The Trust’s Constitution states that:

31.1 Meetings of the Board of Directors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons.

In view of the current coronavirus pandemic and governmental advice, the Board of Directors has taken the decision that members of the public are excluded from this meeting for special reasons, i.e. governmental advice re social distancing.

However, should members of the public have any questions relating to the items on the agenda, please forward these to dawn.stewart4@nhs.net by 1pm on Thursday 04 March 2021.

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**Procedural Items**

|      | P38/21   | Enc. 3 | For decision | Martin Havenhand, Chairman |
|      |          |        |              |                              |
|      | P39/21   | Verbal | For assurance | Martin Havenhand, Chairman |
|      |          |        |              |                              |
|      | P40/21   | Enc. 18 | For assurance | Martin Havenhand, Chairman |
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**Strategy and Strategic Planning**

<p>|      | P41/21   | Enc. 20 | For decision &amp; information | Martin Havenhand, Chairman |
|      |          |        |                            |                              |
|      | P42/21   | Enc. 27 | For information            | Dr Richard Jenkins, Chief Executive |
|      |          |        |                            |                              |
|      | P43/21   | Enc. 44 | For information            | Michael Wright, Deputy Chief Executive |
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|      | P44/21   | Enc. 48 | For decision              | Michael Wright, Deputy Chief Executive |
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In accordance with §152(4) of the Health and Social Care Act, 2012, a copy of this agenda has been provided to Governors prior to the Board Meeting.
MINUTES OF THE PUBLIC BOARD OF DIRECTORS MEETING HELD VIRTUALLY ON TUESDAY 2 FEBRUARY 2021

Present:  
Mr M Havenhand, Chairman  
Miss N Bancroft, Non-Executive Director  
Mr J Barnes, Non-Executive Director  
Mr G Briggs, Chief Operating Officer  
Mrs H Craven, Non-Executive Director  
Mr S Diggles, Interim Director of Finance  
Mr M Edgell, Non-Executive Director  
Dr C Gardner, Executive Medical Director  
Ms L Hagger, Non-Executive Director  
Dr R Jenkins, Interim Chief Executive  
Mr S Ned, Director of Workforce  
Dr R Shah, Non-Executive Director  
Mr M Smith, Non-Executive Director  
Ms A Wood, Chief Nurse  
Mr M Wright, Deputy Chief Executive

In attendance:  
Ms K Barnfield, Continence Service Lead (minute P04/21)  
Mr A Bennett, Lead Freedom to Speak up Guardian (minute P28/21)  
Ms J Dentith, Corporate Governance Consultant  
Mr I Hinitt, Director of Estates and Facilities  
Mrs S Kilgariff, Deputy Chief Operating Officer  
Mr J Rawlinson, Director of Health Informatics  
Miss D Stewart, Corporate Governance Manager (minutes)  
Mrs L Tuckett, Director of Strategy Planning and Performance

Apologies:  
Ms E Parkes, Director of Communications

P01/21  
CHAIRMAN’S WELCOME AND APOLOGIES FOR ABSENCE

The Chairman welcomed all present with the meeting being streamed live.

P02/21  
QUORACY CHECK

The meeting was confirmed to be quorate.

P03/21  
DECLARATIONS OF CONFLICTS OF INTERESTS

Dr Jenkins’ interest in terms of his joint role as Interim Chief Executive of the Trust and substantive Chief Executive of Barnsley Hospital NHS Foundation Trust, was noted.

Mr Ned’s interest, in terms of his joint role as Director of Workforce of both the Trust and Barnsley Hospital NHS Foundation Trust, was noted.
Colleagues were asked that, should any further conflicts of interest become apparent during discussions, they were highlighted.

**P04/21 PATIENT & STAFF STORY**

The Board of Directors welcomed to the meeting Kristy Barnfield, Continence Service Lead, to present a story which covered both staff and patients perspectives.

The Board was informed that prior to the pandemic the service had not been able to undertake electronic prescribing for continence appliance items required by their client group. At the start of the pandemic and as a consequence of more home working, following discussion with NHS England / Improvement Ms Barnfield had persuaded the regulator to agree to a pilot in this area.

Rotherham Clinical Commissioning Group had been supportive during the pilot which had resulted in increased effectiveness and efficiency for staff and the service, with significant improvements for patients who no longer were delayed in receiving their prescription.

This service model for electronic prescribing of appliance items had now been adopted across the whole Rotherham community and nationally. Ms Barnfield had also published an article on the matter for NHS England.

The Board of Directors congratulated Ms Barnfield on her personal achievement and that of the service improvements being seen for both staff, but most importantly, for improved patient care.

**PROCEDURAL ITEMS**

**P05/21 MINUTES OF THE PREVIOUS MEETING**

The minutes of the previous meeting held on 1 December 2020 were agreed as a correct record subject to the minor typographic amendment, and the following amendment:

Report from the Chief Executive (minute 424/20, third paragraph)

The roll out of the twice-weekly lateral flow testing for staff had commenced. Although its efficacy remained under debate, it would prove a useful tool in managing staff absence, as anyone testing positive would receive a confirmatory polymerase chain reaction (PCR) test. The aim was to stop asymptomatic transmission, and support staff to be at work.

**P06/21 MATTERS ARISING FROM THE PREVIOUS MEETING**

There were no matters arising from the previous meeting not covered by the action log or items for discussion.
P07/21  **ACTION LOG**

The Board of Directors reviewed the action log and agreed that log numbers 62, 65, 74 to 82 be closed. There were no open actions.

**STRATEGY AND STRATEGIC PLANNING**

P08/21  **REPORT FROM THE CHAIRMAN**

The Board of Directors received the Chairman’s Report.

In noting the list of regulatory and statutory roles, appended to the report, it was suggested that the Non-Executive Director chair role of the Board Assurance Committees be added to future lists.

**ACTION – Corporate Governance Consultant**

The Board of Directors noted the Chairman’s Report.

P09/21  **REPORT FROM THE CHIEF EXECUTIVE**

The Board of Directors received the report from the Interim Chief Executive.

Also appended to the report were two reports from South Yorkshire and Bassetlaw Integrated Care System (ICS) which provided updates from across the ICS.

It was noted that the Trust would be participating in the pilot of the NHS 111 first initiative. This pilot would ensure that when patients call NHS 111 they would be signposted to the most appropriate service, including as necessary urgent care where an appointment would be pre-booked. Mr Briggs confirmed that the results from the pilot would be reported to the relevant board assurance committee in due course.

**ACTION – Chief Operating Officer**

In response to a question from Mr Edgell relating to health inequalities, Dr Jenkins indicated that there was undoubtedly a willingness within the ICS to improve health inequalities. However, it was difficult for the issue to be tackled at a regional level with the expectation being that progress would be made across each PLACE through collaborative working.

Ms Hagger commented that there appeared to be a lack of acknowledgment by the ICS of the requirement for a staff recovery plan to maintain health and wellbeing and the intrinsic link to equality and diversity. Whilst the requirement was recognised at a national level, there was little guidance being offered. As such a people recovery plan would need to be integral for the Board moving forward with representations being made at a regional level.

Dr Jenkins agreed with the comments and stated that it should be for the Trust to take the lead on development of plans in relation to its own workforce, as although the ICS recognised the issues they would not provide any steer. He confirmed that the Executive Team had been discussing the matter to enable progress in this area.
In terms of the additional monies being made available from the centre detailed within the appendices, Dr Jenkins indicated that allocations would be identified against bids made by individual organisations with the focus being on matters which would support recovery.

In noting the awards and recognitions section in one of the appendices from the ICS, Mr Ned commented that the Trust should consider how it could promote more widely the Trust’s achievements.

**ACTION - Director of Workforce**

The Board of Directors noted the report from the Interim Chief Executive.

**P10/21 NATIONAL, INTEGRATED CARE SYSTEM AND INTEGRATED CARE PARTNERSHIP REPORT**

The Board of Directors received the National, Integrated Care System (ICS) and Integrated Care Partnership (Place) Report presented by the Deputy Chief Executive.

Mr Wright reported continued significant progress with regard to COVID-19 vaccination rates across the South Yorkshire and Bassetlaw ICS and the Rotherham Place. The expectation remained that local targets would be achieved.

Following a national survey undertaken by Healthwatch England and the British Red Cross during the first wave of the pandemic, Healthwatch Rotherham had completed a local survey on effective discharge. Whilst the results had identified areas of good practice, it also provided opportunities for improvement. The Trust’s Patient Experience Team were utilising the information received to improve the patient experience and remained in dialogue with Healthwatch Rotherham.

In noting that work had commenced in Rotherham Place on prevention and health inequalities, the Board indicated that there should also be clear understanding of the drivers for health inequalities and robust improvement plans. In acknowledging that the new Director of Public Health had given a commitment to work in collaboration with partners, Dr Jenkins was requested to consider the part to be played by the Trust, both within the Place and the ICS in terms of health inequalities. **ACTION – Chief Executive**

Mr Wright agreed to feedback concerns that the RotherHive search engines were inhibiting access to this valuable service which provided a range of verified and practical mental health and wellbeing information, support and advice for adults in Rotherham. **ACTION – Deputy Chief Executive**

The Board of Directors noted the update report.

**P11/21 FREEDOM TO SPEAK UP STRATEGY**

The Board of Directors received the Freedom to Speak Up Strategy (2021 to 2023), presented by the Chief Nurse as Executive lead for Freedom to Speak Up.
Ms Wood reported that this was the Trust’s first Freedom to Speak Up Strategy, which was now a new requirement to enable specific questions in the National Guardians Office self-review tool to be answered.

It was confirmed that the Strategy had been developed in consultation with colleagues and staff side representatives. Prior to the Board it had been formally considered by the People Committee and the Audit Committee. The latter requesting explicit reference to fraud matters raised via the Freedom to Speak Up route to also adhere to the fraud reporting process. Due to timing of the meetings, this was not detailed with the Strategy as presented but would be incorporated prior to dissemination across all areas of the organisation.

In terms of measuring the success of the strategy, it was considered that this would be seen through staff raising concerns directly with the Trust and the staff survey results.

The Board of Directors approved the Freedom to Speak Up Strategy 2021 to 2023 subject to including explicit reference to fraud matters.

**OPERATIONAL**

**P12/20 COVID-19 REPORT**

The Board of Directors received the monthly COVID-19 report presented by the Chief Operating Officer.

Mr Briggs highlighted sections of the comprehensive report which provided detail in terms of arrangements for COVID 19 patients, the local and regional position, activity and waiting list data including cancer, staff sickness and wellbeing, and elements of the recovery plan, including the use of the independent sector.

In terms of utilisation of the independent sector to support ongoing activity and recovery, Dr Gardner reminded the Board that in many instances the independent sector was staffed by those medical colleagues who also worked within the NHS and who were now showing signs of fatigue. The same was also true when considering additional internal waiting lists initiatives which in this case would encompass the organisations nursing workforce.

Mrs Craven confirmed that both use of the independent sector and additional in-house activities formed the basis of the recovery plan, so it would be important to include staffing as part of the discussions and development of the recovery trajectories.

A further factor as highlighted by Ms Hagger was that the pandemic may result in staff re-evaluating their work life balance, and would welcome development of a people recovery plan.

The Board of Directors noted the COVID-19 report and expressed their continued appreciation to all staff for ensuring the organisation operated within the limitations of the pandemic.
The Board of Directors received the Integrated Performance Report (IPR), presented by the Deputy Chief Executive.

Mr Wright indicated that there were four specific areas which had been escalated, with further detail of the position and actions being taken documented within the report. The four areas were:

- Mortality index
- Care hours per patient day
- 62 day performance
- Vacancy rate - nursing

Dr Shah considered that there was insufficient workforce data relating to the medical workforce which would enable triangulation of the position at ward level with other staff groups. Mrs Tuckett confirmed that medical workforce data was presented to the People Committee, whilst there were complexities which would need to be overcome to support simplified reporting within the IPR, once this was resolved such information could be included in future reports. Dr Jenkins indicated that the Executive Team would consider how the Board would be best sighted on the complex matters of the medical workforce and would recommend how this data would be presented.

**ACTION – Chief Executive**

Complaints data relating to the pandemic was detailed within the report, with Miss Bancroft seeking information as to specific actions taken from the matters raised. Ms Wood confirmed that the main themes identified were similar to those from the Healthwatch Rotherham survey, and were around communication and discharge, with both matters being addressed.

Dr Gardner added that all complaints relating to the medical and dental workforce would form part of the appraisals process as part of reflective learning.

Dr Jenkins took the opportunity to highlight the improvement in venous thromboembolism (VTE) assessment rates, a matter previously discussed by the Board. Dr Gardner confirmed that the matter was being specifically monitored by the Clinical Governance Committee and Quality Committee.

The Board additionally noted the rise in re-admission rates coinciding with the pandemic, the rise in incidents, the potential increase in first to follow up rates, and sustained improvement in mandatory and statutory training compliance rates for the medical and dental workforce.

The Board noted the Integrated Performance Report.
P14/21 QUARTERLY REVIEW OF PROGRESS AGAINST OPERATIONAL OBJECTIVES

The Board of Directors received the quarter three report which detailed progress against the operational objectives presented by the Deputy Chief Executive.

Mr Wright confirmed that relevant Board assurance committees had considered progress against each objective and enablers prior to submission of the complete position to the Board.

Of the twenty projects, one had been closed, five were rated Green (on plan), eleven were rated Amber (behind plan with mitigation or actions in place to recover) and three were rated Red (behind plan, no mitigation or more significant action required). Mr Wright confirmed that there remained challenges of delivery of the operational plan in its entirety due to the impact of the pandemic. The next report would provide detail of those objectives which would not be delivered and those which may need to be carried forward into 2021/22.

The Board of Directors noted the report.

P15/21 QUARTERLY REVIEW OF FINANCIAL POSITION

The Board of Directors received the quarterly review of the financial position report presented by the Interim Director of Finance.

The report aimed to provide assurance regarding the financial results for the three-month period ending 31 December 2020 (Quarter 3). It additionally outlined the impact on year to date figures, together with an assessment of the forecast out-turn position for the full financial year ending 31 March 2021.

Mr Diggles reported that for the three months ending 31 December 2020 the Trust has delivered a £1,531K deficit, which was £1,474K favourable to the planned deficit position of £3,005K. It was anticipated that this positive performance would continue into quarter 4.

In terms of the capital programme, Mr Diggles reported that the aim remained to utilise the allocation in year, including the additional national funding received, by the end of the financial year.

The Board of Directors noted the quarterly review of the financial position.

P16/21 DIGITAL STRATEGY AND DATA QUALITY REPORT

The Board of Directors received the quarterly digital strategy and data quality report presented by the Director of Health Informatics.

Mr Rawlinson indicated that the report demonstrated progress in a number of areas including the clinical backbone, the Rotherham Health App, infrastructure and the digital aspirant programme.
In terms of coding, Dr Jenkins commented that whilst freeze targets were being met, linked to other areas of the agenda, further improvement continued to be required in other aspects of coding. Mr Rawlinson reported that a business case for additional resources was being considered to reduce reliance upon agency workers. It was anticipated that improvements, such as depth of coding, would be seen once the team was established.

The Board of Directors noted for assurance the quarterly report against the digital strategy.

ASSURANCE FRAMEWORK

The Chair of each Board Assurance Committee provided a brief update on key matters to support their written reports.

i. People Committee
Ms Hagger highlighted the key areas from the report following the meeting held on 22 January 2021.

The Committee had received a divisional presentation from the Director of Estates and Facilities. It was noted that the lack of a mature clear clinical strategy was hindering the development of the Estates strategy. As this was not within the remit of the People Committee it had not been further discussed; however Ms Hagger did not want the point to be overlooked by the Board.

Dr Jenkins confirmed that over the next six months the Trust would be reviewing its long term strategy which would include the clinical strategy and the estate strategy, both of which were intrinsically linked.

Mr Ned reported that the Executive Team would be considering the recruitment of individuals from diverse backgrounds as part of the model employer work and would be reporting to the People Committee in due course.

It was noted that information contained within the report relating to the Staff Survey was currently embargoed and would be removed from the meeting papers available on the website. A further section would also be removed relating to exclusions.

ACTION – Corporate Governance Consultant

ii. Finance and Performance Committee
Miss Bancroft highlighted key areas from the report following the meeting held on 27 January 2021. These included the current positive financial position, the forecast outturn and key sensitivities and mitigation for the remainder of the financial year.

The Committee continued to monitor the recovery plan and would at its next meeting triangulate the position against the People Plan and Financial Plan. Further consideration would also be given to the operational objectives for 2021/22.
iii. Quality Committee
Dr Shah took the opportunity to verbally highlight areas of discussion from the meeting held on 27 January 2021. These included the Board Assurance Framework, Quality Improvement priorities, Friends and Family Test, NICE compliance, COVID-19, the Care Quality Commission and the Safe and Sound Quality scorecard.

P18/21 CARE QUALITY COMMISSION REPORT

The Board of Directors received and noted for assurance the Care Quality Commission (CQC) report.

Ms Wood confirmed that the matters detailed within the report had been considered by both the CQC Delivery Group and the Quality Committee.

P19/21 GOVERNANCE REPORT

The Board of Directors received, for information, the monthly Governance Report presented by the Corporate Governance Consultant.

Detailed within the report was the white paper and consultation on reforming the Mental Health Act 1983. Mr Smith commented that the proposed changes to the Act did not solely relate to mental health trusts, and it would be appropriate for the Trust to respond to the Consultation. Additionally, he suggested that it would be helpful for the Board to be cognisant of the number of Section 5(2) arrangements enacted for the Trust’s service users.

**ACTION – Chief Nurse**

Dr Gardner confirmed that the Patient Safety Commissioner ‘First do no harm’ report, had been discussed by the Clinical Governance Committee and Medical Devices Safety Group.

The Board of Directors noted the Governance Report.

P20/21 ASSURANCE COMMITTEE TERMS OF REFERENCE

This item was withdrawn and would be considered at the March 2021 meeting.

P21/21 BOARD ASSURANCE FRAMEWORK

The Board of Directors received the quarterly Board Assurance Framework (BAF) report presented by the Corporate Governance Consultant.

Ms Dentith confirmed that each board assurance committee had considered the BAF risks assigned to their committee, with a deep dive having been undertaken at the Quality Committee and Audit Committee. The latter had also been presented with the full BAF as recommended by the Internal Auditors.

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1 Section 5(2) is a temporary hold of an informal or voluntary service user on a mental health ward in order for an assessment to be arranged under the Mental Health Act 1983
The recommendations from each committee and the context to support any changes were detailed within the report.

In addition, the Board of Directors had two specific BAF risks, B11 and B12, which it monitored, with the following being approved as recommended within the report:

**B11:** Misaligned governance and decision-making may arise from divergent Trust and Integrated Care System interests and objectives - risk score to remain unchanged 3 (L) x 4 (C) = 12

**B12:** Ineffective relationships with key partners may lead to a lack of integrated working and poor service configuration across the Rotherham Place – risk score to remain unchanged 2 (L) x 4 (C) = 8

Returning to consideration of BAF risks B1 – B10, Mr Barnes as Chair of the Audit Committee, indicated that in receiving the full BAF, the Committee’s role was to ensure due process was followed and was not to comment on the decisions made by other Committees. It was further noted that at the recent Audit Committee meeting the Internal Auditors had indicated that they considered the BAF process to be effective.

Dr Jenkins questioned the overly pessimistic view with regard to B7 (Insufficiently robust Trust-wide quality and clinical governance arrangements impede the delivery of a number of Trust plans / objectives) and B8 (There is a risk that the delivery of a number of (non-clinical / quality focussed) Trust plans / objectives may be at risk due to there being insufficiently robust governance arrangements in place across the Trust e.g. financial governance arrangements). Both were scored 4(L) x 5(C) = 20, with B7 being recommended by the Quality Committee to be increased from 3(L) x 5(C) = 15.

In terms of B7, the reasons for the proposed increased score as defined by the Quality Committee related to the new Community Division. Dr Jenkins commented that previously this service had been within the Division of Medicine and questioned why separating into a new division warranted an increase in the likelihood score. In addition, Mr Wright commented that not delivering objectives would more than likely be as a result of the pandemic and would not be linked to governance matters.

It was agreed that a further report would be submitted to the next meeting giving the rationale as to the proposed increase in score for BAF risk B7 and detail relating to B8, which was the other governance BAF risk similarly scored (4(L) x 5(C) = 20).

**ACTION – Corporate Governance Consultant**

In conclusion, the Board of Directors approved the risk scores for B11 and B12 and the recommendations from the Board Assurance Committees with the exception of B7 which would be brought back to the Board for consideration in March 2021.
The Board of Directors received, for information, the quarterly Risk Management Report presented by the Chief Nurse.

Ms Wood confirmed that each Board assurance committee had received and considered their assigned risks prior to submission of the full report to the Board of Directors. It was planned that for future meetings further information would be provided in the reporting framework to give additional assurance on management of the risks.

It was reported that an Internal Audit review of Clinical Service Unit Risk Management, with the recommendations having been implemented.

The Board of Directors noted the report.

**P23/21 OCKENDEN REVIEW AND MATERNITY CNST UPDATE**

The Board of Directors received the report from the Chief Nurse which provided detail with regard to the Ockenden Report and an update on the Clinical Negligence Scheme for Trusts (CNST).

Ms Wood confirmed that the report, which had been considered in detail at the 13 January 2021 Board Seminar in order to achieve the original submission deadline, was unchanged from the version previously seen by the Board.

As identified within the Ockenden Report a Non-Executive Director Lead for Maternity Services had been identified and would be Ms Hagger who confirmed that she had attended her first meeting with the Chief Nurse.

The Board of Directors approved the Assurance Assessment Tool and noted the CNST update. Both would be submitted to the Local Maternity System and regional teams by the revised deadline of 15 February 2021.

**POLICIES**

**P24/21 PROCUREMENT POLICY**

The Board of Directors received the revised Procurement Policy presented by the Interim Director of Finance.

The policy had been subject to minor amendments in relation to EU public procurement thresholds, and additional wording in relation to the standards of business conduct.

The Board of Directors welcomed the statements within the policy with regard to supporting regional and local economies and businesses to maximise the potential for skills training, apprenticeships and job creation within Rotherham.

It was noted that upon completion of the review of the Standing Financial Instructions it may be necessary to revisit the Procurement Policy to ensure both documents were in alignment.

The Finance and Performance Committee having reviewed the policy prior to the Board, would recommend it be approved.
The Board of Directors approved the revised Procurement Policy.

REGULATORY AND STATUTORY REPORTING

P25/21 QUARTERLY REPORT FROM RESPONSIBLE OFFICER

The Board of Directors received, for information, the quarterly report from the Responsible Officer as presented by the Executive Medical Director.

Dr Gardner reported that although nationally activities in this area had been suspended due to the pandemic, the Trust had, where feasible, continued the programme. As at the end of December 2020, 79.7% of appraisals had been completed and it was anticipated that by the end of March 100% would be achieved.

The Board of Directors noted the quarterly Responsible Officer Report.

P26/21 QUARTERLY REPORT FROM GUARDIAN OF SAFE WORKING

The Board of Directors received, for information, the quarterly report from the Guardian of Safe Working, presented by the Executive Medical Director.

Dr Gardner took the opportunity to highlight the decrease in working conditions for junior doctors particularly those within medicine, evidenced in the qualitative examples, as a consequence of the significant pressures being experienced during the pandemic. The report also detailed the actions being undertaken to resolve the issues identified.

In noting the report the Board of Directors placed on record their appreciation to the junior doctors for their continued contributions during this challenging period.

P27/21 MONTHLY MORTALITY AND LEARNING FROM DEATHS REPORT

The Board of Directors received the monthly mortality and learning from deaths report, which had replaced the quarterly learning from deaths report.

The report covered quality of care, coding and case-mix, in addition to a number of appendices which included the mortality improvement plan.

When asked by Mr Edgell as to whether there were any key interventions which would reduce mortality rates, Dr Gardner indicated that it would be a combination of actions across a range of areas.

The Board of Directors noted the Mortality and Learning from Deaths report.

P28/21 QUARTERLY FREEDOM TO SPEAK UP GUARDIAN REPORT

Due to the timed attendance of the Lead Freedom to Speak up Guardian, this item was considered after the Board Assurance Framework.

The Board of Directors welcomed to the meeting the Lead Freedom to Speak up Guardian to present his quarterly report.
Mr Bennett reported that during quarter three there had been eleven concerns raised through the process which, compared to the same quarter in 2019/20, was a decrease in number. Of the concerns raised, six had been from one service and had been of a similar theme. As a result, a listening event had been held with the team, with some positive outcomes.

Further listening events had been held in Children’s Services and Pharmacy, with no issues raised which required drawing to the Board’s attention. The Board welcomed the fact that the listening events were being positively seen by the organisation and were proving to be effective.

Implementation of the second e-learning module, aimed at managers, relating to freedom to speak up was under consideration for later in 2021. The Trust having already successfully implemented one module for all staff as part of the mandatory and statutory training programme.

The Board of Directors noted the quarterly Freedom to Speak Up Report and thanked Mr Bennett and the team of guardians for their continued work in this important area of engagement within the organisation.

**P29/21 ANNUAL PUBLIC SECTOR EQUALITY DUTY REPORT**

The Board of Directors received, for information, the annual public sector equality duty report as required under the Public Sector Equality Duty (which was part of the Equality Act 2010) presented by the Director of Workforce.

Mr Ned confirmed that the report had also been considered by the People Committee prior to the Board.

In noting that the equality objectives covered the period 2019 to 2023, it was suggested that any pertinent matters for consideration by the Board should be added to the Board’s forward planner. **ACTION – Director of Workforce**

**BOARD GOVERNANCE**

**P30/21 REGISTER OF INTEREST REPORT**

The Board of Directors received and noted the bi-annual submission of the Board’s Register of Interest.

Mr Barnes commented that there was an inaccuracy in terms of his entry in the register. Mr Havenhand suggested that an updated version of the Register to be appended to the Chairman’s March report to the Board. To ensure that it accurately reflected the position, as stipulated within the report any amendments were to be communicated to the Corporate Governance Consultant by 8 February 2021. **ACTION - ALL**

**P31/21 CORPORATE CALENDAR 2021**

The Board of Directors received and noted the report which detailed the calendar of corporate meetings for 2021.
P32/21 ANY OTHER BUSINESS

There were no items of any other business.

P33/21 DATE OF NEXT MEETING

The next meeting of the Board of Directors would be held on Friday 5 March 2021, commencing at 9am.

At this point in the meeting a question had been posed by a member of the public prior to the meeting, which was as follows:

What is the situation at the moment with elective surgeries?

I know that many trusts have had to pause elective surgery, obviously creating longer waiting lists, can you tell me please are you reviewing current pathways and procedures to see if there are alternative option that can be adopted to allow for day surgeries rather than longer procedures? Any examples?

Following the meeting the response below from Dr Gardner, Executive Medical Director, was forwarded to the member of the public:

Unfortunately, it is true that the pandemic has significantly affected our ability to provide the elective care that we would wish to for our patients, but I can assure the public of Rotherham that as a Trust we are doing everything possible to get people in for their operations as soon as possible.

All elective pathways have been reviewed and validated in line with the national programme requirements and prioritised based on clinical urgency against a matrix agreed by all the surgical speciality associations. Within this, all urgent cases (classed as either Priority 1 or 2, following strict national criteria) that should be completed within 4 weeks of listing are prioritised within the Trust and to date we have been able to meet these time frames in virtually every case. In addition, wherever possible, we have fully utilised our operating lists by filling in with less clinically urgent cases. This clinical validation process also allows the clinicians to review if alternative procedures could be used and discussed with the patients.

When there is an issue meeting the required clinical timeframe, a region-wide process of ‘mutual aid’ has been established, in which cases can be transferred to other providers to expedite surgery. This has been used only for two The Rotherham NHS Foundation Trust (TRFT) patients, who will be having their surgery in Doncaster shortly.

The Trust has fully engaged with the Independent Sector and have performed over 1,000 operations there, and those plans will continue for the next few months.

The Trust has one of the most progressive day case units in the country and a number of cases that wouldn’t ordinarily be ‘day cases’ have been done through bespoke arrangements – this needs careful clinical and anaesthetic assessment but has been successful. Our Day Case lead is the current President of the British Association of Day Surgery and has championed this tailoring of anaesthetic to urgent clinical need. Finally, due to the COVID pressure on critical care capacity, some cases have had to be deferred until high dependency beds have been available – alternatively, bespoke strategies have
been employed, such as starting the case early and providing an extended stay in recovery to minimise the chances of needing HDU. These too have been successful.

Martin Havenhand
Chairman
date
<table>
<thead>
<tr>
<th>Log No</th>
<th>Meeting</th>
<th>Report/Agenda title</th>
<th>Minute Ref</th>
<th>Agenda item and Action</th>
<th>Lead Officer</th>
<th>Timescale/Deadline</th>
<th>Comment/Feedback from Lead Officer(s)</th>
<th>Open /Close</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>02-Feb-21</td>
<td>Chairs Report</td>
<td>P08/21</td>
<td>NED chairs of Board assurance committees to be added to list of regulatory and statutory roles</td>
<td>CGC</td>
<td></td>
<td>This will be actioned 01.04.21 when new NED / Associate NED take up post.</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>2</td>
<td>02-Feb-21</td>
<td>CEO Report</td>
<td>P09/21</td>
<td>Results from 111 pilot to be submitted to relevant assurance committee</td>
<td>COO</td>
<td></td>
<td>The 111 pilot and the Urgent emergency care standards pilot results and outcomes will be on QC and FPC agenda when the national team release the results, this is a must as we cannot change monitoring and reporting new standards until it is approved. Notified to Committee Secretary to add to work plans</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>3</td>
<td>02-Feb-21</td>
<td>CEO Report</td>
<td>P09/21</td>
<td>The Trust should consider how it could promote more widely the Trust’s achievements.</td>
<td>DoW</td>
<td></td>
<td>The Director of Workforce has discussed this matter with the Interim Director of Communications. The Interim Director of Communications and the Communications team will produce an ‘awards calendar’ to ensure that the Trust can put forward nominations for relevant awards.</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>4</td>
<td>02-Feb-21</td>
<td>ICS/Place</td>
<td>P10/21</td>
<td>To consider the part to be played by the Trust, both within the Place and the ICS in terms of health inequalities</td>
<td>ICEO</td>
<td></td>
<td>ICS considering how to progress in this area. Under consideration in Rotherham Place discussions. Recommend TRFT considers its role as part of the forthcoming strategy reviews.</td>
<td>Open</td>
</tr>
<tr>
<td>5</td>
<td>02-Feb-21</td>
<td>ICS/Place</td>
<td>P10/21</td>
<td>To feedback search engine functionality for RotherhamHive</td>
<td>DCEO</td>
<td></td>
<td>Comments communicated to Rotherham Clinical Commissioning Group</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>6</td>
<td>02-Feb-21</td>
<td>IPR</td>
<td>P13/21</td>
<td>Executive Team would consider how the Board would be best sighted on the complex matters of the medical workforce and would recommend how this data would be presented</td>
<td>ICEO</td>
<td></td>
<td>CEO and Medical Director have considered how best to provide assurance on medical workforce matters and propose a quarterly report is produced or 4-monthly report is produced for People Committee and Board. Added to work plans</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>7</td>
<td>02-Feb-21</td>
<td>Chairs Log - People Committee</td>
<td>P17/21</td>
<td>To remove embargoed items from report on website</td>
<td>CGC</td>
<td></td>
<td>Actioned</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>8</td>
<td>02-Feb-21</td>
<td>Governance Report</td>
<td>P19/21</td>
<td>Trust to respond to the Consultation on the Mental Health Act and provide for the Board the number of Section 5(2) arrangements enacted for the Trust’s service users.</td>
<td>CN</td>
<td></td>
<td>We will be commenting on the consultation, and the Chief Nurse is identifying how many Section 5(2) we have issued this year.</td>
<td>Open</td>
</tr>
<tr>
<td>Log No</td>
<td>Meeting</td>
<td>Report/Agenda title</td>
<td>Minute Ref</td>
<td>Agenda item and Action</td>
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<tr>
<td>9</td>
<td>02-Feb-21</td>
<td>BAF</td>
<td>P21/21</td>
<td>Further report relating to B7 and B8 for next meeting</td>
<td>CGC</td>
<td>Agenda item P51/21</td>
<td>Recommend to close</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>02-Feb-21</td>
<td>Public Sector Equality Duty Report</td>
<td>P29/21</td>
<td>Equality objectives covered the period 2019 to 2023 - any pertinent matters for consideration by the Board to be added to the Board’s forward planner.</td>
<td>DoW</td>
<td>Position to be reviewed in six months. Added to Board work plan for August 2021</td>
<td>Recommend to close</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>02-Feb-21</td>
<td>Register of Interest</td>
<td>P30/21</td>
<td>Any amendments to register to be communicated to CGC with updated version to be appended to next Chairs report</td>
<td>All</td>
<td>Register of Interest appended to Chairs Report P41/21</td>
<td>Recommend to close</td>
<td></td>
</tr>
</tbody>
</table>
### Board of Directors’ Meeting
05 March 2020

<table>
<thead>
<tr>
<th>Agenda item</th>
<th>P41/21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report</td>
<td>Chairman’s Report</td>
</tr>
<tr>
<td>Executive Lead</td>
<td>Presenter: Martin Havenhand, Chairman</td>
</tr>
</tbody>
</table>

#### Link with the BAF
The Chairman’s report reflects various elements of the BAF

#### How does this paper support Trust Values
This report supports the core values of Ambitious and Together through the various updates included relating to improving corporate governance and working collaboratively with key partners

<table>
<thead>
<tr>
<th>Purpose</th>
<th>For decision ☒</th>
<th>For assurance ☐</th>
<th>For information ☒</th>
</tr>
</thead>
</table>

#### Executive Summary (including reason for the report, background, key issues and risks)
- Appointment of Vice Chair
- Remuneration Committee Chair
- Board Seminar 10 February 2021
- Council of Governors meeting 10 February 2021
- Freedom to Speak Up meeting 5 February 2021
- Non-Executive Director terms of office
- MPs Briefing 12 February 2021
- The report includes information from Non-Executive Director colleagues about activity in respect of their lead roles
- The updated register of Interest for Board members is appended to this document

#### Due Diligence
This report has not been received elsewhere prior to its presentation to the Board of Directors

#### Board powers to make this decision
The Trust’s Matters Reserved state that the appointment of the Vice Chair and Senior Independent Director are for the Board of Directors to determine (with the Council of Governors approval in the case of the SID)

#### Who, What and When
Actions required will be led by the relevant Executive or Non-Executive Director

#### Recommendations
It is recommended that: the Board of Directors notes this report and approves:
- The confirmation of appointment of the Trust’s Vice Chair (2.1)
- New Chair of the Remuneration Committee (3.2)

#### Appendices
1. Board of Directors’ Register of Interest
1.0 Introduction

1.1 This report provides an update since the last Board Meeting on 2 February 2021.

2.0 Annual Confirmation of Appointment of Vice Chair

2.1 Lynn Hagger is the current Vice Chair and the board is asked to agree that Lynn continues in this position for a further twelve months to 31st March 2022.

3.0 Chair of Remuneration Committee

3.1 Joe Barnes is the current Chair of the Remuneration Committee, and his term of office concludes at end March 2021. It is proposed that Heather Craven becomes Chair of the Remuneration Committee from 01 April 2021.

3.2 The Board is asked to agree that Heather Craven becomes Chair of the Remuneration committee.

4.0 Board Seminar 10 February 2021

4.1 The February Board Seminar focused on the priorities for 2021/22, a review of the digital strategy including an update on the digital aspirant programme presented by the Director of Health Informatics.

5.0 Council of Governors 10 February 2021

5.1 Confirmation of Appointment of Senior Independent Director (SID): As agreed at the February 2021 Board of Directors meeting, the proposal that Lynn Hagger be appointed as Senior Independent Director for 2021/22 was presented to the Council of Governors at their meeting on 10 February 2021 and was approved.

5.2 The Chief Executive reported that the Trust was renewing our five year strategy this year and that there would be arrangements made for the Council of Governors to participate in that process. Dr Jenkins would ensure the Governors were also engaged in determining the final priorities for the 2021/22 Operational Plan.

6.0 Freedom to Speak Up (FTSU) Meeting 5 February 2021

6.1 It is a requirement that the Lead FTSU Guardian meets twice a year with the Chair and Chief Executive. On 5 February the Chair and Chief Executive met with Tony Bennett (FTSU Lead Guardian), and the Chief Nurse who is the Executive lead for freedom to speak up. Tony was thanked for the excellent work that he and his FTSU Guardian colleagues are doing.

7.0 Non-Executive Directors

7.1 Two of our Non-Executive Director colleagues will be stepping down this year: Joe Barnes on 31 March 2021 and Mark Edgell on 31 May 2021.

7.2 The Governors have gone through an appointment process and offers have been made.
8.0 MPs Briefing 12 February 2021

8.1 The Chief Executive and I met with the local MPs which provided a good opportunity to update them on COVID-19 and the vaccination programme.

9.0 Lead Non-Executive Director (Joe Barnes)

9.1 Senior Independent Director: Lynn Hagger and Joe Barnes have started the process of handover; they are having a joint meeting with the Lead Freedom to Speak Up Guardian early in March 2021.

9.2 Rotherham HealthWatch Non-Executive Director lead: Liaison with HealthWatch has been difficult following a number of changes. The advocacy service has moved to Rotherham Council, governance has been restructured from a formal Board structure to a steering group and there have been personnel changes. The Deputy Chief Executive and Deputy Chief Operating Officer have now arranged to meet HealthWatch for a quarterly review and will involve Joe’s Non-Executive Director successor in the next meeting which is scheduled for May 2021.

9.3 Surgery Division Non-Executive Director lead: A follow up meeting between the Division and Lynn Hagger as Health & Wellbeing Guardian is being arranged.

10.0 Lead Non-Executive Director (Lynn Hagger)

10.1 Health and Wellbeing Guardian: Lynn attended the NHSI/E Health and Wellbeing Conference on 28 January 2021 where the key message was that the health and wellbeing agenda should be integrated into the business of the Board and have a particular focus on a preventative approach. Follow up materials provide a basis for how the Board can ensure it is addressing its responsibilities robustly. She also observed the Equality, Diversity and Inclusion Steering Group on 4 February 2021 given this agenda is seen as inextricably linked with that of Health and Wellbeing and participated in a LGBT+ training session on 18 February 2021 which provided very useful insight into how we can improve the experiences of both patients and staff and develop our profile as an inclusive employer in our recruitment materials.

10.2 Family Division Non-Executive Director lead: Lynn attended her first Family Division meeting on 29 January 2021 as part of a handover with Dr Rumit Shah. A wide range of staff were present and provided a very useful overview of the services provided and the current challenges the Division faces as it attempts to address recovery issues.

10.3 Maternity Services Non-Executive Director lead: Lynn participated in her first Maternity and Neonatal Safety Champion’s meeting as a result of one of the Ockenden’s Report recommendations on 28 January 2021. These are scheduled to take place on a monthly basis.

10.4 Clinical Ethics Non-Executive Director lead: The first Clinical Ethics Group since August 2020 took place on 17 February 2021. The main focus of discussion related to the need for reinvigoration after it was established there is still a need for such a group despite staff finding their own means of support throughout the pandemic particularly where nursing staff are concerned.

10.5 Organ Donation Committee Chair: The Organ Donation Committee took place on 1 February 2021 and was observed by the Regional Chair, Malcolm Roberts, who is attending all meetings across Yorkshire and Humber with a view to sharing good practice at the next Regional Chair’s’ meeting. He provided feedback in a follow up call and he
was very complimentary. He thought the agenda covered all the bases, was impressed by the breadth of attendees (especially having the Medical Director and a community representative there) and was particularly impressed by the Communications Team representative. He re-iterated that having an ambassador as an attendee would be added value not least in supporting outreach work. There doesn’t appear to be one in the local area but he’s working hard to see if another Yorkshire ambassador has enough capacity to support the Trust’s Committee. He also mentioned using an enthusiastic Governor to strengthen outreach work.

10.4 Lynn also attended a webinar provided by NHS Blood and Transplant on 3 February 2021 which set out the forthcoming publicity campaign ‘Leave Them Certain’ which will focus on families having discussions about organ donation.

11.0 Lead Non-Executive Director (Heather Craven)

11.1 **Safeguarding Non-Executive Director lead:** Since the February Board meeting Heather has attended the safeguarding task and finish group; the monthly safeguarding meeting with the Chief Nurse and provided challenge to a number of safeguarding documents and safeguarding committee terms of reference.

11.2 **Recovery Non-Executive Director lead:** Heather attended the monthly recovery meeting.

11.3 **Community Division Non-Executive Director lead:** Heather also met with the Divisional General Manager.

12.0 **Register of Interest**

12.1 The updated Board of Directors’ Register of Interest is attached at Appendix 1 to this report

Martin Havenhand
Chairman
February 2021
## Register of Interests of the Board of Directors – February 2021

### Non-Executive Directors

<table>
<thead>
<tr>
<th>Name</th>
<th>Interests Declared</th>
</tr>
</thead>
</table>
| Martin Havenhand Chairman   | - Niece is Associate Operations Director of One Health  
- Member of Rotherham Together Partnership Board  
- Chair of Ambition Rotherham Board of Directors  
- Director of Corporate Trustee                                                                 |
| Joe Barnes                  | - Director of Corporate Trustee                                                                                                                                                                                      |
| Nicola Bancroft             | - Business in the Community Member of Finance and Risk Committee  
- Sister employed by Sheffield Teaching Hospitals NHS Foundation Trust  
- Director of Corporate Trustee                                                                                                                                                                                     |
| Heather Craven              | - No general interests to declare  
- Director of Corporate Trustee                                                                                                                                                                                       |
| Mark Edgell                 | - Employed in a senior role by the Local Government Association (LGA), leading their work with all Councils and partners (including NHS England and PHE) in Yorkshire and Humber, East Midlands and North East.  
- Wife employed as Senior Lecturer in Midwifery at Northumbria University  
- Member of the Labour Party  
- Director of Corporate Trustee                                                                                                                                                                                     |
| Lynn Hagger                 | - Company Secretary, Suburbaret Ltd  
- Director of Corporate Trustee                                                                                                                                                                                      |
| Rumit Shah                  | - Principal GP in Hatfield, Doncaster  
- Local Medical Committee Chair, Doncaster  
- Primary Care Network Clinical Director East Doncaster  
- Managing Director Beckingham Medical Services Ltd  
- Director of Corporate Trustee                                                                                                                                                                                     |
| Michael John Smith          | - Non-Executive Director Humber Teaching NHS Foundation Trust  
- Associate Hospital Manager (under S.23 of Mental Health Act 1983):  
  o Rotherham Doncaster and South Humber NHS Foundation Trust  
  o John Munro Hospital Group  
- Owner/Director MJS Business Consultancy Ltd  
- Director/Trustee Magna Science Adventure Centre  
- Director/Trustee Magna Enterprises Ltd  
- Director of Corporate Trustee                                                                                                                                                                                     |
# Executive Directors

| Richard Jenkins, Interim Chief Executive | - Chief Executive at Barnsley Hospital NHS Foundation Trust  
| - Director of Corporate Trustee Barnsley Hospital NHS Foundation Trust  
| - Executive Reviewer (Well-led Reviews) for the Care Quality Commission  
| - Fellow of The Royal College of Physicians  
| - Member of the British Humanist Association  
| - Wife employed as a Nurse at York Teaching Hospital NHS Foundation Trust  
| - Director of Corporate Trustee |

| George Briggs, Chief Operating Officer | - Shareholder in Briggs Health Ltd  
| - Director of Corporate Trustee |

| Callum Gardner, Executive Medical Director | - Owner & Director of Innovative Medicine Ltd  
| - Director of Corporate Trustee |

| Steve Ned, Director of Workforce | - Director of Steven Ned Ltd  
| - Workforce Director at Barnsley NHS Foundation Trust  
| - Director of Corporate Trustee |

| Stuart Diggles, Interim Director of Finance | - TASK Finance Limited – Director (50% shareholder)  
| - TASK Finance and Consulting Limited – Director and position of significant control |

| Angela Wood, Chief Nurse | - No general interests to declare  
| - Director of Corporate Trustee |

| Michael Wright, Deputy Chief Executive | - No general interests to declare  
| - Director of Corporate Trustee |

# Non-voting Members

| Jill Denith, Corporate Governance Consultant | - Self-employed through Jill Dentith Consulting  
| - Lay member for Governance, Derby and Derbyshire Clinical Commissioning Group |

| Ian Hinitt | - Trustee, Director and immediate past President of The Institute of Healthcare Engineering and Estates Management (IHEEM)  
|  
|  
|  
|  
| - IHEEM is a registered charity, with the positions being honorary, with no remuneration, only reasonable expenses |

| Sally Kilgariff | - No general interests to declare |

| Emma Parkes, Interim Director of Communications | - Substantive Director of Communications and Marketing at Barnsley Hospital NHS Foundation Trust |

<p>| James Rawlinson, Director of Health Informatics | - No general interests to declare |
| Louise Tuckett, Director of Strategy, Planning &amp; Performance | No general interests to declare |</p>
<table>
<thead>
<tr>
<th>Agenda item</th>
<th>P42/21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report</td>
<td>Chief Executive Report</td>
</tr>
<tr>
<td>Executive Lead</td>
<td>Dr Richard Jenkins, Interim Chief Executive</td>
</tr>
<tr>
<td>Link with the BAF</td>
<td>The Chief Executive’s report reflects various elements of the BAF.</td>
</tr>
<tr>
<td>How does this paper support Trust Values</td>
<td>The contents of the report have bearing on all three Trust values.</td>
</tr>
<tr>
<td>Purpose</td>
<td>For decision ☐ For assurance ☐ For information ☒</td>
</tr>
<tr>
<td>Executive Summary (including reason for the report, background, key issues and risks)</td>
<td>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. The items are not reported in any order of priority.</td>
</tr>
<tr>
<td>Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors’ meeting)</td>
<td>This paper reports directly to Trust Board.</td>
</tr>
<tr>
<td>Board powers to make this decision</td>
<td>No decision is required.</td>
</tr>
<tr>
<td>Who, What and When (what action is required, who is the lead and when should it be completed?)</td>
<td>No action is required.</td>
</tr>
<tr>
<td>Recommendations</td>
<td>It is recommended that: The Board note the contents of the report.</td>
</tr>
<tr>
<td>Appendices</td>
<td>1. Integrated Care System CEO Update Reports for February 2021 2. Table of External Meetings attended by Executive Director colleagues</td>
</tr>
</tbody>
</table>
1.0 Reflections on the last 12 months as Interim CEO

1.1 It’s now just over 12 months since I joined the Trust. The pandemic has been the overriding priority through this period and I am very proud of how well our staff has risen to the challenges it has brought. In addition, there were of course a range of non-covid priorities that the Trust required to be tackled and it seems an opportune time to briefly recap these and provide a short update on progress. A full report will follow at year end.

1.2 **Mortality:** The latest 4 months for which data is available (July-October 2020) show much improved standardised mortality levels and there has been a downturn in the rolling 12 month rate. A Mortality Improvement Group is established and making progress in delivering an overarching action plan focused on the three Cs of Care, Case mix and Coding.

1.3 **CQC:** Regular engagement meetings are taking place and effective working arrangements established with our new CQC leads. Delivery against a range of reactive improvement action plans is ongoing and a monthly CQC Oversight Group is focussed on a proactive range of activities. Additional recruitment is underway to augment the resources available for this work over the next year.

1.4 **Staff Engagement:** Considerable work has been undertaken through the pandemic to improve engagement. Additional efforts to keep staff informed of our COVID-19 response and more generally about the organisations business have been taken. Divisions have focussed significantly on supporting the health and well-being of their staff through this year. The embargoed staff survey demonstrates improvement in engagement.

1.5 **Executive Team effectiveness:** The Executive Team has a new, simpler approach to shared leadership and decision making through a revised weekly Executive Team Meeting, with a summary of this work coming to Board each month. A new business case process is in place and a range of bespoke development processes are in place for the team. A new monthly Senior Leasers Meeting has been introduced to build a better shared leadership approach and has been well-received. Weekly departmental visits by Executive Directors are helping with visibility and connectivity of Directors to the realities of service delivery for our teams. Focus will shortly move to the development of the Divisional teams.

1.6 **Finance:** Much progress has been made throughout the year on addressing financial governance issues, ensuring effective control of costs, reducing reliance on agency staff, effective management of the capital programme and delivery of the financial plan. As we approach year end, the Trust is significantly ahead of our plan. Close working with our regulator is ongoing and we will look to agree a process to facilitate removal of the long-standing financial license breaches over the next 12 months.

1.7 **Urgent and Emergency Care:** The pandemic response has had an enormous effect on how we manage emergency patients. The need for separate Red, Amber and Green pathways plus the infection control precautions staff must employ, have meant it has been difficult to make the desired progress in this area. Nevertheless, ambulance handover times are now some of the best in the region, there has been a significant reduction in long waits in A&E and progress is being made on flow and discharge. An AMU Improvement Group is in place with Improvement Academy support and work is ongoing to capitalise on the learning from the Rotherham Reset.
2.0 COVID-19

2.1 Activity: Overall numbers of Covid-19 positive inpatients have fallen and are between 50 and 60. The community prevalence is falling very slowly and is around 180 per 100,000, a similar level to much of South Yorkshire. Pressure on the critical care unit remains high.

2.2 Vaccination: The Trust’s vaccination programme has successfully completed the first doses for all eligible staff who wish to be vaccinated and also for staff across the wider Rotherham partners. The Rotherham population vaccination programme, under the CCG and Primary Care Networks, has been very effective with completion of the JCVI cohorts 1-4 and now well on with the next groups.

2.3 Recovery: It has remained challenging to accelerate recovery, but the operational teams continue to work with the ICS and the Independent Sector to catch up with activity. Certain areas, such as endoscopy and ultrasound are particularly challenging.

2.4 Staff health and well-being: This remains a key focus and a small task and finish group will consider how the Trust can make this a strength of the organisation going forwards.

3.0 Staff Survey

3.1 The embargo date for the results of the National Staff Survey has been extended to 11th March 2021 and therefore the full report has not been published yet. Early analysis of the results shows a consistent picture with the related Picker report. An action plan will be produced to drive further improvement; the plan will address Trust wide improvements as well as improvements focused on particular staff groups and departments and will report through the People Committee.

4.0 Divisional Leadership

4.1 Vacancies remain for a Divisional Director in both Surgery and Medicine. Internal recruitment has been unsuccessful and therefore the roles have been advertised externally. The closing date is Friday 26th February 2021. Susan Douglas continues as Interim Divisional Director in Surgery pending appointment of a substantive successor at which time she will take up her new role as Deputy Medical Director.

5.0 Integrated Care System (ICS) and Rotherham place development

5.1 Appendix 1 is the usual update from the ICS Chief Executive System Leader, which is provided for information.

6.0 Executive Director participation in External Meetings

6.1 Over recent years, the NHS has been developing more effective partnerships between organisations, culminating in the latest developments towards Integrated Care Systems. All the Executive Directors are involved in this system working and Appendix 2 provides details of the external meetings attending by Executive Directors for information.

7.0 Reset Week

7.1 A ‘Rotherham Reset’ week took place for 7 days from 3rd February. The week was aimed to introduce a range of new measures to more intensively focus on timely patient care in the pathway from admission to discharge for non-elective patients. The week was
extremely successful, both in terms of generating a large number of empty beds but also in testing new approaches and identifying additional areas for improvement. A formal debrief has since occurred and many of the interventions have been continued whilst others are under consideration. Flow and Urgent and Emergency Care performance has been maintained at an improved level since.

7.2 Short Stay Unit (SSU): A new medical SSU opened in the week commencing 22nd February. The unit has 17 beds and has been formed from within the bed complement of the Acute Medical Unit. It has dedicated nurse leadership and a medical hot-week consultant model. It is designed to take patients who have been assessed on the AMU and are felt to need less than a 48 hour length of stay. By co-locating these patients in one place and having a dedicated nursing and medical staffing model, it is anticipated that patient care will be improved and length of stay reduced.

8.0 Care Quality Commission update

8.1 Section 29a Warning Notice: In relation to concerns around the Acute Medical Unit, the CQC has issued a Warning Notice to the Trust. An action plan has been produced and many early actions implemented focussed on staffing, incident management and harm reduction.

8.2 Safeguarding Action Plan: The extensive safeguarding work plan has largely been completed and attention is now focussed on proactive assurance of embedded actions. It is now over a year since there has been a Serious Incident in this area.

8.3 Residual actions from prior inspections: Only 3 actions remain live and there are plans in place to deliver those that are within the Trust’s control. One relates to access to a national training programme which won’t be available until 2022; the CQC are aware of this issue and accept the Trust has done all it reasonably can.

Dr Richard Jenkins
Interim Chief Executive
March 2021
Chief Executive Report
Health Executive Group
9 February 2021

<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Andrew Cash</th>
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Is your report for Approval / Consideration / Noting
For noting and discussion

Links to the ICS Five Year Plan (please tick)

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<th>Developing a population health system</th>
<th>Strengthening our foundations</th>
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<td>✓ Understanding health in SYB including prevention, health inequalities and population health management</td>
<td>✓ Working with patients and the public</td>
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<td>✓ Getting the best start in life</td>
<td>✓ Empowering our workforce</td>
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<td>✓ Better care for major health conditions</td>
<td>✓ Digitally enabling our system</td>
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<td>✓ Reshaping and rethinking how we flex resources</td>
<td>✓ Innovation and improvement</td>
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Building a sustainable health and care system

| ✓ Delivering a new service model | Broadening and strengthening our partnerships to increase our opportunity |
| ✓ Transforming care | ✓ Partnership with the Sheffield City Region |
| ✓ Making the best use of resources | ✓ Anchor institutions and wider contributions |
| | ✓ Partnership with the voluntary sector |
| | ✓ Commitment to work together |

Are there any resource implications (including Financial, Staffing etc)?
N/A

Summary of key issues
This monthly paper from the System Lead of the South Yorkshire and Bassetlaw Integrated Care System
System (SYB ICS) provides a summary update on the work of the SYB ICS for the month of January 2021.

**Recommendations**

The SYB ICS Health Executive Group (HEG) partners are asked to note the update and Chief Executives and Accountable Officers are asked to share the paper with their individual Boards, Governing Bodies and Committees.
Chief Executive Report

SOUTH YORKSHIRE AND BASSETLAW INTEGRATED CARE SYSTEM

Health Executive Group

9th February 2021

1. Purpose

This paper from the South Yorkshire and Bassetlaw Integrated Care System System Lead provides an update on the work of the South Yorkshire and Bassetlaw Integrated Care System for the month of January 2021.

2. Summary update for activity during January

2.1 Coronavirus (COVID-19): The South Yorkshire and Bassetlaw position

As at the end of January, the latest figures show that for South Yorkshire and Bassetlaw over 170k people in the highest priority groups had now been vaccinated. Just over 60k of those are 80 years old or over which is around 80% of the total number of people in this category we need to. The remainder of the 170k are either people 75 years and above, people who are classed as clinically extremely vulnerable and patient facing NHS and social care staff. The numbers are, of course, changing all the time. The latest statistics for South Yorkshire and Bassetlaw are published weekly here: https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-vaccinations/

All local primary care centres continue to vaccinate as planned and additional vaccination capacity has opened at Sheffield Arena. The Arena team is vaccinating 7 days a week, 12 hours a day and the first week of operation saw all available appointment slots taken up. The majority of care home residents across the region have now been vaccinated and vaccinations for patients registered as housebound with their GP practice have also commenced. Patient facing NHS and Social Care staff across the region also continue to be vaccinated.

Partners in each of our places, including NHS, Local Authority and Community, Voluntary and Faith groups are working together to ensure vaccination myths are dispelled and community leaders are helping to support positive messaging around the vaccination campaign, particularly in our communities that have been identified as most vaccine hesitant or who are seldom heard. Partners are also sharing Covid-19 vaccine facts resources to help combat a rise in the incidence of vaccine fraud.

All five places in South Yorkshire and Bassetlaw have been chosen to receive £1.4 million national funding for the Community Champions scheme, which awards councils and voluntary organisations funding to deliver a wide range of measures to protect those most at risk - building trust, communicating accurate health information and ultimately helping to save lives. This will include developing new networks of trusted local champions where they don’t already exist and will also support areas to tackle misinformation and encourage vaccination take-up.

In terms of COVID-19 cases, the trend is a slowly downward. The lockdown is starting to have an effect, albeit slowly, with progress slow because the rates were high before the lockdown and the newer (more contagious) Covid-variants that have since been identified. Across the five places in SYB, rates are all falling with fewer outbreaks reported, and death rates continue to decline. Cases
of COVID-19 in the over 80s are also declining which, it is hoped, is an early sign that the vaccination programme is having an impact.

2.2 Regional update

The North East and Humber Regional ICS Leaders have been meeting weekly with the NHS England and Improvement Regional Director to discuss the ongoing COVID-19 incident, planning that is taking place to manage the pandemic and where support should be focused. Discussions during January focused on Wave 3 surge plans, the COVID-19 response and vaccination programme.

In addition to operational issues, ICS Leaders have been involved in discussions about the development of integrating care across four workstreams. These workstreams mirror the development work that is taking place in SYB: Place-based partnerships; provider collaboratives; how the nature of commissioning will change; and the integrated care system.

2.3 National update

NHS England and NHS Improvement (NHS E/I) issued their Phase Four letter on 23 December in which the operational priorities for winter and 2021/22 were set out. Key elements from the Letter include managing the ongoing demand from COVID-19, rapid implementation of the COVID-19 vaccination programme, maximising capacity to provide treatment to non-COVID-19 patients, preparedness to respond to the seasonal winter pressures and supporting the wellbeing of our workforce.

It also set out clear ambitions around how systems should address pandemic-related population health concerns as a direct result of COVID-19 in the areas of reducing health inequalities, expanding mental health provision and prioritising investment in primary and community care services.

There is also a clear framework for how systems should follow the new financial framework around funding (consistent with the NHS’ Long Term Plan). A helpful summary by the NHS Confederation can be read here.

As part of national efforts to support all regions with the ongoing challenges of COVID-19, Amanda Pritchard, Chief Operating Officer for NHS England and NHS Improvement (NHS E/I) sent a further letter to NHS leaders on Tuesday 26th January.

The letter titled ‘Reducing burden and releasing capacity to manage the COVID-19 pandemic’ explains that systems should ensure they make pragmatic decisions about how best to free up management capacity and resources to focus on additional competing priorities around the vaccination programme and continued non-Covid care.

The letter encourages NHS trusts and foundation trusts to consider options including the pausing of all non-essential oversight meetings, streamlining assurance and reporting requirements and only maintaining those existing development workstreams that support recovery.

2.4 Safe Maternity Services during the COVID-19 Pandemic

The South Yorkshire and Bassetlaw Local Maternity and Neonatal System (LMNS) has published its ‘Safe Maternity Services during the COVID-19 Pandemic’ strategy. The document offers best practice guidelines to midwives and midwifery teams to ensure the care for women (and families) during the pandemic remains as unaffected as possible.

The LMNS has been ensuring service users are engaged with during these unprecedented service adaptations. By providing the most up to date evidence based information, the LMNS is working with partners to enable women to make choices that are personalised to their individual needs, wishes
and requirements.

The full document is published here: 
https://www.healthandcaretogethersyb.co.uk/application/files/9516/0994/1635/Covid_Safety_Strategy_LMS_210104_v7_-_final.pdf

2.5 Sheffield City Region

The Sheffield City Region Mayoral Combined Authority and Local Enterprise Partnership approved their 20-year Strategic Economic Plan (SEP) on 28th January. The Plan sets out local leaders’ blueprint to drive the region’s recovery from COVID-19 and transform South Yorkshire’s economy and society for people, businesses and places.

The SEP paves the way to a stronger, greener and fairer economy as the region looks to unlock its potential and create prosperity and opportunity for all. The ambition of the 20-year Strategic Economic Plan is for the South Yorkshire economy to look very different in 2041, with an extra £7.6bn Gross Value Added (GVA), 33,000 extra people in higher level jobs, reduced income inequality and improved wages by over £1,500 for the lowest paid, and a net zero carbon economy.

2.6 Mental Health White Paper

The government has published the Reforming the Mental Health Act White Paper, which sets out proposed changes to the Mental Health Act 1983. The paper also sets out proposals and ongoing work to reform policy and practice to support the implementation of a new Mental Health Act. The proposals take forward the majority of the recommendations made by the Independent Review of the Mental Health Act 1983.

The government is seeking views, until 21 April 2021, on the implementation and impact of the reforms. Feedback will inform the drafting of the Bill to amend the Act, which will be brought forward when parliamentary time allows.

2.7 SYB Recovery Plan

The pandemic has caused an unprecedented rise in waiting times for hospital and diagnostic care, interrupted ongoing care in the community for mental health and other long-term conditions and assessments for social care support. The impact has been devastating on our population, particularly on health inequalities which continue to widen. Our plan has always been to address inequities in access and outcomes through a collective partnership approach and we must now accelerate our efforts.

Before the Pandemic, South Yorkshire and Bassetlaw (SYB) had one of the lowest number of people nationally waiting over 52 weeks and today the region continues to hold a comparatively smaller over 52-week waiting list. Nonetheless, we are keen to address any delays and reduce the impact on our population.

The innovation and resourcefulness that helped to enable SYB’s health and care system to continue delivering safe patient care during the pandemic will also be integral to our future plans. Our close partnership with the Yorkshire & Humber Academic Health Science Network will see the continuation of our co-developed Rapid Insights research - with a view to implementing recommendations where opportunities exist across the system.

As a partnership, we are now starting to shape the development of priorities for the coming year utilising the expertise and experience of our wider health and care partners to meet these challenges in the months and years ahead.
2.8 Sheffield Olympic Legacy Park

Proposals for the Sheffield Olympic Legacy Park (SOLP) were unveiled in January. The project, which involves and is supported by SYB partners, is set to yield significant economic and health benefits within SYB and across the UK.

It joins up a number of prestigious commercial (IBM and Canon Medical Systems Europe) and regional public sector partners on the 35-acre site benefiting from the cluster of specialised health and care, academia, clinical research and sports engineering centres.

Situated in the east of Sheffield, newly unveiled plans over the next five years are set to see a further 5,600 high value jobs created whilst generating over £2bn in Gross Value Added (GVA) benefits to support a post-pandemic and post-Brexit UK economy.

This development site is already home to a number of established research and development hubs including the English Institute of Sport Sheffield (EISS), Advanced Wellbeing Research Centre (AWRC) and National Centre of Excellence for Food Engineering (NCEFE), alongside the Oasis Academy Don Valley and the FlyDSA Arena, ensuring that it provides excellent transport links to the M1, tramway inter-connectivity to Sheffield and Rotherham but also with the possibility of greener links via the Sheffield & Tinsley Canal.

Perhaps one of the standout facilities on the Park will be development of the new national Centre for Child Health Technology (CCHT), thought to be the first of its kind globally, tasked with focusing on addressing issues that affect children and young people – with the added benefit of delivering over £200m in savings to the NHS in the next ten years.

In addition, Canon Medical Systems Europe will also host a world-leading diagnostic imaging lab and research centre, delivering ultramodern digital research and development capabilities to support the enhancement of diagnostics in the NHS.

I would like to acknowledge SYB partners Sheffield City Council, Sheffield Teaching Hospitals NHS Foundation Trust, Sheffield Hallam University, Sheffield City Trust, Sheffield Children’s NHS Foundation Trust and Yorkshire & Humber Academic Health Sciences Network for their exceptional work in supporting this key transformational project.

2.9 Anchor Networks

The impact the NHS has on people’s health extends beyond the role as a provider of treatment and care. As large employers, buyers, and capital asset holders, our health care organisations are well positioned to use their spending power and resources to address social, economic and environmental factors that widen inequalities and contribute to poor health.

Anchor institutions are key to making a strategic contribution to the health and wellbeing of the local population and the local economy and include the NHS, along with local authorities, universities and other non-profit organisations. An Anchor Network goes one step further to bring the institutions together and early discussions are now taking place with the national team on what this means for SYB. A proposal is being developed with the four North ICSs taking a collective approach which will be informed by a system-wide event.

3. Finance update

At Month 9 the system is reporting a forecast surplus of £36.1m compared with a plan deficit of £3.9m. This is a significant improvement on the Month 8 forecast and reflects a reassessment of the forecast position at Month 9 and the continued impact of under-performance on elective activity and reduced cost pressures on CCG budgets.

Capital slippage has increase in Month 9 to a forecast £21.6m on planned spend of £163m or 13.2%. The slippage is due to the challenges of delivering a capital programme during the
pandemic, significant additional capital allocations for COVID-19 and critical infrastructure and the revisiting of a material business case. The slippage has been offset by a forecast unplanned charge of £9.5m for the Rotherham Carbon Energy scheme.

Because of the ongoing impact of the pandemic the financial framework that is in place for the second half of 20/21 will be rolled forward into at least the first quarter of 21/22. Further details are awaited.

Andrew Cash  
System Lead, South Yorkshire and Bassetlaw Integrated Care System  

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<td>NHSI/E</td>
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<td>Organisations</td>
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<td>Simon Enright/Callum Gardner</td>
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<td>Callum Gardner (HN element)</td>
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<td>Michael Wright, Deputy Chief Executive</td>
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<td>For decision ☐  For assurance ☐  For information ☒</td>
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**Executive Summary (including reason for the report, background, key issues and risks)**

The purpose of this report is to provide the Trust Board with an update on national developments and also developments across the South Yorkshire and Bassetlaw Integrated Care System (SYB ICS) and Integrated Care Partnership (Rotherham Place).

Key points to note are:

1. The Prime Minister was able to announce a road map out of national lock down and a return to normal life based on four key tests.

2. On 11th February 2021, the Government published its white paper setting out legislative proposals for a Health and Care Bill.

3. Through February, South Yorkshire continued to support national pressures with the transfer of critical care patients from outside the region into beds within the ICS.

4. Rotherham Place continues to make exceptional progress in its vaccination programme achieving over 94% take up for the over 70s.

5. Rotherham Place is continuing to increase its efforts and work to make improvements in health inequalities across Rotherham as we exit the pandemic.

Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors’ meeting)

N/A

Board powers to make this decision

N/A
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<td>(what action is required, who is the lead and when should it be completed?)</td>
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<td>Recommendations</td>
<td>It is recommended that the Board note the information in this paper</td>
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<tr>
<td>Appendices</td>
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</table>
1.0 Introduction

1.1 This report provides an update on national developments, developments across the South Yorkshire and Bassetlaw Integrated Care System (SYB ICS) and Integrated Care Partnership (Rotherham Place).

2.0 National Update

2.1 The country remained in a national lockdown throughout February as the effects of the 2nd wave of Covid-19 continued to be felt. At the end of January, the UK passed the milestone of over 100,000 deaths within 28 days of testing positive for Covid-19.

2.2 The number of cases confirmed each day, hospital admissions and deaths have all fallen through February to a position where on 22nd February 2020, the Prime Minister was able to announce a road map out of national lock down and a return to normal life based on four key tests. These being:

- The vaccine deployment programme continues successfully
- Evidence shows vaccines are sufficiently effective in reducing hospitalisations and deaths in those vaccinated
- Infection rates do not risk a surge in hospitalisations which would put unsustainable pressure on the NHS
- Our assessment of the risks is not fundamentally changed by new Variants of Concern

2.3 Whilst this is positive news, the number of hospital beds occupied by Covid-19 positive patients has fallen slower than other key metrics, particularly in Intensive Care Units where pressures remain. As of 22nd February 2021 there were 14,137 beds occupied in England with Covid-19 positive patients of which 2,072 were on Mechanical Ventilation.

2.4 The vaccine roll out across the country has continued at pace and the government declared that it had met its target of offering the vaccine to the first four priority groups by 15th February with over 90% of over 70s reported to have accepted the vaccine. The government is now offering the vaccine to the other groups and aims to have offered the vaccine to 17million people in groups 5 to 9 by the end of April 2021.

2.5 Initial data also suggests that the vaccine has had a significant impact on stopping serious illness, with the risk of being admitted to hospital reduced by at least three quarters for the over 80s. Data also suggests that the vaccine is helping to slow transmission.

2.6 On 11th February 2021, the Government published its white paper setting out legislative proposals for a Health and Care Bill. These proposals built on recommendations made by NHS England / Improvement outlined in their paper published in December 2020, with a marked shift away from competition as a driver of quality and performance improvement to one focused on collaboration and integration.

2.7 The white paper focused on four main areas as follows:

- **Enabling integrated care**: ICS’s playing a greater role in bringing together the parts of the NHS and the NHS with local government
- **Remove transactional bureaucracy**: Maintain the commissioner / provider split, but look to base it on collaboration, focus on Population Health and digital enablers
• **Accountability at the top will change**: NHS England (formally merged with NHSI) will be more accountable to Government, while maintaining day to day independence. Will also focus on enhancing quality and safety, but more powers to the SoS to intervene on big issues

• **Additional Measures**: A range of other, smaller, more direct measures intended to support social care, public health and the NHS

3.0 **South Yorkshire and Bassetlaw Integrated Care System (System)**

3.1 South Yorkshire and Bassetlaw Covid-19 cases remained stable and fell in line with the national picture through February. Whilst the prevalence of the new strain of Covid-19 has impacted London and the South has increased, it has been countered by the measures brought in nationally to reduce transmission.

3.2 Through February, South Yorkshire continued to support national pressures with the transfer of critical care patients from outside the region into beds within the ICS.

3.3 Identification of the P2 Brazilian variant was identified in Sheffield with local surge testing taking place to support additional measures to stop the spread.

3.4 As of 22nd February, South Yorkshire and Bassetlaw ICS has vaccinated over 90% of its population aged 70yrs and older and is making good progress against other key groups, such as NHS and Social Care workers.

4.0 **Rotherham Integrated Care Partnership (Place)**

4.1 RMBC and the CCG are contacting Rotherham residents who form part of the 1.7m additional people who have been asked to shield as part of the Covid-19 response. Initially c.4000 residents had been identified with work on going to ensure everyone is captured.

4.2 Rotherham Place continues to make exceptional progress in its vaccination programme achieving over 94% take up for the over 70s.

4.3 Over 70,000 people in Rotherham have been vaccinated across with the five Primary Care led vaccination centres and the hub at TRFT. Over 2,500 housebound patients have also been vaccinated by place community services.

4.4 Rotherham Place is continuing to increase its efforts and work to make improvements in health inequalities across Rotherham as we exit the pandemic. The Joint Needs Assessment (JSNA) analyses the health and needs of the population to inform and guide health, wellbeing and social care services within Rotherham. This is currently being refreshed by RMBC with engagement from partners including TRFT.

4.5 RMBC has recently appointed a new Director of Public Health, Mr Ben Anderson and the Trust will be working closely with him, his team and the CGG to take forward plans to reduce health inequalities.

Michael Wright
Deputy Chief Executive
March 2021
## Proposed Process for Developing a New Trust Strategy

**Executive Lead**
- Michael Wright, Deputy Chief Executive
- Louise Tuckett, Director of Strategy, Planning and Performance

**Link with the BAF**
- B1, B2, B10

**How does this paper support Trust Values**
- The Trust Strategy will support the engagement with and support for the Trust Values

<table>
<thead>
<tr>
<th>Purpose</th>
<th>For decision ☒</th>
<th>For assurance ☐</th>
<th>For information ☐</th>
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**Executive Summary**

The Trust’s current 5 Year Strategy covers the period 2017 to 2022. This strategy has been refreshed on an annual basis to ensure that it has remained relevant to the organisation while maintaining its overarching themes. However, the Strategy is approaching its natural ‘end date’ of 2022 and as such it is only right that we start the process to develop a new strategy.

Following discussions with both the Chairman, Chief Executive and NHS England and Improvement, the Trust has committed to delivering a new strategy by the end of Quarter 2 (end of September) 2021/22.

This paper sets out the proposed approach for developing the new Strategy, and the associated rationale. In particular, the paper proposes a full re-write of the Strategy rather than a simple refresh. It sets out a proposed timetable for this process, including an outline of the wide-ranging engagement that is planned, in order to ensure views and input from a range of stakeholders can be incorporated into the development. This engagement will also help develop the Strategy as an ‘owned’ document by the Trust and the staff within it.

**Due Diligence**

An outline of this proposal has been discussed with the Chairman and Chief Executive before being taken through the Executive Team Meeting and supported in February 2021.

**Board powers to make this decision**

It is one of the board’s key responsibilities is to have a current and appropriate strategy for the Trust.

**Who, What and When**

The Deputy Chief Executive is the Lead Executive for ensuring the development of the new Five Year Strategy with support from the Operational lead, the Director of Strategy, Planning and Performance.
<table>
<thead>
<tr>
<th>Recommendations</th>
<th>It is recommended that the Board of Directors agrees to the development of a new Five Year Strategy for the Trust based on the timetable presented in the report.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendices</td>
<td>N/A</td>
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</tbody>
</table>
1. Introduction

The Trust has a current Five Year Strategy (Together We Can: Our Five Year Strategy 2017-2022) which has been refreshed on an annual basis in quarter 4. As part of our business planning cycle we need to develop a new strategy for the Trust which reflects the current situation and future opportunities.

The landscape of the NHS has been changing in recent years, we have experienced the impact of COVID-19, the development of Integrated Care Systems, and the evolution of PLACE based working. We have an ideal opportunity to reset the Trust’s long-term goals and ensure there is consistency in our direction of travel over the coming years.

Following conversations with NHS England and Improvement as part of discussion regarding the lifting of the Trust’s breach of licence, it was agreed that the organisation would aim to deliver a new strategy by the end of quarter 2 2021/22. Following further internal discussion with the Chairman it was agreed that the new strategy would be brought to a special meeting of the Board of Directors in September 2021 for approval.

This paper, therefore, sets out the following:

- The case for producing a ‘new’ strategy
- A proposed timetable and outline engagement plan to deliver a new strategy which has organisational support in line with expectations and approval by the Board of Directors

2. A New Strategy

The Trust’s existing five year strategy has been refreshed yearly in quarter 4 (January to March) since 2018 on a planned basis. It is now time to prepare a new five year strategy.

In developing our new strategy we need to acknowledge:

- We have an entirely new Executive team within the Trust
- The very significant impact of COVID-19 on the Trust and the wider NHS
- NHS Reconfiguration
- Our focus on staff engagement
- Duplication of documents

2.1. Trust Executive Team

The current strategy was approved in 2017. Since this time, the Trust has had an almost entirely new Executive Team, with the following colleagues joining the Trust after the approval of the existing strategy:

- Chief Executive (Interim 2020)
- Deputy Chief Executive (Interim and permanent in 2020)
- Medical Director (Interim 2018, permanent 2019)
- Chief Nurse (Interim 2018, permanent 2019)
- Chief Operating Officer (2018)
- Director of Workforce (2019)
• Director of Strategy, Planning and Performance (2019)
• Director of Estates (2020)
• Director of Communications (Interim 2020)
• Director of Finance (Interim 2020 – permanent due to start in 2021)

It is also worth noting that the Trust has also had significant changes in its divisional leadership with a new division created, 5 of the 6 Divisional Directors and 4 of the 6 General Managers being in post (or vacant) for less than 18 months.

While we have undertaken yearly refreshes of the Strategy, it has remained within the current framework. It is important that the new leadership team and Board are able to put forward their vision for the organisation, supported by clear proposals for how the Trust will move forward to deliver this vision.

2.2. COVID-19

The impact of COVID-19 on the current and future state of the NHS cannot be underestimated. It has changed the organisation (and the wider NHS) in ways which no one could have anticipated 12 months ago, let alone in 2017. The current pressures placed upon the Trust by COVID-19 are unprecedented. The second and third waves of COVID-19 admissions to the Trust have seen more than double the number of patients in hospital beds compared to the first peak, with clinical and corporate teams having to manage these challenges for an extended period of almost a year. Our clinical and corporate teams are extremely stretched and fatigued.

As we begin to exit the height of the pandemic and continue into a new normal from spring / summer 2021 and beyond, the demands placed on the Trust and how it needs to prioritise its resources will be different, especially when considered against the same demand and priorities pre COVID-19. It is recognised locally and nationally, that the impact of COVID-19 will have a long-term impact on the NHS.

Therefore, it is the right time to review and reassess our priorities in the medium and long term to ensure that they fully take into account the impact and demands that COVID-19 has placed on the Trust and that its services, workforce, estate, digital infrastructure etc are all moving towards a COVID-19 ‘new normal’ way of working.

2.3. NHS Reconfiguration

The recent white paper presented to parliament by the Secretary of State for Health and Social care sets out a planned reorganisation of the NHS over the coming years. This builds on the proposals that NHS England and Improvement set out in late 2019. Within these documents are some fundamental changes for the structure of the NHS with a clear move away from competition towards collaboration, formalisation of the ICSs (and subsequent disbanding of CCGs) and increasing influence and control of the Secretary of State.

The impact for providers will need to be understood, but requirements such as being part of a provider collaborative will need to be fully considered and will form an important part of our future direction.
2.4. Staff Engagement

The Trust has made a clear commitment to improving its engagement with staff, and this will remain a Trust priority. The benefits of improved engagement are clear and the development of a new Strategy allows a full engagement process to take place. This engagement would be across the organisation with views sought from all staff, which would support staff feeling part of, and having influence in, the organisation.

A rewrite of the Strategy will demand a new approach to staff engagement in developing the plan, as well as a much more structured approach to communications once the plan is agreed, in order to ensure it is part of all colleagues’ every day.

2.5. Duplication of Documents

The Trust currently has two Trust-level, long-term documents – a Five Year Strategy and a Five Year Plan. These documents have overlap in their function and content, and there is a clear opportunity to combine these two documents to simplify the articulation of our vision, and ensure there is clarity on the tangible actions required to deliver it. It is critical that the new strategy is at the forefront of Trust decision-making and day-to-day function.

Additionally the Trust also has a number of other plans / strategies across key areas including the Digital Strategy, Estates Plan and our Safe and Sound Framework. There is an opportunity to ensure the various parts of the Trust’s long-term thinking are fully and better connected from the start within a new strategy.

3. The Proposal

Given the issues and opportunities outlined above, the following is proposed:

- A new strategy is developed through Q1 and Q2 2021/22
- A full engagement programme with staff is put in place to support the development of a new strategy
- The Trust strategy and Five Year Plan are merged into single document which clearly sets out our long term strategy as well as our strategic plan to deliver this over the next five years
- The resulting strategy is fully launched in Q3 2021 and is built as an integral part of the Trust decision-making processes.

3.1. Benefits of this proposal

The proposal outlined above will enable the following benefits:

- The Unitary Board will be able to set out their vision for the Trust to the organisation, its staff and its partners and stakeholders
- Staff engagement will be improved through a full engagement programme in the development of the new strategy
- The Trust will be clear about its role and contribution to Rotherham PLACE and South Yorkshire and Bassetlaw Integrated Care System (SY&BICS)
4. **Timeline**

There is a commitment to deliver a new strategy by the end of Quarter 2 2021/22. Further discussions with the Chairman have identified a proposed Board of Directors meeting on the 10th September 2021 as the final approval date.

Therefore, the proposed timetable below sets out the requirements, particularly around engagement, which demonstrates why a five to six month programme is needed.

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<td>5th MARCH</td>
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<td>6th APRIL</td>
<td>Board Development Day – initial input and workshops with the Board</td>
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<td>• Divisional Leadership Teams (x7 – including Ops) plus engagement with</td>
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<td>• Senior Leaders Meetings (x2)</td>
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<td>• 3-5 virtual managed sessions for staff to contribute proactively to</td>
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<td>• Dedicated email / drop off point for staff to send questions/ideas/</td>
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<td>• Council of Governors</td>
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<td>• Public Engagement via Public Forum</td>
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<td>12th MAY</td>
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5. Conclusion

There is an opportunity and need for the Trust to reset its long-term vision and objectives. Now is the time to develop a new strategy which is built through wide engagement and becomes a living, used document within the Trust. This will require considerable time and resources to develop and deliver a high-quality output. The five-month timetable set out above is likely the minimum time required to fully develop an engaged strategy and enable it to have a significant impact on the organisation.
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<td>Report</td>
<td>Covid-19 Update and Recovery Report</td>
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<td>Mr George Briggs, Chief Operating Officer</td>
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<tr>
<td>Link with the BAF</td>
<td>B1 and B2: Risk scores have remained static from the previous quarter on the basis of the Trust receiving increased pressure from admissions and activity showing the operational activity is off course with its Improvement Plan.</td>
</tr>
<tr>
<td>How does this paper support Trust Values</td>
<td>Ambitious: Ensuring the Trust is delivering high quality services Caring: Ensuring patients are seen within the appropriate time frames Together: Working collaboratively with partners to achieve standards</td>
</tr>
<tr>
<td>Purpose</td>
<td>For decision ☐ For assurance ☒ For information ☐</td>
</tr>
</tbody>
</table>
| Executive Summary | This report is presented to the board for information and assurance that the Trust is managing the pandemic under challenging circumstances and:  
  • provides an update on the Rotherham NHS Foundations Trust’s (TRFT’s) response to the Covid-19 pandemic.  
  • describes the activity and actions the Trust has taken to deal with the pandemic, up to the month of January 2020.  
  • explains our position against the national standards and goes into detail against our recovery plans.  
  • shares the initial trajectories we have developed. |
| Due Diligence (include the process the paper has gone to prior to presentation at Board of Directors Meeting) | This report is taken from the daily Gold dashboard, the monthly IPR and the regional Covid-19 updates, and the notes from the monthly recovery meetings |
| 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?) | A monthly report is provided to the Finance and Performance Committee and to the Board of Directors and any actions required are the responsibility of the Chief Operating Officer with support from colleagues. |
| Recommendations | It is recommended that: The Board note the report. |
| Appendices | 1. Covid-19 Response and Recovery |
Appendix 1

Covid-19 Response

1.0 Introduction

1.1 This paper covers key operational indicators, an overview of Covid-19 related issues and the recovery plans as of January 2021.

1.2 Healthcare in the UK has been in a Covid-19 pandemic for 11 months which has meant the Trust is having to manage patient flow and demand within significant staffing and capacity concerns.

1.3 The Trust has produced an updated recovery plan that has been in operation since August and has appointed Mr J Garner as Associate Medical Director Recovery to support the recovery plans. The plan is being monitored by the Director of Strategy and Performance. The initial recovery has stalled during October to January and this is linked to higher numbers of positive Covid-19 patients, an increase in emergency care and staffing shortages due to Covid-19.

1.4 We have set out the agreed elective care trajectories until the end of Q1 2021/22. These projections are based on specialty-level plans, which have been developed by divisional teams. The paper identifies the assumptions that were used to develop these, as well as noting the key risks to delivery if these assumptions do not hold true going forward.

1.5 Our Critical Care services have been using both Critical Care and Ward B6 since September, with a potential physical capacity of up to 22 beds across both areas. The key area of concern is staffing across Critical Care and theatres, which has reduced our ability to flex at times and affected theatre utilisation, which will knock onto theatre capacity and productivity.

2.0 Elective Care position

2.1 Referral to Treatment

Referral to Treatment performance has improved slightly in January to 70.2% (up from 69.2% in December). There are three specialties now meeting the national incomplete standard – General Medicine, Geriatric Medicine and Dermatology. These are all outpatient-led specialties, which require fewer diagnostics within treatment pathways than other specialties do.

In the latest monthly data, there were over 300 fewer 18+ week waiters than in the previous month (over a 7% reduction), but adversely a higher number of over 52 week waiters, with 721 such patients still waiting at the end of January 2021. The majority of these patients are within surgical specialties, given the reduction in theatre and diagnostic activity over the last 10 months.
Of the over 750 current 52 week wait patients, the five specialties with the most 52-week waiters' account for 85% of this total cohort.

At present, 69 of these patients are currently not wishing to receive treatment due to Covid-19 or other reasons; however, the national guidance from April 2020 dictates that the patients must remain on the Trust’s active waiting list (PTL) and cannot be removed or discharged back to the care of their GP in this situation.

Trauma and Orthopaedics has the highest number of very long waiting patients (over 200), which has been driven by the lack of an orthopaedic elective ward over the last year. Whilst day case activity has been able to continue (in reduced volumes than pre-pandemic due to a reduced theatre timetable and no orthopaedic ward), there is limited levels of elective inpatient activity given the lack of beds.

The Trust has utilised the independent sector as much as possible to mitigate this position and ensure patients can be treated as quickly as possible, but their capacity to do inpatient activity is limited by the number of beds they have available. The plan is to have an Orthopaedic ward running again at TRFT in March / April, following the ring fencing of a general elective ward in March.

2.2 Cancer Performance

The impact of reductions in diagnostic capacity in particular, has led to a deterioration in performance against the 62-day standard; with Q3 performance at 63.2%, (December was 64.9%).

Unlike in wave 1 of Covid-19 earlier in 2020/21, referral volumes are now close to 100% of the previous year’s numbers, and so services are having to manage a similar number of patients with reduced capacity, as well as patient engagement challenges and infection prevention and control measures.

Despite these challenges the latest cancer PTL position for the South Yorkshire and Bassetlaw (SYB) acute trusts shows TRFT has the fewest number of 62+ day patients on the Cancer PTL, which is a more positive relative position than the Trust has been in in recent months.
This has been driven by the hard work of the director of strategy planning and performance and the operational and clinical teams over the last few weeks. With particular focus on the continued work within the endoscopy team.

63+ day waiters on PTL by SYB Provider (as of 14th February 2021)

<table>
<thead>
<tr>
<th>Provider</th>
<th>63-103 day</th>
<th>104+ day</th>
<th>ALL 63+ day</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Rotherham NHS FT</td>
<td>73</td>
<td>18</td>
<td>91</td>
</tr>
<tr>
<td>Barnsley Hospital NHS FT</td>
<td>124</td>
<td>16</td>
<td>140</td>
</tr>
<tr>
<td>Doncaster &amp; Bassetlaw Teaching Hospitals NHS FT</td>
<td>169</td>
<td>22</td>
<td>191</td>
</tr>
<tr>
<td>Sheffield Teaching Hospitals NHS FT</td>
<td>422</td>
<td>125</td>
<td>547</td>
</tr>
</tbody>
</table>

2.3 DM01 Performance

DM01 performance has followed a similar trend to RTT performance. This has been despite efforts to source additional capacity through the CT scanner in a box and the mobile MRI unit, due to lack of sufficient workforce to utilise these to maximum effect.

The endoscopy service have employed additional capacity through weekend lists at TRFT over the last few months (similarly to 2019/20), as well as use of the independent sector since Q3 20/21, with both of these initiatives to continue throughout Q4. The endoscopy activity is currently ahead of the trajectory to clear the backlog by the end of March so that straight to test pathways can be reintroduced as appropriate, this is based on staffing availability.

The Trust’s latest weekly elective care submission shows a significant reduction of 6+ week waiters within endoscopy to the latest figure of 262 patients, compared to over 1,000 just 14 weeks ago.

3.0 Recovery

As mentioned last month the Trust is using a number of actions to ensure we create as much capacity as possible to deliver elective activity,

- Use of the Independent Sector,
- Additional capacity (e.g., weekend theatres, extended clinics)
- Clinical and administrative validation of patients.

3.1 Revision to RTT Patient Tracking List from April 2021

Last year, national and regional guidance relating to the treatment and recording of patients who become ‘Appointment Slot Issues’ (ASIs) following a referral was shared with acute providers. The guidance set out that best practice dictates that all patients waiting for consultant-led care at the Trust should be counted within the Patient Tracking List (PTL), and recognised within the national monthly RTT returns.

The Trust had already been working to deliver this within our reporting, but given the challenges of automatically counting and recording these patients within the Electronic Patient Record (EPR) alongside the start of the pandemic, we had not yet managed to revise the systems to enable us to achieve this best practice. Following several months of further discussions internally, the Executive Team recently approved an amendment
to our reporting practices which will ensure all patients (including those awaiting a first appointment) are counted within our full waiting list from April 2021.

Implementation of this amendment will increase the overall size of the PTL (by approximately 2,500-3,000 patients) but will ensure appropriate visibility of and transparency around our full waiting list at specialty level.

3.2 Assumptions

For the purposes of the trajectory-setting exercise, we agreed a series of assumptions with the divisional teams we will continue to revisit these assumptions at each quarterly iteration of the trajectories.

- Reduction in planned activity (including outpatients) between January and March
- Assume increase in face-to-face activity as a proportion of the total for appropriate specialities
- 1st round of vaccinations delivered to all front line healthcare staff and clinically extremely vulnerable by mid-Feb
- One elective surgical ward available from 1 March (Keppel)
- Two elective surgical wards available from 1 April (Sitwell)
- ICU demands reduce mid-February and any additional capacity released back to divisions – N.B. This has not played out since these assumptions were derived in January
- Independent Sector capacity on line by 18th January at Kinvara (T&O only, Gynae from 2nd week in Feb), Thornbury/Claremont from 1st Feb. Assume contracts deliver as planned. Latest activity figures suggest this assumption is also not holding true, and IS delivery is likely to be less than 50% of planned volumes.
- Referral volumes to be at ‘stabilised pandemic’ level for 1st 4 months, then back to pre pandemic usual seasonal volumes for final 8 months of year
- Factor in increased annual leave provision between March and September 2021 due to amount of carry over.

3.3 RTT Trajectory

The trajectories submitted by the divisional teams show a gradual improvement in RTT performance to just under 80% by the end of June. This includes the impact of including ASIs within the waiting list figure This is reliant on the availability of elective bed capacity and theatre staffing, which has been hugely challenged over the last few weeks, circa 20 WTE theatre staff currently unable to work.

There is a broad range of expectations as to how performance will change at specialty level; the majority of the larger medical specialties are assuming just a small improvement in performance, whereas the surgical specialties are planning to see a much reduced number of long-waiting patients on the PTL by the summer due to the planned re-opening of elective capacity.
As well as forecasting their RTT performance, divisional teams have provided expected figures around the size of the specialty-level waiting list, and numbers of patients waiting over 52 weeks. The full waiting list trajectory shows a reduction of approximately 1,000 patients over the next 5 months, based on an assumption that we will add approximately 2,600 pts to each month. However, our actual figures for January’s return would have been closer to 16,600 including the ASIs, so we are already significantly ahead of expectations.

Within the full waiting list are a significant number of very long-waiting patients, with divisional teams continuing to focus on bringing these patients in for treatment despite the ongoing capacity challenges. It is worth noting that some patients do not currently wish to receive any treatment now, due to Covid-19 or for other reasons. These patients are identified within our waiting list as ‘Priority 5’ or ‘Priority 6’ patients. There are currently fewer than 70 of these patients within the cohort of 52-week waiters, but this number will rise as our 52-week waiter’s increase.
## 52-week wait trajectory

<table>
<thead>
<tr>
<th>Month</th>
<th>Jan-21 (Forecast)</th>
<th>Feb-21 (Forecast)</th>
<th>Mar-21 (Forecast)</th>
<th>Apr-21 (Forecast)</th>
<th>May-21 (Forecast)</th>
<th>Jun-21 (Forecast)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actuas</td>
<td>610</td>
<td>708</td>
<td>723</td>
<td>688</td>
<td>591</td>
<td>486</td>
</tr>
</tbody>
</table>

The below breakdown shows the planned 52-week trajectories by specialty:

### 52-week trajectory by specialty, January 2021 and June 2021

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Jan-21</th>
<th>Jun-21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>197</td>
<td>120</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>128</td>
<td>80</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>104</td>
<td>40</td>
</tr>
<tr>
<td>General Surgery</td>
<td>70</td>
<td>40</td>
</tr>
<tr>
<td>X01 - OMFS</td>
<td>95</td>
<td>39</td>
</tr>
<tr>
<td>Ear, Nose &amp; Throat</td>
<td>46</td>
<td>23</td>
</tr>
<tr>
<td>Urology</td>
<td>59</td>
<td>9</td>
</tr>
<tr>
<td>Cardiology</td>
<td>14</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>721</td>
<td>351</td>
</tr>
</tbody>
</table>

### 3.4 Cancer 62-day Performance Trajectory

The Trust’s 62-day cancer performance is driven by performance across some of the larger tumour sites, including Breast, Lower GI and Urology. However, in recent months, small numbers of breaches across several other tumour sites have pulled overall performance down, and this is therefore an area of focus for the coming weeks.

Divisional teams have developed clear plans for improvement across cancer, with weekly PTL meetings within divisional teams to ensure adequate scrutiny of individual patient pathways. The current trajectories take a measured approach to delivering notable improvement through these plans, which is appropriate given the historic challenges with achieving the 62-day standard at the Trust.

Existing performance improvement forums, including fortnightly Cancer Recovery meetings with operational teams and the monthly joint CCG and Trust Cancer Strategy & Improvement Committee are providing focus on the recovery plans. The resources available to support this vital work will be substantially increased from Q1 2021/22 after the recent approval of a £250k bid to the Cancer Alliance to support 5 new 12-month fixed term posts.
4.0 Next Steps

As outlined above, the recovery trajectories will now be monitored on a monthly basis at the divisional Recovery Meetings and other appropriate forums (including the Trust Bronze RTT and Capacity meeting), in order to ensure there is full understanding of what is driving or inhibiting delivery, and agreement and ownership of any necessary mitigating actions.

Operational teams continue to focus on ensuring clinically prioritised patients are treated within the appropriate timescales, and that long waiting patients are given treatment dates as soon as possible.

5.0 Conclusion

The recovery of previous performance is likely to take many months, and indeed in some services up to a year or more, there has focused developments in recent weeks that I believe demonstrates the validity of the work of divisional teams to recover our position as quickly as possible.

We are on track to open the ring-fenced elective ward on Keppel, beginning of March 2021. Followed by the reopening of the Orthopaedic ward Sitwell.

Ongoing work to identify adequate theatre staff to deliver the additional sessions planned for March and beyond is linked to shielding guidance and Covid numbers given a number of theatre staff are currently redeployed to support the patients requiring the highest levels of clinical support. Alternative options for sourcing theatre staff are being reviewed.
# Integrated Performance Report – January 2021

## Executive Lead
Michael Wright, Deputy Chief Executive

## Link with the BAF
B1, B2, B10

## 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
The Integrated Performance Report is the monthly summary of Trust performance across the four domains of Operational Delivery, Quality, Finance and Workforce.

This month’s report relates to January 2021 data wherever it is available. It highlights performance against agreed national, local or benchmarked targets, and includes four escalation reports for some of the most significant areas of under-delivery. Statistical Process Control charts are included against all key metrics.

The escalation reports this month relate to:
- Mortality
- Care Hours Per Patient Day
- Length of Stay
- Cancer 62 days

## Due Diligence
Each of the three Assurance Committees have received the relevant elements of the Integrated Performance Report, with each Executive Director 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 Chief Executive 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 2021
Integrated Performance Report - January 2021

Board of Directors

Provided by

Business Engagement Team, Health Informatics
## Integrated Performance Report

### PERFORMANCE SUMMARY

<table>
<thead>
<tr>
<th>Quality</th>
<th>Operational Delivery</th>
<th>Finance</th>
<th>Workforce</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortality</td>
<td>Planned Patient Care</td>
<td>Financial Position</td>
<td>Workforce Position</td>
<td>Acute</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control</td>
<td>Emergency Performance</td>
<td></td>
<td></td>
<td>Community Services</td>
</tr>
<tr>
<td>Patient Safety</td>
<td>Cancer Care</td>
<td></td>
<td></td>
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<tr>
<td>Maternity</td>
<td>Inpatient Care</td>
<td></td>
<td></td>
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<tr>
<td>Patient Feedback</td>
<td>Community Care</td>
<td></td>
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</tbody>
</table>

### CQC DOMAINS

<table>
<thead>
<tr>
<th>Responsive</th>
<th>Effective</th>
<th>Safe</th>
<th>Caring</th>
<th>Well Led</th>
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<tr>
<td>Planned Patient Care</td>
<td>Mortality</td>
<td>Infection Prevention &amp; Control</td>
<td>Patient Feedback</td>
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<td>Patient Safety</td>
<td></td>
<td>Financial Position</td>
</tr>
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<td>Cancer Care</td>
<td></td>
<td>Maternity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Care</td>
<td></td>
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</tr>
</tbody>
</table>
accrual funding and high year end capital creditors. Significant closing cash balance as at 31st January of £33,153K, this includes the one month payment in advance on block contract values of £19,390K which will be reversed in month 12. It also includes cash from the decrease in receivables which
Cash position:
- The forecast out-turn is showing an overspend of £9,909K (47%). This is after taking account of the Carbon & Energy Fund scheme (£9,513K) which is now covered by system CDEL. The position includes additional expenditure identified by the
roll-out and go-live in April 2021.

- The Trust is forecasting to deliver a further £1,344K surplus to plan in the final two months of the year adding to the final forecast out-turn position as at 31st March 2021 of £3,206K favourable to plan.

- 62-day performance was well below the national standard again, with 16.5 breaches in the month (of which 5.5 were in Urological cancers and 4.5 in Lower GI). The number of patients waiting over 62 days has also fallen in the month, such that

- The Trust HSMR fell slightly further this month (0.2 points), although the Trust is still a significant outlier on mortality performance across both the SHMI and HSMR. The last 3 months of in-month HSMR scores from July, August and September,

- The number of patients with a decrease in annual performance is relatively similar in all divisions, with the exception of Corporate Operations which has seen an overall increase in performance. This is likely due to the ongoing consolidation of the Lower GI and Urology pathways in particular, and adverts for 3 new Cancer Navigator roles are due to go out imminently for these posts.

- 11.77 WTE Qualified Nurses joined the Trust in January 2021, with the remaining 23.21 WTE from previous month. This brings the total number of super-stranded patients to 19, including four in the division, with a total length of stay of 310 days. The Trust

- 91% of patients were discharged within 24 hours of the intended admission date, with the remaining 5% being discharged within 48 hours. The Trust is reporting nationally against all the required metrics relating to our IPC performance.

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<table>
<thead>
<tr>
<th>KPI</th>
<th>Reporting Period</th>
<th>Type of Standard</th>
<th>Target</th>
<th>Previous Month (3)</th>
<th>Previous Month (2)</th>
<th>Previous Month (1)</th>
<th>Current Month</th>
<th>YTD-20/21</th>
<th>Same Month Prev. Yr.</th>
<th>Forecast-Next 12 months</th>
<th>Trend</th>
<th>Data Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Planned Patient Care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>P1 Waiting List Size</td>
<td>Jan-21</td>
<td>L</td>
<td>14,200</td>
<td>15,085</td>
<td>13,993</td>
<td>14,605</td>
<td>14,012</td>
<td>14,012</td>
<td>14,912</td>
<td>13,500</td>
<td></td>
<td></td>
</tr>
<tr>
<td>P1A Number of RTT Patients with a Decision to Admit</td>
<td>Jan-21</td>
<td>-</td>
<td>-</td>
<td>3,821</td>
<td>3,719</td>
<td>3,755</td>
<td>3,738</td>
<td>3,738</td>
<td>3,451</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>P2 Referral to Treatment (RTT) Performance</td>
<td>Jan-21</td>
<td>N</td>
<td>92%</td>
<td>66.4%</td>
<td>68.8%</td>
<td>69.2%</td>
<td>70.2%</td>
<td>63.5%</td>
<td>91.0%</td>
<td>75%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>P3 Overdue Follow-Ups</td>
<td>Jan-21</td>
<td>L</td>
<td>5,419</td>
<td>11,416</td>
<td>12,512</td>
<td>13,223</td>
<td>12,449</td>
<td>12,449</td>
<td>11,127</td>
<td>10,800</td>
<td></td>
<td></td>
</tr>
<tr>
<td>P4 First to follow-up ratio</td>
<td>Jan-21</td>
<td>B</td>
<td>2.5</td>
<td>3.4</td>
<td>3.3</td>
<td>3.3</td>
<td>3.4</td>
<td>3.3</td>
<td>2.6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>P5 Day case rate (%)</td>
<td>Jan-21</td>
<td>B</td>
<td>80%</td>
<td>85.9%</td>
<td>89.9%</td>
<td>89.1%</td>
<td>89.7%</td>
<td>86.8%</td>
<td>81.4%</td>
<td></td>
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</tr>
<tr>
<td>P6 Diagnostic Waiting Times (DM01)</td>
<td>Jan-21</td>
<td>N</td>
<td>1%</td>
<td>41.6%</td>
<td>37.0%</td>
<td>39.3%</td>
<td>39.2%</td>
<td>49.7%</td>
<td>0.1%</td>
<td>20%</td>
<td></td>
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<tr>
<td><strong>Emergency Performance</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E1 Number of Ambulance Handovers &gt; 60 mins</td>
<td>Jan-21</td>
<td>CQC</td>
<td>0</td>
<td>32</td>
<td>62</td>
<td>107</td>
<td>72</td>
<td>295</td>
<td>188</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>E2 Number of 12 hour trolley waits</td>
<td>Jan-21</td>
<td>N</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E3 Conversion rate from A&amp;E (not including Observations)</td>
<td>Jan-21</td>
<td>-</td>
<td>-</td>
<td>27.1%</td>
<td>26.8%</td>
<td>26.5%</td>
<td>29.1%</td>
<td>26%</td>
<td>21%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E4 Proportion of same day emergency care</td>
<td>Jan-21</td>
<td>L</td>
<td>33%</td>
<td>36.7%</td>
<td>34.2%</td>
<td>33.8%</td>
<td>30.2%</td>
<td>38.8%</td>
<td>24.9%</td>
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<tr>
<td><strong>Cancer Care</strong></td>
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</tr>
<tr>
<td>Ca1 2 Week Wait Cancer Performance</td>
<td>Dec-20</td>
<td>N</td>
<td>93%</td>
<td>95.3%</td>
<td>97.7%</td>
<td>92.9%</td>
<td>95.9%</td>
<td>92.6%</td>
<td>96.5%</td>
<td>93%</td>
<td></td>
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</tr>
<tr>
<td>Ca2 2 Week Wait Breast Symptoms</td>
<td>Dec-20</td>
<td>N</td>
<td>93%</td>
<td>75.5%</td>
<td>86.1%</td>
<td>45.7%</td>
<td>81.8%</td>
<td>74.0%</td>
<td>82.9%</td>
<td>90%</td>
<td></td>
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</tr>
<tr>
<td>Ca3 31 day first treatment</td>
<td>Dec-20</td>
<td>N</td>
<td>96%</td>
<td>92.9%</td>
<td>96.7%</td>
<td>91.0%</td>
<td>98.6%</td>
<td>95%</td>
<td>97.9%</td>
<td>100%</td>
<td></td>
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</tr>
<tr>
<td>Ca4 62 Day Performance</td>
<td>Dec-20</td>
<td>N</td>
<td>85%</td>
<td>59.5%</td>
<td>62.3%</td>
<td>62.6%</td>
<td>64.9%</td>
<td>63.5%</td>
<td>84.3%</td>
<td>80%</td>
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</tr>
<tr>
<td>Ca5 62 day Patient Tracking List Size</td>
<td>Jan-21</td>
<td>L</td>
<td>878</td>
<td>1084</td>
<td>1015</td>
<td>1075</td>
<td>861</td>
<td>861</td>
<td>645</td>
<td>800</td>
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<tr>
<td>Ca6 28 day faster diagnosis standard</td>
<td>Dec-20</td>
<td>N</td>
<td>75%</td>
<td>48.0%</td>
<td>56.1%</td>
<td>56.5%</td>
<td>58.3%</td>
<td>53.6%</td>
<td>75%</td>
<td>75%</td>
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<tr>
<td><strong>Inpatient Care</strong></td>
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</tr>
<tr>
<td>I1 Mean Length of Stay - Elective</td>
<td>Jan-21</td>
<td>-</td>
<td>-</td>
<td>0.4</td>
<td>0.3</td>
<td>0.3</td>
<td>0.3</td>
<td>0.4</td>
<td>0.4</td>
<td></td>
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</tr>
<tr>
<td>I2 Mean Length of Stay - Non-Elective</td>
<td>Jan-21</td>
<td>-</td>
<td>-</td>
<td>4.9</td>
<td>5.7</td>
<td>5.9</td>
<td>6.3</td>
<td>5.0</td>
<td>5.5</td>
<td></td>
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</tr>
<tr>
<td>I3 Length of Stay &gt; 7 days (Proportion discharged)</td>
<td>Jan-21</td>
<td>L</td>
<td>21%</td>
<td>23.6%</td>
<td>27.4%</td>
<td>28.6%</td>
<td>31.4%</td>
<td>24.1%</td>
<td>24.5%</td>
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<tr>
<td>I4 Length of Stay &gt; 21 days (Proportion discharged)</td>
<td>Jan-21</td>
<td>L</td>
<td>3.5%</td>
<td>4.1%</td>
<td>5.5%</td>
<td>5.6%</td>
<td>6.2%</td>
<td>3.8%</td>
<td>5.6%</td>
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<tr>
<td>I5 Length of Stay &gt; 21 days (Snapshot Numbers)</td>
<td>Jan-21</td>
<td>L</td>
<td>20</td>
<td>35</td>
<td>44</td>
<td>52</td>
<td>44</td>
<td>44</td>
<td>60</td>
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<tr>
<td>I6 Right to Reside - % not recorded</td>
<td>Jan-21</td>
<td>-</td>
<td>-</td>
<td>25.2%</td>
<td>22.6%</td>
<td>31.3%</td>
<td>13.3%</td>
<td>13.3%</td>
<td>-</td>
<td></td>
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<tr>
<td>I7 Discharges before midday</td>
<td>Jan-21</td>
<td>L</td>
<td>20%</td>
<td>10.7%</td>
<td>10.0%</td>
<td>9.9%</td>
<td>9.6%</td>
<td>11.5%</td>
<td>10.1%</td>
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<tr>
<td><strong>Outpatient Care</strong></td>
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<tr>
<td>O1 Did Not Attend Rate (OutPatients)</td>
<td>Jan-21</td>
<td>B</td>
<td>8.0%</td>
<td>8.8%</td>
<td>8.8%</td>
<td>7.7%</td>
<td>7.4%</td>
<td>9.8%</td>
<td>9.0%</td>
<td></td>
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</tr>
<tr>
<td>O2 Appointment Slot Issues</td>
<td>Dec-20</td>
<td>N</td>
<td>4%</td>
<td>91%</td>
<td>89%</td>
<td>66%</td>
<td>76%</td>
<td>76%</td>
<td>24%</td>
<td></td>
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<tr>
<td>O3 % of missing outcomes</td>
<td>Jan-21</td>
<td>L</td>
<td>20%</td>
<td>25.7%</td>
<td>24.8%</td>
<td>24.0%</td>
<td>24.0%</td>
<td>23.9%</td>
<td>18%</td>
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<tr>
<td><strong>Community Care</strong></td>
<td></td>
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<tr>
<td>CC1 Musculoskeletal Physio &lt;4 weeks</td>
<td>Jan-21</td>
<td>L</td>
<td>80%</td>
<td>20%</td>
<td>19%</td>
<td>18%</td>
<td>11%</td>
<td>35%</td>
<td>30%</td>
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<tr>
<td>CC2 % urgent referrals contacted within 2 working days by specialist nurse (Continued)</td>
<td>Jan-21</td>
<td>L</td>
<td>95%</td>
<td>90%</td>
<td>89%</td>
<td>88%</td>
<td>92%</td>
<td>86%</td>
<td>68%</td>
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<tr>
<td>CC3 A&amp;E attendances from Care Homes</td>
<td>Jan-21</td>
<td>L</td>
<td>179</td>
<td>135</td>
<td>116</td>
<td>107</td>
<td>107</td>
<td>1048</td>
<td>169</td>
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<tr>
<td>CC4 Admissions from Care Homes</td>
<td>Jan-21</td>
<td>L</td>
<td>86</td>
<td>70</td>
<td>78</td>
<td>83</td>
<td>57</td>
<td>732</td>
<td>91</td>
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<tr>
<td>CC6 Patients assessed within 5 working days from referral (Diabetes)</td>
<td>Jan-21</td>
<td>L</td>
<td>95%</td>
<td>98%</td>
<td>99%</td>
<td>97%</td>
<td>98%</td>
<td>95%</td>
<td>99%</td>
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<tr>
<td>KPI</td>
<td>Reporting Period</td>
<td>Type of Standard</td>
<td>Target</td>
<td>Previous Month (1)</td>
<td>Previous Month (2)</td>
<td>Previous Month (3)</td>
<td>Current Month</td>
<td>YTD 20/21</td>
<td>Same Month Prev. Yr</td>
<td>Forecast Year End</td>
<td>Trend</td>
<td>Data Quality</td>
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<tr>
<td><strong>Mortality</strong></td>
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<tr>
<td>M1 Mortality index - SHMI</td>
<td>Aug-20</td>
<td>B</td>
<td>100</td>
<td>120.9</td>
<td>120.7</td>
<td>118.6</td>
<td>117.3</td>
<td>115.2</td>
<td>115</td>
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<tr>
<td>M2 Mortality index - HSMR (Rolling 12 months)</td>
<td>Sep-20</td>
<td>B</td>
<td>100</td>
<td>121.7</td>
<td>122.6</td>
<td>118.5</td>
<td>118.3</td>
<td>119.0</td>
<td>115.0</td>
<td>114</td>
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<tr>
<td>M3 Number of deaths (crude mortality)</td>
<td>Jan-21</td>
<td>-</td>
<td>-</td>
<td>93</td>
<td>157</td>
<td>141</td>
<td>157</td>
<td>1118</td>
<td>1118</td>
<td>107</td>
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<tr>
<td><strong>Infection, Prevention and Control</strong></td>
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<tr>
<td>in1 Clostridium-difficile Infections</td>
<td>Jan-21</td>
<td>L</td>
<td>TBC - not yet received</td>
<td>1</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>21</td>
<td>8</td>
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<tr>
<td>in2 MRSA Infections (Methicillin-resistant Staphylococcus Aureus)</td>
<td>Jan-21</td>
<td>L</td>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>in3 In-Hospital Mortality - Infectious Diseases</td>
<td>Aug-20</td>
<td>CQC</td>
<td>100</td>
<td>121.8</td>
<td>114.8</td>
<td>0.0</td>
<td>114.8</td>
<td>114.8</td>
<td>N/A</td>
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<tr>
<td><strong>Patient Safety</strong></td>
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<tr>
<td>PS1 Incidents - severe or above</td>
<td>Jan-21</td>
<td>L</td>
<td>0</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>28</td>
<td>3</td>
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<tr>
<td>PS2 Never Events</td>
<td>Jan-21</td>
<td>L</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>1</td>
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</tr>
<tr>
<td>PS3 Number of Patient Harms</td>
<td>Jan-21</td>
<td>-</td>
<td>-</td>
<td>550</td>
<td>551</td>
<td>582</td>
<td>558</td>
<td>4879</td>
<td>650</td>
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<tr>
<td>PS4 Readmission Rates</td>
<td>Jan-21</td>
<td>B</td>
<td>9.04%</td>
<td>14.4%</td>
<td>12.6%</td>
<td>12.5%</td>
<td>11.1%</td>
<td>13.9%</td>
<td>11.5%</td>
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<tr>
<td>PS5 Venous Thromboembolism (VTE) Risk Assessment</td>
<td>Jan-21</td>
<td>N</td>
<td>95%</td>
<td>94.4%</td>
<td>92.2%</td>
<td>92.6%</td>
<td>94.4%</td>
<td>82.5%</td>
<td>85%</td>
<td></td>
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</tr>
<tr>
<td>PS6 Number of complaints per 10,000 patient contacts</td>
<td>Jan-21</td>
<td>L</td>
<td>8</td>
<td>8.7</td>
<td>12.3</td>
<td>10.4</td>
<td>9.2</td>
<td>8.5</td>
<td>7.6</td>
<td></td>
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<tr>
<td>PS7 Proportion of complaints closed within 30 days</td>
<td>Jan-21</td>
<td>L</td>
<td>100%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>90.8%</td>
<td>75.0%</td>
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<tr>
<td>PS8 Care Hours per Patient Day</td>
<td>Jan-21</td>
<td>B</td>
<td>7.3</td>
<td>7.5</td>
<td>6.7</td>
<td>6.7</td>
<td>6.3</td>
<td>6.3</td>
<td>6.8</td>
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<tr>
<td><strong>Maternity</strong></td>
<td></td>
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</tr>
<tr>
<td>Ma1 Bookings by 12 Week 6 Days</td>
<td>Jan-21</td>
<td>N</td>
<td>90%</td>
<td>93.0%</td>
<td>91.1%</td>
<td>95.1%</td>
<td>91.3%</td>
<td>92.8%</td>
<td>91.5%</td>
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</tr>
<tr>
<td>Ma2 % of emergency Caesarean-sections</td>
<td>Jan-21</td>
<td>L</td>
<td>16.5%</td>
<td>17.6%</td>
<td>16.3%</td>
<td>16.2%</td>
<td>18.6%</td>
<td>17.1%</td>
<td>17.4%</td>
<td></td>
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<tr>
<td>Ma3 Breast Feeding Initiation Rate</td>
<td>Jan-21</td>
<td>N</td>
<td>66%</td>
<td>66.3%</td>
<td>67.4%</td>
<td>66.5%</td>
<td>63.1%</td>
<td>67.0%</td>
<td>70.3%</td>
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</tr>
<tr>
<td>Ma4 Stillbirths per 1000 live births</td>
<td>Jan-21</td>
<td>L</td>
<td>4.46</td>
<td>4.8</td>
<td>5.5</td>
<td>5.3</td>
<td>4.9</td>
<td>4.4</td>
<td>5.1</td>
<td></td>
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</tr>
<tr>
<td>Ma5 1:1 care in labour</td>
<td>Jan-21</td>
<td>-</td>
<td>75%</td>
<td>93.7%</td>
<td>96.2%</td>
<td>94.2%</td>
<td>95.5%</td>
<td>88.8%</td>
<td>75.4%</td>
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<tr>
<td>KPI</td>
<td>Reporting Period</td>
<td>Type of Standard</td>
<td>Target</td>
<td>Previous Month (3)</td>
<td>Previous Month (2)</td>
<td>Previous Month (1)</td>
<td>Current Month</td>
<td>YTD 20/21</td>
<td>Same Month Prev. Yr</td>
<td>Forecast - Year End</td>
<td>Trend</td>
<td>Data Quality</td>
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<tr>
<td>W4</td>
<td>Vacancy Rate - TOTAL</td>
<td>Jan-21</td>
<td>B</td>
<td>4.3%</td>
<td>5.9%</td>
<td>5.4%</td>
<td>5.4%</td>
<td>5.4%</td>
<td>4.4%</td>
<td>5.4%</td>
<td>4.4%</td>
<td>5.4%</td>
</tr>
<tr>
<td>W5</td>
<td>Vacancy Rate - Nursing</td>
<td>Jan-21</td>
<td>B</td>
<td>7.4%</td>
<td>9.6%</td>
<td>9.2%</td>
<td>9.1%</td>
<td>8.6%</td>
<td>10.2%</td>
<td>9.3%</td>
<td>9.3%</td>
<td>9.3%</td>
</tr>
<tr>
<td>W6</td>
<td>Time to Recruit</td>
<td>Jan-21</td>
<td>L</td>
<td>34</td>
<td>34</td>
<td>36</td>
<td>32</td>
<td>32</td>
<td>49</td>
<td>34</td>
<td>36</td>
<td>32</td>
</tr>
<tr>
<td>W7</td>
<td>Sickness Rates (%) - exc COVID related</td>
<td>Jan-21</td>
<td>L</td>
<td>3.95%</td>
<td>4.4%</td>
<td>4.5%</td>
<td>4.3%</td>
<td>3.9%</td>
<td>3.7%</td>
<td>4.6%</td>
<td>4.4%</td>
<td>4.5%</td>
</tr>
<tr>
<td>W8</td>
<td>Sickness Rates (%) - inc COVID related</td>
<td>Jan-21</td>
<td>L</td>
<td>0.63%</td>
<td>0.54%</td>
<td>0.59%</td>
<td>0.65%</td>
<td>0.80%</td>
<td>0.66%</td>
<td>0.7%</td>
<td>0.63%</td>
<td>0.54%</td>
</tr>
<tr>
<td>W9</td>
<td>Turnover</td>
<td>Jan-21</td>
<td>L</td>
<td>90%</td>
<td>76.0%</td>
<td>79.1%</td>
<td>81.6%</td>
<td>80.9%</td>
<td>80.9%</td>
<td>79.6%</td>
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<tr>
<td>W10</td>
<td>Appraisals complete (%)</td>
<td>Jan-21</td>
<td>L</td>
<td>85%</td>
<td>91.7%</td>
<td>91.7%</td>
<td>91.5%</td>
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<td>91.0%</td>
<td>89.6%</td>
<td>90%</td>
<td>91.7%</td>
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**Trust Integrated Performance Dashboard - Workforce**

**Workforce**

- **W1**: Whole Time Equivalent against plan - Total
  - Reporting Period: Jan-21
  - Target: -178
  - Previous Month (3): -245
  - Previous Month (2): -225
  - Previous Month (1): -224
  - Current Month: -226
  - YTD 20/21: -226
  - Same Month Prev. Yr: -278
  - Forecast - Year End: -278

- **W2**: Whole Time Equivalent plan - Nursing
  - Reporting Period: Jan-21
  - Target: -94
  - Previous Month (3): -123
  - Previous Month (2): -119
  - Previous Month (1): -116
  - Current Month: -110
  - YTD 20/21: -110
  - Same Month Prev. Yr: -117
  - Forecast - Year End: -117

- **W3**: Total Headcount
  - Reporting Period: Jan-21
  - Target: 4,778
  - Previous Month (3): 4,794
  - Previous Month (2): 4,794
  - Previous Month (1): 4,825
  - Current Month: 4,825
  - YTD 20/21: 4,825
  - Same Month Prev. Yr: 4,707
  - Forecast - Year End: 4,707

- **W4**: Vacancy Rate - TOTAL
  - Reporting Period: Jan-21
  - Target: 4.3%
  - Previous Month (3): 5.9%
  - Previous Month (2): 5.4%
  - Previous Month (1): 5.4%
  - Current Month: 5.4%
  - YTD 20/21: 5.4%
  - Same Month Prev. Yr: 4.4%
  - Forecast - Year End: 4.4%

- **W5**: Vacancy Rate - Nursing
  - Reporting Period: Jan-21
  - Target: 7.4%
  - Previous Month (3): 9.6%
  - Previous Month (2): 9.2%
  - Previous Month (1): 9.1%
  - Current Month: 8.6%
  - YTD 20/21: 8.6%
  - Same Month Prev. Yr: 10.2%
  - Forecast - Year End: 9.3%

- **W6**: Time to Recruit
  - Reporting Period: Jan-21
  - Target: 34
  - Previous Month (3): 34
  - Previous Month (2): 36
  - Previous Month (1): 27
  - Current Month: 32
  - YTD 20/21: 32
  - Same Month Prev. Yr: 49
  - Forecast - Year End: 49

- **W7**: Sickness Rates (%) - exc COVID related
  - Reporting Period: Jan-21
  - Target: 3.95%
  - Previous Month (3): 4.4%
  - Previous Month (2): 4.5%
  - Previous Month (1): 4.3%
  - Current Month: 3.9%
  - YTD 20/21: 3.9%
  - Same Month Prev. Yr: 3.7%
  - Forecast - Year End: 4.6%

- **W8**: Sickness Rates (%) - inc COVID related
  - Reporting Period: Jan-21
  - Target: 0.63%
  - Previous Month (3): 0.54%
  - Previous Month (2): 0.59%
  - Previous Month (1): 0.65%
  - Current Month: 0.80%
  - YTD 20/21: 0.80%
  - Same Month Prev. Yr: 0.66%
  - Forecast - Year End: 0.7%

- **W9**: Turnover
  - Reporting Period: Jan-21
  - Target: 90%
  - Previous Month (3): 76.0%
  - Previous Month (2): 79.1%
  - Previous Month (1): 81.6%
  - Current Month: 80.9%
  - YTD 20/21: 80.9%
  - Same Month Prev. Yr: 79.6%
  - Forecast - Year End: 90%

- **W10**: Appraisals complete (%)
  - Reporting Period: Jan-21
  - Target: 85%
  - Previous Month (3): 91.7%
  - Previous Month (2): 91.7%
  - Previous Month (1): 91.5%
  - Current Month: 91.0%
  - YTD 20/21: 91.0%
  - Same Month Prev. Yr: 89.6%
  - Forecast - Year End: 90%
## Trust Integrated Performance Dashboard - Finance

<table>
<thead>
<tr>
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<th>In Month Plan £000s</th>
<th>In Month Actual £000s</th>
<th>In Month Variance £000s</th>
<th>YTD Plan £000s</th>
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<th>YTD Variance £000s</th>
<th>Forecast Variance £000s</th>
<th>Prior Month Forecast Variance £000s</th>
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<tr>
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<td>(4,666)</td>
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<td>(9,150)</td>
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## Trust Integrated Performance Dashboard - Activity

- **UECC Attendances**
- **Total Outpatients**
- **Inpatient Admissions (including Observations)**
- **Inpatient Admissions (excluding Observations)**
- **Total Referrals (Acute)**
- **2ww Referrals**

71
Trust became field test pilot site on 23rd May with revised Urgent and Emergency Care standards in place.

Zero tolerance communicated.

Covid-19 pandemic forced cancellation of significant volumes of activity.

Significant increase in proportion of non-face-to-face appointments due to Covid-19 pandemic.
### Cancer 2 week wait standard

![Image of Cancer 2 week wait standard chart]

### Cancer 2 week wait breast symptoms standard

![Image of Cancer 2 week wait breast symptoms standard chart]

### Cancer 62 day first treatment standard

![Image of Cancer 62 day first treatment standard chart]

### Diagnostics - % of breaches over 6 weeks (DM01)

![Image of Diagnostics - % of breaches over 6 weeks (DM01) chart]

**Note:** Covid-19 pandemic forced cancellation of significant volumes of activity.
Covid-19 pandemic peaked in Rotherham in April, leading to higher numbers of deaths than otherwise expected.
Covid-19 pandemic has meant the closure of a number of beds and significantly lower bed occupancy figures, meaning nurse:patient ratios have improved.
Covid-19 pandemic has introduced significant additional short-term (self-isolation) and long-term (shielding) sickness.

Decision made to stop face-to-face MAST training and relax expectations for clinicians directly involved in Covid-19 response for a short period.

Aspirant nurses working at the Trust as part of Covid-19 response included in Trust overall workforce figures.
Escalation/Assurance Report

Metric Requiring Improvement: Mortality index - HSMR (Rolling 12 months)  
Type of Standard: National Benchmark  
Assurance Committee: Quality  
Latest Data Period: September 2020

Performance:

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</table>

Driver for Underperformance:

- **Counting:** The Trust has not historically recorded ‘observations’ from A&E (where patients are assessed and treated in an assessment area such as AMU) as non-elective admitted activity. As such, none of these patients count within the Hospital Standardised Mortality Ratio calculation. This is in contrast to most other trusts, where similar patients would be counted within their non-elective admissions figures. This negatively impacts our HSMR all year.

- **Clinical Care:** The Trust continues to outlie in a few specific groups, where deaths are significantly higher than expected. These are being investigated with support from Dr Foster.

- **Covid:** In recent months, the impact of Covid-19 mortality has led to higher HSMR values for most providers, given the overall increased crude mortality rate and lower levels of activity. An initial rebasining of Dr Foster data to account for Covid-19 has taken place, but this is currently based on a relatively limited Covid-19 dataset from April and May 2020 alone.

Actions to Deliver Improvement:

- A Mortality Task & Finish Group has been established to lead and oversee the Trust’s programme of work around mortality, led by the Chief Executive and Executive Medical Director, with expert external guidance from Professor Chris Welsh. A Programme Manager has been appointed to drive this work forwards. In addition, a Mortality Insights Task & Finish Group has been set up, to ensure appropriate insight and intelligence is drawn from our latest data. Both will complement the Trust’s monthly Mortality Group meeting, led by the Trust’s Medical Director.

- From 1st April, Inpatient Observation activity has been flowing to the activity submission as non-elective admitted activity. This will have had a gradual impact on the HSMR from April onwards, given we are now recognising all admissions within our mortality data.

- The Medical Examiner (ME) is reviewing all deaths with a Stage 1 review, and co-ordinating any Stage 2 reviews which are required. The Executive Medical Director is working with the ME to increase the number of MEs and ME officers with a view to the provision of a 7-day service, and on strengthening the Trust’s Learning from Deaths resource via Clinical Effectiveness. A second ME has been recruited, and is now undertaking training before becoming fully operational in role.

- The Community Acquired Pneumonia care bundle has been re-introduced, with one of the key tools within this framework - CURB65 - built into Meditech for use by clinicians.

- Clinical guidelines for the recognition, diagnosis and early management of Sepsis have been published, with e-learning for the management of paediatric Sepsis rolled out.

Expected Trajectory/Forecast:

- The Improvement Plan target is for an HSMR of less than 110 by the time of the March data 2021. Whilst this was an ambitious but deliverable target, the impact of Covid-19 is likely to make this an incredibly challenging target. Recent in-month HSMR scores for July, August and September demonstrate the HSMR has reduced significantly, although a three-month improvement is not enough to suggest sustained and consistent delivery at this stage, and it is likely that with the second wave of Covid-19 arriving from October, the next several months will look much less positive.

- Furthermore, the inclusion of observations within the admitted patient data set has not had as significant an impact as expected, as the majority of these patients do not fall within the Trust’s outlying groups, with a significant proportion receiving a diagnosis of ‘Abdominal Pain’.

- Given the above, we do now not expect to achieve an HSMR of 110 or less by March. This expectation will be continually reassessed as further data on the impact of Covid on the HSMR becomes available.

Lead Executive Director:  
Callum Gardner, Executive Medical Director

Lead Senior Manager:  
Carrie Kelly, Medical Examiner

Lead Analyst:  
Lisa Fox, Associate Director of Health Informatics
### Escalation/Assurance

**Metric:** Care Hours per Patient Day  
**Type of Standard:** National  
**Assurance Committee:** Quality Committee  
**Report Period:** November 2020

#### Performance:

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### Driver for Underperformance:

Care Hours per Patient Day (CHpPD) is a metric introduced following Lord Carter’s review of efficiency in the NHS to record a single consistent way of recording and reporting deployment of staff working on inpatient wards/units. The total combines both registered and non-registered nursing workforce to give a representation of the number of hours available for direct patient care, per patient, in a 24 hour period. Prior to the pandemic, this varied between 6.8 - 8.1 for the past 2 years. During the pandemic this was artificially elevated due to:

- **a)** Reduced number of patients in the organisation
- **b)** Clinical staff redeployed to support wards
- **c)** Student nurses being temporarily assigned as aspirant nurses and therefore losing their supernumerary status
- **d)** Higher than normal percentage of Critical Care beds. The reduced level since November 2020 reflects the high number of Covid-19 in-patients at this time whilst aiming to maintain other services as far as possible. This was combined with an increase in sickness absence and a reduction in fill rates for bank and agency workers. Conversely, nursing establishment increased but this was not sufficient to counter the other reductions in workforce availability.

### Actions to Deliver Improvement:

Recruitment campaigns are ongoing to rapidly increase both registered and non-registered nursing workforce. This includes the international recruitment programme. Funding has been received from NHSE/I to support both of these ambitions (funding relates to support processes rather than funding posts).

Bank and agency fill rates have shown some improvement in recent weeks, and it is hoped this will bring the metric above target in February.

Sickness rates are expected to start improving following the roll out of lateral flow testing for frontline staff and commencement of the Covid vaccination programme.

In agreement with the wider South Yorkshire and Bassetlaw system, a decision has been taken to protect 3rd year student nurses supernumerary status at this time but this is being reviewed on a weekly basis by the Chief Nurses.

### Expected Trajectory/Forecast:

CHpPD is expected to improve in February and for the remainder of the financial year unless there is a significant increase in staff sickness. An additional 11 international recruits arrived at the end of January and will begin to impact on CHpPD figures in February with a further 6 recruits arriving in February.

19 Healthcare Support Worker, undertaking a Care Certificate programme through NHSP will be included in total numbers (although not substantive establishment) from 8th February which will further improve this metric.

---

**Lead Executive Director:** Angela Wood, Chief Nurse  
**Lead Senior Manager:** Helen Dobson, Deputy Chief Nurse  
**Lead Analyst:** Ruth Gallagher, Senior Analyst
# Performance:

<table>
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<tr>
<th>Metric</th>
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<td>FPC</td>
</tr>
<tr>
<td></td>
<td></td>
<td>January 2021</td>
</tr>
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</table>

## Drivers for Underperformance:

- **COVID-19 Inpatients:** In the second wave we have seen significant numbers of COVID-19 patients remaining in hospital for long periods of time.
- **Intermediate Care Capacity:** As in the hospital, capacity remains constrained in the intermediate care and care home sectors, with the same IPC requirements, and with challenges over staffing just as in the acute environment. Patients with COVID need to be cared for in facilities which will accept these patients, and similarly to in the hospital, matching cohorted capacity to the ever-changing needs of our patients is challenging.
- **Rotherham Reset:** The Trust carried out a Rotherham Reset week in early February, in order to ensure best practice was in place from the front door to the back door within the organisation. A lessons learnt engagement event was held in mid-February with a wide cohort of staff in order to determine critical actions to take forward to ensure the learning can be embedded and the improvement sustained.
- **Home First Approach:** The organisation continues to adopt a home first approach with Board rounds twice daily to ensure patients are receiving appropriate medical review. Colleagues work closely with social services and other partners through the Integrated Discharge Team to ensure there is maximum flow out of the organisation.
- **Command structure:** Twice-weekly Gold and Silver meetings are still taking place to manage the increased challenges on site, and ensure very frequent review of the site situation, with escalation as appropriate.
- **Ward RAG Reviews:** On top of the Board rounds already in place, simple patient level discharge RAG reviews are being initiated across the organisation, led by Ward Matrons, to ensure there is adequate oversight of where the most significant resource challenges lie which are preventing patients from leaving the Trust.

## Actions to Deliver Improvement:

- **COVID-19 Inpatients:** The organisation continues to adopt a home first approach with Board rounds twice daily to ensure patients are receiving appropriate medical review. Colleagues work closely with social services and other partners through the Integrated Discharge Team to ensure there is maximum flow out of the organisation.
- **Rotherham Reset:** The Trust carried out a Rotherham Reset week in early February, in order to ensure best practice was in place from the front door to the back door within the organisation. A lessons learnt engagement event was held in mid-February with a wide cohort of staff in order to determine critical actions to take forward to ensure the learning can be embedded and the improvement sustained.
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- **Ward RAG Reviews:** On top of the Board rounds already in place, simple patient level discharge RAG reviews are being initiated across the organisation, led by Ward Matrons, to ensure there is adequate oversight of where the most significant resource challenges lie which are preventing patients from leaving the Trust.

## Expected Trajectory/Forecast:

- Although the numbers of COVID-19 patients is now falling, given the numbers still in beds, we would expect to remain above the target for February. When the volumes of COVID-19 patients start to fall to minimal levels, potentially in March with the ongoing rollout of the vaccine, we would expect to see this metric improve to closer to target.

## Lead Executive Director:

- **George Briggs, Chief Operating Officer**

## Lead Senior Manager:

- **Sally Kilgariff, Deputy Chief Operating Officer**

## Lead Analyst:

- **Ruth Gallagher, Senior Analyst**
### Escalation/Assurance

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Target 85% 85% 85% 85% 85% 85% 85% 85% 85% 85% 85% 85%

#### Driver for Underperformance:
- **Diagnostic Activity:** At the start of the pandemic, there was a national dictat around reducing endoscopy activity to almost minimal levels, which meant a lot of cancer 2ww referrals were deferred for several weeks. The patients within this cohort who do have cancer are now breaching the 62 day standard.
- **Patient Choice:** Over the last 6 months we have had significant numbers of patients not wanting to attend hospital for appointments, particularly for diagnostics, despite them being on a cancer pathway. Some of these patients are now being found to have cancer, at a point when they have breached the 62-day standard.
- **Patient Fitness:** 16% of our long-waiting patients are currently unfit for further treatment until they have received their Covid-19 vaccine or are delaying treatment for other reasons.
- **Pathway management:** Historically, the Trust has struggled to deliver an effective 62-day pathway within Urology, and this remains a challenge. Considerable work has gone on to identify areas of improvement, as noted.

#### Actions to Deliver Improvement:
- **Endoscopy activity:** Endoscopy activity is ahead of trajectory, with the backlog due to be cleared by mid-March. Additional Sunday lists are continuing to take place to deliver this, in order to ensure the backlog can be reduced and straight-to-test activity for appropriate Lower and Upper GI referrals can be re-instated, which will reduce the length of the front-end of the pathway in these tumour sites.
- **Primary Care Involvement:** Where patients have not wanted to attend hospital for critical appointments, we have involved their primary care doctors where appropriate, as GPs often have a long-standing relationship with patients.
- **Urology Pathway Improvement:** An improvement project is underway within Urology to identify the necessary changes to the pathway. The Clinical Lead has agreed to implement a straight-to-test model which should significantly improve the efficiency at the front end of the pathway, with further discussions on the back-end of the pathway ongoing. Urology breaches can account for 40-50% of all breaches across all tumour groups, so improvement in this area will have a significant impact.
- **PTL size:** The PTL grew to over 1,350 patients with suspected cancer at its peak, and over 320 patients who had been waiting 62 days or more, creating a challenge for clinicians, operational managers and cancer services to ensure each patient was being proactively managed as normal. A focus on bringing this down has led it to fall to under 900 patients on the full PTL, with fewer than 100 over 62 days. This work is ongoing.

#### Expected Trajectory/forecast:
- The 62 day standard has been a challenge for the Trust for some time. With the improvements to the Urology pathway and the increased activity within endoscopy, divisionally-led trajectories would see us achieve close to 75% performance by the end of the year. We continue to aim for the 85% figure, but given the continued Covid prevalence and related increasing levels of staff sickness, it is likely this will remain a significant challenge to deliver this year.

#### Lead Executive Director:
George Briggs, Chief Operating Officer

#### Lead Senior Manager:
Louise Tuckett, Director of Strategy, Planning & Performance

#### Lead Analyst:
Roberto Juan-Martin, Cancer Data Manager
The below summary sets out the proposed methodology and colouring we will use at TRFT, noting the different trends that will be shown as special cause variation or out of control.

We will use the following colours to indicate variation:
- **orange** indicates special cause variation of concern and needing action
- **blue** indicates special cause variation where improvement appears to lie
- **grey** data indicates no significant variation
- **red** indicates where the process is out of control (outside control limits)

We will follow the NHS guidance and identify 4 different ways in which a trend will be defined as special cause variation:

1) A single point outside the control limits

2) A run of at least 6 points above or below the mean line

3) Six consecutive points increasing or decreasing

4) A pattern of 2 out of 3 points within the outer thirds

Other SPC methodologies classify a further 4 trends as special cause variation, but these will not be identified by colour coding within our SPC charts, for ease:

5) 14 consecutive points alternating up and down
6) 15 consecutive points in the central third
7) 8 consecutive points with none in the central third
8) 4 out of 5 consecutive points in the middle third

In addition, we will annotate any reasons for special cause variation which we are aware of.
## Board of Directors’ Meeting  
05 March 2021

<table>
<thead>
<tr>
<th>Agenda item</th>
<th>P47/21(i)</th>
</tr>
</thead>
</table>
| Report      | Chair’s Assurance Log  
Finance and Performance Committee (FPC) |
| Chair       | Nicola Bancroft, Non Executive Director |
| Executive Leads | Stuart Diggles, Interim Director of Finance  
George Briggs, Chief Operating Officer |
| Link with the BAF | B9: Financial Plan, B10: Capital Investment |
| Support Trust Values | The work of FPC supports the Trust values of ‘Ambitious’ and ‘Together’ as it seeks to deliver on the financial and operational priorities in a collective way. |
| Purpose | For decision ☐  
For assurance ☒  
For information ☐ |
| Executive Summary | The purpose of the Chair’s Assurance Log is to provide assurance, raise concerns and make recommendations, as appropriate, on key strategic, financial and operational matters.  

Key messages from the various assurance papers received at the FPC meeting on 24 February 2021:  

1. Financial performance favourable to plan, with careful management of capital spend in the lead up to year end;  
2. A high number of the 16 2020/21 operational objectives and enablers are not likely to be achieved by year end, mainly driven by COVID-19. Learning review to be undertaken to inform the forthcoming planning process;  
3. Divisional engagement on the recovery plan trajectories, with further work to manage the financial and people implications;  
4. Good progress on the E-Roster / NHS P integration with further work to be completed by the 3 groups set up to manage pay pressures. |
<p>| Due Diligence | During the FPC meeting, the Committee reviewed the level of assurance after each agenda item. A draft log was completed by the Chair and minor changes reviewed/signed-off with the Interim Finance Director and Chief Operating Officer. |
| Board Powers to Make this Decision | Section 6 of the Standing Orders of the Rotherham NHS Foundation Trust state that the Board of Directors can appoint Committees to act on its behalf. |</p>
<table>
<thead>
<tr>
<th><strong>Who, What and When</strong></th>
<th>The log has been circulated to all Committee members as a record of what was agreed in the meeting. Specific actions summarised in the log have been communicated to relevant individuals and the FPC planner has been updated to reflect timings of additional agenda items.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recommendations</strong></td>
<td>The Board of Directors is asked to receive this report and consider the assurance presented as detailed in appendix 1.</td>
</tr>
</tbody>
</table>
| **Appendices** | 1. Chair’s Assurance Log  
2. Meeting Agenda – Key Papers for Assurance |
Appendix 1

Subject: FINANCE & PERFORMANCE CHAIR’S ASSURANCE LOG

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

| Committee: Finance & Performance Committee (FPC) | Date: 24 February 2021 |
| Chair: Nicola Bancroft |
| Executive Leads: Stuart Diggles, George Briggs |

<table>
<thead>
<tr>
<th>Ref</th>
<th>Agenda Item</th>
<th>Issue and Lead Officer</th>
<th>Receiving Body</th>
<th>Recommendation / Assurance / Mandate to Receiving Body</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Divisional Performance Update – Clinical Support Services</td>
<td>The Committee received a presentation from the Division of Clinical Support Services on financial performance, headcount, agency costs, cost improvement, governance and risk. The Committee were assured that the Division had appropriate action plans in place, and recognised the following key risks: 1. A “do different” approach was required on Pharmacy retention 2. Capital priorities for the Division would be assessed at the forthcoming capital planning prioritisation session for 2021/22. Replacement of the MRI Scanner was seen as the highest priority. Lead: George Briggs.</td>
<td>Board</td>
<td>Limited assurance – pending management of key risks</td>
</tr>
<tr>
<td>2</td>
<td>2020/21 Operational Objectives and Enablers</td>
<td>At the end of month 10, of the 16 projects with which the Committee is tasked to monitor, 1 is closed having achieved its objectives, 6 are green/on plan, 5 are amber/behind plan with actions to recover and 4 are red/significant action required. The Committee again challenged the robustness of the amber action plans in quarter 4 to achieve on plan performance and the likely carry-over into the new financial year. As a result, the Committee received mixed assurance with an anticipated end of financial year position:</td>
<td>Board</td>
<td>Limited assurance – in part driven by COVID-19</td>
</tr>
<tr>
<td>Ref</td>
<td>Agenda Item</td>
<td>Issue and Lead Officer</td>
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<td>Closed, 6 Green, and 8 Red. However, it was recognised that certain initiatives have made good progress, despite not achieving the original milestones plans set at the start of the year e.g. GP out of hours service and gastro-enterology service. A rebasing of the relevant initiatives for 2021/22 is to be included in the forthcoming planning process, along with a review of learning from this financial year. Lead: Stuart Diggles/George Briggs.</td>
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<td>3</td>
<td><strong>CIP Programme Update 2020/21 and 2021/22</strong></td>
<td>Year end forecast cost improvement stands at £1,534k, £81k favourable to the plan of £1.453m, on a risk adjusted basis. Given the late start to this programme activity, this is a very positive performance and an improving position month on month. For noting, the savings identified to date are not 100% recurrent and so this will need to be factored into the planning process for 2021/22. Over 130 schemes have been identified for development so far in 2021/22. Lead: Michael Wright.</td>
<td>Board</td>
<td>Assured – 2020/21</td>
</tr>
<tr>
<td>4</td>
<td><strong>Integrated Performance Report, Operational Performance Report and Recovery Update</strong></td>
<td>The Trust is off track on a number of metrics developed as part of the national recovery program, in the main driven by COVID-19. The mismatch of staffing and demand remains a key concern. The Committee received an update on the work completed to date on the revised recovery trajectories, following engagement of all divisions. These will form the basis of monthly monitoring, albeit recognising the need for iterations on certain of the key assumptions. Key points discussed by the Committee:  - Use of the Independent Sector across the SYB ICS lower than originally anticipated;</td>
<td>Board</td>
<td>Limited Assurance – ongoing ‘end to end’ development of the recovery plan</td>
</tr>
<tr>
<td>Ref</td>
<td>Agenda Item</td>
<td>Issue and Lead Officer</td>
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<td>- Recognition of the need to assess staff well-being in undertaking additional shifts, noting that an amount of Independent Sector clinical activity comes from Trust staff; - When available, assess the financial forecast assumptions and funding envelopes; - The need for a clear exit plan or changes to the Independent Sector usage at the appropriate stage. The Committee was assured of the progress to date but recognised the imperative to better understand the people and financial implications. Lead: George Briggs.</td>
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<td>5</td>
<td>E-Roster, NHSP, Pay Controls Update</td>
<td>The committee received an update on the progress made in managing pay pressures across the Trust. At month 10, there is a £1.54m year on year reduction in agency costs, despite the COVID-19 peak. The Committee was assured by the work completed so far on the interface between E-Roster and NHS P. The Committee agreed on limited assurance overall, given the further work to be undertaken by the 3 groups set up to manage pay pressures. Lead: Michael Wright.</td>
<td></td>
<td>Limited assurance – pending further work</td>
</tr>
<tr>
<td>6</td>
<td>Integrated Financial Performance Report</td>
<td>The Committee received an update on month 10 performance and half 2 to date. Key headlines on actual performance: - I&amp;E on track, £1,883k favourable to plan half 2 to date. - Capital expenditure £3,803k favourable versus plan as at end of January - Closing cash at the end of January: £33,153k.</td>
<td>Board</td>
<td>Assured – on track performance</td>
</tr>
<tr>
<td>Ref</td>
<td>Agenda Item</td>
<td>Issue and Lead Officer</td>
<td>Receiving Body</td>
<td>Recommendation / Assurance / Mandate to Receiving Body</td>
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<td>Forecast out-turn is showing:</td>
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<td>- I&amp;E on track, still showing £3,206k favourable to plan</td>
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<td>- Capital expenditure £9,909k adverse to plan including further additional PDC, after accounting for the impact of the Carbon Energy Fund Scheme of £9,513k</td>
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<td>- Cash £1,415k as at the end of March 2021. This is anticipated to improve significantly given the latest view on capital creditors and working capital at the year end and further income and cash expected to be received.</td>
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<td>The Committee reviewed the current assessment of risks to the I&amp;E forecast. Taking into consideration the current trends in income and costs, the level of contingency and the quantum of prudent accruals, the Committee was assured that the risks could be mitigated.</td>
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<td></td>
<td>The Committee was also assured that key areas of the Trust were focusing on capital monies being spent by the year end in order to minimise any carry-over.</td>
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<td>Lead: Stuart Diggles.</td>
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<tr>
<td>7</td>
<td>Financial Governance Action Plan</td>
<td>As part of the agreed Financial Governance Action Plan, the Committee was assured on progress, recognising 2 areas:</td>
<td>Board</td>
<td>Assured – on track overall</td>
</tr>
<tr>
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<td>- Continue to progress the work on the Integrated Financial Report in readiness for the next cycle;</td>
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<td></td>
<td>- Reassess the milestone date of the Finance Structure review in the light of the start date of the new substantive Finance Director.</td>
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<td>Lead: Stuart Diggles.</td>
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</table>
Appendix 2

Finance and Performance Committee

Meeting Agenda – Papers for Assurance, Information and Decision

24 February 2021

1. Divisional Performance Update – Clinical Support Services
2. 2020/21 Operational Objectives and Enablers
3. CIP Programme Update 2020/21 ad 2021/22
4. Integrated Performance Report
5. Operational Performance Report
6. Recovery Plan
7. E-Roster, NHSP, Pay Controls Update
8. Integrated Financial Performance Report
9. HEG Paper – Finance Update 9 February 2021
10. Financial Impact of Recent Recruitment
11. Financial Governance Action Plan
12. Committee Terms of Reference
13. Committee Effectiveness Survey.
<table>
<thead>
<tr>
<th>Agenda item</th>
<th>P47/21(ii)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report</td>
<td>Chair’s Assurance Log Quality Committee (FPC)</td>
</tr>
<tr>
<td>Chair</td>
<td>Rumit Shah, Non-Executive Director</td>
</tr>
<tr>
<td>Executive Leads</td>
<td>Angela Wood, Chief Nurse Callum Gardner, Medical Director</td>
</tr>
<tr>
<td>Link with the BAF</td>
<td>B1, B2, B3, - excellence in health care, quality of care, safe and sound, patient engagement B7 - effective performance framework</td>
</tr>
<tr>
<td>Support Trust Values</td>
<td>The work of Quality Committee supports the Trust values of ‘Caring’ and ‘Together’ as it seeks to deliver on the quality of care priorities in a collective way.</td>
</tr>
<tr>
<td>Purpose</td>
<td>For decision ☐ For assurance ☒ For information ☐</td>
</tr>
<tr>
<td>Executive Summary</td>
<td>The purpose of the Chair’s Assurance Log is to provide assurance, raise concerns and make recommendations, as appropriate, on key strategic, and quality matters. Key messages from the various assurance papers received at the Quality meeting on 24 February 2021 were:</td>
</tr>
<tr>
<td></td>
<td>- Quality priorities, some will be carried over to 2021/22</td>
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<td>- Care Quality Commission, all but 3 actions completed</td>
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<td>- Concerned that our recovery will not be at the pace to meet external expectations</td>
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<td>- Ockendon Report - we are fulfilling our responsibilities.</td>
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<td>- Safeguarding, risks are being managed</td>
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<td>- Mortality remains a key priority</td>
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<td>- Serious Incidents reports being completed on time.</td>
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<td>- Pressure ulcers, concern about the worsening position in respect of pressure ulcers within the community and in the hospital,</td>
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<td>- Health &amp; Safety Report – Trust has received its 8th consecutive ROSPA gold award</td>
</tr>
<tr>
<td></td>
<td>- BAF B7 requires a board decision</td>
</tr>
<tr>
<td>Due Diligence</td>
<td>During the Quality Committee meeting, the Committee reviewed the level of assurance after each agenda item. A log was then completed by the Chair and then reviewed by the Chief Nurse.</td>
</tr>
<tr>
<td>Board Powers to Make this Decision</td>
<td>Section 6 of the Standing Orders of the Rotherham NHS Foundation Trust state that the Board of Directors can appoint Committees to act on its behalf.</td>
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<td>The log has been circulated to all Committee members as a record of what was agreed in the meeting. Specific actions summarised in the log will be communicated to relevant individuals and the planner has been updated to reflect timings of additional agenda items.</td>
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<td>The Board of Directors is asked to receive this report and consider the assurance presented as detailed in appendix 1.</td>
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| Appendices                        | 1. Chair’s Assurance Log  
2. Meeting Agenda – Key Papers for Assurance                                                                                                                                                      |
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<tr>
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<th>Issue</th>
<th>Lead Officer</th>
<th>Recommendation / Assurance/ Information</th>
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</table>
| 1   | 031/21- QUALITY IMPROVEMENT PRIORITIES | Due to the adverse impact of Covid-19, difficulties with completion of some Quality Priority objectives has been identified. It had previously been hoped that this could be overcome but with the recent further increase in infection rates, this is now seen as a barrier for some priorities. It is therefore proposed that the following Quality Priorities are rolled over into 2021/22:  
• Trust wide Audits – Learning from Incidents element  
• Volunteering  
The committee had a verbal update by the Chief Nurse re progress on some of the key areas:  
• TRFT have continued with the Quality Priorities. Some trusts have paused this work due to covid  
• Virtual Schwartz rounds have been paused due to covid but will be starting up again  
• Still a lack of engagement of the medicine division in particular around mortality, structured judgement reviews,  
• Early days of new process of embedding early learning through Organisational Learning Action Forum (OLAF) no evidence yet seen | Angela Wood / Callum Gardner / Anne Rolfe | Committee assured that some Quality Priorities have progressed and lots of work ongoing however less assured that this work is producing the required outcomes as yet. |
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| 2   | 032/21 CQC MONTHLY UPDATE | Colleagues continue to address the action plan issues and are keeping the CQC updated on a regular basis.  
Three actions still not completed:  
017 The Trust must carry out clinical audit and other quality assurance activity to ensure patients are receiving care and treatment in line with national and RCEM guidance.  
037 The Trust must ensure that oxygen is appropriately prescribed including the documentation of target blood oxygen levels.  
065 The Trust must ensure they have enough staff in the Special Care Baby Unit (SCBU) qualified in speciality, in line with the national guidance. | Angela Wood / Callum Gardner / Anne Rolfe | Assured that the issues are being addressed |
| 3   | 035/21 INTEGRATED PERFORMANCE REPORT – Dashboard | Three areas of activity were escalated to the Committee:  
1. Mortality  
2. Care Hours per patient day  
3. Venous Thromboembolism (VTE)  
Detailed explanations of activity to address these challenges were presented.  
It is hoped that covid activity starts settling down so we can start looking at opening elective wards for orthopaedics as significant waiting lists have built up. Using the independent sector will help although it was highlighted that the same anaesthetic staff are those working in the NHS and they are a very tired group at present.  
Appointment slot issues were discussed, now being added to the Patient Treatment List so possible that the waiting list will go up. | Callum Gardner / Carrie Kelly / Angela Wood / Helen Dobson / Callum Gardner / Richard Slater | Assured that colleagues are focussing on task to improve the position. Not Assured that we will be able to recover at a pace to meet external expectations. |
<table>
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<th>Recommendation / Assurance/ Information</th>
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<td>Recovery plans are being put in place and lot of work is going on to get business back to usual but this will take at least 6-12 months as a result of recovery from covid is dependant on multiple factors.</td>
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<td>4</td>
<td>037/21 CNST MATERNITY REPORT</td>
<td>The Head of Midwifery assured the committee that all actions outlined-on track to meet them by target date. Safety Action 2 data set was submitted last week to NHS Digital and a score of 11 out of 11 was achieved. This is a great credit to the teams that have worked on this. The Committee received an update report on the implementation of the recommendations from the Ockendon Report into maternity services(at Shrewsbury and Telford NHS Trust) and were assured that we are fulfilling our responsibilities.</td>
<td>Angela Wood / Sarah Petty</td>
<td>Assured</td>
</tr>
<tr>
<td>5</td>
<td>038/21 SAFEGUARDING REPORT</td>
<td>In respect of safeguarding the committee were assured that risks are being managed and that the performance of safeguarding standards and compliance is reviewed and assessed through the Safeguarding Strategic Group with partners from the Local Authority, the Rotherham Safeguarding Children Partnership and the Rotherham Safeguarding Adult Board (Business Managers) and the NHS Rotherham Clinical Commissioning Group as members. The Committee were assured that the Trust continues to be fully engaged in all the relevant multi-agency and partnership activity</td>
<td>Angela Wood / Jean Summerfield</td>
<td>Assured</td>
</tr>
<tr>
<td>Ref</td>
<td>Agenda Item</td>
<td>Issue</td>
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<td>Recommendation / Assurance/ Information</td>
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<td>6</td>
<td>039/21 MORTALITY &amp; LEARNING FROM DEATHS REPORT</td>
<td>Mortality figures are still statistically significantly higher than expected. However, it represents a stability in the Trust position. Colleagues are working extremely hard to understand and quickly improve the HSMR. A Mortality action plan is in place but still a long way to go. In particular, importance of assurance rather than reassurance, as demonstrated by some coding improvement opportunities not having yet been put in place. Coding cards will now be given out to all medical staff at induction as an aide memoire showing what can and can’t be coded, along with the introduction of “treat as” on Meditech should improve the depth of coding. It must be noted that there is a time lag of up to 6 months to see actions relating to improvements.</td>
<td>Callum Garner / Carrie Kelly</td>
<td>Not assured over mortality rates but limited assurance is provided that work is ongoing on improving the position</td>
</tr>
<tr>
<td>7</td>
<td>040/21 SERIOUS INCIDENT PANEL</td>
<td>The committee were assured that reports continuing to be completed on time. A new extension requesting process has been rolled out and should soon become embedded. It was reported that there needs to be a key shift of focus to early implementation of learning and there needs to be a focus on improving the quality of the Serious Incident Reports. The SI policy is being reviewed to support resent changes to process.</td>
<td>Helen Dobson / Victoria Hazeldine</td>
<td>Assured that SIs are completed on time and assured that improved procedures are being put in place.</td>
</tr>
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<td>8</td>
<td>042/21 PRESSURE ULCERS INCLUDING ACTION PLAN</td>
<td>The committee were concerned about the worsening position in respect of pressure ulcers within the community and in the hospital. The Trust is not out-with the rest of the country as the position has deteriorated due to covid pressures on staffing. There has been some clear lapses in care which need to be addressed.</td>
<td>Angela Wood</td>
<td>Assured that an action plan is in place to improve the position but this will need to be closely monitored.</td>
</tr>
<tr>
<td>Ref</td>
<td>Agenda Item</td>
<td>Issue</td>
<td>Lead Officer</td>
<td>Recommendation / Assurance/ Information</td>
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<td>9</td>
<td>043/21 HEALTH &amp; SAFETY</td>
<td>It was discussed that a similar situation arose about 4 years ago and there was a positive campaign to address the issues at that time. A big part of addressing this is leadership and accountability. A group is being put together review falls and pressure ulcers and to hold colleagues to account.</td>
<td>Mark Jackson</td>
<td>Assured</td>
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<td>10</td>
<td>047/21 REVIEW OF BAF ITEM B7</td>
<td>The committee reviewed its recommendation at its January 2021 meeting when they recommended an increased Q3 risk score of $4(L) \times 5(C) = 20$ in respect of B7. This was challenged at the February board meeting. The risk was reviewed again and agreement could not be reached after a discussion on the issues.</td>
<td>Lisa Reid</td>
<td>Recommended that a report be presented to the March board for decision</td>
</tr>
</tbody>
</table>
Appendix 2

Quality Committee

Meeting Agenda – Papers for Assurance, Information and Decision

24 February 2021

1. Divisional Performance Update – Clinical Support Services
2. 2020/21 Operational Objectives and Enablers
3. CIP Programme Update 2020/21 ad 2021/22
4. Integrated Performance Report
5. Operational Performance Report
6. Recovery Plan
7. E-Roster, NHSP, Pay Controls Update
8. Integrated Financial Performance Report
9. HEG Paper – Finance Update 9 February 2021
10. Financial Impact of Recent Recruitment
11. Financial Governance Action Plan
12. Committee Terms of Reference
13. Committee Effectiveness Survey.
### Board of Directors’ Meeting
#### 05 March 2021

<table>
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<tr>
<th>Agenda item</th>
<th>P47/21(iii)</th>
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<tr>
<td>Report</td>
<td>Chair’s Assurance Log – Part 1 Agenda People Committee</td>
</tr>
<tr>
<td>Chair</td>
<td>Lynn Hagger, Non-Executive Director</td>
</tr>
<tr>
<td>Executive Lead</td>
<td>Steven Ned, Director of Workforce</td>
</tr>
</tbody>
</table>

**Link with the BAF**

- **B4**: Lack of effective staff engagement will impact on staff experience resulting in poor staff survey results which impact on the organisation's ability to deliver the Trust's plan.
- **B5**: Inability to recruit and retain staff within the organisation leading to impaired ability to deliver the Trust plan and increased temporary staffing costs.
- **B6**: The lack of development of new roles within the organisation leads to continued workforce gaps impacting on the Trust's ability to deliver its plan.

**How does this paper support Trust Values**

The work of the People Committee supports the Trust’s value of Ambitious, Caring and Together as it aims to ensure the workforce is fully supported and is employer of choice.

**Purpose**

For decision ☐ For assurance ☒ For information ☐

**Executive Summary** (including reason for the report, background, key issues and risks)

The purpose of the Chair’s Assurance Log is to provide assurance, raise concerns and make recommendations, as appropriate, on key strategic, and quality matters.

Key messages from the various assurance papers received at the People Committee meeting on 19th February 2021 were:

1. The Finance teams have plans to address their PDR and MAST shortfalls; communication amongst the teams is much improved.
2. There is limited assurance in relation to PDR compliance but there is improvement in other KPIs including nursing recruitment.
3. The Covid-19 vaccination programme is working well with staff and wider stakeholders with second doses planned for 22 March 2021.
4. While plans are in place to address the implementation of e-rostering, concern remains about compliance.
5. We have wide ranging Health and Well-being offers but there needs to be further development of these and communication needs to be addressed; progress is being made with the Trust’s Equality and Diversity agenda.
6. Covid-19 challenges are likely to impede the ability to meet all the operational objectives subject to the scrutiny of the Committee.
| Due Diligence (include the process the paper has gone to prior to presentation at Board of Directors Meeting) | The content of this report was agreed at the People Committee held on 19th February 2021 and is presented to the Board of Directors for assurance. |
| Who, what and when (what action is required, who is the lead and when should it be completed?) | Specific actions summarised in the log will be communicated to relevant individuals and the planner has been updated to reflect timings of additional agenda items. |
| Recommendations | It is recommended that the Board of Directors receive this report and consider the assurance presented as detailed in the attached report. |
| Appendices | Appendix One – Chair’s Assurance Log Appendix Two – Agenda items from People Committee held on the 19 February 2021. |
### CHAIR’S LOG: Chair’s Key Issues and Assurance Model

<table>
<thead>
<tr>
<th>Committee / Group: People Committee (PC)</th>
<th>Date: 19th February 2021</th>
<th>Chair: Lynn Hagger</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Ref</th>
<th>Agenda Item</th>
<th>Issue and Lead Officer</th>
<th>Receiving Body, i.e. Board or Committee</th>
<th>Recommendation / Assurance/ mandate to receiving body</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Divisional Performance – Corporate area (Finance)</td>
<td>The Director of Finance, Lynn Cocksedge (Head of Contracting), Evelyn Allsop (Head of Financial Services) and Carl Wilson (HRBP) provided a presentation on People related matters. The Department recognised the challenges related to delivering against PDR and MAST targets and had plans to address this. (Please put limited assurance in the right hand box against this line). Communication within the Department has improved significantly since the appointment of the interim Directors of Finance including with those working at home. Personal and professional development is continuing but it was unclear whether this was consistent across all teams. Lead Officer: Stuart Diggles</td>
<td>Board of Directors</td>
<td>Limited Assurance Assured Limited Assurance</td>
</tr>
<tr>
<td>2</td>
<td>Workforce report (inc. Covid-19 update) and Integrated Performance Report</td>
<td>The People Committee reviewed the Workforce report in conjunction with the Integrated Performance report. The Committee noted the following key updates: Sick absence performance in January 2021 improved by 0.39%, reducing from 4.25% to 3.86%. This is a 1.58% improvement compared to the same point in January 2020. • Both MAST (91%) and Job Specific (85%) training remain above target. The IG compliance is at 90% against a 95% target. • Although PDR compliance for the month is at 81%. It remains below the 90% target.</td>
<td>Board of Directors</td>
<td>Limited Assurance</td>
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<tr>
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</table>
|     |             | • It’s the 5th consecutive month of reduced vacancies in Nursing and Midwifery.  
  • The Trust welcomed 11 WTE International Nurses to the Trust in January 2021.  
  The Committee are assured as to the progress made in the KPIs overall, PDR compliance remains a concern notwithstanding the effect of the pandemic on the ability to achieve this metric.  
  **Covid-19 Vaccination Programme**  
The Trust continues with its successful vaccination programme with staff and wider stakeholders. The second dose of the vaccine is expected to commence on the 22 March 2021.  
  **E-Rostering**  
The workforce report contained information regarding metrics relating to Electronic rostering. The committee was not assured in relation to the implementation and on-going management of e-roster but recognised that Executive action was being taken to address this.  
  **Health and Well-being**  
A 'stock take' of our Health and Well-being offers was taken in relation to further recent national guidance. The Committee recognised that the Trust provides wide ranging support to staff but that further assurance was required with regards to how offers are communicated and that there is scope for further development of these. The take up of occupational health assistance from PAM had been requested by the Committee but the data provided was thought to provide limited information and further analysis was requested.  
  Lead Officer: Steve Ned | Assured | Limited Assurance | Limited Assurance |
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<tr>
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</thead>
</table>
| 3   | Equality, Diversity and Inclusion update | The Committee received assurance that progress was being made to make appointments to the ED&I team in order to take forward the ED&I agenda. The Committee also received an update on progress on the Reciprocal Mentorship programme and the initial meeting that had taken place with the Leadership Academy. The Committee were assured that colleagues who had expressed an interest in the programme were being kept updated on progress.  
Lead Officer: Emily Wraw                                                                 | Board of Directors                                                                  | Assured                                             |
| 4   | Operational Objectives 2020/21         | The Committee noted the update provided in respect of Operational objectives. Limited assurance was received on achievement of all the objectives set out but it was recognised that a broader view should be taken in light of the challenges facing the Trust in 2020/21.  
Lead Officer: Steve Ned                                                                 | Board of Directors                                                                  | Limited Assurance                                   |
| 5   | Covid-19 risk register re: workforce risks | The Committee reviewed the Covid-19 risk register noting that this was a dynamic document reflecting on-going and emerging risks. The Committee noted the emerging risk related to the possible increase of the number of colleagues who may be asked to shield given the changed definition.  
Lead Officer: Steve Ned                                                                 | Board of Directors                                                                  | Assured                                             |
| 6   | Medical Workforce report               | The Committee had limited assurance with respect to individual and team job planning and/or capacity and demand planning notwithstanding its pause due to the pandemic. A further detailed briefing was requested and placed on the Annual Planner accordingly.  
Lead Officer: Derek Thomas                                                                 | Board of Directors                                                                  | Limited Assurance                                   |
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<tbody>
<tr>
<td>7</td>
<td>Our People Pack – version 2</td>
<td>The Committee received the second version of “Our People Pack” was refreshed at the end of January. The objective remained to support colleagues, teams and those with managerial responsibilities during the pandemic and beyond. The pack had a number of initiatives, tools, and general hints and tips that can support colleagues during these difficult times. It also included a number of programmes the Trust has developed to support colleagues e.g. Mental Health Champions; as well as containing information for national organisations that also offer support to our colleagues e.g. Mind. The Committee was assured that the People Pack was a well thought out guide to the resources available to support staff. Lead Officer: Paul Ferrie</td>
<td>Board of Directors</td>
<td>Assured</td>
</tr>
</tbody>
</table>
| 8   | Staff survey update including lessons learnt    | The Committee received details of the National Staff survey (NSS) including:  
• Details of benchmarked results and activity related to the NSS.  
• Lessons learnt from this year’s distribution of the survey and response levels.  
• NSS 2021 – proposal to change  
The Committee noted the 'lessons learnt' exercise particularly in relation to the receipt and distribution of the survey and was assured that the relevant lessons had been learnt and corrective action would be taken for this year’s survey.  
Lead Officer: Steve Ned                                                                       | Board of Directors                        | Assured                                              |
<p>| 9   | HR systems update                               | The Committee received the HR systems update paper which focussed on actions in respect of e-rostering. The Committee reiterated the lack of assurance regarding the implementation of e-rostering but recognised that there were plans in place to address                                                                                                                                                                                                                       | Board of Directors                        | Limited Assurance                                    |</p>
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>EDS 2 annual review</td>
<td>the issues identified however these issues needed to gain traction across the organisation. Lead Officer: Ros Jacoby</td>
<td>Board of Directors</td>
<td>Limited Assurance</td>
</tr>
<tr>
<td>11</td>
<td>Annual Committee effectiveness review</td>
<td>The Committee received the EDS 2 annual review which reviewed the Trust’s current Equality Objectives (set in 2020), following a review of the Trust’s performance against EDS2, the Equality Delivery System for the NHS. The paper provided an update on progress against the Trust’s equality objectives. The Committee had limited assurance against progress against these objectives but recognised the challenges facing the Trust and the lack of ED&amp;I resource which had now been addressed. Lead Officer: Emily Wraw</td>
<td>Board of Directors</td>
<td>Assured</td>
</tr>
</tbody>
</table>
Appendix Two

People Committee

Meeting Agenda – Papers for Assurance, Information and Decision

19 February 2021

• Presentation from Finance Department
• Workforce Report (including Covid-19 update)
• Integrated Performance Report – monthly update
• Risk Register
• Equality, Diversity and Inclusion update
• Operational objectives 2020/21
• Covid-19 risk register re: workforce risks
• Staff survey update including lessons learnt
• Medical Workforce update
• People Pack (version 2)
• HR systems update
• Equality, Diversity and Inclusion Steering Group - Action Log
• EDS2 Annual review
• Terms of Reference review
• Annual Committee effectiveness review
## Agenda item
P48/21

## Report
Care Quality Commission Report

## Executive Lead
Angela Wood, Chief Nurse

## Link with the BAF
B1

## How does this paper support Trust Values
Demonstrates ambition to manage quality of standards and delivery of good care. Working together to reduce poor standards for patients and staff

## Purpose
- For decision ☐
- For assurance ☒
- For information ☐

## Executive Summary (including reason for the report, background, key issues and risks)
This report is presented to the Board to provide an update on CQC Compliance. The Trust developed an action plan (Appendix 1) to address specific concerns raised by the CQC.

The action plan is updated regularly, with submissions to the CQC on a fortnightly basis. The actions identified as outstanding and updates that were submitted to CQC on 5 February 2021 is attached at Appendix 2.

## Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)
This report was presented to the Quality Committee on 24 February 2021 and the CQC Delivery Group on 25 February 2021.

## Powers to make this decision
Not Applicable

## Who, What and When (what action is required, who is the lead and when should it be completed?)
Once presented, the Chief Nurse, as Executive Lead for CQC will continue to monitor compliance with the CQC actions.

## Recommendations
It is recommended that the progress being made with the CQC actions is noted along with the work to prepare the Trust for a future inspection.
<table>
<thead>
<tr>
<th>Appendices</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. CQC Action Plan</td>
</tr>
<tr>
<td>2. Safeguarding Quality Improvement Action Plan</td>
</tr>
</tbody>
</table>
1. **Introduction**

1.1 The Care Quality Commission is the independent regulator of all health and social care services in England. They monitor, inspect and regulate hospitals and other care providers.

2. **CQC Inspection and Action Plan**

2.1.1 Following the 2016, 2018 and 2019 CQC inspections the Trust has three actions that are classed internally by the Trust as Off Plan and one that has been closed since the last report (located at Appendix 1).

2.1.2 One of the requirements of the NHSE/I Improvement Plan is to achieve 100% of CQC actions by October 2020, or with mitigating action and revised timeline if not. As the deadline has passed detailed action plans have been developed and continue to be reviewed and updated for these four actions.

2.2 **2020 CQC Inspection**

2.2.1 The Trust developed an action plan to address specific concerns raised by the CQC. This is updated on a regular basis, with submissions to the CQC on a fortnightly basis. The actions identified as outstanding and updates of which were submitted to CQC on 5 February 2021 is attached at Appendix 2.

3. **Enquiries**

3.1 The following enquiries have been received from 13 January 2021 to 10 February 2021

<table>
<thead>
<tr>
<th>CQC Reference Number and Date Received</th>
<th>Subject of Enquiry</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENQ1-10254159297 NRLS ID 51629925 Local ID 118390 08/02/2021</td>
<td>Incident theme of Assessment and discharge Falls. Initial datix report and immediate actions taken requested</td>
</tr>
<tr>
<td>ENQ1-10256440082 NRLS ID 51630196 Local ID 117720 22/01/2021</td>
<td>Incident theme of Speciality review and Assessment and discharge Initial datix report and Immediate actions taken requested</td>
</tr>
<tr>
<td>ENQ1-102566440085 StEIS ID 2020/18789/RFR 22/01/2021</td>
<td>Incident theme - Tissue Viability. Initial datix report, immediate actions taken and RCA report when available and timescale for RCA completion requested.</td>
</tr>
<tr>
<td>ENQ1-102566440088 StEIS ID 2020/22389/RFR 22/01/2021</td>
<td>Neonatal death Narrative of the circumstances requested. Also, if this was not expected, the initial datix report and immediate actions taken requested.</td>
</tr>
<tr>
<td>CQC Reference Number and Date Received</td>
<td>Subject of Enquiry</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>--------------------</td>
</tr>
</tbody>
</table>
| ENQ1-10256440171 SteIS ID 2020/24451/RFR 22/01/2021 | Fall with fracture  
Theme: Falls  
Initial datix report and immediate actions taken requested |
| ENQ1-9408601417 SteIS 2020/15732 22/01/2021 | Maternal death at home  
Final RCA, and timescale for completion if this report is not already completed along with HSIB report requested |
| SFR1-10200577577 13/01/2021 | Safeguarding information request |
| 02/02/2021 | AMU Information request in relation to staffing and safety |

3.2 The Trust responded to the above enquiries within the required timescales. It should also be noted that for a number of previous enquires, the CQC have requested additional updates such as loose filing.

3.3 The CQC have also held a number of conversations on information that would normally have been sent through as an enquiry, such as Mortality. They have also observed a number of meetings, including Harm Free Care and Serious Incident Panel.

4. **Section 29A Warning Notice**

4.1 On 27 November 2020 the Trust received a Section 29A Warning Notice. The notice was served under Section 29A of the Health and Social Care Act 2008. The warning notice serves to notify the Trust that the Care Quality Commission has formed the view that the quality of health care provided by The Rotherham NHS Foundation Trust for the regulated activities requires significant improvement.

4.2 On the 16 December 2020 the Trust submitted a representation to the Warning Notice. The Trust wished to make representations in respect of the warning notice as the Trust considered the notice had been wrongly served due to errors, it is based on inaccurate facts and is an unreasonable response to the matters set out within it. The Trust asked the CQC to review its decision to issue the Notice in the light of additional submissions made. The CQC reviewed the representation and have upheld the Warning Notice with only slight modification, which was finalised and issued on 11 February 2021.

4.3 In the warning notice, a number of actions were required to be undertaken in order for the Trust to make significant improvements in the provision of the quality of healthcare by Friday 19 February 2021. Therefore, an action plan has been developed and submitted to the CQC to meet this deadline. The progress against the plans longer term actions, will be monitored through the Executive Management Team, CQC Delivery Group and Quality Committee.

5. **Preparation for Future CQC Inspection**

5.1 Work continues to prepare the organisation for a CQC inspection. Phone calls are held between the Quality Governance, Compliance and Risk Manager and CQC
Data Analyst to support the review of the CQC Provider Information Request and identify how the Trust can be better prepared for future requests.

5.2 Although the CQC’s routine inspection activity has been paused, they have continued to inspect where they are alerted to serious concerns about people’s care and where there are human rights breaches. The CQC are developing plans for a managed return to routine inspection of services.

5.3 On Wednesday 28 October 2020 the CQC held a monitoring conversation in relation to urgent and emergency care in the trust. The CQC have confirmed that similar conversations will occur in the near future with the remaining core services and corporately and so work is being undertaken to prepare services for this including self-assessments.

6. Conclusion

6.1 Work is continuing to address any concerns raised by the CQC in the previous inspections.

Anne Rolfe
Quality Governance, Compliance and Risk Manager
February 2021
<table>
<thead>
<tr>
<th>Agenda item</th>
<th>P49/21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report</td>
<td>Mortality and Learning from Deaths Report (Monthly)</td>
</tr>
<tr>
<td>Executive Lead</td>
<td>Dr Callum Gardner, Executive Medical Director</td>
</tr>
</tbody>
</table>
| Link with the BAF | B1 – Standards and quality of care not being met  
B2 – Demand for care exceeds the resources available  
B7 – Insufficiently robust quality and clinical governance |
| How does this paper support Trust Values | Ambitious – demonstrates that the Trust strives to deliver the highest standards and quality of care possible and to have an HSMR/SHMI below 100.  
Caring – demonstrates that the Trust strives to give outstanding, compassionate care, including around end of life care.  
Together – demonstrates that the Trust strives to ensure that quality improvement and the learning from deaths is achieved through a multi-disciplinary approach. |
| Purpose | For decision ☐  
For assurance ☒  
For information ☐ |

**Executive Summary** (including reason for the report, background, key issues and risks)

This report provides the Board with the monthly mortality data and an update around changes and quality improvements being made as part of the Trust’s learning from deaths. The death data is up until September 2020.

Summary of key points:

**HSMR**: 118.3 - statistically significantly higher than expected. However, it represents a stability in the Trust position.

**SHMI**: 117.3 - statistically significantly higher than expected. This again shows a considerable improvement. There is only one common diagnosis group between HSMR and SHMI - intestinal obstruction without hernia.

Diagnoses code alerts:
- Pneumonia
- Chronic obstructive pulmonary disease and bronchiectasis
- Aspiration pneumonitis
- Skin and subcutaneous tissue infections.
- Intestinal obstruction without hernia
- Cancer of ovary
| Due Diligence | This data has been presented to the Trust’s Safe & Sound Mortality Group, Mortality Analytics Group and Clinical Governance Committee, and was presented to the Quality Committee on 24\textsuperscript{th} February. |
| Board powers to make this decision | N/A |
| Who, What and When | The Trust is working extremely hard to understand and quickly improve the HSMR/SHMI and learning from deaths, coordinated through the Trust Mortality Improvement Group (MIG), chaired by the Chief Executive Officer, with the Medical Director as the Senior Responsible Officer. The overarching action plan is attached at Appendix 3. It is intended to keep the place until the HSMR and SHMI are less than 110. |
| Recommendations | It is recommended that the Board notes the mortality position and the significant actions being taken to make improvements. |
| Appendices | 1. Mortality Insights Report  
2. Dr Foster Report  
3. Mortality Improvement Group - Action Log |
1.0 Quality of Care

1.1 The HSMR for the most recent 12 months shows a statistically significantly higher than expected rate at 118. The Trust continues to be 1 of 6 within the regional peer group of 13 with this rating. This represents a stability that has not been seen before. The 1-month delay of the data has given confidence in this figure.

1.2 There have been 832 deaths within the cohort of patients versus 700 expected.

1.3 The latest data point in the rolling 12 months HSMR trend shows a downward trend, which is an encouraging sign for the amount of focus paid to mortality.

1.4 The Trust's crude rate within HSMR basket sits at 4.1%, with the peer group at 3.3%.

1.5 Following review of the process for examining the Dr Foster alerts, an “enhanced” process will now be implemented. This will ensure that quality improvements are made with diagnosis codes and aims to ensure that the Trust does not continue to alert in that specific area.

1.6 The process will include subject experts, clinicians, coding and clinical effectiveness, and will involve reviewing the NICE guidance, best practice pathways, GIRFT advice and Royal College guidance, if necessary changing pathways to improve patient care.

1.7 The Medical Director is awaiting the final report from the review of pneumonia deaths, along with an in-depth review of a sample of deaths involving sepsis and intestinal obstruction without hernia. This review did not undergo the enhanced process, as it was commissioned prior to the new process being agreed.

1.8 A further 6-week programme for the Mortality Analytics Group has been decided, as the output from this group has been very beneficial and has allowed specific focus on areas where the Trust differs from regional peers.

1.9 DNACPR forms the subject of the Trust's first, fortnightly “Mortality Matters” Newsletter.
2.0 Coding

2.1 The Coding Department have worked with the Medical Examiner to reduce the backlog of residual codes from overdue coding validation forms.

2.2 There has been further distribution of the coding rules cards to clinicians as an aide memoire. They will also be given out to all new medical staff as part of their Trust induction.

3.0 Case-mix

3.1 The Community Teams and the Medical Examiner are working together to determine areas where admissions were deemed avoidable so that processes can be altered to reduce the number of these cases and ensure that patients are in the correct place for treatment, and that there is an enhanced focus on Preferred Place of Death.

4.0 Learning from deaths update

4.1 Initial clinical review (SJRs) of the following Dr Foster Alerts have taken place by an experienced retired clinician:
   - Aspiration Pneumonitis
   - Pneumonia
   - COPD
   - Sepsis
   - Intestinal Obstruction without Hernia

4.2 Draft reports will go to the Mortality Improvement Group over the next few weeks for consideration and learning.

4.3 The Mortality Analytics Group has looked at the usual activity around UroSepsis (the Trust has a high coding for UTI and low for UroSepsis). Initial findings have provided some learning, particularly within coding. The Team will look to re-check in three months’ time to ensure that improvements have been made.

4.4 An external former Deputy Chief Nurse is reviewing all SI and Red incidents involving the death of a patient back to 2019, along with all Coroner’s Inquests from over the last 12 months, with a view to any learning from this review informing further actions that may be required.

4.5 The Team met with colleagues from Coding and the End of Life Care Team at Doncaster and Bassetlaw Hospitals to understand their processes around End of Life care - both provision of service and coding.

4.6 The Medical Director has met with colleagues from Kettering General Hospital in order to hear their reflections on their mortality and learning from deaths quality improvement journey, with a view to introducing what has worked well, including around the introduction of a Trust Mortality Manager (subject to relevant Business Case approval).

4.7 We launched a new Sepsis communication campaign based around “DO CHECK ASK” to support our Clinical Teams and remind them around best practice in the management of Sepsis, including the introduction of a new Sepsis logo:
4.8 Whilst the Trust’s HSMR and SHMI remain far higher than we would like, in-month figures would suggest that sustained improvements have been made, and the Trust is working hard at ensuring that improvement are made around the quality of care, end of life recognition and management, case-mix, and coding. Continued focus will remain in place and the Trust will continue to strive to be better than the national average.

Dr Carrie Kelly
Medical Examiner
February 2021
MORTALITY SUMMARY REPORT

THE ROTHERHAM NHS FOUNDATION TRUST

TRUST LEVEL – JANUARY 2021

<table>
<thead>
<tr>
<th>Report Date</th>
<th>26th January 2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare Intelligence Specialist</td>
<td>Matthew Parry</td>
</tr>
<tr>
<td>Contact details</td>
<td>07583 044963</td>
</tr>
<tr>
<td>Data Period</td>
<td>October 2019 to September 2020 (Unless otherwise stated)</td>
</tr>
</tbody>
</table>
**EXECUTIVE SUMMARY**

<table>
<thead>
<tr>
<th>Metric</th>
<th>Result: Data Period: October 2019 to September 2020 (1 month time lag included)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSMR</td>
<td>118.3 statistically significantly higher than expected</td>
</tr>
<tr>
<td>HSMR position vs. peers</td>
<td>The Trust is 1 of 6 Trusts within the regional peer group of 13 that remain within the statistically significantly higher than expected banding</td>
</tr>
<tr>
<td></td>
<td>Crude rate within HSMR basket = 4.1% (Peer group rate = 3.3%)</td>
</tr>
<tr>
<td>HSMR outlying groups</td>
<td>There are 6 outlying groups attracting significantly higher than expected deaths remain as:</td>
</tr>
<tr>
<td></td>
<td>• Pneumonia</td>
</tr>
<tr>
<td></td>
<td>• Chronic obstructive pulmonary disease and bronchiectasis</td>
</tr>
<tr>
<td></td>
<td>• Aspiration pneumonitis</td>
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<td></td>
<td>• Skin and subcutaneous tissue infections.</td>
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<tr>
<td></td>
<td>• Intestinal obstruction without hernia</td>
</tr>
<tr>
<td></td>
<td>• Cancer of ovary</td>
</tr>
<tr>
<td>Coding and Case-mix</td>
<td>• Palliative care rate (HSMR basket) for the rolling 12 month position is 3.5% vs. an increased national rate of 4.4%</td>
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<tr>
<td></td>
<td>o This will continue to be impacted by the increase in O day emergency admissions and changing case-mix during the COVID-19 pandemic?</td>
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<tr>
<td></td>
<td>o However when reviewing for 1+ LOS the Trust also appears to have a low rate but not significantly so: 4.2% v 5.6%</td>
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<tr>
<td></td>
<td>• Comorbidity Score: The proportion of superspells within the Non-elective HSMR basket with a 20+ score remains low at 12.4% compared to a national rate of 14.2% but retains a comparable proportion of activity with 0 comorbidity.</td>
</tr>
<tr>
<td></td>
<td>o The Trust is seeing a continued increase in 0 day non-elective both within &amp; outside the HSMR basket which will have an impact on the expected mortality, the degree of this impact will depend on the case-mix of this cohort?</td>
</tr>
<tr>
<td>All Diagnosis SMR</td>
<td>• SMR = 113.3 and remains statistically significantly high but represents a continued decrease in the point value compared to the previous month’s data.</td>
</tr>
<tr>
<td></td>
<td>o SMR excluding COVID-19 = 110.3 as at September 2020.</td>
</tr>
<tr>
<td></td>
<td>• There are no further outlying groups (outside of the HSMR)</td>
</tr>
<tr>
<td>New CUSUM alerts this month</td>
<td>• At 99% across the 12 months there are 10 diagnosis groups with CUSUM breaches, notably Pneumonia and COPD but with Acute Bronchitis (significant within the SHMI) and Viral Infection (COVID) breaching in month.</td>
</tr>
<tr>
<td></td>
<td>• Using a 99.9% threshold as per CQC there are 2 diagnosis groups alerting over the 12 month period – Intestinal obstruction without Hernia which is now statistically significantly high in the HSMR along with Pneumonia breaching using both thresholds.</td>
</tr>
<tr>
<td>SHMI (Sept 2019 to Aug 2020)</td>
<td>SHMI = 117.31 significantly higher than expected but again does represent a material reduction in point value interestingly with only one common diagnosis group.</td>
</tr>
<tr>
<td></td>
<td>o Key outlying groups include</td>
</tr>
<tr>
<td></td>
<td>▪ Fluid &amp; Electrolytes</td>
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<tr>
<td></td>
<td>▪ Acute Bronchitis</td>
</tr>
<tr>
<td></td>
<td>▪ Other Connective tissue disease (DF rounded)</td>
</tr>
<tr>
<td></td>
<td>▪ Intestinal obstruction without hernia (Common across the HSMR / SHMI)</td>
</tr>
<tr>
<td></td>
<td>▪ Intracranial Injury (DF – rounded)</td>
</tr>
<tr>
<td></td>
<td>▪ Acute Myocardial Infarction</td>
</tr>
</tbody>
</table>
REPORT OUTLINE

Background

The report will provide an overview of mortality indicators including the Hospital Standardised Mortality Ratio (HSMR), Standardised Mortality Ratio (SMR) for all diagnoses and Summary Hospital-Level Mortality Indicator (SHMI).

The intention of the report is to present intelligence with potential recommendations for further investigation. The report should be used as an adjunct to supplement other pieces of work completed within the Trust and should not be used in isolation.

Methods

Using routinely collected hospital administrative data derived from Hospital Episode Statistics (HES) and analysed in Healthcare Intelligence Portal, in-hospital mortality was examined for all inpatient admissions to The Rotherham NHS Foundation Trust for the 12 month time period October 2019 to September 2020. Although Dr Foster does have access to data up until October 2020 a local decision has been made to apply an additional 1 month time lag because of the volume of residual codes within the latest month’s data.

Risk adjustment is derived from risk models based on the last 10 years of national HES data up to and including July 2020 (unless otherwise stated). This is the most recent benchmark period available. Statistical significance is determined using 95% confidence intervals unless otherwise stated.

SHMI data for the time period September 2019 to August 2020 was obtained from NHS Digital’s Indicator Portal. SHMI is updated and rebased monthly.
HOSPITAL STANDARDISED MORTALITY RATIOS (HSMR)

Key Highlights:

- HSMR = **118.8** statistically significantly high and has been for the last 12 data points.
- Crude rate within HSMR basket = 4.1% (Peer group rate = 3.3%)

*It should be noted that the national Covid-19 pandemic has had a significant impact on the volume of elective and non-elective hospital admissions from March 2020. One of the impacts of the pandemic is a potential reduction in the HSMR denominator, which will affect both the crude and risk adjusted mortality metrics.*

*The model uses a patient’s primary diagnosis to calculate their risk of mortality, therefore patients who present with respiratory and other symptoms but subsequently tested positive for COVID-19, will be attributed to a different primary diagnosis other than COVID-19. Some diagnosis groups within the HSMR basket may therefore have seen a notable rise in the crude mortality. The figures should be viewed taking into account the possible impact of COVID-19, including the late presentation of acutely ill patients, who might previously have sought treatment at an earlier stage.*

There are **6 outlying groups:**

- Pneumonia
- Chronic obstructive pulmonary disease and bronchiectasis
- Aspiration pneumonitis
- Skin and subcutaneous tissue infections.
- Intestinal obstruction without hernia
- Cancer of ovary
HSMR Trends

Fig 1.0 HSMR Trend (month)

As can be seen from Fig 1.1 the activity has reduced markedly in April to June 20 which was potentially being driven by COVID as there has been a reduction nationally in activity. However, this reduction has varied regionally & nationally and the continued decrease nationally has been “off set” at the Trust by the reclassification of the 0 day non-elective admissions.

However although the volumes have remained relatively stable the “expected” value has continued to fall because of the change in case-mix. This will relate to the drop in activity because of COVID-19 and the increase in 0 day (low risk) superspells.
Fig 1.1 HSMR trend (Rolling 12 month)

The rolling 12 month trend demonstrates a continued stable HSMR.

COVID activity would not fall within the HSMR and is mapped to “Viral Infections” which is outside the HSMR basket, however the impact of COVID will be felt through patients with a secondary diagnosis of U07.1 or U07.2 (The nominated COVID19 ICD10 codes) may have a primary diagnosis that is within the HSMR basket.

Fig 1.3 HSMR. Regional Comparison (Rolling 12 months)

It should also be noted that the Trust’s HSMR has increased to July 20 at a faster rate than regional peer and further analysis should be completed to further understand this including an initial focus on primary & secondary diagnosis whilst taking into account the impact of COVID-19.
HSMR 12 Month’s Peer Comparison

The Trust remain 1 of 6 Trusts (within the Regional peer group) with a statistically ‘higher than expected’ HSMR. The crude rate is 4.1% (vs 3.3% for the peer group)

In terms of activity, The Rotherham NHS Foundation Trust retains the second lowest volume of HSMR activity across the Peer Group with a comparable “expected rate”

Fig 2.1 & 2.2 demonstrate the increase in activity is being primarily driven by the 0 day admissions with circa 400 superspells now per month.

Figure 2.0: Regional peer comparison

![Image](image-url)

**Figure 2.1: HSMR Non-elective 0 day & 1+ trend**

![Graph](graph-url)

**Figure 2.2: HSMR Non-elective 0 day Peer comparison trend**

![Graph](graph-url)
HSMR TRACKING BY KEY DIAGNOSIS GROUPS

There are five existing significant high diagnosis groups within the HSMR plus one additional, Cancer of ovary (small numbers).

- Pneumonia
- Chronic obstructive pulmonary disease and bronchiectasis
- Aspiration pneumonitis
- Skin and subcutaneous tissue infections.
- Intestinal obstruction without hernia
- Cancer of ovary (6 superspells, 2 deaths: https://one.drfoster.com/Query/?id=1978322)

*Initial basic analysis has been completed below, however further in-depth analysis should be completed to understand these “alerts” further. Additional analysis was also undertaken in month focusing on the following including recommendations:

- Pneumonia
- Chronic obstructive pulmonary disease and bronchiectasis
- Intestinal obstruction without hernia

Figure 3.0 – HSMR by diagnosis group

<table>
<thead>
<tr>
<th>Diagnosis group</th>
<th>Observed</th>
<th>Expected</th>
<th>Low</th>
<th>High</th>
<th>95% lower confidence limit</th>
<th>95% upper confidence limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pneumonia</td>
<td>1,609</td>
<td>1,983</td>
<td>247</td>
<td>257</td>
<td>36.1</td>
<td>138.1</td>
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<tr>
<td>Chronic obstructive pulmonary disease and bronchiectasis</td>
<td>923</td>
<td>631</td>
<td>32</td>
<td>11.6</td>
<td>27.5</td>
<td>141.3</td>
</tr>
<tr>
<td>Skin and subcutaneous tissue infections</td>
<td>190</td>
<td>190</td>
<td>15</td>
<td>11.1</td>
<td>12.8</td>
<td>188.9</td>
</tr>
<tr>
<td>Intestinal obstruction without hernia</td>
<td>66</td>
<td>66</td>
<td>27</td>
<td>13.6</td>
<td>28.8</td>
<td>161.5</td>
</tr>
<tr>
<td>Cancer of ovary</td>
<td>6</td>
<td>3.6 %</td>
<td>2</td>
<td>13.9</td>
<td>1.9</td>
<td>172.1</td>
</tr>
</tbody>
</table>

20210118_Diagnosisoverview.pptx
Figure 3.1 Peer analysis

The relative risk regional peer comparison and trend for the 6 outlying groups is shown below.

In addition further commentary is provided with recommendations for further analysis.
Figure 3.2 Key diagnosis monthly trend

126


Figure 3.2 Key diagnosis impact of COVID-19

Diagnosis group: Aspiration pneumonitis, food/vomitus, Cancer of ovary, Chronic obstructive pulmonary disease and bronchiectasis, Intestinal obstruction without hernia, Pneumonia, Skin and subcutaneous tissue infections
Expected: 273.0 (7.7%) DC: 74.0 (2.1%) Relative Risk: 127.3 (114.16*141.2) Model: Month: Jul 2020 C-Statistic: Multiple

<table>
<thead>
<tr>
<th>Diagnosis group</th>
<th>COVID-19 T/N</th>
<th>Superscripts</th>
<th>% of All</th>
<th>Spills Observed</th>
<th>Crude rate (%)</th>
<th>Expected</th>
<th>Expected rate (%)</th>
<th>Observed/expected</th>
<th>Relative risk</th>
<th>95% lower confidence limit</th>
<th>95% upper confidence limit</th>
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</thead>
<tbody>
<tr>
<td>All</td>
<td>2,796</td>
<td>1,121 (100.1%)</td>
<td>351</td>
<td>9.5%</td>
<td>177,1</td>
<td>7.7%</td>
<td>74.0</td>
<td>127.3</td>
<td>49.9</td>
<td>144.3</td>
<td></td>
</tr>
<tr>
<td>Cancer of ovary</td>
<td>Yes</td>
<td>6</td>
<td>0.2%</td>
<td>6</td>
<td>23.3%</td>
<td>0.1</td>
<td>1.6%</td>
<td>1.9</td>
<td>175.3</td>
<td>146.4</td>
<td>626.9</td>
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<tr>
<td>No</td>
<td>5</td>
<td>0.1%</td>
<td>5</td>
<td>20.0%</td>
<td>0.1</td>
<td>2.2%</td>
<td>0.9</td>
<td>90.6</td>
<td>11.8</td>
<td>804.5</td>
<td></td>
</tr>
<tr>
<td>Pneumonia</td>
<td>Yes</td>
<td>1,666</td>
<td>47.2%</td>
<td>1,666</td>
<td>244</td>
<td>14.6%</td>
<td>127.6</td>
<td>12.5%</td>
<td>39.1</td>
<td>117.4</td>
<td>103.1</td>
</tr>
<tr>
<td>No</td>
<td>1,126</td>
<td>46.8%</td>
<td>1,126</td>
<td>226</td>
<td>13.5%</td>
<td>126.1</td>
<td>12.2%</td>
<td>27.3</td>
<td>133.8</td>
<td>90.4</td>
<td>159.6</td>
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<tr>
<td>Chronic obstructive pulmonary disease and bronchiectasis</td>
<td>Yes</td>
<td>831</td>
<td>23.6%</td>
<td>831</td>
<td>39</td>
<td>4.7%</td>
<td>27.5</td>
<td>3.3%</td>
<td>11.5</td>
<td>141.6</td>
<td>100.7</td>
</tr>
<tr>
<td>No</td>
<td>1,126</td>
<td>46.8%</td>
<td>1,126</td>
<td>36</td>
<td>4.5%</td>
<td>27.1</td>
<td>3.7%</td>
<td>11.9</td>
<td>140.3</td>
<td>95.7</td>
<td>192.6</td>
</tr>
<tr>
<td>Aspiration pneumonitis, food/vomitus</td>
<td>Yes</td>
<td>64</td>
<td>1.9%</td>
<td>64</td>
<td>27</td>
<td>4.9%</td>
<td>17.6</td>
<td>26.6%</td>
<td>9.4</td>
<td>153.3</td>
<td>101.1</td>
</tr>
<tr>
<td>No</td>
<td>1,126</td>
<td>46.8%</td>
<td>1,126</td>
<td>27</td>
<td>4.9%</td>
<td>17.6</td>
<td>26.6%</td>
<td>9.4</td>
<td>153.3</td>
<td>101.1</td>
<td>227.4</td>
</tr>
<tr>
<td>Intestinal obstruction without hernia</td>
<td>Yes</td>
<td>180</td>
<td>5.1%</td>
<td>180</td>
<td>20</td>
<td>11.1%</td>
<td>12.0</td>
<td>6.7%</td>
<td>8.0</td>
<td>166.8</td>
<td>101.7</td>
</tr>
<tr>
<td>No</td>
<td>1,126</td>
<td>46.8%</td>
<td>1,126</td>
<td>19</td>
<td>10.7%</td>
<td>11.6</td>
<td>4.5%</td>
<td>7.4</td>
<td>164.3</td>
<td>96.9</td>
<td>206.6</td>
</tr>
<tr>
<td>Skin and subcutaneous tissue infections</td>
<td>Yes</td>
<td>277</td>
<td>23.9%</td>
<td>277</td>
<td>15</td>
<td>5.4%</td>
<td>7.9</td>
<td>1.6%</td>
<td>7.1</td>
<td>160.3</td>
<td>106.4</td>
</tr>
<tr>
<td>No</td>
<td>772</td>
<td>76.1%</td>
<td>772</td>
<td>17</td>
<td>2.2%</td>
<td>7.2</td>
<td>0.9%</td>
<td>4.8</td>
<td>166.3</td>
<td>85.9</td>
<td>290.3</td>
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<tr>
<td>Yes</td>
<td>6</td>
<td>0.2%</td>
<td>6</td>
<td>50.0%</td>
<td>0.7</td>
<td>11.2%</td>
<td>2.3</td>
<td>446.4</td>
<td>60.1</td>
<td>1301.8</td>
<td></td>
</tr>
</tbody>
</table>
SKIN AND SUBCUTANOUS TISSUE DISEASE

- There was a spike mortality in July 20 (3 deaths) with activity increasing materially from June 20.
- Discuss with the service given that the expected mortality is not increasing at the same rate?
- Small numbers, however it may be prudent to review the 6 deaths from July?
  https://one.drfoster.com/Query/?id=1978407

Non-elective activity trend

Standardised mortality by LOS (0/1+)

Non-elective activity trend
TRENDS IN CODING & CASEMIX

Key Highlights:

- Palliative care coding rate (HSMR basket) for the rolling 12 month position is 3.5% vs. an increased national rate of 4.4%
  - This will continue to be impacted by the increase in 0 day emergency admissions and changing case-mix during the COVID-19 pandemic?
  - However when reviewing for 1+ LOS the Trust also appears to have a low rate but significantly so: 4.2% v 5.6%
- The proportion of superspells within the Non-elective HSMR basket with a 20+ score remains low at 12.5% compared to a national rate of 14.2% but retains a comparable proportion of activity with 0 comorbidity.
  - As with palliative care when just looking at 1+ LOS the Trust does have a low proportion of 20+ scored superspells – Fig 7.0
  - However reviewing the 0 day LOS admissions the Trust has a significantly high proportion of activity with no Charlson comorbidity – Fig 7.1
- The Trust has also again a spike in the volume of ‘residual coded’ activity for the latest 1 month which is the key reason that the report has an additional 1 month time lag applied.

HSMR INFLUENCERS

The following analysis shows how the Trust compares in terms of key elements of the HSMR:

Figure 5.0

<table>
<thead>
<tr>
<th>Performance Description</th>
<th>Site</th>
<th>Trust</th>
<th>Peer</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSMR</td>
<td>118.8</td>
<td>104.2</td>
<td>99.5</td>
<td></td>
</tr>
<tr>
<td>SWR</td>
<td>113.3</td>
<td>104.1</td>
<td>99.7</td>
<td></td>
</tr>
<tr>
<td>Non-elective (HSMR)</td>
<td>118.0</td>
<td>103.8</td>
<td>99.4</td>
<td></td>
</tr>
<tr>
<td>Weekday, emergency (HSMR)</td>
<td>121.8</td>
<td>102.7</td>
<td>97.9</td>
<td></td>
</tr>
<tr>
<td>Weekend, emergency (HSMR)</td>
<td>112.3</td>
<td>107.7</td>
<td>104.4</td>
<td></td>
</tr>
<tr>
<td>Saturday, emergency (HSMR)</td>
<td>95.2</td>
<td>105.4</td>
<td>104.3</td>
<td></td>
</tr>
<tr>
<td>Sunday, emergency (HSMR)</td>
<td>129.1</td>
<td>110.2</td>
<td>104.3</td>
<td></td>
</tr>
<tr>
<td>Coding/Casemix</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Non-elective deaths with palliative care (HSMR)</td>
<td>33.8%</td>
<td>27.1%</td>
<td>33.8%</td>
<td></td>
</tr>
<tr>
<td>% Non-elective spells with palliative care (HSMR)</td>
<td>3.5%</td>
<td>3.7%</td>
<td>4.4%</td>
<td></td>
</tr>
<tr>
<td>% Spells in Symptoms &amp; Signs chapter</td>
<td>9.2%</td>
<td>5.2%</td>
<td>6.3%</td>
<td></td>
</tr>
<tr>
<td>% Non-elective spells with Charlson comorbidity score = 0 (HSMR)</td>
<td>42.8%</td>
<td>40.0%</td>
<td>42.0%</td>
<td></td>
</tr>
<tr>
<td>% Non-elective spells with Charlson comorbidity score = 20+ (HSMR)</td>
<td>12.5%</td>
<td>15.0%</td>
<td>14.2%</td>
<td></td>
</tr>
<tr>
<td>% Non-elective spells in Risk Band (0-10%) (HSMR)</td>
<td>85.3%</td>
<td>83.3%</td>
<td>83.2%</td>
<td></td>
</tr>
</tbody>
</table>

It is worthy of note that only the Weekday non-elective HSMR remains significantly high.

The Trust retains a lower palliative rate than both the regional and national percentage.

The Trust has a high proportion of Sign & symptoms coding primarily driven by the increase in Abdominal Pain activity 0 day admissions.

The Trust retains a lower proportion of activity with score of 20+ however this is being “skewed” by the volume of 0 day admissions.
Figure 6.0 – Palliative Care Coding Rate Vs National (HSMR Basket) 1+LOS

Figure 7.0 – Comorbidity profile coding comparison (HSMR non-elective Basket) 1+ Day LOS
Figure 7.1 – Comorbidity profile coding comparison (HSMR non-elective Basket) 0 Day LOS

The Trust currently has the highest proportion of Abdominal Pain 0 day admissions nationally.

Figure 7.2 – Diagnosis group profile comparison (HSMR non-elective Basket) 0 Day LOS
Figure 9.0 – Residual Codes – 12 months to October 2020

Although this cohort of activity does not fall within the HSMR this is essentially activity with no valid primary diagnosis code within the 1st or 2nd episode of care and so will be attracting a different expected risk of mortality than possibly it should?

The Trust has the highest volume regionally which primarily relates to October 20 (This will be impacting on both the HSMR and SMR, the SMR as it will potentially impact on the expected mortality and the HSMR because a proportion of this activity will potentially become a HSMR diagnosis following resubmission of SUS.

Figure 9.1 – Non-elective Residual Codes – 12 months to August 2020

Figure 9.2 – Residual Codes – Trend
STANDARDISED MORTALITY RATIOS (SMR) ANALYSIS

Key Highlights:

- SMR = 113.3 and remains statistically significantly high but represents a continued stable in point value.
  - Fig 11.0 shows the SMR excluding COVID-19 activity with the point value being 110.3 as at August 2020.

- There are no further outlying groups (outside of the HSMR).

Figure 10.1 – SMR All Diagnosis trend (month)

Figure 10.2 – SMR All Diagnosis trend (rolling 12 month) – last 24 months

Figure 11.1 – Potential impact of COVID-19.

COVID activity and mortality removed – September – 110.3
CUSUM ALERTS @ 99% & 99.9%

Key Highlights:
- At 99% across the 12 months there are 10 diagnosis groups with CUSUM breaches, notably Pneumonia and COPD but with Acute Bronchitis (significant within the SHMI) and Viral Infection (COVID) breaching in month.
- Using a 99.9% threshold as per CQC there are 2 diagnosis groups alerting over the 12 month period – Intestinal obstruction without Hernia which is now statistically significantly high in the HSMR along with Pneumonia breaching using both thresholds.

Figure 13 – CUSUM Alerts at 99%

Over the 12 month period there have been 9 diagnosis groups with a CUSUM trigger at 99% as highlighted below (Including Viral Infection):
<table>
<thead>
<tr>
<th>Condition</th>
<th>Graph 1</th>
<th>Graph 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intestinal obstruction without hemia</td>
<td>[Graph]</td>
<td>[Graph]</td>
</tr>
<tr>
<td>Other connective tissue disease</td>
<td>[Graph]</td>
<td>[Graph]</td>
</tr>
<tr>
<td>Cancer of ovary</td>
<td>[Graph]</td>
<td>[Graph]</td>
</tr>
<tr>
<td>Gout and other crystal arthropathies</td>
<td>[Graph]</td>
<td>[Graph]</td>
</tr>
<tr>
<td>Viral infection</td>
<td>[Graph]</td>
<td>[Graph]</td>
</tr>
</tbody>
</table>
SHMI (DATA PERIOD: SEPTEMBER 2019 TO AUGUST 2020)

Key Highlights:

- SHMI = **117.31** significantly higher than expected but again does represent a material reduction in point vale interestingly with only one common diagnosis group.
  - Key outlying groups include
    - Fluid & Electrolytes
    - Acute Bronchitis
      - Although the Trust is not alerting within the DF model it does have the highest crude rate nationally. [https://one.drfoster.com/Query/?id=1955457](https://one.drfoster.com/Query/?id=1955457)
      - Like COPD and Pneumonia the LOS profile is variant to the national position skewed towards 3 days +
    - Other Connective tissue disease (DF rounded)
    - Intestinal obstruction without hernia (Common across the HSMR / SHMI)
    - Intracranial Injury (DF – rounded)
    - Acute Myocardial Infarction
      - Although not significant within the DF model it does appear that the cohort of patients admitted and discharged from the Trust (no transfer in or out) is significant.
  - See also supporting documents

Figure 14 – SHMI Summary

![SHMI Summary](image-url)
SHMI analysis – August 2020

Figure 15 – Acute Bronchitis – LOS profile

Figure 16 – Acute Myocardial Infarction
RECOMMENDATIONS FOR FURTHER ANALYSIS

- Continue to monitor the HSMR & SHMI on a monthly identifying key themes including comorbidity rates given the continued lower rate of superspells with a 20+ score.

- Continue to monitor the level of residual coded activity within the latest month of data with a view to returning to using the latest data set as volumes reduce?

- Continue to complete full reviews on existing diagnosis groups particularly focussing on the Respiratory Chapter given that Aspiration Pneumonitis along with Pneumonia and COPD are all statistically significantly high within the HSMR plus Acute Bronchitis which is now significant within the SHMI?
  - Discuss and agree analysis to be completed focussing on Skin and subcutaneous tissue infections to further understand the raised crude rate and spike in activity during August 2020.
  - Discuss further analysis in conjunction with Dr Foster regarding Intestinal obstruction without hernia given it’s continued significant position and high crude rate.
  - Further analysis should be completed to understand the Acute Myocardial Infarction significant SHMI value in conjunction with Dr Foster.
REFERENCES

SMR
A calculation used to monitor death rates. The standardised mortality ratio is the ratio of observed deaths to expected deaths, where expected deaths are calculated for a typical area with the same case-mix adjustment. The SMR may be quoted as either a ratio or a percentage. If the SMR is quoted as a percentage and is equal to 100, then this means the number of observed deaths equals that of expected. If higher than 100, then there is a higher reported mortality ratio.

HSMR
The Hospital Standardised Mortality Ratio is the ratio of observed deaths to expected deaths for a basket of 56 diagnosis groups, which represent approximately 80% of in hospital deaths. It is a subset of all and represents about 35% of admitted patient activity. Further information can be found at http://www.drfoster.com/about-us/our-approach/metrics-methodologies-and-models-library/

Benchmark
The benchmark used in this analysis is the monthly benchmark available within the Quality Investigator tool.

CUSUM
A cumulative sum statistical process control chart plots patients' actual outcomes against their expected outcomes sequentially over time. The chart has upper and lower thresholds and breaching this threshold triggers an alert. If patients repeatedly have negative or unexpected outcomes, the chart will continue to rise until an alert is triggered. The line is then reset to half the starting position and plotting of patients continues.

HSMR Comparison
In order to give an indication of how performance for the current incomplete year compares to the national average we show a rebased HSMR for the current year. This is estimated for each of the 56 diagnoses by dividing the trust's SMR (using the existing benchmark) by the national SMR and multiplying by 100. The 56 rebased SMRs are then aggregated to produce the estimated rebased HSMR.

Charlson Index of Comorbidities
The original Charlson weights were derived 25 years ago in the USA. We have updated them (e.g. HIV had the highest weight then but its mortality has fallen greatly since) and calibrated them on English data due to differences in coding practice and hospital patient population characteristics. We had advice from some clinical coders on current English coding practice and, where possible, also assessed the consistency of comorbidity recording among admissions for the same patient.

Charlson Upper-Quartile Rate
For each financial year we calculate the proportion of a trust's HSMR spells where the Charlson index for the diagnosis-dominant episode is in the national upper quartile for that diagnosis and admission type, this is the observed value. The expected value is the equivalent proportion nationally i.e. 25%. The trust's index value is calculated as the observed/expected x 100.

Palliative Care Coding Rate
For each financial year we calculate the proportion of a trust's HSMR superspells excluding day cases which are coded as having palliative care, this is the observed value shown. The expected value is the proportion nationally for the equivalent mix of diagnosis and admission type. The trust's index value is calculated as observed/expected x 100
<table>
<thead>
<tr>
<th>#</th>
<th>ID</th>
<th>ACTION</th>
<th>Workstream</th>
<th>Description</th>
<th>Assigned to - Group</th>
<th>Assigned to - Person</th>
<th>Action Due Date</th>
<th>Progress</th>
<th>Current Action Due / Outstanding</th>
<th>25/02/2021 Update</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>C1</td>
<td>OUTPUT</td>
<td>CARE</td>
<td>Investigation into Dr Foster Alerts (Backlog and BAU Process)</td>
<td>Improvement Group</td>
<td>Richard J Ben G</td>
<td>01/01/2021</td>
<td>Complete</td>
<td>SOP Finalised and Shared</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>C1.1</td>
<td>TASK</td>
<td></td>
<td>Confirmation of SOP for this process based around clinical notes and coding reviews</td>
<td>Improvement Group</td>
<td>Callum G Lisa F</td>
<td>02/03/2021</td>
<td>On Track</td>
<td>DRAFT report due to MIG on 02/03/2021 for review and comment</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>C1.2</td>
<td>TASK</td>
<td></td>
<td>Confirm areas with highest variance between expected and actual deaths</td>
<td>Analytical Group</td>
<td>Lisa F</td>
<td>07/01/2021</td>
<td>Complete</td>
<td>Identification of high impact areas - Waterfall Completed</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>C1.3</td>
<td>TASK</td>
<td></td>
<td>Review of Pneumonia</td>
<td>Improvement Group</td>
<td>Callum G Lisa F</td>
<td>02/03/2021</td>
<td>On Track</td>
<td>DRAFT report due to MIG on 02/03/2021 for review and comment</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>C1.4</td>
<td>TASK</td>
<td></td>
<td>Review of COPD and Bronchiectasis</td>
<td>Improvement Group</td>
<td>Callum G Lisa F</td>
<td>02/03/2021</td>
<td>On Track</td>
<td>DRAFT report due to MIG on 02/03/2021 for review and comment</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>C1.5</td>
<td>TASK</td>
<td></td>
<td>Review of Aspiration pneumonia</td>
<td>Improvement Group</td>
<td>Callum G Lisa F</td>
<td>02/03/2021</td>
<td>On Track</td>
<td>DRAFT report due to MIG on 02/03/2021 for review and comment</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>C1.6</td>
<td>TASK</td>
<td></td>
<td>Review of Skin and subcutaneous tissue infections</td>
<td>TBC</td>
<td></td>
<td></td>
<td>Not Started</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>C1.7</td>
<td>TASK</td>
<td></td>
<td>Review of Intestinal obstruction without hernia</td>
<td>TBC</td>
<td></td>
<td></td>
<td>Not Started</td>
<td>As above - SJR's complete</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>C1.8</td>
<td>TASK</td>
<td></td>
<td>Development of ProForma for Dr Foster Reviews - Coding and Notes</td>
<td>Improvement Group</td>
<td></td>
<td>16/02/2021</td>
<td>Behind</td>
<td>Confirm standardised approach / template to undertaking Dr Foster Reviews</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>C1.9</td>
<td>TASK</td>
<td></td>
<td>Review of Cancer of ovary</td>
<td>TBC</td>
<td></td>
<td></td>
<td>Not Started</td>
<td>Complete notes and coding review inline with SOP</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>C2</td>
<td>OUTPUT</td>
<td>CARE</td>
<td>Investigation into quality of care in areas with high avoidable deaths</td>
<td>Improvement Group</td>
<td>Callum G Susan D Richard J</td>
<td>16/03/2021</td>
<td>On Track</td>
<td>Findings to come to MIG on the 16th March</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>C2.1</td>
<td>TASK</td>
<td></td>
<td>Thematic review of last 12 months of avoidable deaths from Sh's, Reds and Inquests (expected to be 70 reviews) to confirm high impact areas</td>
<td>Improvement Group</td>
<td>Callum G Susan D Richard J</td>
<td>16/03/2021</td>
<td>On Track</td>
<td>Findings to come to MIG on the 16th March</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>C2.2</td>
<td>TASK</td>
<td></td>
<td>Collection of base line information / audit in selected areas to provide baseline information</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Complete</td>
<td>Picked up as part of the requirements for individual areas (i.e. Sepsis) No longer needed as a separate action</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>C2.3</td>
<td>TASK</td>
<td></td>
<td>Improving management of AKI (in particular fluid balance)</td>
<td>S&amp;S Deteriorating Patient and Sepsis</td>
<td>TBC</td>
<td>TBC</td>
<td>Not Started</td>
<td>Managed through S&amp;SDP&amp;S Group</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>C2.4</td>
<td>TASK</td>
<td></td>
<td>Improving management of Sepsis and how this will be undertaken</td>
<td>Improvement Group</td>
<td>Callum G</td>
<td>02/03/2021</td>
<td>On Track</td>
<td>Update on progress of work between Dr Arefin and Helen Canning Managed through S&amp;SDP&amp;S Group</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>C2.5</td>
<td>TASK</td>
<td></td>
<td>Improvement in management of deteriorating patients</td>
<td>S&amp;S Deteriorating Patient and Sepsis</td>
<td>TBC</td>
<td>TBC</td>
<td>Not Started</td>
<td>Ongoing work at S&amp;S Deteriorating Patient and Sepsis group. Additional actions to be fed in as needed following reviews</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>C2.6</td>
<td>TASK</td>
<td></td>
<td>Improving management of VTE and how this will be undertaken</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
<td>Not Started</td>
<td>Work ongoing but not managed through MIG</td>
<td></td>
</tr>
<tr>
<td></td>
<td>C2.7 TASK</td>
<td>Confirm the use of the Improvement Academy to look at areas of improvement</td>
<td>Improvement Group</td>
<td>Richard / Callum</td>
<td>05/02/2021</td>
<td>On Track</td>
<td>Decision from MIG / Richard and Callum as to Pneumonia proposal from IA</td>
<td>Proposals received for the Pneumonia work. Being considered by MIG and Richard / Callum. Decision next week.</td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>C3 OUTPUT CARE</td>
<td>Ongoing improvement into areas with excess deaths</td>
<td>Improvement Group</td>
<td>Ben G</td>
<td>31/03/2021</td>
<td>On Track</td>
<td>Build into BAU governance process review</td>
<td>IA undertaking a governance review. Will form part of the overall governance work. Will focus on this post IA report</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>C3.1 TASK</td>
<td>System in place for information from SIs, inquests, complaints etc. to be brought together to inform decisions / areas of focus</td>
<td>Improvement Group</td>
<td>Ben G</td>
<td>31/03/2021</td>
<td>On Track</td>
<td>Updated Mortality Policy in DRAFT for consideration</td>
<td>Extension submitted to mortality policy. Outline draft being updated by BG for discussion</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>C3.2 TASK</td>
<td>Have an up to date, approved mortality policy which captures all elements</td>
<td>TBC</td>
<td>Callum G</td>
<td>31/03/2021</td>
<td>On Track</td>
<td>Share of External Reviews with Improvement Group and ensure actions are being delivered / picked up</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>C3.3 TASK</td>
<td>Review external Mortality review for areas of additional focus</td>
<td>Improvement Group</td>
<td>Callum G</td>
<td>08/01/2021</td>
<td>Complete</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>C3.4 TASK</td>
<td>Understand process for Elective Care Deaths and monitoring</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
<td>Not Started</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

|   | C3 OUTPUT CARE | Care improvement on AMU | AMU Improvement Group | Callum G | 19/01/2021 | Complete | No current actions - AMU improvement group has commenced - update by exception. No longer managed by MIG | |
|   | C3.1 TASK | Improvements in continuity of care | AMU Improvement Group | T&F | | 19/01/2021 | Complete | |
|   | C3.2 TASK | Clinical Leadership on AMU | | | | | |

| M1 OUTPUT CASE MIX | Improvements in Palliative Care Pathways and Coding | |
|---|---|---|---|---|---|---|---|---|
|   | M1.1 TASK | Palliative Care Coding review - looking at Specialist V Generalist in particular | Analytical Group | Lisa F | 31/03/2021 | Not Started | Next Action TBC - review at MIG mid/late March | Mandatory field now in place for the Specialist Palliative Care Team. Palliative Care will need to be considered as a wider piece of work looking at capacity / process as well as coding |
|   | M1.2 TASK | Ensure every palliative care patient is coded as palliative | Analytical Group | Michael W | 31/03/2021 | Not Started | Next Action TBC - review at MIG mid/late March | Team met with DEFT. Learning taken and will form part of the focus when we start to talk about Palliative care in more detail |
| M1.3 TASK | Joint Audit with Primary Care of known palliative care patients who came into Hospital and Died | Callum G | 16/03/2021 | At Risk | Identify lead from TRFT and agree audit proforma for audit | Confirmed we have enough 'inappropriate admissions' for a audit. Will be a lower priority than actions in Care - consider Mid March |
| M1.4 TASK | Ensure that ReSPECT documentation is in place and being used | TBC | TBC | TBC | not started | |
| M1.5 TASK | Review of hospice capacity or primary care | TBC | TBC | TBC | not started | Awaiting findings of joint audit to confirm if Hospice Capacity is an issue |
| M1.6 TASK | DNACPR Decision Making / Planning | S&S Mortality Group | Carrie K | 16/02/2021 | Behind | Confirm role of MIg or is this BAU | Calum G to pick up concerns at CLDD meetings. Carrie K to record RU numbers and clinician which it’s a issue at Stage 1 reviews |

**D1 OUTPUT CODING** Improved quality and depth of coding (i.e. comorbidities)

| D1.1 TASK | Review Charleston Index Score and evidence if this is a concern / issue | Analytical Group | Lisa F | 05/01/2021 | Complete | No outstanding action. Charleston Index within expected range. General improvement work now as BAU |
| D1.2 TASK | Coding team member to be collocated with ME | Analytical Group | Lisa F | 05/01/2021 | complete | No outstanding action - rota in place |
| D1.4 TASK | Explore the '2 FCE' coding rule and consider options for resolution if an issue | Analytical Group | Lisa F | 05/02/2021 | not started | On hold - lower priority | Placed down the priority list as suggestive that this is a minimal impact |
| D1.5 TASK | External coding review from 3M / IQVIA | Analytical Group | Lisa F | 04/03/2021 | On Track | Submission of Business case to ETM | Business case shared with MIg. On ETM on 4th March for approval |
| D1.6 TASK | R' codes and issues with coding completeness | Analytical Group | Lisa F | 07/01/2021 | Complete | No outstanding action - Decision on use of 'Freeze' data for Dr Foster rather than 'Flex' |

**D2 OUTPUT CODING** Improve documentation in notes to enable accurate coding

<p>| D2.1 TASK | Confirm that 'treat as' is in place within Meditech and is being used | Improvement Group | Ben G | 05/02/2021 | Complete | Confirm current text can be used by coding, if not update to 'treat as' |
| D2.2 TASK | Improve the process of asking for notes reviews on deaths by coding team to consultant | Analytical Group | Ben G | 31/03/2021 | Not Started | Build the Meditech form as part of the planned improvement | Update needed - not considered a priority |
| D2.3 TASK | Establish training / refresh programme for documentation and coding for clinical teams | TBC | TBC | TBC | Not Started | Confirm timeline and expectations |</p>
<table>
<thead>
<tr>
<th></th>
<th>OUTPUT</th>
<th>COMMS</th>
<th>Task</th>
<th>Task Description</th>
<th>Responsible</th>
<th>Status</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>S1</td>
<td>OUTPUT</td>
<td>COMMS</td>
<td>TASK</td>
<td>Confirm layout / input / distribution list (inc. methodology - i.e. WhatsApp) and branding</td>
<td>Improvement Group</td>
<td>Complete</td>
<td>No further actions - though need to confirm regular publications. 1st edition has been sent. Need to be go out on a regular basis.</td>
</tr>
<tr>
<td>S2</td>
<td>OUTPUT</td>
<td>COMMS</td>
<td>TASK</td>
<td>Undertake meeting with Respiratory medical teams to increase awareness of current situation</td>
<td>Improvement Group</td>
<td>Not Started</td>
<td>on Hold - may not be needed - awaiting outcomes of reviews.</td>
</tr>
<tr>
<td>S2.1</td>
<td>TASK</td>
<td>Chief Executives Messages on Mortality</td>
<td>Improvement Group</td>
<td>Ben G</td>
<td>19/01/2021</td>
<td>Behind</td>
<td>Outline of CEO message to be shared with MIG. Need to provide a draft message for review.</td>
</tr>
<tr>
<td>S3</td>
<td>OUTPUT</td>
<td>GOVERNANCE</td>
<td>TASK</td>
<td>Review current governance through service, division and corporate where mortality is considered and reviewed</td>
<td>Improvement Group</td>
<td>18/02/2021</td>
<td>Behind</td>
</tr>
<tr>
<td>S3.1</td>
<td>TASK</td>
<td>Confirm Medical input into Rapid Improvement Group</td>
<td>Improvement Group</td>
<td>Callum G</td>
<td>ASAP</td>
<td>Behind</td>
<td>Have medical leadership represented on the MIG. Ongoing challenges in recruitment. Ongoing.</td>
</tr>
<tr>
<td>S3.2</td>
<td>TASK</td>
<td>Appoint mortality lead for the Trust - separate v part of the role</td>
<td>Callum G</td>
<td>ASAP</td>
<td>Behind</td>
<td>Richard and Callum to discuss outside the meeting and confirm time line. Ongoing challenges with recruitment - ongoing.</td>
<td></td>
</tr>
<tr>
<td>S4</td>
<td>OUTPUT</td>
<td>GOVERNANCE</td>
<td>TASK</td>
<td>Ensure information is consistent, shared and accessible from Ward to Board on mortality</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC Started</td>
</tr>
<tr>
<td>S4.1</td>
<td>TASK</td>
<td>Local discussion to be taking place of learning from deaths / mortality to improve practice.</td>
<td>Safe and Sound Mortality Group</td>
<td>TBC</td>
<td>TBC</td>
<td>Not Started</td>
<td>Confirm mortality reviews are taking place within each division - linked to G4.1.</td>
</tr>
<tr>
<td>S4.2</td>
<td>TASK</td>
<td>Evidence of MDT SJRs within medicine are timetabled in weekly and that actions are in place</td>
<td>Improvement Group</td>
<td>Callum G</td>
<td>05/02/2021</td>
<td>Complete</td>
<td>Confirm SJRs are taking place in medicine in line with guidance. SJRs are scheduled in. Further work will drop out of G1.1.</td>
</tr>
</tbody>
</table>
Board of Directors’ Meeting
05 March 2021

Agenda item | P50/21
---|---
Report | Board Committees Terms of Reference
Executive Lead | Jill Dentith, Corporate Governance Consultant
Link with the BAF | B8 – the risk of insufficiently robust governance arrangements
How does this paper support Trust Values | Good corporate governance underpins achievement of the Trust’s values
Purpose | For decision ☒, For assurance ☐, For information ☐

Executive Summary (including reason for the report, background, key issues and risks)

Section 6 of the Standing Orders of the Rotherham NHS Foundation Trust (the Trust) state that the Board of Directors can appoint committees to act on its behalf. This section further states that each committee will have terms of reference and Section 5 of the Standing Orders state that such terms of reference shall be approved by the Board. The current board committees are:

- Audit Committee;
- Remuneration Committee;
- Nomination Committee;
- Finance and Performance Committee;
- Quality Committee;
- People Committee; and
- The Rotherham NHS Foundation Trust Committee in Common.

When the Standing Orders are reviewed in the next few months the above will be included to reflect the current committee structure approved by the Board.

As part of the wider review of its governance arrangement the Board of Directors have had discussions in October, November and December 2020 considering governance and assurance processes which underpin the Board and committee structure. These discussions considered the membership and attendance at Board and its committees and reporting arrangements for some operational groups into committees. These proposals form the majority of the changes proposed. Other small changes relate to nomenclature, consistency and assurance processes have been made.

A standard template has been used. The text in black font is standard across all, whilst the text in blue is that which is specific to each committee.
As part of their annual review of effectiveness each committee has reviewed its terms of reference, taking account of recommendations relating to membership, attendees and reporting arrangements.

<table>
<thead>
<tr>
<th>Due Diligence</th>
<th>The Remuneration Committee, Finance and Performance Committee, Quality Committee and People Committee have all reviewed their terms of reference at their meeting in February 2021. The Audit Committee considered the draft terms of reference at their meeting in January 2021 and made final amendments virtually to meet the deadline for recommendation to March 2021 Board. The Chair of the Nomination Committee has been consulted on the proposed changes and recommends them to the Board for approval. The Chair of the Board has been consulted on all of the proposed changes and recommends them to the Board for approval.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board powers to make this decision</td>
<td>The Board has power to approve these terms of reference as per Annex 8 of the Constitution – Standing Orders for the Board of Directors, Sections 5 and 6 of the Standing Orders.</td>
</tr>
<tr>
<td>Who, What and When (what action is required, who is the lead and when should it be completed?)</td>
<td>If approved by the Board the Chairs of the relevant committees will ensure that the revised terms of reference are enacted and that they will be reviewed in a further 12 months’ time. The Board of Directors have acknowledged that during 2021/22 financial year, a significant amount of the Trust’s resources will be deployed towards the challenges presented by the coronavirus pandemic. During this time the Board committees will take this into account when planning their agendas.</td>
</tr>
<tr>
<td>Recommendations</td>
<td>It is recommended that the Board approve the terms of reference for the:</td>
</tr>
<tr>
<td></td>
<td>• Audit Committee;</td>
</tr>
<tr>
<td></td>
<td>• Remuneration Committee;</td>
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<tr>
<td></td>
<td>• Nomination Committee;</td>
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<tr>
<td></td>
<td>• Finance and Performance Committee;</td>
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<td></td>
<td>• Quality Committee;</td>
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<td></td>
<td>• People Committee; and</td>
</tr>
<tr>
<td></td>
<td>• The Rotherham NHS Foundation Trust Committee in Common</td>
</tr>
<tr>
<td>Appendices</td>
<td>Appendix 1 - Audit Committee Appendix 2 - Remuneration Committee Appendix 3 - Nomination Committee Appendix 4 - Finance and Performance Committee Appendix 5 - Quality Committee Appendix 6 - People Committee Appendix 7 - The Rotherham NHS Foundation Trust Committee in Common</td>
</tr>
</tbody>
</table>
## Audit Committee

### TERMS OF REFERENCE

#### Committee Status

The Audit Committee ("the Committee") is a standing committee of the Board of Directors (the Board) of The Rotherham NHS Foundation Trust (the Trust).

It is authorised to consider any matter within its terms of reference and to be provided with the Trust resources to do so.

It also has the right of access to all information that it deems relevant to fulfil its duties which may require any Trust colleague to attend a meeting of the Committee to present information or answer questions on a matter under discussion.

The Committee is empowered to obtain external professional advice and to invite external consultants with relevant experience to attend if necessary.

The Committee has no executive powers other than those set out in these Terms of Reference.

#### Reporting to

The Committee is accountable to the Board.

The Committee shall report to the Board on how it discharges its responsibilities. The minutes of the Committee’s meetings shall be formally recorded and submitted to the Board, once approved by the Chair of the Committee. The Chair of the Committee will also provide the Board with a Chair’s Assurance Log at each meeting of the Board in the month following the Committee meeting. The Assurance Log will provide assurance or highlight risks to the Board or issues that require executive action.

The Committee will report to the Board annually on its work in support of the annual governance statement, specifically commenting on:

- the fitness for purpose of the assurance framework;
- the completeness and extent to which risk management is embedded at the Trust;
- the integration of governance arrangements;
• the appropriateness of the evidence that shows the organisation is fulfilling regulatory requirements relating to its existence as a functioning business; and

• the robustness of the processes behind the quality report.

This annual report will also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed.

In addition the Chair of the Committee will provide a quarterly report on the Committee's activities to the Council of Governors.

**Purpose and Duties**

The Board has approved the establishment of the Committee for the purpose of advising the Board of Directors and providing an independent and objective review on the adequacy of Trust’s system of internal control, including audit arrangements (internal and external), financial systems, financial information, assurance arrangements including governance, risk management and compliance with legislation.

The Committee will discharge this purpose through the following duties:

1. **Integrated Governance, Risk Management and Internal Control**

The Committee shall review the establishment and maintenance of an effective system of integrated risk management and internal control, across the whole of the Trust’s activities (including those of any subsidiary, either currently in existence or to be established) that support the achievement of the organisation’s strategic objectives.

In particular, the Committee, will review the adequacy and effectiveness of:

- all risk and control related disclosure statements, (in particular, the Annual Governance Statement) together with any accompanying Head of Internal Audit Opinion, prior to endorsement by the board;
- the underlying assurance processes that indicate the degree of achievement of the organisation’s objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
- the risk management strategy, structures, processes and responsibilities for identifying and managing key risks facing the organisation;
- the policies and procedures for all work related to anti-fraud, bribery and corruption as set out by the NHS Counter Fraud Authority;
- the work of counter-fraud services; to ensure that there is an effective LCFS established by management that meets mandatory requirements and provides appropriate
independent assurance to the Committee, Chief Executive and Board;

- the policies for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements as set out in regulators’ standards and guidance;
- the operational effectiveness of policies and procedures; and
- the financial control systems.

In carrying out this work, the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

These will be evidenced through the Committee’s use of an effective assurance framework to guide its work and the audit and assurance functions that report to it.

2. Internal Audit

The Committee shall ensure that there is an effective Internal Audit function established by management that meet the Public Sector Internal Audit Accounting Standards 2017, that utilises an independent risk based approach.

In addition, the Committee will:

- consider the appointment of the internal audit service, the internal audit fee and any questions of resignation or dismissal and make appropriate recommendations to the Board;
- following consultation with all executive and Non-Executive Board members, approve the internal audit programme and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework;
- consider the major findings of internal audit investigations (and management’s response) and report progress on material matters to the Board;
- ensure co-ordination and co-operation between the Internal and External Auditors to optimise the use of audit resources;
- ensure that the Internal Audit function is adequately resourced and has appropriate standing within the organisation;
- review annually the effectiveness of Internal Audit; and
- meet in private with the internal auditor to discuss issues or matters arising.

3. External Audit
The Committee shall review and monitor the external auditors’ independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management’s responses to their work. This will be achieved by:

- A report by the Committee to the Council of Governors in relation to the performance of the External Auditors, including details such as the quality and value of the work, and the timeliness of report and fees, to enable the Council of Governors to consider whether or not to re-appoint them. The Committee should also make recommendation to the Council of Governors about the appointment, re-appointment and removal of the External Auditor and approve the remuneration and terms of engagement of the External Auditor;
- discussion and agreement with the External Auditor, before the annual audit commences, of the nature and scope of the audit, as set out in the annual plan;
- reviewing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee;
- review and monitoring of External Audit reports, including the report to those charged with governance (before its submission to the Board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses;
- review and monitor the External Auditor’s independence, objectivity and effectiveness, particularly with regard to non–audit services that may be provided to the Trust;
- developing and recommend to the Board as required, the Trust’s formal policy on the provision of non-audit services by the External Auditor, including approval of non-audit services by the Committee and specifying the types of non-audit service to be pre-approved, and assessment of whether non-audit services have a direct material effect on the audited financial statements ; and
- meet as required in private with the external auditor to discuss issues or matters arising.

4. Other assurance functions

The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation.

These could include any reviews undertaken by regulators (such as NHSEI and the Care Quality Commission), NHS Resolution and professional bodies with responsibility for the performance of staff or functions (such as Royal Colleges and accreditation bodies).

The Audit Committee will also receive and review annual reports from the board’s committees in support of the annual governance statement prior to them being submitted to the Board.
The Committee will provide assurance to the Board that the organisation is properly managing its cyber risk, including appropriate risk mitigation strategies.

The Committee will review the complete Board Assurance Framework (BAF) document on a quarterly basis prior to its submission to the Board.

5. Financial Reporting

The Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust’s financial performance.

The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

The Committee shall review the Annual Report and Financial Statements before submission to the Board, focusing particularly on:

- the wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee;
- changes in, and compliance with, accounting policies, practices and estimation techniques;
- unadjusted mis-statements in the financial statements;
- significant judgments in the preparation of the financial statements;
- significant or proposed adjustments resulting from the audit;
- letters of representation;
- explanations for significant variances;
- qualitative aspects of financial reporting; and
- the rigour with which the Auditor has undertaken the audit.

6. Counter Fraud

The Committee shall satisfy itself as to having adequate arrangements in place for counter fraud that meets the NHS Counter Fraud Authority’s standards; fraud, bribery and corruption, and shall review the outcomes of work in this area.

In accordance with 1.2 of the NHSCFA’s Fraud Standards for Providers, the Committee has ‘stated its commitment to ensuring the Trust strive to achieve these standards and therefore requires assurance that they are being met via NHSFCA’s self-review tool submission’.

The Committee will refer any suspicions of fraud, bribery, and corruption to the Trust’s Counter Fraud Specialist or the NHSCFA.

7. Annual Report
The annual report shall include a separate section to cover the work of the Committee in discharging the responsibilities outlined above.

The annual report should:

- explain the significant issues that the Committee considered in relation to the financial statements, operations and compliance, and how these issues were addressed;
- explain, if the auditor (internal / external) provides non-audit services and how auditor objectivity and independence is safeguarded;
- the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and
- include details of the full auditor (internal / external) appointment process where relevant.

8. Whistleblowing Policies

The Committee shall review the Trust’s arrangements for its employees to raise concerns, in confidence, about possible wrongdoing in financial reporting and control, clinical quality, patient safety or other matters. The Committee shall ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow up action, and reassure individuals raising concerns that they will be protected from potential negative repercussions.

9. Other matters

The Committee shall:

- review the appropriateness of single tender actions which have been approved by the Executive;
- give due consideration to laws and regulations, and the provisions of The NHS Foundation Trust Code of Governance; and
- committee members shall receive the development and training that they need to fulfil their role on the Committee.

The Committee will also:

- Review the BAF risks delegated to the Committee for review, and make recommendations to the Board for any required changes of risk score or content.
| Committee Membership | The Committee shall be appointed by the Board of Directors and shall consist of **four Non-Executive Directors**, with at least one member having recent and relevant financial experience.  

The Board shall appoint the Chair and Vice Chair of the Committee from its Non-Executive Directors.  

The Trust Chair shall NOT be a member of the Committee. |
|----------------------|---------------------------------------------------------------------------------------------------------------|
| Quorum               | A quorum shall be made up of **two** members.  
No business shall be transacted by the Committee unless a quorum is present. |
| Attendees            | Attendees to include:  
- Director of Finance (who will act as the Lead Executive);  
- Director of Corporate Affairs / Company Secretary, to ensure coordination of Board committees and to provide appropriate support to the Committee Chair and members;  
- Representatives from internal audit and external audit. |
| Observers            | Meetings are not open to members of the public, however two Governors, representing the Council of Governors, may attend Committee meetings as observers, once confidentiality agreements have been signed on an annual basis. As observers Governors may not participate in the meeting unless specifically invited to do so by the Chair of the Committee.  
However, the Chair reserves the right to hold all, or part of the meeting in private without Governors observing if deemed appropriate.  
A copy of the agenda and papers will be provided on the day to Governors who are observing the meeting. All papers will be returned to the secretary of the meeting at the end of the meeting. |
| Frequency of Meetings| Meetings shall usually be held at least five times per financial year, but may be held more or less frequently should circumstances require (which will be determined by the Chair of the Committee). |
Meetings shall be scheduled, and endure, for no longer than three hours in length, unless exceptional circumstances demand an extended session.

At least once a year, the Committee should meet privately with both the Internal Auditors and External Audit on a separate basis. In addition the Head of Internal Audit, representatives of external audits and counter-fraud specialists have the right of access to the Chair of the Committee at times, to be requested by them.

<table>
<thead>
<tr>
<th>Meeting administration</th>
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<tbody>
<tr>
<td>Notice of meetings will be given at least seven working days in advance unless members agree otherwise.</td>
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<tr>
<td>The Chair of the Committee and Lead Executive will meet to agree the agenda for each meeting. The agenda will be based on the Committee Annual Work Plan.</td>
</tr>
<tr>
<td>The Lead Executive Director for the Committee will be the Director of Finance. The Director of Corporate Affairs / Company Secretary will support the Chair of the Committee and Lead Executive Director in the management of the Committee's business and for drawing the Committee’s attention to best practice, national guidance and other relevant documents, as appropriate.</td>
</tr>
<tr>
<td>Administrative support to the Committee will be provided by the secretary. The secretary will take minutes. Items for inclusion on the agenda shall be submitted to the secretary at least ten working days prior to the meeting. Agendas can then only be amended by agreement of the Committee Chair and Lead Executive Director.</td>
</tr>
<tr>
<td>The agenda and papers will normally be circulated at least four working days prior to the meeting to Committee members and regular attendees.</td>
</tr>
<tr>
<td>Draft minutes and action logs will be produced by the secretary within five working days, reviewed by the Lead Executive Director and then approved by the Committee Chair within ten working days of the meeting.</td>
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</table>

<table>
<thead>
<tr>
<th>Operational Groups which report into the Committee</th>
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<tbody>
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<td>There are no operational groups which report into the Committee.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Monitoring and review</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Committee’s Terms of Reference will be subject to annual review. Proposed variations will require approval of the Board.</td>
</tr>
<tr>
<td>The Committee will undertake an annual review of its performance, via self-assessment by its members and any agreed actions, will be reported to the Board.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reviewed by Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 2021</td>
</tr>
<tr>
<td>Approved by the Board of Directors</td>
</tr>
<tr>
<td>-----------------------------------</td>
</tr>
<tr>
<td>Next Review date</td>
</tr>
</tbody>
</table>

Based on Terms of Reference Template – February 2021 v4
Terms of Reference – Audit Committee – February 2021 v7 - FINAL
Remuneration Committee

TERMS OF REFERENCE

| Committee Status | The Remuneration Committee (“the Committee”) is a standing committee of the Board of Directors (the Board) of The Rotherham NHS Foundation Trust (the Trust).

It is authorised to consider any matter within its terms of reference and to be provided with the Trust resources to do so.

It also has the right of access to all information that it deems relevant to fulfil its duties which may require any Trust colleague to attend a meeting of the Committee to present information or answer questions on a matter under discussion.

The Committee is empowered to obtain external professional advice and to invite external consultants with relevant experience to attend if necessary.

The Committee has no executive powers other than those set out in these Terms of Reference. |
| Reporting to | The Committee is accountable to the Board.

The Committee shall report to the Board on how it discharges its responsibilities. The minutes of the Committee’s meetings shall be formally recorded. The Chair of the Committee will provide the Board with a Chair’s Assurance Log at each meeting of the confidential Board in the month following the Committee meeting. The Assurance Log will provide assurance or highlight risks to the Board or issues that require executive action.

The Committee will report to the Board annually on its work in support of the annual governance statement. The annual report should also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee has considered and how these were addressed. |
| Purpose and Duties | The Board has approved the establishment of the Committee for the purpose of setting levels of executive remuneration that are sufficient to attract, retain and motivate executive directors of the quality required to run the organisation successfully, but should ensure that paying more than necessary for this purpose is avoided. |
The Committee has responsibility relating to the remuneration of Executive Directors who may be appointed in an “acting up”, “interim” or “secondment” basis. In such circumstances the Committee shall seek recommendations from the Chief Executive.

The Committee will also consider all relevant and current directions relating to contractual benefits such as pay and redundancy entitlements.

The duties of the Committee are to:

- Review the ongoing appropriateness and relevance of the Trust’s remuneration policy.
- Exercise delegated responsibility for setting remuneration for all executive directors within the terms of the agreed remuneration policy and after consultation with the Chief Executive. This will include basic salary, pension rights (insofar as these fall within the Committee’s powers), any benefits in kind, any incentive arrangements and compensation commitments on early termination. No executive director, director or senior manager shall be involved in any decision as to their own remuneration.
- Consider the output of the evaluation of the performance of individual executive directors, in accordance with the remuneration policy.
- Consider the performance criteria and any upper limits for annual bonuses and incentive schemes including in the remuneration of executive directors. These should be set and disclosed, and should be designed to align the interests of executive directors with those of patients, service users and taxpayers to give these directors keen incentives to perform at the highest level. The Committee should also take account, as a baseline for performance, any competencies required and specified within the job description for the post. Recommendations should then be made to the Board.
- Develop mechanisms to ensure that the Committee is adequately informed of comparative levels of remuneration for executive directors and other Trust employees who may be contracted on terms which are not part of national NHS terms and conditions, such as “agenda for change”.
- Be sensitive to pay and employment conditions elsewhere in the Trust, when determining remuneration matters, within the remit of the Committee, especially when determining salary increases.
- Determine, where the Trust releases an executive director to serve as a non-executive director elsewhere – whether or not the executive director will retain any associated earnings – and a statement to this effect will be included in the remuneration disclosures of the annual report.
- The Committee should not agree to an executive Director leaving the employment of the Trust, except in accordance with the terms of their contract of employment, including but not limited to service of their full notice period and/or material
reductions in their time commitment to the role, without the Board first having completed and approved a full risk assessment.

- Carefully consider what compensation commitments (including pension contributions and all other elements) executive directors’ terms of appointment would entail in the event of early termination, with the aim of avoiding rewarding poor performance and reflecting a departing director’s obligation to mitigate loss. Appropriate clawback provisions should be considered in case of a director returning to the NHS within a period of any putative notice.

- Ensure compliance with the requirements of HMRC and regulators, such as NHS England / Improvement, with regard to severance payment and / or other payments outside of contractual obligations. The Committee must be satisfied that such payments are in the best interest of the Trust and represents value for money.

In this regard, the Committee’s role is to:

- satisfy itself that it has the relevant information before it, to make a decision to approve a submission for payment outside of contractual obligations;
- conscientiously discuss and assess the merits of the case;
- consider the payment or payment range being proposed and addressing whether it is appropriate, taking into account the issues set out under initial considerations. The Committee should only approve such sum or range which it considers value for money, the best use of public funds and in the public interest, in accordance with HMT guidance, “Managing Public Money”;
- keep a written record summarising its discussions and its decision; and
- to monitor redundancy / capitalised pension costs for all staff groups and to approve any redundancy / capitalised pension costs in excess of £100,000.

- To monitor compliance with IR35 / off payroll requirements.

### Committee Membership

The Committee members shall be appointed by the Board and shall consist of **four Non-Executive Directors**

The Board shall appoint the Chair and Vice Chair of the Committee from its Non-Executive Directors.

The Chair of the Board shall not be a member of the Committee.

### Quorum

A quorum shall be made up of **two members**

No business shall be transacted by the Committee unless a quorum is present.
Those in attendance or observing do not count towards the quorum.

<table>
<thead>
<tr>
<th>Attendees</th>
<th>Attendees to include:</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>• The Chief Executive who will have a standing invitation to attend, unless this is deemed inappropriate (for example, when discussing the Chief Executive’s salary)</td>
</tr>
<tr>
<td></td>
<td>• The Director of Workforce, who will act as Lead Officer; and</td>
</tr>
<tr>
<td></td>
<td>• The Director of Corporate Affairs / Company Secretary</td>
</tr>
</tbody>
</table>

Other Executive Directors or their colleagues may be invited to attend for specific agenda items.

<table>
<thead>
<tr>
<th>Observers</th>
<th>Meetings are not open to members of the public or Members of the Council of Governors.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Frequency of Meetings</th>
<th>Meetings shall be held at least twice a year, but may be held more frequently should circumstances require (to be determined by the Committee Chair).</th>
</tr>
</thead>
</table>

Meetings shall be scheduled, and endure, for no longer than three hours in length, unless exceptional circumstances demand an extended session.

<table>
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<tr>
<th>Meeting administration</th>
<th>Notice of meetings will be given at least seven working days in advance unless members agree otherwise.</th>
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The Chair of the Committee and Lead Executive will meet to agree the agenda for each meeting. The agenda will be based on the Committee Annual Work Plan.

The Lead Executive Director for the Committee will be Director of Workforce. The Director of Corporate Affairs / Company Secretary will support the Chair of the Committee and Lead Executive Director in the management of the Committee’s business and for drawing the Committee’s attention to best practice, national guidance and other relevant documents, as appropriate.

Administrative support to the Committee will be provided by the secretary. The secretary will take minutes. Items for inclusion on the agenda shall be submitted to the secretary at least ten working days prior to the meeting. Agendas can then only be amended by agreement of the Committee Chair and Lead Executive Director.

The agenda and papers will normally be circulated four working days prior to the meeting to Committee members and regular attendees.

Draft minutes and action logs will be produced by the secretary within five working days, reviewed by the Lead Executive Director and then approved by the Committee Chair within ten working days of the meeting.
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<th><strong>Operational Groups which report into the Committee</strong></th>
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<tr>
<td><strong>Monitoring and review</strong></td>
<td>The Committee’s Terms of Reference will be subject to annual review. Proposed variations will require approval of the Board. The Committee will undertake an annual review of its performance, via self-assessment by its members and any agreed actions, will be reported to the Board.</td>
</tr>
<tr>
<td><strong>Reviewed by Committee</strong></td>
<td>19 February 2021</td>
</tr>
<tr>
<td><strong>Approved by the Board of Directors</strong></td>
<td>March 2021</td>
</tr>
<tr>
<td><strong>Next Review date</strong></td>
<td>January 2022</td>
</tr>
</tbody>
</table>

Based on Terms of Reference Template – February 2021 v4
Terms of Reference RemCom – February 2021 v3 FINAL
# Nomination Committee

## TERMS OF REFERENCE

| Committee Status | The Nomination Committee (“the Committee”) is a standing committee of the Board of Directors (the Board) of The Rotherham NHS Foundation Trust (the Trust).
|                  | It is authorised to consider any matter within its terms of reference and to be provided with the Trust resources to do so.
|                  | It also has the right of access to all information that it deems relevant to fulfil its duties which may require any Trust colleague to attend a meeting of the Committee to present information or answer questions on a matter under discussion.
|                  | The Committee is empowered to obtain external professional advice and to invite external consultants with relevant experience to attend if necessary.
|                  | The Committee has no executive powers other than those set out in these Terms of Reference.
| Reporting to     | The Committee is accountable to the Board.
|                  | The Committee shall report to the Board on how it discharges its responsibilities. The minutes of the Committee’s meetings shall be formally recorded. The Chair of the Committee will provide the Board with a Chair’s Assurance Log at each meeting of the confidential Board in the month following the Committee meeting. The Assurance Log will provide assurance or highlight risks to the Board or issues that require executive action.
|                  | The Committee will report to the Board annually on its work in support of the annual governance statement. The annual report should also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee has considered and how these were addressed.
| Purpose and Duties | The Board has approved the establishment of the Committee with the responsibility for executive director nominations and shall identify suitable candidates to fill executive director vacancies as they arise, and will make recommendations to the Chair, the other
Non-Executive Directors and, except in the case of the appointment of a Chief Executive, the Chief Executive.

It will discharge this purpose through the following duties:

- To regularly review the structure, size, diversity and composition (including the skills, knowledge and experience) required of the Board and making recommendations to the Board with regard to any changes.
- To make recommendations to the Board for the appointment of Vice Chair of the Board of Directors, and Senior Independent Director, the latter being in consultation and with the approval of the Council of Governors.
- To give full consideration to, and making plans for, the Chief Executive and other Executive Directors taking into account the challenges and opportunities facing the Trust and the skills and expertise needed on the Board of Directors to meet them in the future.
- To be responsible for identifying and nominating for appointment, candidates to fill posts within its remit as and when they arise.
- To be responsible for identifying and recommending a suitable candidate, for approval by the Council of Governors, to fill the position of Chief Executive, in line with the Foundation Trust Code of Governance.
- Before an appointment is made, to evaluate the balance of skills, knowledge, diversity and experience on the Board, and, in the light of this evaluation, prepare a description of the role and capabilities required for a particular appointment. In identifying suitable candidates, the Committee shall use open advertising or the service of external advisers to facilitate the search; consider candidates for a wide range of backgrounds; consider candidates on merit against objective criteria.
- To consider whether suitable candidates meet the “fit and proper persons test” criteria described in the provider licence, and in guidance issued by the CQC regarding the appointments to senior positions subject to CQC regulations but whilst ensuring the Trust’s compliance with employment policies and practice.
- To consider any matters relating to the continuation in office of any executive director at any time including the suspension or termination of service of an individual as an employee of the Trust.
- To consider the engagement or involvement of any suitably qualified third party or advisers to assist with any aspects of its responsibilities.
| Committee Membership | The Committee members shall be appointed by the Board and shall consist of the following:

- The Trust Chair, who will chair the meeting;
- Three other Non-Executive Directors; and
- The Chief Executive, who will act as the Lead Executive.

The Board shall appoint the Chair and Vice Chair of the Committee from its Non-Executive Directors. |
<table>
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<td>Quorum</td>
<td>A quorum shall be made up of three members. No business shall be transacted by the Committee unless a quorum is present. Those in attendance or observing do not count towards the quorum.</td>
</tr>
</tbody>
</table>
| Attendees            | Attendees to include:

- Executive Director of Workforce, who may be invited to attend in an advisory capacity; and
- The Director of Corporate Affairs / Company Secretary, or nominated deputy.

Other Executive Directors or their colleagues may be invited to attend for specific agenda items. |
| Observers            | Meetings are not open to members of the public or Members of the Council of Governors. |
| Frequency of Meetings | Meetings shall be held at least twice per year. Additional meetings may be held after consultation with the Chair of the Board. Meetings shall be scheduled, and endure, for no longer than three hours in length, unless exceptional circumstances demand an extended session. |
| Meeting administration| Notice of meetings will be given at least seven working days in advance unless members agree otherwise. The Chair of the Committee and Lead Executive will meet to agree the agenda for each meeting. The agenda will be based on the Committee Annual Work Plan. The Lead Executive Director for the Committee will be the Chief Executive, unless (s)he is conflicted, in which case the Director of Corporate Affairs / Company Secretary will fulfill this role. The Director of Corporate Affairs / Company Secretary will support the Chair of the Committee and Lead Executive Director in the management of the Committee’s business and for drawing the Committee’s attention to best practice, national guidance and other relevant documents, as appropriate. |
Administrative support to the Committee will be provided by the secretary. The secretary will take minutes. Items for inclusion on the agenda shall be submitted to the secretary at least ten working days prior to the meeting. Agendas can then only be amended by agreement of the Committee Chair and Lead Executive Director.

The agenda and papers will normally be circulated four working days prior to the meeting to Committee members and regular attendees.

Draft minutes will be produced by the secretary within five working days, reviewed by the Lead Executive Director and then approved by the Committee Chair within ten working days of the meeting.

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<th>Operational Groups which report into the Committee</th>
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<td>Monitoring and review</td>
<td>The Committee’s Terms of Reference will be subject to annual review. Proposed variations will require approval of the Board. The Committee will undertake an annual review of its performance, via self-assessment by its members and any agreed actions, will be reported to the Board.</td>
</tr>
<tr>
<td>Reviewed by Committee</td>
<td>Agreed by the Chair of the Committee 11 February 2021</td>
</tr>
<tr>
<td>Approved by the Board of Directors</td>
<td>March 2021</td>
</tr>
<tr>
<td>Next Review date</td>
<td>January 2022</td>
</tr>
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</table>
# Finance and Performance Committee

## TERMS OF REFERENCE

| Committee Status | The Finance and Performance Committee ("the Committee") is a standing committee of the Board of Directors (the Board) of The Rotherham NHS Foundation Trust (the Trust).

It is authorised to consider any matter within its terms of reference and to be provided with the Trust resources to do so.

It also has the right of access to all information that it deems relevant to fulfil its duties which may require any Trust colleague to attend a meeting of the Committee to present information or answer questions on a matter under discussion.

The Committee is empowered to obtain external professional advice and to invite external consultants with relevant experience to attend if necessary.

The Committee has no executive powers other than those set out in these Terms of Reference. |
| --- | --- |
| Reporting to | The Committee is accountable to the Board.

The Committee shall report to the Board on how it discharges its responsibilities. The minutes of the Committee’s meetings shall be formally recorded and submitted to the Board, once approved by the Chair of the Committee. The Chair of the Committee will also provide the Board with a Chair’s Assurance Log at each meeting of the Board in the month following the Committee meeting. The Assurance Log will provide assurance or highlight risks to the Board or issues that require executive action.

The Committee will report to the Board annually on its work in support of the annual governance statement. The annual report should also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee has considered and how these were addressed.

In addition the Chair of the Committee will provide a quarterly report on the Committee’s activities to the Council of Governors. |
| Purpose and Duties | The Board has approved the establishment of the Committee for the purpose of supporting the timely delivery of the Trust’s strategic... |
objectives and the Operational Plan giving detailed consideration to the Trust's financial and operational issues whilst being assured as to compliance with appropriate regulatory and statutory requirements. It will discharge this purpose through the following duties:

- Oversee implementation of the Trust’s priority in year operational and financial objectives/enablers against agreed milestones;
- Review in year actual operational and financial performance against plan;
- Review in year forecast operational and financial performance against plan;
- Review the Trust’s efficiency and productivity plans (including cost improvement performance) and processes;
- Oversee all aspects of cash management, including borrowing and temporary overdraft facilities, as detailed in the Trust’s Scheme of Delegation;
- Oversee implementation of the Financial Governance Action Plan;
- Review key operational and financial plans/policies to ensure they are up to date and fit for purpose (including Finance, Procurement, IT and Estates); and
- In accordance with the Trust's Scheme of Delegation:
  - Review business cases, tenders and contracts for approval by the Board, ensuring that they have been developed within the terms of the business case protocol; and
  - Review post implementation reviews of the above to agree key action points to inform future decision making.

The Committee will also:

- Review the Board Assurance Framework risks delegated to the Committee for review, and to make recommendations to the Board for any required changes of risk score or content; and
- Review the 15+ scored risks from the Risk Register relating specifically to the remit of the Committee, as determined by the Risk Management Committee.
| **Committee Membership** | The Committee members shall be appointed by the Board and shall consist of:

- three Non-Executive Directors;
- the Executive Director of Finance, who will act as Lead Executive; and
- the Chief Operating Officer.

The Board shall appoint the Chair and Vice Chair of the Committee from its Non-Executive Directors. |
| **Quorum** | A quorum shall be made up of three members comprising at least two Non-Executive Directors and one Executive Directors.

No business shall be transacted by the Committee unless a quorum is present.

Those in attendance or observing do not count towards the quorum. |
| **Attendees** | Attendees to include:

- Executive Medical Director;
- Deputy Director of Finance;
- Director of Operations / Deputy Chief Operating Officer;
- Divisional General Managers;
- Director of Health Informatics;
- Director of Estates and Facilities;
- Director of Strategy, Planning and Performance; and
- Director of Corporate Affairs / Company Secretary, or nominated deputy.

Other Executive Directors or their colleagues may be invited to attend for specific agenda items. |
| **Observers** | Meetings are not open to members of the public, however two Governors, representing the Council of Governors, may attend Committee meetings as observers, once confidentiality agreements have been signed on an annual basis. As observers Governors may not participate in the meeting unless specifically invited to do so by the Chair of the Committee.

However, the Chair reserves the right to hold all, or part of the meeting in private without Governors observing if deemed appropriate.

A copy of the agenda and papers will be provided on the day to Governors who are observing the meeting. All papers will be returned to the secretary of the meeting at the end of the meeting. |
| Frequency of Meetings | Meetings shall be held **monthly**. Additional meetings may be held after consultation with the Chair of the Board.  
Meeting shall be scheduled, and endure, for no longer than three hours in length, unless exceptional circumstances demand an extended session. |
|----------------------|--------------------------------------------------------------------------------------------------|
| Meeting administration | Notice of meetings will be given at least seven working days in advance unless members agree otherwise.  
The Chair of the Committee and Lead Executive will meet to agree the agenda for each meeting. The agenda will be based on the Committee Annual Work Plan.  
The Lead Executive Director for the Committee will be **the Executive Director of Finance**. The Director of Corporate Affairs / Company Secretary will support the Chair of the Committee and Lead Executive Director in the management of the Committee’s business and for drawing the Committee’s attention to best practice, national guidance and other relevant documents, as appropriate.  
Administrative support to the Committee will be provided by the secretary. The secretary will take minutes. Items for inclusion on the agenda shall be submitted to the secretary at least ten working days prior to the meeting. Agendas can then only be amended by agreement of the Committee Chair and Lead Executive Director.  
The agenda and papers will normally be circulated four working days prior to the meeting to Committee members and regular attendees.  
Draft minutes and action logs will be produced by the secretary within five working days, reviewed by the Lead Executive Director and then approved by the Committee Chair within ten working days of the meeting. |
| Operational Groups which report into the Committee | The operational groups which report into the committee are:  
- CIP Board;  
- Divisional Performance Meeting; and  
- Capital Monitoring Group.  
The Chair from each of the operational groups will provide:  
- a report to the next meeting of the Committee; and  
- the minutes from the group’s meeting to the Committee following approval of the minutes at the next group meeting. |
| Monitoring and review | The Committee’s Terms of Reference will be subject to annual review. Proposed variations will require approval of the Board.  
The Committee will undertake an annual review of its performance, via self-assessment by its members and any agreed actions, will be reported to the Board. |
# Quality Committee

## TERMS OF REFERENCE

| Committee Status | The **Quality Committee** ("the Committee") is a standing committee of the Board of Directors (the Board) of The Rotherham NHS Foundation Trust (the Trust).

It is authorised to consider any matter within its terms of reference and to be provided with the Trust resources to do so.

It also has the right of access to all information that it deems relevant to fulfil its duties which may require any Trust colleague to attend a meeting of the Committee to present information or answer questions on a matter under discussion.

The Committee is empowered to obtain external professional advice and to invite external consultants with relevant experience to attend if necessary.

The Committee has no executive powers other than those set out in these Terms of Reference. |
|---|---|
| Reporting to | The Committee is accountable to the Board.

The Committee shall report to the Board on how it discharges its responsibilities. The minutes of the Committee's meetings shall be formally recorded and submitted to the Board, once approved by the Chair of the Committee. The Chair of the Committee will also provide the Board with a Chair’s Assurance Log at each meeting of the Board in the month following the Committee meeting. The Assurance Log will provide assurance or highlight risks to the Board or issues that require executive action.

The Committee will report to the Board annually on its work in support of the annual governance statement. The annual report should also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee has considered and how these were addressed.

In addition the Chair of the Committee will provide a quarterly report on the Committee’s activities to the Council of Governors. |
| Purpose and Duties | The Board has approved the establishment of the Committee for the purpose of supporting the timely delivery of the Trust’s strategic

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objectives and the Operational Plan giving detailed consideration to the Trust’s quality issues, whilst being assured as to compliance with appropriate regulatory and statutory requirements. It will discharge this purpose through the following duties:

**Oversight of the development and implementation of the Trust’s:**
- Quality improvement plan (incorporating the quality priorities);
- Clinical service plan (incorporating joint patient pathways with other trusts);
- Safeguarding plan;
- Patient and public engagement plan;
- Plan for safe staffing levels;
- Freedom to speak up or raising concerns plan; and
- Health and Safety plan.

**Other duties will include, but not limited to, seeking assurance on:**
- Our CQC readiness for inspections;
- Our response to CQC inspections and reports;
- Safe and Sound Quality Scorecard;
- Quality Governance;
- Patient Safety;
- Patient Experience;
- Clinical Effectiveness;
- Safe staffing;
- Mortality and learning from deaths;
- Infection and prevention control;
- Our response to complaints;
- GIRFT (Getting It Right First Time); and
- CNST Maternity.

The Committee will also:

- Review the Board Assurance Framework risks delegated to the Committee for review, and to make recommendations to the Board for any required changes of risk score or content; and
- Review the 15+ scored risks from the Risk Register relating specifically to the remit of the Committee, as determined by the Risk Management Committee.
| Committee Membership | The Committee members shall be appointed by the Board and shall consist of:  
• Three Non-Executive Directors;  
• Chief Nurse, who will act as Lead Executive; and  
• Medical Director.  

The Board shall appoint the Chair and Vice Chair of the Committee from its Non-Executive Directors. |
|---|---|
| Quorum | A quorum shall be made up of three members comprising at least two Non-Executive Directors and one Executive Director.  

No business shall be transacted by the Committee unless a quorum is present.  
Those in attendance or observing do not count towards the quorum. |
| Attendees | Attendees to include:  
• Chief Operating Officer;  
• Director of Corporate Affairs / Company Secretary, or nominated deputy;  
• Quality Governance and Compliance Manager;  
• Deputy Chief Nurses;  
• Representative from each Division – Head of Nursing or Divisional Director;  
• Clinical Effectiveness Lead;  
• Medical Examiner;  
• Head of Patient Experience;  
• Head of Patient Safety;  
• Deputy Medical Director or Associate Medical Director;  
• Head of Safeguarding;  
• Head of IPC; and  
• Head of Health and Safety.  

Other Executive Directors or their colleagues may be invited to attend for specific agenda items. |
| Observers | Meetings are not open to members of the public, however two Governors, representing the Council of Governors, may attend Committee meetings as observers, once confidentiality agreements have been signed on an annual basis. As observers Governors may not participate in the meeting unless specifically invited to do so by the Chair of the Committee.  

However, the Chair reserves the right to hold all, or part of the meeting in private without Governors observing if deemed appropriate. |
A copy of the agenda and papers will be provided on the day to Governors who are observing the meeting. All papers will be returned to the secretary of the meeting at the end of the meeting.

<table>
<thead>
<tr>
<th>Frequency of Meetings</th>
<th>Meetings shall be held monthly. Additional meetings may be held after consultation with the Chair of the Board. Meetings shall be scheduled, and endure, for no longer than three hours in length, unless exceptional circumstances demand an extended session.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meeting administration</td>
<td>Notice of meetings will be given at least seven working days in advance unless members agree otherwise. The Chair of the Committee and Lead Executive will meet to agree the agenda for each meeting. The agenda will be based on the Committee Annual Work Plan. The Lead Executive Director for the Committee will be the Chief Nurse. The Director of Corporate Affairs / Company Secretary will support the Chair of the Committee and Lead Executive Director in the management of the Committee’s business and for drawing the Committee’s attention to best practice, national guidance and other relevant documents, as appropriate. Administrative support to the Committee will be provided by the Committee Secretary (the secretary). The secretary will take minutes. Items for inclusion on the agenda shall be submitted to the secretary at least ten working days prior to the meeting. Agendas can then only be amended by agreement of the Committee Chair and Lead Executive Director. The agenda and papers will normally be circulated four working days prior to the meeting to Committee members and regular attendees. Draft minutes and action logs will be produced by the secretary within five working days, reviewed by the Lead Executive Director and then approved by the Committee Chair within ten working days of the meeting.</td>
</tr>
</tbody>
</table>
| Operational Groups which report into the Committee | The operational groups which report into the committee are:  
  - Clinical Governance Committee;  
  - Infection Control Committee;  
  - Strategic Safeguarding Group;  
  - Health and Safety Committee; and  
  - CQC Delivery Group. The Chair from each of the operational groups will provide:  
  - a report to the next meeting of the Committee; and |
- the minutes from the group’s meeting to the Committee following approval of the minutes at the next group meeting.

### Monitoring and review

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The Committee’s Terms of Reference</strong></td>
<td>The Committee’s Terms of Reference will be subject to annual review. Proposed variations will require approval of the Board. The Committee will undertake an annual review of its performance, via self-assessment by its members and any agreed actions, will be reported to the Board.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reviewed by Committee</th>
<th>24 February 2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approved by the Board of Directors</td>
<td>March 2021</td>
</tr>
<tr>
<td>Next Review date</td>
<td>January 2022</td>
</tr>
</tbody>
</table>

Based on Terms of Reference Template – February 2021 v4
Terms of Reference – Quality Committee – February 2021 v3 FINAL
# People Committee

## TERMS OF REFERENCE

| Committee Status | The People Committee ("the Committee") is a standing committee of the Board of Directors (the Board) of The Rotherham NHS Foundation Trust (the Trust).

It is authorised to consider any matter within its terms of reference and to be provided with the Trust resources to do so.

It also has the right of access to all information that it deems relevant to fulfil its duties which may require any Trust colleague to attend a meeting of the Committee to present information or answer questions on a matter under discussion.

The Committee is empowered to obtain external professional advice and to invite external consultants with relevant experience to attend if necessary.

The Committee has no executive powers other than those set out in these Terms of Reference. |
|---|
| Reporting to | The Committee is accountable to the Board.

The Committee shall report to the Board on how it discharges its responsibilities. The minutes of the Committee’s meetings shall be formally recorded and submitted to the Board, once approved by the Chair of the Committee. The Chair of the Committee will also provide the Board with a Chair’s Assurance Log at each meeting of the Board in the month following the Committee meeting. The Assurance Log will provide assurance or highlight risks to the Board or issues that require executive action.

The Committee will report to the Board annually on its work in support of the annual governance statement. The annual report should also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee has considered and how these were addressed.

In addition the Chair of the Committee will provide a quarterly report on the Committee’s activities to the Council of Governors. |
| Purpose and Duties | The Board has approved the establishment of the Committee for the purpose of supporting the timely delivery of the Trust’s strategic |
objectives and the Operational Plan giving detailed consideration to the Trust’s people issues whilst being assured as to compliance with appropriate regulatory and statutory requirements, It will discharge this purpose through the following duties:

Oversight of the development and implementation of the Trust’s:

- People Plan (with reference to the national People Plan, a focus on Health and Wellbeing and Equality, Diversity and Inclusion); and
- Workforce Plan (including leadership development, succession planning and talent management) for the Board.

Other duties will include, but not limited to, seeking assurance that:

- Staff engagement is sufficiently effective, resulting in improved staff engagement particularly as measured through staff survey results;
- Staff recruitment and retention is effective and support the delivery of high quality patient care and leading to a decrease in temporary staffing costs;
- The prevalence of workforce gaps in the organisation are minimised by the development of new roles; and
- Ensuring key workforce metrics are met e.g. sickness absence, appraisals, mandatory and statutory training completion, time to hire etc.; and
- The Trust has an efficient and effective Occupational Health Service.

The Committee will also:

- Review the Board Assurance Framework risks delegated to the Committee for review, and to make recommendations to the Board for any required changes of risk score or content; and
- Review the 15+ scored risks from the Risk Register relating specifically to the remit of the Committee, as determined by the Risk Management Committee.
| Committee Membership | The Committee members shall be appointed by the Board and shall consist of:  
  - three Non-Executive Directors;  
  - the Executive Director of Workforce, who will be Executive Lead; and  
  - The Deputy Chief Executive.  

The Board shall appoint the Chair and Vice Chair of the Committee from its Non-Executive Directors. |
|---|---|
| Quorum | A quorum shall be made up of three members comprising at least two Non-Executive Directors and one Executive Director.  
No business shall be transacted by the Committee unless a quorum is present.  
Those in attendance or observing do not count towards the quorum. |
| Attendees | Attendees to include:  
  - The Chief Nurse;  
  - The Deputy Director of HR;  
  - Head of Equality and Diversity;  
  - Head of Learning and Development; and  
  - Head of Medical Staffing (Quarterly).  

The General Manager, Head of Nursing and Divisional Director for each division will be routinely invited as part of the work plan in order to provide evidence to support assurance matters, or to provide an account of the performance of their area, or for the performance against specific areas of the strategy or plan, for which they have a responsibility.  
Other Executive Directors or their colleagues may be invited to attend for specific agenda items. |
| Observers | Meetings are not open to members of the public, however two Governors, representing the Council of Governors, may attend Committee meetings as observers, once confidentiality agreements have been signed on an annual basis. As observers Governors may not participate in the meeting unless specifically invited to do so by the Chair of the Committee.  
However, the Chair reserves the right to hold all, or part of the meeting in private without Governors observing if deemed appropriate.  
A copy of the agenda and papers will be provided on the day to Governors who are observing the meeting. All papers will be returned to the secretary of the meeting at the end of the meeting. |
**Frequency of Meetings**

Meetings shall be held **monthly**. Additional meetings may be held after consultation with the Chair of the Board.

Meetings shall be scheduled, and endure, for no longer than three hours in length, unless exceptional circumstances demand an extended session.

**Meeting administration**

Notice of meetings will be given at least seven working days in advance unless members agree otherwise.

The Chair of the Committee and Lead Executive will meet to agree the agenda for each meeting. The agenda will be based on the Committee Annual Work Plan.

The Lead Executive Director for the Committee will be the **Executive Director of Workforce**. The Director of Corporate Affairs / Company Secretary will support the Chair of the Committee and Lead Executive Director in the management of the Committee’s business and for drawing the Committee’s attention to best practice, national guidance and other relevant documents, as appropriate.

Administrative support to the Committee will be provided by the secretary. The secretary will take minutes. Items for inclusion on the agenda shall be submitted to the secretary at least ten working days prior to the meeting. Agendas can then only be amended by agreement of the Committee Chair and Lead Executive Director.

The agenda and papers will normally be circulated four working days prior to the meeting to Committee members and regular attendees.

Draft minutes and action logs will be produced by the secretary within five working days, reviewed by the Lead Executive Director and then approved by the Committee Chair within ten working days of the meeting.

**Operational Groups which report into the Committee**

The operational groups which report into the committee are:

- **Operational Workforce Group**.

The Chair from each of the operational groups will provide:

- a report to the next meeting of the Committee; and
- the minutes from the group’s meeting to the Committee following approval of the minutes at the next group meeting.

**Monitoring and review**

The Committee’s Terms of Reference will be subject to annual review. Proposed variations will require approval of the Board.

The Committee will undertake an annual review of its performance, via self-assessment by its members and any agreed actions, will be reported to the Board.
<table>
<thead>
<tr>
<th>Reviewed by Committee</th>
<th>19 January 2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approved by the Board of Directors</td>
<td>March 2021</td>
</tr>
<tr>
<td>Next Review date</td>
<td>January 2022</td>
</tr>
</tbody>
</table>
TERMS OF REFERENCE
FOR A COMMITTEE OF THE BOARD
TO MEET IN COMMON WITH
COMMITTEES OF OTHER TRUSTS

Approved by the Board of Directors on 24 September 2019
Reviewed March 2021
1.1 In this terms of reference, the following words bear the following meanings:

<table>
<thead>
<tr>
<th>NAME</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Federation Executive</td>
<td>the Group, represented by Acute Federation Trust Chief Executive Officers, to provide strategic leadership and oversight of the delivery of agreed collaborative activities;</td>
</tr>
<tr>
<td>Acute Federation CiCs</td>
<td>the committees established by each of the Trusts to work alongside the committees established by the other Trusts and “Acute Federation CiC” shall be interpreted accordingly;</td>
</tr>
<tr>
<td>Acute Federation Executive</td>
<td>the Group, represented by Acute Federation Trust Chief Executive Officers, to provide strategic leadership and oversight of the delivery of agreed collaborative activities;</td>
</tr>
<tr>
<td>Acute Federation CiCs</td>
<td>the committees established by each of the Trusts to work alongside the committees established by the other Trusts and “Acute Federation CiC” shall be interpreted accordingly;</td>
</tr>
<tr>
<td>Committee in Common (CiC)</td>
<td>The Committee established by The Rotherham NHS Foundation Trust, pursuant to these Terms of Reference, to work alongside the other CiCs in accordance with these Terms of Reference.</td>
</tr>
<tr>
<td>CiC Chair</td>
<td>The TRFT member nominated (in accordance with paragraph 6.3 of these terms of reference) to chair the TRFT CiC meetings.</td>
</tr>
<tr>
<td>“Joint Working Agreement” or “JWA”</td>
<td>The agreement signed by each of the Trusts in relation to their joint working and the operation of TRFT CiC, together with the other Acute Federation CiCs</td>
</tr>
<tr>
<td>Meeting Lead</td>
<td>The CiC member nominated (from time to time) in accordance with paragraph 6.4 of these Terms of Reference, to preside over and run the Acute Federation CiC meetings when they meet in common</td>
</tr>
<tr>
<td>Member</td>
<td>a person nominated as a member of an Acute Federation CiC in accordance with their Trust’s Terms of Reference, and Members shall be interpreted accordingly;</td>
</tr>
<tr>
<td>South Yorkshire and Bassetlaw Acute Federation Partnership or “Acute Federation Partnership”</td>
<td>the partnership formed by the Trusts to work together to improve quality, safety and the patient experience; deliver safe and sustainable new</td>
</tr>
</tbody>
</table>
models of care; and make collective efficiencies. This operates within the South Yorkshire and Bassetlaw Integrated Care System.

**South Yorkshire and Bassetlaw Integrated Care System or “SYB ICS”**
The Health and Care Partnership across South Yorkshire and Bassetlaw administrated via Programme Office based at 722 Prince of Wales Road Sheffield. The Acute Federation operates within the SYB ICS.

**Trusts**
- Barnsley NHS Foundation Trust
- Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust
- The Rotherham NHS Foundation Trust
- Sheffield Children’s NHS Foundation Trust
- Sheffield Teaching Hospitals NHS Foundation Trust

and “Trust” shall be interpreted accordingly

1.2 The Rotherham NHS Foundation Trust has put in place a governance structure which will enable it to work together to implement change.

1.3 Each Trust has agreed to establish a committee which shall work in common with the other Acute Federation CiCs, but which will each take its decisions separately on behalf of its own Trust.

1.4 Each Trust has decided to adopt terms of reference in substantially the same form to the other Trusts, except that the membership of each Acute Federation CiC will be different.

1.5 Each Trust has entered into the Joint Working Agreement and agrees to operate its Acute Federation CiC in accordance with the Joint Working Agreement.

**2.0 Aims and Objectives of The Rotherham NHS Foundation Trust CiC**

2.1 The aims and objectives of the Rotherham CiC (the Rotherham CiC) are to work with the other Acute Federation CiCs to:

2.1.1 provide strategic leadership, oversight and delivery of new models of care through the development of the Acute Federation and its work-streams;

2.1.2 set the strategic goals for the Acute Federation, defining its ongoing role and scope, ensuring recommendations are provided to Trusts’ Boards for any changes which have a material impact on the Trusts;

2.1.3 consider different employment models for service line specialities including contractual outcomes and governance arrangements;

2.1.4 review the key deliverables and hold the Trusts to account for progress against agreed decisions;

2.1.5 ensure all Managed Clinical Networks or other collaborative forums have clarity of responsibility and accountability and drive progress;
2.1.6 establish monitoring arrangements to identify the impact on services and review associated risks to ensure identification, appropriate management and mitigation;

2.1.7 receive and seek advice from the relevant Reference Groups, including Clinical, Finance, Human Resources;

2.1.8 receive and seek advice from the ICS Boards in South Yorkshire and Bassetlaw; West Yorkshire and Derbyshire;

2.1.9 review and approve any proposals for additional Trusts to join the founding Trusts;

2.1.10 ensure compliance and due process with regulating authorities regarding service changes;

2.1.11 oversee the creation of joint ventures or new corporate vehicles where appropriate;

2.1.12 review and approve the Terms of Reference for the Acute Federation Executive on an annual basis;

2.1.13 improve the quality of care, safety and the patient experience delivered by the Trusts;

2.1.14 deliver equality of access to the Trusts service users; and

2.1.15 ensure the Trusts deliver services which are clinically and financially sustainable.

3.0 Establishment

3.1 The Rotherham NHS Foundation Trust’s board of directors has agreed to establish and constitute a committee with these terms of reference, to be known as the Rotherham CiC. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Rotherham CiC.

3.2 The Rotherham CiC shall work cooperatively with the other Acute Federation CiCs and in accordance with the terms of the Joint Working Agreement.

3.3 The Rotherham CiC is a committee of The Rotherham NHS Foundation Trust’s board of directors and therefore can only make decisions binding on The Rotherham NHS Foundation Trust. None of the Trusts, other than The Rotherham NHS Foundation Trust, can be bound by a decision taken by Rotherham CiC.

4.0 Functions of the Committee

4.1 Paragraph 15(2) and (3) of Schedule 7 of the National Health Service Act 2006 allows for any of the functions of a Foundation Trust to be delegated to a committee of directors of the Foundation Trust. This power is enshrined in paragraph 8.8.3 of The Rotherham NHS Foundation Trust’s Constitution.

4.2 The Rotherham CiC shall have the following function: decision making in accordance with Appendix A to these Terms of Reference.
5.0 Decisions and / or functions reserved to the Board of the Foundation Trust

5.1 Any decisions and / or functions not delegated to the Rotherham CiC in paragraph 4 of these Terms of Reference shall be retained by The Rotherham NHS Foundation Trust’s Board or Council of Governors, as applicable. For the avoidance of doubt, nothing in this paragraph 5 shall fetter the ability of The Rotherham NHS Foundation Trust to delegate any decisions and / or functions to another committee or person.

6.0 Reporting requirements

6.1 On receipt of the papers detailed in paragraph 13.1.2, the Rotherham CiC Members shall consider if it is necessary (and feasible) to forward any of the agenda items or papers to The Rotherham NHS Foundation Trust’s Board for inclusion on the private agenda of The Rotherham NHS Foundation Trust’s next Board meeting in order that The Rotherham NHS Foundation Trust’s Board may consider any additional delegations necessary in accordance with Appendix A.

6.2 The Rotherham CiC shall send the minutes of Rotherham CiC meetings to The Rotherham NHS Foundation Trust’s Board, on a monthly basis, for inclusion on the private agenda of The Rotherham NHS Foundation Trust’s Board meeting.

6.3 Rotherham CiC shall provide such reports and communications briefings as requested by The Rotherham NHS Foundation Trust’s Board for inclusion on the private agenda of The Rotherham NHS Foundation Trust’s Board meeting.

7.0 Membership

7.1 The Rotherham CiC shall be constituted of directors of The Rotherham NHS Foundation Trust. Namely:

- The Rotherham NHS Foundation Trust’s Chair; and
- The Rotherham NHS Foundation Trust’s Chief Executive; and each shall be referred to as a “Member”.

7.2 Each Rotherham CiC Member shall nominate a deputy to attend Rotherham CiC meetings on their behalf when necessary (“Nominated Deputy”).

7.3 The Nominated Deputy for The Rotherham NHS Foundation Trust’s Chair shall be a Non-Executive Director of The Rotherham NHS Foundation Trust, and the Nominated Deputy for The Rotherham NHS Foundation Trust’s Chief Executive shall be an Executive Director of The Rotherham NHS Foundation Trust.

7.4 In the absence of the Rotherham CiC Chair Member and/or the Rotherham CiC Chief Executive Member, his or her Nominated Deputy shall be entitled to:

- attend Rotherham CiC’s meetings;
- be counted towards the quorum of a meeting of the Rotherham CiC; and
- exercise Member voting rights,

and when a Nominated Deputy is attending a Rotherham CiC meeting, for the purposes of these Terms of Reference, the Nominated Deputy shall be included in the references to “Members”.
7.5 The chair of the Rotherham CiC shall be nominated by the Rotherham CiC. In the absence of the Rotherham CiC Chair, the Nominated Deputy of The Rotherham NHS Foundation Trust’s Chair, shall chair the meeting.

7.6 When the Acute Federation CiCs meet in common, one person nominated from the Members of the Acute Federation CiCs shall be the Meeting Lead and preside over and run the meetings on a rotational basis for a period of six months.

8.0 Non-voting attendees

8.1 The Members of the other Acute Federation CiCs shall have the right to attend the meetings of Rotherham CiC.

8.2 The Meeting Lead’s Trust Corporate Secretary shall have the right to attend the meetings of the Meeting’s Lead’s CiC to support the provision of governance advice and ensure that the working arrangements comply with the accountability and reporting arrangements of the Acute Federation CiCs.

8.3 The Acute Federation Partnership Programme Lead shall have the right to attend the meetings of The Rotherham CiC.

8.4 Without prejudice to paragraphs 8.1 to 8.3 inclusive, the Meeting Lead may, at his or her discretion, invite and permit other persons relevant to any agenda item to attend any of the Acute Federation’s CiC meetings, but for the avoidance of doubt, any such persons in-attendance at any meeting of the Acute Federation’s CiCs shall not count towards the quorum or have the right to vote at such meetings.

8.5 The attendees detailed in paragraphs 8.1 to 8.4 (inclusive) above, may make contributions, through the Meeting Lead, but shall not have any voting rights, nor shall they be counted towards the quorum for the meetings of the Rotherham CiC.

9.0 Meetings

9.1 Subject to paragraph 9.2 below, the Rotherham CiC meetings shall take place monthly.

9.2 Any Trust CiC Chair may request an extraordinary meeting of the Acute Federation CiCs (working in common) on the basis of urgency etc. by informing the Meeting Lead. In the event it is identified that an extraordinary meeting is required, the Acute Federation Partnership Programme Lead shall give five (5) Working Days’ notice to the Trusts.

9.3 Meetings of the Rotherham CiC shall not be held in public.

9.4 Matters to be dealt with at the meetings of the Rotherham CiC shall be confidential to the Rotherham CiC Members and their Nominated Deputies, others in attendance at the meeting and the members of The Rotherham NHS Foundation Trust Board.

10.0 Quorum and Voting

10.1 Members of the Rotherham CiC have a responsibility for the operation of the Rotherham CiC. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

10.2 Each Member of the Rotherham CiC shall have one vote. The Rotherham CiC
shall reach decisions by consensus of the Members present.

10.3 The quorum shall be two (2) Members.

10.4 If any Member is disqualified from voting due to a conflict of interest, they shall not count towards the quorum for the purposes of that agenda item.

11.0 Conflicts of Interest

11.1 Members of the Rotherham CiC shall comply with the provisions on conflicts of interest contained in The Rotherham NHS Foundation Trust’s Standing Orders. For the avoidance of doubt, reference to conflicts of interest in The Rotherham NHS Foundation Trust’s Standing Orders also apply to conflicts which may arise in their position as a Member of the Rotherham CiC.

11.2 All Members of the Rotherham CiC shall declare any new interest at the beginning of the Rotherham CiC meeting and at any point during the Rotherham CiC meeting if relevant.

12.0 Attendance at meetings

12.1 The Rotherham NHS Foundation Trust shall ensure that, except for urgent or unavoidable reasons, the Rotherham CiC Members (or their Nominated Deputy(ies)) shall attend the Rotherham CiC meetings (in person) and fully participate in all the Rotherham CiC meetings.

12.2 Subject to paragraph 12.1 above, meetings of the Rotherham CiC may consist of a conference between Members who are not all in one place, but each of whom is able directly, or by secure telephonic or video communication, (the Members having due regard to considerations of confidentiality) to speak to the other or others, and be heard by the other or others simultaneously.

13.0 Administrative

13.1 Administrative support for the Rotherham CiC will be provided by the Acute Federation Partnership Programme Support (or such other person as the Trusts may agree in writing). The Acute Federation Partnership Programme Support will:

13.1.1 draw up an annual schedule of Acute Federation CiC meeting dates and circulate it to the Acute Federation CiCs;

13.1.2 circulate the agenda and papers three (3) Working Days prior to Acute Federation CiC meetings; and

13.1.3 take minutes of the Rotherham CiC meetings and, following approval by the Meeting Lead, circulate them to the Trusts and action notes to all Members within ten (10) Working Days of the relevant Rotherham CiC meeting.

13.2 The agenda for the Rotherham CiC meetings shall be determined by the the Acute Federation Partnership Programme Lead and agreed by the Meeting Lead prior to circulation.

13.3 The Meeting Lead shall be responsible for approval of the first draft set of minutes for circulation to Members and shall work with the the Acute Federation Partnership Programme Support to agree such within five (5) Working Days of receipt.
APPENDIX 7

APPENDIX A – DECISIONS OF The Rotherham NHS Foundation Trust CIC

The Board of each Trust within the Acute Federation Partnership remains a sovereign entity and will be sighted on any proposals for service change and all proposals with strategic impact.

Subject to The Rotherham NHS Foundation Trust’s Scheme of Delegation, the matters or type of matters that are fully delegated to the Rotherham CIC to decide are set out in the table below.

If it is intended that the Acute Federation Partnership CICs are to discuss a proposal or matter which is outside the decisions delegated to the Rotherham CIC, where at all practical, each proposal will be discussed by The Rotherham NHS Foundation Trust’s Board prior to the Rotherham CIC meeting with a view to the Rotherham CIC requesting individual delegated authority to take action and make decisions (within a set of parameters agreed by The Rotherham NHS Foundation Trust’s Board). Any proposals discussed at the Rotherham CIC meeting outside of these parameters would come back before The Rotherham NHS Foundation Trust’s Board.

References in the table below to the “Services” refer to the services that form part of the joint working between the Trusts and may include both back office and clinical services.

<table>
<thead>
<tr>
<th>Decisions delegated to The Rotherham NHS Foundation Trust CIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Providing overall strategic oversight and direction to the development of the Acute Federation Partnership programme ensuring alignment of all Trusts to the vision and strategy</td>
</tr>
<tr>
<td>2. Promoting and encouraging commitment to the Key Principles</td>
</tr>
<tr>
<td>3. Seeking to determine or resolve any matter referred to it by the Acute Federation Partnership Programme Office or any individual Trust;</td>
</tr>
<tr>
<td>4. Reviewing the key deliverables and ensuring adherence with the required timescales including; determining responsibilities within workstreams; receiving assurance that workstreams have been subject to robust quality impact assessments; reviewing the risks associated in terms of the impact to the WTP Partnership Programme and recommending remedial and mitigating actions across the system.</td>
</tr>
<tr>
<td>5. Formulating, agreeing and implementing strategies for delivery of the Acute Federation Partnership Programme.</td>
</tr>
<tr>
<td>6. In relation to the Services, preparing business cases.</td>
</tr>
<tr>
<td>7. Provision of staffing and support and sharing of staffing information in relation to the Services.</td>
</tr>
<tr>
<td>8. Decisions to support service reconfiguration (pre consultation, consultation and implementation), including but not limited to:</td>
</tr>
<tr>
<td>a. provision of financial information;</td>
</tr>
</tbody>
</table>
### APPENDIX 7

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>b.</td>
<td>communications with staff and the public and other wider engagement with stakeholders;</td>
</tr>
<tr>
<td>c.</td>
<td>support in relation to capital and financial cases to be prepared and submitted to national bodies, including NHS England and/or NHS Improvement;</td>
</tr>
<tr>
<td>d.</td>
<td>provision of clinical data, including in relation to patient outcomes, patient access and patient flows;</td>
</tr>
<tr>
<td>e.</td>
<td>support in relation to any competition assessment;</td>
</tr>
<tr>
<td>f.</td>
<td>provision of staffing support; and</td>
</tr>
<tr>
<td>g.</td>
<td>provision of other support.</td>
</tr>
</tbody>
</table>

---

<table>
<thead>
<tr>
<th>9</th>
<th>Decisions relating to information flows and clinical pathways outside of the reconfiguration, including but not limited to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>redesign of clinical rotas;</td>
</tr>
<tr>
<td>b.</td>
<td>provision of clinical data, including in relation to patient outcomes, patient access and patient flows; and</td>
</tr>
<tr>
<td>c.</td>
<td>developing and improving information recording and information flows (clinical or otherwise).</td>
</tr>
</tbody>
</table>

---

<table>
<thead>
<tr>
<th>10</th>
<th>Planning, preparing and setting up joint venture arrangements for the Services, including but not limited to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>preparing joint venture documentation and ancillary agreements for final signature;</td>
</tr>
<tr>
<td>b.</td>
<td>evaluating and taking preparatory steps in relation to shared staffing models between the Trusts;</td>
</tr>
<tr>
<td>c.</td>
<td>carrying out an analysis of the implications of TUPE on the joint arrangements;</td>
</tr>
</tbody>
</table>
### APPENDIX 7

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>d.</strong></td>
<td>engaging staff and providing such information as is necessary to meet each employer's statutory requirements;</td>
</tr>
<tr>
<td><strong>e.</strong></td>
<td>undertaking soft market testing and managing procurement exercises;</td>
</tr>
<tr>
<td><strong>f.</strong></td>
<td>aligning the terms of and/or terminating relevant third party supply contracts which are material to the delivery of the Services; and</td>
</tr>
<tr>
<td><strong>g.</strong></td>
<td>amendments to joint venture agreements for the Services.</td>
</tr>
<tr>
<td><strong>11</strong></td>
<td>Services investment and disinvestment as agreed within Trust Board parameters and delegated authority;</td>
</tr>
<tr>
<td><strong>12</strong></td>
<td>Reviewing and approving the Terms of Reference and Joint Working Agreement of the CIC on an annual basis.</td>
</tr>
</tbody>
</table>
APPENDIX B: DECISIONS RESERVED TO THE Rotherham NHS Foundation Trust
Board of Directors

See the Matters Reserved to the Board of The Rotherham NHS Foundation Trust
<table>
<thead>
<tr>
<th>Agenda item</th>
<th>P51/21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report</td>
<td>Board Assurance Framework</td>
</tr>
<tr>
<td>Executive Leads</td>
<td>Jill Dentith, Corporate Governance Consultant</td>
</tr>
<tr>
<td>Link with the BAF</td>
<td>B7 and B8: this paper provides an update to the Board of Directors on these two BAF items following the discussion on 2 February 2021</td>
</tr>
<tr>
<td>How does this paper support Trust Values</td>
<td>The Board Assurance Framework is one of the key elements through which good governance is evidenced thereby underpinning all of the Trust’s Values.</td>
</tr>
<tr>
<td>Purpose</td>
<td>For decision ☒ For assurance ☐ For information ☐</td>
</tr>
</tbody>
</table>

**Executive Summary** (including reason for the report, background, key issues and risks)

Following the discussion at the February 2021 Board of Directors’ meeting regarding the Quarter (Q) 3 risk score for Board Assurance Framework (BAF) items B7 and B8 this paper is presented to the Board of Directors for consideration and to confirm the risk scores for B7 and B8.

The paper includes an overview report and supporting documents Appendix 1 and Appendix 2 provide more detail.

Appendix 1 gives an overview of Q1 – 3 risk scores and the target risk scores for all BAF risks.

Appendix 2 provides detailed information in relation to the risks, controls, assurances, gaps in controls and gaps in assurances for risks B7 and B8.

**Due Diligence**

At the February 2021 Board of Directors meeting there was discussion and challenge regarding the proposed risk scores for B7 and B8 for Q3.

It was agreed that the risk scores would be reviewed and a proposal and full rationale would be presented to the March 2021 Board of Directors meeting.

The Quality Committee discussed risk B7 at their meeting in February 2021 and in the absence of an Audit Committee the Interim Director of Finance and the Deputy Chief Executive, as the Lead Executives for the risk, have reviewed B8.

**Board powers to make this decision**

The Matters Reserved include:

- **Ensuring maintenance of a sound system of internal control and risk management, including (but not limited to):**
- **Approval of the BAF, the Trust Risk Register (risks scoring 15 and above)**

**Who, What and When**

The actions to be taken, by whom and within which timescales are detailed in the Gaps in Control / Assurance section of the BAF.
| **Recommendations** | The Board is asked to note the content of this report and:
| | • Confirm a risk score for BAF item B7 at Q3; and
| | • Confirm the risk score of 20 for BAF item B8 at Q3 as recommended by the Audit Committee |
| **Appendices** | Appendix 1 gives an overview of Q1 – 3 risk scores and the target risk scores for all BAF risks.
| | Appendix 2 provides detailed information in relation to the risks, controls, assurances, gaps in controls and gaps in assurances for risks B7 and B8. |
1.0 Introduction

1.1 At the Board of Directors meeting in February 2021 the proposed Q3 risk scores for Board Assurance Framework (BAF) risks B7 and B8 were presented as:

- B7: a proposed increase in risk score from 15 (3 (L) x 5 (C)) to 20 (4 (L) x 5 (C)); and
- B8: a risk score of 20 (4 (L) x 5 (C)) which had not changed from Q2.

1.2 The proposed increase in Q3 risk score for BAF item B7 was discussed and challenged on the basis that the current quality governance arrangements were such that changing from a likelihood score of 3 to a likelihood score of 4 did not reflect the current position.

1.3 There was also a discussion which challenged the proposed Q3 risk score for BAF item B8, particularly considering the progress in relation to the Financial Governance Action Plan.

1.4 It was therefore agreed that a review of the Q3 risk scores for B7 and B8 would be undertaken and a proposal for both brought to the March 2021 Board of Directors meeting, including the rationale for the scores.

2.0 BAF Risk B7

2.1 The B7 risk is described as “Insufficiently robust Trust-wide quality and clinical governance arrangements impede the delivery of a number of Trust plans / objectives.”

2.2 The Quality Committee is the committee with oversight of this BAF risk. The Quality Committee considered the Q3 risk score at its meeting in January 2021 and again, at the request of the Board, at its February 2021 meeting.

2.3 At Q2 this risk was rated at 15 (3 (L) x 5 (C)). The proposed risk score for Q3 was 20 (4 (L) x 5 (C)). The increased risk score of 20 was proposed at the January 2021 meeting because during Q3 the Care Quality Commission (CQC) wrote to the Trust regarding a potential Section 29A warning notice. Whilst the Trust has challenged some of the data and concerns presented by the CQC, the Quality Committee felt that it was appropriate to increase the risk score for B7 since it focused on quality governance mechanisms.

2.4 At the request of the Board the Quality Committee reconsidered its recommendation regarding the rationale for the Q3 proposed risk score of 20 at its February 2021 meeting. There was a robust discussion, however a consensus view could not be reached. It was therefore agreed that the matter be escalated to the Board for resolution at the March 2021 meeting.

3 BAF Risk B8

3.1 The B8 risk is described as “There is a risk that the delivery of a number of (non-clinical / quality focussed) Trust plans / objectives may be at risk due to there being insufficiently robust governance arrangements in place across the Trust e.g. financial governance arrangements.”

3.2 The Audit Committee is the committee with oversight of this BAF risk.

3.3 In relation to BAF item B8 the January 2021 meeting of the Audit Committee discussed the possibility of reducing the risk score of 20 (4 (L) x 5 (C)) to 15 (3 (L) x 5 (C)) noting that progress had been made in the quarter in relation to the financial governance action plan. The decision was taken by the Committee that a prudent approach to the risk score should
be adopted for Q3 and that it should remain at 20 (4 (L) x 5(C)) for Q3. The rationale for this recommendation is that at the end of December 2020 a number of actions relating to the financial governance action plan were outstanding and required more time to embed, with a number of them being implemented in, and by the end of, quarter 4. It should be noted that work continues on the financial governance action plan and Board will be updated on progress.

4.0 Recommendation

4.1 The Board is asked to note the content of this report and:

• Confirm a risk score for BAF item B7 at Q3; and
• Confirm the risk score of 20 for BAF items B8 at Q3 as recommended by the Audit Committee.

Lisa Reid, Head of Governance and Jill Dentith, Corporate Governance Consultant
February 2021
<table>
<thead>
<tr>
<th>ID</th>
<th>Risk title</th>
<th>Risk Owner</th>
<th>Oversight Committee</th>
<th>Date on which oversight Committee reviewed Q3 BAF scores</th>
<th>Q1 2020/21 risk score</th>
<th>Q2 2020/21 risk score</th>
<th>Q3 2020/21 risk score</th>
<th>Target Risk Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>B1</td>
<td>Standards and quality of care do not deliver the required patient safety, clinical effectiveness and patient experience that meet regulatory requirements</td>
<td>CN / MD QC</td>
<td>27-Jan-21</td>
<td>4x5</td>
<td>4x5</td>
<td>4x5</td>
<td>3x5</td>
<td></td>
</tr>
<tr>
<td>B2</td>
<td>Demand for care exceeds the resources available, leading to failure to achieve recognised healthcare standards</td>
<td>COO QC</td>
<td>27-Jan-21</td>
<td>4x4</td>
<td>3x4</td>
<td>5x4</td>
<td>3x4</td>
<td></td>
</tr>
<tr>
<td>B3</td>
<td>Should the Trust fail to actively engage with, or listen to the experience of service users, there is a risk that the organisation will not learn or improve the quality of care (experience, quality and outcomes) for those who use our services</td>
<td>CN / MD QC</td>
<td>27-Jan-21</td>
<td>4x4</td>
<td>4x4</td>
<td>4x4</td>
<td>2x4</td>
<td></td>
</tr>
<tr>
<td>B4</td>
<td>Lack of effective staff engagement will impact on staff experience resulting in poor staff survey results which impact on the organisation's ability to deliver the Trust's plan</td>
<td>DoW PC</td>
<td>22-Jan-21</td>
<td>4x4</td>
<td>4x4</td>
<td>4x4</td>
<td>2x4</td>
<td></td>
</tr>
<tr>
<td>B5</td>
<td>Inability to recruit and retain staff within the organisation leading to impaired ability to deliver the Trust plan and increased temporary staffing costs</td>
<td>DoW PC</td>
<td>22-Jan-21</td>
<td>4x4</td>
<td>4x4</td>
<td>3x4</td>
<td>2x4</td>
<td></td>
</tr>
<tr>
<td>B6</td>
<td>The lack of development of new roles within the organisation leads to continued workforce gaps impacting on the Trust's ability to deliver its plan</td>
<td>DoW PC</td>
<td>22-Jan-21</td>
<td>4x4</td>
<td>3x4</td>
<td>3x4</td>
<td>2x4</td>
<td></td>
</tr>
<tr>
<td>B7</td>
<td>Insufficiently robust Trust-wide quality and clinical governance arrangements impede the delivery of a number of Trust plans / objectives</td>
<td>CN / MD QC</td>
<td>24-Feb-21</td>
<td>3x5</td>
<td>3x5</td>
<td>4x5</td>
<td>2x5</td>
<td></td>
</tr>
<tr>
<td>B8</td>
<td>There is a risk that the delivery of a number of (non-clinical / quality focussed) Trust plans / objectives may be at risk due to there being insufficiently robust governance arrangements in place across the Trust e.g. financial governance arrangements</td>
<td>DCE DoF Audit</td>
<td>29-Jan-21</td>
<td>4x5</td>
<td>4x5</td>
<td>4x5</td>
<td>3x5</td>
<td></td>
</tr>
<tr>
<td>B9</td>
<td>The financial plan is not delivered</td>
<td>DoF F&amp;PC</td>
<td>27-Jan-21</td>
<td>4x5</td>
<td>4x5</td>
<td>2x3</td>
<td>3x5</td>
<td></td>
</tr>
<tr>
<td>B10</td>
<td>The lack of capital investment may affect the delivery of some services</td>
<td>DoF F&amp;PC</td>
<td>27-Jan-21</td>
<td>4x5</td>
<td>4x5</td>
<td>3x5</td>
<td>3x5</td>
<td></td>
</tr>
<tr>
<td>B11</td>
<td>Misaligned governance and decision-making may arise from divergent Trust and ICS interests and objectives</td>
<td>DCE BoD</td>
<td>02-Feb-20</td>
<td>3x4</td>
<td>3x4</td>
<td>3x4</td>
<td>2x4</td>
<td></td>
</tr>
<tr>
<td>B12</td>
<td>Ineffective relationships with key partners may lead to a lack of integrated working and poor service configuration across the Rotherham Place</td>
<td>COO BoD</td>
<td>02-Feb-20</td>
<td>2x4</td>
<td>2x4</td>
<td>2x4</td>
<td>2x4</td>
<td></td>
</tr>
</tbody>
</table>
**GOVERNANCE: trusted, open governance**

<table>
<thead>
<tr>
<th>Q2 Risk</th>
<th>Q3 Risk</th>
<th>Q4 Risk</th>
<th>Target Risk Score</th>
<th>Ref</th>
<th>SAP</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>C (Catastrophic)</td>
<td>3 x 5 = 15</td>
<td>C (Catastrophic)</td>
<td>4 x 5 = 20</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>L (Likely)</td>
<td>2 x 5 = 10</td>
<td>L (Likely)</td>
<td>2 x 5 = 10</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**CONTROLS AND MITIGATION:**

**(i) Assurance for Evidence Actual Risk 1:**

<table>
<thead>
<tr>
<th>Control</th>
<th>Description</th>
<th>Target</th>
<th>Actual</th>
<th>Other Categories</th>
<th>GAP WILL BE CLOSED</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**INTERNAL CONTROLS:**

1. **Internal (Operational):**
   - Monitoring of CQC 'well-led' framework across the Trust
   - Backlog of serious incidents has been cleared and a sustainable process is now in place. CQC section 29A warning notice raised

2. **Internal (Oversight):**
   - Medicine Management group continuing to meet. Other workstreams have

3. **External:**
   - Safe & Sound workstreams: some meetings paused due to COVID-19

**EXTERNAL CONTROLS AND MITIGATION:**

**UNAUDITED 2020-21 OVERVIEW:**

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**EXECUTIVE SUMMARY - Quarterly Update:**

1. **Be outstanding on the CQC 'well-led' framework across the Trust**

2. **GOVERNANCE: Trusted, open governance**

   - 1. Internal (operational)
   - 2. Internal: (oversight)
   - 3. External

   - Internal: (oversight)
   - 1. Backlog of serious incidents has been cleared and a sustainable process is now in place. CQC section 29A warning notice raised
   - 2. Medicine Management group continuing to meet. Other workstreams have
   - 3. Safe & Sound workstreams: some meetings paused due to COVID-19

   - External
   - 1. Furthermore, CQC 'well-led' framework across the Trust

3. **Report on results of internal reviews (a. CQC, b. Commissioning Board, NHS England/Quality Improvement National Director, c. Internal Audits, d. NSW/IEP and e. Internal Control Committee) on a monthly basis**

4. **Quality, Divestment Framework (Safe & Sound)**

   - 1. Quality, Divestment Framework (Safe & Sound)

   - 2. Implementation of Chief Nurse and Medical Director structure with increased focus on medication and nursing leadership capacity, insight and challenge

   - 3. Risk Management Strategy in place

5. **Medicine Management group continuing to meet. Other workstreams have paused due to COVID-19**

6. **Internal (operational):**

   - Backlog of serious incidents has been cleared and a sustainable process is now in place. CQC section 29A warning notice raised

7. **Quality, Divestment Framework (Safe & Sound):**

   - 1. Quality, Divestment Framework (Safe & Sound)

   - 2. Implementation of Chief Nurse and Medical Director structure with increased focus on medication and nursing leadership capacity, insight and challenge

   - 3. Risk Management Strategy in place

8. **Implementation of Chief Nurse and Medical Director structure with increased focus on medication and nursing leadership capacity, insight and challenge**

9. **Quality, Divestment Framework (Safe & Sound):**

   - 1. Quality, Divestment Framework (Safe & Sound)

   - 2. Implementation of Chief Nurse and Medical Director structure with increased focus on medication and nursing leadership capacity, insight and challenge

   - 3. Risk Management Strategy in place

10. **Implementation of Chief Nurse and Medical Director structure with increased focus on medication and nursing leadership capacity, insight and challenge**

11. **Quality, Divestment Framework (Safe & Sound):**

   - 1. Quality, Divestment Framework (Safe & Sound)

   - 2. Implementation of Chief Nurse and Medical Director structure with increased focus on medication and nursing leadership capacity, insight and challenge

   - 3. Risk Management Strategy in place

12. **Implementation of Chief Nurse and Medical Director structure with increased focus on medication and nursing leadership capacity, insight and challenge**

13. **Quality, Divestment Framework (Safe & Sound):**

   - 1. Quality, Divestment Framework (Safe & Sound)

   - 2. Implementation of Chief Nurse and Medical Director structure with increased focus on medication and nursing leadership capacity, insight and challenge

   - 3. Risk Management Strategy in place

14. **Implementation of Chief Nurse and Medical Director structure with increased focus on medication and nursing leadership capacity, insight and challenge**

15. **Quality, Divestment Framework (Safe & Sound):**

   - 1. Quality, Divestment Framework (Safe & Sound)

   - 2. Implementation of Chief Nurse and Medical Director structure with increased focus on medication and nursing leadership capacity, insight and challenge

   - 3. Risk Management Strategy in place

16. **Implementation of Chief Nurse and Medical Director structure with increased focus on medication and nursing leadership capacity, insight and challenge**

17. **Quality, Divestment Framework (Safe & Sound):**

   - 1. Quality, Divestment Framework (Safe & Sound)

   - 2. Implementation of Chief Nurse and Medical Director structure with increased focus on medication and nursing leadership capacity, insight and challenge

   - 3. Risk Management Strategy in place
<table>
<thead>
<tr>
<th>Date</th>
<th>GAP</th>
<th>MITIGATION ACTIONS TO BE TAKEN TO CLOSE THE GAP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dec-20</td>
<td>Lack of Trust-wide consistent and reliable Quality governance arrangements (QGA)</td>
<td>Internal Audit Quality Governance report received and action recommendations to improve situation. A member of the Chief Nurse in Medical Director team is working with each Divisional Quality Governance Lead to integrate standardised audit cycles. Standardising Divisional Governance arrangements. 1 medium and 2 low recommendations were implemented, 1 medium recommendation remains outstanding. Medical Director &amp; Chief Nurse</td>
</tr>
<tr>
<td>Dec-21</td>
<td>Patient safety incident report not fully sighted</td>
<td>Patient safety incident report fully sighted. Medical Director &amp; Chief Nurse</td>
</tr>
<tr>
<td>Sep-20</td>
<td>100% of deaths reviewed by Coroner</td>
<td>Medical Director &amp; Chief Nurse</td>
</tr>
</tbody>
</table>

**Table Notes:**
- Date: The date when the action was taken.
- GAP: The gap that needs to be addressed.
- MITIGATION ACTIONS TO BE TAKEN TO CLOSE THE GAP: The actions taken to address the gap.

---

**Controlled Access:**

- **Access to this file:** restricted access
- **Access to this page:** restricted access

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**Clinical Effectiveness & Research Committee:**

- **Chair:** Associate Medical Director for Clinical Effectiveness
- **Date of meeting:** 29th March 2021
- **Next meeting:** 29th June 2021

---

**Clinical Governance Committee:**

- **Chair:** Based on monthly reports to Clinical Governance Committee and Divisional governance meetings by senior members of the quality directorate including Chief Nurse and Medical Director to ensure performance with wider stakeholder input than previous ETM. All new risks reviewed on a weekly basis at Executive Team Meeting.

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**Divisions:**

- **Organisational Learning Action Forum (OLAF):** introduced in late September 2020.
- **Serious Incidents and deaths:** reports are due on time with oversight by Medical Director and Chief Nurse and Head of Nursing or Divisional Director.

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**Quality Improvement:**

- **Mortality Group:** continues to meet and are well attended. Other groups, Deteriorating patient and sepsis group; Mortality Group and Medicine Management group continuing to meet and are well attended. Deteriorating patient and sepsis group; Mortality Group and Medicine Management group continuing to meet and are well attended. Deteriorating patient and sepsis group; Mortality Group and Medicine Management group.
- **PSCSA:** monthly report goes through Clinical Governance Committee and Divisional governance meetings.
- **OLAF:** monthly report goes through Clinical Governance Committee and Divisional governance meetings.
- **Quality Improvement:** monthly report goes through Clinical Governance Committee and Divisional governance meetings.

---

**Internal Audit:**

- **Quarterly Internal Audit Reports:** received and using recommendations to improve situation. A member of the Chief Nurse or Medical Director team is attending each Divisional Quality Governance meeting.
- **Performance Meetings:** allow Divisions to be held to account.

---

**OLAF:**

- **Quarterly Meeting:** discussed at the Divisional Quality Governance meeting.
- **Performance Meetings:** allow Divisions to be held to account.

---

**Standards:**

- **HSMR / SHMI:** remain a standing agenda item on Clinical Governance Committee agenda until 100% of deaths reviewed by Medical Examiner and standing mortality section.
- **Dec-20:** CQC action plan, safeguarding action plan and risks scoring 15+ received scrutiny, confirmation and challenge at ETM from beginning of Q3 2020/21.
Executive Summary - Quarterly Update:

Date the risk last reviewed: 29-Jan-21

- Be outstanding on the CQC 'well-led' framework across the Trust
- Have an effective performance framework to help deliver outstanding results

GOVERNANCE: Trusted, open governance

C5 A5
C6 A6
C3 A3

EXECUTIVE SATISFACTORY - QUANTITY UPDATE:

Q2: All operational objectives rated as either green or amber at Q2. Concerns about delivery of operational objectives therefore reduction in this score not proposed for Q2 but will be reviewed for Q3 when systems to embed delivery have further evolved.

Q3: Financial governance review may now not be required due to the review of financial issues in Q4 2019/20 having been undertaken and governance recommendations being made as part of the review. Review into Carbon Emissions Trust also undertaken.

Q4: A number of actions taken to improve financial governance and a robustly developed action plan is in place, with many actions now complete. Challenges remain regarding operational objectives delivery which has been impacted by the second wave of COVID-19. It is envisaged that it will be possible to reduce the current risk score at the end of Q4 when the vast majority of the actions in the financial governance action plan have been implemented.

The risk appetite for actions and decisions taken in relation to Information Governance (6-10) has a LOW for financial risk appetite which remains at LOW for financial risk appetite which remains.

Governance

Executive Team Away Day held in June 2020 focusing on team members step outside their individual portfolios and make positive contributions to achieve 'Good' rating at next CQC well-led review.

Executive presentations re: committee structure to October 2020 Board of Directors meeting. Proposed changes to be made in Q3. Committee structure revised in line with recommendations for actions to be taken from September 2020. New member of the Board of Directors some of whom have not worked together before.

Gap in assurance = exist where there is a failure to gain evidence that the controls are effective

What are the key controls that are in place to mitigate this risk?

CONTROLS AND MITIGATION:

- (N.B. These meetings were stood down during the pandemic but recommenced in September 2020)
- (C) - Gap in assurance - exist where there is a failure to gain evidence that the controls are effective
- (A) - Assurance or evidence actually received

GAPS IN CONTROL (C) or ASSURANCE (A)

Link to 2020/21 in-year objectives from Well-led Review Improvement Plans: Link to Operational Risk (scoring 15+):

- Review 10 for purpose operational performance framework in place for 2020/21 (approved by Executive Team Meeting 27 May 2020)
- Scale of Board documentation in paper (50%): Standard Compliance, Contractor, Market (Relevant). 30% require updating in relation to Digital Management Framework (see Q1).
- Staging documentation from internal audits received at every audit committee meeting and Executive Directors directed to attend as necessary. Senior leaders then to attend at least 60% of all meetings at Q1 and a minimum of 50% at a monthly basis.
- Board Assurance Integration of General Ledger and Financial Reporting audit February 2020 gave 'significant assurance' rating (positive).
- Board Assurance Compliance with General Data Protection Regulation audit January 2020 gave 'significant assurance' rating (positive).

ASSURANCE OR EVIDENCE ACTUALLY RECEIVED

- In June 2020 presented revised structure to support colleagues to exercise their potential. Revised Divisional composition.
- Stage 1 Head of Internal Audit Opinion 2020/21 evidenced that the Trust had a number of missing or expired controls (6-10).
- Joint Executive Team and Financial Governance internal review in December 2020 for actions to be taken in Q3 (A) (positive).
- The combined review plan has been virtually developed with actions led by members of the Board of Directors. A significant number of actions are already underway, a number of processes are being reviewed and new team members are being brought in to achieve 'Good' rating at next CQC well-led review.
- The Board Assurance Committee has been meeting monthly to discuss the progress of the 'well-led' review. Senior leadership team not aligned with objectives of the organisation (A) (negative).
- All Assurance actions to be taken to close the gap

Responsible Executive Director: Chair

In order to achieve 'Good' rating at next CQC well-led review.

- (A) - Assurance or evidence actually received
- (C) - Gap in assurance - exist where there is a failure to gain evidence that the controls are effective

DEADLINE BY WHICH GAP TO BE CLOSED

- 21st April 2020
- Sept-20
- Sept-20
- Dec-20
- Jan-21
- Feb-21
- Feb-21
- Feb-21
- Aug-20
- July 2021
- July 2021
- March 2021
- March 2021
- July 2021
- July 2021
- July 2021
## References

### Sources of Assurance

<table>
<thead>
<tr>
<th>Ref</th>
<th>Source of Assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Internal: Management, operational day-to-day internal reporting.</td>
</tr>
<tr>
<td>2</td>
<td>Internal: Oversight function is reviewed by Controlling.</td>
</tr>
<tr>
<td>3</td>
<td>Independent, external verifier.</td>
</tr>
</tbody>
</table>

### Gap in Control

Gap to control if not addressed adequately could result in a gap in assurance, e.g. where there is a failure to gain evidence that the controls are effective.

### Gap in Assurance

Gap in assurance = exist where there is a failure to gain evidence that the controls are effective.

### Gaps in Control (C) or Assurance (A)

**GAP**

<table>
<thead>
<tr>
<th>Ref</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G1</td>
<td>Upper limit of exposure + control (e.g. risk management) processes not comprehensive in all areas</td>
</tr>
<tr>
<td>G2</td>
<td>Intermediate reporting process not effective (e.g. lack of key information)</td>
</tr>
<tr>
<td>G3</td>
<td>Framework between Deputy Director of Finance and Divisional Heads not well defined</td>
</tr>
<tr>
<td>G4</td>
<td>Financial performance management framework not effective (e.g. lack of clear financial management objectives)</td>
</tr>
<tr>
<td>G5</td>
<td>Financial performance management framework not well aligned with strategy (e.g. lack of clear financial management objectives)</td>
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**Quantitative Data**

<table>
<thead>
<tr>
<th>Ref</th>
<th>Data</th>
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<tbody>
<tr>
<td>G5.1</td>
<td>Financial performance management framework not effective (e.g. lack of clear financial management objectives)</td>
</tr>
<tr>
<td>G5.2</td>
<td>Financial performance management framework not well aligned with strategy (e.g. lack of clear financial management objectives)</td>
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**Qualitative Data**

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<td>G5.3</td>
<td>Financial performance management framework not effective (e.g. lack of clear financial management objectives)</td>
</tr>
<tr>
<td>G5.4</td>
<td>Financial performance management framework not well aligned with strategy (e.g. lack of clear financial management objectives)</td>
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**Actions Taken to Close the Gap**

<table>
<thead>
<tr>
<th>Ref</th>
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</thead>
<tbody>
<tr>
<td>G1.1</td>
<td>Implement risk management processes</td>
</tr>
<tr>
<td>G1.2</td>
<td>Benchmark against best practice</td>
</tr>
<tr>
<td>G1.3</td>
<td>Review and update risk management processes</td>
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**Actions Taken to Close the Gap**

<table>
<thead>
<tr>
<th>Ref</th>
<th>Action Taken</th>
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<tbody>
<tr>
<td>G2.1</td>
<td>Implement intermediate reporting process</td>
</tr>
<tr>
<td>G2.2</td>
<td>Benchmark against best practice</td>
</tr>
<tr>
<td>G2.3</td>
<td>Review and update intermediate reporting process</td>
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**Actions Taken to Close the Gap**

<table>
<thead>
<tr>
<th>Ref</th>
<th>Action Taken</th>
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</thead>
<tbody>
<tr>
<td>G3.1</td>
<td>Implement framework between Deputy Director of Finance and Divisional Heads</td>
</tr>
<tr>
<td>G3.2</td>
<td>Benchmark against best practice</td>
</tr>
<tr>
<td>G3.3</td>
<td>Review and update framework between Deputy Director of Finance and Divisional Heads</td>
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**Actions Taken to Close the Gap**

<table>
<thead>
<tr>
<th>Ref</th>
<th>Action Taken</th>
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<tbody>
<tr>
<td>G4.1</td>
<td>Implement financial performance management framework</td>
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<tr>
<td>G4.2</td>
<td>Benchmark against best practice</td>
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<tr>
<td>G4.3</td>
<td>Review and update financial performance management framework</td>
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</table>

**Actions Taken to Close the Gap**

<table>
<thead>
<tr>
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<th>Action Taken</th>
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<tbody>
<tr>
<td>G5.1</td>
<td>Implement financial performance management framework</td>
</tr>
<tr>
<td>G5.2</td>
<td>Benchmark against best practice</td>
</tr>
<tr>
<td>G5.3</td>
<td>Review and update financial performance management framework</td>
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**Actions Taken to Close the Gap**

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<tr>
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<th>Action Taken</th>
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</thead>
<tbody>
<tr>
<td>G5.4</td>
<td>Implement financial performance management framework</td>
</tr>
<tr>
<td>G5.5</td>
<td>Benchmark against best practice</td>
</tr>
<tr>
<td>G5.6</td>
<td>Review and update financial performance management framework</td>
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</table>
### Agenda item
P52/21

### Report
Compliance with Regulatory and Legislative Frameworks, including a review of enforcement actions

### Executive Lead
Jill Dentith, Corporate Governance Consultant

### Link with the BAF
B8 – the risk of insufficient robust governance arrangements

### How does this paper support Trust Values
Good governance and compliance with regulatory and legislative underpins achievement of the Trust’s values

### Purpose
For decision ☐ For assurance ☒ For information ☐

### Executive Summary
(Ncluding reason for the report, background, key issues and risks)

NHS foundation trusts operate within a governance structure which includes:

- complying with the conditions of the provider licence;
- their performance against the Care Quality Commission (CQC) and NHS Improvement standards; and
- delivering against the NHS Oversight Framework.

In addition, NHS organisations are required to comply with regulatory and legislative frameworks and inspections.

In December 2020 the Board received a report on the above in the confidential meeting, however it was agreed the future reports would be presented on a quarterly basis in public.

This paper provides assurance to the Board (the Board) of Rotherham NHS Foundation Trust (the Trust) in relation to the Trust’s current status regarding the above regulatory frameworks.

### Due Diligence
(Include the process the paper has gone through prior to presentation at Board of Directors’ meeting)

This paper has not been discussed in full at other committees of the Board, however, sections of the information presented in this report have been discussed at Quality Committee, Finance and Performance Committee and the Executive Management Team meetings. The paper has also been complied with the support of the Deputy Chief Executive, the Interim Director of Finance and the Chief Nurse.

### Board powers to make this decision
The Board have corporate responsibility for ensuring that the Trust operates within the regulatory and legislative framework as well as within the conditions of its Provider Licence.
| **Who, What and When**  
(what action is required, who is the lead and when should it be completed?) | A further report monitoring progress will be brought to the public Board in June 2021 |
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td><strong>Recommendations</strong></td>
<td>It is recommended that the Board gain assurance from the update presented in this paper.</td>
</tr>
<tr>
<td><strong>Appendices</strong></td>
<td>Not applicable</td>
</tr>
</tbody>
</table>
1.0 Introduction

1.1 An NHS foundation trust’s board has a duty to promote the success of the organisation so as to maximise the benefits for the members of the trust as a whole and for the public who will be treated by the trust. Therefore, a board needs to be able to deliver prudent and effective leadership and effective oversight of the trust’s operations to ensure it is functioning in the best interests of patients.

1.2 Governance is the means by which the corporate body ensures that it makes informed decisions and properly manages its risks. It is also the process by which the board gains assurance over the effective operation of internal controls.

1.3 At a strategic and operational level NHS Foundation Trusts operate within a governance structure which includes:
- complying with the conditions of the provider licence (these include compliance with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009 and the Health and Social Care Act 2012, and having regard to the NHS Constitution);
- performance against the Care Quality Commission (CQC) and NHS Improvement standards; and
- delivering against the NHS Oversight Framework, which among other things, takes into account any conditions against the provider licence and the CQC ratings.

1.4 NHS organisations are also required to comply with regulatory and legislative frameworks and inspections which include those developed and monitored by:
- Human Tissue Authority;
- Health and Safety Executive;
- NHS England Quality Surveillance Team;
- The British Standards Institution (BSI);
- United Kingdom Accreditation Service (UKAS);
- Specialist Pharmacy Service; and
- Medicines & Healthcare products Regulatory Agency (MHRA).

1.5 This paper provides an update for the Board on the current status of The Rotherham NHS Foundation Trust (the Trust) in relation to the above regulatory frameworks.

2.0 Provider Licence

2.1 In April 2013 the Trust was issued with a Provider Licence (no 130128) which covered the following:
- Section 1 – General (G1 – G9);
- Section 2 – Pricing (P1 – P5);
- Section 3 – Choice and Competition (CoS1 – CoS7);
- Section 4 – NHS Foundation Trust Conditions (FT1 – FT4); and
- Section 5 – Interpretation and Definitions (D1).

2.2 In addition, the Trust was issued with licence conditions imposed under Section 111 of the Health and Social Care Act 2012 which were attached to the licence. The Trust were then issued with the following:
- Notice of Imposition of Additional Licence Condition under section 111 of the Health and Social Care Act 2012 – issued April 2013;
2.3 On an annual basis the Trust is required to approve and publish a self-certification in respect of:

- The Trust’s systems for compliance with provider licence conditions and related obligations (G6);
- Corporate Governance arrangements (FT4); and
- Training of Governors.

2.4 The annual self-certification for 2019/20 was considered and approved at the Board meeting in June 2020. This document stated compliance with a number of conditions but non or partial compliance with FT 4(5) (a) – (d). Updates relating to items FT 4(5) (a) – (d) is detailed in the following table:

<table>
<thead>
<tr>
<th>FT4(5)</th>
<th>The Board is satisfied that the Trust effectively implements systems and/or processes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td>To ensure compliance with the Licensee’s duty to operate efficiently, economically and effectively</td>
</tr>
<tr>
<td></td>
<td>a) Not confirmed for 2019/20</td>
</tr>
<tr>
<td></td>
<td>2019/20 External Audit ISA 260 issued a modified value for money ‘adverse’ conclusion due to:</td>
</tr>
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<td></td>
<td>- continuing licence conditions re finances</td>
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<tr>
<td></td>
<td>- financial performance during the year showing a deficit position prior to additional funding from the ICS and</td>
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<tr>
<td></td>
<td>- no update to the CQC inspection results which have an overall “requires improvement” rating.</td>
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<tr>
<td></td>
<td>Material uncertainty also raised in relation to going concern</td>
</tr>
<tr>
<td></td>
<td><strong>Update:</strong> Financial performance - In 20/21 financial performance has significantly improved and is forecast to be favourable to plan, with other additional income recently advised this may produce an in year surplus. Guidance is awaited on the approach to the Value for Money opinion for 20/21, noting however that the Licence conditions will still be in force. Guidance on the approach to going concern is also awaited. Due to the uncertainty about future financial envelopes and income levels the material uncertainty around Going Concern is likely to remain. These will be evaluated as part of the external audit in May/June 2021.</td>
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<tr>
<td>b) For timely and effective scrutiny and oversight by the Board of the Licensee’s operations</td>
<td><strong>CQC</strong> - The Trust has not been inspected since the last rating was identified due to the CQC restrictions during the pandemic. A new inspection procedure is currently under consultation, although overview and scrutiny of services has been undertaken and regular engagement is in place.</td>
</tr>
</tbody>
</table>
| c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions | b) Confirmed for 2019/20. However, as highlighted in the ‘Risks to the organisation’ section of the Trust’s Annual Governance Statement, the Trust commissioned an independent review into financial governance during Q1 2020/21. This was in response to a deterioration of the Trust’s forecast outturn for the year during Q4 2019/20. The outcome of the review had not been received at the time of writing.  
**Update:** The review has now been received and an extensive action plan has been produced with many of the actions now complete. |
| d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee’s ability to continue as a going concern) | c) Not confirmed for 2019/20  
CQC inspection result from Sept 2018 overall: ‘requires improvement’. UECC August 2019 CQC inspection improved overall core service rating to: ‘requires improvement’. Action plans implemented to improve areas highlighted, with regular monitoring.  
**UPDATE:** A new inspection procedure is currently under consultation by CQC, although overview and scrutiny of services has been undertaken and regular engagement is in place. A service specific inspection of Children’s Pathway and Safeguarding was undertaken in July 2020 and enquiries into the Medical Admissions in November 2020 resulting in a Section 29a Warning Notice. Action plans in relation to both areas have been progressed. |
|   | d) Unable to confirm for 2019/20 at the time of writing. Legacy, outstanding financial planning enforcement undertakings given to NHS Improvement (Monitor) have not yet been removed by the regulator. At the time of writing this report, ongoing independent review is being undertaken with regard to the
processes used to monitor financial management during Q4 2019/20 due to the worsening financial position and outturn.

**Update:** financial planning enforcement undertakings remain in place. The independent review undertaken with regard to the processes used to monitor financial management during Q4 2019/20 highlighted weaknesses in management control and governance. An action plan is in place with many of the action now complete.

2.5 The Executive Team continue to meet with representatives from NHSEI and have agreed an action plan. The plan maps the Trust’s progress to ensure compliance with these outstanding conditions against the licence.

### 3.0 Care Quality Commission (CQC) standards

3.1 The CQC is the independent regulator of all health and social care services in England. They monitor, inspect and regulate hospitals and other care providers.

3.2 Following the 2019 CQC inspections the Trust has been rated as follows:

- **Overall** – Requires improvement, which included:
  - Safe – Requires improvement;
  - Effective – Requires improvement;
  - Caring – Good;
  - Responsive – Good; and
  - Well-led – Requires improvement.

- Use of resources – Requires improvement; which resulted in:

A Combined Trust rating - Requires Improvement.

3.3 As at November 2020 the Trust had addressed 103 out of 106 actions identified by the CQC. The Trust has not been fully re-inspected by the CQC since this date. Of the 106 actions, 3 are classed internally by the Trust as ‘Off Plan’, but with mitigating actions in place and timescales identified when they will be closed. These are being monitored internally.

3.4 One of the requirements of the agreed NHSE/I Improvement Plan that was developed early 2020, was to achieve 100% of CQC actions by October 2020, or to have mitigating actions and revised timeline if not.

3.5 The Trust was inspected by the CQC in July 2020 on the Children’s Pathway and Safeguarding. As a result, the Trust has developed an action plan to address the issues raised. 194 actions were developed, which are monitored by a fortnightly Safeguarding Quality Improvement action plan meeting chaired by the Chief Nurse and at the weekly Executive Team Meeting. There are regular submissions to the CQC of updated action plans, evidence and minutes of the discussion held at Executive Team Meeting. Good
progress has been made with the actions, with 9 actions being outstanding but currently on plan. The CQC are informed of any off plan actions.

The Trust received enquiries in late 2020 around the staffing and safety in relation to Acute Medical Care that resulting in the Trust receiving a Section 29a Warning Notice. The requirement was to make sufficient changes to address concerns raised and the action plan outlining the changes made has been submitted to the CQC by the required deadline.

3.6 Monthly CQC engagement meetings are held with the CQC, which are attended by a number of Trust individuals including the Chief Executive or Deputy and Chief Nurse.

3.7 The Trust introduced the CQC Delivery Group during 2020 which is chaired by the Chief Executive or Deputy CEO. This was fortnightly initially, and now has moved to monthly. Progress on all action plans, along with any other CQC information is discussed at this meeting.

3.8 CQC is an agenda item on all divisional Governance meetings along with the Trust’s Clinical Governance Committee and Quality Committee, where assurance is obtained on the progress being made on delivery of the actions and the preparation for any future inspections.

3.9 The action plans for the overarching CQC standards and safeguarding are updated and reported to the Quality Committee meeting on a monthly basis.

3.10 The Trust is required to register with the CQC and its current registration status is ‘Registered with Conditions’. The Rotherham NHS Foundation Trust has the following conditions on registration:

- In October 2018, the CQC served a condition on the Trust registration relating to mitigating the risks within paediatric Urgent and Emergency Care Centre with a focus on medical and nursing staffing levels. The Trust remains compliant with requirements identified and in the future an application will be made to the CQC to remove this condition.

3.11 The CQC has not taken enforcement action against the Trust during 2019/20 or to date in 2020/21.

4.0 NHS Oversight Framework

4.1 The NHS Oversight Framework (last published in 2019/20) outlines the joint approach NHSEI will take to oversee organisational performance and identify where commissioners and providers may need support.

4.2 Under the Framework, NHSEI allocates each provider to a segment based on the level of support needed. This covers support around quality of care, finance and use of resources, operational performance, strategic change and leadership and improvement capability. Trust are them put into one of four categories:

- Segment 1 – providers with maximum autonomy;
- Segment 2 – providers offered targeted support;
- Segment 3 – providers receiving mandated support for significant concerns; and
- Segment 4 – providers in special measures.
4.3 For 2019/20 NHSEI determined that the Trust should be put into Segment 3, specifically for support needs identified in quality of care, finance and use of resources and operational performance.

4.4 The Chair and Chief Executive recently meet with the Regional Director and representatives from NHSEI and have discussed what actions need to be taken to comply with the requirements of the Oversight Framework. An update on progress will be presented to the Board, by the Chief Executive, as part of the next quarterly update.

5.0 Compliance with other regulatory and legislative frameworks and inspections

5.1 Human Tissue Authority (HTA)
The Trust’s most recent visit from the Human Tissue Authority was in September 2019. On 5 June 2020 the Trust received confirmation from HTA that all the actions from the visit had been closed to the Authority’s satisfaction.

5.2 Health and Safety Executive (HSE)
The Health and Safety Executive Microbiology and Biotechnology Unit undertook a routine inspection at the end July 2020. No areas of non-compliance were identified. The systems and processes in place were assessed as suitable and sufficient, however, there were four verbal instructions made which required minor amendments to practice and which were accepted by the department as areas for positive improvement. All four amendments to practice have now been implemented.

5.3 NHS Quality Surveillance Team
5.3.1 Cervical Cancer Screening QA visit January 2018: there is one outstanding action from this visit. A further update on progress to close this action is scheduled for receipt at the March 2021 Clinical Governance Committee meeting.

5.3.2 Breast Screening QA visit February 2018: the action plan has been closed with the agreement of SQAS\(^1\) that the three outstanding recommendations would be picked up at the Breast Screening Prioritisation Meeting (two surgical audits and a business case for an additional breast cancer nurse. The business case has now been approved). Two outstanding actions now remain, both relating to surgical audits. Progress with these audits is being monitored by the Clinical Governance Committee.

5.3.3 Antenatal and Newborn QA visit June 2018: there were two outstanding recommendations which were due for completion by early December 2020 and spring 2021 respectively. Confirmation of the closure of the first action was received at the February 2021 Clinical Governance Committee meeting and progress on the completion of the second action is scheduled for receipt at the May 2021 Clinical Governance Committee meeting.

5.4 British Standards Institute
The most recent visit from BSI to the Sterile Services department was on 12 November 2020. This was a virtual visit at which no non-conformance issues were raised and the findings from the April 2020 visit were also closed. One minor non-conformance remains from the April 2019 visit as this cannot be closed until the BSI Inspector is physically present on site to assess compliance. It is anticipated that the BSI Inspector will be on site for the next planned inspection on 15 April 2021 at which point they will be able to close this non-conformance.

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\(^1\) Screening Quality Assurance Service (SQAS)
5.5 **United Kingdom Accreditation Service (UKAS)**  
The 2020 inspection of the Laboratory Medicine Service by UKAS took place in February 2020. On 26 October 2020 the Trust received confirmation from UKAS that all the improvement actions from this inspection had been closed and that the Trust’s accreditation for ISO15189:2012 had been maintained.

The third surveillance visit to Laboratory Medicine by UKAS took place during February 2021 and initial feedback from the inspection will be presented to the Clinical Governance Committee at its March 2021 meeting.

5.6 **Specialist Pharmacy Service**  
The most recent inspection of the Trust’s Aseptic Unit by the Regional Quality Assurance Specialist took place on 11 March 2020. The report from this inspection showed minor non-compliance with seven individual standards. The actions to close five of these non-compliance issues has been completed. Action to complete the remaining two is scheduled for completion by April 2021 and is being monitored by the Clinical Governance Committee.

5.7 **Medicines & Healthcare products Regulatory Agency (MHRA)**  
The MHRA were due to inspect the Medical Physics department on 11 November 2020 in relation to the manufacture of radiopharmaceuticals for use in nuclear medicine examinations however this visit was postponed the day before the visit. Their last inspection of Medical Physics was in 2015 and there are no outstanding actions from that visit. As yet there is no date for the rescheduled inspection.

6.0 **Recommendations**

6.1 It is recommended that the Board gain assurance from the update presented in this paper.
The purpose of this report is to brief Trust Board on changes required to the Trust’s Accounting Policies, which form Note 1 to its accounts, and on changes to the accounting requirements when preparing the 2020/2021 financial year annual accounts.

There have been a few minor changes to the accounting requirements which will affect the preparation of the Trust’s accounts for 2020/2021 compared to the 2019/2020 accounts. Only a couple of minor adjustments are required to update the Accounting Policies, in summary this consists of:

- Update to the accounting treatment of service Concessions within the scope of leases, previously this was covered by IAS 17 (Leases) but has been superseded by IFRIC 12 (Service Concessions)
- Update to the inflation adjusted expected cash flow discount rates for the calculation of the early retirement provision
- Change to the date of implementation of IFRS 16 (Leases), which should have been from 1 April 2021 (now 1 April 2022)
- Change to the date of implementation of IFRS 17 (Insurance Contracts), which was due on or after 1 January 2021 (this will now be 1 January 2023)

There have been no new standards implemented during 2020/2021.

A copy of the draft Accounting Policies for the 2020/2021 annual accounts have been attached at Appendix 1; amendments from the 2019/2020 Accounting Policies have been highlighted through the use of tracked changes.
| Due Diligence                                                                 | The Accounting Polices for the 2020/2021 financial year have been reviewed against the Department of Health and Social Care (DHSE) Group Accounting Manual (GAM) for 2020/2021, which interprets the Financial Reporting Manual (FReM) for the NHS sector. This report was presented at the Trust's Audit Committee for endorsement on 29 January 2021 prior to it being put on the agenda for Board Approval. The Director of Finance and Deputy Director of Finance received a copy of the report for review and consideration prior to it being presented to the Audit Committee. |
| Board powers to make this decision                                           | This report complies with the Trust’s Constitution: 40. Accounts 40.1 The Trust must keep proper accounts and proper records in relation to the accounts. 40.2 In preparing its annual accounts, the corporation must comply with any directions given by the regulator with the approval of the Treasury as to— (a) the methods and principles according to which the accounts must be prepared, (b) the information to be given in the accounts. Accounting standards require the Trust’s Board of Directors to review the Accounting Principles which underpin the way in which the Trust’s accounts are prepared, as set out in the Accounting Policies. |
| Who, What and When                                                            | Once approved, these Accounting Policies will form the basis upon which the accounts are prepared, and will be included within the Trust’s annual accounts at note 1. Trust Board need to approve the Accounting Policies prior to the end of the financial year in order to ensure the timely preparation of the annual accounts. |
| Recommendations                                                               | It is recommended that Trust Board approve the changes to the 2019/2020 Accounting policies made in preparing the 2020/2021 Accounting Policies disclosures, having noted the changes in the Annual Report and Accounting guidance and the Accounting Standards this year and the impact of these for the Trust's Annual Report and Accounts. A copy of the draft Accounting Policies, which will form Note 1 to the 2020/2021 annual accounts are included at Appendix 1 to this report. |
Following the end of the financial year, further wording will be included within Note 1.1.2 Going Concern, which will provide a brief overview of the Trust’s financial position during the year.

The NHS Pension Scheme mandated wording will need to be updated when received from the DHSC and the final cross references to accounting notes will be re-checked once the accounts are complete.

Any changes that are required to the Accounting Policies upon completion of the Trust’s annual accounts will be brought to the Board’s attention when the annual accounts are presented for approval at it’s meeting.

| Appendices   | 1. Note 1 Accounting Policies and Other Information |
1 Introduction

1.1 This report sets out the Accounting Policies which will be adopted in the preparation of the 2020/2021 annual accounts.

2 Background

2.1 The Trust’s Accounting Policies, which are contained within Note 1 to the Trust’s accounts have been reviewed in line with changes made to the Department of Health and Social Care’s (DHSC) Group Accounting Manual (GAM) 2020/2021.

2.2 On the whole there has been very little change to the Group Accounting Manual for 2020/2021 compared to the 2019/2020 financial year. A copy of the proposed Accounting Policies have been included at Appendix 1, with proposed changes shown using tracked changes.

2.3 The main changes include:

Note 1.4 Income (Revenue from Contracts with Customers): the paragraph deleted (as shown in Appendix 1) has been removed as it is no longer relevant due to it being out of date.

Note 1.14 Leases, Private Finance Initiative (PFI) Transactions: the GAM has amended the requirement for adopting IAS17, replacing it with the requirement to adopt the accounting convention of IFRIC 12 in relation to service concession arrangements. This will be relevant to the Trust when the Carbon and Energy Fund (CEF) lease commences, which is expected to start during the 2021/2022 financial year, with some element of assets under construction being recognised as at 31 March 2021. Work undertaken during the financial year has confirmed that the accounting treatment of the CEF lease falls within the scope of service concessions as set out in IFRIC 12; the Trust’s External Auditors have confirmed that they agree with this assessment.

Note 1.15 Provisions, Early Retirement Provisions: the inflation adjusted expected cash flow discount rates have been updated, as set out in the GAM.

Note 1.17 Public Dividend Capital (PDC) and PDC dividend: the GAM has added two additional bullet points to the list of exemptions for relevant net assets used in the calculation of PDC dividends payable.

Within this note to the Accounting Policies, additional disclosure has been made by the Trust in relation to the NHS cash regime effective from 1 April 2020.

Note 1.26 Standards, amendments and interpretations in issue but not yet effective or adopted: IFRS 16 was expected to replace IAS 17 in respect of the treatment of leases from 1 April 2021, however this has been delayed with implementation to now take place from 1 April 2022.
In addition IFRS 17 (Insurance Contracts) was expected to come into effect from 1 January 2021; this has been put back to 1 January 2023.

Adoption of IFRS 16 (leases) and IFRS 17 (Insurance Contracts) were originally included as standards, amendments and interpretations in issue but not yet effective or adopted within Note 1.26 as part of the 2019/2020 Accounting Policies, as implementation was originally anticipated for the 2020/2021 accounts. The only required changes to make to the 2020/2021 Accounting Policies is the amendment to the implementation date.

There have been a few minor amendments (not shown on tracked changes) which update date references (updating the financial year to 2020/2021 from 2019/2020).

2.4 There have been no new standards implemented during the 2020/2021 financial year.

2.5 Whilst this report recommends the approval of the Accounting Policies which are contained within Appendix 1, some changes will be required at the point at which the accounts are prepared, these include (but not may not be restricted to):

- Following the end of the financial year, further wording will be included within Note 1.1.2 Going Concern, which will provide a brief overview of the Trust’s financial position during the year; this wording can only be completed after 31 March 2021.

- The NHS Pension Scheme mandated wording will need to be updated when received from the Department of Health and Social Care (DHSC) and the final cross references to accounting notes will be re-checked once the accounts are complete.

2.6 Any further changes that are required to the Accounting Policies as part of revisions to the DHSC’s GAM and Foundation Trust’s Annual Reporting Manual (FT ARM) will be brought to Trust Board’s attention when the annual accounts are presented at its meeting for approval.
Appendix 1 Accounting Policies

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Rotherham NHS Foundation Trust (‘the Trust’) is a public benefit corporation authorised, in England, by Monitor (trading as NHS Improvement) in accordance with the National Health Service Act 2006. The Trust provides healthcare mainly to the region. The address of the Trust is Moorgate Road, Rotherham, S60 2UD.

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of NHS Foundation Trust shall meet the accounting requirements of the Department of Health and Social Care (DHSC) Group Accounting Manual (GAM), which shall be agreed with HM Treasury.

Consequently, the following financial statements have been prepared in accordance with the GAM issued by the DHSC. The accounting policies contained in the GAM follow International Financial Reporting Standards (IFRS) to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

1.1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, and certain financial assets and financial liabilities.

1.1.2 Going Concern

The Rotherham NHS Foundation Trust's annual report and accounts have been prepared on a going concern basis. Non-trading entities in the public sector are assumed to be going concerns where the continued provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

Note 1.2 Critical accounting judgements and key sources of estimation uncertainty

In the application of The Rotherham NHS Foundation Trust's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.
1.2.1 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying The Rotherham NHS Foundation Trust’s accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

- Management make judgements in determining when substantially all the significant risks and rewards of ownership of financial assets and lease assets are transferred to other entities.

1.2.2 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

**Income estimates**
In measuring income for the year, management have taken account of all available information. Income estimates that have been made have been based on actual information related to the financial year. Included in the income figure is an estimate for open spells: patients undergoing treatment that is only partially complete at twelve midnight on 31 March. The number of open spells for each specialty is taken and multiplied by the average specialty price and adjusted for the proportion of the spell which belongs to the current year.

Injury compensation scheme income is also included to the extent that it is estimated it will be received in future years. It is recorded in the current year as this is the year in which it was earned. However as cash is not received until future periods, when the claims have been settled, an estimation must be made as to the collectability.

**Expense accruals**
In estimating expenses that have not yet been charged for, management have made a realistic assessment based on costs actually incurred in the year to date, with a view to ensuring that no material items have been omitted.

**Impairment of property, plant and equipment**
The Trust has undertaken an annual impairment exercise of its Property, Plant and Equipment. Following an interim professional valuation carried out at 31 March 2021, the Trust has considered items such as: indices movements; deterioration of assets and its further estates plans to support its impairment assessment. It is the judgement of management following this review that there is not an indication of impairment.

**Recoverability of receivables**
In accordance with the stated policy on impairment of financial assets, management have assessed the impairment of receivables and made appropriate adjustments to the existing allowance account for expected credit losses.

Provisions
In accordance with the stated policy on provisions, management have used best estimates of the expenditure required to settle the obligations concerned, applying HM Treasury’s discount rate as stated, as appropriate. Management have also taken into account all available information for disputes and possible outcomes.

Note 1.3 Operating Segments

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within The Rotherham NHS Foundation Trust.

Note 1.4 Income (Revenue from Contracts with Customers)

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

In the adoption of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows;

- as per paragraph 121 of the Standard the Trust will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less
- the Trust is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date
- the Financial Reporting Manual (FReM) has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the Trust to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar
pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Payment terms are standard reflecting cross government principles.

The value of the benefit received when the Trust accesses funds from the Government’s apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

Note 1.5 Expenditure on Employee Benefits

1.5.1 Short-term employee benefits

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including non-consolidated performance pay earned but not yet paid. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

1.5.2 Retirement Benefit Costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore,
each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the NHS body commits itself to the retirement, regardless of the method of payment.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows:

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2021 is based on valuation data as 31 March 2020 updated to 31 March 2021 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6%, and the scheme Regulations were amended accordingly. The DHSC have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.
The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018, the Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

**NEST Pension Scheme**

The Trust is a member of the National Employment Savings Trust (NEST) pension scheme which operates as a defined contribution plan. The Trust pays contributions into a fund but has no legal or constructive obligation to make further payments if the fund does not have sufficient assets to pay all of the employees' entitlements to post-employment benefits. The Trust's obligation is therefore limited to the amount it agrees to contribute to the fund and effectively place actuarial and investment risk on the employee. The amount recognised in the period is the contribution payable in exchange for service rendered by employees during the period.

**Note 1.6 Expenditure on other goods and services**

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

**Note 1.7 Property, plant and equipment**

**1.7.1 Recognition**

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably, and either
  - the item has cost of at least £5,000, or collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.
  - items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost

Where a large asset, for example a building, includes a number of components with significantly different asset lives, for example, plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.
1.7.2 Measurement

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at valuation. Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus, with no plan to bring them back into use and where there are no restrictions preventing access to the market at the reporting date, are valued at fair value under IFRS 13.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings - market value for existing use
- Specialised buildings - depreciated replacement cost, modern equivalent asset basis

Where applicable, assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the service being provided.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset, and thereafter to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.
1.7.3 Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is derecognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

1.7.4 Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as ‘held for sale’ ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position Public Finance Initiative (PFI) contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless there is an expectation that the asset will be acquired at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

1.7.5 Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of ‘other comprehensive income’.

1.7.6 Impairments
In accordance with the DHSC GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of ‘other impairments’ are treated as revaluation gains.

1.7.7 De-recognition

Assets intended for disposal are reclassified as ‘held for sale’ once all of the following criteria are met;

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable, that is:
  - management are committed to a plan to sell the asset
  - an active programme has begun to find a buyer and complete the sale - the asset is being actively marketed at a reasonable price
  - the sale is expected to be completed within 12 months of the date of classification as ‘held for sale’ and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their ‘fair value less costs to sell’. Depreciation ceases to be charged and the assets are not revalued except where ‘fair value less costs to sell’ falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as ‘held for sale’ and instead is retained as an operational asset and the asset’s economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.
1.7.8 Donated, government grant and other grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

1.7.9 Useful Economic lives of property, plant and equipment

<table>
<thead>
<tr>
<th>Plant, Property and Equipment</th>
<th>Minimum life (Years)</th>
<th>Maximum life (Years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Land</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Buildings (excluding dwellings)</td>
<td>3</td>
<td>90</td>
</tr>
<tr>
<td>Plant and machinery</td>
<td>5</td>
<td>15</td>
</tr>
<tr>
<td>Transport equipment</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>Information technology</td>
<td>5</td>
<td>20</td>
</tr>
<tr>
<td>Furniture and fittings</td>
<td>10</td>
<td>10</td>
</tr>
</tbody>
</table>

Note 1.8 Investment properties

Investment properties are measured at fair value. Changes in fair value are recognised as gains or losses in income/expenditure.

Only those assets which are held solely to generate a commercial return are considered to be investment properties. Where an asset is held, in part, for support service delivery objectives, then it is considered to be an item of property, plant and equipment. Properties occupied by employees, whether or not they pay rent at market rates, are not classified as investment properties.

Note 1.9 Intangible assets

1.9.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of sale separately from the rest of the Trust’s business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust, where the cost of the asset can be measured reliably and where the cost is at least £5,000.
Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised; it is recognised as an operating expense in the period in which it is incurred.

Internally-generated assets are only recognised if, and only if, all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
- the Trust intends to complete the asset and sell or use it
- the Trust has the ability to sell or use the asset
- how the intangible asset will generate probable future economic or service delivery benefits, e.g., the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset
- the Trust can measure reliably the expenses attributable to the asset during development

Software

Software which is integral to the operation of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset.

1.9.2 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

1.9.3 Subsequent Expenditure

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value.

Intangible assets held for sale are measured at the lower of their carrying amount or “fair value less costs to sell".
1.9.4 Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

1.9.5 Useful economic life of intangible assets

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

<table>
<thead>
<tr>
<th>Intangible assets</th>
<th>Minimum life (Years)</th>
<th>Maximum life (Years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purchased software</td>
<td>2</td>
<td>20</td>
</tr>
</tbody>
</table>

Note 1.10 Revenue government and other grants

Government grants are grants from government bodies other than income from commissioners or NHS trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

Note 1.11 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method.

Note 1.12 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.13 Financial assets and financial liabilities

Financial assets are recognised when the Trust becomes party to the contractual provision of the financial instrument or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or when the asset has been transferred and the Trust has transferred substantially all of the risks and rewards of ownership or has not retained control of the asset.
Financial assets are initially recognised at fair value plus or minus directly attributable transaction costs for financial assets not measured at fair value through profit or loss. Fair value is taken as the transaction price, or would be otherwise determined by reference to quoted market prices, where possible, or by valuation techniques where relevant. (See IFRS 9 B5.1.2A.).

Financial assets are classified into the following categories: financial assets at amortised cost, financial assets at fair value through other comprehensive income, and financial assets at fair value through profit and loss. The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

**Note 1.13.1 Financial assets at amortised cost**

Financial assets measured at amortised cost are those held within a business model whose objective is to hold financial assets in order to collect contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables, loans receivable, and other simple debt instruments.

After initial recognition, these financial assets are measured at amortised cost using the effective interest method, less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

**Note 1.13.2 Financial assets at fair value through other comprehensive income**

Financial assets measured at fair value through other comprehensive income are those held within a business model whose objective is achieved by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest.

At present the Trust does not hold any financial assets or financial liabilities held for trading.

**Note 1.13.3 Financial assets at fair value through profit and loss**

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term.

**Note 1.13.4 Impairment of financial assets**

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the Trust
recognises a loss allowance representing expected credit losses on the financial instrument.

The Trust adopts the simplified approach to impairment, in accordance with IFRS 9, and measures the loss allowance for trade receivables, contract assets and lease receivables at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2), and otherwise at an amount equal to 12-month expected credit losses (stage 1).

A provision matrix approach is adopted, as one of the recommended methodologies, to calculate lifetime expected credit losses of trade receivables at the reporting date. The Trust does not currently hold any lease receivables or contract assets.

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds, and Exchequer Funds' assets where repayment is ensured by primary legislation. The Trust therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies.

Additionally, the DHSC provides a guarantee of last resort against the debts of its arm’s length bodies and NHS bodies (excluding NHS charities), and the Trust does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

**Note 1.13.5 Financial Liabilities**

Financial liabilities are recognised when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been extinguished - that is, the obligation has been discharged or cancelled or has expired.

**Note 1.13.6 Financial Liabilities at fair value through profit and loss**

Derivatives that are liabilities are subsequently measured at fair value through profit or loss. Embedded derivatives that are not part of a hybrid contract containing a host that is an asset within the scope of IFRS 9 are separately accounted for as derivatives only if their economic characteristics and risks are not closely related to those of their host contracts, a separate instrument with the same terms would meet the definition
of a derivative, and the hybrid contract is not itself measured at fair value through profit or loss.

The Trust has reviewed all its main contracts and concluded that any derivatives the contracts may have are 'closely related' and therefore do not warrant separate disclosure or accounting.

**Note 1.13.7 Other Financial Liabilities**

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the amortised cost of the financial liability. In the case of DHSC loans that would be the nominal rate charged on the loan.

**Note 1.14 Leases**

**Finance leases**
Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property plant and equipment.

The annual rental is apportioned between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability is de-recognised when the liability is discharged, cancelled or expires.

Contingent rents are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

**Operating leases**
Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.
**Private Finance Initiative (PFI) transactions**

PFI transactions that meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the trust. In accordance with IAS17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

1. payment for the fair value of services received - the cost of the services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

2. repayment of the finance lease liability, including finance costs - The Public Finance Initiative (PFI) assets are recognised as Plant, Property and Equipment when they come into use.

A PFI liability equal to the capital value of the contract is recognised at the same time as the PFI assets are recognised. This does not include service elements and interest charges within the PFI contract which are expensed in accordance with IFRIC 12 as adapted and interpreted by the FReM, and as detailed below.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

3. payment for the replacement of components of the asset during the contract 'lifecycle replacement' - Components of the asset replaced by the operator during the contract (lifecycle replacement) are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalise at the time they are provided by the operator and are measured initially at cost.

The element of the annual unitary payment allocated to lifecycle replacement is predetermined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term accrual or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised.
The deferred income is released to operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the trust to the operator for use in the PFI scheme: Assets contributed for use in the scheme continue to be recognised as items of Plant, Property and Equipment in the Trust's Statement of Financial Position.

Other assets contributed by the trust to the operator: Other assets contributed (e.g., Cash payments, surplus property) by the Trust to the operator before the asset is brought into use, where these are intended to defray the operators capital costs, are recognised initially as prepayments during the construction phase of the contract. When the asset is made available to the Trust, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

**Note 1.15 Provisions**

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation at the end of the reporting period. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury. This applies to early retirements and injury benefits provisions.

**Clinical negligence costs**

NHS Resolution (NHSR) operates a risk pooling scheme under which the Trust pays an annual contribution to NHSR, which, in return, settles all clinical negligence claims. Although the NHSR is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSR on behalf of the Trust is disclosed in the notes to the Accounts but is not recognised within the Trust’s Accounts.

**Non-clinical risk pooling**

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHSR and in return receives assistance with the costs of claims arising. The annual membership contributions, and any “excesses” payable in respect of particular claims are charged to operating expenses when the liability arises.

**Early Retirement Provisions**

Early retirement provisions are discounted using the HM Treasury’s pension discount rate of negative 0.95% (negative 0.5% in 2019/2020) in real terms. All general provisions are subject to four separate discount rates according to the expected timing of cash flows from the Statement of Financial Position date:
A nominal short-term rate of minus 0.02% (positive 0.51% in 2019/2020) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.

A nominal medium-term rate of positive 0.18% (positive 0.55% in 2019/2020) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.

A nominal long-term rate of positive 1.99% (positive 1.99% in 2019/2020) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.

A nominal very long-term date of positive 1.99% (positive 1.99% in 2019/2020) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

**Note 1.16 Contingencies**

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the Trust’s control) are not recognised as assets, but are disclosed in the notes to the Accounts where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in the notes, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the Trust’s control
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability

**Note 1.17 Public Dividend Capital (PDC) and PDC dividend**

Public Dividend Capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. It represents the DHSC investment in the Trust. HM Treasury has determined that, being issued under statutory authority rather than under contract, PDC is not a financial instrument within the meaning of IAS 32.

At any time the Secretary of State can issue new PDC to, and requirement repayments of PDC from, the Trust. PDC is recorded at the value received.
An annual charge, reflecting the cost of capital utilised by the Trust, is payable to DHSC as PDC dividend. The charge is calculated at the real rate set by the Secretary of State with the consent of HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year.

Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for:

- donated assets (including lottery funded assets)
- average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility
- assets under construction for nationally directed schemes
- any PDC dividend balance receivable or payable
- Approved expenditure on COVID-19 capital assets

In accordance with the requirements laid down by the DHSC (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the “pre-audit” version of the annual accounts.

The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts. PDC dividend calculation is based upon the Trust's group accounts (that is, including subsidiaries), but excluding consolidated charitable funds.

As part of the reforms to the NHS cash regime effective from 1 April 2020, any interim revenue loans, including specified working capital facilities, and interim capital debt at 31 March 2020 were extinguished during the 2020/2021 financial year. £67.459million of PDC was provided to the Trust to enable the principal repayment of the outstanding balance.

1.18 Value Added Tax (VAT)

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable.

Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.19 Corporation tax

However, the Trust has evaluated that it is has no Corporation Tax Liability, as all activities are either ancillary to healthcare or below the de minimis level of profit at which tax becomes payable.

**Note 1.20 Foreign exchange**

The functional and presentational currencies of the Trust are sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items (other than financial instruments measured at “fair value through income and expenditure”) are translated at the spot exchange rate on 31 March
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

**Note 1.21 Third party assets**

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury’s FReM.

**Note 1.22 Losses and special payments**

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.
Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

**Note 1.23 Gifts**

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

**Note 1.24 Transfers of functions to / from other NHS bodies / local government bodies**

As public sector bodies are deemed to operate under common control, business reconfigurations with the DHSC group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the GAM requires the application of absorption accounting. Absorption accounting requires that entities account for their transactions in the period in which they took place.

For functions that have been transferred to the Trust from another NHS or local government body, the assets and liabilities transferred are recognised in the accounts as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain/loss corresponding to the net assets/liabilities is recognised within income/expenses, but not within operating activities.

For property plant and equipment assets and intangible assets, the cost and accumulated depreciation / amortisation balances from the transferring entity’s accounts are preserved on recognition in the Trust’s accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the Trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

For functions that the Trust has transferred to another NHS / local government body, the assets and liabilities transferred are de-recognised from the accounts as at the date of transfer. The net loss / gain corresponding to the net assets / liabilities transferred is recognised within expenses / income, but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve. Adjustments to align the acquired function to the Trust's accounting policies are applied after initial recognition and are adjusted directly in taxpayers’ equity.
Note 1.25 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2020/2021.

Note 1.26 Standards, amendments and interpretations in issue but not yet effective or adopted

The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2020/2021. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2020/21, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

IFRS 16 Leases: The standard is effective 1st April 2022 as adapted and interpreted by the FReM.

IFRS 17 Insurance Contracts: Application required for accounting periods beginning on or after 1st January 2023, but not yet adopted by the FReM: early adoption is not therefore permitted.

The Trust has considered the above new standards, interpretation and amendments to published standards that are not yet effective and concluded that, with the exception of IFRS 16 that is dealt with below, they are currently either not relevant to the Trust or that they would not have a significant impact on the Trust's financial statements, apart from some additional disclosures.

This conforms with the Foundation Trust Annual Reporting Manual (FT ARM) which requires that any amendments to standards are applied in accordance with the applicable timetable, with early adoption not permitted.

IFRS 16 Leases

IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The Trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.
On transition to IFRS 16 on 1 April 2022, the Trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust’s incremental borrowing rate. The Trust’s incremental borrowing rate will be a rate defined by HM Treasury. Currently this rate is 1.27% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/2023, the Trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.
<table>
<thead>
<tr>
<th>Agenda item</th>
<th>P53/21(ii)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report</td>
<td>2020/2021 Accounts: Operating Segments</td>
</tr>
<tr>
<td>Executive Lead</td>
<td>Stuart Diggles – Interim Director of Finance</td>
</tr>
<tr>
<td>Link with the BAF</td>
<td>B9 and B13</td>
</tr>
<tr>
<td>How does this paper support Trust Values</td>
<td>Effective financial management assists the Trust in achieving all of its values.</td>
</tr>
<tr>
<td>Purpose</td>
<td>For decision ☒  For assurance ☐  For information ☐</td>
</tr>
</tbody>
</table>

**Executive Summary (including reason for the report, background, key issues and risks)**

<table>
<thead>
<tr>
<th>Purpose of this paper:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The purpose of this paper is to present the Operating Segments disclosure note required under IFRS 8 in the Trust’s 2020/2021 Annual Report and Accounts.</td>
</tr>
</tbody>
</table>

**Summary of Key Points:**

This paper specifically deals with the area of segmental reporting for the Trust under IFRS and requests ratification of assumptions and disclosures required under IFRS 8 - Operating Segments. There have been no changes to assumptions and disclosures required from the 2019/2020 financial year in the 2020/2021 operational year.

- The Chief Operating Decision Maker remains the Board of Directors.
- The Board continues to review the financial position of the Foundation Trust as a whole in their decision making process, rather than reviewing individual components included in the totals; therefore the Board continues to only consider the one segment of healthcare in its decision-making process.
- Per the criteria laid out in IFRS 8, all of the operating segments can be aggregated together to form one reporting segment – the provision of healthcare.

In conclusion, the Trust has one “reporting” segment for the 2020/2021 financial year as per previous years, namely the provision of healthcare, and the accounts will be prepared on that basis.
| Due Diligence  
(include the process the paper has gone through prior to presentation at the meeting) | This report was presented at the Trust’s Audit Committee for endorsement on 29 January 2021 prior to it being put on the agenda for Board Approval.  
The Director of Finance received a copy of the report for review and consideration prior to it being presented to the Audit Committee. |
|---|---|
| Board powers to make this decision | This report complies with the Trust’s Constitution:  
40. Accounts  
40.1 The Trust must keep proper accounts and proper records in relation to the accounts.  
40.2 In preparing its annual accounts, the corporation must comply with any directions given by the regulator with the approval of the Treasury as to—  
(a) the methods and principles according to which the accounts must be prepared,  
(b) the information to be given in the accounts.  
Accounting Standards require the Trust to consider its operating segments, as per IFRS 8 and as interpreted by the Department of Health and Social Care’s (DHSC) Group Accounting Manual (GAM). |
| Who, What and When  
(what action is required, who is the lead and when should it be completed?) | Audit Committee endorsed this report at their meeting on 29 January 2021.  
Board need to approve the operating segments prior to the end of the financial year in order to ensure the timely preparation of the annual accounts. |
| Recommendations | It is recommended that Trust Board approve the following Note 2 for inclusion within the 2020/2021 annual accounts:  
“All of the Trust's activities are in the provision of healthcare, which is an aggregate of all the individual specialty components included therein, and the large majority of the healthcare services provided occur at the one geographical main site. Trust revenue derives within the UK. The majority of expenses incurred are payroll expenditure on staff involved in the production or support of healthcare activities generally across the Trust together with the related supplies and overheads needed to establish this production. The business activities which earn revenue and incur expenses are therefore of one broad combined nature and therefore on this basis one segment of 'Healthcare' is deemed appropriate.  
The operating results of the Trust are reviewed monthly by the Trust's chief operating decision maker which is the overall Foundation Trust |
Board of Directors, which includes senior professional non-executive directors. The Board of Directors review the financial position of the Trust as a whole in their decision making process, rather than individual components included in the totals, in terms of allocating resources. This process again implies a single operating segment under IFRS 8.

The finance report considered monthly by the Board of Directors contains summary figures for the whole Trust together with directorate expense budgets with their cost improvement positions. Likewise only total balance sheet positions and cash flow forecasts are considered for the whole Trust. The Board of Directors as chief operating decision maker therefore only considers one segment of healthcare in its decision-making process.

The single segment of 'Healthcare' has therefore been identified consistent with the core principle of IFRS 8 which is to enable users of the financial statements to evaluate the nature and financial effects of business activities and economic environments.

<table>
<thead>
<tr>
<th></th>
<th>Healthcare</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2019/20</td>
<td>2018/19</td>
</tr>
<tr>
<td>Income</td>
<td>288,614</td>
<td>257,201</td>
</tr>
<tr>
<td>Retained Earnings / (Accumulated Deficit)</td>
<td>9 (19,982)</td>
<td>9 (19,982)</td>
</tr>
<tr>
<td>Segment net assets</td>
<td>43,654</td>
<td>40,403</td>
</tr>
</tbody>
</table>

(Format of table shown – the figures above are those included within the 2019/2020 accounts, the numbers will be updated on production of the 2020/2021 accounts, with reference to appropriate year’s updated at that point.)

**Appendices**

Not applicable
2020/2021 Accounts: Operating Segments

1.1 Introduction

This paper deals with segmental reporting for the Trust under IFRS and requests ratification of assumptions and disclosures required under IFRS 8 - Operating Segments.

1.2 Background

1.2.1 The objective of IFRS 8 is to require the Trust to disclose information, within a note to the annual accounts, to enable users of these financial statements to evaluate the nature and financial effects of the activities in which it engages and the economic environment in which it operates. This relates to both Statement of Comprehensive Income and the Statement of Financial Position.

1.2.2 Annual review should be made of the core principle above when forming a judgement about how and what information should be disclosed.

1.3 Key Issues Relating to IFRS 8

IFRS 8 places emphasis on reporting disclosures in the annual accounts that reflect the way that senior management runs the Trust. This involves:

1.3.1 Identifying the Chief Operating Decision Maker (CODM)

This is the person or persons who receive NHSI financial information analysed by internal segments and uses that information to allocate resources. Following a detailed review undertaken on the introduction of IFRS 2009/2010 and each review since, this was determined to be the Board of Directors. No changes to the organisation have since affected this, and the CODM therefore remains the Trust Board.

1.3.2 Determining the Internal Operating Segments

These are the segments reported to the CODM internally and are primarily the Trust’s Clinical and Corporate Divisions.

In terms of allocating resources, the Board reviews the financial position of the Foundation Trust as a whole in their decision making process, rather than reviewing individual components included in the totals.

The finance report considered monthly by the Board contains summary figures for the whole Trust, although some subsidiary divisional performance data regarding budgets and cost improvement positions is included.

Importantly, only the trust-wide detailed and itemised Income and Expenditure performance is reported upon. Likewise, only the trust-wide total Statement of Financial Position and Statement of Cash flows are reported. Finally, the trust’s Annual Financial Plan is considered on a whole Trust basis.

The Board, therefore, only considers the one segment of healthcare in its decision-making process.

Following reviews in previous years, it has been ratified that the Trust has one “reporting” segment, namely the provision of healthcare. This remains the position for the 2020/2021 year.
1.3.3 Determining the ‘Significant’ Operating Segments to be Disclosed (i.e. the Reporting Segments)

In accordance with IFRS 8, a ‘significant segment’ is one whose revenue is at least 10% of the entity’s overall revenues. However, two or more operating segments may be aggregated if:

(i) The segments have similar economic characteristics
(ii) Aggregation allows the users of the financial statements to evaluate the nature and financial effects of the business activities
(iii) Segments are similar in each of the following respects
   a. The nature of the products and services
   b. Nature of the production processes
   c. The type or class of customer for their products and services
   d. The methods used to distribute their products or provide their services and
   e. If applicable the nature of the regulatory environment

These points are considered in detail on an individual basis:

(i) Economic Characteristics

The funding of the services provided by the Trust, and reported through these operating segments, is provided by Government backed organisations, demonstrating a common funding profile and risk.

The operating segments within the Trust have similar economic characteristics in that the operational goal of the clinical and corporate divisions is to break-even on an annualised basis. The operational aim of all of the divisions is to provide health care, in accordance with the Trust’s objectives.

(ii) Evaluation of Organisational Activities

The aggregation of all of the operating segments allows users of the financial statements to evaluate the nature and financial effects of the Trust’s activities – being the provision of healthcare. Non aggregation of the Trust’s performance would cause confusion to the readers of the annual accounts, rather than provide any clarification of the Trust’s internal decision making process.

(iii) Other Characteristics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Similarity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nature of service provided</td>
<td>The services provided by the Trust are all concerned with the core mission of the Trust – “to improve the health and wellbeing of the population we serve, building a healthier future together”.</td>
</tr>
<tr>
<td>Nature of production processes</td>
<td>Not applicable for the Trust</td>
</tr>
<tr>
<td>Type / class of customer for services</td>
<td>Whilst the funding for the provision of the Trust’s services are from different areas (for example, NHS bodies, Local Authorities and other Governmental bodies), fundamentally the ‘customers’ for all of the Trust’s service areas are from those in the population requiring healthcare.</td>
</tr>
</tbody>
</table>
Methods used to provide services | The methods and associated risks of service provision are similar through inpatient provision and community teams.
---|---
Nature of regulatory environment | Service areas within the Trust are subject to regulation in the provision of healthcare services by the Care Quality Commission.

In view of the similarities noted above, the Trust therefore considers that the aggregation criteria of IFRS 8 is satisfied and therefore all of the operating segments can be aggregated together to form one reporting segment – the provision of healthcare.

Consequently, one reporting segment will be disclosed in the 2020/2021 annual accounts. This also reflects the fact that the risks and economic characteristics of the operating segments fall within the provision of healthcare and these are not significantly different for each of the segments.

This reporting segment (that is, the provision of healthcare) mirrors the way that the organisation is managed by the Board of Directors as Chief Operating Decision Maker. The operational management of the Trust is concentrated on the provision healthcare. The Board reviews the trust-wide position initially from an Income and Expenditure, Statement of Financial Position and cash flow basis. The review of divisional performance is secondary. It also reflects the core purpose of the Trust - to improve the health and wellbeing of the population we serve, building a healthier future together.

1.3.4 Determining the Disclosures required for the ‘Significant’ Operating Segments (that is, Reporting Segment)

As the Trust has determined that there is only one reporting segment (that is, the provision of healthcare), the following disclosures are required under IFRS 8 for all entities, including those that have a single reportable segment:

(i) Information about services
   - Revenue from external customers for each service provided

(ii) Information about geographical areas
   - Split of revenues from customers by country

(iii) Information about major customers
   - Revenues from transactions with one major customer is in excess of 10% of total revenue

The vast majority of these disclosures are covered by the disclosures already required in the annual accounts for related parties and the analysis of income from activities. The geographical information disclosure will simply state that all revenues are derived within the UK within Note 2 of the accounts.
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<th>P53/21(iii)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report</td>
<td>2020/2021 Accounts: Going Concern</td>
</tr>
<tr>
<td>Executive Lead</td>
<td>Stuart Diggles, Interim Director of Finance</td>
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<td>Purpose</td>
<td>For decision ☒ For assurance ☐ For information ☐</td>
</tr>
</tbody>
</table>

**Executive Summary** (including reason for the report, background, key issues and risks)

**Reason for the Report:**

Accounting standards require the Trust’s Board of Directors to assess and satisfy itself that it is appropriate to prepare the Trust’s financial statements on a going concern basis for at least 12 months from the date of the accounts.

Whilst the Trust is expected to face continued financial pressures to manage within its financial resources and with respect to its cash flow position (especially once financial support is withdrawn in light of the current COVID pandemic), there is no expectation that the Trust will not continue to operate in the future, and especially over the next 12 months.

This report sets out the arguments for supporting the going concern concept for the Trust, mainly being:

- The management of the Trust has not, nor does it intend to, apply to the Secretary of State for the dissolution of the Trust.
- The Secretary of State has not informed the Trust that it intends to dissolve the Trust.
- Management is not aware of any operating or other issues that would prevent the annual accounts for 2020/2021 being prepared on a going concern basis.
- Whilst the Trust is facing continued financial pressures, it is working to manage its expenditure within available financial resources.

and, recommends that the 2020/2021 annual accounts are prepared on a going concern basis.
| **Due Diligence**  
**(include the process the paper has gone through prior to presentation at the meeting)** | It is likely that due to the current financial uncertainties that exist, that the Trust will get an Emphasis of Matter report as part of its Independent Auditor’s Report concerning the its going concern position, as it did for the 2019/2020 annual accounts.  
Since this report has been presented to the Audit Committee, the financial position at month 10 has been prepared by the Trust, which continues to show a favourable variance.  
At month 10 (January), the Trust is expecting an outturn deficit position of £4.467million, (£3.206million better than plan). |
| **Board powers to make this decision** | This report was presented at the Trust’s Audit Committee for endorsement on 29 January 2021 prior to it being put on the agenda for Board Approval.  
The Director of Finance and Deputy Director of Finance received a copy of the report for review and consideration prior to it being presented to the Audit Committee. |
| **Who, What and When**  
**(what action is required, who is the lead and when should it be completed?)** | This report complies with the Trust’s Constitution:  
40. Accounts  
40.1 The Trust must keep proper accounts and proper records in relation to the accounts.  
40.2 In preparing its annual accounts, the corporation must comply with any directions given by the regulator with the approval of the Treasury as to—  
(a) the methods and principles according to which the accounts must be prepared,  
(b) the information to be given in the accounts.  
Accounting standards require the Trust’s Board of Directors to assess and satisfy itself that it is appropriate to prepare the Trust’s financial statements on a going concern basis for at least 12 months from the date of the accounts. |
| **Recommendations** | Audit Committee endorsed this report at their meeting on 29 January 2021.  
This report needs to be ratified by Trust Board prior to the end of the financial year to enable the timely preparation of the Trust’s annual accounts.  
Trust Board approve that the going concern concept is applied to The Rotherham Foundation Trust before the end of the financial year to ensure the timely preparation of the annual accounts. |
| **Appendices** | None |
Introduction

1.1 The accounting concept of going concern is fundamental to the way in which the assets and liabilities of an organisation are recorded within its accounts. Under this concept an entity is usually expected to continue to operate for the foreseeable future with the assets and liabilities being valued on this basis.

1.2 If the entity is not expected to continue to operate the assets and liabilities would be recorded in the accounts on the basis of their value on the winding up of the entity. As a result, the assets would be recorded at a lower break-up value and medium/long-term liabilities would become short term. It is important to note that the going concern consideration applies to The Rotherham NHS Foundation Trust as an entity and not to the hospitals or services which it runs.

1.3 NHS Foundation Trusts (FTs) are required to prepare their accounts in accordance with International Financial Reporting Standards (IFRSs) as interpreted by the Department of Health and Social Care’s (DHSC) Group Accounting Manual (GAM). The requirement to prepare accounts on a going concern basis is set out in International Accounting Standard (IAS) 1: Presentation of Financial Statements, which states:

• When preparing financial statements, management shall make an assessment of an entity’s ability to continue as a going concern,
• An entity shall prepare financial statements on a going concern basis unless management intends to liquidate the entity or to cease trading, or has no realistic alternative but to do so,
• In assessing whether the going concern assumption is appropriate, management takes into account all available information about the future, which is at least, but is not limited to, twelve months from the end of the reporting period,
• When management is aware, in making its assessment, of material uncertainties related to events or conditions which may cast significant doubt upon the entity’s ability to continue as a going concern, the entity shall disclose those uncertainties.

1.4 External Audit will consider what the Trust’s Board has done to satisfy itself that the accounts should be prepared on a going concern basis. This paper considers the basis on which the 2020/2021 accounts should be prepared and the conclusion reached on the going concern issue.

Going Concern in The Public Sector / NHS Context

2.1 It is important to consider the guidance stated in the Group Accounting Manual (GAM), which sets the requirements of IAS 1 in the context of a public sector organisation. The key extracts are as follows:

Going Concern

4.11 The Financial Reporting Manual (FReM) notes that in applying paragraphs 25 to 26 of IAS 1, preparers of financial statements should be aware of the following interpretations of Going Concern for the public sector context:

4.12 For non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern. Department of Health and Social Care (DHSC) group bodies should therefore prepare
their accounts on a going concern basis unless informed by the relevant national body or Department of Health and Social Care (DHSC) sponsor of the intention for dissolution without transfer of services or function to another entity. A trading entity needs to consider whether it is appropriate to continue to prepare its financial statements on a going concern basis where it is being, or is likely to be, wound up.

4.13 Sponsored entities whose statements of financial position show total net liabilities should prepare their financial statements on the going concern basis unless, after discussion with their sponsor division or relevant national body, the going concern basis is deemed inappropriate.

4.14 Where an entity ceases to exist, it should consider whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern in its final set of financial statements.

4.15 Where a Department of Health and Social Care (DHSC) group body is aware of material uncertainties in respect of events or conditions that cast significant doubt upon the going concern ability of the entity, these uncertainties must be disclosed. This may include for example where continuing operational stability depends on finance or income that has not yet been approved.

4.16 Should a Department of Health and Social Care (DHSC) group body have concerns about its “going concern” status (and this will only be the case if there is a prospect of services ceasing altogether) it must raise the issue with its sponsor division or relevant national body as soon as possible. “

2.2 The NHSI Annual Reporting Manual also provides guidance and it states:

**Overview: Going Concern**

2.12 There is no presumption of going concern status for NHS foundation trusts. Directors must decide each year whether or not it is appropriate for the NHS foundation trust to prepare its accounts on the going concern basis, taking into account best estimates of future activity and cash flows.

2.13 In making this assessment NHS foundation trusts should also be mindful of table 6.2 of the Financial Reporting Manual (FReM), which emphasises that: “The anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern.”

2.14 The NHS foundation trust should include a statement in the performance report: overview on whether or not the financial statements have been prepared on a going concern basis and the reasons for this decision, with supporting assumptions or qualifications as necessary (NHS Foundation Trust Code of Governance C.1.2).

2.16 Where there is material uncertainty over the going concern basis (for instance, continuing operational stability depends on finance or income that has not yet been approved), or where the going concern basis is not appropriate, the directors will need to disclose the relevant circumstances and should discuss the basis of accounting and the disclosures to be made with their auditors.
The Rotherham Foundation Trust’s Financial Position

3.1 2019/2020:

During the 2019/2020, the Trust delivered a £4.960million deficit against a planned break even position for the year. However, as a result of the South Yorkshire and Bassetlaw Integrated Care System being in aggregate balance, the Trust received additional non-recurrent Financial Recovery Fund monies to clear the deficit resulting in a surplus of £9K.

As a consequence, the Trust achieved its annual control total and secured its Quarter 4 Provider Sustainability Fund/Financial Recovery Fund monies of £5.170million, which is part of the deficit position referred to above.

The 2019/2020 annual accounts were prepared and approved by the Trust on a going concern basis.

As part of the 2019/2020 external audit review of the Trust’s Accounts, PWC, raised a material uncertainty relating to going concern through their Independent Auditor’s Report, on the basis that the Trust continues to face financial challenges and “is operating under interim financial arrangements.”

3.2 2020/2021:

Financial planning for the 2020/2021 financial year was suspended during the first half of the year as a result of COVID. To assist NHS providers during this time top up payments were introduced, in addition to block contracting income, which was provided in advance to give NHS providers the financial means to help them deal with the impact of the pandemic on the hospital.

These monthly advance top up payments have resulted in the Trust holding healthy cash balances since the start of April 2020, however once these top up payments cease it is likely that the Trust will face cash flow pressures.

Reforms to the NHS cash regime effective from 1 April 2020, has meant that any interim revenue loans, including specified working capital facilities that existed at 31 March 2020 were extinguished during the 2020/2021 financial year and were converted to Public Dividend Capital (PDC).

Planning was re-introduced during the second half of the financial year, at which point the Trust anticipated a deficit position of £7.653million. At month 9 (December), the Trust is expecting an outturn deficit position of £4.447million, (£3.227million better than plan).

The Trust has identified cost improvement programmes to help it meet targeted efficiencies for the current financial year. At month 9 (December) the Trust is forecasting to deliver £467k recurrent (£1.050million full year) and £678k non-recurrent savings against a plan of £1.453million.

3.3 2021/2022:

The Trust is starting its budget planning process for the 2021/2022 financial year, however at this point it is too early in the process to know what the financial position of the Trust is.
The deadline for planning has been delayed until the end of June, and will therefore still be in progress at the time when the Trust’s External Audit will be completing their audit of the annual accounts and giving their Independent Auditor’s Report. This delay in business planning could leave further uncertainty around the Trust’s financial performance.

The position with regard to COVID remains a great uncertainty and ultimately how this will affect the Trust and its financial position is unknown.

As previously mentioned, once the advanced monthly COVID top up payments are stopped, there is a risk that the Trust will revert back to cash flow difficulties and will have to rely on working capital loans. Cash flow monitoring continues to be a priority of the Finance function, with regular reports being presented to Finance and Performance Committee and Board.

The Trust will continue to identify cost improvement programmes across all departments to help deliver savings in order to manage expenditure within the financial resources that it has available to utilise.

4 Assessment of Going Concern for the Trust’s 2020/2021 Annual Accounts

4.1 The following points are noted in making an assessment of the Trust’s going concern status:

- The management of the Trust has not, nor does it intend to, apply to the Secretary of State for the dissolution of the Trust.
- The Secretary of State has not informed the Trust that it intends to dissolve the Trust. It is most unlikely that a Foundation Trust would be disestablished without a major process over some time, particularly given the absolute requirement for the services it provides. None of this would suggest any immediate likelihood of the Trust ceasing to be a going concern.
- Management is not aware of any operating or other issues that would prevent the annual accounts for 2020/2021 being prepared on a going concern basis.
- Whilst the Trust continues to experience financial pressures as a result of central funding not keeping up with the inflationary increases in the costs it incurs in delivering health care provision, it continues to identify and implement cost improvement programmes aimed at maintaining expenditure within its available financial resources.

4.2 On the basis of the above considerations, and in line with the Group Accounting Manual (GAM) which states that NHS providers should prepare their accounts on a going concern basis unless told otherwise (see paragraph 3, of section 2.1), it is recommended that the Rotherham Foundation Trust’s annual accounts for the 2020/2021 financial year are prepared as such.

4.3 Although it is recommended that the annual accounts are prepared on a going concern basis, it is expected that the Trust will receive an Emphasis of Matter paragraph in its Independent Auditor’s Report for 2020/2021 to draw attention to the uncertainties that it is currently facing.
## Report

### Governance Report

**Executive Lead:** Jill Dentith, Corporate Governance Consultant

**Link with the BAF:** B8: this report provides a horizon scan of regulatory, statutory or legislative reviews, updates and changes

**How does this paper support Trust Values?**

This report supports the core value of Ambitious ensuring the Board of Directors is aware of any changes in the regulatory or legislative landscape as soon as possible

### Purpose

- **For decision**
- **For assurance**
- **For information**

*The report includes sections on:*

- The White Paper *Working together to improve health and social care for all;*
- Modifying the NHS provider licence;
- Advice on the complaints process; and
- Reducing burden and releasing capacity to manage the COVID-19 pandemic

### Due Diligence

This report has not been received elsewhere prior to its presentation to the Board of Directors

### Board powers to make this decision

This paper is presented for information and therefore no decisions are required.

### Who, What and When

Actions required will be led by the relevant Executive Director

### Recommendations

It is recommended that the Board of Directors receive this report for information

### Appendices

None
1 Introduction

1.1 This report provides an update on governance matters since the last Board meeting in February 2021.

2 Working together to improve health and social care for all

2.1 Thursday 11 February 2021 saw the publication of the Government’s White Paper, *Working together to improve health and social care for all*, on the future of integrated care. This paper follows consultation across the health and social care community. This paper sets out our legislative proposals for a Health and Care Bill. The proposals build on the Long Term Plan and the work providers and commissioners have done to respond to the pandemic, which are making lasting changes across health and social care.

2.2 It is hoped that local operational flexibility and an updated legal framework will help to better support local communities to work together across the health and social care sectors. The proposals will also help to strengthen the case for continued development of Integrated Care Systems.

2.3 The current timeframes, and subject to Parliamentary business, is that the legislative proposals for health and care reform outlined in this paper will begin to be implemented in 2022.

2.4 A copy of the paper can be found at [Integration and innovation: working together to improve health and social care for all (HTML version) - GOV.UK (www.gov.uk)](https://www.gov.uk)

3. Modifying the NHS provider licence

3.1 NHSEI are consulting on a proposed technical amendment to condition G4 of the provider licence (fit and proper persons).

3.2 Licence condition G4 applies to all licensees and NHS trusts are required to ensure governors and directors meet appropriate standards of personal behaviours, technical competence and business practice. The objective is to prevent unfit persons from holding office or continuing in office as a governor or director.

3.3 Since Monitor published the standard conditions of the provider licence in February 2013, the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (fit and proper persons requirements - FPPR) have been brought into force. Regulation 5 of the FPPR sought to address concerns expressed by the Francis report on Mid-Staffordshire NHS Foundation Trust.

3.4 As the intention of this consultation is to modify condition G4 to align with the current provisions of the FPPR and the Trust would support the proposal. This consultation will close at midnight on 29 March 2021.

3.5 The proposed modifications can be found by using the following link [Proposed modification of the NHS provider licence standard conditions: Condition G4 (fit and proper persons) - NHS England - Citizen Space](https://www.gov.uk)
4. Advice on the complaints process

4.1 The Department of Health and Social Care has advised that the Local Authority Social Services and NHS Complaints Regulations 2009 have not been repealed or amended, and all healthcare organisations must continue to comply with them. However, they have agreed that in some settings it may take longer to respond to a complaint. This will be effective from 1 February to 30 April 2021. Every effort should be made to avoid developing backlogs of complaints where it is possible to investigate and respond to the issues raised.

5. Reducing burden and releasing capacity to manage the COVID-19 pandemic

5.1 In late January 2021 NHSEI advised NHS bodies that they would continue to support organisation to free up management capacity and resources to focus on the challenges of the pandemic. The letter updates and reconfirms the position on regulatory and reporting requirements for NHS trusts and foundation trusts, including:

- pausing all non-essential oversight meetings;
- streamlining assurance and reporting requirements;
- providing greater flexibility on various year-end submissions;
- focussing our improvement resources on COVID-19 and recovery priorities; and
- only maintaining those existing development workstreams that support recovery.

5.2 This letter has now been updated, to reflect that Friends and Family Test reporting has resumed. NHSEI will keep this under close review, making further changes where necessary.

5.3 You can find the document by following the link below:

6. Recommendation

6.1 It is recommended that the Board of Directors receive this report for information.

Produced by: Jill Dentith, Corporate Governance Consultant
February 2021
Board of Directors’ Meeting  
05 March 2021

<table>
<thead>
<tr>
<th>Agenda item</th>
<th>P55/21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report</td>
<td>Register of Seal Report</td>
</tr>
<tr>
<td>Executive Lead</td>
<td>Jill Dentith, Corporate Governance Consultant</td>
</tr>
<tr>
<td>Link with the BAF</td>
<td>B8 – robust governance arrangements</td>
</tr>
<tr>
<td>How does this paper support Trust Values</td>
<td>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</td>
</tr>
<tr>
<td>Purpose</td>
<td>For decision ☐ For assurance ☐ For information ☒</td>
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**Executive Summary (including reason for the report, background, key issues and risks)**

The Board is asked to note that the Trust Seal has been used since the last report, to the Board, as detailed in the table at Appendix 1. The table giving details of the seal number, description of the document and the date the document was executed.

The Board is advised that items 234 and 234a were both signed and sealed in accordance with the Trust process and both documents executed appropriately. Due to an administrative error item 234 and 234a are recorded in the Register of Seals but have only been signed by one of the two Trust signatories to the documents. Copies of both documents have been obtained from the Trust’s solicitors, who hold the originals, which provide the evidence that they were signed, sealed and executed as necessary. Copies of these documents will be retained in the Trust safe with the Register of Seals.

An internal review of the process adopted for the signing and sealing of documents has been conducted. The individual with responsibility for the administration of the Register has now left the Trust and procedures have been updated to prevent such incidents occurring in the future. A note of the actions taken relating to items 234 and 234a has also been saved in the Register of Seals to provide an audit trail of issues identified and actions taken.

**Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors’ meeting)**

The draft paper has been discussed with the Interim Chief Executive and Interim Director of Finance. An informal discussion was also had with colleagues at 360 Assurance who provide internal audit services to the Trust.
Board powers to make this decision

<table>
<thead>
<tr>
<th>Standing Orders (Section 10)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>10.3 Register of Sealing</strong></td>
</tr>
<tr>
<td>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. A report of all sealings shall be made to the Board of Directors at least bi-annually. (The report shall contain details of the seal number, the description of the document and date of sealing). The book will be held by the Secretary.</td>
</tr>
</tbody>
</table>

**Who, What and When**
(what action is required, who is the lead and when should it be completed?)

| Procedures have been updated to prevent such incidents occurring in the future. The Director of Corporate Affairs will be charged with compliance with the relevant procedures and will be supported by the Head of Governance and Corporate Governance Manager. |

**Recommendations**

| It is recommended that the Board receive this report and the table at Appendix 1 for information relating to the use of the Trust Seal. |

**Appendices**

| Appendix 1 - Details of documents sealed on behalf of The Rotherham NHS Foundation Trust for the period 07 July 2020 to 28 February 2021 |
### Appendix 1

**Details of documents sealed on behalf of The Rotherham NHS Foundation Trust for the period 07 July 2020 to 28 February 2021**

<table>
<thead>
<tr>
<th>Seal number</th>
<th>Description of documents</th>
<th>Date of Seal</th>
</tr>
</thead>
<tbody>
<tr>
<td>234</td>
<td>Underlease of part relating to ground floor and first floor and second floor, Rotherham Community Health Centre. This document is between NHS Property Services Ltd and the Rotherham NHS Foundation Trust (the Trust)</td>
<td>05 August 2020</td>
</tr>
<tr>
<td>234a</td>
<td>Counterpart licence to carry out works relating to Rotherham Community Health Centre. This document is linked to item 234 above and is between PHP Investments No1 Ltd (the Landlord) and NHS Property Services Ltd (the Tenant) and the Trust (as under tenant)</td>
<td>05 August 2020</td>
</tr>
<tr>
<td>235</td>
<td>Lease for Breathing Space Badsley Moor Lane between NHS Property Services Ltd and the Trust.</td>
<td>01 September 2020</td>
</tr>
<tr>
<td>236</td>
<td>Transfer of title units 4 and 5 of concourse at TRFT with HM Land Registry. The transferor being Clark &amp; Partners and the transferee being the Trust.</td>
<td>01 September 2020</td>
</tr>
</tbody>
</table>