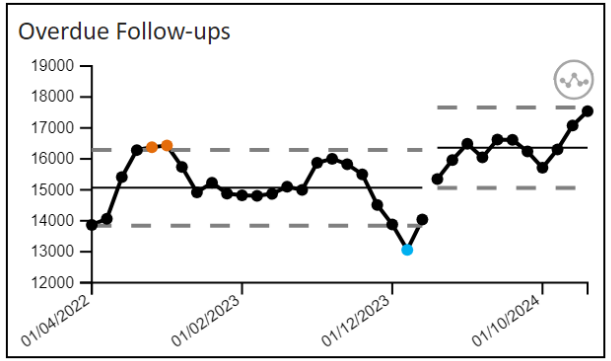
Potential risks to improvement?

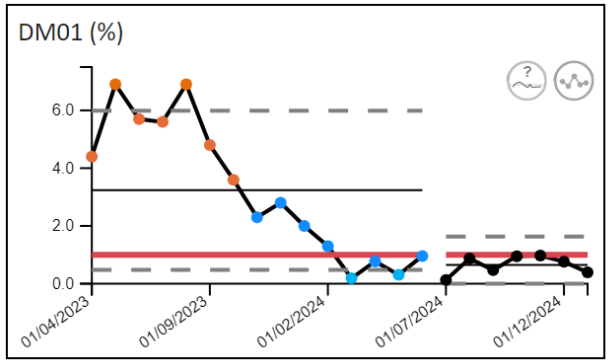
- Operational pressures could divert resources and delay the implementation of planned actions i.e. HDU capacity, elective activity
- Limited staff availability, high sickness rates, and change fatigue may impact the adoption of new processes and technologies
- Availability of financial resource to support 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 9 months have seen a step change in the average number of overdue follow ups, with recent increases seen in Gastroenterology, ENT, Respiratory, Orthopaedics and Urology. Work is ongoing to reduce the number of patients waiting for a follow up appointment.

•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 (%)	2.5	2.5	Sally Kilgariff	Andrea Squires
Overdue Follow-ups	17,538	-	Sally Kilgariff	Andrea Squires
DM01 (%)	0.4	1.0	Sally Kilgariff	Andrea Squires

What actions are planned?

- Continue to develop standardised SoP to support discharge following no abnormality detected diagnostic tests which result in discharge and roll out to all specialties
- Continue to plan and deliver super clinics for Orthopaedics, ENT, OMFS and Gynaecology
- 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?

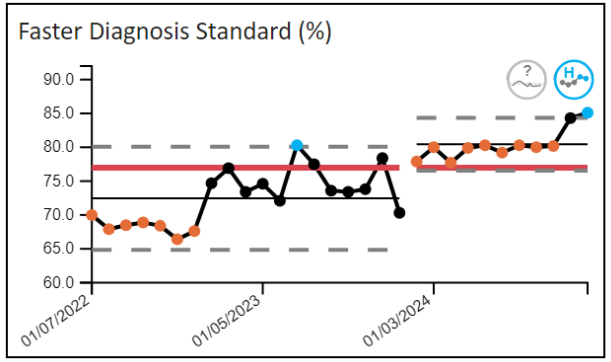
- Increased outpatient capacity released by March 2025
- Reduction in patients waiting for first outpatient appointment, with progress expected by February 2025
- Sustainability of DM01 performance through to March 2025

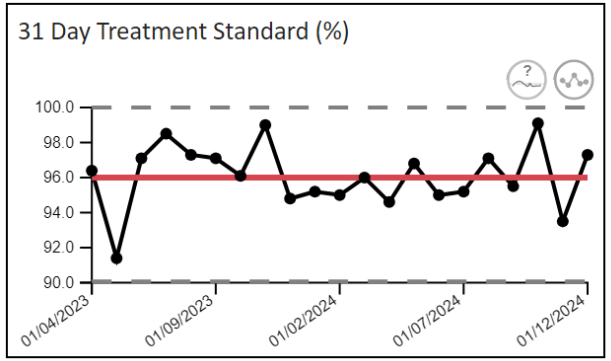
Potential risks to improvement?

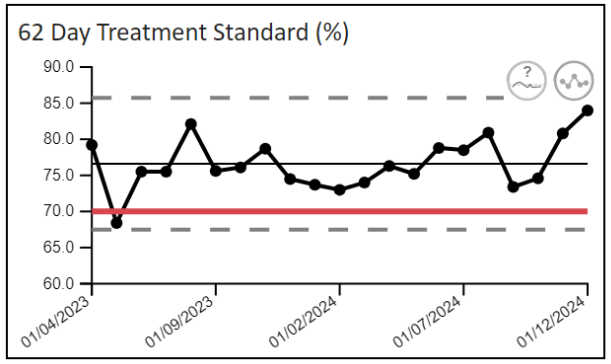
- Addition of overdue surveillance patients in endoscopy to DM01 from September 2024 requiring additional capacity may impact on DM01 performance
- Availability of financial resource to support additional activity.
- Impact of the transfer of long waits in DM01 as part of any mutual aid agreements across 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. 9 out of the last 10 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 the Lower GI tumour site 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 (%)	85.1	77.0	Sally Kilgariff	Andrea Squires
31 Day Treatment Standard (%)	97.3	96.0	Sally Kilgariff	Andrea Squires
62 Day Treatment Standard (%)	84.0	70.0	Sally Kilgariff	Andrea Squires

What actions are planned?

- Review Breast GRIFT review outputs for local consideration
- Review local 28 and 62 day stretch targets following national target uplift and successful delivery of these targets in Dec-24
- Progress Cancer Access Policy to ratification
- Progress MDT optimisation across all tumour groups
- Strengthening of improvement plans for Lower GI and Gynaecology using the CA analysis tool, as pressures across both tumour sites continue to impact on sustainability of performance

What is the expected impact?

•Improve Breast pathway to ensure patients are receiving timely access to cancer care by March 2025
•Ensure timely diagnostics and treatments to sustain compliance with the 77% 62 Day target, with sustainability achieved by March 2025
•Launch new Cancer Access Policy to raise awareness and improve oversight of CWT deliverability
•Agreed improvement plan which supports sustained performance delivery in Lower GI and Gynaecology 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

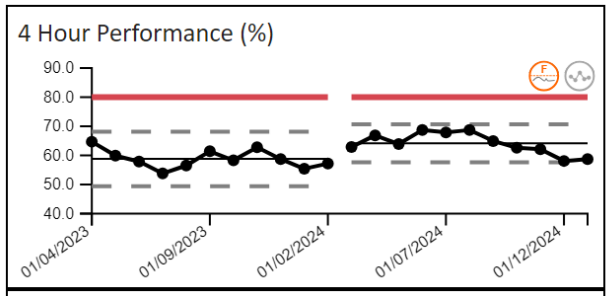
Non-elective and Flow

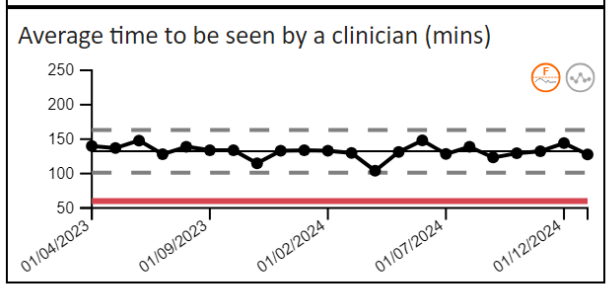
Metric	Trust Target	Latest Data	Period	Achieved (in Month)	Assurance	Variation	Quartile	Grid*
4 Hour Performance (%)	80.0	58.7	Jan-25	☒	F			C
Ambulance Handover Times >30 mins (%)	0.0	36.4	Jan-25	☒	F	H		VC
Average time to be seen by a clinician (mins)	60.0	127.7	Jan-25	☒	F		-	C
Patients spending >12 hours in A&E from time of arrival (%)	2.0	9.1	Jan-25	☒	?			S
12hr Trolley Waits	0	109	Jan-25	☒	?	H	-	C
Bed Occupancy (%)	92.0	93.5	Jan-25	☒	?			S
Length of Stay over 21 Days	64	48	Jan-25	☑	?		-	S
Patients where Date of Discharge = Discharge Ready Date (%)	85.0	83.5	Sep-24	☒	?		-	S
Criteria to Reside is No (%)	10.0	21.0	Jan-25	☒	F		-	C

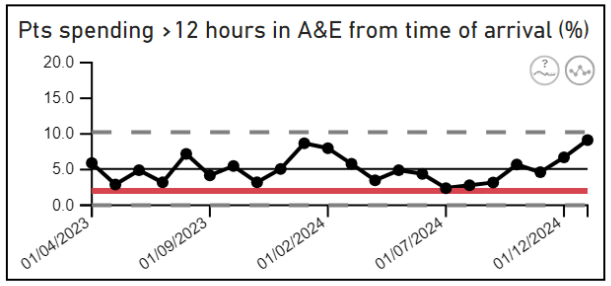
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

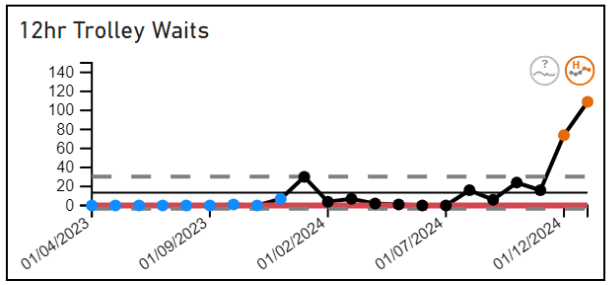
Subtheme: Emergency Care - Waiting Times

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 alongside workforce challenges continues to impact the ability to sustain improvements.
- The number of patients spending more than 12 hours in the department is a key national focus. The number of patients spending more than 12 and 16 hours within the UECC continues to increase. This is largely driven by patients awaiting admission
- The Trust has set a standard to achieve zero trolley waits in line with national guidance. Significant increase in month of patients waiting more than 12 hours for admission, with waits seen up to 24 hours.
- Ongoing challenges remain with patient flow across the trust footprint.

Metric	Value	Target	Exec Lead	Ops Lead
4 Hour Performance (%)	58.7	80.0	Sally Kilgariff	Lesley Hammond
Average time to be seen by a clinician (mins)	127.7	60.0	Sally Kilgariff	Lesley Hammond
Pts spending >12 hours in A&E from time of arrival (%)	9.1	2.0	Sally Kilgariff	Lesley Hammond
12hr Trolley Waits	109	0	Sally Kilgariff	Lesley Hammond

What actions are planned?

- Additional actions agreed through UECC recovery plan to achieve 80% by March
- Additional medic and nurse to support additional demand
- Data available to analysis delays with radiology
- New consultant started 1st February and 2nd to start 24th February
- Utilisation of Outpatients at weekends and evenings for Urgent Primary Care and GPOOH's to reduce overcrowding with Yellow area and create additional majors capacity, on going
- Internal challenge for clinician teams 59 mins to be seen by a clinician at 1600

What is the expected impact?

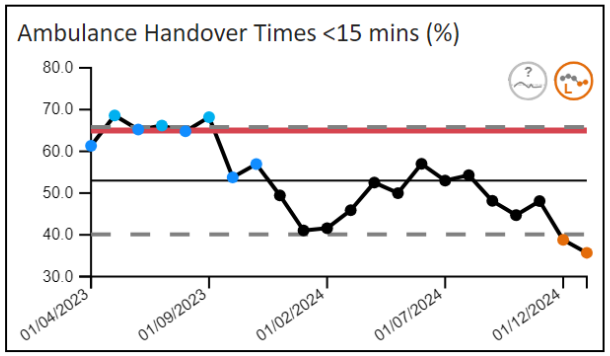
- Non-admitted performance for Primary Care, Minor Injuries will improve by March 2025
- Increased streaming to Medical SDEC
- Ongoing reduction in time to see clinician
- Improvement in the total time patients spend in the department by March 2025
- Improved time to be seen by a clinician by February 2025
- Reduction in over crowding in yellow area

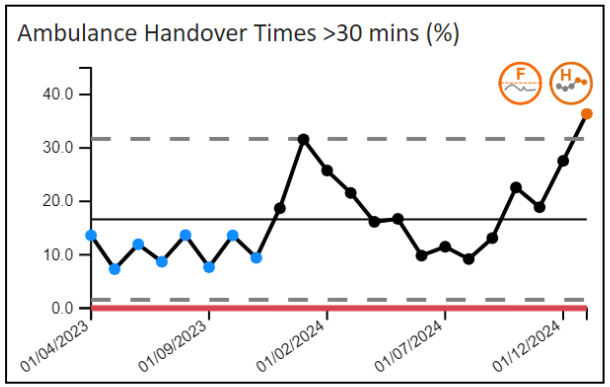
Potential risks to improvement?

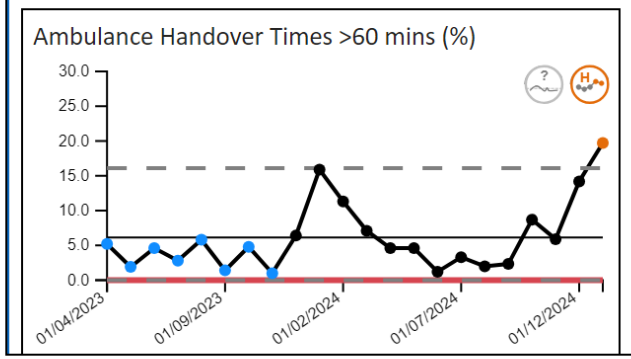
- Increase in demand will impact the Trust ability to achieve the 4 hour performance standards.
- Medical workforce staffing availability through February and March particularly at Tier 4 level
- Sickness across medical and nursing workforce
- Infection control challenges in relation to bed occupancy

Subtheme: Emergency Care - Ambulance

Data, Context and Explanation







- The Operational Planning Guidance set an objective to achieve an average of 30 minutes to handover 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%. The increased demand alongside challenges across the acute footprint with operational flow saw significant deterioration in ambulance handover times in month.

Metric	Value	Target	Exec Lead	Ops Lead
Ambulance Handover Times <15 mins (%)	35.7	65.0	Sally Kilgariff	Lesley Hammond
Ambulance Handover Times >30 mins (%)	36.4	0.0	Sally Kilgariff	Lesley Hammond
Ambulance Handover Times >60 mins (%)	19.7	0.0	Sally Kilgariff	Lesley Hammond

What actions are planned?

- YAS working along side Transfer of care team to reduce conveyance to hospital
- 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
- Early escalation by UECC on inbound demand
- Ongoing work with YAS around fit to sit patients
- Workshop to look at direct referral to SDEC for the new build with YAS and community teams

What is the expected impact?

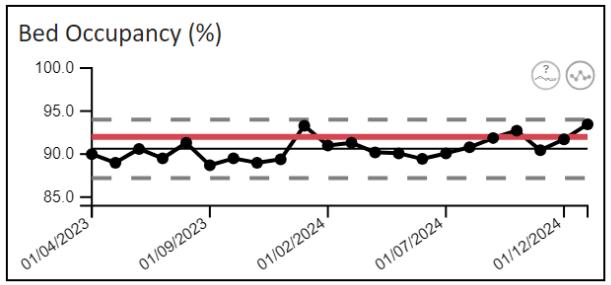
•There will be an improvement in ambulance handover times and TRFT sustained high levels of performance by February 2025
•Pilots will support reduction in conveyance to ensure all pathways in and out of hospital are utilised by March 2025
•Patients seen by the right clinician at the right time in the right place first time

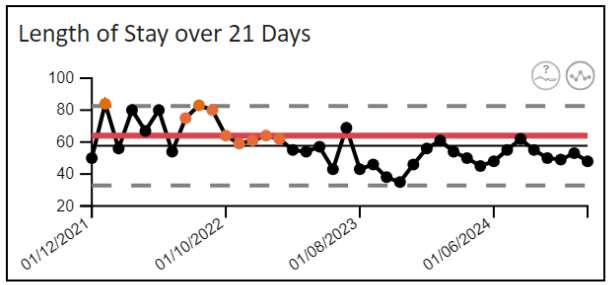
Potential risks to improvement?

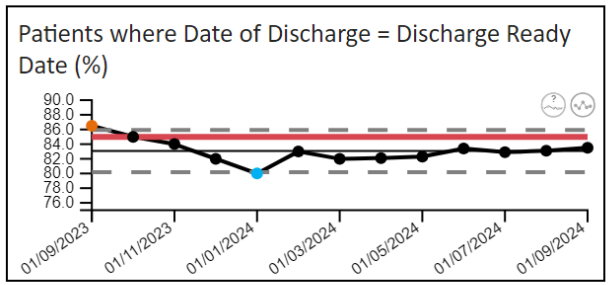
•High demand resulting in possible increase in ambulance attendances or batching of ambulances
•Ongoing demands for UEC services
•Peaks in demands for services
•Flow within the Trust/organisation and Place
• IPC challenges in relation to bed occupancy

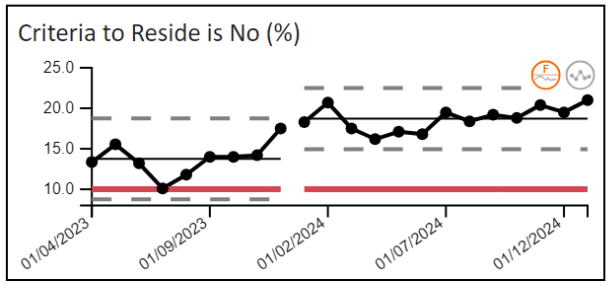
Subtheme: Inpatient Flow

Data, Context and Explanation









- Bed occupancy for January 93.47% this includes both core and escalation capacity in line with national reporting requirements. If the escalation beds were excluded General and Acute bed occupancy would be 95.66%. (B5 102%, Rockingham 98.29% and SU 110.14%)
- 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 (%)	93.5	92.0	Sally Kilgariff	Lesley Hammond
Length of Stay over 21 Days	48	64	Sally Kilgariff	Lesley Hammond
Patients where Date of Discharge = Discharge Ready Date (%)	83.5	85.0	Sally Kilgariff	Lesley Hammond
Criteria to Reside is No (%)	21.0	10.0	Sally Kilgariff	Lesley Hammond

What actions are planned?

- Plan to de-escalate additional inpatients beds on B6 to maximise SDEC throughput
- 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
- Electronic handover for CRU established
- Electronic handover for VW

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

Potential risks to improvement?

- Increase demand through UECC sustained
- Continued pressures across the system in health and social care and discharge delays become more frequent
- De-escalation of inpatient beds not possible due to ongoing pressures

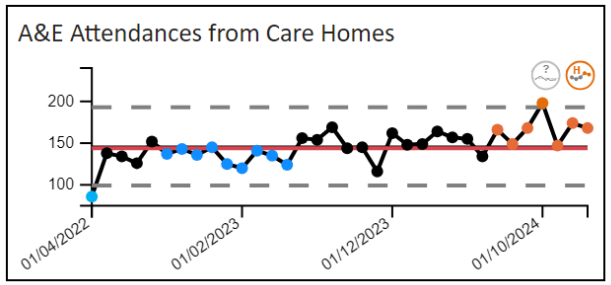
Community

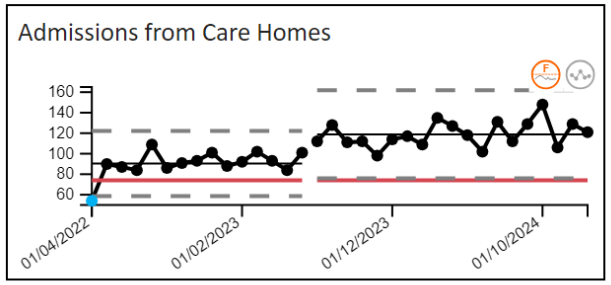
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
A&E Attendances from Care Homes	144	168	Jan-24	✗	?	H	-	S
Admissions from Care Homes	74	121	Jan-24	✗	F		-	C
Number of Patients on Virtual Ward	80	72	Jan-24	✗	?		-	S
Urgent 2 Hour Community Response (%)	70.0	79.0	Oct-24	✓	P	H	-	VG

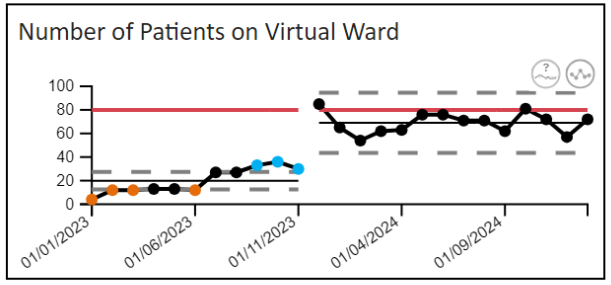
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

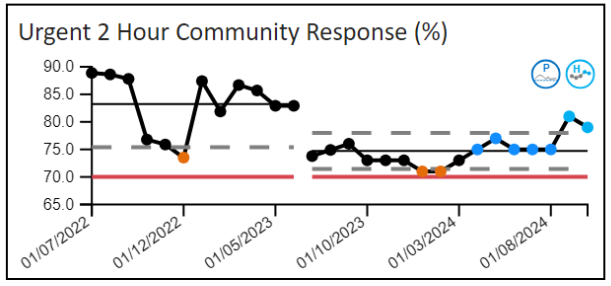
Subtheme: Community

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.
- Community Teams continue to work with YAS. YAS colleagues to join the TOCH early January
- All care homes attendances and admissions are analysis each month. The average number of inpatients from care homes throughout January was 22, approximately 1.4% of the total care home bed base
- The number of patients on Virtual Wards has decreased in month. The average occupancy in December' was 73, January's average was 58 against a Trust standard of 80. Occupancy reached a peak of 72 on the 31 January. Capacity was impacted in month by acuity, sickness and vacancies
- 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.

Metric	Value	Target	Exec Lead	Ops Lead
A&E Attendances from Care Homes	168	144	Sally Kilgariff	Penny Fisher
Admissions from Care Homes	121	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.
- Undertake a review of capacity and demand
- Improve sickness and absence rates
- 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

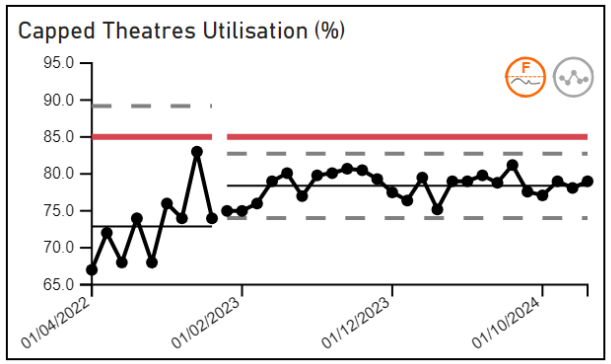
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
Clinic Utilisation (%)	85.0	76.2	Jan-25	☒	F		-	C
Capped Theatres Utilisation (%)	85.0	79.0	Jan-25	☒	F			C
Did Not Attend (%)	7.0	7.6	Jan-25	☒	?			S
First Outpatients (% of Plan)	100.0	95.0	Jan-25	☒	?			S
Inpatients (% of Plan)	100.0	94.0	Jan-25	☒	?		-	S
Daycases (% of Plan)	100.0	107.0	Jan-25	☑	?		-	S
Length of Stay over 7 days	-	188	Jan-25	-	-		-	S
Mean Length of Stay (Non-elective)	-	5.8	Jan-25	-	-			S
Mean Length of Stay (Elective excluding Daycases)	-	2.6	Jan-25	-	-			S
Discharged before 5pm (%)	70.0	63.5	Jan-25	☒	F			C

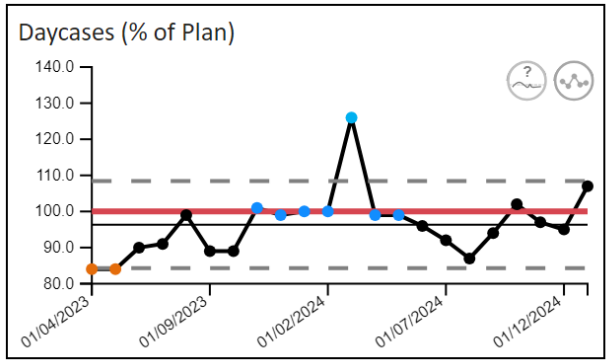
Plan is 19/20 + 3% i.e. *103% of 19/20*, therefore 100% achievement against Plan is 103% of 19/20

*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 77.8% against the 85% standard. Ophthal theatre utilisation has improved with increased cases from Jan.
- Working with FF20 national team to improve Theatre utilisation and capacity, introduction of a Theatre manager, to commence Feb 25.
- Day case activity had been achieving plan for a number of months. Work continues across a variety of targeted specialties.
- Anaesthetic and theatre staffing sickness has continued through January with the loss of 108 cases in month. This has also impacted trauma capacity, with resulting elective cancellations

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?

- Change in emergency theatre staff shift patterns
- Increased anaesthetic SAS additional session payments for a 6 month period for uncovered theatre sessions
- Improved utilisation of MEOC for simple cases
- Continue to increase cases per list in Ophthalmology
- Rockingham back to Elective inpatient
- Theatre Manager appointed and awaiting start date

What is the expected impact?

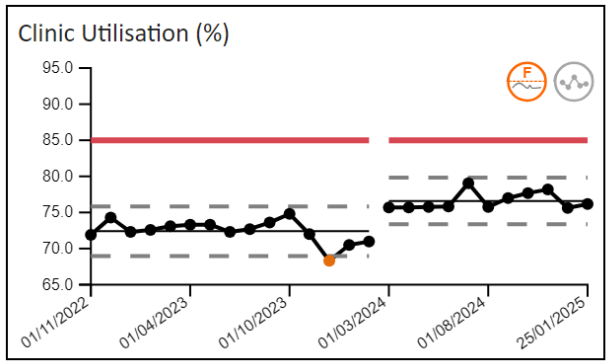
- Reduced gaps in emergency theatre will lead to less cancellations of extended trauma
- Reduced elective and extended trauma theatre session cancellations
- Improved overall utilisation and avoidance of 65 week breaches
- Increased day case rate in Ophthalmology
- Avoidance of 65 week breaches, challenges in scheduling
- More cohesive on the day theatre co-ordination and management of sickness

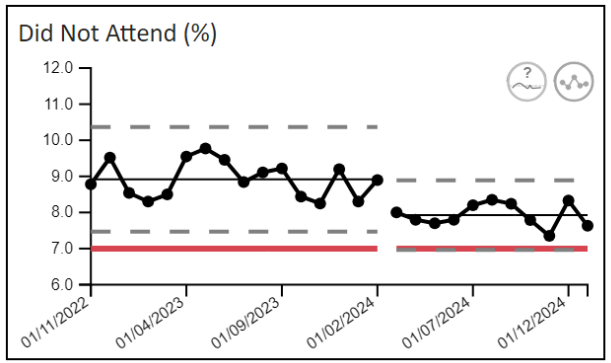
Potential risks to improvement?

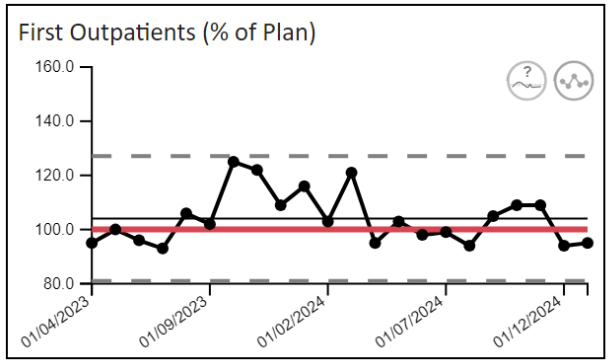
- Anaesthetic rotas may continue to impact on the ability to run theatre activity which significantly impacts on T&O in particular
- Capacity to deliver pre-op assessment may impact on patients available and fit for surgery
- High levels of anaesthetic and theatre staff absence impacting on lists being 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 below plan, but are expected to recover in the remainder of the year.
- 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 (%)	76.2	85.0	Sally Kilgariff	Jodie Roberts
Did Not Attend (%)	7.6	7.0	Sally Kilgariff	Jodie Roberts
First Outpatients (% of Plan)	95.0	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?

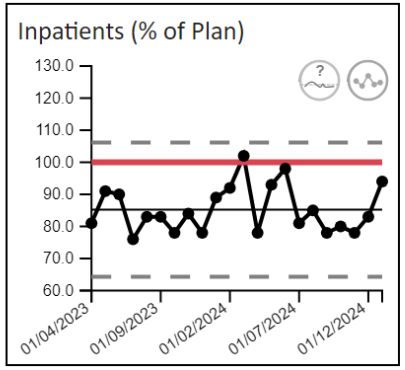
- Increase in clinic utilisation by 5% by Q3 2024/25, with continued improvement through Q4. Reduction in patients that DNA to 7% by Q4 2024/25
- Increase in outpatient activity by 2% by Q3 2024/25, with sustained delivery at 100% through Q4.

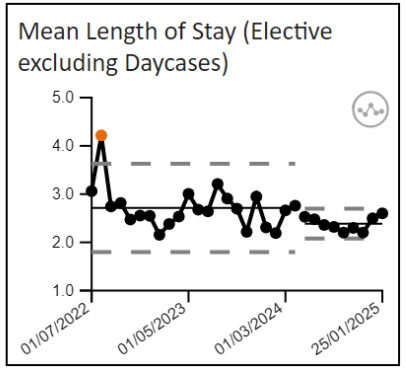
Potential risks to improvement?

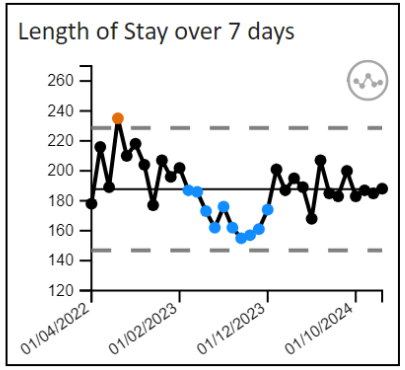
- Capacity in the contact centre to ensure that clinics are fully utilised, and any cancellations are back filled.
- Patient availability may impact on the ability to improve clinic utilisation, particularly short notice backfilled appointments.
- GP collective action and impact on referrals to specialities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

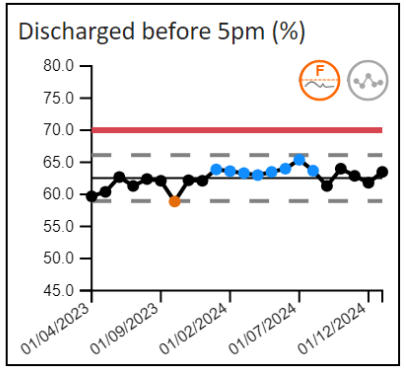
Subtheme: Inpatients

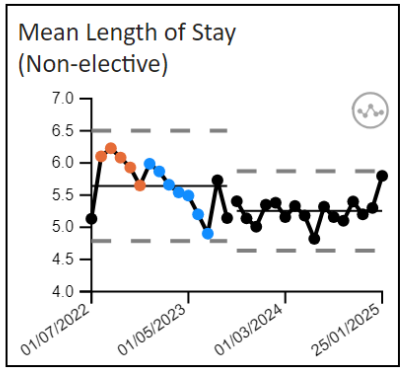
Data, Context and Explanation











- 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)	94.0	100.0	Sally Kilgariff	Jodie Roberts
Length of Stay over 7 days	188	-	Sally Kilgariff	Jodie Roberts
Mean Length of Stay (Non-elective)	5.8	-	Sally Kilgariff	Jodie Roberts
Mean Length of Stay (Elective excluding Daycases)	2.6	-	Sally Kilgariff	Jodie Roberts
Discharged before 5pm (%)	63.5	70.0	Sally Kilgariff	Jodie Roberts

What actions are planned?

- Increase daily numbers through the discharge lounge by 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

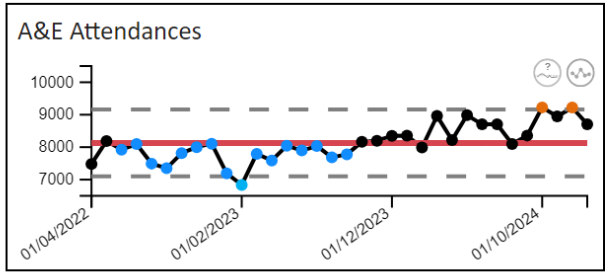
Activity

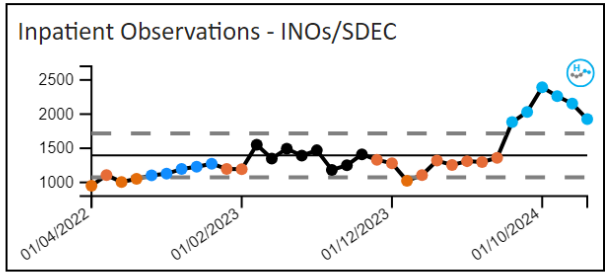
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
A&E Attendances [Block]	8,124	8,708	Jan-25	☒	?		-	S
Inpatient Observations – INOs/SDEC [Block]	-	1,926	Jan-25	-	-	H	-	G
Non-Elective Inpatients [Block]	-	2,632	Jan-25	-	-	H	-	C
Outpatients Follow Up - Attendances [Block]	14,130	14,221	Jan-25	☒	?		-	S
Daycases [ERF]	2,086	2,236	Jan-25	☑	?		-	S
Inpatients - Electives [ERF]	366	343	Jan-25	☒	?		-	S
Outpatients New - Attendances [ERF]	6,337	6,017	Jan-25	☒	?		-	S
Outpatient Procedures - New and Follow Up [ERF]	4,994	5,258	Jan-25	☑	?		-	S
Referrals [Outpatient Demand]	-	8,447	Jan-25	-	-		-	S
2ww Referrals [Outpatient Demand]	-	1,204	Jan-25	-	-		-	S

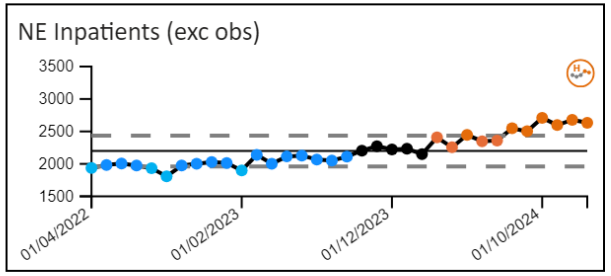
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

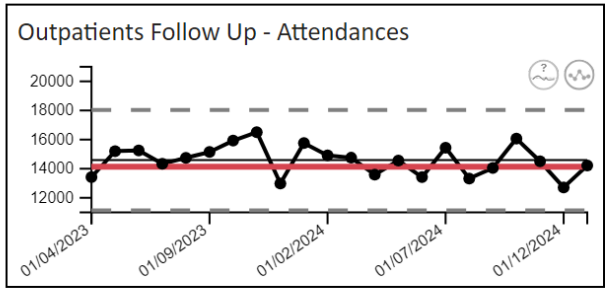
Subtheme: Block

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 and year-to-date.
- Non-Elective admissions (excluding obs/SDEC) have been increasing month on month.
- Outpatient Follow-ups have increased slightly in-month but look to be sustained at lower levels when compared to previous months. An improvement in performance is linked to a) resolution to the outpatient procedure recording issues, b) introduction of SDEC returners, increased use of Patient Initiated Follow-up (PIFU)
- Despite the improving follow-up position, the Trust continues to experience significant follow-up backlogs therefore over performance in some areas is expected to continue/increase whilst we look to clear these.

Metric	Value	Target	Exec Lead	Ops Lead
A&E Attendances	8,708	8,124	Sally Kilgariff	Jodie Roberts
Inpatient Observations - INOs/SDEC	1,926	-	Sally Kilgariff	Jodie Roberts
NE Inpatients (exc obs)	2,632	-	Sally Kilgariff	Jodie Roberts
Outpatients Follow Up - Attendances	14,221	14,130	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 and improve level of transfer to PIFU pathways
- Identify any areas of correlation between non-elective pressures and reduction in elective procedures (impacting ERF)

What is the expected impact?

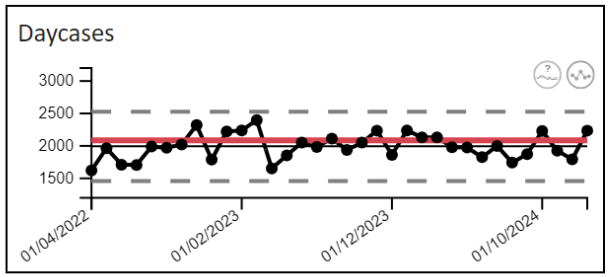
- Confirm SDEC/NEL activity is accurately being reflect in the data submission/contract monitoring. Fully understand the impact of EDS4.
- Ensure accurate record keeping for A&E attendances (should the contract mechanism change in the future this could potentially impact any re-basing)
- Identify areas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

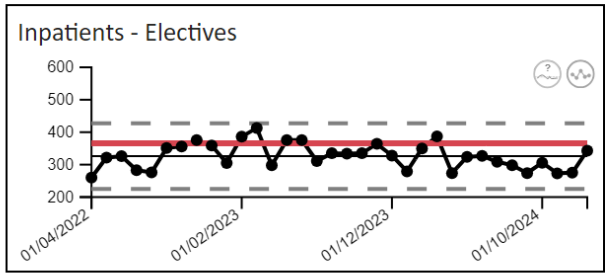
Potential risks to improvement?

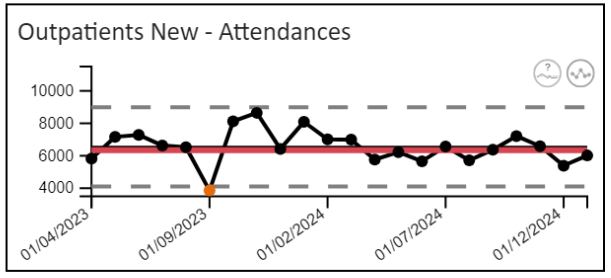
- Despite being on block, all key lines require scrutiny to ensure the Trust a) understands how this is impacting on financial performance b) we maintain an accurate position to safeguard changes to future contracting models
- Continuing increase in non elective demand, which is unfunded due to block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

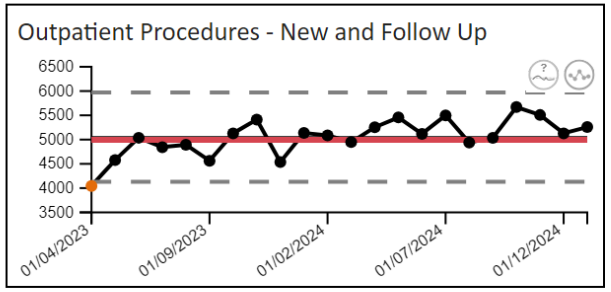
Subtheme: ERF

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
- The updated tariff price uplifts for the pay award were transacted on both plan and actuals in October.
- Daycase activity is 150 above – the first time in 24/25 this has been above plan in-month. Ophthalmology, General Surgery, T&O, OMFS are the biggest contributors to the year-to-date under performance. Actions are being taken to address the position.
- In-month Elective is 23 below activity plan. General Surgery, T&O, Urology are the biggest contributors to the year-to-date under performance but improvements are being made and actions are being taken.
- In-month Outpatient New Attendances are 320 below planned levels. Schemes agreed in Q4 will improve the overall position.
- In-month Outpatient Procedures are 215 above activity plan. This is a result of the corrective action taken to address technical system issues.

Metric	Value	Target	Exec Lead	Ops Lead
Daycases	2,236	2,086	Sally Kilgariff	Jodie Roberts
Inpatients - Electives	343	366	Sally Kilgariff	Jodie Roberts
Outpatients New - Attendances	6,017	6,337	Sally Kilgariff	Jodie Roberts
Outpatient Procedures - New and Follow Up	5,258	4,994	Sally Kilgariff	Jodie Roberts

What actions are planned?

- Outsourcing of T&O procedures in Q4
- Insourcing of OMFS, ENT, Dermatology outpatient first attendances in Q4
- Insourcing of Dermatology skin surgery
- Exploring Orthodontics insourcing to support ERF
- Review of additional internal capacity in Q4
- Review core capacity utilisation
- Residual activity recording issues continue to be addressed and corrected

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.
- Finalising waiting list initiative payments is likely to increase uptake of additional sessions by our own staff

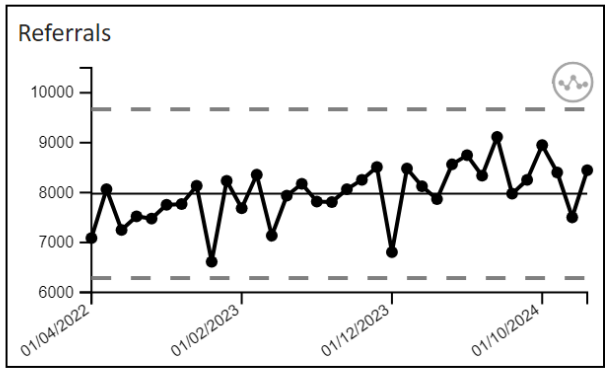
Potential risks to improvement?

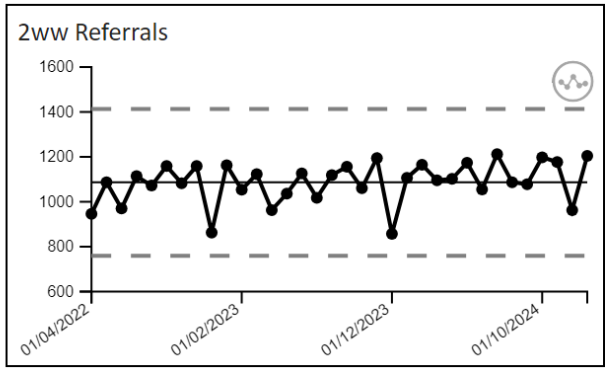
- Internal workforce (consultant and wider) to support additional sessions
- Efficient utilisation of core capacity (e.g. if core lists are stood-down or consistently underutilised, any additional sessions/insourcing will be replacing that loss of activity as opposed to delivering additional capacity)
- Timely rectification of IT system data mapping issues
- Activity fixes are sustained in the position

Subtheme: OP Demand

Metric	Value	Target	Exec Lead	Ops Lead
Referrals	8,447	-	Sally Kilgariff	Jodie Roberts
2ww Referrals	1,204	-	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

April 24 to Jan 25

Key Headlines	Month			YTD			Forecast Variance	Prior Month Forecast variance
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	£000s	£000s
I&E Performance (Actual)	(109)	582	691	(1,735)	(2,320)	(585)	(4,648)	(7,302)
I&E Performance (Control Total)	(48)	646	694	(493)	(1,544)	(1,051)	(5,114)	(7,700)
Efficiency Programme (CIP)	1,449	1,249	(200)	9,843	5,856	(3,987)	(3,410)	(3,791)
Capital Expenditure	1,160	793	367	8,100	5,979	2,121	0	0
Cash Balance	(1,964)	(4,459)	(2,495)	3,779	6,094	2,315	4,718	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** • Appraisal Rates (12 month rolling)
Special Cause: Concern	**CONCERNING: INVESTIGATE AND UNDERSTAND** • MAST - Core	**CONCERNING:INVESTIGATE & TAKE ACTION**	**VERY CONCERNING: INVESTIGATE & TAKE ACTION** • Sickness Rates (12 month rolling) • Sickness Rates

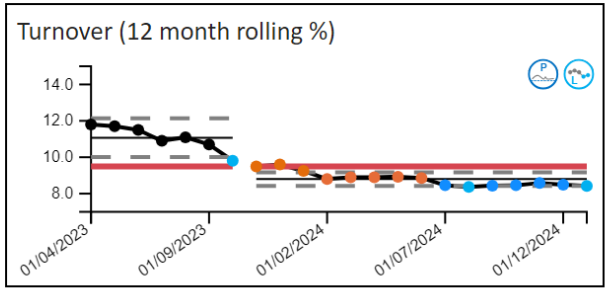
People and Culture

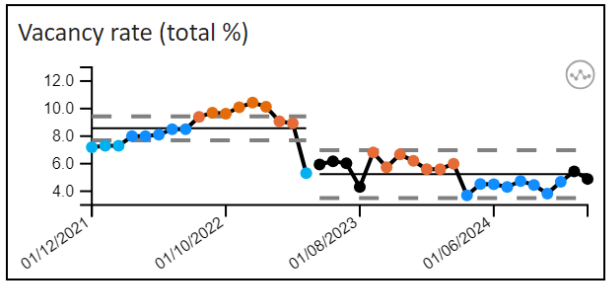
Metric	Trust Target	Latest Data	Period	Achieved in Month	Assurance	Variation	Quartile	Grid*
Turnover (12 month rolling %)	8.0-9.5	8.4	Jan-24	☑	P	L		VG
Vacancy Rate (total %)	-	4.9	Jan-24	-	-		-	G
Sickness Rates (12 month rolling %)	4.8	6.0	Jan-24	☒	F	H	-	VC
Sickness Rates (%)	4.8	7.3	Jan-24	☒	F	H		VC
Appraisal Rates (12 month rolling %)	90.0	80.2	Jan-24	☒	F		-	C
Appraisals Season Rates (%)	90.0	79.8	Jan-24	☒	F		-	C
MAST – Core (%)	85.0	89.9	Jan-24	☑	P	L	-	C
MAST – Job Specific (%)	85.0	87.0	Jan-24	☑	P		-	G

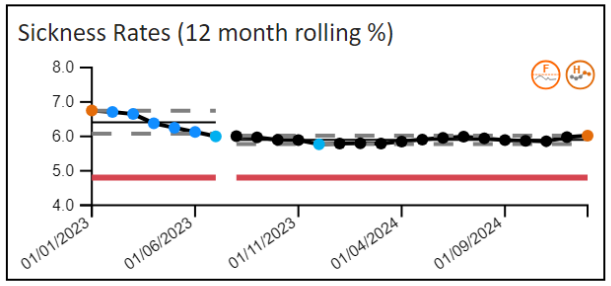
*Key – **VG** = Very Good, **G**= Good, **GI** = Good-Improving **S** = Static **CI** = Concerning-Improving, **C** = Concerning, **VC** = Very Concerning.

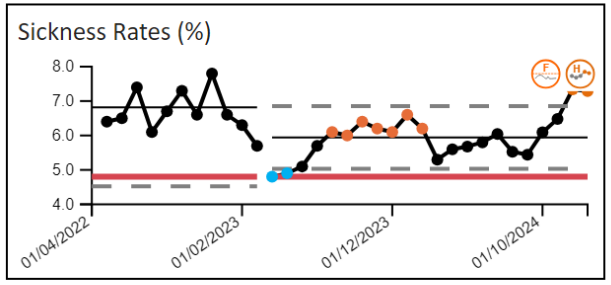
Subtheme: People

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 %)	8.4	9.5	Daniel Hartley	Paul Ferrie
Vacancy rate (total %)	4.9	-	Daniel Hartley	Paul Ferrie
Sickness Rates (12 month rolling %)	6.0	4.8	Daniel Hartley	Paul Ferrie
Sickness Rates (%)	7.3	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?

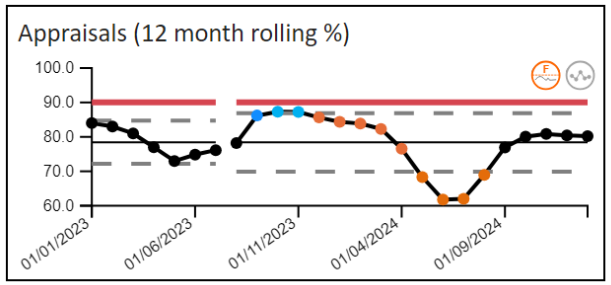
- Continued strong performance on retention and vacancy rates
- Improvement in sickness absence rates

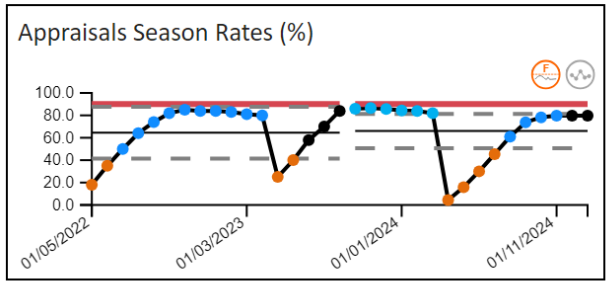
Potential risks to improvement?

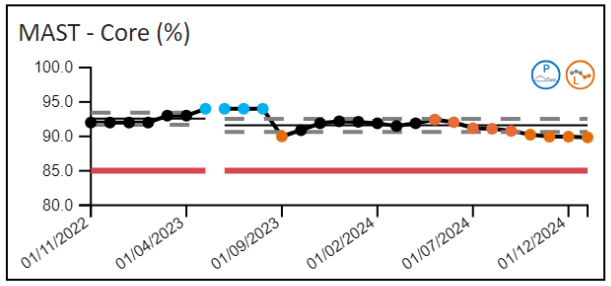
- Continued impact of ill-health of staff on attendance

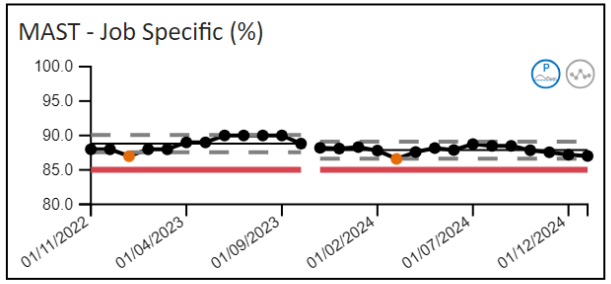
Subtheme: MAST & Appraisals

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 80.2% 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 %)	80.2	90.0	Daniel Hartley	Paul Ferrie
Appraisals Season Rates (%)	79.8	90.0	Daniel Hartley	Paul Ferrie
MAST - Core (%)	89.9	85.0	Daniel Hartley	Paul Ferrie
MAST - Job Specific (%)	87.0	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

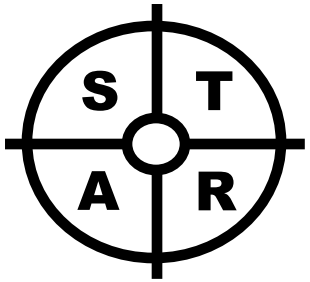
Assurance Icons

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 at the end of the month in line with the National Trajectories submission	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	100.0	
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	100.0	
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	100.0	
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	

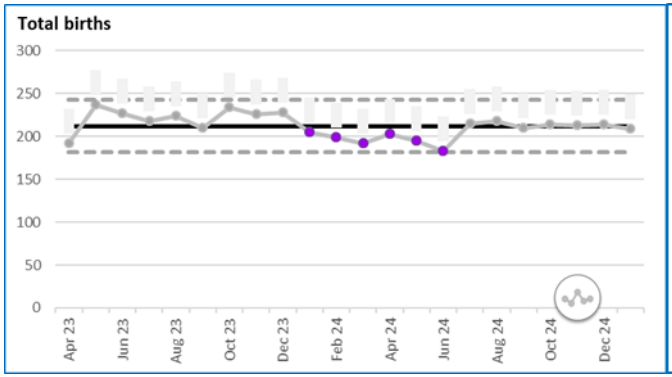
Board of Directors' Meeting
7 March 2025

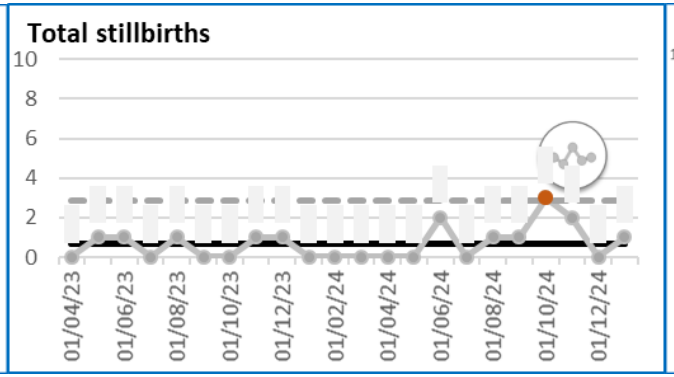
The Rotherham NHS Foundation Trust

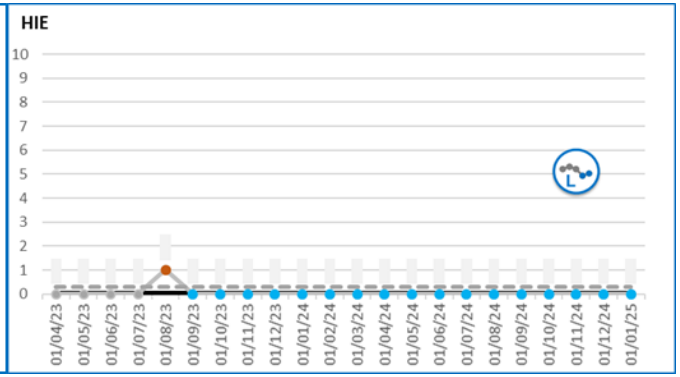
Agenda item	P47/25
Report	**Maternity and Neonatal Safety**
Executive Lead	Helen Dobson, Chief Nurse
Link with the BAF	P1: There is a risk that we will not embed quality care within the 5-year plan because of lack of resource, capacity and capability leading to poor clinical outcomes and patient experience 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. • Included within February's paper is an overview of the newly released MBRRACE report that has TRFT's 2023 perinatal statistic. A review of Quarter 3 data is shared including actions and learning from PMRT cases. • The recent Local Maternity and Neonatal System (LMNS) external thematic review that looked at the recent spike in stillbirth cases is discussed with safety recommendations explained. • The recent Unicef BFI report has now been received by the Trust and shows that with some minor additions to the current evidence, re-accreditation has been awarded to the Maternity Unit at TRFT. • LMNS engagement undertaken including the attendance at regional PMRT learning events, attendance at the TRFT annual perinatal day. • Information around the 3-year delivery plan assurance visit from the LMNS in which TRFT were able to share successes and challenges with the external team on current progress. • Staff concerns raised to the Safety Champions regarding the lack of theatre capacity to meet the demands of increase elective caesarean births.
Due Diligence	This paper has been prepared by the Interim Head of Midwifery and approved by the Director of Midwifery. The report is shared through Maternity and Care Group 3 Business and Governance meetings, the Maternity and Neonatal Safety Champions and Quality Committee

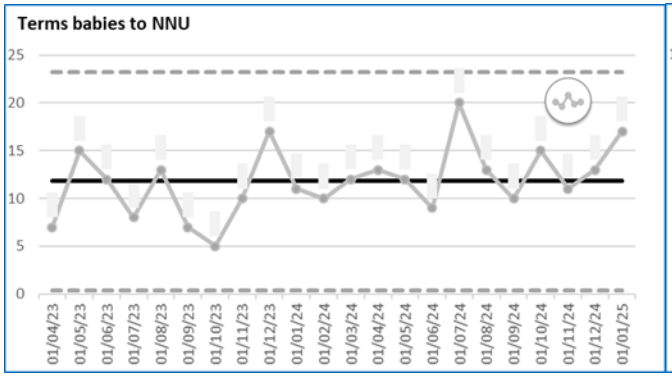
Board powers to make this decision	The Trust Board are required to have oversight on the maternity and neonatal safety work streams.
Who, What and When	Helen Dobson, Chief Nurse, is the Board Executive Lead. The Interim Head of Midwifery attends Quality Committee and The Director of Midwifery attends the Trust Board bi-monthly to discuss the Maternity and Neonatal Safety agenda.
Recommendations	It is recommended that the Trust Board are assured by the maternity and neonatal outcome data and update provided.
Appendices	The Appendices below are in the reading room: Appendix one: LMNS thematic review of stillbirths. Appendix two: TRFT MBRRACE-UK perinatal mortality report Appendix three: PMRT grading and learning Appendix four: PSII, MNSI cases and learning Appendix five: BFI re-accreditation report. Appendix six: ODN optimisation report for pre-term babies

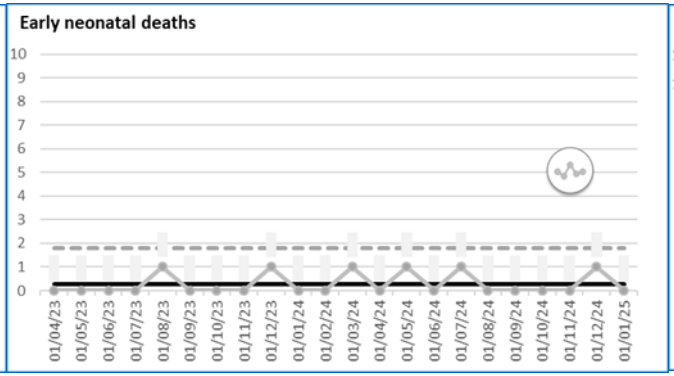
Maternity Safety Statistical Process Control charts (SPC)

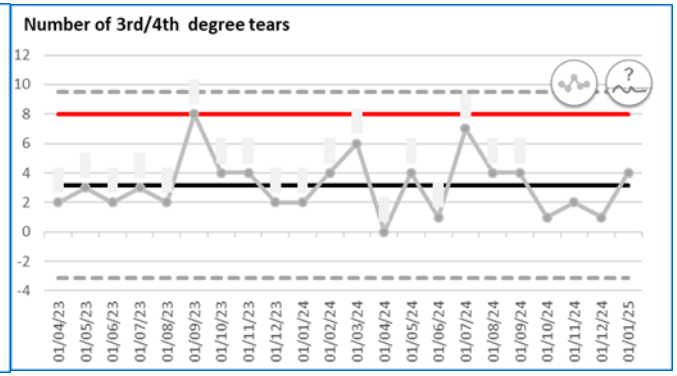


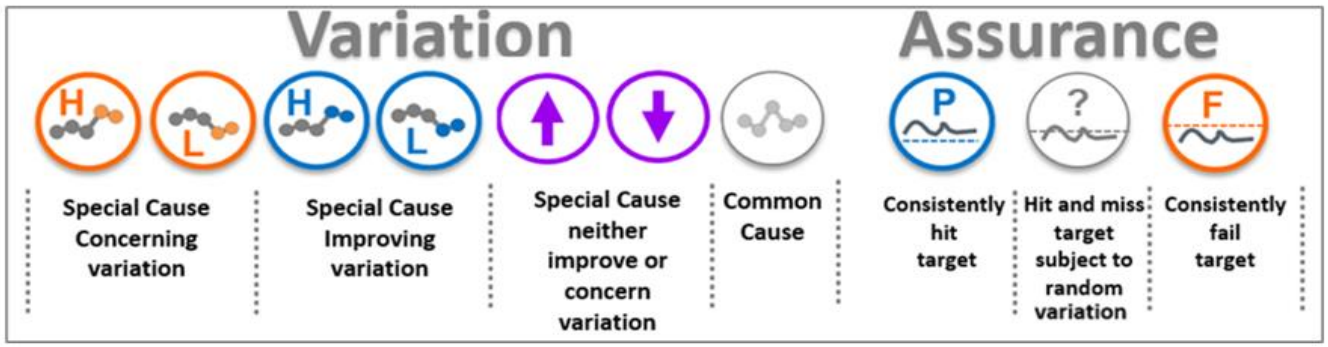


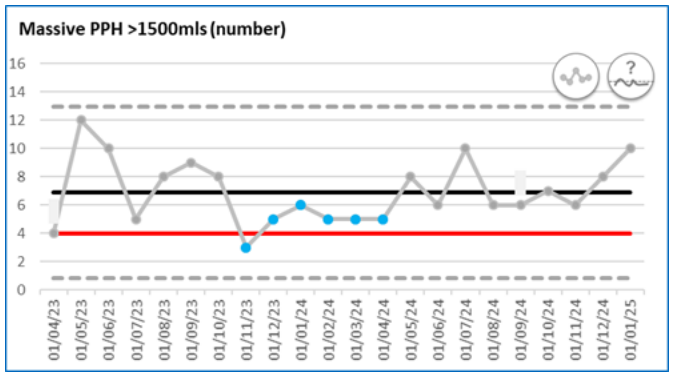












TRFT Maternity Dashboard: General

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Smoking at booking %	Jan 25	7.9%	6.0%			10.7%	4.6%	16.8%
Smoking at birth %	Jan 25	10.6%	6.0%			10.2%	4.6%	15.8%
Number of bookings	Jan 25	283	-			252	193	311
Booking < 13 weeks	Jan 25	89.8%	90.0%			90.2%	84.9%	95.4%
Booking < 10 weeks	Jan 25	64.3%	90.0%			70.6%	60.8%	80.4%
Personalised Care Plan	Jan 25	98.6%	95.0%			97.8%	94.7%	100.9%
Total Induction rate	Jan 25	32.3%	32.8%			37.7%	28.2%	47.2%
Augmentation IOL	Jan 25	32	-			42	23	60
Augmentation 1st Stage	Jan 25	9	-			14	0	28
Augmentation 2nd stage	Jan 25	3	-			3	0	6
Shoulder dystocia	Jan 25	4	2			3	-3	8
Massive PPH >1500mls (number)	Jan 25	10	4			7	1	13
Massive PPH >1500mls (%)	Jan 25	4.8%	2.0%			3.2%	0.4%	6.0%
Number of 3rd/4th degree tears	Jan 25	4	8			3	-3	10
3rd/4th degree tears in spontaneous vaginal birth	Jan 25	2	-			2	-3	7
3rd/4th degree tears in spontaneous vaginal birth (%)	Jan 25	2.1%	2.8%			1.7%	-2.7%	6.1%
3rd/4th degree tears assisted birth	Jan 25	2	-			1	-3	5
3rd/4th degree tears assisted birth (%)	Jan 25	14.2%	6.0%			6.9%	-18.8%	32.6%
Number of eclamptic fits	Jan 25	0	-			0	0	0
Pressure ulcers	Jan 25	0	-			0	0	1
Optimal Cord Clamping	Jan 25	91.0%	-			90.6%	84.2%	97.0%
APGARS 0-6 @ 1 minute	Jan 25	10	-			11	-1	23
APGARS 7-10 @ 1 minute	Jan 25	198	-			200	172	228
Skin to skin	Jan 25	82.2%	80.0%			82.6%	74.3%	90.8%
Breastfeeding	Jan 25	59.6%	72.7%			60.0%	51.6%	68.4%

DATA MEASURES – REVISED PERINATAL QUALITY SURVEILLANCE TOOL

Trust:

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

Maternity Safety Support Programme	Select	No

	Dec 2024 / Jan 2025	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	See section 3	.							.		
2. Findings of review of all cases eligible for referral to MNSI	See section 5										
Report on: 2a. The number of incidents logged graded as moderate or above and what actions are being taken	See section 5										
2b. Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training	See section 12										
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 section 10										
3.Service User Voice Feedback	See section 11				.						
4. Staff feedback from frontline champion and walk-abouts. Executive / NED meeting with the perinatal leadership team	See section 11										
5.HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	Nil										
6.Coroner Reg 28 made directly to Trust	0										
7.Progress in achievement of CNST 10	Achieved										

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

1. Report Overview

1.1 This report outlines TRFT's commitment to the NHS England national ambition of halving rates of stillbirth, neonatal death, maternal deaths and brain injury sustained during birth by 2025 (from the baseline of 2010) and demonstrates how the Perinatal Surveillance Model (2020) is followed to strengthen oversite of TRFT maternity services. The purpose of this 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 Following the cluster of stillbirths that took place in Q2 and Q3 of 2024/2025, a thematic review of all cases was undertaken both internally and with the support of the LMNS. This peer review allowed for an unbiased independent view of the care that TRFT provided. The Perinatal Quality Surveillance Model was applied to the external review by the Lead LMNS clinicians. (See appendix 1 for the final report from the LMNS).

2.2 Findings from the external review attempted to find themes and commonalities from each of the cases with the aim to focus QI efforts on areas that may bring significant improvement. A PSIRF approach was taken to inform the investigation. Table 2.1, 2.2 and 2.3 gives example of the tool used to collect information from the review. Diagram 2.1 shows the locality of the stillbirth cases within Rotherham.

Operational factors	*Work planning and delivering (scheduling of ANC and CMW app'ts)*	/	/	/	/	/	/		6
	Work planning and delivering – personalised care plans – commenced	/	/	/	/	/	/	N/A	6
	Work planning and delivering – personalised care plans – not commenced								0
Individual Patient / Clinical Factors	*Safeguarding/ social factors*								0
	Domestic Abuse routine enquiry - positive								0
	Domestic Abuse routine enquiry - negative	/	/	/	/	/	/	N/A	6
	Psychological factors			/	/				2
	White British	/	/	/	/	/	/	/	7
	White Romanian								0
	Black African								0
	Indian								0
	Pakistani								0
	Decile 1-3			/	/	/	/	/	5
	Decile 4-6		/						1
	Decile 7-10	/							1

Table 2.1 example thematic review of stillbirth cases via the LMNS

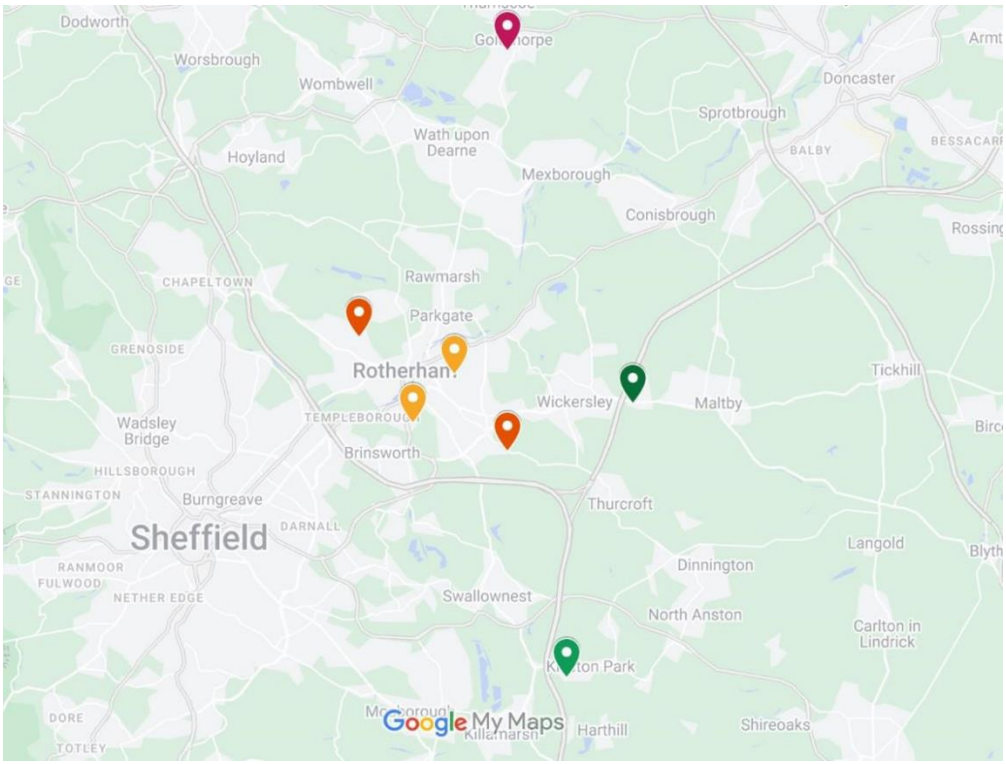
Broad Ethnic Group - SY&B	Bookings	%	Cases
White	**2,245**	**78.5%**	**7**

Other Ethnicity	**615**	**21.5%**	**0**

Table 2.2 Births in Rotherham

Deprivation	Bookings	%	Cases	%
Most deprived 20%	**745**	**24.9%**	**3**	**42.9%**
Other	**2,250**	**75.1%**	**4**	**57.1%**

Table 2.3 Spread of deprivation in Rotherham Maternity bookings



Map 2.1 demonstrates the locality of the stillbirth cases

2.3 The following commonalities were identified in order of occurrence (highest to lowest).

- All cases were on the right pathway.
- Personalised care and support plans were commenced where possible.
- Domestic violence enquiry was asked in all booked women.
- Ethnicity and deprivation findings did not reflect the national findings.
- BMI (6 out of the 7 cases had a BMI of below 30)
- Previous Intrauterine Growth Restrction (IUGR) in last pregnancy in 50% of cases – all on correct pathway.
- Fetal movements were acted on by attending triage except for one case.
- All English speaking.

2.3 Whilst the external review was unable to identify overarching safety themes for the cases review, four safety recommendations were made which included, improving triage advice, (Quality improvement work underway with the Birmingham Symptom

Specific Obstetric Triage System (BSOTS) staffing model implemented in January 24 and net call where calls will be recorded, due to go live from the 24th February 2025), communication with women where their waters had ruptured prior to labour, fetal movement advice and documentation and communication with women who have opted for an induction of labour. The final report will be reviewed at the Safety Champions meeting along with the associated action plan from both the internal and external thematic review.

2.4 Staff support and feedback of the learning from the thematic reviews continues, an open invite to all teams within the unit has been extended for a meeting that took place on 11th February 2025. The meeting was well attended by the MDT including midwives, doctors and sonographers, where the Bereavement Midwife and the Governance Midwife communicated the findings. Staff have also had the opportunity to speak with a PMA should they wish.

2.5 On the 24th of January 2025 the 8th annual perinatal event took place which involved reviewing 9 case of perinatal loss that occurred in 2023. Each case was presented to an audience of local and external midwifery, medical, ultrasound specialists and service user representatives with the aim of finding commonalties or learning opportunities that may have been previously missed or not apparent when undertaking each review at the time on an individual approach. The day was well received with other local Trust planning to follow this model of annual review and learning.

3. Perinatal Mortality Summary for month of January 2024

3.1 Table 3.1 reports perinatal data from Jan 2025 in comparison to the last two years data as a rolling tracker.

	2023 Total	2024 Total	Cumulative 01/01/2025 - 31/01/2025	In Month: Jan 2025	Information
Total Stillbirths (All)	6	9	1	1	See 1 Below
Stillbirths >37 weeks	1	5	1	1	
Stillbirths 24 - 36+6 weeks	5	4			
Intrapartum Stillbirths	-	2			
MTOP Anomaly >24 weeks	2	-			
Adjusted Stillbirths	6	9	1	1	See 1 Below
Total Neo-Natal Deaths (NND)	4	5			
ENND >24 weeks up to 7 days of life	2	2			
LNND 7-28 days	1	1			
Adjusted Neonatal Deaths – All gestation (EXCL MTOP)	2	2			
Total Adjusted Perinatal (24 wk – 28 days)	8	11	1	1	
MTOP ENND	-	-			
Stillbirth Elsewhere (booked at RFT)	-	-			
Neo-Natal Deaths Elsewhere (outside of TRFT)	2	4	1	1	See 2 Below
Maternal Deaths	1	1			
NVF <24 weeks	10	14			
NPMRT entered	10	14	1	1	
NPMRT Closed	10	8	1	1	

Table 3.1 TRFT perinatal deaths (the end of this report for key)

3.2 The rolling figure of stillbirths and neonatal deaths from January 2024 to December 2024 are as demonstrated within Tables 3.5a and 3.5b below. The TRFT adjusted rate has increased to 3.66 per 1000 births for stillbirths following the spike in cases from Q2 and Q3 2024/25. The current South Yorkshire stillbirth rate is 3.29 per 1000 births.

Perinatal mortality All deaths (including congenital anomalies) Total perinatal **5.69/1000 births**		
Type of death	Number	Rate per 1000 births
Stillbirth	9	3.66
Neonatal death	5	2.03

Table 3.5a Unadjusted perinatal deaths

Adjusted Perinatal Mortality (excludes deaths due to congenital anomalies and MTOP) Adjusted Total Perinatal **4.47/1000 births**		
Type of death	Number	Rate per 1000 births
Stillbirth	9	3.66
Neonatal Death	2	0.81

Table 3.5b Adjusted perinatal deaths

3.3 MBRRACE released the perinatal mortality report of perinatal deaths of babies born in 2023 on the 13TH February 2025 Trusts receive a supplementary report exclusively about stillbirths and neonatal deaths of babies born within individual Trusts in 2023. The TRFT report is included in appendix two for information. Key messages from the report can be seen below in tables 3.6, 3.7, 3.8 and 3.9.

3.4 Crude neonatal deaths (Table 3.7) for 2023 included 2 off pathway births (babies who were born at TRFT rather than at a tertiary centre, off pathway births for TRFT are babies born below 27 weeks gestation or below 800 grams birth weight and any multiple births below 28 weeks gestation. Any mother with a baby within this criteria should be cared for in a tertiary centre in order to have the best outcomes). 1 off pathway baby died at 22 weeks gestation following birth, and a further baby which died at 25 weeks gestation following a premature rupture of membranes from 16 weeks gestation. The 2 neonatal death recorded were a baby with a known congenital anomaly and a baby born at 28 weeks gestation. The crude mortality rate includes all deaths.

Key messages

All deaths

1. Your stabilised & adjusted stillbirth rate is **2.88 per 1,000 total births**. This is around the average for similar Trusts & Health Boards.
2. Your stabilised & adjusted neonatal mortality rate is **0.95 per 1,000 live births**. This is around the average for similar Trusts & Health Boards.
3. Your stabilised & adjusted extended perinatal mortality rate is **3.83 per 1,000 total births**. This is around the average for similar Trusts & Health Boards.

Excluding deaths due to congenital anomalies

1. Your stabilised & adjusted stillbirth rate excluding deaths due to congenital anomalies is **2.65 per 1,000 total births**. This is around the average for similar Trusts & Health Boards.
2. Your stabilised & adjusted neonatal mortality rate excluding deaths due to congenital anomalies is **0.69 per 1,000 live births**. This is around the average for similar Trusts & Health Boards.
3. Your stabilised & adjusted extended perinatal mortality rate excluding deaths due to congenital anomalies is **3.34 per 1,000 total births**. This is around the average for similar Trusts & Health Boards.

Full details of your perinatal mortality rates can be found on page 2.

Table 3.6 TRFT key messages

Crude mortality by year of birth (all deaths)

Crude mortality rates for each type of death compared to the average mortality rate for Trusts and Health Boards in the same comparator group (shown in grey) by year of birth.

Due to updates to the data, these results might differ slightly from those in previous reports.

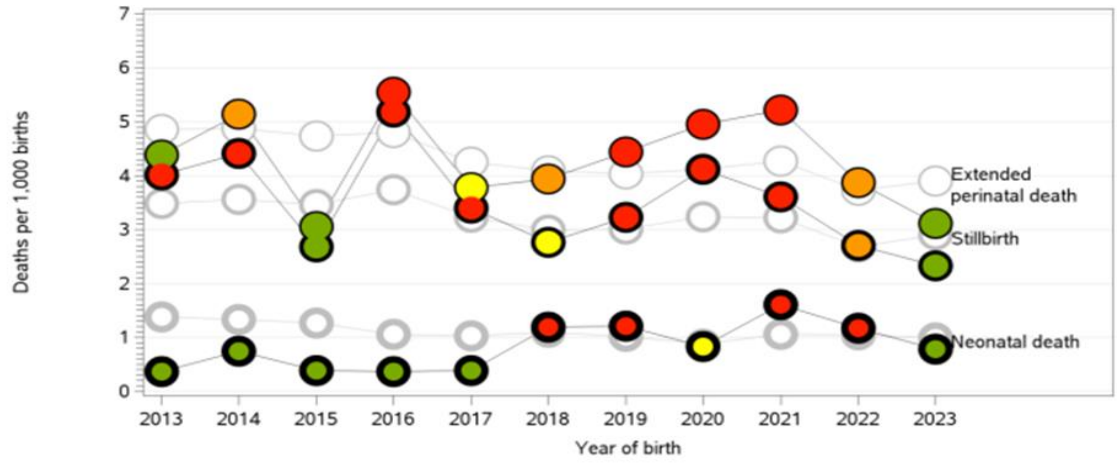


Table 3.7 TRFT crude mortality by year of birth (all deaths)

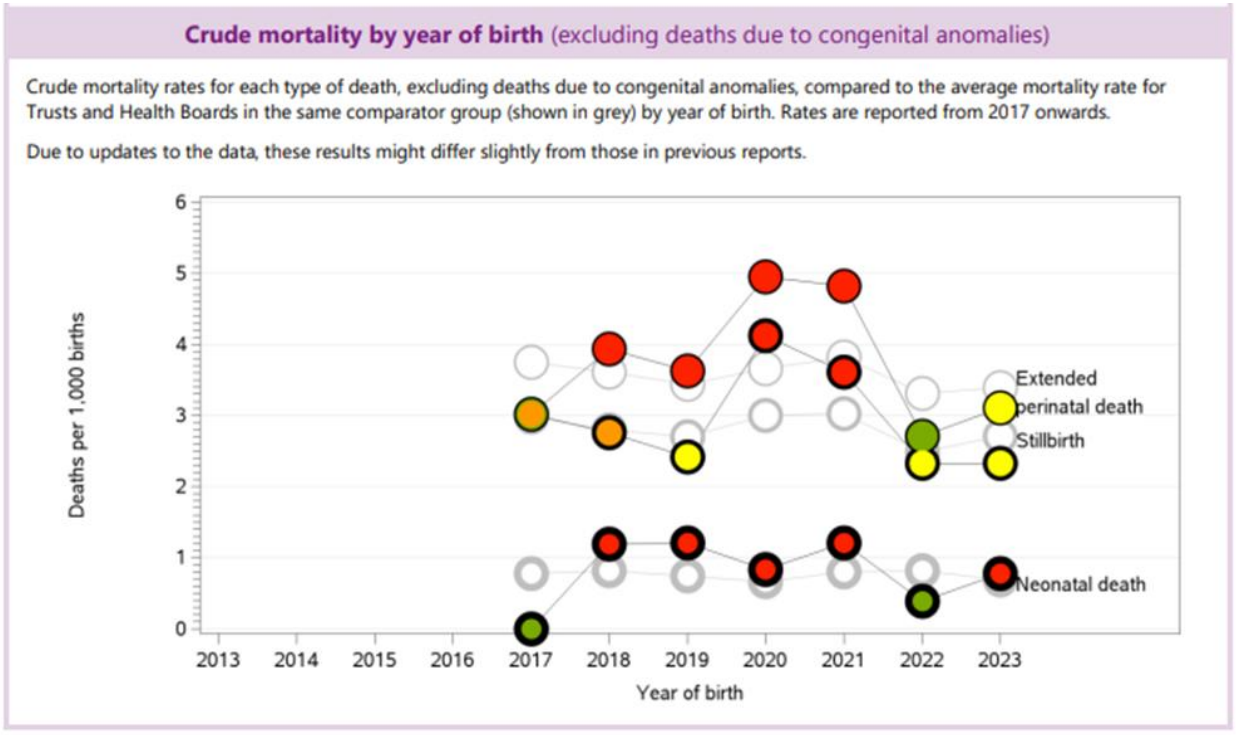


Table 3.8 TRFT crude mortality by year of birth

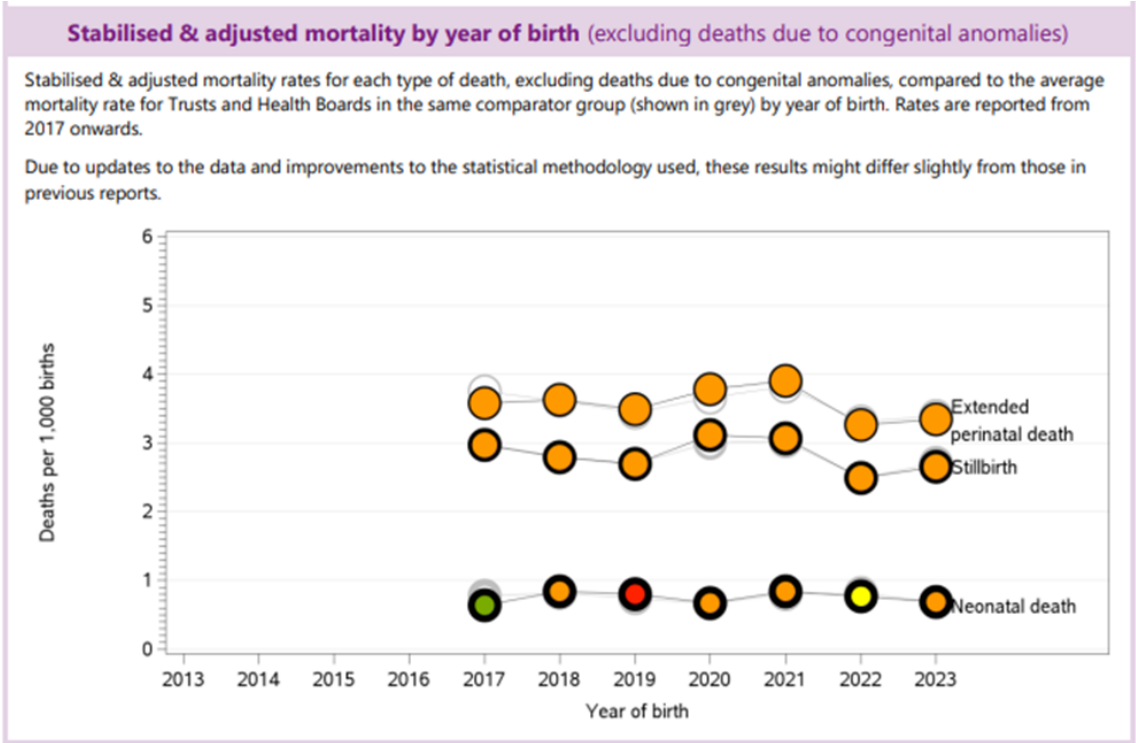


Table 3.9 Stabilised and adjusted mortality by year of birth

4. PMRT real time data monitoring tool

4.1 In October 2024 to January 2025, four PMRT cases were closed and the reports published. Details were also inputted into a further four PMRT cases that are held by other trusts. The cases graded include 1 neonatal death and 3 stillbirths.

4.2 Appendix three of this report shows the learning from each of the closed cases mentioned above and the questions raised by the family that have been discussed at

the MDT (including external peers), PMRT meetings. Appendix 3 table 4.1 shows the grading of the four cases as per the PMRT template. All findings have been shared with the families involved.

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	Jan 25
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%	100%	100%
Percentage of eligible perinatal deaths notified to MBRRACE – UK within 7 working days (100%)						100%		100%	100%	100%	100%	100%	100%
Surveillance information completed within 1 calendar month.						100%		100%	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%	100%	100%
Percentage of PMRT reviews started within 2 months (95%)						100%		100%	100%	100%	100%	100%	100%
Percentage of PMRT reports published within 6 months (60%)													

Table 4.2 reporting compliance for PMRT and timeframes

4.3 Table 4.2 is a CNST tracker to demonstrate that TRFT are maintaining compliance with the CNST timescales for PMRT. As the TRFT cases were all within the last 6 months of 2024, the final publishing date was outside of the CNST reporting period which explains the final column being left incomplete at this time.

4.4 On the 31st of January 2025, TRFT maternity and neonatal teams were invited to take part in an LMNS regional learning event to review the current offer of Bereavement care and PMRT processes across the South Yorkshire and Bassetlaw footprint. It was noted that there was inconsistencies between Trusts with resources for Bereavement care and processes of how the PMRT MDT meetings take place. Other areas of discussion included communication with bereaved families, investigation processes and good practice from each maternity unit. Moving forwards, TRFT will begin to input grading of the care onto the PMRT template in real time during the meeting, this will bring the unit in line with the wider region.

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

5.1 Since the commencement of MNSI (formally HSIB) maternity investigations in 2018, TRFT have reported 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 in appendix 4) has now been completed and the final report shared with staff and the family following a baby having seizures at 36 hours of age and abnormal head CT which occurred in March 2024 (the later MRI scan was normal). MNSI will approach the family to offer a tripartite meeting with themselves, the Trust and the family. An improvement plan meeting has taken place to develop an action plan for the final report which includes the 3 safety recommendations from MNSI. The action plan focuses on improvements to fetal surveillance training and updates for all staff, centralised fetal monitoring system, which the service has recently implemented and human factors training for all Labour Ward co-ordinators.

5.3 Ongoing PSII cases can also be see within appendix 4.

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 Within appendix 4, table 7.1 highlights of recent closed PSII cases can be see along with identified learning.

7.2 Table 7.2 and 7.3 within appendix 4 show highlights the number of women who suffered a moderate harm in the months of December 2024 and January 2025 and shows the cases in comparison to the rest of the birthing population at TRFT for the same month. It can be seen within both tables that there is a spread of moderate harms over the various deprivation deciles and that no one group is affected by moderate harms over another. The ethnic demographic of moderate harms (Table 7.4) is representative of the diversity of women who birthed at Rotherham in December 2024 and January 2025.

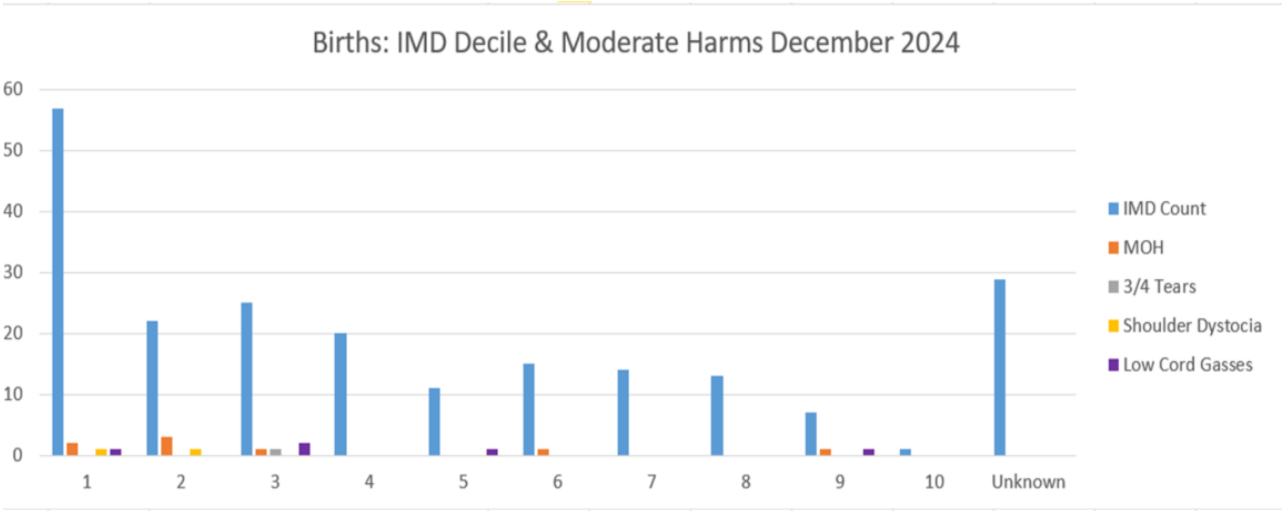


Table 7.2 Moderate harms & deprivation in maternity December 2024

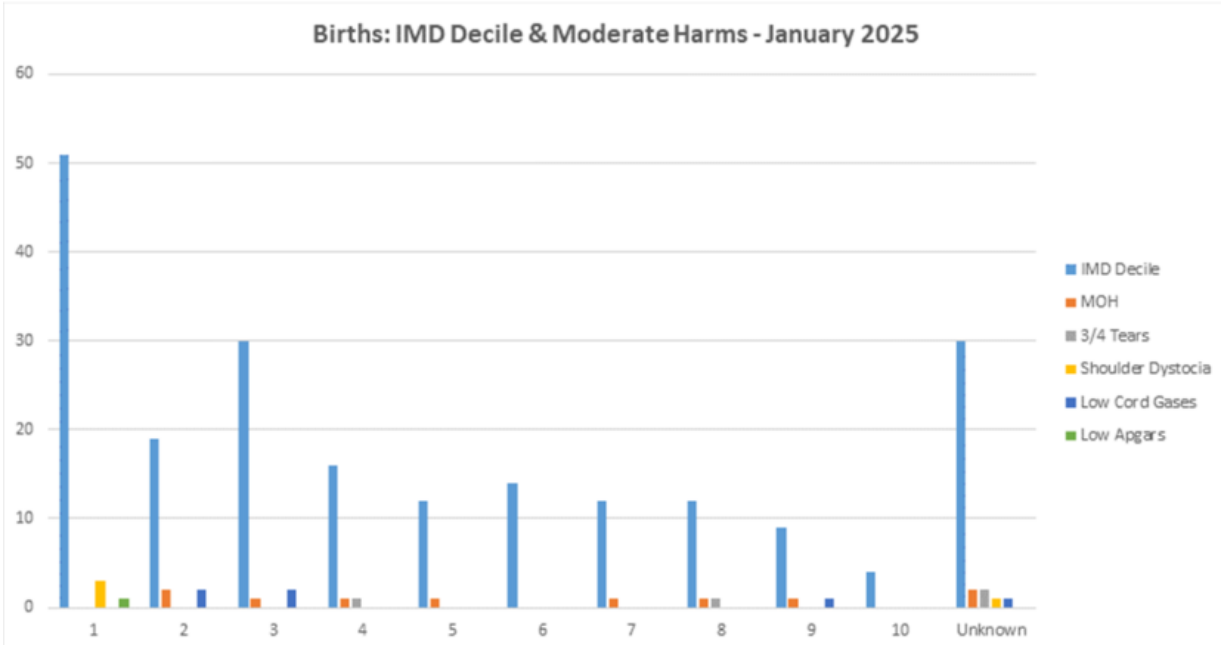
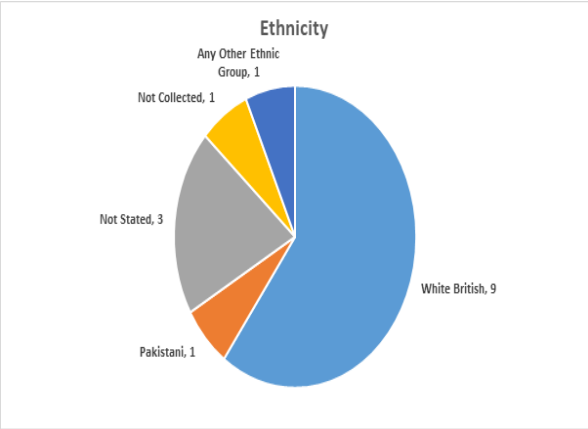


Table 7.3 Moderate harms & deprivation score in maternity January 2025

7.3 In December 2024 there were 16 incidents that were graded as a moderate harm, following MDT review all incidents were downgraded to either low or no harm. In January there were 25 incidents reported as a moderate harm. 20 cases have been examined by the MDT and downgraded to low or no harm, a further 5 cases of massive obstetric haemorrhage (MOH) are pending investigation via a thematic review which began in January 2025.



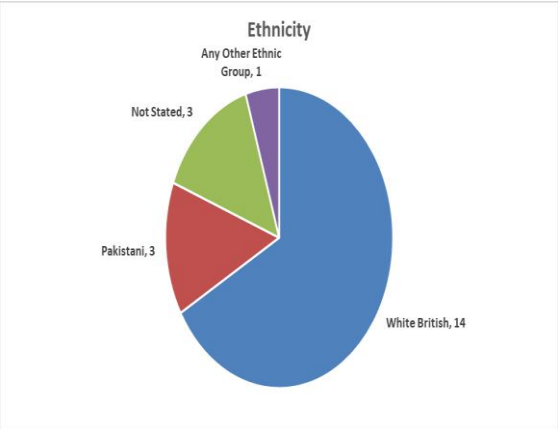


Table 7.4 Ethnicity of women who suffered a moderate harm in December 2024 & January 2025

7.4 MOH remains one of our top reported moderate harms at TRFT and so a change in how learning is gathered was required. The transition to the new PSIRF method of reviewing MOH has already begun to show commonalities with most women having undergone an induction of labour or having had an emergency caesarean birth, prior to the MOH. The thematic analysis will inform further quality improvement work to reduce harm from MOH further.

8. **Below is an update on the progress of the 3 Year Delivery plan for Maternity and Neonatal services**

8.1 On the 23rd of January 2025, TRFT had an assurance visit from the LMNS, the external assurance team comprised of; the ICB Chief Nurse and deputy, the ICB Director of Nursing for Patient Safety and the LMNS PMO team along with service user representation. The day was split into 5 focus groups with the topics of the main themes from the 3 year plan including; Neonatal Care, Listening to Women, Workforce, Safety and Processes and Structures for the service. Each focus group began with a presentation from the TRFT teams, demonstrating how TRFT are working towards full compliance with the three year plan. This was followed by a question and answer session where the external assessors had the opportunity to explore how this journey feels for the staff and women and explore any challenges and successes.

8.2 Initial informal feedback from the visiting team was positive, a full report with the findings from the assurance visit is expected in March 2025, this will be shared via the usual governance and safety champions meetings to monitor any associated actions required for improvement.

9 BFI re-accreditation

9.1 Following the UNICEF Baby Friendly Initiative re-accreditation visit to TRFT in November 2024, the final report has been received which found that they assessed Rotherham Maternity Unit to have met most of the BFI standards to be re-accredited at level 3. (See appendix 5 for full report).

9.2 Although most of the BFI standards continue to meet the necessary criteria, a small number have not been maintained. However, the assessment team have requested that the Designation Committee to consider re-accrediting the service with further audits to follow to demonstrate improvement in the unmet criterion. Further supporting information required includes;

- Evidence of an increase in the percentage of staff who understand how to support mothers to maximise breastmilk given and why supplements should be avoided unless clinically indicated.
- Evidence of an increase in the percentage of breastfeeding mothers who recall information about responsive breastfeeding.
- Evidence of an increase in the percentage of mothers who are formula feeding who:

  A) Confirmed they had skin contact for at least one hour and offered the first feed in skin contact (small sample)

  B) Were supported with responsive bottle feeding.
- Supplements of infant formula are referred to the Designation Committee.

9.3 An action plan has been developed by the Infant Feeding Midwife to assist in the development of the final evidence required and will be monitored via the Safety Champions meeting.

9.4 Positive comments are made within the report as to the level of staff knowledge around infant feeding and from service users interviewed. Below is a sample of the feedback obtained by the visiting assessment team from our service users.

"I was going to mixed feed after the last experience, but now I am exclusively breastfeeding."

"The maternity infant feeding support workers really helped with my feeding."

"The staff on the ward were lovely, they even gave me a cake as it was my birthday."

"Only negative was waiting a long time for pain relief"

"They say you can't over cuddle your baby, he is always in my arms"

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 Whilst the contracted vacancies is 1.01WTE under establishment, the maternity leave, long term sickness and planned leavers result in the total gaps of 11.29 WTE for January 2025, this is a slight increase from last month. NHSP is supporting staffing levels only when the gaps equate to above the designated headroom to maintain grip and control of spending. The current budgeted establishment remains in line with Birthrate+ but the current mix of Maternity Support Workers (MSWs) versus Registered Midwives is being reviewed to ensure that the areas that require a skill mix weighted to more midwives and less MSWs is maintained.

10.3 Work is ongoing in partnership with the Senior Leadership Team and finance and the LMNS to review potential future vacancies for the earlier career midwives later in the year. Currently the maternity unit has 10, third year students who will be looking for employment in the autumn of 2025.

10.4 A full staffing paper will be presented to Board in May 2025 which will demonstrate workforce strengths, challenges and resilience planning for the whole of the maternity unit including obstetric, neonatal medical and nursing and anaesthetic cover for the service.

he Rotherham NHS Foundation Trust - **Finance Dept**

laternity Staffing live nominal roll as at :
31/12/2024

	2024/25											
rajectory	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
ontracted Vacancies	-3.24	-1.64	-0.96	-0.48	0.29	0.29	0.29	2.26	1.01	1.01	1.01	1.01
laternity 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
ong term sickness	2.64	3.80	4.12	8.88	7.00	2.36	2.56	2.56	0.00	1.64	1.64	0.64
lpcoming Leavers	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.17	1.33	1.33	3.15	3.57
ther - 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
otal Gaps	**6.88**	**9.64**	**11.44**	**14.72**	**13.25**	**7.97**	**10.97**	**14.31**	**11.30**	**12.30**	**13.48**	**12.26**
lew Starters (reducing gaps)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-1.64	-2.44
lew 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
rajectory - for planning	**6.88**	**9.64**	**11.44**	**14.72**	**13.25**	**7.97**	**10.97**	**9.14**	**5.22**	**6.22**	**5.76**	**3.74**
; Workforce Gaps	**7.0%**	**9.7%**	**11.6%**	**14.9%**	**13.4%**	**8.1%**	**11.1%**	**9.2%**	**5.3%**	**6.3%**	**5.8%**	**3.8%**

Table 10.1 Midwifery establishment

10.5 Table 10.2 highlights the acuity data for labour ward for December 2024 and January 2025 and demonstrates that midwifery staffing met acuity 92% of the time in December and 89% of the time in January, with 8% showing that the unit was short by up to 2 Midwives in December and 10% in January. Only on one occasion in January was the unit short by 2 or more 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 remained above the 80% compliance for both months which is required for accurate data. There were no safety incidences reported linked to a lack of staffing for either December or January 2025.

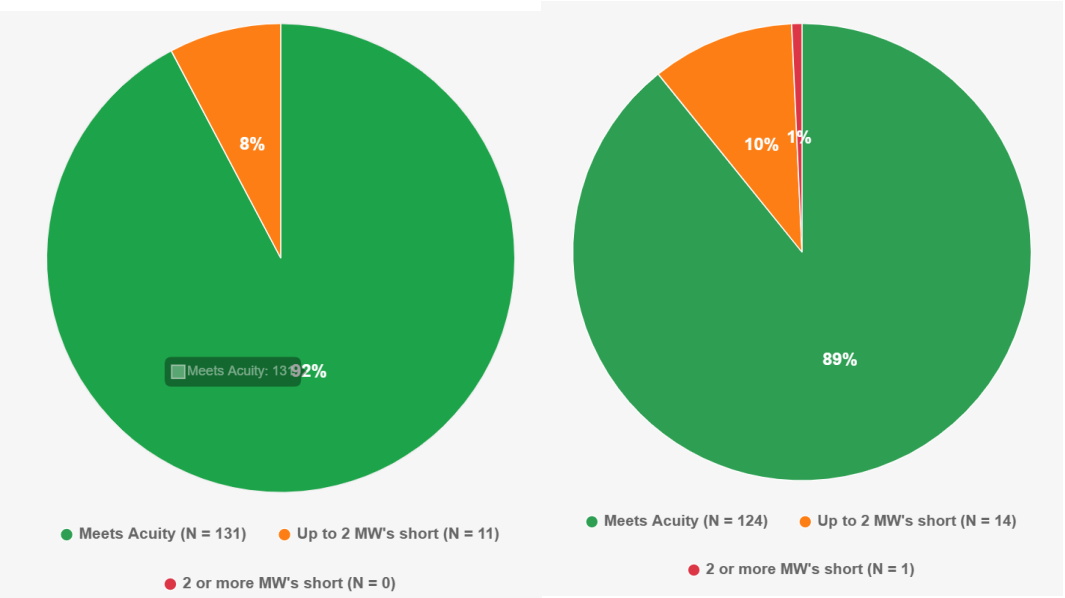


Table 10.2 Midwifery acuity for the month of December 2024 and January 2025

10.6 Medical workforce locum covers can be seen in Table 10.3 for January 2025, 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 and work is ongoing to implement the supernumerary status of the shift co-ordinator role as detailed in the BAPM service and quality standards. Other work streams include Neonatal Nurses attending leadership training and skill development for potential shift co-ordinators. This work will be further explored further in the May 2025 full staffing paper. Anaesthetic cover for labour ward also remains compliant with no issues raised for the months of December and January.

Grade	No of Shifts	Reason	Internal / External
ST1/2	28	18 Vacancies 9 x sickness absence 1 x ward pressures	4 x Internal 24 x External
ST3/7	5	2 x sickness absence 1 x Vacancy 2 x additional weekend theatres	5 x Internal
CONSULTANT	44	11 x Annual/Study Leave 18 x Additional clinics 5 X Additional Theatres 9 x Vacancies 1 x SI's	44 x Internal

Table 10.3 Medical vacancies

10.7 Table 10.4 below represents December 24 and January 25 workforce data. Sickness rates increased in 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.

	Dec 24	Jan 25	
Maternity unit closures	**0**	**0**	**Datix / Birth-rate Plus®**
Utilisation of on call midwife to staff labour ward (Night Duty)	**1**	**1**	**Birth-rate Plus® data/ Datix**
1-1 care in labour	**100%**	**100%**	**Data from Birth-rate Plus® acuity tool / Maternity Dashboard**
Redeploy staff internally	**19**	**7**	**Birth rate plus Acuity (Occasions)**
Redeploy staff from Community	**1**	**2**	**Birth rate plus Acuity (Occasions)**
Matron Working Clinically	**0**	**2**	**Birth rate plus Acuity**
Delay in Induction of Labour, women awaiting artificial rupture of membranes (ARM)	**11**	**5**	**Birth rate plus Data and Datix**
Supernumerary labour ward co-ordinator	**100%**	**100%**	**Data from Birth-rate Plus® acuity tool/Maternity Dashboard/Datix**
Staff absence 1	**5.6%**	**7.3%**	**December 24 data, 2.76% short term 2.84% long term January 25 Short term 2.48%, long term 4.82%**
Obstetric compliance at mandatory consultant escalation	**100%**	**100%**	**No Datix incidents reported**
Compliance with twice daily face to face ward round	**100%**	**100%**	**Datix**

Table 10.4 safety points

11. Developing a Safety Culture

Safety Champions meetings:

11.1 In December 2024 the safety champions meeting took place and all CNST 10 standards and associated evidence was shared with Safety Champions. It was agreed that the evidence demonstrated compliance and could be shared with the LMNS and Trust Chief Executive for final sign off. In the January 2025 TRUST Board meeting, issues and action plans discussed included the national oxytocin alert with instructions on how to minimise the risk of oxytocin being given over the prescribed amount. The action plan from this national has been recently completed. The CQC picker in patient survey was also discussed with the MNVP and wider teams, an action plan is currently being co-produced with service users and will be shared with the LMNS and via maternity Governance for assurance and traction on actions.

11.2 Concerns raised by service users

During December 2024 the service had 1 formal complaint, the complaint was in relation to a birth in 2023 and was regarding postnatal management of perineal wound healing and some aspects of labour care. A local resolution meeting has been offered and accepted by the family.

During January 2025 the service had 3 formal complaints. 1 complaint was in regarding the care received during the antenatal period up to the point of attending with a stillbirth. 1 complaint was around labour care and wound healing. A further complaint was reopened around incorrect information in medical records. A local resolution meeting has been offered to all families involved in complaints apart from the incorrect information complaint as the mother wishes to have a formal written letter.

11.3 Concerns raised by staff via safety champions walk around

11.1 Concerns have been raised by both medical and midwifery teams around the safety of the increasing amount of elective caesarean births taking place in the labour ward emergency theatre. This increase in demand is not currently being able to be met within the main theatre elective theatres which has resulted in an increase of use of the labour ward theatre to facilitate the increased demand. The labour ward theatre would normally be reserved for labour ward emergency cases. Table 11.1 shows the number of elective caesareans that have taken place on labour ward and the day surgery unit (DSU) and the required additional cases that have been facilitated in 2024.

THEATRE	Attended	Slots Available	Slots not Used	Unavailable lists
DSU	142	151	9	5
LABOUR SUITE	186	202	16	4
ADDITIONAL	71	71	0	0
TOTAL	399	424	25	9

Table 11.1 caesarean section demand for 2024

11.2 Safety champions have been made aware of these safety issues and have supported the SLT to discuss these concerns in the most appropriate forums to attempt to find a solution. Mitigations are being put in place for if a second theatre is required urgently in the form of an updated SoP to ensure that there is a clear process and lines of communication in place for both theatre teams and maternity teams. The use of an emergency second theatre is also now recorded via Datix to monitor the volume of this event. The SLT have identified this a one of their top priorities for 25/26. Working with colleagues in Care Group 2 to scope a plan for additional theatre capacity. This is currently graded as a 12 risk on the obstetric risk register.

12. Year 6, CNST 10 standards and training figures (current status)

12.1 Final sign off of the CNST evidence has now passed through the appropriate governance streams to ensure that there has been a robust assessment of the provided information which has resulted in assurance that TRFT has adequately achieved the 10 safety standards for year 6 CNST. The final Board assurance

document is currently being signed off by the Trust Chief Executive and by the ICB responsible officer.

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.	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

Date:	% by staff group / Subject	Obstetric Consultants	Obstetric Registrars (ST3-7)	Obstetric Trainees (ST1-2)	Midwives (All bands)	NHSP Midwives	Clinical Support staff	Obs roster anaes	Non obs roster anaes
Total Attendance Core Competency Day (Modules 1/4/5/6)		91%	100%	100%	85%	80%	85%	N/A	N/A
Total Attendance full day PROMPT (Module 3 PROMPT)		100%	92%	100%	82%	100%	78%	88%	26%

Table 12.2 CNST Standard 6 training percentages

12.2 Training compliance for the core competency training and the PROMPT emergency skill day can be seen in table 12.2. The new fetal monitoring training programme has begun in January 2025, compliance will be shared within the next full report.

13. Saving Babies Lives V3 (SBLV3)

13.1

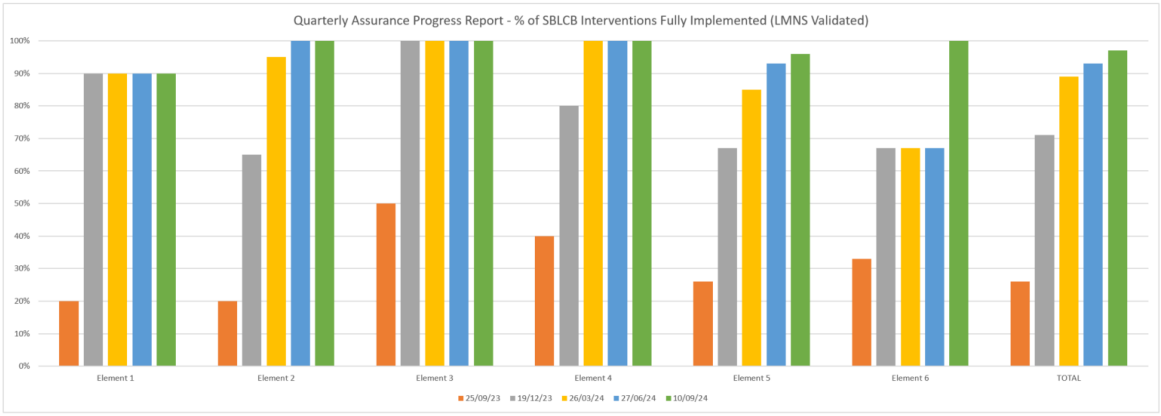


Table 13.1 TRFT progress for SBLV3

13.2 Saving babies lives compliance continue to be at 97% (see Table 13.1). 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.

13.3 As part of the SBLV3 pre-term QI work, optimisation continue with positive results shown in the form of a sustained decrease in pre-term births over recent months Table 13.2 shows that TRFT have remained below the 6% target.

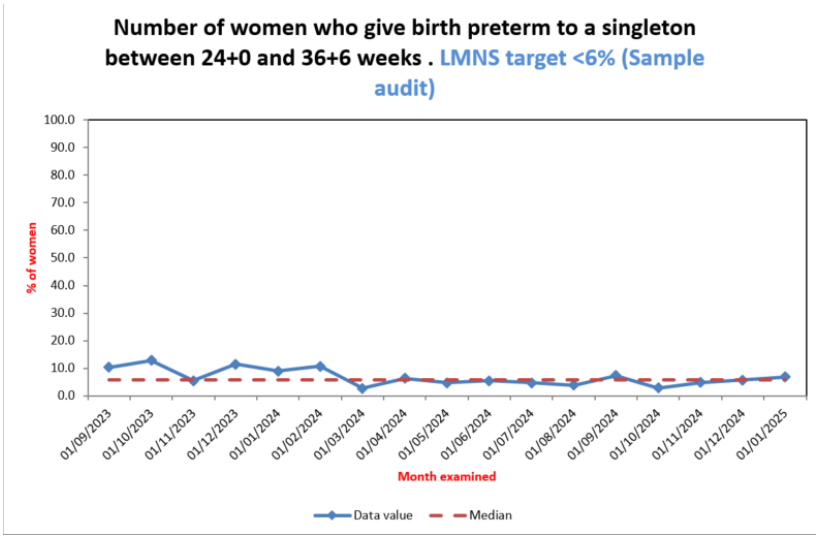


Table 12.2 pre-term birth rates at TRFT since QI began

13.4 Other matrix that are closely monitored to ensure compliance with the Saving Babies Lives V3 include our optimisation rates for stabilising and giving the best care to optimise outcomes for baby born below 34 weeks. Table 13.3 shows our percentage of pre-term babies that have received all of the appropriate aspects of optimisation. The full report for optimisation can be found in appendix six. Optimisation include; antenatal steroids, early breastmilk, intrapartum antibiotics, delayed cord clamping, antenatal magnesium sulphate and temperature control of the new-born. There were no cases in October for TRFT.

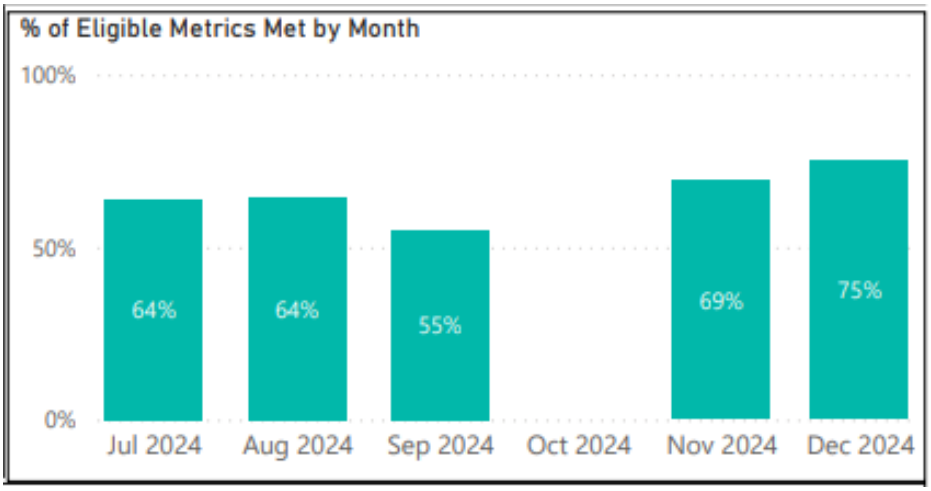


Table 13.3 percentage of pre-term babies receiving all elements of optimisation

14. Avoidable Admission into the Neonatal Unit (ATAIN)

14.1

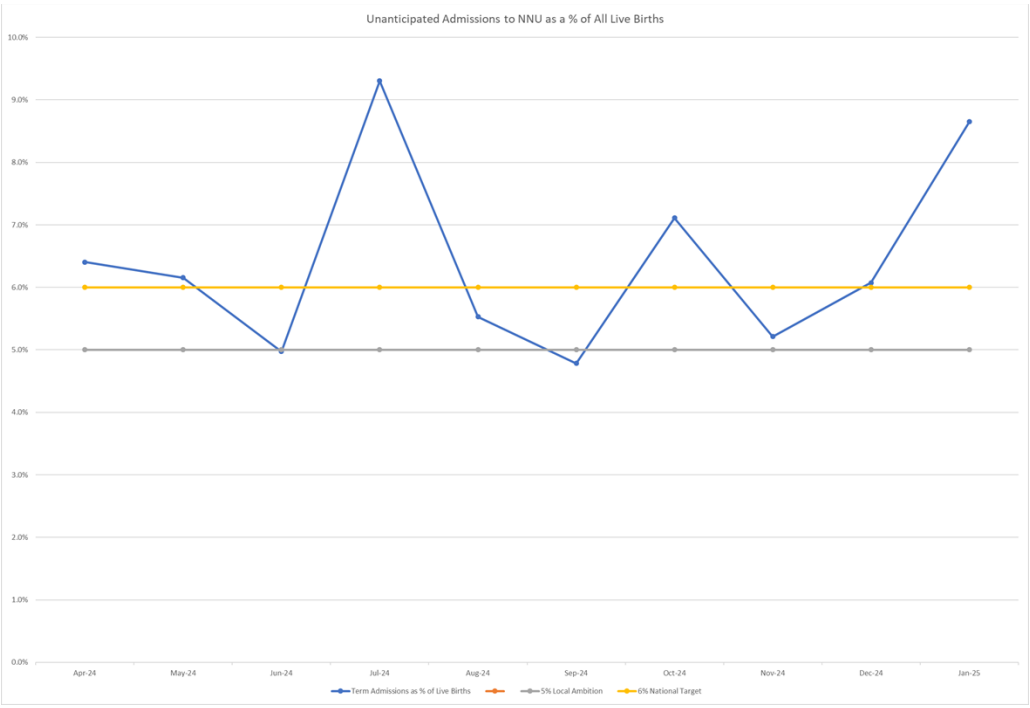


Table 14.1 Term admissions to the NNU

14.2 Term admissions for December and January have increased as can be seen in table 14.1. None of the admissions have been deemed avoidable following an MDT review of cases and all care was within guidance. Table 14.2 shows when a case has been

deemed avoidable. A QI project, registered on AMAT, is underway to look at themes and commonalities across admissions to see if there are any change actions highlighted to improve the term admission numbers. This QI project will be shared through the LMNS and is part of the CNST Year 6, standard 3 work stream. The LMNS are hosting discussions across the region regarding the approach to ATAIN and considering the possibility of adopting PSIRF principles rather than being numbers focused.

Primary reason	Secondary reason/detail	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Management of a respiratory problem									1				
Hypothermia/temperature management					1	1							
Hypoglycaemia/management of blood glucose				1									
Antibiotics													
Requires period of observation					1								
Observation following resuscitation													
Suspected sepsis													
Jaundice after 24h													
Seizures where concerns with clinical care													
Diagnosed NAS													
Other: Social Reasons													
Other: Congenital anomaly manageable on PNW													
Other: Other													

Table 12.2 reasons for avoidable term admissions

15. Staff Survey

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

16. Red Risks/Risk register highlights

16.1 There is currently 1 risk scored as a 15 which is in regards to the CTG equipment used on labour ward being old. Since this has been recognised the SLT have worked quickly to procure new equipment to replace the old. Delivery of the new CTG machines is expected within the next few months.

17. Recommendation

17.1 The Quality Committee/Board of Directors are asked to receive and discuss the content of the report. 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.

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

Public Board of Directors' Meeting

The Rotherham NHS Foundation Trust

Agenda item	P48/25
Report	Annual Health & Safety Report
Executive Lead	Scott Dickinson, Director of Estates and Facilities
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	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)	The Annual Health and Safety Report provides an annual update to the Trust Board on the Trust's performance in terms of the Health & Safety and welfare of staff, patients and visitors to the Trust. The report was initially presented to the Quality Committee in October 2024. The updated final report, with all requested amendments, was presented to the Quality Committee in February 2025.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	The Health & Safety Committee is informed of health and safety matters arising with contributions from membership including Staff Side representation and representation from The Radiation Committee, Estates & Facilities Health & Safety Group, Fire Safety Management Group, Medical Gases Group, Medical Devices Safety Committee, Water Safety Group and Ventilation Safety Group. A summary of the various working groups' activities and reports are included within this report.
Board powers to make this decision	For assurance that the Trust has processes in place to manage Health & Safety.
Who, What and When (what action is required, who is the lead and when should it be completed?)	• Health & Safety will monitor and investigate incidents and RIDDOR statistics to identify trends and report findings to the H&S Committee. • Regular Health & Safety audits will be conducted in alignment with the approved Health & Safety Strategy 2024/27, contributing to ongoing improvement efforts. • Regular fire audits will be conducted across all TRFT sites in line with the Fire Strategy 2024/2026.

	• Health & Safety and Moving & Handling teams will collaborate with Learning & Development and ESR to complete the mapping of Patient and Manual Handling Training MaST requirements. • The Trust remains dedicated to providing a safe, non-violent, and non-threatening environment for employees, patients, and visitors, and will take all reasonable measures to protect staff from aggression, violence, or abuse in the workplace. • The Trust continues to enhance physical security in the short to medium term with increased door access controls, CCTV, and body-worn cameras. • Embed Health & Safety KPI's as per monthly reporting. • For 2023/24, the focus on Sharps safety is to ensure continued compliance with UK Sharps legislation. • General Risk Assessor training will continue with two sessions available monthly for booking through ESR. • Continue to horizon scan for any upcoming changes in legislation that may impact on the Trust. • Monitor and improve risk register reports for corporate H&S related issues.
Recommendations	It is recommended that the Board approve the report.
Appendices	Appendix 1: Annual Health & Safety Report

The Rotherham NHS Foundation Trust

Annual Health and Safety Management Report 2023/24

Joint report covering Fire Risk Management, Sharps Safety, Moving and Handling, Estates and Facilities, Ionising Radiation and Security

Report compiled by:

James Kitchen — Head of Health and Safety

Supporting information provided by:

Rachel Bell	Professional Lead/Senior RPS Medical Imaging
Duncan White	Consultant Physicist
Allison Cranmer	Health & Safety Advisor
Glyn Brown	Fire Safety Advisor
Anthony Bennett	Trust Security Manager
Kris Goodwin	Security Trainer
June Cadman	Waste Management & Environmental Services Officer

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1. INTRODUCTION

All organisations have a legal duty to put in place suitable arrangements to manage Health and Safety. Ideally, this should be recognised as a part of the everyday process of conducting business and / or providing a service, and an integral part of workplace culture, behaviours, and attitudes. Notwithstanding, a comprehensive legislative framework exists, within which the main duties placed on employers are defined and enforced.

The Health and Safety Executive (HSE) are the regulatory body with responsibility for enforcing Health and Safety legislation. The HSE also fulfils a major role in providing advice on Health and Safety issues and practical guidance on the interpretation and application of the provisions of the legislative framework.

The HSE has an agreement called a Memorandum of Understanding (MoU, 2017) with the CQC to help ensure that there is effective, co-ordinated and comprehensive regulation of health and safety for patients, service users, workers and members of the public. It allows sharing of information and a collaborative working approach between the two enforcement bodies.

Regardless of the size, industry or nature of an organisation, the keys to effectively managing for Health and Safety are:

- Leadership and management (including appropriate and effective processes).
- A trained / skilled workforce.
- An environment in which people are trusted and involved.

This is an important definition of how TRFT understands its H&S responsibilities. The Trust has a collective responsibility and the level of leadership required at Care Group, directorate and department levels, is supported by a management system that incorporates the support of the central team at each level.

The HSE provides guidance to support organisations of all sizes to effectively manage Health and Safety based on the principles of 'Plan, Do, Check, Act' (PDCA). This is described in detail within the HSE's 'Managing for Health and Safety Guidance' (HSG65). The key components of the PDCA framework being applied within The Rotherham NHS Foundation Trust are summarised, as follows:

- Plan Determine policy, plan for implementation.
- Do Profile Health and Safety risks; organise for Health and Safety management; implement the plan.
- Check Measure performance; investigate accidents and incidents.
- Act Review performance; apply learning.

The remaining sections of this report detail the Health and Safety management arrangements and performance contributions from various stakeholders to inform the Trust Health and Safety compliance. The PDCA cycle approach is applied to report the Trust's Health and Safety activity.

This annual report provides an update to the Board of Directors of the Rotherham NHS Foundation Trust (TRFT) on the Trust's Health and Safety (H&S) performance across its sites. It ensures that the Board is informed of the Trust's H&S performance, enabling them to verify compliance with corporate policies, legal standards, and best practices.

The report outlines both proactive, and reactive measures that are continuously monitored and reviewed to maintain effective, health and safety management throughout the Trust. It has been prepared using data from the Datix reporting system, encompassing all aspects of health and safety reporting. As part of the corporate assurance process, this report is presented to the Board of Directors.

Additionally, the report serves to:

- Comply with the Health and Safety Executive (HSE) requirement for Boards to receive an annual health and safety report.
- Provide evidence for the CQC assessment process.

This report covers non-clinical topics such as health and safety, fire safety, security, sharps, ionising radiation, ergonomics, and the carriage of dangerous goods. These topics fall under the remit of the Health and Safety Committee. The report details non-clinical risks and incidents for the period from April 2023 to March 2024.

1.1 Royal Society for the Prevention of Accidents (RoSPA) Occupational Health & Safety Awards 2023

RoSPA external Awards Adjudication Panel has awarded the Trust with its eleventh consecutive Gold Award for Occupational Health and Safety. This is a tremendous achievement for the Trust, which demonstrates our continued commitment to managing health and safety.

In recognition of our continued commitment to health and safety, RoSPA has also awarded the President's Award for 2023; the highest tier award available.

1.2 Executive summary

The purpose of this report is to inform the Trust Board of the principal activities associated with the promotion and management of Health and Safety at the Trust for the period 1st April 2023 to 31st March 2024. During the current reporting period, the Health and Safety team has continued to support clinical and non-clinical areas with managing Health and Safety.

In the last reporting year, there have been no HSE enforcement actions for health and safety related fatalities or safety related non-compliance.

Incidents requiring reporting under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) have remained low with 18 reported in 2023 and one in 2024. This is an increase of one report over the 2022 to 2023 reporting period.

There have been no Fire and Rescue Authority enforcement actions or fires reported within the main hospital site. There were 69 unwarranted fire alarm activations, demonstrating an increase of 40 activations over the previous 12 months. These are attributed to malicious activations, dust, maintenance works and faulty detectors. The fire advisor monitors all alarm activations.

Ionising radiation safety continues to perform with no material risks reported.

Conflict resolution training has improved to 92.16% of all staff and benchmarks with the national average for conflict resolution training, which is also at 91%.

The Health and Safety Strategy implementation continues and responses from departmental health and safety self-assessments show no significant identified trends and indicate good overall management processes for health and safety risks.

1.3 Learning from other organisations

The Health and Safety Executive is a regulatory / advisory organisation which:

- Provides advice and guidance to individual businesses or groups
- Undertakes proactive interventions including inspection
- Reactive interventions e.g. to investigate accidents or complaints.

Enforcement Notices are published by the Health and Safety Executive throughout the year and, where applicable, these will instigate preventative / review actions to assess and reduce the risk of those incidents occurring in our Trust. There were no unplanned visits which resulted in any regulatory action.

The Health and Safety Team participates in the Yorkshire Regional NHS Health and Safety Group. This group is made up of H&S teams across sister Trusts and meets on a minimum of quarterly basis. Any messages received here are shared with the Health and Safety committee and relevant departments as appropriate.

Two of the team are members of the Institute of Safety and Health (IOSH) which is the chartered body which offers professional status and offers advice and support on all matters concerning health and safety including CPD opportunities.

2. HEALTH AND SAFETY MANAGEMENT FRAMEWORK

The Trust's health and safety management framework reflects the HSE guidance 'Managing for Health and Safety (HSG65)'. The principles of this guidance and the framework for this report are depicted in Figure 1.

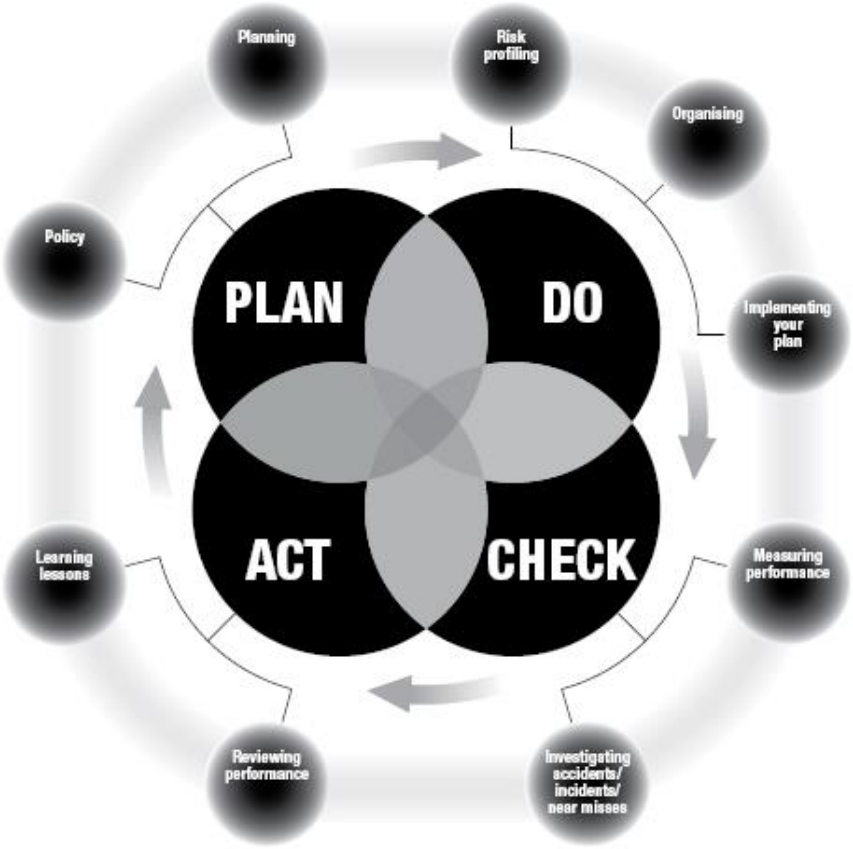


Figure 1. Health and Safety Management Framework

2.1 Trust's Health and Safety Committee

The Trust's Health & Safety Committee met three times during the reporting year. All meetings met quorum requirements, except for the June session, which was postponed as outlined in the committee's Terms of Reference. The meetings were well-supported by staff side representatives. The committee reviews health and safety reports, addresses issues related to general business activities, and tackles concerns raised by staff safety representatives and other stakeholders. Regular agenda items include incident trends, risk assessments, and significant concerns such as musculoskeletal disorders, needlestick injuries, slips, trips, falls, and violence against staff.

3. INTERNAL HEALTH AND SAFETY AUDIT REPORT

3.1 Self-assessment questionnaires

The Health and Safety Strategy 2021 - 2024 requires 18 departmental health and safety self-assessments be undertaken. In the current reporting period, 95% of departments and wards have returned their completed questionnaire. Analysis of the returned questionnaires shows there are three minor trends identified, these being missing Health & Safety Law posters, a lack or risk assessors and a lack of COSHH risk assessments; all of which have been addressed.

3.2 Inspections/Audits

In the reporting period seven audits of community facilities, including Health and Safety, Fire Safety and Waste, have been undertaken at Anston Medical Centre, Aston Joint Service Centre, Breathing Space, Brookfields Family & Children's Clinic, Dinnington Primary Family & Children's Centre, Kiveton Park, Maltby Joint Service Centre, The Place Family & Children's Clinic and Thorpe Hesley Medical Centre.

3.3 Incident audits

Health and Safety incidents reported via Datix are reviewed to ensure that the information including incident grades are reported in a consistent manner and that all incidents are reported in the agreed Trust format. Work will take place to improve the efficacy of reporting Health and Safety incidents.

4. INCIDENT REPORTING

4.1 Incidence rate

The incidence rate for employees reporting Health and Safety incidents is calculated by using the total number of reported incidents in the period divided by the number of employees, multiplied by 100.

548 employees have reported Health and Safety related incidents for the 2023/24 period.

Based on the data collated in this report, the Trust's Health and Safety incidence rate has slightly increased over the last 12 months as shown in Figure 2.

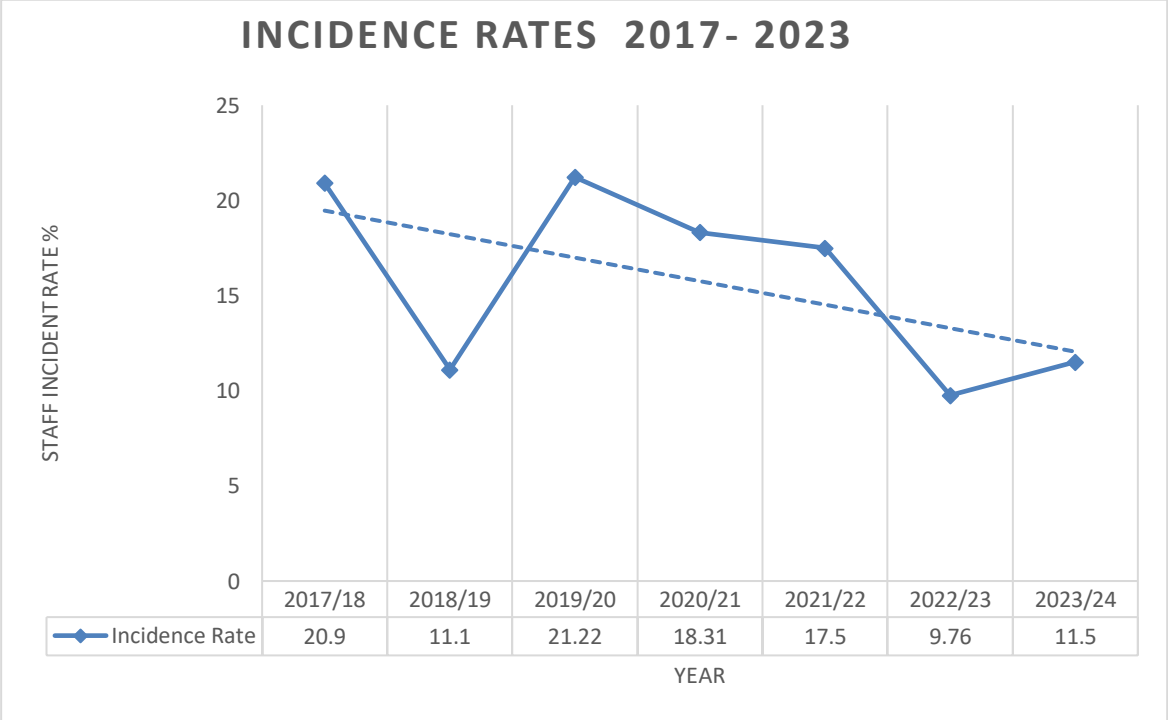


Figure 2. Health and Safety Incidence Rate

NB: The incidence rate is shown for employees and contractors, and reflects incidents recorded in Datix.

4.2 Abuse against employees

Figure 3 below shows the number of abuse incidents against staff by patients, relatives or visitors that have been reported in the period 2023/24.

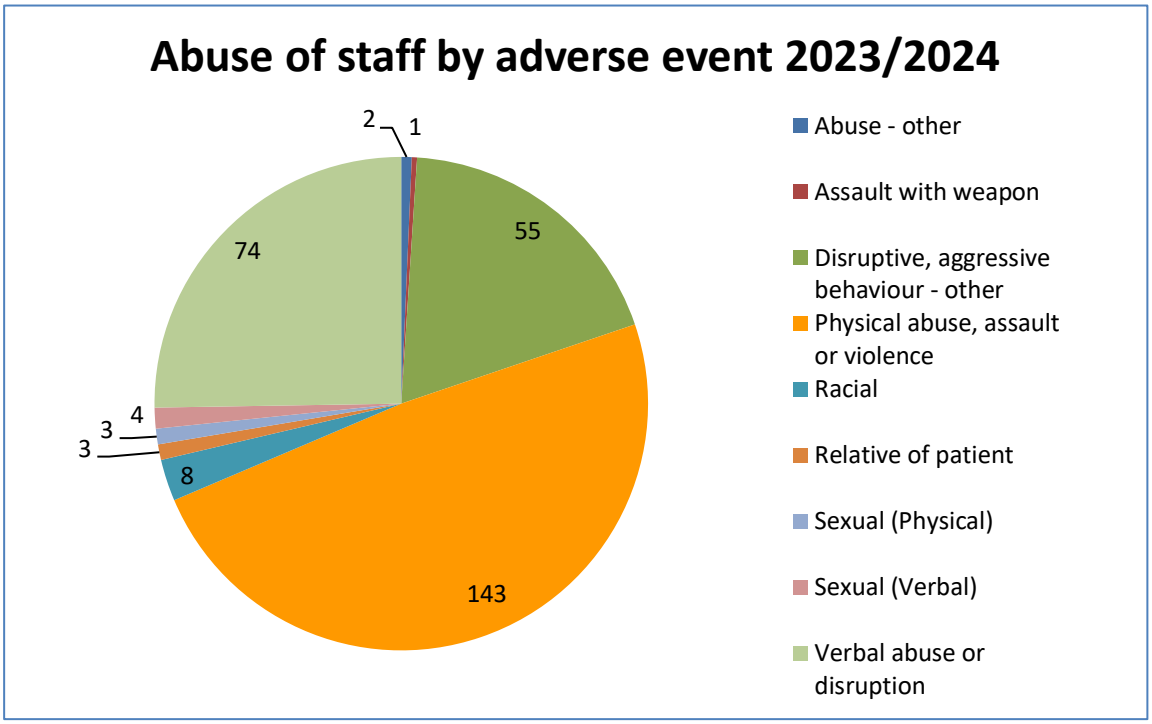


Figure 3. Abusive incidents by patients against staff

Physical abuse or verbal aggression towards Trust staff form the majority of these incidents and represent a 3.5% increase in the number of incidents reported, from 283 incidents in 2022/2023 to 293 incidents in 2023/2024. We are continuing to train staff in Conflict Resolution as part of their mandatory and statutory training (MaST) which now includes breakaway techniques. We are now also offering staff in higher risk areas a full course on physical intervention and breakaway techniques. This year's training figures are slightly higher than the previous year's figure of 92%, reaching 92.16%.

4.3 Accidents that may result in personal injury

Accidents that may result in personal injury in the 2023/24 reporting period, shown in Figure 5 below, detail the category of personal injury.

Personal injury claims 2022/23

The Trust uses a robust set of investigation procedures to assist with mitigation, defence, and trial preparation using a system that better captures the incident detail at the time.

4.4 Employee and Public Liability Claims (LTPS Scheme)

Similar to the Clinical Negligence Scheme for Trusts for clinical negligence claims, NHS Resolution also provide indemnity for member NHS Trusts for claims made by employees (Employer Liability/EL) and claims by visitors to hospital premises (Public Liability/PL) claims via the Liabilities to Third Parties Scheme (LTPS).

The Trust had **18** LTPS claims in FY23/24, compared to **17** claims in the last financial year; of the active claims, 14 are EL claims and 3 are PL claims.

For FY2023/2024, 8 new LTPS claims were notified to the Trust, of which 2 claims are being pursued by the same Claimant.

4.5 Claims Linked to Incidents and Complaints

Of the LTPS claims, 3 are linked to a complaint, 8 are linked to incidents and 1 is linked to an SI.

4.6 Cost of LTPS Claims

Unlike CNST claims, EL and PL claims attract an excess of £10,000 for EL claims and £3,000 for PL claims which is paid directly by the Trust and is deducted from the relevant division where the alleged negligence took place.

The total estimated cost of LTPS claims for FY23/24 is £504,757. This is compared to £515,536 in FY22/23 which represents a decrease of £10,779.

4.7 Closed Claims

During FY 23/24, the Trust closed 11 LTPS claims.

Of those closed claims, 4 (36%) closed with damages paid and 7 (64%) were successfully defended, resulting in nil damages paid.

The highest amount of damages paid in FY23/24 related to a slip claim, whereby the Claimant had slipped and fallen on a wet floor resulting in fractures and soft tissue injuries (CLM2006). Damages were settled at £20,000.

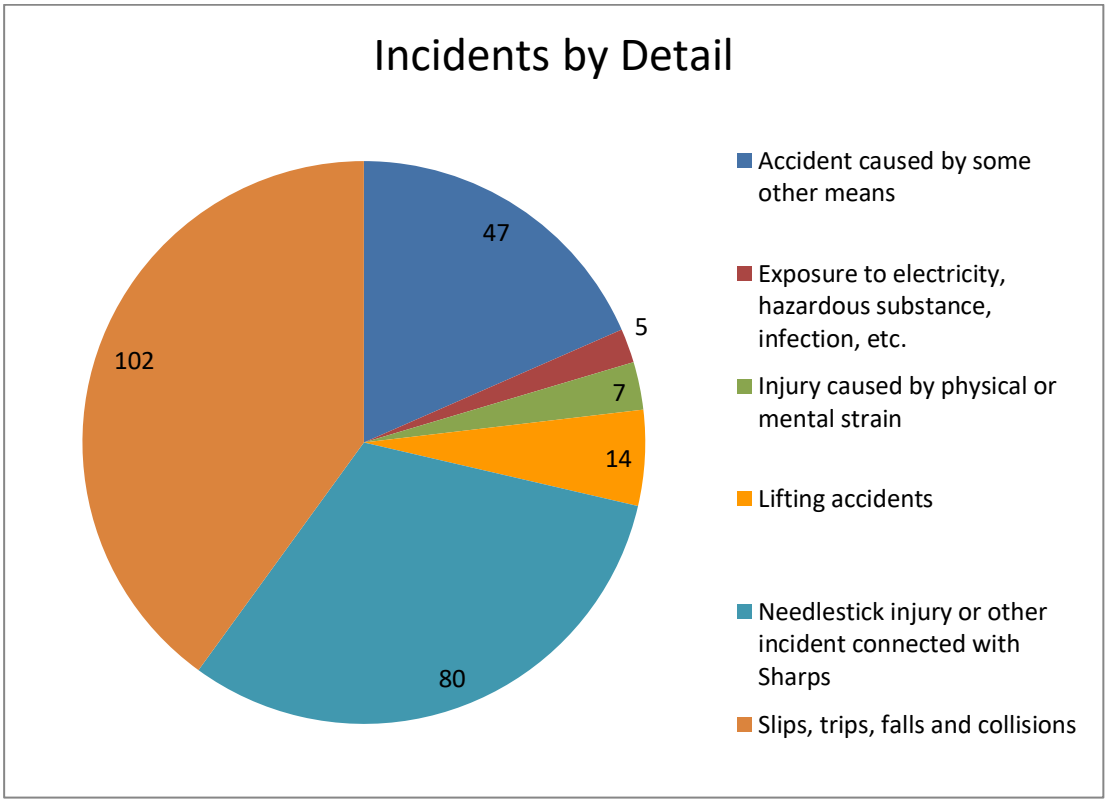


Figure 4. Incidents by detail

Figure 4 indicates that the highest number of incidents fall into the categories of slips, trips, falls, and collisions, as well as needlestick injuries.

4.8 Slip, trips,falls and collisions incidents

Figure 5 shows the number of staff and visitor incidents reported in the 2023/24 period for slips, trips and falls.

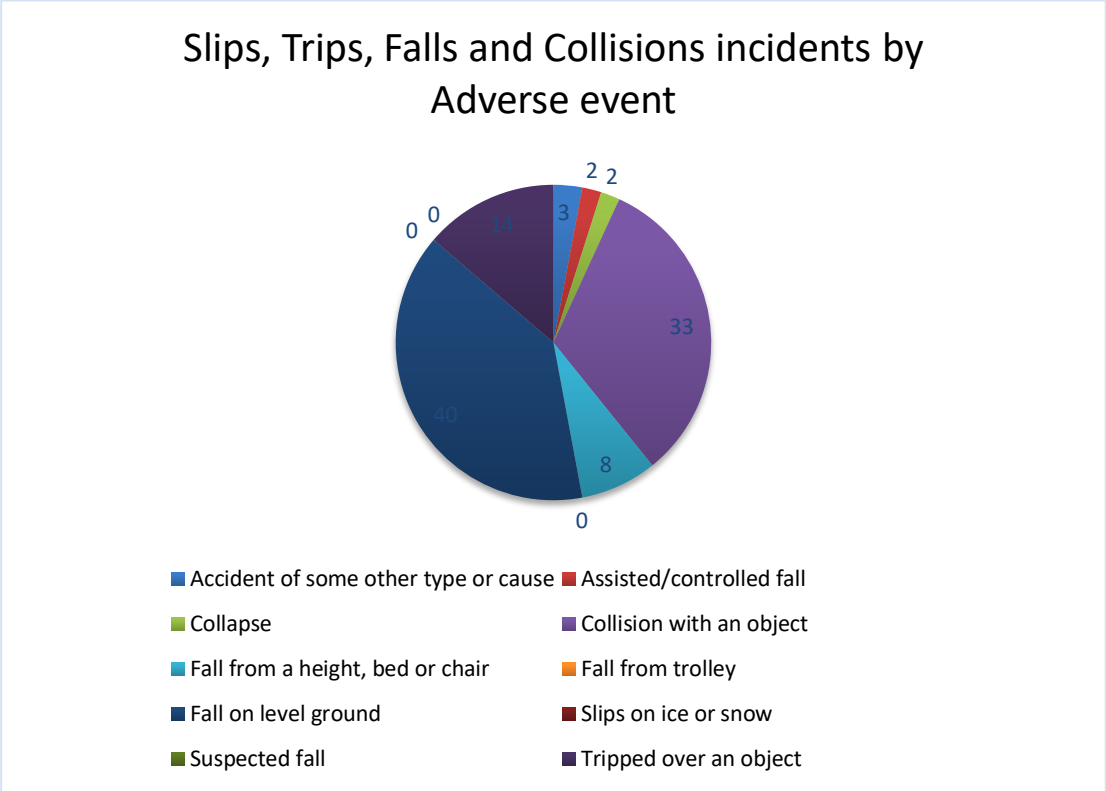


Figure 5. Slips, trips, falls and collisions incidents

There were 102 incidents relating to slips, trips, falls and collisions. 33 of the incidents are due to a 'collision with an object'. These incidents are where employees have walked into an object such as a trolley, however due to the setup of Datix these fall under the category of falls.

340 of the incidents are due to falls 'on level ground' however, there is no identified trend or single location of concern for these incidents. 14incidents of 'tripped over an object' will be a focus of the Health and Safety MaST training for 2024 as a preventative measure. The generic risk assessment for slips, trips and falls was reviewed and revised in March 2023. The 8 falls from height included 3 staff falling off wheeled chairs. We did review the use and communicated with staff the importance of taking care when sitting on wheeled chairs in clinical settings.

4.9 Sharps incidents

Below shows that of the 79 sharps incidents, 55 involved dirty sharps detailed in Figure 6. 24 incidents related to incidents such Splashes, incorrect disposal and items found. Whilst there is no national benchmark with which to compare the Trust's incident rate, the Health and Safety Committee monitor these incidents.

4.10 Sharps safety

The focus for sharps safety for 2023/24 is in ensuring continued compliance with the UK sharps legislation.

A review of disposed sharps by the Trust's sharps disposal contractor, Sharp Smart, is programmed for 2024 and will look to provide assurance that safety devices are being activated prior to disposal and that no non-safety devices are in use when there is a safe alternative available.

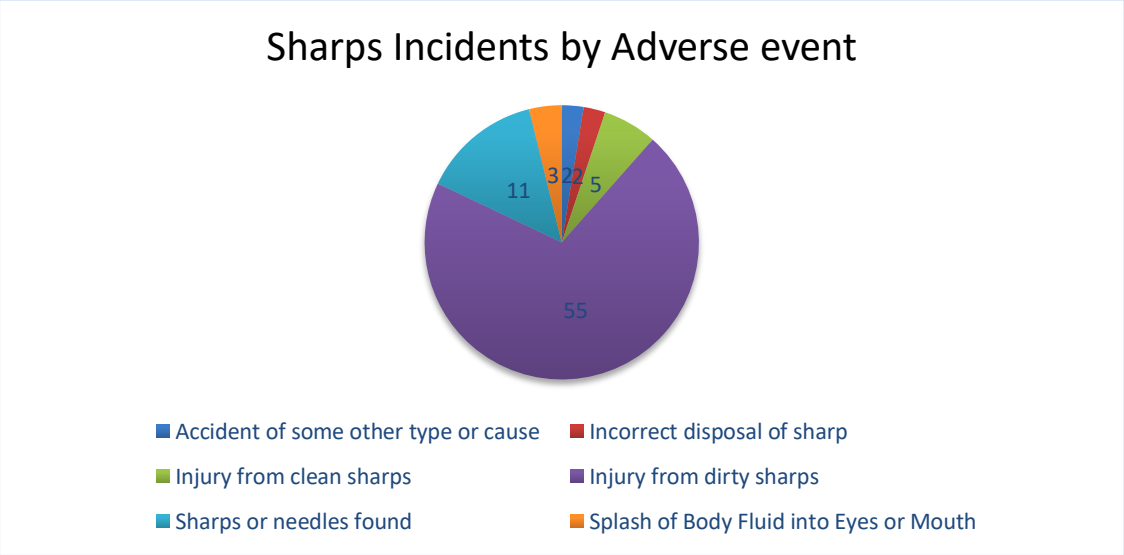


Figure 6. Sharps incidents by adverse event

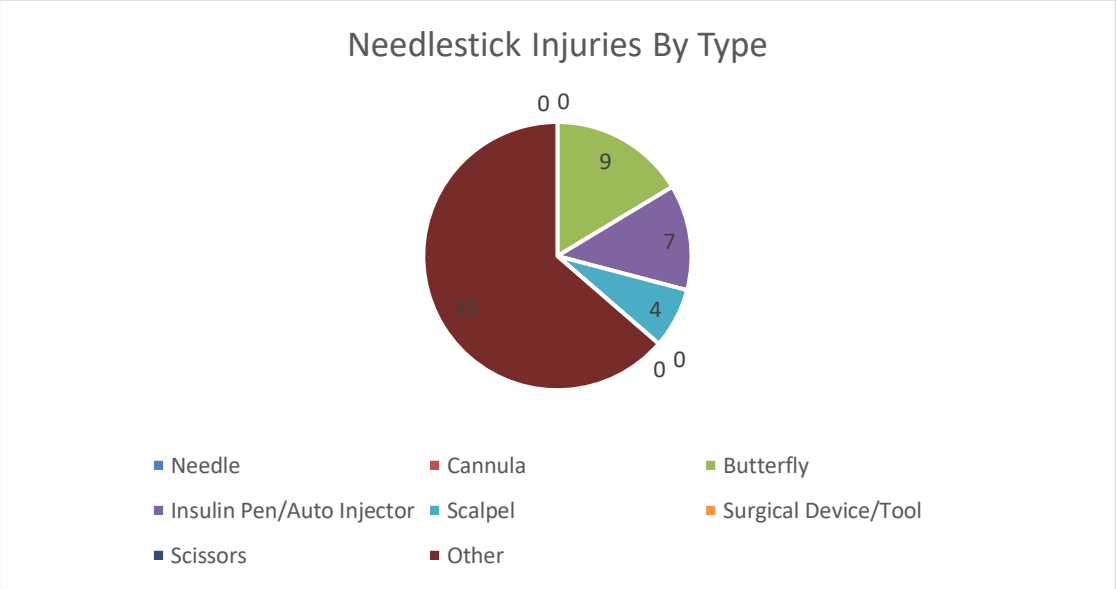


Figure 7. Needlestick Injuries By Type

All sharps injuries are reviewed by the Health & safety team and investigated by Infection Prevention & Control.

Sharps Safety forms part of the Health and Safety Committee agenda.

Sharps incidents reported via Datix are on automatic alert to the Lead Nurse/Assistant Director for Infection Prevention and Control, and the the Head

of Health and Safety who review all incidents reported on a monthly basis and share the information with the Health and Safety Committee.

All incidents are investigated locally in accordance with Trust policy. Reports that are related to disposal or incorrect disposal are forwarded to the Waste Officer for investigation.

The Occupational Health (OH) contract is managed by Sheffield Teaching Hospitals (STH) with a Standard Operating Procedure (SOP) in place for staff to ensure that any required support is offered.

4.11 Safety products

The regulations for preventing sharp injuries in the hospital (Health and Safety (Sharp Instruments in Healthcare) Regulations 2013) came into force on 11 May 2013.

Work has continued during 2023/24 to identify any new safety devices that have become available that would support the regulations.

Sharp smart waste disposal continues to be used on the main hospital site. Standardised disposable sharps bins are used at all other Trust sites ensuring compliance with the carriage of dangerous goods (ADR 2019).

Where the waste contract is managed by another organisation, the choice of bin remains with the service, however this has not been raised as a risk by any staff groups who work at these various sites.

4.12 Moving and Handling

There have been a total of 14 moving and handling incidents recorded during this period as shown in Figure 8. This is an decrease of two incidents from the same period last year.

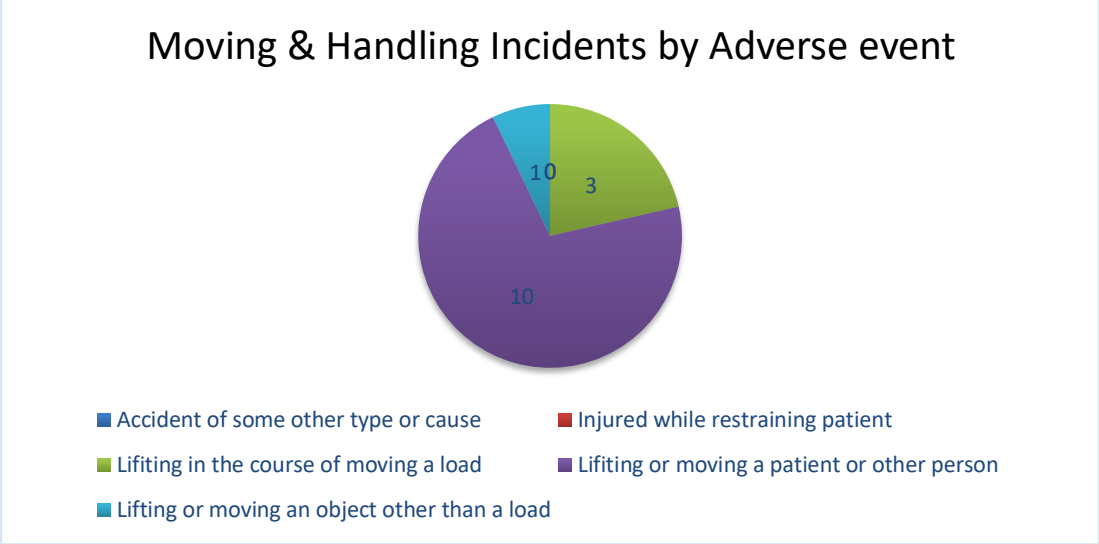


Figure 8. Moving and handling incidents by adverse event

All Datix recorded incidents are fully investigated in accordance with the Policy for the Reporting, Investigation, Management and Analysis of Incidents. The outcome of the incidents and investigations assist in identifying any trends that help in the development of training packages, the Health and Safety Strategy and annual work programme, so lessons can be learned and disseminated.

5. STRESS MANAGEMENT STANDARDS

Work related stress is now in the 2023/24 work plan for the HSE. The Trust uses the annual staff survey results as an indicator to identify areas of concern and to assist in the development of the Trust-wide risk assessment.

ViVUP provide data to the Trust Wellbeing team on employee usage of the EAP. The top 5 presenting issues are Stress, Anxiety, Other, Depression Low mood, bereavement/Loss.

6. RIDDOR REPORTS TO THE HEALTH AND SAFETY EXECUTIVE

Under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR), the Health & Safety Executive (HSE) require all employers to notify them when there is a specified accident or incident resulting in a fatality, major injury, disease or notifiable dangerous occurrence (whether or not anyone is injured).

It is a requirement for managers on behalf of the Trust to inform the Head of Health and Safety or Health and Safety Advisor of such incidents or occurrences so that the Trust complies with this legal requirement as identified in the Trust policy.

Three community staff fell on patients' premises when doing house calls. All three falls resulted in fractures to staff's limbs. Two slips and falls were outside and house and one was inside the house where the floor was uneven.

Summary of Trust RIDDOR reportable incidents

	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	Total
PATIENT	0	0	0	0	0	0	0	0	0	1	0	0	1
STAFF	2	3	0	0	2	0	3	1	2	2	0	0	15
VISITOR	0	0	0	0	0	0	0	1	0	0	0	0	1

Table 1. Summary of RIDDOR reportable incidents by month

The Trust continues to identify key risk areas for incidents that lead to RIDDOR reporting. The single patient incident was due to loss of consciousness in a clinical area, resulting in a back injury. The single visitor incident was due to a fall in the road after dark, resulting in a lower limb fracture.

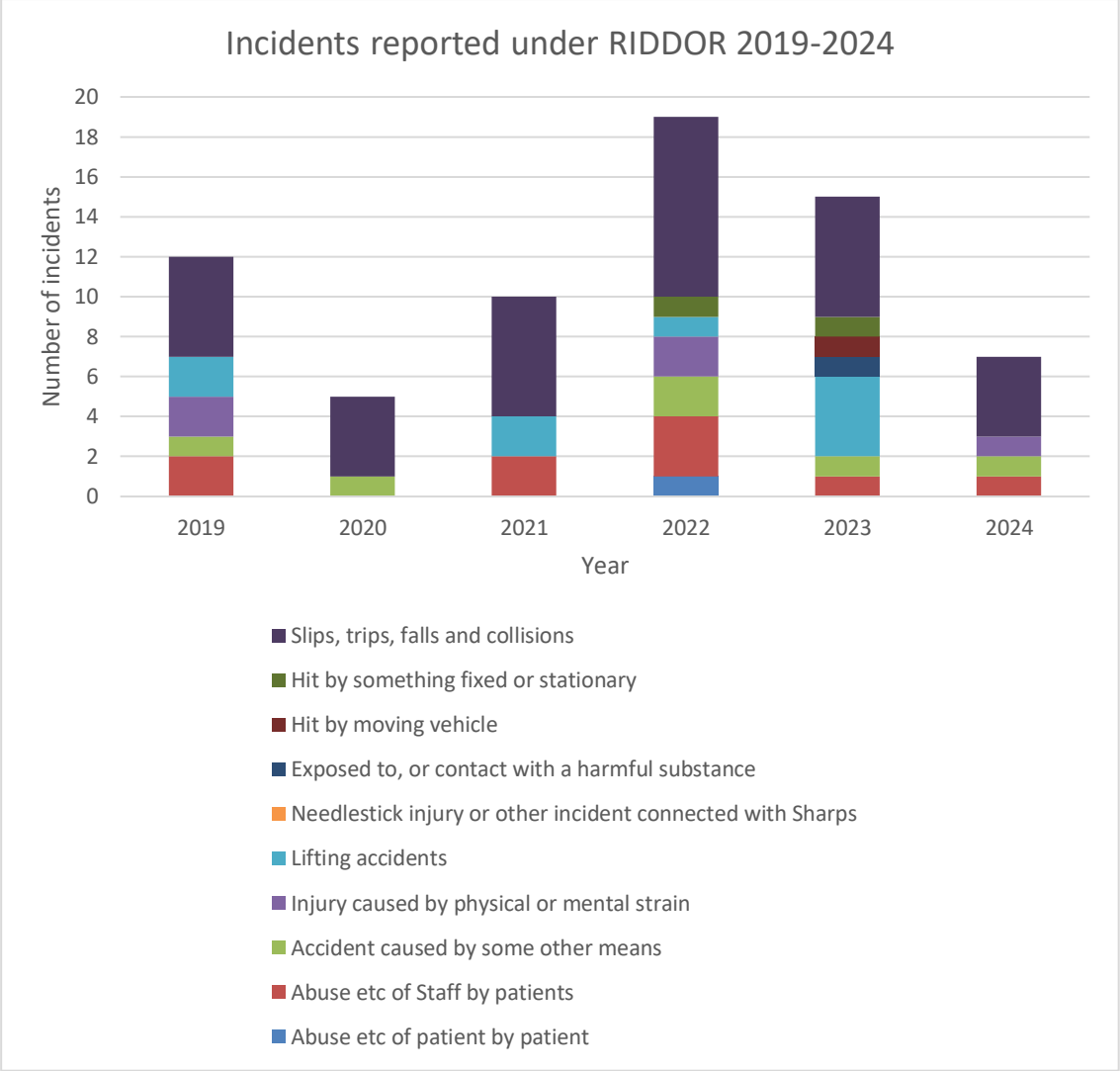


Figure 9. RIDDOR incidents by type 2019 – 2024

On average there are 39 health and safety Datix recorded incidents reported each month; these include employee, public and fire/security incidents. The incidents refer to injury, loss or near miss incidents and deal with all incidents outside the clinical risk reporting process. Figure 9 above shows the number of incidents broken down by incident that required reporting under RIDDOR.

Reportable instances of abusive/behaviour towards employees has decreased, but continue to be monitored. There has been a continued high level of slips, trips and falls in 2023/2024, which in the main is due to a change in reporting and the number of community staff falls reported. Communications were sent out to staff in the community advising them of the importance of wearing foot wear suitable for the weather conditions.

7. TRAINING

7.1 Risk assessment and risk management training

During 2023/24, 21 staff received Risk Assessor training and there are now 125 general risk assessors trained as a result of hosting one course per month. Staff are also trained in the risk assessment of violence and aggression, ligature, pregnancy and stress risk assessments through online

Teams sessions. All staff that complete the general risk assessor course are invited to these sessions.

7.2 Fire Safety training

86.62% of the workforce are currently in date for their fire safety training as shown in Figure 10. Fire safety training sessions are being offered face-to-face, via *Teams* or e-learning. This is a 3.38% decrease on the MaST fire training compliance from 2023-2024.

	Core
Division	Fire Safety - 1 Year
Clinical Support Services	88.44%
Community Services	88.68%
Corporate Operations	78.53%
Corporate Services	80.58%
Emergency Care	89.00%
Family Health	89.34%
Medicine	82.08%
Surgery	90.94%
Grand Total	86.62%

Figure 10. Fire Safety Training compliance %

8. MOVING AND HANDLING

Level 1 Moving and Handling training is completed through e-learning. Level 2 Moving and Handling training compliance is below the required standards due to a lack of capacity in the Moving and Handling Team.

8.1 Moving and handling training

People handling sessions are face-to-face with the life-size manikin.

Group sizes are eight staff per session for all face-to-face training for induction and update.

Level 1 Moving and Handling training is completed through e-learning (theory and legislation) and staff will complete this element prior to booking onto a Level 2 practical session.

8.2 Moving and handling link workers

There are currently 23 link workers who deliver moving and handling training within departments. All require training skills refresher training, which is planned in the near future.

8.3 Training figures 1 April 2023- 31 March 2024

Level 1 Moving and Handling e-learning training went live in late 2023, and compliance is currently 80.67%.

Display Screen Equipment (DSE) e-learning training went live in late 2023 and compliance has not yet reached the minimum reporting threshold.

8.4 Moving and handling equipment

Slide sheets

The Moving and Handling team reviewed an optional tube slide sheet from Elis. This was much more suitable. These are continuing to flow into the slide sheet stock. There are still ongoing issues relating to slide sheet availability. The Moving and Handling team and facilities managers are monitoring.

8.5 Risk management

New legislation and HSE bulletins are promptly reviewed to minimise risks to staff, patients, and the public. Risk assessments are conducted as needed to enhance safety and manage costs efficiently.

9. FIRE SAFETY

It is a statutory requirement for all public bodies to take the necessary precautions to ensure that their premises are safe, suitable and sufficient concerning fire management. Failure to provide adequate fire management can lead to public prosecution, including imprisonment or fines for the Trust's Responsible Person/s, enforcement orders from the fire authority and an increased risk of fire.

The Trust has a statutory responsibility to ensure that all of the premises owned and/or operated by it comply with current fire safety legislation. The Trust has to ensure that suitable and sufficient arrangements are in place for the management of fire safety and for the implementation of any necessary improvements relating to increased fire safety measures as required under the Regulatory Reform (Fire Safety) Order 2005 (RRO).

Health Technical Memorandum (HTM) 05-01 Managing Healthcare Fire Safety (2013) DH, describes that an Annual Report should be undertaken and presented to the Trust Board.

The Chief Executive Officer is responsible for ensuring that, through appropriate delegation of responsibility within the organisation, current fire legislation is met and that, where appropriate, Fire code guidance is implemented in all premises owned or occupied by the Trust.

This section has been developed in accordance with HTM 05-01: Managing Healthcare Fire Safety.

The following summary gives brief details of the Trust's development towards compliance with the mandatory requirements for the NHS in England (considered as best practice for NHS Foundation Trusts).

REQUIREMENT	PROGRESS	R	A	G
Clearly defined fire policy.	Compliant			✔
Board level Director accountable to the Chief Executive for fire safety.	Compliant			✔
Fire Safety Manager to take the lead on all fire safety activities.	Compliant			✔

Have an effective fire safety management strategy, which enables:

REQUIREMENT	PROGRESS	R	A	G
Preparation and upkeep of the organisation's fire safety policy.	Fire Safety Committee - responsible for the monitoring and review of fire policy and protocols. Fire Policy last reviewed in August 2024.			✔
Adequate means for quickly detecting and raising the alarm in case of fire.	Estates - Compliant			✔
Means for ensuring emergency evacuation procedures are suitable and sufficient for all areas, without reliance on external services.	Fire Safety Dept. - Compliant			✔
Staff to receive fire safety training appropriate to the level of risk and duties they may be required to perform.	MaST training ensures all staff have access to correct fire safety training required for their place of work. Additional training sessions for fire wardens and evacuation aids provided to improve resilience in community premises.			✔
Fire risk assessments are carried out and reviewed.	Department Managers and Fire Safety Dept. - Compliant			✔
Fire drills/desk top exercises are carried out in all departments and wards.	Department Managers and Fire Safety Dept. - Compliant			✔
Reporting of fires and unwanted fire signals.	Fire Safety Dept. - Compliant			✔
Partnership initiatives with other bodies and agencies involved in the provision of fire safety.	Compliant			✔

Table 2 - Trust's development towards compliance with the mandatory requirements for the NHS in England

9.1 Fire safety procedures

All employees are aware of the importance of good communication and a good relationship has been established between them and the Fire Safety Advisor. Any concerns or problems have been freely communicated and dealt with by all concerned.

All requirements under the Regulatory Reform (Fire Safety) Order 2005 (RRO) are being met; this includes full fire risk assessments for all wards and departments. The maintenance of the fire alarm system, emergency lighting and firefighting equipment are also being met.

9.2 Trust fire risk assessments and strategy

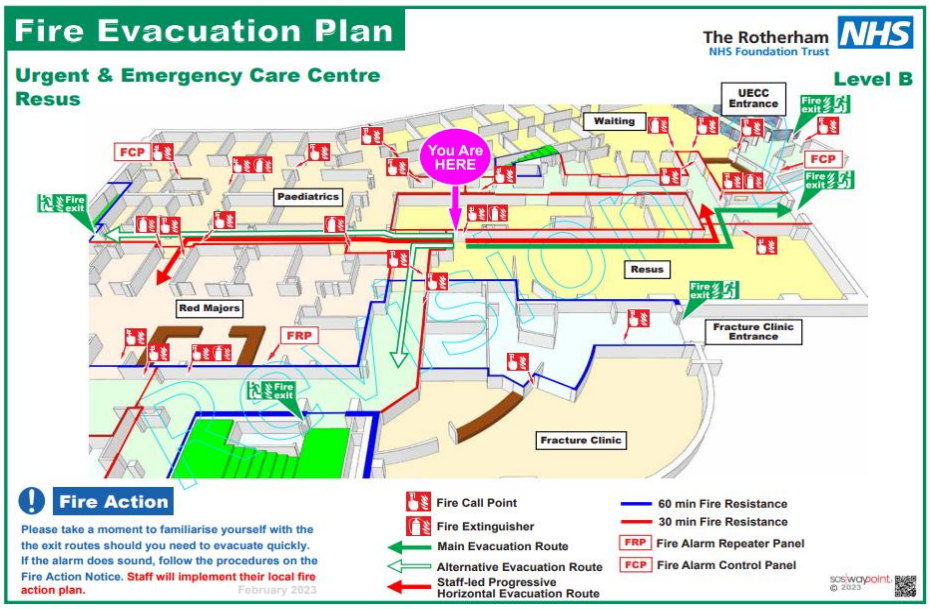
Fire risk management is an integral part of the risk management process and, as such, remains a priority for the Fire Safety Advisor.

The Department of Health Document 'Managing healthcare fire safety' (HTM 05-01) requires that a Fire Risk Assessment Programme be put in place. This programme is in place with full reference to the Firecode Health Technical Memorandums (HTM) and the RRO. All wards and departments have a full fire risk assessment and an annual audit process is now in place. All risk assessments were fully reviewed and rewritten in 2022-2023. The Fire Safety Advisor continues to use HTM 05-03 Part K risk assessment, as this type of assessment continues to be the best practice for healthcare premises.

The Fire Safety Advisor has been working to update fire risk assessments, maintain a risk log and reintroduce fire marshals with the support of the Estates Governance training team.

There are trained fire marshals at all community sites and training has commenced for training marshals on the acute hospital site. This involves the practical use of fire extinguishers.

Below is a template of the new 3D fire evacuation plans that are installed around the acute hospital building.



Template 1 – Example of 3D Fire Evacuation Plan

9.3 Issues raised and improvements made 2023/24

After hospital ward restructuring, a significant amount of work was actioned to relocate and refurbish wards. All work was completed ensuring the Trust fire strategy was not compromised.

The major work for this year included:

- Refurbishment of the Neo-natal unit (SCBU).
- Installation of fire doors on main corridors.
- Fire alarm upgrades to Derwent Court, Loxley Court & Swale Court residence blocks.

Staff continue to operate from a variety of shared premises in the Rotherham, Barnsley and Doncaster regions, which are managed either by single

ownerships or within Joint Service Centres. To ensure compliance with Regulatory Reform (Fire Safety) Order 2005, an up to date copy of the fire risk assessment is kept in liaison with the relative landlords. Fire risk assessments have been carried out by the Fire Safety Advisor in a number of locations that are owned by NHS Property Services. All of these properties have Trust staff located in them.

Both the fire alarm system and the fire extinguishers are an important part of fire safety within the Trust and have been maintained and tested by the Trust's approved contractors during the reporting period. A new tender process has been undertaken for all fire safety components, ensuring all testing and servicing is carried out to correct specification and ensuring the Trust is compliant with all legislation and guidance.

9.4 Planned major improvements for 2023/24

The major developments for the coming year will be:

- Full fire compartmentation & fire door surveys on the main hospital building.
- Fire door improvements/replacements.
- Fire stopping of compartmentation breeches.

9.5 Fires and unwanted fire signals

Any fire is serious within the Trust environment and no matter how small can have a big impact on the organisation as a whole. No fires took place within the hospital or community sites in this period.

The total number of unwanted false calls during the year was 69 (see Figure 13), an increase of 17 over the same period last year. As a large organisation, the Trust is still committed to reducing the amount of unwanted calls and all staff must ensure that they keep calls to a minimum.

Of these 69 false alarms, 16 were due to steam/dust, The Trust is continuing with a program to have all detector heads that are coming to the end of their life span replaced, but this has already proven to reduce activations. PPM maintenance to ensure the condition and efficacy of detectors is conducted routinely.

Due to the size of the alarm system, the faults that occur cannot be prevented but are still monitored by the Fire Safety Advisor and the Estates Department. The hospital has its own Fire Response Team that reacts to all fire calls and South Yorkshire Fire & Rescue Service are only called if there is a confirmed fire or exceptional reason. The Fire Service was not called for any of the false alarms as the Fire Response Team and staff dealt with them promptly.

After recent liaison meetings with South Yorkshire Fire & Rescue Service, they have once again congratulated the Trust in the attitude towards unwanted calls and the way the Trust deals with them.

The Trust Fire Response Team has responded promptly to every fire incident, ensuring effective and efficient management to maintain the safety of staff, patients, and visitors."

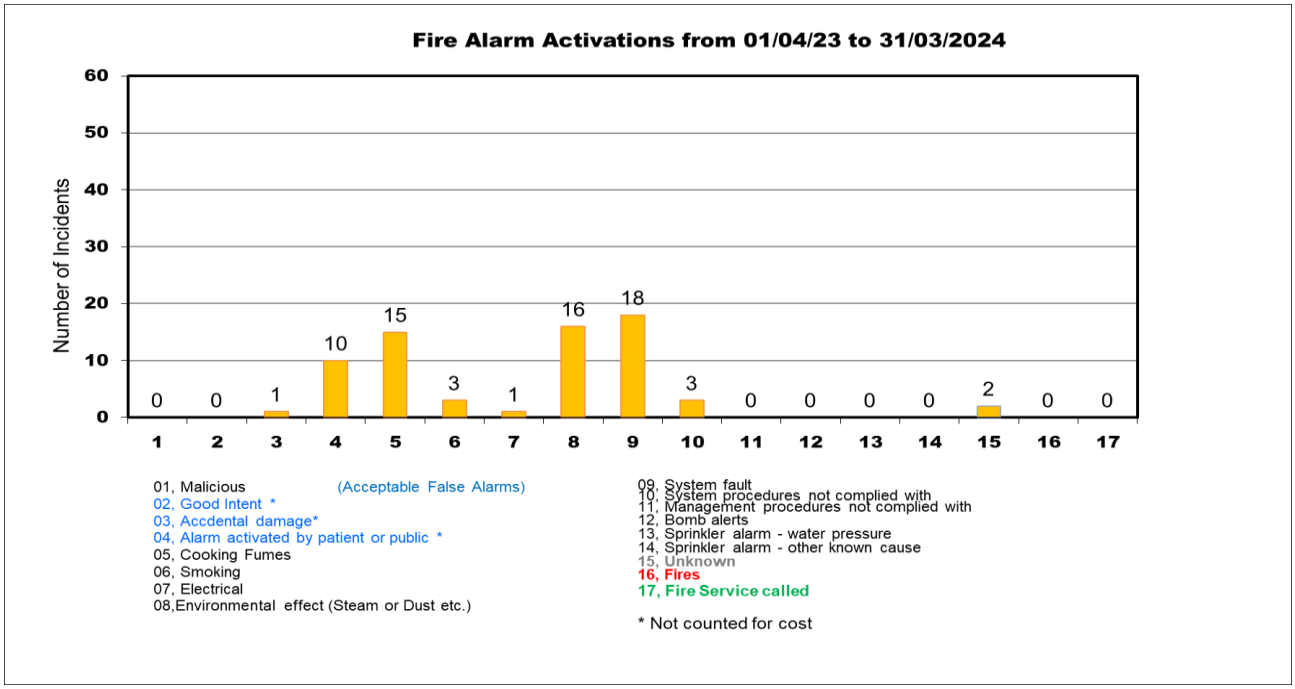


Figure 11. Unwanted fire alarm activations

10. SECURITY

10.1 Conflict Resolution Training 2023 / 2024

All MaST training concerning Conflict Resolution is still part of the staff Trust Induction programme; however, since August 2022 the CRT full session has been upgraded to help support staff further with dealing with challenging & aggressive behaviour. The full session must be completed by all new and existing front line patient facing staff, which now involves 2-hour verbal de-escalation skills along with 2 hours of physical intervention training (breakaway). Front line patient facing staff will then have the option to complete the full session of physical intervention, along with a further additional CRT refresher training every 3 years. There is also an option for non-patient facing staff to carry out CRT by way of e-learning, however, non–patient facing staff must carry out a face-to-face session on their next CRT refresher training following e-learning. This year's figures are slightly higher than the previous year's figure of 92%, reaching 92.16%.

Note: Charts reflect previous divisions and are yet to be updated to care groups.

Division	Conflict Resolution
Clinical Support Services	94.41%
Community Services	94.61%
Corporate Operations	81.47%
Corporate Services	90.14%
Emergency Care	95.50%
Family Health	93.31%
Medicine	91.67%
Surgery	93.96%
Grand Total	92.16%

Figure 12 – Conflict Resolution Training &ages

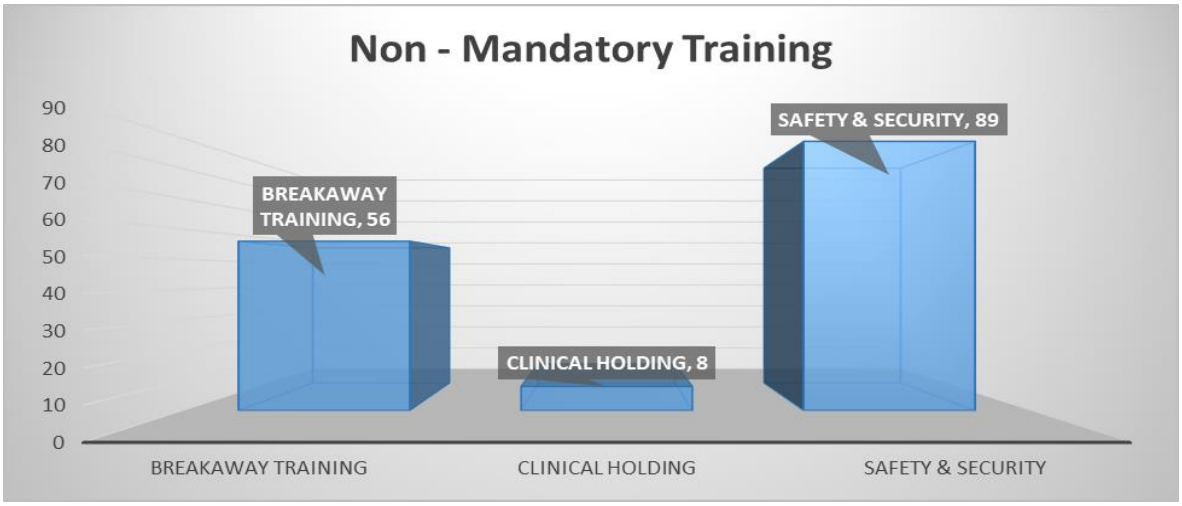


Figure 13 - Non-Mandatory Training 2023 / 2024

10.2 Security new installs / upgrades 2023/24

This year, the Trust has continued with the improvements of security within the Hospital, and wider Community locations. The below table identifies areas of improvements to the Security systems.

DATE	ITEM	LOCATION
May	CCTV Body cameras x10	Security / UECC
May	Car park Barrier	Moorgate wing
May	ANPR system	Main car park & site entrance roads
May	Door Access	Drug cabinets all Wards / UECC
June	Baby Tagging system	Wharncliffe
June	PA speaker system throughout Trust	Corridors
Sept	X3 CCTV cameras	I.T Department
Sept	x2 CCTV hard drive replacment	CCTV
Oct	Door access pax locks x2	I.T Department
Jan-24	Access control	Breathing space Consultant rooms
Feb-24	X2 CCTV cameras	New substation Moorgate wing
Mar-24	Door access x2	A level new changing rooms

Table 3. Areas of improvement to security systems

10.3 Security personnel

The Trust has continued to contract Outsourced Client Solutions (OCS) to meet the physical Security and CCTV monitoring requirements of the Main Hospital, Woodside and Park Rehabilitation/Breathing space sites.

As of November 2023, the security team are no longer required to provide support to clinical staff with medical restraint that may be required. However, where spontaneous acts of violence or abuse occurs, support is still required to ensure the safety and protection of patients, visitors and staff.

However, the Security team will continue to still be trained in Clinical Holding (restraint) and to the current standard of the Restraint Reduction Network (RRN).

The Security team still continue to monitor (out of hours) alarm activations such as:

- Pharmacy fridge alarms

- Mortuary fridge alarms
- Winter temperature alarms
- Park Rehabilitation intruder alarm
- Woodside intruder alarm

All OCS staff are holders of the required Security Industry Authority (SIA) licences; this is a legal requirement in England and Wales for all individuals working in Security and Public Space Surveillance CCTV.

10.4 The Criminal Justice and Immigration Act 2008

The NHS continued to deal with low-level anti-social behaviour through Sections 119–120 of the Criminal Justice and Immigration Act (CJIA); this is used when attendees are causing a nuisance or disturbance on NHS hospital premises and refusing to leave - and a power for authorised NHS staff to remove a person suspected of committing this offence. The offence and power of removal apply only to NHS hospital premises. Physical removal must be the last resort and not a substitute for established verbal conflict resolution techniques to persuade a disruptive individual to leave voluntarily. The Trust currently has 1 Authorised Officer.

10.4.1 Datix violence and aggression incidents 2023/2024

There are 248 reports of Non-Physical assaults, which include the following:

- Abuse – other
- Staff to patient
- Patient to patient
- Staff by patient
- Staff by staff

and a further 203 reported incidents of Physical assaults which were recorded through Datix.

	Non Physical - Abuse	Physical - Abuse	TOTAL
Abuse etc of Staff by patients	202	186	**388**
Abuse - other	0	0	**0**
Abuse of patient by staff	5	2	**7**
Abuse etc of patient by patient	5	13	**18**
Abuse of Staff by friend or relative	10	0	**10**
Abuse of staff by other staff	23	0	**23**
Abuse of patient by friend or relative	3	2	**5**
Total	**248**	**203**	**451**

Table 4 - Datix proven alleged or suspected theft reports 2023/2024

There were also 28 reported incidents of “proven, alleged or suspected thefts” recorded through Datix, which is an increase of 2 thefts from the previous year.

		2022/2023	2023/2024
Proven, alleged suspected Theft	related to Equipment	4	4
	related to Personal property	21	22
	related to Vehicles	1	2
	Total	26	28

Table 5. Incidents of proven, alleged and suspected theft

All staff are given crime prevention advice and, after each incident, an e-mail is sent to all e-mail users reminding them not to leave property on view. In some cases, a Security safety and awareness training course has been provided to several departments.

10.5 Security serious incidents

10.5.1 19/10/2023 Burglary

This took place in the education & development office, which is currently located in the canteen area of the Trust. Because of this burglary the following equipment was stolen:

- X2 laptops
- Mobile phones

However further investigation took place with CCTV, which identified the offender & subsequently led to their arrest. All valuables were recovered and returned to the trust.

10.5.2 18/01/2024 – 19/01/2024

A Patient from Sitwell Ward, who was under a Section 5.2, climbed on the roof of the Pre-Admission Centre. Fortunately, both Security/Medical staff safely brought down the male from the roof. Unfortunately, this male again climbed on the same roof the following day and again was safely brought down by Police/Security and Medical staff. Once identified how the patient actually gained access to the roof, measures were put in place to prevent further incidents occurring.

10.6 Monthly security incidents based on Daily Occurrence Book (D.O.B.)

As of May 2018, the Trust LSMS has been provided with a Monthly Security report, which is based on the Security daily occurrence book (D.O.B.). This information provides a more accurate account of Security incidents that have occurred at the Trust, due to staff not always reporting via Datix. A summary of these incidents is set out in Figure 13.

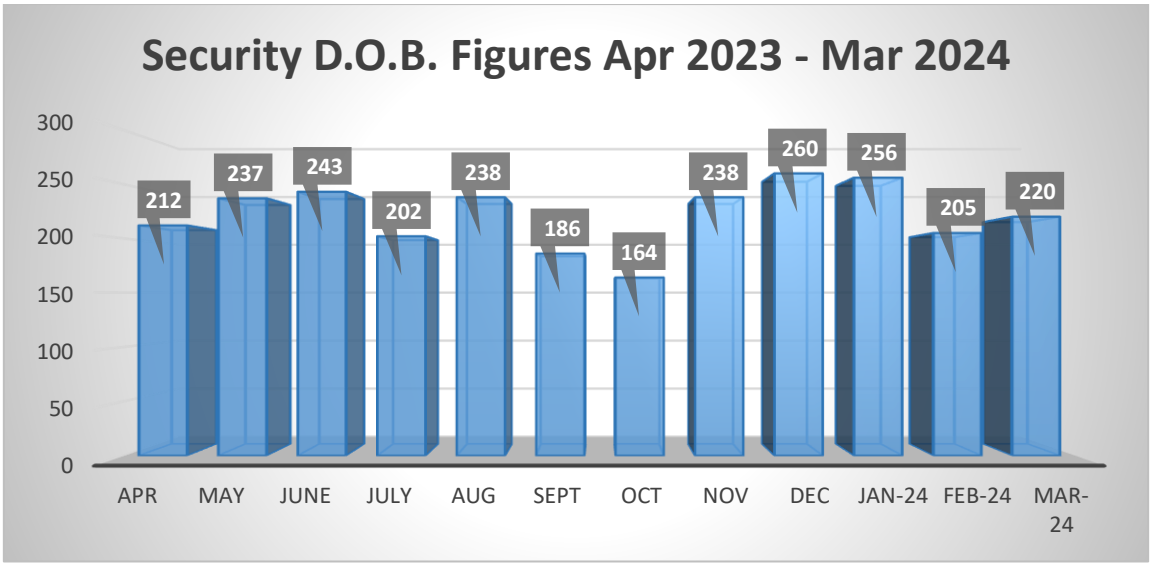


Figure 14. Security daily occurrence figures

10.7 Security

The Trust remains committed to providing a safe non-violent/non-threatening environment for all its employees, patients and visitors, and will take all reasonable steps to secure the health and safety of staff that may be exposed to the risk of aggression, violence or abuse in the workplace.

The Trust does not tolerate any form of violence or aggression, including verbal abuse against its staff, visitors or patients. The Trust response to violence and aggression is underpinned by the principle that prevention is better than cure. Our public health approach recognises that there are opportunities to be preventative even after a problem has emerged. Violence is not something that just happens, nor is it normal or acceptable in our care settings. Many of the key risk factors that make individuals, families or communities vulnerable to violence are changeable, including exposure to adverse experiences in childhood and subsequently the environments in which individuals live, learn and work throughout youth, adulthood and older age.

Having an understanding of these factors means the Trust can develop and adopt new public health based approaches to tackling violence. Such approaches focus on the primary prevention of violence through reducing risk factors and promoting protective factors over the life course. Interventions to achieve these goals have been tested and are beginning to form part of the Trust's response to violence and aggression. The impact of violence on the health of individuals and the costs it imposes on health care systems are substantive and are akin to those for other major public health priorities such as smoking and alcohol.

Together with these longer-term strategies, the Trust continues to invest in its short to medium term physical security with increased door access control, CCTV and body worn cameras.

The Trust has also invested in lone worker technology to increase the safety of our community teams.

The most fundamental change in the last year has been the formation of a Violence Reduction Group chaired by the Deputy Chief Executive, which meets

quarterly, with representation from all areas. The group considers best practice from around the world, and will work in collaboration with partner organisations to encompass any learning into a new revised security strategy.

11. RADIATION

11.1 External assurance reports

This annual radiation protection and assurance report by the Professional Lead /Senior Radiation Protection Supervisor (RPS) is based on the Radiation Protection Advisors annual report and covers aspects of ionising and non-ionising radiation protection from April 2023 to March 2024.

11.2 Legislation and regulation

Advice is provided proactively throughout the year by the trusts appointed Radiation Protection Advisor and medical physics experts based at the Sheffield Teaching Hospitals NHS Trust. As they receive information from regulators or other Trusts. Guidance on implementing the advice is also provided where appropriate, including document templates, spreadsheets, etc. to assist in providing governance assurance. The responsibility for delivery of governance assurance under the Ionising Radiations Regulations 2017 and Ionising Radiations (Medical Exposure) Regulations 2017 rests with the Employer. Ad hoc advice and service support is provided in response to queries and requests for commissioning, investigation, protocol optimisation, staff and patient dose estimates as required.

Regular meetings with Radiology staff are scheduled, in addition to quarterly X-ray radiation protection meetings, to ensure all matters of regulatory compliance and actions required are followed up systematically. The Radiation Protection Advisers and Medical Physics Experts use these meetings to provide updates and explanations of any new regulatory developments. These meetings minutes are recorded, evidencing the advice supplied. Other ad hoc meetings are scheduled with a range of staff to discuss and address any specific advice or regulatory matters raised.

The minutes and escalations from the Radiation Protection Meetings are shared with the TRFT Health and safety Committee to provide the trust with assurance that the regulations are being met.

11.3 HSE national updates advised by the Radiation Protection Advisor

The Trust should have received a letter from the HSE asking them to re-register and provide additional information under Reg 6(4)(b) of IRR17 - This has been completed for TRFT.

The HSE has indicated that all controlled areas should be monitored for environmental radiation doses annually - The Trust has appointed The Radiation Protection Advisor services to perform this monitoring and report on the findings.

The HSE has identified additional information which is required in Risk Assessments - All of the TRFT Radiation risk assessment have been updated

to include the recent recommendations and these are reviewed on an annual basis.

The HSE has stated that ALL staff entering active (X-ray) Controlled Areas must be monitored in some fashion (as detailed in the Approved Code of Practice (Nuclear Medicine staff occupational exposure and monitoring is considered separately in their risk assessments). However, the radiation protection service have now had feedback that there is no strict requirement to monitor everybody (though this may still be subject to the interpretation of individual HSE Radiation Inspectors) - All staff at employed by TRFT who work regularly in radiation controlled areas are monitored for radiation dose. This is carried out by our approved dosimetry service RRPPS. Dose assessment for staff occupational exposure is required and is included in the Radiation Protection Assessment, detailing accessible and instantaneous doses for a range of Reasonably Foreseeable Incidents. For x-ray departments we have estimated that the range of possible doses arising from Reasonably Foreseeable Incidents all fall below the public dose limit of 1 mSv. Also, there is no accident scenario where incident exposures might be greater than 6 mSv, which would require staff to be classified in advance and monitored.

The HSE have issued a Notification of Contravention Regards Trusts failing to have a process for obtaining prior dose histories for new staff, giving rise to the risk that a member of staff could exceed their annual dose limits, TRFT work with our approved dosimetry service to ensure we are compliant with this.

11.4 Care Quality Commission IR(ME)R Inspectorate

The CQC IR(ME)R Inspectorate have issued their annual report.

The Trust must have up to date records of all those entitled under Employers Procedure 2 to act as referrer, practitioner or operator- TRFT keeps up to date records of all operator, referrers and practitioners, as well as non-medical referrers.

The Trust must ensure that the audits and quality assurance processes identified in Employers Procedure 4 are undertaken and reported to a suitable committee in all areas where x-ray equipment is used - These are all recorded for TRFT and reported through the quarterly radiation protection meetings and through the TRFT Health and Safety Committee meetings.

11.5 Incidents requiring notification

The Care group has a well-developed Clinical Governance approach to the management of radiation protection under both the IR(ME)R and IRR legislation. The radiation protection advisor also states that, greater direct engagement of Trust Level management would further enhance evidence of governance assurance to the regulators.

Incidents (Patients) Between 1st April 2023 and 31st March 2024
The Trust has notified the RPA of 2 incidents where exposure of carers or an over/unnecessary exposure of a patient, as defined in the Significant Accidental and Unintended Exposures (SAUE) CQC Guidance for employers and has exceed a reportable threshold and for which we have received reports.

Date of Incident	Modality	Patient / Staff Dose (mSv)	Explanation/comment
09/08/2023	Plain X-ray	0.021	The patient attended the department for a Leg Length examination on 09/08/2023. However, after the first image (hip/pelvis region) was acquired, the equipment experienced a communication error, and the subsequent exposures (knees and ankles) were terminated by the system and not performed. The patient was successfully re-examined for a complete Leg Length examination, as the initial acquired hip/pelvis region image was required to be repeated for image stitching purposes to enable a complete leg length image. Therefore, the patient received an unnecessary dose of radiation from the initial hip/pelvis section Leg Length exposure.
09/11/2023	Nuclear Medicine	8.2	The patient was incorrectly referred to the Medical Physics department and on 9th November 2023, received a bone scan and CT. As no exposure of this patient was intended and the effective dose for the procedures exceeded 3mSv, this is externally reportable to the IRMER Inspectorate as an accidental exposure.

Table 6 - Incidents (Patients)
Between 1st April 2023 and 31st March 2024

Where the CQC believe an incident may involve IRR17, they will report it to the HSE directly.

Incidents (Staff) Between 1st April 2023 and 31st March 2024
Between 1st April 2023 and 31st March 2024, there has not been any instances from where exposure of staff has been suspected to exceed an IRR17 occupational dose limit which required a report.

11.6 Actions as identified by the Radiation Protection Advisor

1. The Trust should ensure it has re-registered with the HSE on RADAN and provided additional information under Reg 6(4)(b) of IRR17 as required. – Due in 2028
2. A programme of annual environmental monitoring of all controlled areas must be implemented. TRFT have appointed the Radiation protection services to perform this on our behalf.
3. The Trust must ensure that all policies, procedures, risk assessments and local rules are revised to reflect the requirements of IRR17 and IR(ME)R17. This includes updates of guidance references as soon as the guidance is published, to ensure that staff are directed to the most current guidance. All TRFT policies and risk assessment are up to date or under review.
4. The Trust must ensure that there are sufficient resources to allow departments using ionising radiation to meet the HSE expectations for supervision by Radiation Protection Supervisors (RPS) – TRFT have 13 approved RPS.

5. The Trust must be able to individually identify all staff who act as Referrers (including GPs), Practitioners and Operators, and ensure they maintain their competencies through various training routes, including Non-Medical Referrers. Radiology should keep evidence of staff training within the department. Other departments with Non-Medical Referrers or Operators must establish their own corporate and clinical governance systems and report them to the Trust Radiation Protection Committee. – At TRFT lists are kept which includes operators, referrers, practitioners and Non – medical referrers.

6. The training records and competency of locum radiography staff must be established to ensure that the number of incidents recorded is reduced. Steps should be taken to ensure and be able to demonstrate that such locums can evidence their competence under the requirements of IR(ME)R. –At TRFT IRMER checks are completed on all Locum staff and bank staff, local induction and training on equipment is also performed.

7. The Trust must ensure IR(ME)R procedures to appoint and train non-radiological staff as Practitioners and Operators are followed and identify where in Trust management the responsibility for this will be placed. This may be particularly relevant for Cardiology and some surgeons in Theatres. – All non-radiographic staff at TRFT who are designated as practitioners have documented training.

8. The Trust must ensure that all staff who act as Referrers (including Non-Medical Referrers), Practitioners and Operators, maintain their competencies through various training routes and ensure this can be evidenced on demand. There is an expectation that Medical Staff will be able to demonstrate appropriate practical training as operators – this is in place at TRFT

9. The growth in the number of non-medical referrers (NMRs) has required systems be put in place to manage these requests for referral authorisation. – we have a robust system of monitoring and training for Non-medical refers at TRFT

10. The Trust must ensure that it obtains prior dose histories of all new starters who will be occupationally exposed – this is performed at TRFT.

11 Radiologist's and cardiologist's eye doses should be monitored for one monitoring period per year to ensure doses remain well controlled – this is completed at TRFT.

12. Compliance with IRR17 Reg 16, 'Cooperation between Employers' requires that the Hospital identify where staff employed from outside the hospital are receiving radiation monitoring badges, that the supplier of these is aware that the staff concerned may receive exposure from activities other than those in their employment. It may be necessary to have a written agreement to share dose and risk information – this is in progress at TRFT and is being addressed at an ICS level as the response by installers to local approaches have fallen short of the required level.

13. Advice from the Department of Health IR(ME)R Inspectorate recommends that the Trust communicate its IR(ME)R policy to all GPs and other referrers external to the Trust on an annual basis, to ensure that any revisions to practice are communicated and that any new staff into the area receive appropriate information – the IREFER CDS program is in use for the GP surgeries referring into TRFT.

11.7 Ionising Radiation Regulations 2017 – updates from the Radiation Protection Advisor

Thirteen healthcare inspections were performed in 2022-23, which 6 identifying a material break of the regulations resulting in the issue of 1 Improvement Notice and 6 Notification of Contravention.

Mobile CT shielding

Mobile CT vans typically move locations almost daily, but it's difficult to get assurance that the radiation protection shielding hasn't shifted in transit. The HSE have investigated failures in shielding design and require a shielding survey every time a mobile van is delivered to site (All modalities, not just CT).

A Memorandum of Understanding which sets out both IRR and IR(ME)R responsibilities should be agreed before the van arrives on site (We have provided an IRR17 Reg 16 Cooperation between Employers agreement which can be used as a template). Mobile van suppliers apparently have letters from HSE lawyers stating that they are not the radiation employer and only need to co-operate with the host site. However, they are responsible for demonstrating that the van they have provided is fit for purpose and meets safety requirements.

UK Radon Map

All Trust Properties addresses need to be checked against the online Radon map. Any addresses which are indicated as being at risk require assessment monitoring, which needs to be repeated every decade. Where doses are found to be above action levels, remedial measures must be implemented. The HSE have prosecuted for failure of an employer to consider Radon as a risk to its employees and others.

Where an Employer has staff working at leased premises, while the Landlord has responsibility for demonstrating Radon levels are acceptable, this is often difficult to achieve.

The advice of the HSE is that the staff Employer should undertake their own monitoring to ensure their staff safety.

TRFT Radon assessment was carried out in 2018 monitoring all TRFT sites, Radon monitors were used to monitor the radon levels on our sites and these were returned to public health England (PHE), 6 sites were identified as showing elevated levels of radon. PHE have advised that these do not meet the IRR17 regulations threshold, therefore there is no need for radon controls.

This assessment will be due again in 2028.

11.8 Locally reported incidents

The Medical imaging, Physics and Illustration CSU have a well-developed Clinical Governance approach to the management of radiation protection under both the IRMER and IRR legislation, as referenced by the Radiation protection supervisor.

Between 1st April 2023 and 31st March 2024, we notified the Radiation protection advisor of 20 incidents where exposure of carers or an over/unnecessary exposure of a patient, as defined in the Significant Accidental and Unintended Exposures (SAUE) CQC Guidance for employers and duty holders did not exceed a reportable threshold, but for which the radiation protection service has provided reports. This is a comparable to the number of incidents as reported by the Trust in 2022 (17 incidents).

Date of Incident	Modality	Patient / Staff Dose (mSv)	Explanation/comment
12/04/2023	CT	1.0	The patient attended the department for a CT head examination on 12/04/23. However, the patient was not able to confirm their identity and was therefore identified by their wristband. Unfortunately, the wristband details were incorrect, being those of another patient, due to an error occurring before they attended CT. As the imaging was recorded under the wrong name, the patient was then returned to the department around 9 hours later and was scanned again under the correct name. Consequently, the patient received an unintended CT head scan.
30/04/2023	CT	18.7	A patient recently attended for a CT chest-abdo-pelvis examination on 30/04/23. However, the patient was scanned before they should have been scheduled; they should have been booked for an interval CT chest abdo-pelvis examination for six weeks' time, but the patient was scanned a few days after the incorrectly timed referral was received. As the patient was scanned too soon, an accurate assessment to the patient's response to treatment was not possible. Therefore, the patient returned later to the department for the correct time interval CT examination. The patient therefore received an unnecessary dose of radiation from the incorrectly timed CT chest-abdo-pelvis examination.
13/06/2023	Dental	0.019	The patient attended the department for an upper standard occlusal (USO) intraoral dental examination on 13/06/2023. However, the Operator performed an Orthopantogram (OPT) examination instead. Once the error was realised, the correctly referred USO examination was performed successfully. The patient therefore received an unnecessary dose of radiation from the unnecessary OPT dental examination.
24/05/2023	Plain X-ray	0.004	The patient was referred for a right shoulder X-ray exam on 24/05/2023. Unfortunately, when the Operator asked the patient to turn 45Â° for the axial image, the patient turned the opposite direction than intended and the left shoulder was imaged incorrectly. Therefore, the patient received an unnecessary dose of radiation.

Date of Incident	Modality	Patient / Staff Dose (mSv)	Explanation/comment
15/06/2023	Plain X-ray	0.015	The patient attended the department for a Leg Length examination on 15/06/2023. However, after the first image (hip/pelvis region) was acquired, the detector disconnected from the workstation and the subsequent exposures were terminated by the system. After performing test exposures for a leg length examination, the patient was re-examined successfully. As a result, the initial image (hip/pelvis region) had to be repeated and consequently the patient received an unnecessary dose of radiation form the initial first image acquisition.
17/06/2023	Plain X-ray	0.018	The patient underwent a Chest AP examination on 17/06/2023. However, the Operator had incorrectly identified the patient who had attended the department for an ultrasound exam, and no x-ray examination should have taken place. The patient therefore received an accidental dose of radiation from the unrequested Chest AP examination.
29/06/2023	Plain X-ray	0.04	A chest AP examination was recently requested on the above patient on 29/06/2023. The examination was performed, but only the thumbnail image was displayed; the main image did not appear. The Operator waited 5 minutes and then changed the battery in the detector, but the image did not appear. The Operator then informed management who followed the manufacturer recovery process, but the image did not reappear, probably as a result of the battery change. The patient was then reimaged successfully and therefore received an unnecessary dose of radiation from the initial examination with the lost image.
14/07/2023	Plain X-ray	0.006	The patient attended the department for left shoulder and elbow examinations on 14/07/2023. However, when a second radiographer helped with patient positioning part way through the examinations, the incorrect (right) shoulder was imaged twice for an axial view. Once the error was realised, the correct (left) shoulder was imaged for the axial views. The patient therefore received an unnecessary dose of radiation from the unnecessary right shoulder examinations.
04/08/2023	CT	10.3	A CT Chest-Abdo Pelvis examination was recently performed upon the above patient on 04/08/2023. The examination was booked through a consultant in the short stay unit. After the examination was performed successfully, the patient was discharged. However, the patient returned for another CT Chest-Abdo Pelvis examination on 09/08/2023 that had been previously requested by their GP, but the booking was never cancelled. The patient underwent this additional CT examination and therefore received an unnecessary dose of radiation.

Date of Incident	Modality	Patient / Staff Dose (mSv)	Explanation/comment
27/08/2023	Plain X-ray	0.56	The patient underwent an AP Pelvis Exam on 27/08/2023. However, the exposure was unnecessary as the patient had already undergone a CAP CT scan which sufficiently covered the relevant pelvis anatomy. The AP pelvis exposure was undiagnostic due to retained contrast media from the CT scan. The patient therefore received an unnecessary dose of radiation from the AP pelvis exposure.
16/10/2023	Plain X-ray	0.0003	It is understood that a member of staff was inadvertently exposed to ionising radiation on 16/10/2023 while an abdomen X-ray was performed without donning a lead apron. The member of staff was standing at around 1 metre from the patient.
25/10/2023	Plain X-ray	0.15	A patient recently attended for Chest and Lumbar Spine X-ray examinations on 25/10/2023. However, the Operator initially used the lumbar spine exposure settings for the chest projection. The error was noted immediately, and the correct exposures were subsequently carried out. The patient therefore received an unintended radiation dose from the incorrect chest exposure.
07/11/2023	Dental	0.05	A patient recently attended for an upper right 5 intraoral dental X-ray on 07/11/2023. However, the Operator performed an intra-oral X-ray of the upper left 5 instead of the upper right 5. The mistake was noticed immediately, and the patient received the correct exposure. The patient therefore received an unnecessary dose of radiation from the intraoral examination.
16/11/2023	Plain X-ray	0.0001	A patient recently attended for X-ray examinations of the left wrist and right thumb on 16/11/2023. However, the Operator X-rayed the left wrist and left thumb. The mistake was noticed by the referrer and the correct thumb imaged. The patient therefore received an unnecessary dose of radiation from the left thumb X-ray.
19/12/2023	CT	0.05	A patient recently attended for a CTPA examination on 19/12/2023. However, the equipment errored during topogram imaging. As a result, the topogram had to be repeated and the patient therefore received an unnecessary dose of radiation from the initial topogram.
17/01/2024	Dental	0.02	A patient recently attended for an OPT examination on 17/01/2024. However, due to a loose connection on the equipment, the image did not appear on the workstation. As a result of the appropriate recovery procedure not being followed by the Operator, the image was not retrieved. The equipment was put back into clinical use once the loose connection issue was addressed. However, the patient was too unwell to have the examination repeated. The patient received an unnecessary dose of radiation from the OPT examination which resulted in a â€˜lostâ€™ image.

Date of Incident	Modality	Patient / Staff Dose (mSv)	Explanation/comment
25/01/2024	Plain X-ray	0.01	A patient recently attended for a right clavicle X-ray examination on 25/01/2024. However, the referrer requested an examination of the left clavicle in error. The mistake was noticed by the parent of the patient after the images were acquired and the correct left clavicle examination was subsequently performed.
11/02/2024	Plain X-ray	0.06	The patient recently attended the department for a Chest AP examination on 11/02/2024. However, the patient had already had a CTPA examination performed previously and therefore the Chest AP examination was not required, resulting in the patient receiving an unnecessary dose of radiation.
06/03/2024	CT	0.03	The above patient recently attended the department for a Cervical Spine CT examination on 06/03/2024. However, the Operator misidentified the patient and performed a CT Wrist examination that was requested for another patient. Once the error was realised, the correctly referred Cervical Spine CT examination was performed upon the patient. The patient therefore received an unnecessary dose of radiation from the CT wrist examination.
02/03/2024	Plain X-ray	0.02	The patient recently attended the department for a Chest AP examination on 02/03/2024. However, the Operator had not performed patient identification checks correctly and the examination was intended for another patient. The patient was only referred for a Pelvis examination, which was performed successfully once the error was realised. The patient therefore received an unnecessary dose of radiation form the accidental Chest AP examination.

Date of Incident	Modality	CQC Reportable	Patient/Staff Dose (mSv)	Explanation/comment
17/01/2023	Plain X-ray	No	0.011	A paediatric patient attended for an AP chest X-ray examination on 17/01/2023. A chest X-ray was performed using a CR cassette, but the operator did not think the exposure had been made and therefore repeated the exposure on the same CR cassette without reading it. Upon reading the CR cassette the operator realised the mistake and returned to acquire a third, diagnostic image. The patient received two unnecessary exposures of radiation before the diagnostic image was successfully acquired.

Date of Incident	Modality	CQC Reportable	Patient/Staff Dose (mSv)	Explanation/comment
19/03/2023	Plain X-ray	No	0.04	The patient recently underwent a Chest AP examination on 19/03/23 which was correctly referred and imaged. However, a second request was made later the same day and this was also performed due to a failure to identify the previous relevant imaging. The RIS system was unavailable due to upgrade, but PACS was not checked and the patient and ward staff were also not questioned about previous imaging. The patient therefore received an unnecessary dose of radiation from the second chest examination.
20/03/2023	Plain X-ray	No	1	The patient recently attended the Radiology department for an Abdomen examination on 20/03/2023 with the query 'lost coil'. The Operator performed a Pelvis exam which did not answer the query and the patient will need to be recalled for the requested Abdomen exam.

Table 7 – Incidents of exposure of carers or an over/unnecessary exposure of a patient between 1st April 2023 and 31st March 2024

11.9 Occupational Monitoring

The Trusts Approved Dosimetry Service (ADS) has changed from thermoluminescent dosimeters (TLDs) to Optically Stimulated Luminesence Dosimeters (OSL). These have a higher sensitivity to radiation and lower background noise, so can report recorded doses of 0.1 mSv, rather than the previous 0.2 mSv. This means some users may find they appear to be recording a dose on their badges. This is not a consequence of their practice, but the increased badge sensitivity.

11.10 Whole body Monitoring

A total of 153 staff in the Medical Imaging and Medical Physics departments were provided with 813 personal dosimeters in the 2023 calendar year by the Approved Dosimetry Service in Birmingham, with monitoring TLD badges supplied over 2 month periods. The results are tabulated below.

All staff members staff received an annual whole-body effective dose foreseeably below 6mSv (the dose level at which staff must be classified, which is also three-tenths of the annual dose limit).

	X-Ray 4030	Medical Physics 4031	Breast Imaging 4032	Cardiology 4033	Total
Total staff supplied/2-mth	95	12	11	35	153
TLD ≥0.2 mSv/2-mth	5	0	0	0	5
Max WB dose per year mSv	1.5	0	0	0	
Number of staff > 1mSv/yr.	2	0	0	0	2
Number of TLD assumed lost	30	0	2	11	43

Table 8 – Results of monitoring staff TLD badges – 2 month period

Two members of staff received more than 1mSv (the dose limit for 'Members of the Public'). One staff member has a recorded cumulative whole-body dose of 1.1mSv for 2023. The same staff member also had extremity doses recorded. Extremity doses are available for the Jan-Apr period only with cumulative doses recorded at 4.9mSv to the left hand and 4.9mSv to the right hand (Classification level >150mSv).

One staff member has a 1.5mSv WB dose recorded for the May-June period.

The TLD lost/spoiled figure is 5.3% which is higher than the figure of 4.8% from 2022. Staff are reminded of their legal responsibility to look after and return their badges in a timely manner.

11.11 Eye Dose Monitoring

Eye dose measurements were monitored for one staff member with cumulative dose of 0.0mSv recorded. A correction factor of x0.5 is applied for any recordable eye doses (Jan-Apr period only is available to report).

No other staff members had eye dose monitoring carried out in the 2023 period.

The conclusion from this monitoring is that annual Eye Doses fall well below the level for classification (16 mSv). Routine Eye Dose monitoring is not considered necessary at this time but will be kept under annual review.

11.12 Nuclear Medicine

In the Nuclear Medicine section, 8 measurable extremity TLD doses were recorded. Finger dosemeters supplied by the Sheffield Extremity Dosimetry Service gave annual doses for 4 staff involved as follows (7.45 mSv average per extremity and <5% of dose limit for 12 monthly users):

	CD	CL	JM	KP
Right Hand	8.4	1.5	6.2	9.5
Left Hand	15.2	1.4	6.2	11.2

Table 9 – Record of Measurable Extremity TLD doses

Personnel monitoring enables the Trust to demonstrate that it is complying with the requirements of IRR17 for staff protection and in general. While the dose results returned indicate that risk assessments remain accurate and that high levels of radiation protection are being maintained for all occupationally exposed staff.

The HSE have stated that any member of staff who systematically fails to wear, use and return their monitoring badges is committing an offence under Section 7 of the Health and Safety at Work act 1974. It was re-iterated that employees must comply with instructions for their monitoring.

11.13 Radiation Protection Assessment for New Installations

Project meetings have been regularly attended for General X-ray, Fluoroscopy and Breast Screening developments as and when these have arisen.

The Radiation protection service was asked to review plans for a number of areas, which in many cases required site visits to assess locations' suitability,

including wall attenuation measurements where Estates records lack sufficient detail of wall construction.

- CT01
- Mammography Room2

The Radiation Protection Assessment reports include the detail required to enable the Trust to comply with the requirements for risk assessments as detailed in L121, the HSE Approved Code of Practice Paras 70 and 71.

11.14 Environmental Monitoring

Environmental monitoring has been performed at installation of new equipment to confirm that the radiation protection installed meets the specification identified in the Radiation Protection Assessment.

The Radiation protection service is providing environmental monitoring for all controlled areas on TRFT site and community settings. The results will be recorded and reported through the radiation protection meetings.

11.15 Documentation

11.15.1 Employers Procedures

The CQC have provided detailed suggestions about the contents of the Employer's Procedures during a recent inspection. TRFT is in the process of reviewing the employer's procedures policy and will be updated to reflect the recent suggestions.

11.15.2 Risk Assessments

The Risk Assessment proforma has been revised to included primary beam dose rates.

11.15.3 Local Rules

The HSE have recently advised minor revisions to the structure of local rules to simplify the content.

11.16 QA Surveys

11.16.1 Commissioning & Acceptance Testing

Critical Inspections and Commissioning were performed for 9 new installations (including tube replacements, loan units and moved units) between 1st April 2023 and 31st March 2024.

Room	Comments
Room 5 A&E wall detector	Commissioning
Nuclear Medicine SPECT CT2 Siemens Symbia Intevo Bold	Commissioning
Nuclear Medicine SPECT CT2 Siemens Symbia Intevo Bold	Critical Inspection
CT Suite CT1 Siemens Definition AS+	Critical Inspection
CT Suite CT2 Siemens Somatom Drive Syngo CT VB20	Commissioning
CT Suite CT2 Siemens Somatom Drive Syngo CT VB20	Critical Inspection
RDG2 FFDM Hologic 3Dimensions	Commissioning
RDG2 FFDM Hologic 3Dimensions	Critical Inspection
GE OEC One mobile fluoro (short term loan unit)	Commissioning

GE OEC One mobile fluoro	Commissioning
Philips Pulsera mobile fluoro	Critical Inspection
RDG2 Tomo Hologic 3Dimensions	Commissioning

Table 10 – Details of Critical Inspections and Commissioning Between 1st April 2023 and 31st March 2024

11.16.2 Investigation

Investigations are performed when Local Quality Control indicates, or equipment performance suggests that it is not operating within expected tolerances. This may include data review, site visits to perform quality assurance tests, communication with manufacturers/service agents to return the equipment to acceptable performance.

The following 2 investigations took place:

Room	Comments
Room 4 C-arm Siemens Artis Zee	Investigation following upgrade
Agfa X-Raymond 100 mobile DR	Investigation following detector calibration

Table 11 – Details of Investigations Undertaken

11.17 Routine Quality Assurance

11.17.1 Diagnostic X-ray

The Trust has 36 units of digital radiographic, fluoroscopy, mammography and CT equipment.

These are checked annually with dental units and bone densitometers checked less frequently.

Mammography units are checked every 6 months, Specimen Cabinets annually. From 1st April 2023 to 31st March 2024 in total 52 quality assurance visits were made on the following equipment:

Checks	Total Number In situ	Visits	Equipment Tested This Period
Fixed Fluoroscopy	2	3	Room 4 Siemens Artis Zee C-arm routine QA Cardiology Cath Lab Philips Azurion Clarity C-arm routine QA & investigation post upgrade
Mobile Image Intensifiers	5	7	GE Elite Mini MCA01 routine QA GE Elite Mini MCA02 routine QA Ziehm Vision routine QA Philips Pulsera critical inspection (x1) & routine QA (x1) GE OEC One (short term loan unit) commissioning GE OEC One commissioning
Digital Fixed Radiography	4	7	Room 1 Agfa routine QA Room 2 Agfa routine QA Room 3 Agfa routine QA Room 5 A&E Agfa investigation after tube recalibration (x2), wall detector commissioning (x1) and routine QA (x1)
Mobile DR	3	4	Carestream DRXR-1 routine QA Agfa DR 100S routine QA

Checks	Total Number In situ	Visits	Equipment Tested This Period
			Agfa X-Raymond 100 routine QA (x1) & investigation after detector calibration (x1)
Mammography	3	6	RDG1 Hologic 3Dimensions FFDM routine QA (x1) RDG2 Hologic 3Dimensions FFDM critical inspection (x1), commissioning (x1) & routine QA (x1) RDG3 Hologic Dimensions FFDM routine QA (x2)
Mammography Tomo	2	3	RDG2 Hologic 3Dimensions Tomo commissioning RDG3 Hologic 3Dimensions Tomo routine QA (x2)
Specimen Cabinet	2	2	RSPEC Faxitron BioVision SC routine QA Bioptics Faxitron OR SC routine QA
Dental	3	1	Room 5 Instrumentarium OP30 OPT routine QA
CR Readers	1	1	Agfa DX-G CR reader viewing area routine QA
CT Scanner	5	7	Siemens Definition AS+ CT1 critical inspection (x1) & routine QA (x1) Siemens Somatom Drive Syngo CT VB20 CT2 critical inspection (x1) & commissioning (x1) Siemens Symbia TruePoint NM SPECT CT1 routine QA Siemens Symbia Intevo Bold NM SPECT CT2 critical inspection (x1) & commissioning (x1) CT cabin was not accessible due to service needs
Dexa Scanner	1	0	Hologic Horizon DEXA scanner due 2024
Workstation Monitor	4	10	Directors Office 1 Barco monitors routine QA (x2) Directors Office 2 Barco monitors routine QA (x3) Directors Office 3 Jusha monitors routine QA (x2) Reporting Office Barco monitors routine QA (x3)
CBCT	1	1	Orthodontics Kavo OP3D CBCT routine QA

Table 12 – Details of assurance visits undertaken Between 1st April 2023 and 31st March 2024

Other than minor actions, such as Light Beam Diaphragm accuracy, in general the equipment performance and safety was satisfactory. However, the following points required attention:

Room	Comments
Room 1 Agfa	AEC: The home table position under AEC is displayed as 100cm and grid focus is 100cm. However the measured focus to detector distance was nearer 110cm. Can the engineer check and adjust if necessary. The measured ROI deviation across the uniformity image (uniformity 1mmCu 70kV @ 100cm) was 6%. (IPEM Tolerance 5%). The detector may benefit from recalibration.
Room 4 C-arm Siemens Artis Zee	Dapmeter is reading ~25-30% high and should be adjusted at the next service, and a correction factor used for patient dose assessments.
CR reader viewing area	Streaking artefacts can be observed on the uniformity and phantom QA test images which indicates that the CR Reader's optics are required to be cleaned.

Room	Comments
Agfa X-Raymond mobile DR	Measured uniformity on both the large and small detector has been determined to be greater than the ±5 tolerance level. Additionally, there is a substantial variation in EI (Exposure Index) across both detectors in the vertical and horizontal directions. It is advised that the detectors are recalibrated at the next earliest opportunity. Determined that the automated calibration procedure was flawed as this unit's calibration procedure instructions suggested a FDD of 100cm leading to a large variation of the field across the detector and some collimator cut-off at the edge. A recal at 130cm was performed on the large detector (this is standard distance for Agfa systems) and the uniformity was comfortably within tolerance. The stripe artefacts on the small detector were also removed after a recalibration at 100cm but the uniformity could be improved further with a recalibration at 130cm.
Philips Pulsera mobile fluoro	Error message began appearing, 'M208 subsystem error-system still available'. This could be cleared by restarting, but inevitably reoccured after making an exposure. Engineer found that a replacement tube was needed
GE Elite Mini View MCA01 mobile fluoro	There is no foot pedal for this unit - Used foot pedal from MAC02. It is advised to obtain a new foot pedal for this unit so that both fluoro units can be used independently.
Ziehm Vision mobile fluoro	The Ethernet network connection on the back of the monitor console is frayed and we advise repair.

Table 13 – Details of points requiring attention as a result of assurance visits Between 1st April 2023 and 31st March 2024

The Above are all being discussed with the manufacturers and are addressed.

11.17.2 Departmental Quality Control

Annual Quality Control reports are submitted by each Modality Area to the radiation Protection Committee (X-ray, Mammography, including Orthopaedic mini c-arms and DEXA). These reports include equipment servicing, Quality Control, Image Reject Analysis, equipment dose performance, compared against relevant national or local Diagnostic Reference Levels.

The Medical imaging CSU is working with theatre colleagues to submit a report for the mini c arms which are in use in theatres and are not used by radiology staff.

11.17.3 Mammography

The responsibility for organisation of QA rests with the Screening Quality Assurance Service (North). Following national guidelines, checks on all mammography and ultrasound units and primary reporting monitors are made at 6-monthly intervals. Specimen cabinets are tested annually.

Within Breast Screening quality control checks are performed on the mammography machines by radiographers in accordance with the NHSBSP recommendations. Routine testing of Stereotactic accuracy is now a requirement. As Contract-enhanced Spectral Mammography is

introduced additional quality control and quality assurance tests are required.

In general, the equipment was found to be reliable with dose and other QA aspects meeting the published national standards.

Of the routine 6 monthly tests performed, the following action items were identified:

Room 1 Hologic Selenia 3Dimensions	
21/08/2023	All aspects of safety and performance tested were satisfactory.
Room 2 Hologic Selenia 3Dimensions	
06/09/2023	All aspects of safety and performance tested were satisfactory
26/02/2024	FFDM: The gantry start/stop button behind the control panel does not cut power to the gantry or stop movement to the unit when tested. It appears to just cut power to the control panel and should be labelled as such. This switch should be brought to the attention of electrical contractors for this room and rectified if practicable. (Note - the control panel has its own UPS). As with other Dimensions units, the maximum motorised compression was still intermittently able to significantly exceed the 200N suspension limit. The max compression setting has been reduced to lessen this effect and the radiographers are aware. Manual compression cannot exceed the 300N limit. Tomo: All aspects of safety and performance of the tomosynthesis system tested were satisfactory..
Room 3 Hologic Selenia Dimensions	
31/07/2023	FFDM: All aspects of safety and performance tested were satisfactory Tomo: All aspects of safety and performance of the tomosynthesis system tested were satisfactory.
29/01/2024	FFDM: All aspects of safety and performance tested were satisfactory Tomo: All aspects of safety and performance of the tomosynthesis system tested were satisfactory.
Display Monitor Calibration	
Director's Office Workstation 1 – Barco/Impax	
04/08/2023	All aspects of performance tested were satisfactory.
01/03/2023	All aspects of performance tested were satisfactory.
Director's Office Workstation 2– Barco/Impax	
06/04/2023	All aspects of performance tested were satisfactory.
27/10/2023	All aspects of performance tested were satisfactory.
01/03/2024	All aspects of performance tested were satisfactory.

Director's office Workstation 3 Jusha/Impax	
04/08/2023	All aspects of performance tested were satisfactory.
01/03/2024	All aspects of performance tested were satisfactory.
Reporting Room – Barco/Impax	
06/04/2023	All aspects of performance tested were satisfactory.
27/10/2023	All aspects of performance tested were satisfactory.
01/03/2024	All aspects of performance tested were satisfactory.
Faxitron Specimen Cabinet – RSPEC1	
27/11/2023	All safety functions and performance of this unit tested are satisfactory
Faxitron Specimen Cabinet – RSPEC2	
25/08/2023	Warning lights and interlocks all function as intended. Outputs are all satisfactory though consistent and accurate kV measurement was not possible.

Table 14 – Details of action items identified of the routine 6 monthly tests performed.

11.17.4 Routine Local Mammography Quality Control

Within Breast Screening quality control checks are performed on the mammography machines by radiographers in accordance with the NHSBSP recommendations. The routine QA is performed regularly and is satisfactory. The DMAM phantom is being used for routine IQ testing. Routine testing of Stereotactic accuracy is also a requirement.

11.17.5 Patient Dose Monitoring

No patient or staff dose estimates were required.

11.17.6 Foetal Dose Assessments

There has been 1 foetal dose estimate was performed between 1st April 2023 and 31st March 2024, which has met the criteria for reporting to the CQC:

Date of Incident	Modality	Foetal Dose (mSv)	Explanation/comment
13/12/2023	CT	0.011	A paediatric patient attended for an AP chest X-ray examination on 17/01/2023. A chest X-ray was performed using a CR cassette, but the operator did not think the exposure had been made and therefore repeated the exposure on the same CR cassette without reading it. Upon reading the CR cassette the operator realised the mistake and returned to acquire a third, diagnostic image. The patient received two unnecessary exposures of radiation before the diagnostic image was successfully acquired.

Table 15 – Details of Foetal dose estimate which met reporting criteria to CQC Between 1st April 2023 and 31st March 2024

11.18 Diagnostic Reference Levels

Diagnostic Reference Levels (DRLs) are displayed, where relevant, in all the x-ray rooms. All DRLs need to be regularly audited against national values in compliance with IRMER regulations. This may be particularly relevant after software upgrades, which can introduce changes to clinical protocols.

A 50 women dose survey was carried out in breast screening and doses remain well below the national DRL.

11.19 Research Ethics Approvals

No MREC or Local research approval requests were received during 2023.

11.20 Conclusions from the radiation protection advisor annual report

1. Radiation doses (Whole body, Eye and Extremity) to staff are well within acceptable levels so that the statutory requirements of the Ionising Radiations Regulations 2017 are being met across the Trust.
2. There is a well-established QA programme. Dose audits are regularly performed in accordance with the requirements of IR(ME)R (see 10), to ensure that safety and quality control procedures are carried out effectively. However, any areas of the program which may not be comprehensive should be audited to identify any shortcomings in demonstrating full compliance with CQC expected standards.
3. Detailed DRL audits have been performed for all modalities, indicating that all equipment audited is generally well optimised. The standardisation of protocols between Campuses has led to a more consistent set of LDRLs across the Trust, with steady reductions in LDRLs for many standard examinations. Target 'Diagnostic Reference Levels' should be reviewed for all equipment and procedures listed in the 2022 National DRL Guidance. Patient doses so far received have been audited against these values. DRLs may need reviewing after each occasion a major software upgrade is undertaken.
4. The Breast Screening Unit should assure the Trust that incidents and faults with equipment pertaining to the Mammography service (x-ray, Ultrasound and MR) are reported to the NCCPM in a timely manner. Such reports should also be reported to local governance meetings.

11.21 Nuclear Medicine Department

11.21.1 Radiation protection report

General

The department has registration under IRR17 for:

- Working with artificial radionuclides and naturally occurring radionuclides which are processed for their radioactive, fissile or fertile properties.

Consent under IRR17 for:

- The deliberate administration of radioactive substances to people or animals for medical or veterinary diagnosis, treatment or research.
- The deliberate addition of radioactive substances in the production or manufacture of consumer products or other products, including medicinal products.
- Discharging significant amounts of radioactive material into the environment.

A new process for renewal of consents required by the Ionising Radiations Regulations 2017 (IRR17) being implemented by the HSE has started with one hospital in the Region going through the process already. To clear the backlog associated with renewing existing consents over the next five years, HSE will be contacting 20% of existing consent holders each year. Existing consent holders will be selected at random and invited to submit an application to renew their consents. Further advice will be provided by the RPAs when more details are known.

The likely cost for HSE to process these applications is between £2,000 and £5,000 for each consent an organisation holds and the costs are largely dependent on how much time is spent by HSE inspectors reviewing each application. The Trust currently holds two consents; one for the administration of radioactive substances to patients and the other for the deliberate addition of radioactive substances in the production or manufacture of medicinal products, so the Trust will need to budget for renewal of these consents.

They will require the submission of a safety assessment to HSE; templates to assist with the submission are currently being developed. Other documentation will need to be submitted in addition to the safety assessment (local rules and contingency plans may be required, but this has not been confirmed). The inspectors will then review the safety assessment and the requested documentation. If they consider the safety assessment to be satisfactory then they will visit the site. If the review the inspector completes at site is also successful, once the appropriate fee is paid, the consents will be renewed. There is some uncertainty in what will happen if the inspectors are not satisfied with their findings but it is likely that the applicant will be given a specified period of time to rectify the deficiencies identified by the inspector.

1. Currently there is one ARSAC holder (for the Trust. She has a licence issued on 18/12/2023. The site also requires a licence, which was issued on 07/03/2024. Both licences are valid for 5 years.
2. Local rules are in place. They have been reviewed and are going through governance processes.
3. Risk assessments for all activities relating to nuclear medicine are in place and have been reviewed recently and updated in line with IRR17.
4. The Trust has appointed corporate RPA and Radioactive Waste Advisor (RWA) services through Sheffield Teaching Hospitals Radiation Protection Services.

5. The Trust has a Medical Physics Expert (MPE) for nuclear medicine; the Consultant Physicist in Medical Physics. The MPE has registered as required under IR (ME) R 2017.

6. The department currently has one Radiation Protection Supervisors. This individual has had their letter of appointment formally updated to reflect IRR17. A second RPS is being trained and is expected to be formally appointed in 2024

7. IR(ME)R 17 has placed additional requirements on the Trust as follows:

   - Requirement for information on benefits/risks attached to a radiation exposure to be provided to the individual wherever practicable, before the exposure takes place.
   - Communication requirements following “significant” unintended exposure with referrer, practitioner and patient.
   - Establishment of dose constraint for comforters and carers.

   Policies and procedures are in place to address these requirements.

11.22 Facilities and equipment

The Intevo Bold SPECT/CT system was successfully installed during 2023.

The Radiopharmacy is being replaced with a new suite that meets current regulatory requirements. This is a lengthy project and is expected to be fully up and running in December 2024. While our Radiopharmacy is out of action we are purchasing radiopharmaceuticals from Sheffield Teaching Hospitals under mutual support agreements.

11.23 Staff doses

11.23.1 Classification of staff

a) Body doses

During 2023/24 measurable whole body TLD doses were recorded in line with that expected for the work undertaken for Nuclear Medicine Technologists, the highest dose received for 2023/24 was 0.3 mSv.

The cardiology nurses who staff the stress sessions for myocardial perfusion scans have been included in the routine personal dose monitoring.

(b) Classification of staff

Despite never recording doses close to those requiring that staff be Classified Workers under IRR17, the HSE has decided that there is a foreseeable risk that any nuclear medicine worker handling unsealed radioactive sources could exceed a dose limit in the event of a contamination incident. They are therefore pushing for all nuclear medicine staff in the country to be classified. Our programme to Classify staff is progressing well. We have organised for all staff to have the required occupational health examination and for the RRPPS Approved Dosimetry

Service to provide all of our dosemeters. All relevant staff should be Classified from July 2024.

11.24 Contingency plans

There was no requirement to invoke any of the department's contingency plans as defined in the local rules.

The last contingency plan rehearsal took place as part of staff training in February 2024.

This must be done as a requirement of IRR17.

11.25 Radioactive materials, waste and transport

The receipt and accounting for radioactive isotopes received documentation are up to date.

The control, accounting and disposal records of waste are up to date.

The Trust also holds an authorisation certificate from the Environment Agency (EA) to accumulate and dispose of radioactive waste. Detailed records of disposals are maintained, and the annual statutory return was submitted in February. The Trust has worked within the limits of the certificate of authorisation during 2023/24.

The Trust was last inspected by the South Yorkshire Police on 13/04/2022. No significant issues were identified.

The Trust only engages in very limited radioactive transport operations.

These were reviewed by the Trust's appointed DGSA during an annual audit, which found generally good compliance and security.

11.26 Radon

In 2018, radon monitors were sourced from Public Health England (PHE) and placed in hospital and community locations identified by the Health and Safety Advisor. None of the levels in any areas are of concern, with a maximum annual average estimate of 83 Bq m^{-3} (from a community site in Barnsley) compared with the action level of 300 Bq m^{-3}. No further action is required.

11.27 PET/CT service

The mobile PET/CT service operated by Alliance Medical, has not been used in 2023/24.

11.28 Incidents in Nuclear Medicine

Date of incident reported	Patient dose	Reportable		
	mSv	HSE	CQC	Brief explanation
19/05/23	10.4	No	No	Isotope administration failure. Injected 800MBq 99mTc for MUGA scan via Cannula. Cannula wasn't in a vein, hence

Date of incident reported	Patient dose	Reportable		
	mSv	HSE	CQC	Brief explanation
				unable to acquire any images. Explained situation to patient and rebooked scan
19/11/23	8.2	No	Yes	Patient was referred for a bone scan from Urology but the wrong patient was referred. The clinical details were appropriate and when the patient was questioned by the operators he confirmed that he had been seen by Urology and was expecting to be referred for a bone scan. Following identification of the incident, further questioning revealed that he had seen Urology for kidney issues and was expecting a (DEXA) bone scan for osteoporosis.
10/01/24	4.1	No	No	Cannula not sited correctly. Patient attended for Myocardial perfusion scan. As per procedure a cannula was inserted in to their arm (right) and flushed with 10ml of saline.No indication of a problem (i.e. no swelling, no discomfort). As procedure another operator (nurse) checked cannula with 5ml saline, still no signs of an unsited cannula. 5ml Regadenson given followed by 5ml saline. Technologist administered isotope 99mTc 600MBq tetrofosmin followed by 10ml saline flush. No obvious signs, but no expected patient response to the regadenson (e.g. increased HR and Rsep rate). Checked with Geiger monitor if isotope was in bloodstream but just located in arm at cannula site. Massaged arm to encourage dispersal. After 20 minutes checked with monitor and isotope had started to disperse.

Table 16 – Details of Incidents in Nuclear Medicine

11.29 Research

There are no current research project involving radioisotopes.

11.30 Procedural audits

The following procedural audits took place in June 2023:

- Administered activity vs. DRL
- Request justification / last menstrual Period (LMP) and breast feeding checks

Results for both of these audits were satisfactory. They were fed back to staff at staff meetings and reported at the annual Radiation Safety Committee meeting.

Quality assurance

A quality assurance programme is in place for the equipment within the department. This includes the gamma cameras, SPECT/CT, isotope calibrators and contamination meters.

The annual calibration exercise for the isotope calibrators against NPL secondary standard was undertaken in September 2022.

The new CT scanner had its critical examination carried out in April 2023. The CT component of the older SPECT/CT system was carried out at the end of June 2023.

11.31 <u>Non ionising safety protection report 2023-2024</u>

Dermatology

- Administration controls (local rules and risk assessment) fine
- Scheduled laser audit has been postponed as both lasers have faults and will be seen first by service engineers
- Audit is due to take place 26.04.24
- RDGH NIR report will be updated in due course

Ophthalmology

- Laser equipment has been tested at Rotherham. Ophthalmology, Dermatology and Day Case Theatre
- Ophthalmology's new laser is yet to be serviced
- All actions undertaken. Door lock is working. Reflective window in the door has been obscured
- YAG laser to be removed
- All aspects of laser safety are okay in room G69
- Administration paperwork in order for both lasers
- LPA has updated local rules and risk assessment for the new laser
- LPS has prepared documents for authorised users to sign

Theatres

There was an incident regarding laser fibre breaking which resulted in the surgeon suffering burns in 2023. LPA not provided with further information regarding the incident. Presumption is the matter is now close. Any update on findings and corrective actions need to be passed to the LPA.

Phototherapy

- Equipment was tested on 14.09.2023
- No issues with any of the UV treatment cabins or the hand and foot units
- TL01 cabin output was down from last year, this can be expected when new tubes are installed
- MED testing refresher to be arranged.

Mammography ultrasound

- Two ultrasound scanners in mammography have regular QA checks in accordance with NHSBSP guideline report 70 and PHE governance
- Both scanners are now located in the mammography department
- Scanner and probe commissioning carried out over the past year
- Monthly user QA performed regularly from April 2023 to March 2024

- No issues with either the scanners or the probes.

General ultrasound

- The Radiographer-led QA programme for ultrasound is working well.
- 3 new machines installed
- WS3 has now moved to radiology
- US3 general has now gone
- No other issues.

11.32 MRI safety report 2023-2024

This safety report covers non-ionising (Magnetic Resonance Imaging) Radiation Protection services provided to Rotherham Hospital between April 2023 and April 2024.

The MRI Safety Policy was updated in May 2023 to reflect the new MHRA guidelines.

Implant safety policies covering many commonly encountered implants have been provided by STH.

Updated and/or annually reviewed policies have been provided in May, Aug, and Nov 2023, and February 2024 by STH.

A safety audit conducted on 29 April 2024 for both scanners found all areas were fully complaint.

Scanner 1: Siemens MAGNETOM Avanto 1.5T

Performance testing was performed on the Siemens MAGNETOM Avanto 1.5 T MRI scanner at Rotherham Hospital on the 29th April 2024. The American College of Radiologists (ACR) test phantom was imaged using the Siemens matrix head coil.

The images acquired and QA tests performed have been updated in line with IPEM 112 guidance. These images were acquired alongside the previous images to ensure continuity of performance and to set a new baseline for future tests.

Action criteria were based upon recommendations from the ACR [1], the AAPM [2] and IPEM [3], and from results following an eight year audit [4]. All measurements should fall within the required action levels.

All QA test results were within tolerance.

Scanner 2: Siemens MAGNETOM Sola 1.5T Commissioned (20 April 2022)

Acceptance testing was performed on the Siemens MAGNETOM Sola 1.5 T MRI scanner at Rotherham Hospital on the 29th April 2024. The American College of Radiologists (ACR) test phantom was imaged using the Siemens matrix head coil.

The images acquired and QA tests performed have been updated in line with IPEM 112 guidance. These images were acquired alongside the previous images to ensure continuity of performance and to set a new baseline for future tests.

Action criteria were based upon recommendations from the ACR [1], the AAPM [2] and IPEM [3], and from results following an eight year audit [4]. All measurements should fall within the required action levels.

All QA test results were within tolerance.

12. ESTATES AND FACILITIES

12.1 Compliance and risks

The high rated risks have been reviewed and completed for the directorate and added to the Datix Risk Register.

The maintenance of a safe workplace, access/egress, safe systems of work, safe storage and transportation of materials, supervision, training and maintaining records are all being met.

The Directorate has continued to update its SOP Control of Contractors and the Permit to Work Systems, which are issued to staff and contractors. A contractor's induction programme is managed by Reset ensuring full on-site awareness of health, safety and welfare precautions and procedures. A total of 54 companies and 523 individuals have registered with Reset and completed the Trust's inductions and further 80 individuals from 35 companies have attended face to face site induction in this reporting period, which is having a positive impact on the reduction of accidents, near misses and untoward incidents to the Trust.

The Estates and Facilities risk assessments and safe working systems have been reviewed with departmental managers being kept up to date on a monthly basis of all risk score of eight and above.

The Estates Department has two high risks with a score of 16:

1. Absence of an isolated power supply (IPS) within all Theatres.
2. Theatre 5&6 Ventilation.

The Health and Safety Team work closely with Estates Management Team promoting specific issues such as slips, trips, and falls and the safe management of hazardous substances. The Teams collaborate in ensuring compliance with Safety Alerts and co-operate when undertaking incident investigations and developing control measures to reduce the risk of re-occurrence.

12.2 Premises Assurance Model (PAM) & Risk Profile

Premises Assurance Model (PAM) provides Estates & Facilities with oversight of H&S operational issues via the standard question Q3 (Risk Assessments) referenced in all SH`s. Overall progress is reported to the EMT committee. This systemic approach provides a real time view of assurance on differing aspects and features of the day to day running of Estates & Facilities including operational compliance with Health and Safety Regulations.

13. EXTERNAL HSE VISITS

There was no external routine visit carried out by the HSE (Health and Safety Executive) within this period.

14. POLICIES, SOPS and OTHER DOCUMENTS

The Health and Safety Policy and related policies are reviewed in light of any changes to health and safety legislation and other requirements e.g. revised Health Technical Memorandums (HTM). Policies are being ratified by the Risk and Ratification Group and the appropriate updates made. New Estates & Facilities policies, SOPs and other documents will be available on the Hub with the older documents being archived.

14.1 Estates and Facilities Policies reviewed and ratified during 2023/24:

Document Title	Date Ratified
Mobile Communication Equipment Policy	30/06/23
Guideline for Staff in the Event that Police use a Taser or Irritant Spray on an Inpatient whilst Responding to an Incident	30/0623
Environmental Sustainability Policy	30/06/23
Health & Safety Policy	10/10/23
Pest Control Policy	20/10/23
Policy for Undertaking RIDDOR Notifications	20/10/23
Safe Operation of Ventilation Systems	19/11/23
Water Safety Policy	24/11/23
Waste Management Policy	25/01/24
Moving and Handling Policy	22/02/24

14.2 Policies currently due review 2024/25:

Document Title	Review Due
Trust Lease Car Scheme	11/04/24
Security Policy	11/04/24
Policy Governing the Recording NHS Staff in Health and Social Care Setting	16/05/24
Management of Occupational Road Risk	16/05/24
Policy for the Management of Stress at Work	16/05/24
Safe Operation of Ventilation Systems	16/05/24
Key Management Policy	02/08/24
Medical Devices Policy	02/08/24
Violence Prevention and Reduction Policy	26/08/24
Policy for the Use of Internal and External Closed Circuit Television (CCTV)	25/11/24
Parking Policy	21/12/24
Handling, Supply & Storage of Linen	27/01/25
Electrical Safety Policy	03/03/25
Control of Substances Hazardous to Health	24/03/25

14.3 Other Estates and Facilities Documents reviewed and ratified during 2023/24:

Document Title	Date Ratified
Facilities Services Business Continuity Plan	31/05/23
Estates Safety & Training Business Continuity Plan	31/05/23
Security & Car Parking Business Continuity Plan	31/05/23
Energy and Utilities Annual Report	12/06/23
Trust Travel Plan	14/06/23
Prisoner-Patient Concordant	20/06/23
Waste Management Annual Report	25/06/23
Estates Strategy & Capital Strategy – 2023-2027	07/07/23
UECC Lockdown Plan	27/07/23
Bomb Threat Plan	27/07/23
Trust Lockdown Plan	27/07/23
Health & Safety Annual Report	01/08/23
Health & Safety Information and Guidelines for Contractors/Consultants and Sub-Contractors	14/09/23
Estates Services Business Continuity Plan	30/09/23
Water Safety Plan	08/11/23
SAGE Newsletter (Winter Edition)	14/12/23
Key Environmental Objectives	16/02/24
Security Strategy Workplan	22/03/24

14.4 Other Estates and Facilities Documents due review during 2024/25:

Document Title	Review Due
Facilities Services Business Continuity Plan	31/05/24
Estates Safety & Training Business Continuity Plan	31/05/24
Security & Car Parking Business Continuity Plan	31/05/24
Energy and Utilities Annual Report	12/06/24
Waste Management Annual Report	25/06/24
SAGE Newsletter (Summer Edition)	30/06/24
UECC Lockdown Plan	31/07/24
Bomb Threat Plan	31/07/24
Trust Lockdown Plan	31/07/24
Health & Safety Annual Report	01/08/24
Key Management Register (Form)	02/08/24
Master Key Certificate (Form)	02/08/24
Master Key Register (Form)	02/08/24
Key Cutting Request (Form)	02/08/24
Lock Replacement (Form)	02/08/24
Trust ID Badge Application (Form)	02/08/24
Fire Safety Strategy	05/08/24
Estates Services Business Continuity Plan	30/09/24
Health & Safety Strategy	11/11/24
Security Strategy Workplan	28/11/24
Security Management & Violence Prevention and Reduction Strategy	25/11/24
Key Environmental Objectives	16/02/25

Document Title	Review Due
Trust Green Plan	28/02/25

14.5 <u>Estates and Facilities Standard Operating Procedures (SOPs) reviewed and ratified during 2023/24:</u>

Document Title	Ratified
Reporting of Accidents / Carriage of Dangerous Goods (SOP 321)	27/04/23
Safe Use of Power Tools (SOP 036)	02/06/23
Safe Movement of Waste (SOP 201)	08/06/23
Road Transport Security Plan (SOP 324)	22/06/23
Basic Battery Maintenance (SOP 038)	04/08/23
Wet Mopping (SOP 234)	26/09/23
Site Winter Maintenance Plan (SOP 050)	11/10/23
Administration of TRFT Parking Facilities (SOP 301)	20/10/23
Parking Payment Form	20/10/23
Parking Concession Form	20/10/23
Free Parking Authorisation Form	20/10/23
Blue Badge Application Form	20/10/23
Parking Terms & Conditions (Form)	20/10/23
Parking Permit Application (Form)	20/10/23
Parking Scheme – Opt Out (Form)	20/10/23
Procedure for Working on or near Neutral Conductors (SOP 040)	15/11/23
Accessing, for Repair, Machines/Equipment with Potential to Cause Infection (SOP 035)	19/11/23
Delivery & Handling of Pool Associated Chemicals (SOP 008)	28/11/23
Safe Use of Kubota Tractor (SOP 015)	02/12/23
Sealy Parts Cleaning Tanks (SOP 014)	06/12/23
Safe Use of Grinding Machines (SOP 006)	06/12/23
Hand Digging/Excavation Off Roads & Pathways (SOP 039)	10/12/23
Procedure for Fixed Wire Testing on Non IP2X Distribution Boards (SOP 044)	12/12/23
Duplex Cleaning Machine (SOP 235)	31/01/24
Safe Use of the Master SmartMover SM60/SM100 (SOP 210)	31/01/24

14.6 <u>SOPs due Review during 2024/25:</u>

Document Title	Review Due
Collection and Delivery of SharpSmart Bins (SOP 202)	31/03/24
Guidance on Radiation Protection (EPD 104)	30/06/24
Working on Internal Stairways (SOP 012)	15/08/24
Administration of TRFT Parking Facilities (SOP 301)	20/10/24
Parking Payment Form	20/10/24
Parking Concession Form	20/10/24
Free Parking Authorisation Form	20/10/24
Blue Badge Application Form	20/10/24
Parking Terms & Conditions (Form)	20/10/24
Parking Permit Application (Form)	20/10/24
Parking Scheme – Opt Out (Form)	20/10/24

Document Title	Review Due
Site Winter Maintenance Plan (SOP 050)	11/10/24
Management of Legionella (Facilities) (SOP 222)	31/01/25
THOR UVC Room Disinfection SOP (SOP 233)	31/01/25

15. RISK REGISTER

The total number of risks on Datix related to Estates & Facilities stands at 109.

Monthly risk register review meetings have been scheduled to ensure all risk are reviewed and supported by appropriate actions plans.

This is primarily down to the work of the Risk Manager and compliance leads removing duplications and bring other risks together.

The system is an integral part of producing corporate risk registers for a number of committees throughout the organisation.

16. CARRIAGE OF DANGEROUS GOODS

The Trust underwent an external audit during November/December 2023 for compliance against the carriage of dangerous goods (ADR 2023). The external auditor spent three days on site, two of which covered the main hospital site and the third was a visit to community settings.

The main areas covered during the community visits ensured that all staff had received their Dangerous Goods Awareness Training and were packaging their samples, sharps and waste correctly in line with the ADR regulations.

The report was received in February 2024, identifying 21 recommendations, all minor. 11 of the recommendations were completed at the time of the audit. The remaining actions have all now been completed.

17. AREAS FOR FUTURE HEALTH and SAFETY DEVELOPMENT

17.1 Priorities for 2024/25

- Continue implementing and monitoring the 2024/26 Health and Safety Strategy.
- Maintain the delivery of health and safety training programs for COSHH and risk assessment throughout 2024/25, including providing ongoing support to staff.
- Strengthen the embedding of risk registers across the Trust by supporting and training risk assessors, ensuring the development and allocation of resources for risk assessments.
- Continue the review of moving and handling training, and further the introduction of new moving and handling link workers in all areas, including non-clinical ones.
- Ensure the Trust's adherence to the Board-approved security management work plan for 2023/24.
- Regularly review and update policies and Standard Operating Procedures (SOPs) as required for 2024/25.

- Conduct fire audits across TRFT sites and community buildings.
- Achieve established Health & Safety key performance indicators (KPIs) in the new monthly E&F reporting dashboard.
- Review of current HSMS and ensure continued compliance.
- Monitor and improve risk register reports for corporate H&S related issues.

18. SUMMARY

18.1 Health and safety

The continued development and implementation of the Health and Safety Strategy 2021/24 has significantly advanced the Trust's management of health and safety risks. Regular audits, aligned with this strategy, have played a crucial role in ensuring continuous improvement in our health and safety practices.

Revised training arrangements for the appointment of staff health and safety risk assessors across the Trust have enhanced awareness, compliance and assurance regarding health and safety risk management throughout all departments.

Achieving the RoSPA Gold Award for the eleventh consecutive year and receiving the President's Award is a significant milestone. This accomplishment highlights and reinforces our long-standing commitment to ensuring a safe working environment for our staff, patients, and visitors through dedicated partnership efforts.

Note: All data used to compile the annual health and safety management report for the 2023/24 period is sourced from the Datix risk management database.

18.2 H&S Team values

The management system framework will focus on establishing robust systems supported by innovation and KPIs. Positive challenges will be implemented to ensure these systems become embedded, which is essential for continually enhancing the profile of Health and Safety at the Trust.

Health and Safety Team will continue to provide a clear picture of what the Trust is doing well within the Health and Safety Management system (based on the principles set within HSG65) and will continue to identify shortfalls and develop realistic action plans and timescales to maintain and improve compliance.

The Health and Safety Team will additionally provide support for other Departments such as Occupational Health, Infection Prevention as part of awareness activities and training to spread the Health and Safety message throughout the Trust.

Above all, the team are looking forward to working with our valued colleagues throughout the coming year to ensure a safe and healthy workplace. 2023/24 has provided the Health and Safety Team with another varied, exciting, and challenging year regarding the management of Health and Safety throughout the Trust.

We will continually review the H&S Strategy to ensure we are aligned with Trust strategic objectives and continue delivering the Trust and our vision core values; ensuring continued statutory compliance whilst remaining pragmatic, sensible and clear on H&S requirements.

Board of Directors Meeting
7th March 2025

The Rotherham NHS Foundation Trust

Agenda item	P49/25
Report	**Controlled Drugs: Annual Report 2024**
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 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** - demonstrates that the trust strives to deliver the highest standards and quality of care possible where medicines are concerned. **Caring** – demonstrates that the Trust strives to give outstanding, compassionate care. **Together** - demonstrates that the Trust strives to ensure that quality improvement and the learning from medication incidents is achieved through a multidisciplinary approach.
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	This annual report presents a summary of controlled drug incidents reported via Datix for the period January 2024 to December 2024. The Chief Pharmacist is the Controlled Drugs Accountable Officer for the Trust and reports Trust CD incidents into the CD Local Intelligence Network hosted by NHS England with CQC, police, and other organisations where CDs are used in attendance, the aim to share intelligence of controlled drugs issues and share learning and good practice. Overall, patient harm from controlled drugs is very low. Use of the Medicines Management audit via Tendable on a monthly basis at ward level has provided visibility of issues and the opportunity to address them in a timely manner. Pharmacy CD audits are planned to occur quarterly from November 2024 in order to provide greater visibility and cross referencing with other medicines audits in Tendable carried out by nursing colleagues at ward level.
Due Diligence (include the process the paper has gone through prior to presentation at the meeting)	The contents of this report has been presented to the Medication Safety Committee on 14.01.25
Board powers to make this decision	The Medical Director is the lead for medicines in the Trust, supported by the Chief Pharmacist. The Medical Director is the Chair and Chief Pharmacist Deputy Chair of the Medication Safety Committee.

Who, What and When (what action is required, who is the lead and when should it be completed?)	To note the current themes and trends and the actions taken and proposed.
Recommendations	It is recommended that Quality Committee note this report prior to the report going to public board in March
Appendices	None

1. Background

Controlled drug (CD) incidents reported via Datix are reviewed by respective areas and actions taken as required. Wards monitor their practice via Tendable every month and pharmacy is auditing practice every quarter.

This report gives an overview of incident reports and audits between January and December 2024.

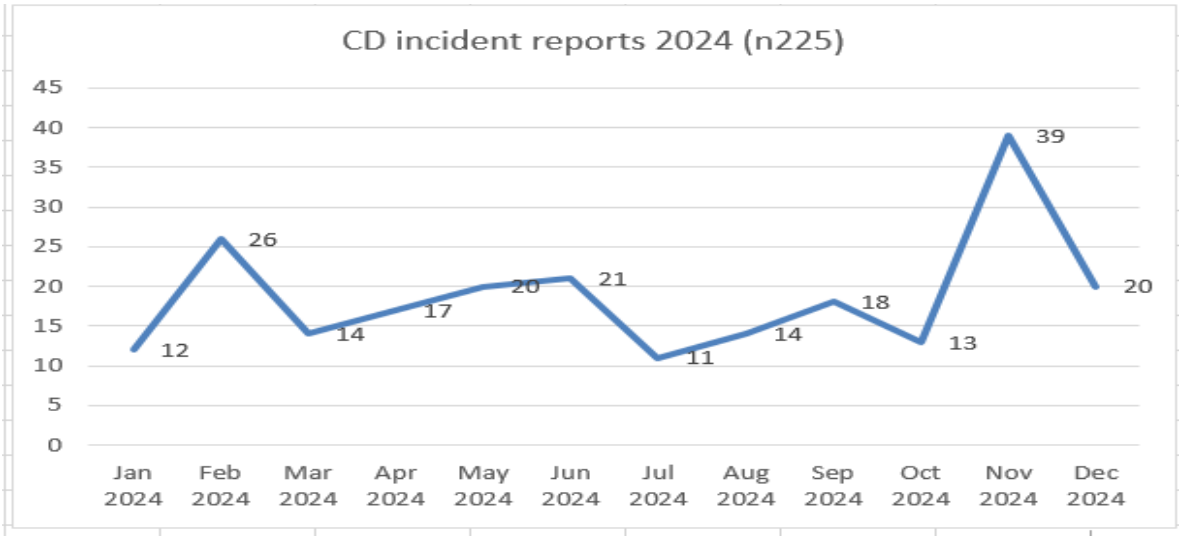
2. Controlled drug: statistics and observations

2.1 The Medication Safety Officer (MSO) and Lead Medication Safety Technician categorise medication incidents in accordance with the National Reporting and Learning System (NRLS) categories, into which Trust incident data feeds. They also ensure that all relevant fields in the Datix reports are completed.

2.2 Number of CD incident reports

225 CD incidents were reported in 12 months. The number reported every month ranged from 11 to 39. The increase in November 2024 was due to mandatory reporting of the pharmacy CD audit findings. For comparison, in 2023 240 controlled drugs incidents were reported over the 12 month period.

Figure 1: number of incidents reported each month



2.3 Incidents by stage of care

134 (59.1%) incident reports were for administration, other 43 (19.1%), prescription 26 (11.6%), dispensing 18 (8.0%).

Other incidents were documentation related and reports of mandatory pharmacy wards audits.

Figure 2: Incidents by stage of care

	CD incident reports	
Incident stage	Total	%
Administration or supply of a medicine from a clinical area	134	59.6
Other medication error	43	19.1
Medication error during the prescription process	26	11.6
Preparation of medicines / dispensing in pharmacy	18	8.0
Patient's reaction to Medication	3	1.3
Medical device/equipment	1	0.4
Total	225	100

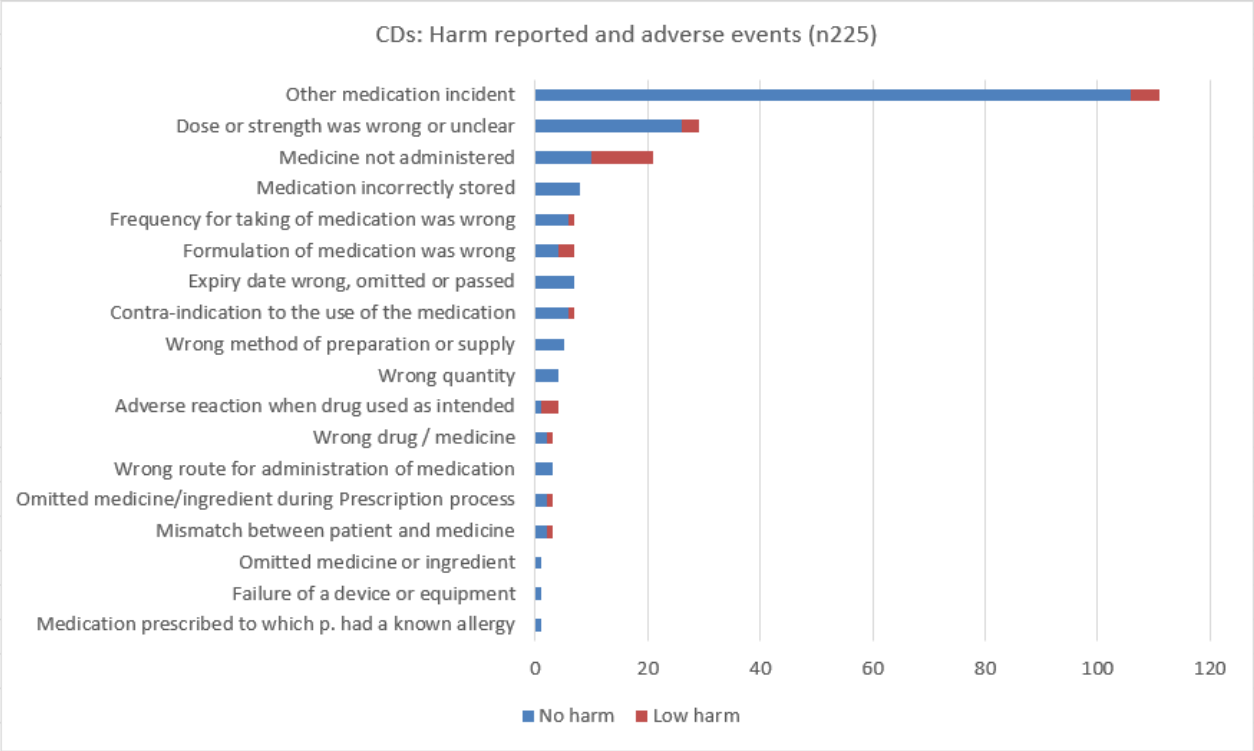
134 administration incidents, these were mainly documentation related. 43 'other incidents, these were mainly documentation related e.g. the daily CD checks at ward level not done (or not recorded as done). Discrepancies in liquid volumes versus cumulative balance (however there is an allowance for a 10% discrepancy with liquids and these incidents were within these limits). Second signatures missing in registers.

2.3 Harm from CDs

There were 195 (86.7%) 'no harm' and 30 (13.3%) 'low harm' reports.

Low harm incidents related to medicines not administered, adverse reaction, wrong formulation and wrong patient. There was no mention of use of antidotes naloxone or flumazenil use.

Figure 3: Harm and adverse event



2.4 Incident themes

Figure 4: CD themes

System	Themes
Tools and technology	• Range of CD formulations (modified release and standards release of codeine and morphine) • Syringe drivers
Persons	• Patient self-administration of CDs (codeine, ketamine, pregabalin) • Prescribers • Nursing staff • Dispensary staff

Task	• Prescription – another patient
	• Administration
	  • Measurement of oral liquid (used IV syringe)
	  • Buprenorphine multiple patches, previous patch not removed
	  • CD documentation in registers
	  • Liquid CDs not marked with expiry days
	  • Storage of patients CDs
	• Dispensing - handing over CDs to ward staff
	• Labelling expiry dates on liquid CDs once opened

Organisation	Use of terminology (immediate release/standards release)
External	• Methadone dose record in summary care record was not current

3. Audits

3.1 Tendable audits

These are monthly audits conducted by nursing staff. Figure below shows reports for the last quarter. Recording of errors in registers requires improvement.

Figure 4: Tendable audits compliance

Controlled drugs	Compliance %		
	Oct 2024	Nov 2024	Dec 2024
Has any CD wastage been recorded correctly in the last 30 days or since the last audit? (e.g. xmg given, xmg wasted)	95	100	100
Are all alterations bracketed, signed, dated and not crossed out in the last 30 days or since the last audit?	85	86	81
Has the department's CD register been checked and countersigned daily for the last 30 days or since the last audit?	89	96	100
Over the last seven days has the CD order book been signed and dated when received (pink sheet) in the last 30 days or since the last audit?	94	86	91

3.2 Pharmacy audit

A programme has been established to audit CDs every three months, November, February, May and August.

- The new template has been piloted and the report shared with MOG and MSS in September /October 2024. Areas of improvements were identified, for which Care Groups were developing action plans.

Recording of errors in CD registers and labelling bottle with expiry dates once opened required reinforcing.

- A report of the data collected in November/December 2024 will be shared with Pharmacy, Care Groups, MOG and MSC.

4. Actions recommended

Continue linking with the CD Local Intelligence Network (CDLIN) (the Chief Pharmacist is the Controlled Drugs Accountable Officer for the Trust and reports Trust CD incidents into the CDLIN, hosted by NHS England with CQC, police, and other organisations where CDs are used in attendance; the aim to share intelligence of controlled drugs issues and share learning and good practice).

In consultation with Pharmacy and Pain team:

- A reminder that purple oral/enteral syringes for using with oral liquids (include medical staff)
- Security of patient own CD supplies on admission to hospital.
- Process for recording removal of buprenorphine and fentanyl patches
- Guidance on difference release preparations of morphine, oxycodone and codeine and use of the term immediate release. .
- Guidance of using multiple strengths to make up a dose
- Storage of dispensed CD TTOs on the wards
- Receipt of dispensed CDs on the wards
- Considering expiry labels for writing expiry dates on CDs liquid bottles.

5. Conclusion

Incident data suggests patients are not experiencing harm from controlled drugs and that good progress and improvement are being made with documentation in CD registers through daily checks, monthly auditing and quarterly Pharmacy checks. The discrepancies were accounted for and no concerns for diversion are evident.

Esoop Bharoocha (Yusuf)
Interim Chief Pharmacist
January 2025

Board of Directors' Meeting
07 March 2025

Agenda item	P52/25
Report	**Application of the Company Seal Report**
Executive Lead	Angela Wendzicha, Director of Corporate Affairs
Link with the BAF	Not applicable for this report.
How does this paper support Trust Values	This report supports the core value of Ambitious ensuring the Board complies with the requirements it sets out in its Constitution in relation to the signing and sealing of documents with third parties
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☒
Executive Summary	The following register of use of the Trust Seal is presented to the Trust Board in accordance with Section 10.3 of the current Standing Orders. Following the last report to the Trust Board in November 2024, the Trust Seal has been not been applied since.
Due Diligence	This report has not been, and is not required to be considered by any other Committee.
Board powers to make this decision	No decision is required by the Trust Board, however, the Board will note that the current Trust Standing Orders (Section 10.3) requires a report to be made to the Board when the Seal has been applied.
Who, What and When	No additional action is required. The Director of Corporate Affairs will be charged with compliance with the relevant procedures and will be supported by the Deputy Director of Corporate Affairs during this process.
Recommendations	It is recommended that the Board receives and notes the content of the report.
Appendices	Nil

Register of Use of the Trust Seal

1. Introduction

1.1 In accordance with Section 10.3 of the current Standing Orders.

> *"An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal."*

1.2 The last report to the Board on matters relating to the Trust Seal was November 2024.

2. Use of the Trust Seal

2.1 Following the last report, the Trust Seal has not been applied since.

3. Recommendations

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

Board of Directors
7th March 2025

The Rotherham NHS Foundation Trust

Agenda item	P53/24
Report	**Register of Interests Bi Annual Review**
Executive Lead	Angela Wendzicha
Link with the BAF	**Links with all BAF risks**
How does this paper support Trust Values	The Standards of Business Conduct are an extension of the Trust's values and reflect our continued commitment to ethical business practices and regulatory compliance
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	In accordance with Section 20(1) (e), Schedule 7 of the National Health Service Act 2006 (as amended), the Trust, as a public benefit corporation is required to maintain a Register of Interests of Directors that is available to the public. This includes where there is a nil return. The attached report illustrates the Board of Directors Register of Interests for 2024/25. The Board should note there are no declarations of interest noted that may compromise the business of the organisation.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	The Register of Interest is also presented to the Audit and Risk Committee.
Board powers to make this decision	Constitution: Section 33 refers to the manner in which conflicts of interests of the Board members should be dealt with.
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 all declarations of interest are kept up to date, recorded, reviewed and accurate. Following the Board meeting the Register of Interests will be published on the public facing website.
Recommendations	It is recommended that the-Board of Directors: • Note the content of the Report
Appendices	Register of Interests

All Conflict of Interest Declarations Held in ESR - Data as at - 31 January 2025										
Employee Name	**Service Department**	**Cost Centre Department**	**Role**	**Position Title**	**Interest Category**	**Interest Situation**	**Interest Description**	**Comments**	**CoI Date From**	**CoI Date To**
Beahan, Dr Joanne	165 Chief Executive L5	165 Chief Executive	Medical Director	Medical Director	Indirect interests	Outside employment	CQC Specialist Advisor for Urgent and Emergency care	attend a monthly meeting and attend inspection visits	28/03/2023	01/04/2024
Beahan, Dr Joanne	165 Chief Executive L5	165 Chief Executive	Medical Director	Medical Director	Non-financial personal interests	Shareholdings and other ownership interests	Company Director Ellerthwaite Management Company Limited - holiday accomodation. Owner of a flat in the property. No financial benefits from company		28/03/2023	01/04/2024
Beahan, Dr Joanne	165 Chief Executive L5	165 Chief Executive	Medical Director	Medical Director	Non-financial personal interests	Shareholdings and other ownership interests	Relationships; Son employed by Barnsley Facilities Services and works at Barnsley Hospital NHS Trust as a porter Daughter registered to work as administrative assistant at Barnsley Hospital NHS Trust through NHSP Husband equity partner / solicitor at Irwin Mitchell Solicitors. Commercial litigation.		28/03/2023	01/04/2024
Wendzicha, Miss Angela	165 Chief Executive L5	165 Chief Executive	Senior Manager	Director of Corporate Affairs (Company Secretary)	Non-financial professional interest	Outside employment	I have a Joint role as Director of Corporate Affairs with Barnsley Hospital NHS Foundation Trust	Position ongoing at the time of declaration.	01/02/2023	
Kilgariff, Mrs. Sally	165 Chief Executive L5	165 Chief Executive	Chief Operating Officer	Chief Operating Officer	Indirect interests	Loyalty interests	Sister is Finance Director for Marks and Spencer		01/04/2022	31/03/2026
Dobson, Mrs. Helen	165 Chief Executive L5	165 Chief Executive	Director of Nursing	Chief Nurse	I have no interests to declare				21/07/2022	31/12/2025
Dobson, Mrs. Helen	165 Chief Executive L5	165 Chief Executive	Director of Nursing	Chief Nurse	I have no interests to declare				21/07/2022	31/12/2025
Hackett, Mr. Steven Mark (Steve)	165 Chief Executive L5	165 Chief Executive	Finance Director	Director of Finance	I have no interests to declare				01/04/2024	31/03/2025
Hackett, Mr. Steven Mark (Steve)	165 Chief Executive L5	165 Chief Executive	Finance Director	Director of Finance	I have no interests to declare				28/03/2024	31/03/2025
Hackett, Mr. Steven Mark (Steve)	165 Chief Executive L5	165 Chief Executive	Finance Director	Director of Finance	I have no interests to declare			I have no declarations to make	21/02/2024	31/03/2024
Hackett, Mr. Steven Mark (Steve)	165 Chief Executive L5	165 Chief Executive	Finance Director	Director of Finance	I have no interests to declare				28/03/2023	31/03/2024
Hackett, Mr. Steven Mark (Steve)	165 Chief Executive L5	165 Chief Executive	Finance Director	Director of Finance	I have no interests to declare				10/10/2022	
Hackett, Mr. Steven Mark (Steve)	165 Chief Executive L5	165 Chief Executive	Finance Director	Director of Finance	I have no interests to declare				01/04/2022	31/03/2023
Hartley, Mr. Daniel	165 Chief Executive L5	165 Chief Executive	Chief People Officer	Director of People	I have no interests to declare				01/03/2024	31/03/2025
Richmond, Dr Michael Nicol	165 Company Secretary L5	165 Board of Directors	Chair	Chairman	I have no interests to declare				25/04/2024	
Burrows, Ms. Julia Margaret	165 Company Secretary L5	165 Board of Directors	Non-Executive Director	Non Executive Director	Non-financial professional interest	Outside employment	Honorary Professor Sheffield Hallam University Honorary Senior Lecturer University of Sheffield	Both are unpaid honorary appointments	09/11/2023	06/11/2026
Congdon, Professor Shirley	165 Company Secretary L5	165 Board of Directors	Non-Executive Director	Non Executive Director	I have no interests to declare				09/12/2024	
Craven, Mrs. Heather Ann	165 Company Secretary L5	165 Board of Directors	Non-Executive Director	Non Executive Director	I have no interests to declare				01/04/2024	31/03/2025
Craven, Mrs. Heather Ann	165 Company Secretary L5	165 Board of Directors	Non-Executive Director	Non Executive Director	I have no interests to declare				31/03/2023	31/03/2024
Craven, Mrs. Heather Ann	165 Company Secretary L5	165 Board of Directors	Non-Executive Director	Non Executive Director	I have no interests to declare				01/04/2022	31/03/2023
Craven, Mrs. Heather Ann	165 Company Secretary L5	165 Board of Directors	Non-Executive Director	Non Executive Director	I have no interests to declare				17/12/2021	17/12/2021

Malik, Mr. Kamran Rashid	165 Company Secretary L5	165 Board of Directors	Non-Executive Director	Non Executive Director	Financial interests	Outside employment	NED for Birmingham University Hospitals NHS Trust		25/11/2024	
Malik, Mr. Kamran Rashid	165 Company Secretary L5	165 Board of Directors	Non-Executive Director	Non Executive Director	Financial interests	Shareholdings and other ownership interests	Director of Red Button Consulting Ltd	Offering Coaching and Consulting Services	01/02/2023	
Malik, Mr. Kamran Rashid	165 Company Secretary L5	165 Board of Directors	Non-Executive Director	Non Executive Director	I have no interests to declare				10/10/2022	31/03/2023
Mondon, Mr. Andrew Paul	165 Company Secretary L5	165 Board of Directors	Non-Executive Director	Non Executive Director	I have no interests to declare				09/12/2024	
Shah, Dr Rumit Zaverchand Lalji	165 Company Secretary L5	165 Board of Directors	Non-Executive Director	Non Executive Director	Non-financial professional interest	Outside employment	Senior Partner General Practice - Hatfield health centre- Doncaster Doncaster LMC chair, Designated Representative Doncaster Primary care collaborative SYB ICB	none of these have changed since I became a NED	04/05/2022	31/03/2025
Shah, Dr Rumit Zaverchand Lalji	165 Company Secretary L5	165 Board of Directors	Non-Executive Director	Non Executive Director	Indirect interests	Outside employment	I am a director of Beckingham Medical Services Ltd This is for provision of non NHS related work .	Non has changed since became a NED	30/06/2013	30/06/2025
Temple, Mr. Martin John	165 Company Secretary L5	165 Board of Directors	Non-Executive Director	Non Executive Director	I have no interests to declare				29/03/2023	
Temple, Mr. Martin John	165 Company Secretary L5	165 Board of Directors	Non-Executive Director	Non Executive Director	Non-financial professional interest	Outside employment	Chair of Council and Pro Chancellor of the University of Sheffield	No obvious conflict , but a Medical School and nursing and medical research. This is ongoing at the time of declaration.	01/08/2022	08/02/2023
Watson, Mrs. Hannah Elizabeth	165 Company Secretary L5	165 Board of Directors	Non-Executive Director	Non Executive Director	Indirect interests	Loyalty interests	My daughter works for our local MP in a constituency support role.	My daughter has commenced work for an MP and is employed under a contract with IPSA (Independent Parliamentary Standards). I have no personal involvement in her work and understand I am bound by confidentiality and impartiality in respect of this role, as I am for my role in the Civil Service. I do not envisage any conflicts that cannot be mitigated through this.	30/05/2024	
Watson, Mrs. Hannah Elizabeth	165 Company Secretary L5	165 Board of Directors	Non-Executive Director	Non Executive Director	Non-financial professional interest	Outside employment	Permanent employment as HRD Director, Department for Transport		01/12/2023	
Watson, Mrs. Hannah Elizabeth	165 Company Secretary L5	165 Board of Directors	Non-Executive Director	Non Executive Director	Non-financial professional interest	Outside employment	Permanent employment as Director of Learning and Talent Aquisition, HMRC		17/08/2023	30/11/2023
Dickinson, Mr. Scott	32748661	32748661	Employee	165 Corporate L3	I have no interests to declare				19/12/2024	19/12/2024
Kirton, Mr Bob	165 Chief Executive L5	165 Chief Executive L5	Managing Director	Managing Director	I have no interests to declare				21/10/2024	21/10/2024

Jenkins, Dr Richard	0592 - Chief Executive	0592 - Chief Executive	Chief Executive	Chief Executive	Outside Employment	Outside Employment	Joint CEO	The Rotherham NHS FT	15/12/2021	2019/20,2020/21,2021/22,2022/23
Jenkins, Dr Richard	0592 - Chief Executive	0592 - Chief Executive	Chief Executive	Chief Executive	Loyalty Interests	Loyalty Interests	My wife works as a Band 5 Community Nurse for the York and Scarborough Hospitals NHS FT. There is no known actual conflict.	Melanie Jenkins	15/12/2021	2015/16 & before,2016/17,2017/18,2018/19,2019/20,2020/21,2021/22,2022/23
Jenkins, Dr Richard	0592 - Chief Executive	0592 - Chief Executive	Chief Executive	Chief Executive	Nil Declaration	Nil Declaration			21/12/2021	2020/21
Jenkins, Dr Richard	0592 - Chief Executive	0592 - Chief Executive	Chief Executive	Chief Executive	Nil Declaration	Nil Declaration			18/02/2022	2021/22
Jenkins, Dr Richard	0592 - Chief Executive	0592 - Chief Executive	Chief Executive	Chief Executive	No Change to existing declarations	No Change to existing declarations			31/03/2022	2021/22
Jenkins, Dr Richard	0592 - Chief Executive	0592 - Chief Executive	Chief Executive	Chief Executive	No Change to existing declarations	No Change to existing declarations			13/06/2022	2022/23
Jenkins, Dr Richard	0592 - Chief Executive	0592 - Chief Executive	Chief Executive	Chief Executive	Loyalty Interests	Loyalty Interests	Member of the labour party since November 2022	Labour Party	31/03/2023	2022/23
Jenkins, Dr Richard	0592 - Chief Executive	0592 - Chief Executive	Chief Executive	Chief Executive	Outside Employment	Outside Employment	I occasionally undertake CQC inspections of NHS Trusts as a Well Led Advisor. This is not remunerated although accommodation and expenses are covered.	Care Quality Commission	16/02/2024	2023/24
Parkes, Ms Emma	0601 - Director of Marketing and Communication	0601 - Director of Marketing and Communication	Director of Marketing and Communication	Director of Marketing and Communication	Nil Declaration	Nil Declaration			30/04/2024	2024/25
Parkes, Ms Emma	0601 - Director of Marketing and Communication	0601 - Director of Marketing and Communication	Director of Marketing and Communication	Director of Marketing and Communication	Outside Employment	Outside Employment	Joint Director role for Barnsley Hospital NHS Foundation Trust and The Rotherham NHS Trust. This is a non-voting director role.	The Rotherham NHS Foundation Trust	01/05/2024	2024/25
Rawlinson, Mr. James	165 Director of Health Informatics L5	165 Director of Health Informatics L5	Chief Information Officer	Chief Information Officer	I have no interests to declare				22/08/2023	22/08/2023
Rawlinson, Mr. James	166 Director of Health Informatics L5	166 Director of Health Informatics L5	Chief Information Officer	Chief Information Officer	I have no interests to declare				04/09/2020	04/09/2020
Roberts, Mrs. Jodie Leigh	165 Corporate L3	165 Corporate L3	Deputy Chief Operating Officer	Deputy Chief Operating Officer	I have no interests to declare				27/12/2024	27/12/2025
Roberts, Mrs. Jodie Leigh	165 Corporate L3	165 Corporate L3	Deputy Chief Operating Officer	Deputy Chief Operating Officer	I have no interests to declare				25/06/2024	25/06/2025
Roberts, Mrs. Jodie Leigh	165 Corporate L3	165 Corporate L3	Deputy Chief Operating Officer	Deputy Chief Operating Officer	I have no interests to declare				05/07/2022	00/01/1900

Board Planner

Event/Issue

Action	TRUST BOARD MEETINGS		2025								2026	
			Jan	March		May	June	July	Sept	Nov	Jan	March
			9	7		2		4	5	7	9	6
			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					●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		●		● Annual report		●		●		●
	Gender Pay Gap Report and Action Plan	DoW		●								●
	Integrated EDI Plan - WRES, WDES, PSED	DoW							●			
	Patient Experience and Inclusion Annual Report	CN						●				
	End of Life Annual Report	DCN						●				
	PERFORMANCE											
	Integrated Performance Report:	COO	●	●		●		●	●	●	●	●
	Maternity including Ockenden	CN	●	●		●		●	●	●	●	●
	Safe Staffing & Establishment Nurse review (6 monthly)	CN	●					●			●	
	Safe Staffing & Establishment Nurse review	CN		●								
	Reports from Board Assurance Committees	NEDs	●	●		●		●	●	●	●	●
	Finance Report	DoF	●	●		●		●	●	●	●	●
	Car Parking Review (via ETM)	DOE				●		●				
	Summary of review on Laboratory safety prior to TUPE of staff	MD		●								
	ASSURANCE FRAMEWORK											
	Governance Report	DoCA	●	●		●		●			●	●
	Board Assurance Framework	DoCA	●	●		●		●	●	●	●	●
	Quarterly Risk Management Report	DoCA		●		●			●		●	
	Corporate Risk Register	DoCA	●	●		●		●	●	●	●	●
	Annual Review of risk appetite	DoCA						●	●			
	Assurance Board Committee ToRs - Audit & Risk Committee	DoCA								●		
	Assurance Board Committee ToRs - FPC, QC, PC	DoCA		●								
	Health and Safety Annual Report	DoE									●	
	Quality Assurance Quarterly Report	CN		●		●			●	●		●

	SIRO Annual Report	DCEO						●dfd	●			
	Safeguarding Annual Report	CN							●			
	Infected Blood Inquiry	MD							● dfd			
	Organ Donation Annual Report	HC						●				
	POLICIES											
	Health and Safety Policy (review date August 2026)	DoE										
	Freedom to Speak Up Policy (Updated when National Policy available)	CN										
	Management of Complaints and Concerns Policy (review due 2025)	CN										
	Procurement Policy (due for renewal February 2026)	DoF										
	Risk Management Policy (due April 2026)	DoCA										
	REGULATORY AND STATUTORY REPORTING											
	Annual Report and Audited Accounts	DoF					●					
	Audit & Risk Committee Annual Report	Com Chair					●					
	People & Culture Committee Annual Report	Com Chair					●					
	Finance and Performance Committee Annual Report	Com Chair					●					
	Quality Committee Annual Report	Com Chair					●					
	Nomination and Remuneration Committee Annual Report	Com Chair					●					
	Annual Quality Account (approval)	CN					●					
	Data Security and Protection Toolkit Recommendation Report	SIRO						●dfd	●			
	Quarterly Report from the Responsible Officer Report (Validation)	MD	●			●			●		●	
	ANNUAL Responsible Officer report (Validation)	MD							●			
	Quarterly Report from the Guardian of Safe Working	MD	Q4 ●			●			Q2 ●	Q3 ●		
	ANNUAL Report from the Guardian of Safe Working	MD				●					●	
	Learning from Deaths Quarterly Report	MD		●		●		●		●		●
	Learning from Deaths Annual Report	MD							●			
	Emergency preparedness, resilience and response (EPRR) assurance process sign off/Annual Report	COO						●				
	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	RS		SH
	NED Review of complaints files (Quarterly)		KM			JB		HW		MT	New NED		
	CORPORATE TRUSTEE (AD HOC)												
	Approved Minutes (Oct 23, Jan, 24, Mar 24 plus confidential)							•					
	Chair's Logs (Oct 23, Jan 24, Mar 24, May 24)							•					
	Terms of Reference							•					
	Summary of Performance Against Objectives							•					
	Objectives to f24/25							•					
	Financial plan and budget 24/25							•					
	Cancer Appeal							•					
	Legacy Giving							•					
	Annual CFC Report							•					