Board of Directors
Public AGENDA

Date: Friday 09 April 2021
Time: 0900hrs – 1130hrs

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 08 April 2021.

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1130 Close of meeting.
MINUTES OF THE PUBLIC BOARD OF DIRECTORS MEETING HELD VIRTUALLY ON FRIDAY 5 MARCH 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:  
Mr O Chohan, Chief Pharmacist (minute P45/21)  
Ms J Dentith, Corporate Governance Consultant  
Ms P Fisher, Divisional General Manager, Community Services (minute P37/21)  
Mr I Hinitt, Director of Estates and Facilities  
Mrs S Kilgariff, Director of Operations / Deputy Chief Operating Officer  
Mrs S Newbold, Head of Engagement (minute P45/21)  
Ms E Parkes, Interim Director of Communications  
Mr J Rawlinson, Director of Health Informatics  
Miss D Stewart, Corporate Governance Manager (minutes)  
Mrs L Tuckett, Director of Strategy Planning and Performance

Apologies:  
None

P34/21  
CHAIRMAN’S WELCOME AND APOLOGIES FOR ABSENCE

The Chairman welcomed all present, with members being informed that the meeting would be streamed live.

P35/21  
QUORACY CHECK

The meeting was confirmed to be quorate.

P36/21  
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.

Ms Parkes interest in terms of her joint role as Interim Director of Communications at the Trust and substantive Director of Communications of Barnsley Hospital NHS Foundation Trust, was noted.

Colleagues were asked that, should any further conflicts of interest become apparent during discussions, they were highlighted.

**P37/21 PATIENT STORY**

The Board of Directors welcomed to the meeting Ms Fisher, Divisional General Manager for Community Services, to present the patient story.

By means of an introduction, the Chief Nurse indicated that the story would demonstrate the impact from the recent ‘reset week’ in terms of systems and processes, and the difference it had made for the patient and carer.

As part of reset week Ms Fisher had been based in the Urgent and Emergency Care Centre (UECC). During that time, an elderly couple, both living independently in their own home; the female having dementia and was cared for by her husband, had been brought to the UECC. The attendance was purely related to the dementia, with no immediate medical requirements.

Prior to Ms Fisher becoming involved in the case, acute hospital beds had been arranged for the couple and they were awaiting transfer from the UECC once diagnostics were available. Working in liaison with colleagues within the UECC, Integrated Discharge Team and Community Hospital Admission Avoidance Team, Ms Fisher had investigated alternative pathways for the couple.

These conversations resulted in the acute admission being cancelled, once diagnostics had been received, with the couple instead transferred for a two week stay in a local care home. During the stay assessments were undertaken as to the support they would require. The couple were both discharged safely back to their own home, with appropriate support packages now being in place.

This case had identified a number of improvements to the UECC patient pathway, including joint working with other Divisions and services. One area which would support sustained improvement, would be implementation of a Frailty Service.

As described by Mrs Kilgariff, the story epitomised reset week, it had focussed on operational flow and timely care for patients rather than being driven by data and targets. The story had been shared with operational teams, as an example of Divisions working together and the resulting benefit for the patient.
In addition, Dr Jenkins commented that the story identified the discussions to be had with external agencies, to ensure that the default position was not one of attending UECC.

The Board of Directors expressed their appreciation to Ms Fisher and her colleagues and thanked her for sharing the story.

PROCEDURAL ITEMS

P38/21 MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting held on 2 February 2021 were agreed as a correct record subject to the following amendments:

i. Chief Executive Report (minute P09/21)
   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 be unlikely to provide guidance in the short term.

ii. Governance Report (minute P19/21)
   Footnote to be amended to the following:
   Section 5(2) refers to “an in-patient in a hospital ...who may be detained ...for [up to] 72 hours.”

iii. Quarterly Risk Management Report (P22/21)
   It was reported that an Internal Audit review of Clinical Service Unit Risk Management had been completed, with the recommendations having been implemented.

P39/21 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.

P40/21 ACTION LOG

The Board of Directors reviewed the action log and agreed that log numbers 1, 2, 3, 5, 6, 7, 9, 10, and 11 would be closed.

The two remaining open actions were log numbers 4 and 8.

In terms of log number 3 which related to promoting the Trust’s achievements, whilst this action was formally closed, a new action would be added relating to ensuring that Trust achievements were appropriately recognised and displayed where possible within the hospital.

ACTION – Interim Director of Communications
The Board of Directors received the Chairman’s Report.

The appointment of Ms Hagger as Vice Chair for a further period of twelve months until 31 March 2022, was approved by the Board of Directors.

In addition, the Board approved Mrs Craven becoming the Chair of the Remuneration Committee from 1 April 2021, due to Mr Barnes term of office as a Non-Executive Director concluding at the end of March 2021.

The Board of Directors noted the Chairman’s Report.

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

Dr Jenkins reflected that he had now been at the Trust for over twelve months. Whilst challenging due to managing two organisations during a pandemic, the experience had been rewarding, and he thanked Board colleagues for their support during that time.

The report highlighted a number of matters, with the appendices providing an update from the Integrated Care System (ICS) and, as requested at a previous meeting, a summary of the Executive Director commitments across the Rotherham Place and the ICS.

Details of the reset week were documented within the report with Mr Edgell questioning as to how the results would be sustained and embedded. Dr Jenkins explained that the approach, led by the Director of Operations, had been one of all Divisions and the wider system including external partners, working together. When identified, change had immediately been enacted, this had result in improved patient flow and additional beds capacity being released.

A full debrief had taken place following the week, with actions identified to be implemented and embedded. This would include those external to the Trust.

Whilst acknowledging that reset week had been a team effort, the Board particularly thanked Mrs Kilgariff for her leadership on the matter. The Board noted that further reset weeks were being planned.

The Board noted the list of external meetings attended by the Executive Directors as appended to the report, which highlighted significant partnership working. However, as commented by Mr Diggles, those Executives also continued to have commitments to be undertaken within the Trust, which did create capacity challenges.

In supporting this comment, Dr Jenkins indicated that there were potential development opportunities from colleagues, such as deputies, attending these external meetings, to gain knowledge of the wider system.
Internal recruitment to the roles of Divisional Director in both Surgery and Medicine had been unsuccessful, with both posts now being externally advertised. To develop medical leaders of the future from within the Trust, Dr Jenkins and Dr Gardner were discussing a leadership programme.

Ms Hagger raised the matter of insufficient provision of Child and Adolescent Mental Health Services (CAMHS) tier four beds, highlighted at a recent meeting she had held with the Division of Family Health.

Dr Jenkins agreed that the matter was concerning, and had been problematic for a number of years across the NHS. The position was now becoming more challenged as there became a greater need for such young people services as a consequence of the pandemic.

It was confirmed that the matter had been escalated to the Locality Director of NHS England / Improvement, had been discussed by the Health and Care Management Team and by the Chief Executive’s within the ICS, who in turn had escalated the matter to the regional commissioners. The view was that there now was an urgent requirement to increase capacity in this service.

Ms Wood additionally commented that following discussion at the ICS Quality Meeting with the Care Quality Commission, NHS England / Improvement and the Commissioners, a formal request had been made for the matter to be included on the regional and national risk registers.

It was confirmed that the Division of Family Health continued to be supported through the current challenges relating to this patient group.

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

\[ \text{P43/21 NATIONAL, INTEGRATED CARE SYSTEM AND INTEGRATED CARE PARTNERSHIP REPORT} \]

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

Firstly, Mr Wright took the opportunity to highlight the successful COVID vaccination programme across the Rotherham Place. To date 94% of the over 70’s population had received their vaccination.

As detailed within the report, Rotherham Place continued to develop its plans to address health inequalities as the area transitioned out of the pandemic. The Health and Wellbeing Board was also giving the matter significant focus. It was noted that the recently appointed Director of Public Health was already proactively working with the Trust and the Clinical Commissioning Group on health inequalities issues.

Additionally, there would be a role for the Anchor Networks, outlined in one of the appendices to the Chief Executive Report, once they were established as
such institutions they would be key in making a strategic contribution to the health and wellbeing of the local population and the local economy.

The Board of Directors noted the update report.

P44/21 PROPOSED PROCESS FOR DEVELOPING A NEW TRUST STRATEGY

The Board of Directors received the report presented by the Deputy Chief Executive and Director of Strategy, Planning and Performance, which outlined the proposed process to develop a new five year Trust Strategy.

The Trust’s current strategy concludes in 2022 and therefore it was proposed that a new strategy be developed.

It is the right time to be producing a new five year strategy as a result of a number of factors including, but not limited to, a new executive team, changes in the national and local environment, and the impact of the pandemic. This new strategy would enable a number of supporting plans, such as the People Plan, Digital Plan and the developing Estates Plan to be aligned with the future direction of the organisation.

In developing any new strategy there would be a requirement for significant engagement, both within the Trust, including our staff and the Council of Governors and externally with key partners, including voluntary organisations and the general public.

Public engagement would need to be through virtual activities, with both the Patient Forum and Public Panel, being integral to this in obtaining views on the proposals.

Based upon earlier discussions in the meeting it was agreed that Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) should be added to the list of organisations to specifically engage with, to ensure that mental health requirements were taken into account when developing the Strategy. ACTION - Director of Strategy, Planning and Performance

It was noted that once the Strategy had been developed in September 2021, it would enable the 2021/22 Board Assurance Framework to be developed for implementation in quarters 3 and 4 (October 2021 – March 2022).

Whilst the proposed timetable for the work to be completed to enable approval by the Board of Directors at their September 2021 meeting was ambitious, it was considered to be an exciting opportunity for the Trust.

The Board of Directors agreed the development of a new Five Year Strategy, with the timetable as detailed within the report.
The Board of Directors received the monthly COVID-19 report presented by the Chief Operating Officer.

The report set out to identify the key operational indicators and their trajectories, provide an overview of Covid-19 related issues and the recovery plans as of January 2021.

It was noted that elective care trajectories had been agreed until the end of quarter one (2021/22). The Associate Medical Director for Recovery would support the plans in collaboration with the Divisions, with the position monitored by the Director of Strategy, Planning and Performance.

Challenges remained in terms of cancer performance and were detailed within the report. The Trust was reliant upon a number of key specialities, who had been impacted by the pandemic and staff sickness.

In response to a comment from Dr Shah that many patients with potential lung cancer, may not be presenting to their GP due to the pandemic, Mr Briggs confirmed that the Trust continued to work closely with the Cancer Alliance Network in a number of areas. The new national lung cancer campaign was welcomed by the Board.

A significant number of long-waiting patients were included in the waiting list. The Divisional teams continued their focus on bringing these patients in for treatment despite the ongoing capacity challenges. The trajectory was for around 17000 patients to be on the list at the end of June 2021.

To ensure that waiting lists continued to be managed, regular meetings were held with GPs to offer advice and highlight flexibilities in the pathways due to the pandemic. This approach was to ensure patients continued to be referred and avoid any sudden increase in patient numbers.

Mrs Craven questioned utilisation of the independent sector, as the data would suggest that opportunities were not being maximised. Mr Briggs confirmed that the Trust continued to access the independent sector, both in Rotherham and Sheffield. Management processes had recently been changed to maximise theatre utilisation. However, it should be noted that the medical staff tended to work in both the NHS and the independent sector, and many were showing signs of fatigue.

Additionally, Mrs Tuckett commented that there were significant complexities when using the independent sector including identification of patients and procedures as many providers may not be resourced for clinically complex cases.

The Board of Directors noted progress in a number of areas and, the recovery trajectories as documented within the report.
At this point in the meeting, Mr Havenhand welcomed the Head of Engagement and Chief Pharmacist to provide an update on the vaccination programme.

During quarter three, the Trust had prepared in readiness for national approval to use the vaccines, at that time, in development. Once approved, the Trust had received its first supply and commenced the programme at the beginning of January 2021. In the first phase, 3000 Trust staff and over 7000 colleagues within the Rotherham Place, had received their vaccination with positive feedback regarding the approach taken.

The programme for the second dose would commence on 22 March 2021, and would last for one month.

The Board of Directors thanked Mrs Newbold, Mr Chohan and Mr Ned for their leadership in the vaccination programme, with the Board also recognising the contributions from all colleagues within the vaccination team.

The Board of Directors noted the COVID-19 report.

P46/21 MONTHLY INTEGRATED PERFORMANCE REPORT

The Board of Directors received the Integrated Performance Report (IPR), presented by the Deputy Chief Executive.

The report provided data across a range of metrics as detailed within the report. Specific commentary was also provided, including actions to be taken for improvement, for the following four escalations:

- Mortality index (Rolling 12 months)
- Care Hours per Patient Day
- Length of Stay over 21 days (Snapshot Numbers)
- 62 Day Cancer Performance

With regard to cancer, it was noted that the position was always two months behind due to the requirement for validation. However, the position was monitored and managed on a monthly basis.

It was noted that significant proactive work had been undertaken with the Local Authority and Care Homes to reduce the requirement for unnecessary hospital admissions.

The drivers for under performance in terms of care hours per patient day were as documented within the report and included the reduced number of staff being available due to sickness. A number of steps were being taken to improve the position, with the formal six month nurse staffing review underway.

It was reported that the Quality Committee would be receiving an in-depth report on the thematic nature of complaints during the pandemic. Dr Gardner confirmed that any compliant relating to a member of the medical staff was reviewed by him personally, with reflective learning as part of individual’s performance appraisal.
In terms of the validation of waiting lists, it was noted that significant work continued on Appointment Slot Issues (ASI) to ensure waiting lists were accurate, and support recovery plans.

Mr Ned reported that mandatory and statutory training compliance stood at 91%, with all Divisions above the 85% target. It was also pleasing to report that the nurse vacancy rate was at its lowest level in two years and would have a significant positive benefit on the provision of high quality patient care.

From a financial perspective, Mr Diggles reported a strong position, with a surplus to plan for income and expenditure of £1.8m, and a year-end favourable forecast surplus of £3.2m. There remained a lot of capital activities to be undertaken in quarter four. The current cash position stood at £33m.

Due to the pandemic and vacancies in some specialities, agency spend remained 20% higher than anticipated as highlighted by Mr Edgell. Although this statement was correct, Mr Wright highlighted that at month ten there had been £1.5m less expenditure against the same period 12 months ago.

There continued to be month on month savings in some areas, with a £800k reduction in admin and clerical spend alone. Whilst there remained some challenging specialities which required more expensive locums, it was anticipated that the target to achieve a 10% reduction in agency costs would be achieved by the year end.

The Board noted the Integrated Performance Report.

ASSURANCE FRAMEWORK
P47/21 BOARD COMMITTEES CHAIRS ASSURANCE LOGS

The Board of Directors received and noted for assurance the reports and Chairs logs from the following Board Committees held in February 2021.

i. Finance and Performance Committee – no additional comments were made in terms of the content of the report

ii. Quality Committee - In terms of virtual Schwartz rounds the Executive Medical Director clarified that the roll out of face to face Schwartz rounds has been paused due to COVID-19, but the roll-out of virtual Schwartz rounds was still being pursued, with an indicative launch date of April 2021.

iii. People Committee – no additional comments were made in terms of the content of the report

P48/21 CARE QUALITY COMMISSION REPORT

The Board of Directors received the Care Quality Commission (CQC) report presented by the Chief Nurse.
Ms Wood indicated that progress continued to be made in implementing recommendations from previous inspections by the CQC, and preparations for the next routine inspection of services.

Since the last meeting there had been further information enquiries from the CQC, with the Trust providing the responses within the required timeframe.

Furthermore, it was noted that the CQC had formally issued a Section 29A Warning Notice on 11 February 2021. An action plan had been developed to address the matters raised.

In response to a question from Dr Shah regarding the Trust being proactive in identifying issues before it required intervention by the regulator, Ms Wood indicated that she would closely review the work of the newly established CQC resource supporting quality improvement and the patient experience. Although this resource would be piloted for a period of six months, this should enable a number of systems and processes to become embedded.

In addition thematic information would be proactively utilised, and electronic systems more actively used, including reminders for certain aspects of patient care. These should ensure patients were appropriately managed and reduce cases of harm.

The Board of Directors noted for assurance the CQC report.

P49/21 MORTALITY AND LEARNING FROM DEATHS REPORT

The Board of Directors received the report presented by the Executive Medical Director which provided an update on both mortality data and the actions being taken to support learning from deaths.

As detailed with the report the Hospital Standardised Mortality Ratio (HSMR) as at the end of September 2020 stood at 118.3, with the Summary Hospital-level Mortality Indicator (SHMI) standing at 117.3.

Whilst the reports demonstrated improvement across both indicators, they remained statistically higher than would be expected. Dr Gardner indicated that due to the reporting period, it was too early for the data to fully reflect the actions taken to date by the Trust. The aim remained to reduce the mortality score.

One of the Trust’s retired Consultant Anaesthetists, had undertaken a peer review of a number of the Dr Foster alerts. He had identified no deaths of significant concern, had been complimentary in a number of areas and highlighted some areas to support improvement.

External regional and national feedback on the Trust’s Medical Examiner Service, had been that it served as an exemplar in terms of systems and processes and the use of digital technology. However, the Trust would continue to explore learning opportunities from other organisations.
It was noted that the service would shortly be expanding following recent recruitment, and would be supported further in due course with separate resources to undertake the learning from deaths portfolio.

The Board of Directors noted the report providing assurance on the actions being taken with regard to mortality. The Board placed on record its appreciation to Dr Kelly, Medical Examiner, for developing a strong service upon which to further build.

P50/21  
**BOARD COMMITTEES TERMS OF REFERENCE**

The Board of Directors received the report which detailed the proposed revision to a number of Board Committee terms of reference.

These Committees were:

i. Audit Committee  
ii. Remuneration Committee  
iii. Nomination Committee  
iv. Finance and Performance Committee  
v. Quality Committee  
vi. People Committee

It was confirmed that each terms of reference had been considered by the relevant Committee, and/or Chair of the Committee where no meetings had been held in month. The Trust Chair had also overseen and reviewed each document.

In terms of the People Committee, it was noted that the Head of Medical Staffing title would be amended to Head of Medical and Dental Workforce.  

**ACTION – Corporate Governance Consultant**

The Board of Directors approved the revised terms of reference for each Committee.

In addition also forming one of the appendices to the report were the revised terms of reference for The Rotherham NHS Foundation Trust Committee in Common. These terms of reference would form part of the Joint Working Agreement to be signed by each Trust across the South Yorkshire and Bassetlaw Integrated Care System.

The Board of Directors approved the Committee in Common Terms of Reference. It was agreed that the Chairman would now sign the Joint Working Agreement on behalf of the Board.

**ACTION – Corporate Governance Consultant**

P51/21  
**BOARD ASSURANCE FRAMEWORK**

The Board of Directors received the report which provided the additional information as requested with regard to the Board Assurance Framework (BAF) risks of B7 and B8, whose quarter three scores had been challenged at the February 2021 Board meeting.
In relation to B7 (Insufficiently robust Trust-wide quality and clinical governance arrangements impede the delivery of a number of Trust plans / objectives), the score had been reviewed by the Quality Committee at their 24 February 2021 meeting. However, although a robust discussion had taken place, the Committee had not been able to reach a consensus as to the quarter three score. As such, the Committee was seeking a decision from the Board.

To support the Board discussion, members of the Quality Committee were asked to provide their views as to the proposed risk score.

Ms Wood, as Lead Executive to the Committee, commented that at quarter two, the risk had been rated as 15 (3 (L) x 5 (C)). In conjunction with Dr Gardner, she had reviewed the position for quarter three, with both agreeing that the quarter three score should remain unchanged at 15. This took into account the potential for a Section 29A warning notice from the Care Quality Commission having been notified to the Trust in quarter three.

However, the Non-Executive Directors on the Committee believing that the Section 29A did have wider implications and potentially highlighted that aspects of quality were not being addressed. Dr Shah, as Chair of the Committee, had considered the score for quarter three should be 4x5, upon reflection he now suggested a score of 4x4.

In seeking the views of Dr Jenkins the Board was reminded that the wording of the BAF risk related to governance arrangements, and as written considered a risk score of 4(L) x (5) consequence as too high particularly as the Section 29A had related to practices at ward level. Although there were a number of scoring options, and the potential to reflect on the scoring during the year, he would support the quarter three risk being scored at 4x4 as suggested by the Chair of the Quality Committee.

The Board of Directors agreed that the quarter three risk score for B7 would be 16 (4 (L) x 4 (C)), whilst noting the comments from Ms Wood.

With regard to BAF 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). The quarter three recommendation from the Audit Committee had been 20 (4 (L) x 5(C)). Mr Barnes as Chair of the Audit Committee was now recommending a revised quarter three score to the Board of 16 (4 (L) x 4(C)), with an anticipated quarter four score of 12 (3 (L) x 4(C)).

The Board of Directors approved the quarter three risk score for B8 at 16.

P52/21

**COMPLIANCE WITH REGULATORY AND LEGISLATIVE FRAMEWORKS**

The Board of Directors received the quarterly report which provided an update on the Trust’s compliance across a number of regulatory and legislative frames, including the provider licence and the Care Quality Commission.
The Board of Directors were able to gain assurance from the report and actions taken.

**REGULATORY AND STATUTORY REPORTING**

**P53/21  2020/21 ANNUAL ACCOUNTS**

The Board of Directors received three separate reports, all relating to the preparation of the 2020/21 Annual Accounts.

The three reports, all of which had been considered by the Audit Committee at its meeting on 29 January 2021, attended by the Internal and External Auditors, were:

i. Accounting Policies
ii. Operating Segment
iii. Going Concern

The Board of Directors in noting the content of each report, based upon the advice from the Audit Committee, approved the recommendations contained within each report.

**BOARD GOVERNANCE**

**P54/21  GOVERNANCE REPORT**

The Board of Directors received and noted the Governance Report.

**P55/21  REGISTER OF SEAL REPORT**

The Board of Directors received and noted the six-monthly report which documented the use of the Trust Seal. The Board were assured that systems and processes were in place to manage the use of the seal and the register.

**P56/21  ESCALATIONS FROM COUNCIL OF GOVERNORS**

There were no items to escalate from the Council of Governors meeting held on 10 February 2021.

**P57/21  ANY OTHER BUSINESS**

There were no items of any other business.

**P58/21  DATE OF NEXT MEETING**

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

The Board noted that the March 2021 meeting would be the last meeting for Mr Barnes, Non-Executive Director, as his term of office concluded on 31 March 2021.

On behalf of the Board of Directors, Mr Havenhand wished to place on record their appreciation to Mr Barnes for his significant contributions to the Trust...
during his time as Non-Executive Director. This included his role as Chair of the Audit Committee and Senior Independent Director. He had supported the organisation in becoming a stronger Trust.

At this point in the meeting, the Chairman asked if there had been any questions received from any members of the public, which there had been none.

The meeting declared closed.

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>2020</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></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>CEO</td>
<td>06-Apr</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. To be discussed as part of Board Development Day on 6 April 2021</td>
<td>Recomm 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 have had 6 Section 5(2) We have contributed to the consultation.</td>
<td>Recomm to close</td>
</tr>
<tr>
<td>12</td>
<td>05-Mar-21</td>
<td>Action log</td>
<td>P40/21</td>
<td>Trust achievements to be appropriately recognised and displayed were possible within the hospital.</td>
<td>DoC</td>
<td>Sep-21</td>
<td>Initial discussion held with Director of Estates and Facilities. Will be picked up as part of the Communications work flow. Ideally to be completed and in place before full visiting restrictions are lifted.</td>
<td>Open</td>
</tr>
<tr>
<td>13</td>
<td>05-Mar-21</td>
<td>Proposed Process for Developing a new Trust Strategy</td>
<td>P44/21</td>
<td>Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) to be added to the list of organisations to specifically engage with.</td>
<td>DoSPP</td>
<td>Complete</td>
<td></td>
<td>Recomm to close</td>
</tr>
<tr>
<td>14</td>
<td>05-Mar-21</td>
<td>Board Committee ToR</td>
<td>P50/21</td>
<td>Change job title in People Committee ToR</td>
<td>CGC</td>
<td>Complete</td>
<td></td>
<td>Recomm to close</td>
</tr>
<tr>
<td>15</td>
<td>05-Mar-21</td>
<td>Board Committee ToR</td>
<td>P50/21</td>
<td>Arrange for Chairman to sign the Joint Working Agreement on behalf of the Board.</td>
<td>CGC</td>
<td>Complete</td>
<td></td>
<td>Recomm to close</td>
</tr>
<tr>
<td>16</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agenda item</td>
<td>P66/21</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Report</td>
<td>National Staff Survey 2020</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Executive Lead</td>
<td>Steven Ned, Director of Workforce</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Link with the BAF</td>
<td>B4, B5, B6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How does this paper support Trust Values</td>
<td>The NSS results is one of the key metrics the Trust uses to gauge how people feel about working at the Trust, do they feel cared for and/or supported, it also identifies opportunities for how we can improve the workplace and with each other. The NSS links across the whole value set.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Purpose</td>
<td>For decision ☐ For assurance ☐ For information ☒</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Executive Summary (including reason for the report, background, key issues and risks)</td>
<td>The National Staff Survey results have now been published. The Trust has been mentioned in a HSJ article in regards to the 3rd most improved survey performance. The Chief Executive is meeting with Staff Side representatives with the Director of Workforce and Deputy Director of Workforce in order to discuss the results and actions that need to be taken to make improvements. The HR Business Partners are working with their Division in order to produce an action plan. The action plans will be discussed as part of Divisional performance review meetings with the Executive team and progress reported at this Committee meeting. National Staff Survey is also a standing agenda item on Operational Workforce Group and Joint Partnership Forum.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Board powers to make this decision</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors’ meeting)</td>
<td>The high-level National Staff Survey results have already been shared at Board, People Committee, Executive Team, Exec/Senior Leaders Team Meeting, Operational Workforce Group, Equality Diversity and Inclusion Steering Group, and Joint Partnership Forum. The final reports/papers have been shared with the forum outlined above.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **Who, What and When**  
(what action is required, who is the lead and when should it be completed?) | N/A |
|---|---|
| **Recommendations**  
It is recommended that the Board of Directors note the above for information. | |
<p>| <strong>Appendices</strong> | N/A |</p>
<table>
<thead>
<tr>
<th>Agenda item</th>
<th>P67/21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report</td>
<td>Gender Pay Gap Report</td>
</tr>
<tr>
<td>Executive Lead</td>
<td>Steven Ned, Executive 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 |
| How does this paper support Trust Values | Ambitious – the Trust is ambitious to improve the diversity of its workforce and to meet the health needs of the whole of the population it serves |
| Purpose | For decision ☐  
For assurance ☒  
For information ☐ |
| Executive Summary | As a public body employing over 250 staff the Trust is required to publish gender pay gap information annually.  
As at 31st March 2020, the Trust employed 4382 full-pay relevant employees. Of these, 3600 were women and 782 were men. 17.8% of full-pay relevant employees were men. Employees who are on maternity, maternity support, adoption or sick leave, or on a career break are not full-pay relevant employees.  
The Trust’s Gender Pay Gap (median) as at 31st March 2020 is 19.41%. This is a slight deterioration on 2019, and a significant deterioration on 2018, when it stood at 10.58%. |
<p>| Due Diligence | This paper has been presented to the People Committee, Operational Workforce Group, Joint Partnership Forum, EDI Steering Group and the Executive Team. At the request of the Executive Team, further detail around the gender pay gap within Agenda for Change bands and a breakdown of the gender pay gap within the medical workforce by age has been added. |
| Board powers to make this decision | N/A |
| Who, What and When | Through the Operational Workforce Group, actions will be identified to address the issues arising from the Gender Pay Gap report. Amongst other things this will include encouraging female applicants for Employer Based Awards and continuing to implement a range of flexible working policies to support career development. |
| Recommendations | The Board of Directors note the contents of the report. |</p>
<table>
<thead>
<tr>
<th>Appendices</th>
<th>N/A</th>
</tr>
</thead>
</table>

1 Introduction

1.1. The gender pay gap report shows the difference between the average (mean or median) earnings of men and women. This is expressed as a percentage of men’s earnings e.g. women earn 15% less than men. Used to its full potential, gender pay gap reporting is a valuable tool for assessing levels of equality in the workplace, female and male participation, and how effectively talent is being maximised.

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

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

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

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

2. Gender Pay Gap Reporting

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

2.2. As at 31st March 2020, the Trust’s workforce included 3910 women, and 818 men. Men made up 17.3% of the overall workforce. The national NHS Electronic Staff Record system does not facilitate the recording of genders other than male or female.

2.3. As at 31st March 2020, the Trust employed 4382 full-pay relevant employees. Of these, 3600 were women and 782 were men. 17.8% of full-pay relevant employees were men. Employees who are on maternity, maternity support, adoption or sick leave, or on a career break are not full-pay relevant employees.

2.4. (a) Mean Gender Pay Gap and (b) Median Gender Pay Gap
The Trust’s Gender Pay Gap (median) as at 31st March 2020 is 19.41%. This is a slight deterioration on 2019, and a significant deterioration on 2018, when it stood at 10.58%. There does not appear to be a single explanation for this change, but some of the reasons are explored further in this report.

For the second year running, there has been a slight increase in the proportion of men in the highest paid quartile, accompanied by a reduction in the proportion of men in the lowest paid quartile.

The lowest-paid staff within the Trust are those on apprentice wages. All staff on apprenticeship wages as at 31st March 2020 were female.

2.5. (c) Mean Bonus Gender Pay Gap and (d) Median Bonus Gender Pay Gap

<table>
<thead>
<tr>
<th>Gender</th>
<th>Mean Bonus Pay</th>
<th>Median Bonus Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>£11,326.51</td>
<td>£8,545.34</td>
</tr>
<tr>
<td>Male</td>
<td>£10,179.95</td>
<td>£9,048.00</td>
</tr>
<tr>
<td>Difference</td>
<td>-£1,146.55</td>
<td>£502.66</td>
</tr>
<tr>
<td>Pay Gap %</td>
<td>-11.26%</td>
<td>5.56%</td>
</tr>
</tbody>
</table>

* This data excludes Long Service Awards

Bonus pay is made up of Clinical Excellence Awards (CEAs) which are paid only to medical staff. No additional CEAs were awarded during the relevant period, however the relevant period did see the full-year effect of the awards during in the previous year. Females continue to receive a higher mean bonus value than males, and there has been a significant decrease in the median bonus pay gap. However, as the table below shows, a significantly larger number of males than females received CEAs.
2.6. (e) Proportion of Males Receiving a Bonus Payment and (f) Proportion of Females Receiving a Bonus Payment

<table>
<thead>
<tr>
<th>Gender</th>
<th>Employees Paid Bonus</th>
<th>Total Relevant Employees</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>14</td>
<td>3803</td>
<td>0.37%</td>
</tr>
<tr>
<td>Male</td>
<td>44</td>
<td>864</td>
<td>5.09%</td>
</tr>
</tbody>
</table>

* This data excludes Long Service Awards

A significantly larger number of males than females are paid CEAs. There are also much smaller numbers of males than females in the overall workforce, so the proportion of males receiving bonus payments is significantly higher than the proportion of females receiving bonus payments.

Taking into account the numbers of male and female medical staff within the Consultant workforce (approximately 62% of the consultant workforce are male, which is a reduction of approximately 3 percentage points since last year), male consultants are significantly more likely than female to be paid CEAs. CEAs have to be applied for, and nationally, male consultants are significantly more likely than female consultants to apply for CEAs.

The Trust did not run CEAs for a number of years. During 2018-19 the Trust started to work through a backlog of missed CEA rounds. Two CEA rounds occurred in 2018-19, and both involved significant back pay. This had a substantial impact on the Trust’s Gender Pay Gap.

2.7. (g) Proportion of Males and Females in each Quartile Pay Band

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

During the period, there has been a decrease in the proportion of staff in quartiles 1 and 3 who are male, and an increase in the proportion of staff in quartiles 2 and 4 who are male.

<table>
<thead>
<tr>
<th>Quartile</th>
<th>Female</th>
<th>Male</th>
<th>Female %</th>
<th>Male %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>950</td>
<td>142</td>
<td>87.00%</td>
<td>13.00%</td>
</tr>
<tr>
<td>2</td>
<td>930</td>
<td>169</td>
<td>84.62%</td>
<td>15.38%</td>
</tr>
<tr>
<td>3</td>
<td>952</td>
<td>127</td>
<td>88.23%</td>
<td>11.77%</td>
</tr>
<tr>
<td>4</td>
<td>768</td>
<td>344</td>
<td>69.06%</td>
<td>30.94%</td>
</tr>
</tbody>
</table>

* This data excludes Long Service Awards
The graph below shows a steady decrease in the proportion of staff within quartile 4 who are female over the last three years.

2.8. The data shows that statistically the Trust pays the male workforce more than the female workforce. After further analysis, this is believed to be partly as a result of the highest earners being within the medical workforce, which is a predominantly male workforce. It takes up to 14 years of under and postgraduate training for individuals to achieve the highest grade of consultant and a further 20 years to achieve the top of the consultant salary scale.

2.9. The graph below shows number of female and male trainee Foundation Years 1 and 2 new starters for all years since 2015/2016. Over the period, there have been 133 female new starters within this group, compared to 112 male new starters. Coupled with long-term trends showing increased numbers of female medical students, it is likely that the gender balance of the medical workforce will shift over time, however this may be significantly influenced by the availability or otherwise of flexible working opportunities within hospital medical posts.
2.8 Comparison of hourly pay rates amongst medical and non-medical staff groups

Non-medical

<table>
<thead>
<tr>
<th>Gender</th>
<th>Mean Hourly Rate</th>
<th>*Median Hourly Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>£14.75</td>
<td>£13.43</td>
</tr>
<tr>
<td>Male</td>
<td>£16.31</td>
<td>£13.89</td>
</tr>
<tr>
<td>Difference</td>
<td>£1.55</td>
<td>£0.46</td>
</tr>
<tr>
<td>Pay Gap %</td>
<td>9.53%</td>
<td>3.29%</td>
</tr>
</tbody>
</table>

* This data excludes Long Service Awards

The gender pay gap amongst non-medical staff is relatively small compared to the Trust’s overall gender pay gap, although both the mean and median pay gaps for non-medical staff have increased slightly over the last year.

Medical and Dental:

<table>
<thead>
<tr>
<th>Gender</th>
<th>Mean Hourly Rate</th>
<th>*Median Hourly Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>£32.94</td>
<td>£30.76</td>
</tr>
<tr>
<td>Male</td>
<td>£39.51</td>
<td>£40.69</td>
</tr>
<tr>
<td>Difference</td>
<td>£6.57</td>
<td>£9.93</td>
</tr>
<tr>
<td>Pay Gap %</td>
<td>16.62%</td>
<td>24.40%</td>
</tr>
</tbody>
</table>

* This data excludes Long Service Awards

There is a significant pay gap within the medical and dental workforce. Over the last year, the mean hourly pay gap within medical workforce has grown, whilst the median has decreased slightly. This seems to have been contributed to by a large intake of female F1 Doctors.

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

Non-medical

<table>
<thead>
<tr>
<th>Quartile</th>
<th>Female</th>
<th>Male</th>
<th>Female %</th>
<th>Male %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>950</td>
<td>142</td>
<td>87.00%</td>
<td>13.00%</td>
</tr>
<tr>
<td>2</td>
<td>925</td>
<td>163</td>
<td>85.02%</td>
<td>14.98%</td>
</tr>
<tr>
<td>3</td>
<td>922</td>
<td>122</td>
<td>88.31%</td>
<td>11.69%</td>
</tr>
<tr>
<td>4</td>
<td>631</td>
<td>162</td>
<td>79.57%</td>
<td>20.43%</td>
</tr>
</tbody>
</table>

* This data excludes Long Service Awards
Within our non-medical workforce, there has been a reduction in the proportion of male colleagues in quartiles 1 and 3 and an increase within quartiles 2 and 4.

Medical

<table>
<thead>
<tr>
<th>Quartile</th>
<th>Female</th>
<th>Male</th>
<th>Female %</th>
<th>Male %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2</td>
<td>5</td>
<td>6</td>
<td>45.45%</td>
<td>54.55%</td>
</tr>
<tr>
<td>3</td>
<td>30</td>
<td>5</td>
<td>85.71%</td>
<td>14.29%</td>
</tr>
<tr>
<td>4</td>
<td>137</td>
<td>182</td>
<td>42.95%</td>
<td>57.05%</td>
</tr>
</tbody>
</table>

* This data excludes Long Service Awards

17.8% of the Trust's full-pay relevant employees are male. Male staff are underrepresented in the lowest 3 quartiles of the non-medical workforce. Males are significantly over-represented within the medical workforce, and particularly within the highest paid quartile. Approximately 25% of the Trust's male staff are medical and dental, whereas only around 4% of the Trust's female workforce are medical and dental.
The table above shows the gender pay gap between male and female staff within specific Pay Bands. From Band 3 to Band 8A, within each pay band, women are paid on average (both mean and median) more than men. For Agenda for Change staff, hourly rate within a pay band is primarily influenced by the number of years spent working at that grade, with progression to the top of a pay band generally taking between 5 and 8 years.

This data suggests that male staff in Bands 3-8A are spending fewer years, on average, working within each grade than women, and are leaving roles prior to reaching the top of the pay band. This, combined with the data around gender split by pay band, may indicate that men are experiencing swifter career progression, and moving upwards through bands, whilst female staff are more likely to spend longer working at each band and are less likely to progress to higher bands.
### 2.11 Consultant Age Split Pay Gap

<table>
<thead>
<tr>
<th>Age Band</th>
<th>Headcount</th>
<th>Mean Hourly Rate</th>
<th>Median Hourly Rate</th>
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<tbody>
<tr>
<td></td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>&lt;=20 Years</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>21-25</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>26-30</td>
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<td>0</td>
<td>0</td>
</tr>
<tr>
<td>31-35</td>
<td>3</td>
<td>2</td>
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<tr>
<td>36-40</td>
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<tr>
<td>66-70</td>
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<td>3</td>
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</tr>
<tr>
<td>&gt;=71 Years</td>
<td>0</td>
<td>2</td>
<td>£51.62</td>
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</table>

The above table shows the gender pay gap (in terms of ordinary pay) between male and female consultants within specific age bands. It follows no clear pattern. Based on this table, the gender split by pay band data and the data on F1/F2 recruitment, the gender pay gap (in terms of ordinary pay) for medical staff seems to primarily be influenced by the relatively high numbers of male medical and dental staff historically, and a more recent influx of females into the profession. This is distinct from the analysis of bonus pay for medical and dental staff.

**Steven Ned**  
**Director of Workforce**  
**March 2021**
## Agenda item

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## Report

<table>
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## Executive Lead

<table>
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<th>Jill Dentith, Corporate Governance Consultant</th>
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## Link with the BAF

<table>
<thead>
<tr>
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<th>B8 – this paper provides evidence of a robust governance process in place at the Trust</th>
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## How does this paper support Trust values

<table>
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<th>Good corporate governance underpins achievement of the Trust values</th>
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## Purpose

<table>
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<th>For decision ☐</th>
<th>For assurance ☒</th>
<th>For information ☐</th>
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## Executive Summary  
(including reason for the report, background, key issues and risks)

As part of the Chair’s report to the December 2020 public Board meeting it was agreed that the Board Code of Conduct would be circulated for signature in April every year to align it with the declaration of interest process.

At the same meeting the Board of Directors also agreed an additional item to the Code of Conduct stating *’that for virtual Board meetings, the same standards of professional attire should apply as for meetings in person’*.

Attached at Appendix 1 is the updated Code of Conduct. Board members are required to abide by the Code. Board members should also read, sign and date the document and return it to the Head of Governance as soon as possible, but no later than 30 April 2021.

## Due Diligence  
(include the process the paper has gone to prior to presentation at Board of Directors Meeting)

The Code of Conduct was circulated to Board members in November 2020, discussed and amended at the Board meeting in December 2020 and is now recommended to the Board of Directors for action and approval.

## Who, what and when  
(what action is required, who is the lead and when should it be completed?)

Board members are required to abide by the Code. Board members should also read, sign and date the document and return it to the Head of Governance as soon as possible, but no later than 30 April 2021.

## Recommendations

- Approve the attached Code of Conduct;
- Abide by the Code; and
- Read, sign and date the document and return it to the Head of Governance as soon as possible, but no later than 30 April 2021.

| Appendices | Appendix 1 – The Rotherham NHS Foundation Trust Board Code of Conduct |
BOARD OF DIRECTORS
CODE OF CONDUCT
1. INTRODUCTION

1.1 Public service values are and must remain at the heart of the National Health Service. High standards of corporate and personal conduct based on a recognition that patients come first, have been a requirement throughout the NHS since its inception. Moreover, since the NHS is publicly funded, it must be accountable to Parliament for the services it provides and for the effective and economical use of those public funds.

1.2 As an NHS Foundation Trust, The Rotherham NHS Foundation Trust is required by the Terms of its Provider Licence to comply with the principles of best practice applicable to corporate governance in the NHS and Health Sector and with any relevant code of practice.

The purpose of this Code is to provide clear guidance on the standards of conduct and behaviours expected of members of the Trust Board\(^1\), plus non-voting attendee directors (together collectively referred to as “the Directors”) of The Rotherham NHS Foundation Trust.

1.3 The expectations of the NHS in respect of standards of corporate conduct are set out in guidance issued by the Department of Health in a ‘Code of Conduct and Code of Accountability in the NHS’\(^2\), and in ‘Standards for members of NHS boards and Clinical Commissioning Group governing bodies in England’\(^3\). This Code is consistent with that guidance.

The introduction of new fundamental standards regulations – the Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2018 – has also introduced new requirements relating to, inter alia, the “fit and proper persons” standard and applies to all Directors and equivalents.

2. PUBLIC SERVICE VALUES

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1 “Trust Board” refers to the Chairman, Non-Executive Directors and Executive Directors only (i.e. voting members of the Board).
2 Issued by the NHS Appointments Commission and Department of Health, 1997
3 Issued by the Professional Standards Authority, November 2013.
2.1 All Directors and employees are expected to abide by the Nolan principles of: selflessness, integrity, objectivity, accountability, honesty, transparency and leadership:

| **Selflessness** | Holders of public office should take decisions solely in terms of public interest. |
| **Integrity** | Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships. |
| **Objectivity** | Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias. |
| **Accountability** | Holders of the public office are accountable to the public for their decisions and actions and must admit themselves to the scrutiny necessary to ensure this. |
| **Openness** | Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing. |
| **Honesty** | Holders of public office should be truthful. |
| **Leadership** | Holders of the public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs. |

3. THE ROTHERHAM NHS FOUNDATION TRUST VALUES
3.1 Members of the Board of Directors expected to conduct themselves in a manner that reflects positively on the Trust and not to conduct themselves in a manner that could reasonably be regarded as bringing their office, or the Trust, into disrepute.

All members of the Board of Directors are required to respect and display the Trust values of Ambition, Caring and Together, and to ‘lead by example’.

4. BOARDROOM PROTOCOLS

4.1 Members of the Board of Directors are expected to follow certain boardroom behaviours (which apply equally to board committees):

- Meetings should start on time and finish on time;
- All members and attendees should arrive on time and be available for the duration of the meeting, unless the Chair has been agreed otherwise before the meeting begins;
- If any member or attendee expects to be called away during the meeting (which might be more pertinent for clinical colleagues), they should inform the Chair before the start of the meeting – taking into account that there will be a rare occasion where this will not be possible;
- All phones and devices should be turned to silent for the duration of the meeting, except in particular circumstances as above;
- No reading or writing of emails should take place during a meeting;
- No reading or sending of texts should take place during a meeting; and
- All members and attendees should read all of the pack before the meeting so that they are able to fully contribute.
- For Virtual Board meetings, the same standards of professional/formal attire should apply as for meetings in person.

5. GENERAL PRINCIPLES

5.1 Public service values matter in the NHS and those who work in it have a duty to conduct NHS business with probity. They have a responsibility to respond to staff, patients and suppliers impartially, to achieve value for money from the public funds with which they are entrusted and to demonstrate high ethical standards of personal conduct.

5.2 The success of this Code depends on a vigorous and visible example from the Directors and the consequential influence on the behaviour of all those who work within the Trust. The Directors accept their clear individual and collective responsibility for corporate standards of conduct and expects that this Code will inform and govern the decisions and conduct of the Directors.
5.1.1 Openness and Public Responsibilities

Health needs and patterns of provision of health care do not stand still. There should be a willingness to be open with the public, patients and with staff as the need for change emerges. It is a requirement that major changes are consulted upon before decisions are reached. Information supporting those decisions should be made available, in a way that is understandable, and positive responses should be given to reasonable requests for information and in accordance with the Freedom of Information Act 2000 and other applicable legislation.

NHS business should be conducted in a way that is socially responsible. As a large employer in the local community, the Trust should forge an open and positive relationship with the local community and should work with staff and partners to set out a vision for the organisation in line with the expectations of patients, members and the public. The Trust will seek to demonstrate to the public that it is concerned with the wider health of the population including the impact of the Trust’s activities on the environment.

The Trust has adopted policies and procedures to protect confidentiality of personal Information and to ensure compliance with the Data Protection Act, the Freedom of Information Act and other relevant legislation which will be followed at all times by the Directors and all staff. The Directors must comply with the Trust’s confidentiality policies and procedures and must not disclose any confidential information, except in specified lawful circumstances.

5.1.2 Public Service Values in Management

It is unacceptable for the Trust Board of any NHS organisation, or any individual within the organisation for which the Trust Board is responsible, to ignore public service values in achieving results. The Trust Board has a duty to ensure that public funds are properly safeguarded and that at all times the Trust Board conducts its business as economically, efficiently and effectively as possible - as required by statute.

Accounting, tendering and employment practices within the Trust must therefore reflect the highest professional standards. Public statements and reports issued by or on behalf of the Trust Board should be clear, comprehensive and balanced, and should fully represent the facts. Annual and other key reports should be issued in good time to all individuals and groups in the community who have a legitimate interest in health issues to allow full consideration by those wishing to attend public meetings on local health issues.

The standards of conduct expected by the Trust are set out in the Standing Financial Instructions and accompanying Scheme of Delegation which will be followed by the Directors and all staff.
5.1.3 Public Business and Private Gain

The Chairman and Directors should act impartially and should not be influenced by social or business relationships. None should use their public position to further their private interests. Where there is a potential for interests to be material and relevant to NHS business, the relevant interests should be declared and recorded in the Board minutes, and entered into a register which is available to the public. When a conflict of interest is established, the Director should withdraw and play no part in the relevant discussion or decision.

*The Constitution defines those interests which must be declared by the Directors. In addition, the Trust Board has adopted Standing Orders for the conduct of Trust Board business and a policy on the Standards of Business Conduct which will be followed at all times by Directors and all staff.*

5.1.4 Hospitality and Other Expenditure

The Directors will set an example in the use of public funds and the need for good value in incurring public expenditure. The use of NHS monies for hospitality and entertainment, including hospitality at conferences or seminars, will be carefully considered. All expenditure on these items should be capable of justification as reasonable in the light of the general practice in the public sector. The Directors are conscious of the fact that expenditure on hospitality or entertainment is the responsibility of management and is open to be challenged by the internal and external auditors and that ill-considered actions can damage respect for the NHS in the eyes of the community.

*The Trust Board has adopted a policy on the Standards of Business Conduct which will be followed at all times by the Directors and all staff.*

5.1.5 Relations with Suppliers

The Directors acknowledge the need for an explicit procedure for the declaration of hospitality and sponsorship offered by, for example, suppliers. Their authorisation should be carefully considered and the decision should be recorded. The Directors are mindful of the risks in incurring obligations to suppliers at any stage of a contracting relationship. Suppliers should be selected on the basis of quality, suitability, reliability and value for money.

*The Trust Board has adopted Standing Financial Instructions and a policy on the acceptance of gifts and hospitality (the Standards of Business Conduct Policy) which will be followed at all times by the Directors and all staff.*
5.1.6 Colleagues

The Directors acknowledge that colleagues must have a proper and widely publicised procedure for voicing complaints or concerns about maladministration, malpractice, breaches of this code and other concerns of an ethical nature.

The Directors affirm that:

- colleagues who have concerns should raise these reasonably and responsibly with the right parties as identified by the Trust;

- Trust gives a clear commitment that colleagues’ concerns will be taken seriously and investigated;

- the Trust gives an unequivocal guarantee that colleagues who raise concerns responsibly and reasonably in accordance with its policies will be protected against victimisation.

*The Board has adopted a Whistleblowing Policy (Raising Concerns) on raising matters of concern which will be followed at all times by the Directors and all colleagues.*

6. CODE PROVISIONS

6.1 Directors must:

- Act in the best interests of the Trust and adhere to its values and this Code of Conduct.

- Respect others and treat them with dignity and fairness.

- Seek to ensure that no one is unlawfully discriminated against because of their religion, belief, race, colour, gender, marital status, disability, sexual orientation, age, social and economic status or national origin

- Promote equal opportunities and social inclusion.

- Be honest and act with integrity and probity.

- Contribute to the workings of the Trust Board in order for it to fulfil its role and functions.

- Recognise that members of the Trust Board are collectively responsible for the exercise of its powers and the performance of the Trust, but raise concerns about the running of the Trust or a proposed action where appropriate.
• Recognise the unitary board framework and the need for cohesive, but objective decision making.

• Recognise the differing roles of the Chairman, Senior Independent Director, Chief Executive, Executive Directors and Non-Executive Directors.

• Make every effort to attend meetings where practicable.

• Adhere to good practice in respect of the conduct of meetings and respect the views of others.

• Take and consider advice on issues where appropriate.

• Acknowledge the responsibility of the Council of Governors to represent the interests of the Trust’s members and partner organisations in the local health economy in the governance of the Trust, and to have regard to the views of the Council of Governors.

• Respect the confidentiality of the information they are made privy to as a result of their role as a Director.

• Declare any conflict of interest to the Trust Board as soon as they become aware of it.

• Have regard to expected ethical standards of behaviour expected of Trust Board members.

• Not use their position for personal advantage or seek to gain preferential treatment. Act transparently, avoiding undue influence over others.

• Comply with the Trust’s Standards of Business Conduct Policy in relation to the acceptance of gifts and hospitality.

• Conduct themselves in such a manner as to reflect positively on the Trust, and be ambassadors of the Trust when attending events in their role as a Director.

• To only speak or take action on behalf of the Trust Board or the Trust after agreement with the Chairman or the Trust Board.

• Accept responsibility for their performance, learning and development.

7. BREACH OF CODE OF CONDUCT – ACTIONS

7.1 In the event that an individual Director breaches the principles of the Code, certain sanctions will apply and these will result in either a reprimand or in
serious incident suspension or ultimately dismissal in accordance with their terms
of engagement (where applicable).

The process will differ depending on whether the breach is by an Executive
Director, a Non-Executive Director or a non-voting Director

**Executive Directors**
In the case of an Executive Director, the matter will be dealt with by the
Chairman and, where considered necessary, the Non-Executives collectively.

**Non-Executive Directors**
Where a Non-Executive Director breaches the Code, the matter will be dealt with
by the Chairman, and where considered appropriate, the Council of Governors.

**Chairman**
In the event of the Chairman being in breach of the Code, the matter will be
handled by the Senior Independent Director (SID), and if considered appropriate
the SID will raise the matter with the Council of Governors.

**Non-voting Directors**
In the event of a non-voting Director being in breach of the Code, the matter will
be dealt with at the discretion of the Chief Executive, in conjunction with the
Chairman.

**Company Secretary**
In all instances, the Chairman and/or SID will be supported by the Company
Secretary.

**8. COMPLIANCE**

8.1 The Directors will satisfy themselves that the actions of the Trust Board and
its Directors in conducting Board business, fully reflect the values, general
principles and provisions in this Code and, as far as is reasonably practicable,
that concerns expressed by staff or others are fully investigated and acted upon.

8.2 For the purposes of the Health and Social Care Act 2008 (Regulated
Activities) (Amendment) Regulations, 2018, each Director will confirm that:

(a) they consider themselves to be of good character (appendix 1);
(b) they consider themselves to have the qualifications, competence, skills and
experience which are necessary for the relevant office or position or the
work for which they are employed;
(c) they consider that they are able, by reason of their health, after reasonable
adjustments are made, of properly performing tasks which are intrinsic to
the office or position for which they are appointed or to the work for which
they are employed;
(d) they have not been responsible for, privy to, contributed to or facilitated any
serious misconduct or mismanagement (whether unlawful or not) in the
course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity;

(e) none of the grounds of unfitness specified in Part 1 of Schedule 4 (appendix 2) apply to the individual;

(f) they have provided all information requested by The Rotherham NHS Foundation Trust in order to meet the requirements of Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations, 2018; and

(g) none of the automatic disqualifying rules issued by the Charity Commission (appendix 3) apply to the individual.

All Directors, on appointment, will therefore be required to subscribe to this Code of Conduct.

I the undersigned duly acknowledge the content of the Board of Directors Code of Conduct.

Signed: ........................................................................................................

Print: ........................................................................................................

Date ........................................................................................................

The content of the Code of Conduct will be reviewed on an annual basis and Board members will also be required to sign on an annual basis

(Updated September 2018, reviewed November 2019)
Appendix 1

CQC’s guidance sets out the procedure for when it receives information that potentially alleges a director is not of good character. While there is no statutory guidance on what constitutes "good character", it names the following features that are "normally associated" with good character that trusts should take into account when assessing an individual under FPPR, in addition to the matters specified in Part 2 of Schedule 4:

- honesty
- trustworthiness
- integrity
- openness
- ability to comply with the law
- a person in whom the public can have confidence
- prior employment history, including reasons for leaving
- if the individual has been subject to any investigations or proceedings by a professional or regulatory body
- any breaches of the Nolan Principles of Public Life
- any breaches of the duties imposed on directors under the Companies Act
- the extent to which the director has been open and honest with the trust
- any other information which may be relevant, such as disciplinary action taken by an employer.
Appendix 2

Part 1 of Schedule 4 lists categories of 'unfitness' that would prevent people from holding office or necessitate their removal from their position as a director, and for whom there is no discretion:

- the person is an undischarged bankrupt or a person whose estate has had a sequestration awarded in respect of it and who has not been discharged
- the person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland
- the person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986
- the person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it
- the person is included in the children’s barred list or the adults’ barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland
- the person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.
Appendix 3

You are automatically disqualified from acting as a trustee or senior manager if:

1. You have an unspent conviction for any of the following
   a) an offence involving deception or dishonesty
   b) a terrorism offence
      a. to which Part 4 of the Counter-Terrorism Act 2008 applies
      b. under sections 13 or 19 of the Terrorism Act 2000
   c) a money laundering offence within the meaning of section 415 of the Proceeds of Crime Act 2002
   d) a bribery offence under sections 1, 2, 6 or 7 of the Bribery Act 2010
   e) an offence of contravening a Commission Order or Direction under section 77 of the Charities Act 2011
   f) an offence of misconduct in public office, perjury or perverting the course of justice yes/no
   g) In relation to the above offences, an offence of: attempt, conspiracy, or incitement to commit the offence; aiding, or abetting, counselling or procuring the commission of the offence; or, under Part 2 of the Serious Crime Act 2007 (encouraging or assisting) in relation to the offence

2. You are on the sex offenders register (ie. subject to notification requirements of Part 2 of the Sexual Offences Act 2003)

3. You have an unspent sanction for contempt of court for making, or causing to be made, a false statement or for making, or causing to be made, a false statement in a document verified by a statement of truth

4. You have been found guilty of disobedience to an order or direction of the Commission under section 336(1) of the Charities Act 2011.

5. You are a designated person for the purposes of Part 1 of the Terrorist Asset-Freezing etc. Act 2010, or the Al Qaida (Asset Freezing) Regulations 2011.

6. You have previously been removed as an officer, agent or employee of a charity by the Charity Commission, the Scottish charity regulator, or the High Court due to misconduct or mismanagement

7. You have previously been removed as a trustee of a charity by the Charity Commission, the Scottish charity regulator, or the High Court due to misconduct or mismanagement

8. You have been removed from management or control of any body under section s34(5)(e) of the Charities and Trustee Investment (Scotland) Act 2005 (or earlier legislation)

9. You are disqualified from being a company director, or have given a disqualification undertaking, and leave has not been granted (as described in section 180 of the Charities Act) for you to act as director of the charity

10. You are currently declared bankrupt (or subject to bankruptcy restrictions or an interim order)

11. You have an individual voluntary arrangement (IVA) to pay off debts with creditors

12. You are subject to a moratorium period under a debt relief order, or a debt relief restrictions order, or an interim order

You are subject to an order made under s.429(2) of the Insolvency Act 1986. (Failure to pay under a County Court Administration Order.)
**Board of Directors’ Meeting**  
**09 April 2021**

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<td>Report</td>
<td>Chairman’s Report</td>
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<tr>
<td>Executive Lead</td>
<td>Presenter: Martin Havenhand, Chairman</td>
</tr>
<tr>
<td>Link with the BAF</td>
<td>The Chairman’s report reflects various elements of the BAF</td>
</tr>
<tr>
<td>How does this paper support Trust Values</td>
<td>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</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)

This report provides an update on a number of issues for the Board and also seeks the approval of Board committee membership for 2021/22.

- Board Assurance Committee proposed membership changes
- Appointment of new Non-Executive Directors
- Governor Engagement Group 16 March 2021
- Social Value Event 08 March 2021
- Board Seminar 10 March 2021
- NHS Confederation Annual General Meeting 11 March 2021
- NHS Providers Chairs and Chief Executives Network 16 March 2021
- Board Development
- Ambition Rotherham 17 March 2021
- The report also provides information from Non-Executive Director colleagues about activity in respect of their lead roles

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

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 document details that approving the membership and Chairmanship of Board Committees is a matter which it has reserved unto itself.

**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 proposed Board committee membership for 2021/22 (appendix 1)

**Appendices**

1. Board Committee membership 2021/22
2. Corporate Calendar 2021
1.0 Introduction

1.1 This report provides an update since the last Board Meeting on 05 March 2021.

2.0 Board Assurance Committee proposed membership changes

2.1 There are a few proposed changes to membership of our Board committees. Attached at Appendix 1 is the revised Board Assurance Committee membership for 2021/22.

3.0 Non-Executive Directors

3.1 As I mentioned in my report to the March 2021 Board of Directors meeting, two of our Non-Executive Director colleagues are be stepping down this year: Joe Barnes’ term of office ended on 31 March 2021 and Mark Edgell’s term of office will end on 31 May 2021.

3.2 The Governors have gone through an appointment process and the Council of Governors has approved the following appointments.

3.3 Michael Killick has been appointed as the Non-Executive Director with experience of audit and risk from 01 April 2021 for three years.

3.4 Dr Joanne Bibby has been appointed as the Non-Executive Director with experience of the wider determinants of health including health inequalities. Her term of office will also be for three years from 01 June 2021.

3.5 In addition Kamran Malik has been appointed as an Associate Non-Executive Director for a twelve month period from 01 April 2021.

4.0 Governor Engagement Group 16 March 2021

4.1 The Governor Engagement Group met to review the significant work that had been done about communicating the forthcoming public Governor elections. It was also mentioned that all public Governors and partner Governors had been invited to join the recently established Public Panel.

5.0 Social Value Event 08 March 2021

5.1 The Social Value event was organised and hosted by Rotherham Metropolitan Borough Council. The Leader, Councillor Chris Read, and the Chief Executive, Sharon Kemp, explained the background to Rotherham’s social value policy and then introduced three private sector companies who each explained how they were operating to achieve social value. Of particular relevance was the presentation by Julie Dalton, Managing Director of Gulliver’s Valley who explained how the company had evolved over the last 40 years and had always addressed social value as part of its business model.

6.0 Board Seminar 10 March 2021

6.1 Assurance Committee Chairs’ Logs

We took the opportunity to further refine the production of the Chairs’ assurance logs for presentation to Board meetings. Everybody agreed that the introduction of the Chairs’ logs had been a positive improvement in providing the Board with different levels of assurance.
6.2 Five Year Strategy
The Board at its last meeting received a report on the process for producing a new five year strategy for the Trust. At the seminar we took the opportunity to further refine the process and understand the next steps.

6.3 Operational plan 2021/22
Board members had a further opportunity to consider the key issues which will form our Operational Plan for 2021/22. The outcome of the seminar will be presented to the April 2021 Board meeting.

6.4 Financial Governance
Board members received a presentation on good financial governance which provided an opportunity to reflect on the improvement which had been made during the year.

7.0 NHS Confederation Annual General Meeting 11 March 2021

7.1 I attended this event which included a debate on Mental Health and Wellbeing led by Professor Neil Greenberg (a psychiatrist) and Isobel Hardman (a journalist and author of books on the NHS).

7.2 A few key points for the Board to consider as part of our Staff Health and Wellbeing plans emanating from this event included:
- Post COVID-19 we should not just be focussing on recovery but ‘building back better’
- Our people should come first, before recovery of services.
- What is the impact on work impairment?
- How do we achieve equality of service delivery in the future?
- We need to understand ‘moral injury’: our staff members’ desire to deliver quality care versus the number of sick patients
- Teams that have a good link with their line manager can be more resilient
- Resilience is more effective across individuals in teams
- Important to provide managers with some psychological skills to support colleagues with 1:1 discussions
- Ensure staff take leave now as this will achieve better results in the medium to long term
- Handling this right will produce huge dividends
- Investment in staff now will pay dividends later
- Establish return to work interviews: how are you? how is your family? what can we do to make the next few months better for you?
- Arrange reflective practice sessions
- Some people will need mental health treatment
- How do we get people to ask for help when they need it?
- There is an armed forces covenant which provides ongoing mental health support caused in action. There are proposals to establish a similar covenant for NHS staff post COVID-19
- Proper ‘thank yous’ are so important

8.0 NHS Providers Chairs and Chief Executives Network 16 March 2021

8.1 Chris Hopson, NHS Providers’ Chief Executive, emphasised that recovery should be clinically-led rather than just clearing the backlog. Prerana Issar, Chief People Officer at NHS England / Improvement, provided a presentation on issues affecting staff in the NHS:
• The national health and wellbeing offer has been accessed on 700,000 occasions by 500,000 employees
• Trusts should be considering enhanced occupational health services due to the impact of COVID-19 and the increase in mental health cases
• 85% of NHS Trusts now have Black, Asian and Minority Ethnic (BAME) networks
• Since April 2020 we have recruited 8,100 international nurses and 3,400 retired nurses have returned to the NHS
• It is pleasing to note that 95% of front line staff have been vaccinated against COVID-19
• Recent Workforce Race Equality Standard (WRES) indicators show that 10% of current Non-Executive Directors and Chairs are from the BAME community. However the progress in recruiting the numbers at Executive level is still slow.
• Health and wellbeing and staff morale has improved in the recent national staff survey. Experience shows that action plans for improvement at team level are the most effective.
• In respect of recovery, the focus is on people, activity and finance. That is patient recovery, people recovery and financial sustainability.
• Recovery will be at the individual level and there will be many ups and downs. We should be looking at recovery and then supporting colleagues to re-engage in their roles using an approach of reflect, recovery and engage. Health and wellbeing needs to be embedded in organisational practices going forward
• Reflective practice resource is important
• Mental health hubs must be available to staff who need mental health support
• Let’s invest in people recovery then we will get better activity recovery
• Job planning can be a key part of planning for recovery
• We all need to be more impatient about health inequalities
• We are all trying to build back better through our recovery plans, but we also need to build back fairer
• ‘Help me manage my guilt and help me focus on what I have achieved’
• She is proposing that more staff Pulse surveys are introduced and she is looking to systems to develop equality, diversity and inclusion (EDI) plans and also much improved recruitment plans.

9.0 Board Development

9.1 The Board had a further Board Development session facilitated by Integrated Development which focussed on the production of the Trust’s Five Year Strategy.

10.0 Ambition Rotherham 17 March 2021

10.1 The Rotherham Together Partnership Place Board Ambition Rotherham met to review the progress made in retaining and developing the Rotherham Pioneers business network. A revised terms of reference for Ambition Rotherham Board was approved for recommendation to the next meeting of the Rotherham Together Partnership.

10.2 On 19 March 2021 I spoke at the Rotherham Pioneers event to explain the transition from Ambition Rotherham to a new, not for profit company.
11.0 Lead Non-Executive Director (Heather Craven)

11.1 Safeguarding Non-Executive Director lead: Since the March Board meeting Heather has attended the Operational Safeguarding monthly meeting and the Rotherham Safeguarding Children’s Partnership Executive meeting. She has also met separately with the Chief Nurse, the Mental Capacity Act Lead and the Named Nurse for Adult Safeguarding.

11.2 Community Division Non-Executive Director lead: Heather attended the first Community Division Governance meeting

12.0 Lead Non-Executive Director (Rumit Shah)

12.1 Dr Shah attended the Resuscitation Committee Meeting on 04 March 2021 at which ward based cardiac arrest drills and the results of the Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) audit undertaken in October 2020 and resulting actions were discussed.

13.0 Lead Non-Executive Director (Lynn Hagger)


13.2 On 04 March 2021 Lynn attended the Yorkshire and Humber Regional Chairs’ Collaborative. This highlighted the good levels of transplant in the region and the impressive number of awards, commendations, posters and presentations at the recent annual Congress. The UK is a world leader in heart retrieval and transplantation generally and the ability to transplant adult hearts into children is now possible as a result of work carried out here. The NHS Blood and Transplant (NHSBT) marketing team presented the ‘Leave Them Certain’ campaign to encourage families to have discussions about their donation wishes to address the gap between intention and behaviour. The role of Ambassadors and the Donor Family Network were described and the former, together with enthusiastic Governors, were thought to be a useful addition to Organ Donation Committees with respect to supporting outreach work. Since this meeting I have arranged for Mahmud Nawaz, an Ambassador from elsewhere in the region, and Mac MacPherson, Public Governor, to attend the next Organ Donation Committee.

13.3 Senior Independent Director (SID): Joe Barnes (the Trust’s SID until end March 2021) and Lynn had a handover meeting with Tony Bennett, Freedom to Speak Up Guardian and Head of Security, on 04 March 2021 to discuss both roles and gained assurance that the security position is robust given a recent simulation and an actual incident.

13.4 Maternity Services Non-Executive Director lead: Lynn attended her first Maternity and Neonatal Safety Champion meeting on 24 February 2021 (meetings are held on a monthly basis). She received helpful guidance through the many processes in place to enhance patient safety.

13.5 On 18 March 2021 Lynn attended the Advancing Quality Alliance (AQuA) Safety Culture Programme for Maternity and Neonatal Leaders Co-design Session. This was a forum for gaining insight into what training and support Champions require. The information gleaned to be used in further development sessions. Champion roles are embryonic but some Trusts have greater involvement of their Non-Executive Director (NED) leads than
others. Being able to be present physically is a great advantage in becoming familiarised with services and processes. Most NED champions she met had their photographs on relevant walls to highlight their role and liaised with their local Maternity Voices Partnership group which provide useful feedback on services.

13.6 On 19 March 2021 Lynn attend the Maternity and Neonatal Safety Champion Meeting. In addition to routine matters, her role was discussed including how it may evolve and Angela Wood, Chief Nurse and Executive Champion for Maternal and Neonatal Safety, and Lynn plan to consider this further.

13.7 The AQuA Maternity & Neonatal Safety Leadership Programme Launch Event on 24 March 2021 set the scene for the forthcoming programme. It highlighted the commitment to safe, personal and equal care and the significant improvement made in the key metrics associated with maternity and neonatal care over the last five years. However, there is still work to be done, which recent scandals illustrate only too well. Key themes emerge from these: poor leadership, poor culture, staffing / rota challenges, poor transparency and weak governance at Board level. It was recommended that relatively rare adverse incidents (e.g. maternal or neonatal death) should be considered in detail in the private part of the Board meeting. There needs to be a culture of safety and continuous improvement in an atmosphere of psychological safety and include a code of conduct or equivalent. A key way to address health inequalities is to provide care differently with lower thresholds for face to face meetings, a higher rate of continuity of carer and a linked obstetrician who is accessible. It is also crucial to listen to service users through the Maternity Voices Partnership and use them for service design, development and evaluation.

13.8 **Family Health Division Non-Executive Director lead:** On 26 February 2021 Lynn attended a catch up session with the Family Heath Division. The main ‘take away’ message from this meeting was that some processes need to be improved but that new clinical leadership will facilitate this.

13.9 **Health and Wellbeing Guardian:** On 04 March 2021 Lynn had a discussion with Chris Bott, Staff Governor, about seeking staff views on Health and Wellbeing at a forthcoming Staff Governor Surgery. The webinar on 10 March entitled ‘Caring4NHSPeople’ explored how the recovery of NHS staff will enable the recovery of our services and highlighted a range of useful approaches including Pulse surveys (which have now been procured for longer term use); ProjectM which aims to forge virtual support communities and the training available at a national level so that line managers etc may gain more confidence in having skilful health and wellbeing conversations as part of routine activities. NICE guidelines suggest Trusts should monitor health and wellbeing for a number of years.

13.10 On 25 March 2021 Lynn had a catch up meeting with the Surgery Divisional leadership to discuss health and well-being.

13.11 **Clinical Ethics Non-Executive Director lead:** the UK Clinical Ethics Network webinar entitled ‘The Function and Constitution of Clinical Ethics Committees’ held on 22 February 2021 looked at their authority and the lack of appropriate guidance regarding the rationing of critical care. An example of a well-functioning committee was provided which used an ethics grid, sent its minutes to the Board and invited patients / families to attend where appropriate. A further webinar on the same day entitled ‘Guiding Ethical and Legal Principles in the Pandemic’ used the Norwegian and German approach to ethical frameworks to address the rationing process as a basis for discussion.
14. Lead Non-Executive Director (Nicola Bancroft)

14.1 **Procurement Non-Executive Director lead:** Nicola attended a discussion session for providers on the ‘NHS Provider Selection Regime’, hosted by NHS England and NHS Improvement. To inform the consultation process, the presentation covered the following areas:
- Overview of statutory Integrated Care Systems (ICS)
- Aims of the provider selection regime
- Regime application and decision circumstances
- Key criteria for decision making
- Transparency and scrutiny
- Conflicts of interest
- Patient choice and any qualified provider arrangements.

Much of the discussion centred on cultural change, the use of the Private Sector and the need to understand what is working well within specific ICS’s.

14.2 Nicola met with the Trust’s Head of Procurement to review the latest Procurement Strategy Board Metrics in order to understand on and off track performance and the implications for 2021/22 plan priorities. In addition, it was discussed how best practice procurement in non-NHS organisations might be used to inform the thinking on new ways of working and initiatives for 2021/22. Key procurement and category management specialists have been suggested from the retail sector.

14.3 Nicola attended a webinar, hosted by the Healthcare Financial Management Association (HFMA), on ‘Moving to a value-based healthcare approach to contracts with industry’, which showcased a particular collaboration from the University Hospital Southampton NHS Foundation Trust.

14.4 **Lord Carter Non-Executive Director lead:** Nicola met with Michael Wright, Deputy Chief Executive, to understand what work had been undertaken within the Trust on the Lord Carter Review recommendations to drive productivity and efficiency. It was agreed that a review of the work, alongside other relevant external benchmarking information, should be used to inform how the Cost Improvement Programme Board agrees efficiency targets for the new financial year.

14.5 In her roles as Chair of the Finance and Performance Committee and member of the Audit Committee, Nicola attended a webinar on ‘Year-end accounting issues 2020/21’, led by Grant Thornton. The focus of the presentation was on ‘Value for Money’ audit work and the impact of COVID-19 on financial reporting in the NHS.

14.6 In addition, following recent reviews of two key business cases at the Finance and Performance Committee for the Patient Flow Command Centre and Discharge Lounge Development, Nicola undertook a site visit with the Trust’s Deputy Chief Operating Officer and Director of Estates and Facilities. Nicola reviewed the key positive changes for colleagues and patient outcomes and was able to personally thank colleagues for their tremendous efforts in driving these initiatives at pace.

Martin Havenhand
Chairman, March 2021
## Board Committee Membership 2021/22

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### Notes:
1. Kamran Malik, Associate Non-Executive Director, will be attending one assurance committee each Board cycle on a rotational basis: People Committee, Quality Committee and Finance & Performance Committee.
2. Executive ‘attendees’ do not count towards the quorum and neither are they voting members. It is not expected that they will provide regular reports to the committee. However, it is envisaged that their attendance will bring greater depth and understanding to support the assurance role of the committee.
3. The Chairman or Chief Executive may attend any committee meeting as an ex officio, non-voting attendee.
4. The Company Secretary may attend any committee meeting as part of their governance role.
5. EL* = non-member, non-voting committee lead Executive.
6. First four committees on the chart = assurance committees.
7. Charitable Funds Committee included for information – requires approval of Corporate Trustee.

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April Board meeting 2021
Corporate Calendar 2021

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**Key:**

- **Board of Directors**
- **Finance & Performance Committee**
- **People Committee**
- **Audit Committee**
- **Quality Assurance Committee**
- **Council of Governors**
- **Executive Team Meetings**
- **Senior Leaders Meeting**
- **Lead Exec: DoF**
- **Lead Exec: DoW**
- **Lead Exec: DoF**
- **Lead Exec: CN**

**Dates in blue indicate date of Board paper circulation**

**Lead Exec: CEO**

53
The Rotherham NHS Foundation Trust

Revised Board and Committee meeting schedule following “What we might do less of” review - March 2021 to June 2021

<table>
<thead>
<tr>
<th>Meeting</th>
<th>March 2021</th>
<th>April 2021</th>
<th>May 2021</th>
<th>June 2021</th>
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</table>
| Board      | 05.03.21   | 09.04.21   | 07.05.21 (to include financial plan if info from NHSEI available – SD to advise) | 04.06.21 for normal business plus review of “what we might do less of”.  
Plus extraordinary confidential meeting on the afternoon of 11.06.21 to approve final accounts prior to submission no later than 12 noon 15.06.21 |
<p>| Audit      | No meeting planned | 30.04.21 | Provisionally scheduled for 25.05.21 but as timeline for final account pushed back now cancelled and rearranged for June 2021 | 08.06.21 to review and recommend Final Accounts / Annual Report to Board |
| People     | 26.03.21   | Meeting planned for 23.04.31 cancelled | 21.05.21 | Meeting planned for 25.06.21 cancelled |
| FandP       | Meeting as planned on 31.03.21 only for 1.5 hrs and to include Integrated Financial Report, draft SFI update and budget 2021/22 update | 28.04.21 (to include financial plan if info from NHSEI available – SD to advise) | Meeting on 26.05.21 for review of Final Accounts / Annual Report prior to June Audit Committee and any urgent business cases only | 30.06.21 |
| Quality    | 31.03.21   | 28.04.21   | 26.05.21 | 30.06.21 |
| COG        | No meeting | No meeting | 12.05.21 | No meeting |
| Governors Forum | 31.03.21 | No meeting | No meeting | 30.06.21 |
| Board Seminar | 10.03.21 | No seminar | 12.05.21 | 09.06.21 |</p>
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<tr>
<th>Meeting</th>
<th>March 2021</th>
<th>April 2021</th>
<th>May 2021</th>
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<tr>
<td>Board Development Session</td>
<td>No session</td>
<td>06.04.21 MW and LT to liaise with MH re facilitation and content of session</td>
<td>No session</td>
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<td>Corporate Trustee</td>
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<td>No meeting</td>
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<td>Charitable Funds Committee</td>
<td>No meeting</td>
<td>14.04.21</td>
<td>No meeting</td>
<td>01.06.21</td>
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### Agenda item
P70/21

### Report
Chief Executive Report

### Executive Lead
Dr Richard Jenkins, Interim Chief Executive

### Link with the BAF
The Chief Executive’s report reflects various elements of the BAF.

### How does this paper support Trust Values
The contents of the report have bearing on all three Trust values.

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

### Executive Summary
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.

### Due Diligence
This paper reports directly to Trust Board.

### Board powers to make this decision
No decision is required.

### Who, What and When
No action is required.

### Recommendations
It is recommended that:
- The Board note the contents of the report.

### Appendices
1. Integrated Care System CEO Update Report for March 2021
2. Communications in relation to the stepping down of the children’s emergency surgery pathway
3. NHSE/I Guidance on Finance and Contracts Arrangements for H1 2021/22
1.0 COVID-19

1.1 Activity: Overall numbers of Covid-19 positive inpatients have continued to fall during March and are currently between 20 and 30. I am pleased to report that critical activity for Covid-19 patients is now low and has been down to zero cases.

Whilst the numbers of positive tests in the community have risen, and is currently amongst the highest level nationally, it is felt that this is to some degree driven by the change in testing regime and particularly Lateral Flow Testing in schools and families of staff and pupils. As a result of this, asymptomatic cases which previously would have gone undetected are now also being picked up. A further factor may be that the more transmissible ‘New Variant’ that arose in Kent last year, reached this area later and this may explain why activity hasn’t yet settled as has been seen elsewhere.

It is also worth noting that the rates in the over 60s is now the lowest they have been for some time (51.3, down from around 250 at the peak of this last wave). The highest rates currently are in the under 18s.

The formal Gold command structure remains in place, however this has been reduced in terms of frequency of meetings and now meets twice weekly. Silver Command has also reduced the frequency in line with the reduction in cases.

1.2 Vaccination: The Trust has now commenced the process of second dose vaccinations to staff and Health and Social Care colleagues. The programme will run for approximately four weeks and is expected to be complete by the end of April 2021 and currently over 3000 appointments have been scheduled. In conjunction with this, a communication has been sent to all staff and managers encouraging those who have not taken up the offer to receive their first dose to do so.

1.3 Recovery: The Trust continues to work on its recovery programme in collaboration with the wider Integrated Care System and other hospitals. The new planning guidance, referred to below, describes the approach the NHS will take to address this over the 2021-22 year. As well as the recovery of activity, there is a major focus on the health and wellbeing of staff which resonates well with the Trust’s intentions.

2.0 Staff Update

2.1 The embargo date for the results of the National Staff Survey has now passed and the full report has been published. A presentation on the results was shared at the confidential session of the Board last month and work is now ongoing by Divisions and Departments to develop detailed action plans, which will report through the People Committee. I am very pleased to report that the Trust ranked 3rd in a recent HSJ analysis on the national survey in terms of the most improvement compared to last year for the key question ‘I would recommend my organisation as a place to work’. Similarly, the Trust ranked 5th most improved nationally on 'minority ethnic staff experiencing discrimination from colleagues/managers' (Health Service Journal 15th March 2021).

This is fantastic news and is exceptionally positive particularly as the survey was undertaken during the peak of the second wave of the pandemic. However, this takes the Trust to an overall position that could be described as average for Trusts and we need to make much more effort over the next year to build on the improvements.
3.0 Divisional and Corporate Leadership update

3.1 The posts of Divisional Director in both Surgery and Medicine remain vacant but the roles have been advertised externally with the closing date being 25th March 2021. Interviews are due to take place on 13th April 2021. (No applications as of 22.03.21)

3.2 The Director of Corporate Governance vacancy has attracted considerable interest and interviews will be held on 23rd April 2021. I would like to thank Jill Dentith for her excellent work over recent months in providing support for this role. Jill’s last working day in the interim role will be 8th April 2021 and Julie Dawes will cover the period from 6th April 2021 until the substantive appointee joins the Trust.

4.0 Integrated Care System (ICS) and Rotherham place development

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

4.2 Work is ongoing within the Rotherham place to design new ways for the local organisations to work effectively in partnership to deliver the new integrated care approach described in the recent White Paper. Once clear proposals are produced, partner organisations will be asked to consider and approve a new approach.

5.0 Children’s Emergency Surgery Pathway

5.1 The ICS Children’s Network Manager has written to the Local Resilience Forum to confirm that formal agreement has been given by the Health and Care Management Team to step down the paediatric emergency surgery pathway, which was stepped up on the 2nd November 2020 as part of the system response to the 2nd wave of the Covid-19 pandemic. Appendix 2 provides the detail for information.

6.0 Care Quality Commission update

6.1 The Trust continues to meet with CQC colleagues every fortnight. Delivery of the two key action plans is on track and is monitored weekly through the Executive Team meeting.

7.0 NHSE/I Guidance on Finance and Contracts Arrangements

7.1 NHSE/I published its guidance on Finance and Contracts arrangements for the six-month period from 1 April 2021 to 30 September 2021. These arrangements are supported by an additional £8.1bn of funding provided by government, of which £7.4bn is available over the first half of 2021/22 to reflect the on-going impact of Covid-19. A key focus of the ‘planning guidance’ is recovery which is underpinned by five major priorities for the next year. A detailed analysis of the guidance is in train and plans will be brought through committees to Board in due course. Please see the key documents in Appendix 3.

8.0 Reciprocal mentoring

8.1 The Trust was selected in late 2020 to participate in the National Leadership Academy’s Reciprocal Mentoring for Inclusion Programme. An initial information session about reciprocal mentoring was held with Board members and a number of BAME, Disabled and LGBT+ Trust colleagues who had expressed an interest in joining the programme in November 2020.
Following some delays to the launch of the national programme, an initial meeting was held between the Trust and the Leadership Academy in early February 2021. Further progress since this initial meeting has been slow due to a lack of responsiveness from the Leadership Academy, thought to be linked to a combination of restructurings and redeployment to Covid-19 related work. Further clarity is currently being sought from the Leadership Academy as to likely delivery timescales. Board members and staff who have expressed an interest in the programme will be invited to undertake some informal, semi-structured discussions around their aspirations for the programme in late April/early May. The Trust’s Staff Networks have been informed of the delay and that the Trust remains committed to reciprocal mentoring.

Dr Richard Jenkins
Interim Chief Executive
April 2021
# Chief Executive Report

**Health Executive Group**

9 March 2021

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<th>Andrew Cash</th>
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<td>Links to the ICS Five Year Plan (please tick)</td>
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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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<th>Broadening and strengthening our partnerships to increase our opportunity</th>
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<td>✓ Delivering a new service model</td>
<td>✓ Partnership with the Sheffield City Region</td>
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<td>✓ Transforming care</td>
<td>✓ Anchor institutions and wider contributions</td>
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<td>✓ Making the best use of resources</td>
<td>✓ Partnership with the voluntary sector</td>
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<td>✓ Commitment to work together</td>
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| 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 provides a summary update on the work of the South Yorkshire and Bassetlaw health and care partners for the month of February 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.
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 health and care partners for the month of February 2021.

2. Summary update for activity during February

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

South Yorkshire and Bassetlaw (SYB) continues to experience a downward trend in COVID-19 infections across the five places in common with the wider North East and Yorkshire region where the rolling seven-day rate of positive cases is 150 per 100,000 population.

Sheffield currently has a reduction in positive COVID-19 cases (now below 100 per 100,000 population) compared with the rest of SYB, with Barnsley and Doncaster experiencing a similar steady decrease also. Whilst there are slightly higher rates in Bassetlaw and Rotherham, the overall picture is one that is showing a gradual decline in community infections, and an overall feeling of optimism that SYB has passed the peak of the third wave.

The number of hospital admissions is falling faster than the number of new cases, with the fall in hospitalisations also faster among the age groups already vaccinated (compared with those in younger age groups yet to get a jab). This steady decline in admissions, particular among the COVID-19 vaccination priority groups (1-4), has the added positive effect on reducing hospital bed occupancy rates - much improved since early October 2020.

Data from the Office for National Statistics shows that Covid-related deaths across Yorkshire and the Humber are around 320 per week (as per the latest report) with the trend steadily decreasing.

Whilst there are small increases in the infection rate among individuals of a working age (16 – 64), and particularly within younger age groups, we are not seeing any stacking (incidental passing of the virus to older generations in their family or household who are more likely to develop serious illness).

Similarly, as a result of the good weather at the end of February, mobility data shows that more people were leaving the house for walking which saw a steady increase in park use and workplace visitations. Data and reports also suggest that people are still very much abiding by the rules.

In summary, the news is encouraging and means that we are starting to see the parallel impact of SYB’s vaccination programme and lockdown restrictions curtailing the spread of COVID-19.
2.1.1 SYB Vaccination Programme

We are now more than 12 weeks into the vaccination programme with over 20 million people in the UK having now received their first dose of a COVID-19 vaccine. In SYB, over 415,000 have now received their vaccination as of 2nd March.

To support the national target, SYB Vaccination Programme Steering Group met last week to discuss modelling and supply lines and we remain on-track to meet our 18 April target to vaccinate JCVI priority groups 5-9.

2.1.2 Additional funding to tackle vaccine inequalities

An additional 100k funding been awarded to SYB to support the improved vaccine uptake among Black Asian and Minority Ethnic (BAME) groups. It is part of the national pot of £4.2 million pounds being made available to deliver the COVID-19 vaccine deployment programme. This NHS funding complements the £1.4m awarded to councils and voluntary organisations in the five SYB places in February to support those most at risk from COVID-19 and boost vaccine take up.

The funding will help 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.

These developments to help reduce vaccine inequality were further boosted by the addition of individuals on the GP learning disability register now being fast-tracked for a COVID-19 vaccination in England (as part of Group 6), equating to an additional 150,000 people, supporting some of our most vulnerable groups across SYB.

2.1.3 National Vaccination Programme

To further support the national roll-out, NHS England and NHS Improvement (NHS E/I) issued a letter setting out the key priorities and actions for immediate review.

The letter pays particular focus in the areas of ensuring maximum reach/uptake across Joint Committee on Vaccination and Immunisation (JCVI) priority cohorts, including second dose planning and delivery preparations for vaccination when supplies increase. There are also new recommendations around how to boost vaccination uptake from within social care staff groups.

At this point, two million more invites will sent to people aged 60 to 63 years-old with Primary Care Networks continuing to invite their patients (of all ages) who are particularly at risk due to a health condition/or living with a learning disability.

This follows the news of sixteen frontline charities (including The British Heart Foundation, Macmillan Cancer Support and Mencap) joining up to form a new partnership to encourage those with long-term health conditions and their carers to get the COVID-19 vaccine.

2.2 Regional update

The North East and Humber Regional ICS Leaders continue to meet 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 February focused on recovery and military supported planning, ICS development, the COVID-19 response and vaccination programme.

2.3 National update

On February 11th 2021, the same day the Department for Health and Social Care published its White Paper Integration and Innovation: working together to improve health and social care for all,
NHS England and NHS Improvement (NHS E/I) set out its response to its earlier engagement on Integrating Care: Next Steps and its recommendations to government.

The document, *Legislating for Integrated Care Systems: five recommendations to Government and Parliament*, makes recommendations to Government on the question of how to legislate to place Integrated Care Systems (ICSs) on a statutory footing, having gathered the views of the NHS, local government and wider stakeholders. The recommendations built on the successful integration, collaboration and partnership efforts of ICSs to date. The recommendations are:

- **Legislative recommendation 1**: The Government should set out at the earliest opportunity how it intends to progress the NHS’s own proposals for legislative change.

- **Legislative recommendation 2**: ICSs should be put on a clear statutory footing, but with minimum national legislative provision and prescription, and maximum local operational flexibility. Legislation should not dictate place based arrangements.

- **Legislative recommendation 3**: ICSs should be underpinned by an NHS ICS statutory body and a wider statutory health and care partnership. Explicit provision should also be made for requirements about transparency.

- **Legislative recommendation 4**: There should be maximum local flexibility as to how an ICS health and care partnership is constituted, for example using existing arrangements such as existing ICS partnership boards or health and wellbeing boards where these work well.

The composition of the board of the NHS ICS body must be sufficiently streamlined to support effective decision-making. It must be able to take account of local circumstances as well as statutory national guidance.

Legislation should be broadly permissive, mandating only that the members of the NHS ICS Board must include a chair and CEO and as a minimum also draw representation from (i) NHS trusts and Foundation Trusts, (ii) general practice, and (iii) a local authority. As with CCGs now, NHSE/I should approve all ICS constitutions in line with national statutory guidance.

- **Legislative recommendation 5**: Provisions should enable the transfer of primary medical, dental, ophthalmology and pharmaceutical services by NHS England to the NHS ICS body. Provision should also enable the transfer of delegation by NHS England of appropriate specialised and public health services we currently commission. And at the same time, NHS England should also retain the ability to specify national standards or requirements for NHS ICSs in relation to any of these existing direct commissioning functions.

2.4 Department for Health and Social Care white paper Integration and Innovation: working together to improve health and social care for all

On February 11th 2021, the Department for Health and Social Care published its White Paper *Integration and Innovation: working together to improve health and social care for all*.

As anticipated, the White Paper proposals follow the journey of integrating care in neighbourhoods, places and across the system that we have been on across SYB for many years and is designed to support us by removing many of the obstacles that stand in our way on a daily basis. It builds on the ambitions of the Long-Term Plan to tackle health inequalities through a whole population health approach, to plan for improvements in health and health care at system level and to work in partnerships at place and in provider collaboratives. This will allow us to join up care and to ensure that no matter where people live, they have the same opportunity to access services and the opportunity to level up health outcomes across the system.
ICSs will be established, to include an NHS body and a Health and Care Partnership

The NHS body will be:

- Responsible for strategic planning, taking on the commissioning functions of CCGs and be directly accountable for NHS spend and performance within the system, with its chief executive becoming the accounting officer for NHS money allocated to the NHS ICS body
- As a minimum, include a chair, the chief executive and representatives from NHS trusts, general practice and local authorities, with others determined locally. ICSs will also need to ensure they have appropriate clinical advice when making decisions
- Responsible for developing a plan to meet the health needs of the population within their defined geography; developing a capital plan for the NHS providers within their health geography; and securing the provision of health services to meet the needs of the system population.

The Health and Care Partnership will be responsible for developing a plan that addresses the wider health, public health and social care needs of the system, with the NHS ICS board and local authorities having to regard that plan when making decisions.

SYB health and care partners have agreed a framework for taking forward the proposals and this is set around the four key building blocks of an ICS:

- Place Partnerships
- Provider collaboratives
- Future commissioning and how the nature of commissioning will change
- ICS operating model

In addition, there are two enabling work streams:

- HR and people transition
- ICS Financial framework

An ICS Development Steering Group, made up of partners from across the ICS, has been formed to oversee all workstreams and it is working on a Compact for the Health and Care Partnership to support the direction of travel in the 2021/22 transition years and until the Bill is enacted. The Compact is based around the SYB quadruple aim of better health and wellbeing for the whole population, better quality care for all patients, sustainable services for the taxpayers, reduction in health inequalities. The HCP roles, responsibilities and terms of reference are also being developed as part of the work.

In the coming weeks, we expect to conclude the governance arrangements for the transition year and capture the outputs from the wider workstreams. This will include a review of the existing meeting arrangements to streamline them where possible.

At the same time, we are embarking on a collective approach to the transition with staff working in CCGs, the ICS PMO and NHS E/I. All four ICSs in the North are taking a consistent approach with agreed HR principles that build on the FAQs that came out with the white paper. These are minimum disruption, smooth transition, reducing anxiety, employment commitment and “one workforce”, while recognising the importance of place and place teams.

National HR principles to guide the transition and further guidance after the second reading of the Bill are expected in due course. In the meantime, the HR transition is being supported by Christine Joy, ICS Change and HR/OD Programme Lead from the national HR and OD team. Christine is working closely with the ICS to develop an inclusive engagement approach with staff to minimise uncertainty and enable us to work together to co-create the new SYB ICS NHS Body.
2.5 Government roadmap for England

The release of the Government’s four-step roadmap on February 22nd outlined the plan for the coming months. The plan will be punctuated by five-week intervals to assess the impact at every phase, with ‘data not dates’ being used to guide and steer the decision-making process on future relaxations. It will be assessed against the data performance in four key areas:

1. Vaccine deployment - the programme continuing successfully.
2. Variants of Concern - the assessment of the risks is not fundamentally changed by new strains.
3. Hospitalisations and deaths in those vaccinated - evidence showing vaccines are sufficiently effective in reducing both numbers.
4. Surge in hospitalisations causing high concern - infection rates do not translate into unmanageable spikes in new cases that would put unsustainable pressure on the NHS.

Benchmarking against these measures will be vital and will take place over four-week intervals, allowing public health teams to safely evaluate effectiveness of each new phase. If the data at these check-points show a worsening position or public health concern, the dates and timelines may be altered accordingly. If each of the criteria is met, this will trigger a seven-day notice to proceed with the next step of relaxations.

2.6 What Matters to You

World Cancer Day took place on Thursday 4 February and as part of the commitment to providing high quality, personalised care for patients who experience cancer, the South Yorkshire and Bassetlaw Cancer Alliance has launched an important new initiative to help shift the focus of health and care professionals from, “What is the matter with you” to “What matters to you?”

Every person is different. As is their journey and experience of cancer. In partnership with Voluntary Action Rotherham (VAR) the What Matters To You initiative provides an online learning platform for any health and care professional in contact with people with a cancer diagnosis to become a Certified Care Professional.

Launching primarily within the voluntary and community sector, we hope that the What MattersTo You certification becomes synonymous with quality personalised care which can be recognised by both professionals and patients throughout South Yorkshire and Bassetlaw.

2.7 QUIT Programme

The funding agreement with Yorkshire Cancer Research has now been signed which will secure £1.8m to support the delivery of the QUIT Programme. This will fund the appointment of 45 whole time equivalent specialist Tobacco Treatment Advisors (TTAs) who will help deliver QUIT across SYB NHS Trusts in the Programme.

The first Trusts (Barnsley Hospital NHS Foundation Trust and the Rotherham, Doncaster and South Humber NHS Foundation Trust) are now recruiting and the first TTAs will be in post by May 1, 2021. They will be supported by the Trust Healthy Hospital Programme Managers and Health Improvement Managers.

The QUIT Programme recognises that smoking is an addiction, a preventable illness that can and should be treated - NOT a lifestyle choice. It will ensure that treatment for tobacco dependency is built into the routine care offered to every patient attending any hospital in South Yorkshire and Bassetlaw. Support and treatment will also be available for Trust staff who wish to quit and for parents of paediatric patients.

A wide range of training and treatment resources have been put together and will be accessible through a dedicated QUIT website that will go live at the beginning of April.
Nearly 200,000 people smoke in South Yorkshire and Bassetlaw. More than half of those people will die prematurely from smoking-related illness, losing on average 10 years of life. Decreasing the prevalence of smoking is a key Long Term Plan ambition for South Yorkshire and Bassetlaw Integrated Care System and a major strand to our developing health inequalities plan.

The QUIT Programme is based on evidence from Ottawa, Canada, and if it proves as successful in South Yorkshire and Bassetlaw, we have the potential to save 2,000 lives and up to 4,000 hospital readmissions in a year.

2.8 Voluntary, Community and Social Enterprise SRO Update

In recent months, the ICS strengthened and embedded partnership working with the VCSE within the SYB system with the formation of the South Yorkshire and Bassetlaw Voluntary Community and Social Enterprise (VCSE) Leaders Group and the appointment of Catherine Burn as ICS VCSE Senior Responsible Officer (SRO).

Catherine, who is both Director at Bassetlaw Community and Voluntary Services (BCVS) and Chair of the Bassetlaw Place Partnership, is stepping down from her role at BCVS at the end of March 2021 to take up a new appointment in Cumbria. Catherine has been on the integrated care journey with SYB from the very beginning when we started life as a Sustainability and Transformation Partnership in 2016, through to becoming an Integrated Care System in October 2018. Throughout the last five years she has provided VCSE leadership and been instrumental in establishing strategic partnerships with the voluntary sector. We have been extremely fortunate to have such an experienced and talented VCSE leader in our system and we wish Catherine all the very best in her new role.

The VCSE Leaders Group will now discuss and agree which of its members will take on the VCSE SRO role and put forward their recommendation to the HEG in due course.

2.9 SYB Reporting Radiographer Academy

Twelve new trainee radiographers started their training at the SYB Reporting Radiographer Academy in January 2021. There have been many challenges to getting the Academy started this year and it is credit to the team that the trainees are now well underway with the programme. When fully trained, the radiographers will go on to provide crucial extra support for image reporting across South Yorkshire and Bassetlaw.

3. Finance update

The financial position at Month 10 forecasts a surplus of £42.7m which is £6.6m better than the Month 9 forecast and £46.6m better than the planned deficit of £3.9m. Forecast capital slippage against plan is £21m. This will allow the system to meet its two key financial targets for the year.

The planning round for 21/22 has been deferred and the financial framework that has been in place for months 7/12 20/21 will be rolled forward to Q1 and possibly to Q2. No decision has yet been taken on the financial framework for the remainder of the financial year. System capital envelopes are due out shortly with an indicative timetable of mid-April for submission of system capital plans.

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

Date: 4 March 2021
To: Eithne Cummins, Clinical Director, NHS 111 Service

Stepping down the Paediatric Emergency Surgery Pathway (Covid-19 response) from 22nd March 2021

We are writing to you to confirm that formal agreement has been given by the Health and Care Management Team to step down the paediatric emergency surgery pathway, which was stepped up on the 2nd November 2020 as part of the system response to the 2nd wave of the Covid-19 pandemic. In the last 14 weeks 293 children in South Yorkshire and Bassetlaw have successfully been transferred to Sheffield Children’s Hospital, with 126 requiring emergency surgery within 24 hours.

The pathway was re-established as part of the Covid-19 response to workforce and hospital capacity concerns enabling DGHs to release anaesthetists and other staff from paediatric services to support adult services and focus on patients presenting with Covid-19.

The data evidence now shows a reduction in the number of Covid-19 patients across all acute Trusts, with DGHs stating they are in a position to resume emergency surgery. Chief Executives have agreed that this is now an appropriate time to step down the pathway.

As you know, following conversations with colleagues in 111 in October we agreed not to change the 111 referral pathway for surgery. This letter is therefore for information, and will not involve any change to 111’s dispositions.

- From the 22nd March 2021 Barnsley, Bassetlaw, Doncaster and Rotherham will resume all emergency surgery within their Trusts with two exceptions:
  - Appendectomies for the under-8s will be transferred from all SYB DGHs to Sheffield Children’s as per the permanent pathway put in place last June.
  - Maintaining the diversion for torsion of the testes 24/7, 7 days a week from Barnsley and Doncaster and Bassetlaw to Sheffield Children’s.

We will continue to monitor review children’s emergency surgery with Trusts through the SYB PMO weekly Care of the Acutely Unwell Child monitoring group. Should it be necessary, the emergency surgery pathway can be stepped back up to support a surge of Covid-19.
We would like to take this opportunity to thank your contribution to help create a safe pathway under difficult circumstances for NHS services.

We will keep you updated on any further developments but if you have any questions or queries please don’t hesitate to get in touch.

Kind Regards

Nicola Ennis
ICS Children’s Network Manager
To: Simon Enright, Medical Director, Barnsley Hospital NHS Foundation Trust

Dear Simon

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We would like to take this opportunity to thank you and your colleagues for all their time and input into developing, implementing and monitoring of this pathway. Their contributions have been invaluable and we have really enjoyed working with them.
We will keep you updated on any further developments but if you have any questions or queries please don't hesitate to get in touch.

Kind Regards

Nicola Ennis
ICS Children’s Network Manager
To: Timothy Noble, Medical Director, Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Dear Tim

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We would like to take this opportunity to thank you and your colleagues for all their time and input into developing, implementing and monitoring of this pathway. Their contributions have been invaluable and we have really enjoyed working with them.
We will keep you updated on any further developments but if you have any questions or queries please don’t hesitate to get in touch.

Kind Regards

Nicola Ennis
ICS Children’s Network Manager
To: Leon Roberts, Medical Director, East Midlands Ambulance Service

Dear Leon

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  - We are also maintaining the diversion for torsion of the testes 24/7, 7 days a week from Barnsley and Doncaster and Bassetlaw to Sheffield Children’s.

We will continue to monitor review children’s emergency surgery with Trusts through the SYB PMO weekly Care of the Acutely Unwell Child monitoring group. Should it be necessary, the emergency surgery pathway can be stepped back up to support another surge of covid-19.

We would like to take this opportunity to thank you and your colleagues once again for their time towards monitoring of this pathway.
We will keep you updated on any further developments but if you have any questions or queries please don’t hesitate to get in touch.

Kind Regards

Nicola Ennis
ICS Children’s Network Manager
To: GP Practices/Primary Care providers/OOH providers

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We would like to take this opportunity to thank you and your colleagues for all their time and input into developing, implementing and monitoring of this pathway. Their contributions have been invaluable and we have really enjoyed working with them.

We will keep you updated on any further developments but if you have any questions or queries please don’t hesitate to get in touch.
Kind Regards

Nicola Ennis
ICS Children’s Network Manager
LOCAL RESILIENCE FORUM -

INFORMATION FOR STAFF WHOSE WORK INVOLVES SAFEGUARDING CHILDREN

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While the pathway has been operating, Sheffield Children’s Hospital has had links to safeguarding teams across South Yorkshire and Bassetlaw, in the event of any safeguarding concerns being raised about any child on the new pathway.

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- As the pathways step down, the normal (pre-covid) arrangements around safeguarding will be in place.

We will continue to monitor review children’s emergency surgery with Trusts through the SYB PMO weekly Care of the Acutely Unwell Child monitoring group. Should it
be necessary, the emergency surgery pathway can be stepped back up to support another surge of covid-19.

We will keep you updated on any further developments but if you have any questions or queries please don’t hesitate to get in touch.

Kind Regards

Nicola Ennis
ICS Children’s Network Manager
To: Jeff Perring, Medical Director, Sheffield Children’s NHS Foundation Trust

Dear Jeff

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We will keep you updated on any further developments but if you have any questions or queries please don’t hesitate to get in touch.

Kind Regards

Nicola Ennis
ICS Children’s Network Manager
To: Callum Gardner, Medical Director, The Rotherham NHS Foundation Trust

Dear Callum

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We will keep you updated on any further developments but if you have any questions or queries please don't hesitate to get in touch.

Kind Regards

Nicola Ennis
ICS Children’s Network Manager
To: Steven Dykes, Deputy Medical Director, Yorkshire Ambulance Service

Dear Steven

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We will keep you updated on any further developments but if you have any questions or queries please don’t hesitate to get in touch.

Kind Regards

Nicola Ennis
ICS Children’s Network Manager
2021/22 priorities and operational planning guidance

25 March 2021
Thank you to you and your teams for your extraordinary efforts over the last year. On 29 January we marked 12 months since we started to treat this country’s first patients with COVID-19 and began to see the impact of the pandemic on our health services. Since then, with thanks to the whole NHS team, we have treated over 390,000 people with COVID-19 in hospitals, and many more in primary, community and mental health care. We have continued to deliver other essential services, treating over 275,000 people with cancer and dealing with increases in urgent and emergency demand.

At the time of writing, the NHS has delivered more than 26 million COVID-19 vaccinations to people across England, and is on course to hit its target of offering a first dose of the vaccine to all people in the top nine priority groups by 15 April. Data shows that the vaccination programme is having a significant impact on transmission rates and, coupled with the public’s adherence to social restrictions, this means that hospitalisation rates have been falling across all regions and local areas.

While this gives us cause for optimism, we do not yet know what the pattern of COVID-19 transmission will look like over the next 12 months and it is clear that the impact of the last year will be felt throughout 2021/22 and beyond. As we rise to the challenge of restoring services, meeting the new care demands and reducing the care back logs that are a direct consequence of the pandemic, we know that it has also taken its toll on our people. By supporting staff recovery, their health and wellbeing and improving workforce supply we can restore services in a sustainable way.

The pandemic has shone a brighter light on health inequalities. We will need to take further steps to develop population health management approaches that address inequalities in access, experience and outcomes, working with local partners across health, social care, and beyond. To support this, we have set out five priority areas for tackling health inequalities that systems are asked to give particular focus to in the first half of 2021/22 (see accompanying guidance). Tackling inequalities of outcome is also central to the investments we will make this year to improve outcomes on cancer, cardiovascular disease, mental health and maternity services as well as to expand smoking cessation and weight management services.

To achieve these goals, while restoring services and recovering backlogs, will require us to do things differently, accelerating delivery against and redoubling our commitment to strategic goals we all agreed in the Long Term Plan (LTP). The NHS has shown this year it’s ability to adapt, develop new services at scale and pace and has, for example, made real strides in embedding digital approaches to patient care. We now need to build on these improvements alongside the development of system working and collaboration.
Effective partnership working across systems will be at the heart of this and the financial framework arrangements for 2021/22 will therefore continue to support a system-based approach to funding and planning.

It is within this context that we are setting out our priorities for the year ahead:

A. Supporting the health and wellbeing of staff and taking action on recruitment and retention

B. Delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with COVID-19

C. Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services

D. Expanding primary care capacity to improve access, local health outcomes and address health inequalities

E. Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (ED), improve timely admission to hospital for ED patients and reduce length of stay

F. Working collaboratively across systems to deliver on these priorities.

The Government has agreed an overall financial settlement for the NHS for the first half of the year which provides an additional £6.6bn + £1.5bn for COVID-19 costs above the original mandate. The financial settlement for months 7-12 will be agreed once there is greater certainty around the circumstances facing the NHS going into the second half of the year. In addition, £1.5bn funding has been allocated for elective recovery, mental health and workforce development.

While we are setting out priorities for the full year, we are therefore asking systems to develop fully triangulated plans across activity, workforce and money for the first half of the year. For mental health we can provide funding for the full year and these plans should therefore extend to 12 months (see accompanying guidance).

A. Supporting the health and wellbeing of staff and taking action on recruitment and retention

Our people need to be at the heart of plans for recovery and transformation and those plans should reflect the need for staff to get the support, rest and recuperation that they need. For
the first half of 2021/22, we are asking systems to review and refresh their people plans to reflect the progress made in 2020/21, as well as to show: greater progress on equality, diversity and inclusion; progress on compassionate and inclusive cultures; and increasing workforce supply. These themes were highlighted as part of the review of local plans in September 2020.

A1 Looking after our people and helping them to recover

Different people will need to recover from the demands of the pandemic in different ways, and staff safety remains a priority. Employers need to put support in place to help staff given what they have been through over the last 12 months.

• We encourage trusts to allow staff to carry over all unused annual leave and offer flexibility for staff to take or buyback unused leave. System financial performance assessment will exclude higher accruals for annual leave in 2020/21. All staff should be encouraged to take time off to recover, making use of annual leave which may be carried over from 2020/21.

• Individual health and wellbeing conversations should be a regular part of supporting all staff with an expectation that a plan is agreed at least annually and should take place over the course of first half of the year. Staff safety remains a priority and these plans should include risk assessment, flexible working, compliance with infection prevention and control policy, and testing policy, as well as drawing on the range of preventative health and wellbeing support available.

• Occupational health and wellbeing support should be available to all staff, including rapid access to psychological and specialist support. We will provide national investment to roll out mental health hubs in each ICS and to expand.

A2 Belonging in the NHS and addressing inequalities

COVID-19 has surfaced inequalities that can be harmful to our people and addressing this remains an urgent priority. We expect systems to:

• develop improvement plans based on the latest WRES findings, including to improve diversity through recruitment and promotion practices

• accelerate the delivery of the model employer goals.

A3 Embed new ways of working and delivering care

During the pandemic, our people adopted innovative ways of working to make best use of their skills and experience to benefit our patients. Now is the time to embed those workforce transformations to support recovery and longer-term changes:
• Providers should maximise the use of and potential benefits of e-rostering, giving staff better control and visibility of their working patterns, supporting service improvements and the most effective deployment of staff. Providers are asked to show how they intend to meet the highest level of attainment as set out by our ‘meaningful use standards’ for e-job planning and e-rostering.

• Local systems are also encouraged make use of interventions to facilitate flexibility and staff movement across systems, including remote working plans, technology-enhanced learning and the option of staff digital passports.

A4 Grow for the future

During the pandemic we were able to grow our workforce through a range of innovative measures that helped us to successfully deal with COVID-19 while treating patients with a range of other conditions. Now we need to take steps to sustainably increase the size of our workforce in line with measures set out in the NHS Long Term Plan. Systems are asked to:

• Develop and deliver a local workforce supply plan with a focus on both recruitment and retention, demonstrating effective collaboration between employers to increase overall supply, widen labour participation in the health and care system, and support economic recovery.

• Ensure system plans draw on national interventions to introduce medical support workers (MSWs), and make use of associated national funding, increase health care support workers (HCSWs) and international recruitment of nursing staff.

• Support the recovery of the education and training pipeline by putting in place the right amount of clinical placement capacity to allow students to qualify and register as close to their initial expected date as possible.

• Develop and implement robust postgraduate (medical and dental) training recovery plans that integrate local training needs into service delivery planning.

• Ensure that workforce plans cover all sectors – mental health, community health, primary care and hospital services. The plans should support the major expansion and development of integrated teams in the community, with primary care networks (PCNs) serving as the foundation, assisted to make full use of their Additional Roles Reimbursement Scheme funding, including through the options of rotational or joint employment.
B. Delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with COVID-19

Offering a first dose to the adult population by the end of July remains key to saving lives, reducing the likelihood of increased pressure on the NHS, and reducing the spread of COVID-19 as social distancing is eased. This will continue to be delivered through implementing a mixed model of vaccine delivery through vaccination centres, hospital hubs, general practice and community pharmacy capacity. The precise local model will vary according to the needs of the local population and include targeted approaches where these are required to increase uptake, particularly in under-served populations.

General practice will retain an important role in the COVID-19 vaccination programme, with PCN groupings having the option to vaccinate cohorts 10-12 (18-49 year olds) (when the national supply availability means those groups can begin to be vaccinated) if they can also fulfil the requirements of the GMS contract.

It is not currently known for how long people who receive a COVID-19 vaccine will be protected. This is because, as is the case with many vaccines, the protection they confer may weaken over time. It is also possible that new variants of the virus may emerge against which current vaccines are less effective. The Joint Committee on Vaccination and Immunisation (JCVI) will issue advice in due course and systems will need to consider:

- being prepared for a COVID-19 re-vaccination programme from autumn, with high uptake ambitions for seasonal flu vaccination, alongside:
- the possibility of COVID-19 vaccination of children, should vaccines be authorised for use in under 18s and recommended by the JCVI in this population.

PCNs will also have an important ongoing role in response to the pandemic that will involve the continued use of home oximetry, alongside hospital-led ‘virtual wards’, proactive care pathways delivered virtually in people’s homes. As well as enabling safe and more timely discharge, COVID Virtual Wards have the potential to support some COVID patients who would otherwise be admitted to hospital. Systems are encouraged take this into account as they continue to prepare for any future potential surge requirements for COVID patients.

We will continue national funding to maintain the dedicated Post COVID Assessment clinics that have been established and all systems are asked to ensure that they provide timely and equitable access to Post COVID Syndrome (‘Long COVID’) assessment services.
We will also conduct a stocktake of both physical critical care capacity and workforce, which will inform next steps in creating a resilient and sustainable service. This will include critical care transfer services.

All NHS organisations should ensure continued reliable application of the recommendations in the UK Infection Prevention and Control guidance updated by Public Health England to reflect the most up-to-date scientific understanding of how to prevent and control COVID-19 infection.

C. Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services

The pandemic has had a significant impact on NHS activity, and while the majority of care and activity has been maintained through the winter and the second wave, elective care has been disrupted and there are new demands on mental health services.

During the pandemic collaboration across providers helped ensure that every COVID-19 patient requiring hospital treatment received it and staff could work where they were most needed. In addition, pathway changes were rapidly implemented, helping ensure patients were only in hospital if they needed to be. This same approach will now help us transform the design and delivery of services across systems, to reduce unwarranted variation in access and outcomes, redesign clinical pathways to increase productivity, and accelerate progress on digitally-enabled care. In 2021/22 we will:

C1 Maximise elective activity, taking full advantage of the opportunities to transform the delivery of services

The pandemic has had a significant impact on the delivery of elective care and, as a result, on the lives of many patients who are waiting for treatment. We need to be ambitious and plan to recover towards previous levels of activity and beyond where possible over the next few years. An additional £1bn funding has been made available to the NHS in 2021/22 to support the start of this recovery of elective activity, and the recovery of cancer services. Systems are asked to rapidly draw up delivery plans across elective inpatient, outpatient and diagnostic services for adults and children (including specialised services) for April 2021 to September 2021 that:

- maximise available physical and workforce capacity across each system (including via the Independent Sector- IS), learning from other systems and taking into account the high-impact changes including adapting the ward environment to enhance flow
and physical segregation of patients,¹ segregating elective care flow through the hospital and developing service transformation initiatives to drive elective recovery

• prioritise the clinically most urgent patients, eg for cancer and P1/P2 surgical treatments

• incorporate clinically led, patient focused reviews and validation of the waiting list on an ongoing basis, to ensure effective prioritisation and manage clinical risk (drawing on both primary and secondary care)

• include actions to maintain effective communication with patients including proactively reaching out to those who are clinically vulnerable

• address the longest waiters and ensure health inequalities are tackled throughout the plan, with a particular focus on analysis of waiting times by ethnicity and deprivation

• safeguard the health and wellbeing of staff, taking account of the need for people to recover from what they have been through

Given these factors, systems are asked to plan for the highest possible level of activity. We understand that current restrictions affect output. The Government has made additional funding available to allow systems to step activity back up and so systems that achieve activity levels above set thresholds, ie the levels funded from core system envelopes, will be able to draw down from the additional £1bn Elective Recovery Fund (ERF) for 2021/22. The threshold level is set against a baseline value of all elective activity delivered in 2019/20, allowing for available funding, workforce recovery and negative productivity impacts of the pandemic through 2021/22. For April 2021 it will be set at 70%, rising by 5 percentage points in subsequent months to 85% from July.

Acute providers’ access to the ERF will be subject to meeting ‘gateway criteria’ including addressing health inequalities, transformation of outpatient services, implementing system-led elective working, tackling the longest waits and supporting staff.

The remaining national contracts between NHS England and acute independent sector providers end on 31 March and local commissioning will be restored. Targeted collaborative partnerships with IS providers to support delivery of system capacity plans will continue be an important element of elective recovery plans. Over the next 2 months we will explore with system leaders and IS providers evolved mechanisms for effective working, contracting and

¹ In line with infection prevention and control guidance published by Public Health England
planning to establish how we can most effectively use IS capacity to support recovery over the next two to three years.

Systems are asked to recover elective activity in a way that takes full advantage of elective high-impact changes and transformation opportunities, and demonstrates learning from other systems, in particular:

- Create clear accountability for elective recovery, and implement key supporting tools, at system level, including common tracking of waiting lists; clinical review and prioritisation; dynamic planning of elective capacity and shared capacity, demand and monitoring data.

- Maximise opportunities to implement high impact service models in elective care at system level such as dedicated fast track hubs for high volume, low complexity care with standardised clinical pathways; dedicated elective service pathways within acute sites; elective activity coordination hubs for booking and scheduling across sites to tackle backlogs at system level.

- To reduce variation in access and outcomes, systems are expected to implement whole pathway transformations and thereby improve performance in three specialties: cardiac, musculoskeletal (MSK) and eye care with support via the National Pathway Improvement Programme. The aim should be to achieve what was top quartile performance against benchmarks on those pathways, and we will ask the National Pathway Improvement Programme in conjunction with GIRFT to support the development of and accredit plans as part of the national elective recovery programme.

- Embed outpatient transformation, taking all possible steps to avoid outpatient attendances of low clinical value and redeploying that capacity where it is needed, alongside increased mobilisation of Advice & Guidance and Patient Initiated Follow-Up services. Where outpatient attendances are clinically necessary, at least 25% should be delivered remotely by telephone or video consultation (equivalent to c.40% of outpatient appointments that don’t involve a procedure). Initial activity goals and the gateway to access ERF have been set to reflect the feedback on not incentivising the avoidance of clinically unnecessary referrals and appointments. For the second half of the year we anticipate a national data collection and counting methodology. In future we will use this to inform the way in which the payment system further supports implementation of these reforms.

- Access available support to help deploy the innovative approaches to optimising workforce capacity that are best suited to local system needs, including system wide...
Recovery of the highest possible diagnostic activity volumes will be particularly critical to support elective recovery. Capital and revenue funding have been made available to deliver additional capacity and efficiencies through new Community Diagnostic Hubs (CDHs) and pathology and imaging networks. All systems are expected to work with regions to deliver increased capacity to meet the diagnostic needs for their population, in line with the recommendations of the Richards review. System plans should set out their proposals for how this additional capacity will be delivered, including through the development of CDHs.

In order to tackle the backlog, systems will when feasible need to return to, and in time and with support, move above 2019/20 baseline of activity. We will look to support systems who can identify and develop innovative and transformative approaches to restore activity to above pre-pandemic levels, with mechanisms to ensure that the insights generated can be applied across the NHS.

C2 Restore full operation of all cancer services

NHS staff have worked hard to prioritise cancer services during the pandemic, and the overwhelming majority of cancer treatment has continued. However, some people have not contacted their GP with symptoms. Local systems, drawing on advice and analysis from their Cancer Alliance, will ensure that there is sufficient diagnostic and treatment capacity in place to meet the needs of cancer to:

- return the number of people waiting for longer than 62 days to the level we saw in February 2020 (or to the national average in February 2020 where this is lower) and

- meet the increased level of referrals and treatment required to address the shortfall in number of first treatments by March 2022.

The national cancer team will support local systems and Cancer Alliances to learn from each other, and to plan by providing estimates of the level of additional referrals and treatment required to address the shortfall.

Cancer Alliances are asked to draw up a single delivery plan on behalf of their integrated care systems(s) ICSs) for April 2021 to September 2021 to deliver the following actions:

- **Getting patients to come forward**
  - work with GPs and the local population to increase the number of people coming forward and being referred with suspected cancer, with a particular focus on groups under-represented among those who have come forward. Systems should
actively support their practices as they complete the QOF Quality Improvement module on early cancer diagnosis, which has been continued into 2021/22 as part of GP contract arrangements, and

– work with public health commissioning teams to restore all cancer screening programmes. This should include using the additional £50m investment committed funding for breast cancer screening to meet national standards and to recover backlogs by end March 2022. We will also begin to extend bowel cancer screening to include 50-60 year olds, with rollout to 56 year olds from April 2021.

• Investigate and diagnose
  – extend the centralised clinical prioritisation and hub model established during the pandemic for cancer surgery to patients on cancer diagnostic pathways (starting with endoscopy where appropriate), ensuring a joint approach across cancer screening and symptomatic pathways

  – using national service development funding Alliances are encouraged to:
    – increase take up of innovations like colon capsule endoscopy and Cytosponge to support effective clinical prioritisation for diagnostics
    – accelerate the development of Rapid Diagnostic Centre pathways for those cancer pathways which have been most challenged during the pandemic and
    – restore first phase Targeted Lung Health Check projects at the earliest opportunity, and begin planning the launch of the Phase 2 projects.

• Treat
  – embed the system-first approach to collaboration established during the pandemic – including centralised clinical triage and centralised surgical hubs where appropriate – as an enduring legacy of the pandemic

  – agree personalised stratified follow up (PSFU) pathways in three additional cancer types and implement one by March 2022, in addition to breast, prostate and colorectal cancer.

Systems will be expected to meet the new Faster Diagnosis Standard from Q3, to be introduced initially at a level of 75%. To support delivery, Faster Diagnosis Standard data will begin to be published from spring 2021. Systems should, as soon as possible, also ensure a renewed focus on improving performance against the existing Cancer Waiting Times standards. Cancer Alliances are asked to draw up on behalf of their ICS(s) an action plan for improving operational performance, with a particular focus on pathways which are most adversely affecting overall performance.
C3 Expand and improve mental health services and services for people with a learning disability and/or autism

Our mental health workforce has continued to provide people with the support they need during the pandemic. We know, however, that COVID-19 has not only affected the delivery of services but is also likely to cause an increase in demand.

The ambitions set out in the Mental Health Implementation Plan 2019/20–2023/24, which expand and transform services, remain the foundation for our mental health response to COVID-19, enabling local systems to expand capacity, improve quality and tackle the treatment gap. An additional £500m of funding has been made available in 2021/22 to address the impact of COVID-19.

In 2021/22 we expect local systems to:

- Deliver the mental health ambitions outlined in the Long Term Plan, expanding and transforming core mental health services (and in doing so prepare for implementation of recommendations for Clinical Review of Standards for mental health). This includes:
  - continuing to increase children and young people’s access to NHS-funded community mental health services, noting the revised metric and importance of continued focus on quality of care
  - delivery of physical health checks for people with Serious Mental Illness (SMI), noting that GPs will be incentivised to deliver the checks in 2021/22 via a significant strengthening of relevant QOF indicators
  - investing fully in community mental health, including funding for new integrated models for Serious Mental Illness (adult and older adult) and SDF funding to expand and transform services. To support this a new metric will measure those accessing community mental health services. To support integration with general practice, the NHS contract and GP contract have introduced new co-funding requirements for embedded additional PCN posts.

- maintain transformations and beneficial changes made as part of COVID-19, where clinically appropriate, including 24/7 open access, freephone all age crisis lines and staff wellbeing hubs

- maintain a focus on improving equalities across all programmes, noting the actions and resources identified in the Advancing Mental Health Equalities Strategy

- have a workforce strategy and plan that delivers the scale of workforce growth required to meet LTP ambitions
• enable all NHS Led Provider Collaboratives to go live by 1 July 2021

• ensure that all providers, including in scope third sector and independent sector providers, submit comprehensive data to the Mental Health Services Data Set and IAPT Data Set

• have a strategy and effective leadership for digital mental health, and ensure that digitally-enabled models of therapy are rolled out in specific mental health pathways.

All CCGs must, as a minimum, invest in mental health services to meet the Mental Health Investment Standard.

It is vital to continue to make progress on our LTP commitments for people with a learning disability, autism or both. We need to make progress on the delivery of annual health checks for people with a learning disability. We also need to improve the accuracy of GP Learning Disability Registers to make sure the identification and coding of patients is complete, in particular for under-represented groups such as children and young people and people from Black, Asian and Minority Ethnic backgrounds.

Systems will be expected to maintain a strong commitment to reducing reliance on inpatient care for both adults and children with a learning disability, autism or both. This will be supported by improved community capacity to enable more people to receive personalised care, closer to home. Pilots and early adopter sites for keyworkers for children and young people with the most complex needs will continue, with remaining areas preparing for delivery in 2022/23.

To tackle the inequalities experienced by people with a learning disability highlighted and exacerbated by the pandemic, systems are asked to implement the actions coming out of LeDeR reviews. The national programme requirement is for 100% of reviews to be completed within six months of notification.

**C4 Deliver improvements in maternity care, including responding to the recommendations of the Ockenden review**

Donna Ockenden’s interim report has challenged everyone who works in maternity services to redouble efforts to continue to improve outcomes and patient experience and to reduce unwarranted variation. All trusts have completed an assurance assessment tool and reported it though systems as set out in the [14 December letter](#) from Amanda Pritchard, Ruth May and Steve Powis. For 2021/22 we are investing more than £80m of additional funding to improve maternity safety and meet the Immediate and Essential Actions from the [Ockenden report](#).
Local maternity systems (LMSs) should be taking on greater responsibility for ensuring that maternity services are safe for all who access them, and should be accountable to ICSs for doing so. As part of their work to make maternity care safer, more personalised and more equitable, they should oversee local trust actions to implement the seven immediate and essential actions from the Ockenden report.

Systems are expected to continue delivery of the maternity transformation measures set out in the Long Term Plan, including offering every woman a personalised care and support plan, implementing all elements of the Saving Babies’ Lives care bundle, and making progress towards the implementation of the continuity of carer model of midwifery.

Further detail on the full set of actions and priorities under these broad headings is set out in the accompanying guidance.

D. Expanding primary care capacity to improve access, local health outcomes and address health inequalities

The Long Term Plan committed to a significant real terms expenditure increase on primary medical and community health services to improve prevention and keep people out of hospital. In 2021/22 this commitment will again be met and will support:

• restoring and increasing access to primary care services

• implementing population health management and personalised care approaches to improve health outcomes and address health inequalities and

• transforming community services and avoiding unnecessary hospital admissions and improving flow, in particular on the emergency pathway.

D1 Restoring and increasing access to primary care services

The success of the COVID vaccination programme has proven beyond doubt the value and potential of PCNs. Systems should continue to prioritise local investment and support for PCN development, including enabling stronger integration of care with community-based services.

PCNs are the critical enabler of workforce expansion in general practice. All systems are expected to support their PCNs to:

• achieve their share of 15,500 FTE PCN roles to be in place by the end of the financial year, in line with the target of 26,000 by 2023/24
• expand the number of GPs towards the 6,000 target, with consistent local delivery of national GP recruitment and retention initiatives and thereby

• continue to make progress towards delivering 50 million more appointments in general practice by 2024.

National funding for general practice capacity also continues through an additional £120m in first half of the year, which will taper in the second quarter as COVID pressures decrease.

Overall appointment volumes in general practices remain high. Systems are asked to support those practices where there are access challenges so that all practices are delivering appropriate pre-pandemic appointment levels. This includes all practices offering face-to-face consultations. Systems are asked to continue to support practices to increase significantly the use of online consultations, as part of embedding total triage.

Practices continue to reach out to clinically vulnerable patients and, as set out in section C. Systems should support their PCNs to work closely with local communities to address health inequalities. The ongoing effort to tackle the backlog of clinically prioritised long-term condition management reviews, including medication reviews and routine vaccinations will be supported via the re-introduction of QOF indicators from April.

The Community Pharmacy Consultation Service (CPCS) has been extended, as part of the existing advanced service, to include the ability to receive referrals from General Practice and support the management of low acuity patients in alternative settings, supporting workload pressures. Local pharmacy contractors, PCNs and GP practices should be working with their local LPC, LMC and regional teams to agree implementation of this service locally prior to being able to receive referrals.

For dental services, the focus is on maximising clinically appropriate activity in the face of ongoing infection prevention control measures, and targeting capacity to minimise deterioration in oral health and reduce health inequalities. We will continue to support dental teams to deliver as comprehensive a service as possible.

**D2 Implementing population health management and personalised care approaches to improve health outcomes and address health inequalities**

COVID-19 has highlighted the correlation between poorer health outcomes and ethnicity and deprivation, specifically. Systems are encouraged to adopt population health management techniques as part of their targeted recovery strategies, aiming for equitable access, excellent experience and optimal outcomes for all groups. NHS England and NHS Improvement will continue to work with systems to develop the real-time data tools and techniques being used so effectively by the COVID vaccination programme, at a granular
local level. It also includes the use of person-centred segmentation and risk stratification to identify at-risk groups, those with the greatest health inequalities or the most complex needs, and those awaiting multiple appointments. Systems should provide proactive, multi-disciplinary, cross sector support to these patients, in line with the NHS Comprehensive Model for Personalised Care.

The NHS Long Term Plan sets out a path for improvements for people with conditions such as diabetes, CVD and obesity. These are even more important given we now know the clear association with poorer outcomes with COVID-19. We are asking systems to develop robust plans for the prevention of ill-health, led by a nominated SRO, covering both primary and secondary prevention deliverables as outlined in the Long Term Plan. These plans should set out how ICS allocations will be deployed in support of the expansion of smoking cessation services, improved uptake of the NHS diabetes prevention programme and CVD prevention. The NHS digital weight management services will also be made more widely available following additional government investment announced in March. Systems are also asked to review their plans and make progress against the LTP high impact actions to support stroke, cardiac and respiratory care.

Delivering the NHS Comprehensive Model for Personalised Care, thereby giving people more control over their own health, will underpin systems’ efforts to recover services and address health inequalities. Systems will continue and, where possible, accelerate the delivery of existing requirements, including personal health budgets, social prescribing referrals and personalised care and support plans. In 2020/21 1 million personalised care interventions were delivered and we expect at least 1.2 million to be delivered in 2021/22 in line with our LTP ambition. Implementation will be supported by recruitment to three additional roles funded through the ARRS: Social Prescribing Link Workers, Health and Wellbeing Coaches, and Care Coordinators.

E. Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments, improve timely admission to hospital for ED patients and reduce length of stay

E1 Transforming community services and improve discharge

With national transformation funding and the increase in primary and community care services funded through baseline allocations we are asking every system to set out plans to accelerate the rollout of the 2-hour crisis community health response at home to provide consistent national cover (8am-8pm, seven days a week) by April 2022. Additional transformation funding will be released subject to those plans and a commitment by all
community service providers to provide complete and accurate data to the Community Services Dataset (CSDS) in 2021/22.

Systems have achieved significant reductions in long stays during 2020/21 equivalent to freeing up 6,000 beds and 11,000 staff across acute and community settings. All providers should continue to deliver timely and appropriate discharge from hospital inpatient settings and seek to deliver an improvement in average length of stay with a particular focus on stays of more than 14 and 21 days. To support this we will continue to fund the first six weeks of additional care after discharge from an NHS setting during the first quarter and first four weeks from the beginning of July. We will review the position with Government for the second half of the year.

Together, these actions will enable more patients to be cared in the optimal setting and will reduce the pressure on our hospitals by improving flow through the emergency pathway and freeing up capacity to support the restoration of elective care.

E2 Ensuring the use of NHS111 as the primary route to access urgent care and the timely admission of patients to hospital who require it from emergency departments

Systems are asked to continue to progress the work already underway through the NHS 111 First and Same Day Emergency Care programmes. Specifically, systems should:

• promote the use of NHS 111 as a primary route into all urgent care services

• maximise the use of booked time slots in A&E with an expectation that at least 70% of all patients referred to an emergency department by NHS 111 receive a booked time slot to attend

• maximise the utilisation of direct referral from NHS 111 to other hospital services (including SDEC and specialty hot clinics) and implement referral pathways from NHS 111 to urgent community and mental health services

• adopt a consistent, expanded, model of SDEC provision, including associated acute frailty services, within all providers with a type 1 emergency department to avoid unnecessary hospital admissions.

To assess the level of pressure within urgent and emergency care systems and monitor their recovery, systems are asked during Q1 to roll out the Emergency Care Data Set (ECDS) to all services and implement the collection of those measures that are not already in place, including:

• the time to initial assessment for all patients presenting to A&E
• the proportion of patients spending more than 12 hours in A&E from time of arrival

• the proportion of patients spending more than one hour in A&E after they have been declared Clinically Ready to Proceed.

A response to the consultation to the UEC clinically-led review of standards will be published in due course, and with agreement with government on next steps. For the first part of the year, systems are asked to focus on implementing data collection, and UEC recovery.

F. Working collaboratively across systems to deliver on these priorities

F1 Effective collaboration and partnership working across systems

The priorities set out in this guidance will only be delivered through effective partnership working across systems, including effective provider collaboration and place-based partnerships with local government. The accompanying guidance sets out the expectations for how ICSs are expected to build on existing arrangements during 2021/22. These requirements include having system-wide governance arrangements to enable a collective model of responsibility and decision-making between system partners.

ICSs will be asked to set out, by the end of Q1, the delivery and governance arrangements that will support delivery of the NHS priorities set out above. These must be set out in a memorandum of understanding (MOU) and agreed with regional NHS England and NHS Improvement teams. In line with the proposed new NHS System Oversight Framework the MOU will also be expected to set out the oversight mechanisms and structures that reflect these delivery and governance arrangements, including the respective roles of the ICS and regional NHSEI team.

F2 Develop local priorities that reflect local circumstances and health inequalities

ICSs across the country entered the pandemic with a varying range of circumstances and different health groups with a range of needs. COVID-19 has exacerbated this disparity and, in recovering services, systems now face varying challenges.

In recognition of these challenges, systems are asked to develop their own set of local health and care priorities that reflect the needs of their population, aligned to the four primary purposes of an ICS:

• improving outcomes in population health and healthcare

• tackling inequalities in outcomes, experience and access
• enhancing productivity and value for money
• helping the NHS support broader social and economic development.

F3 Develop the underpinning digital and data capability to support population-based approaches

Meeting population need requires smart digital foundations, connected health and care services, locally joined-up person-level data across health and care partners, and robust analytical capability aligned across system partners. This will be described in the forthcoming NHSX What Good Looks Like framework, which will support ICSs to benchmark and enable regional teams to develop an appropriate support offer.

To underpin this, systems should commence their procurement of a shared care record so that a minimum viable product is live in September and roadmap for development to include wider data sources and use for population health is ready for April 2022.

F4 Develop ICSs as organisations to meet the expectations set out in Integrating Care

We expect ICSs to take steps in their development during 2021/22 to ensure they are able to deliver the four core purposes described above. ICSs are asked to set out how they will organise themselves to support this, including through:

• Updating their system development plans, detailing the work they will undertake to ensure their system has the necessary functions, leadership, capabilities and governance
• Preparing for moving to a statutory footing from April 2022, subject to legislation.

F5 Implement ICS-level financial arrangements

The financial framework arrangement for 2021/22 will continue to build on the system-based approach to funding and planning. Systems should ensure that they are continuing to take actions to strengthen their system financial governance arrangements and building collaborative plans to optimise system resources.

For the six-month period to 30 September 2021, we will be issuing system envelopes based on the H2 2020/21 funding envelopes and including a continuation of the system top-up and COVID-19 fixed allocation arrangements. The total quantum will be adjusted to issue additional funding for known pressures and key policy priorities (including inflation, primary care and mental health services).

System envelopes will also be adjusted to reflect an efficiency requirement increasing through the second quarter and with an increased requirement for those systems that had
deficits compared to 19/20 financial trajectories at the end of 2019/20. We will be developing specific system productivity measures to align with the focus on clinical pathway transformation and the reduction in unwarranted variation as part of the national elective recovery programme underpinned by more effective rostering of staff. We will also set goals for outpatient transformation as we approach the second half of the year.

The current block contract payments approach will continue for NHS providers. Further detail on the construction of H1 system funding and organisational plans, the contracting and payments approach for NHS and non-NHS organisations, and the processes to amend plans and access recovery funding, is outlined in the accompanying guidance.

Finally, we are asking local systems to return a draft summary plan by 6 May using the templates issued and covering the key actions set out in this letter, with final plans due by 3 June. These plans need to be the product of partnership working across STPs/ICSs, with clear and transparent triangulation between commissioner and provider activity plans.
2021/22 priorities and operational planning guidance: Implementation guidance

25 March 2021
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1. Overview

1.1 Introduction and background

As outlined in the 2021/22 priorities and operational planning guidance this implementation guidance provides further detailed policy and technical information to enable Integrated Care Systems (ICSs) and their constituent organisations to develop and agree operational plans. Plans should summarise how, as systems, the priorities set out in 2021/22 priorities and operational planning guidance will be delivered, with a focus on the six months to the end of September 2021 for most areas.

This implementation guidance should be read alongside the operational planning guidance and Guidance on finance and contracting arrangements for H1 2021/22

1.2 Timetable

ICSs are expected to work across their partner organisations to produce plans that consider alignment between CCGs and providers, and between activity, workforce and finances.

<table>
<thead>
<tr>
<th>Key Tasks</th>
<th>Date</th>
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<tbody>
<tr>
<td><strong>Publication.</strong></td>
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<tr>
<td>• 2021/22 priorities and operational planning guidance</td>
<td>Thursday 25 March 2021</td>
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<tr>
<td>• Guidance on finance and contracting arrangements for H1 2021/22</td>
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<td>• Implementation guidance</td>
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<td>• Technical definitions</td>
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<td><strong>Templates issued.</strong></td>
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<td>• Non-functional activity, workforce</td>
<td>Friday 26 March 2021</td>
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<td>• Narrative</td>
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<td><strong>System financial planning template and SDF schedules issued</strong></td>
<td>Monday 29 March 2021</td>
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<tr>
<td><strong>Organisation (provider) capital and cash plan submission</strong></td>
<td>Monday 12 April 2021</td>
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<td>• System finance plan submission</td>
<td>Thursday 6 May 2021</td>
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<td>• Mental Health finance submission</td>
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<tr>
<td><strong>Draft plan submission deadline.</strong></td>
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<tr>
<td>• Draft activity, workforce (primary and secondary care) and MH workforce numerical submission</td>
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<td>• Draft narrative plan submission</td>
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<tr>
<td><strong>Non-mandated provider organisation finance plan submission</strong></td>
<td>w/c 24 May 2021</td>
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<tr>
<td><strong>Final plan submission deadline.</strong></td>
<td></td>
</tr>
<tr>
<td>• Final activity, workforce and MH workforce numerical submission</td>
<td>Thursday 3 June 2021</td>
</tr>
<tr>
<td>• Final narrative plan submission</td>
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</table>
2. System development and ICS establishment

2.1 Introduction

With every part of England now covered by an Integrated Care System, this guidance is aimed at supporting ICSs in delivering their four core purposes of:

- **Improving outcomes** in population health and healthcare
- **Tackling inequalities** in outcomes, experience and access
- **Enhancing productivity** and value for money; and
- **Helping the NHS to support broader social and economic development**.

This implementation guidance sets out how ICSs can support that mission through their continued development during 2021/22.

It asks systems to build on the existing consistent operating requirements for ICSs as set out in the April 2020/21 planning guidance and the vision described in *Integrating Care: Next Steps* (November 2020), that has been reinforced in the Government’s recent White Paper and proposals for legislative change.

The intention is that legislation and guidance is as permissive as possible and supports the local arrangements many systems have already been so effectively putting in place. ICSs are different in size, demography and local relationships and arrangements.

2.2 Principles

Building on the NHS Long Term Plan, the White Paper and *Integrating care: next steps* confirm the core ICS design principles of subsidiarity and collaboration and the expectations for system progression during 2021/22.

Key expectations informing the approach (subject to relevant legislation) are:

- There will be **one statutory ICS NHS body** and **one statutory ICS health and care partnership** per ICS from April 2022.
- **CCG functions** will be subsumed into the ICS NHS body and some NHS England and Improvement **direct commissioning functions** will be transferred or delegated to ICSs.
- **Staff below board level who are directly affected** will have an **employment commitment** and local NHS administrative **running costs** will not be cut as a consequence of the organisational changes.
- **Through strong place-based partnerships**, NHS organisations will continue to forge deep **relationships with local government** and communities to join up health and social care and tackle the wider social and economic determinants of health. To enable this, ICS boundaries will align with upper-tier local authority boundaries by April 2022, unless otherwise agreed by exception. Joint working with local government will be further supported by the **health and care partnership** at ICS level.
- **The development of primary and community services** and implementation of **population health management** will be led at place level, with Primary Care Networks as the building blocks of local healthcare integration.
Every acute (non-specialist) and mental health NHS trust and FT will be part of at least one **provider collaborative**, allowing them to integrate services appropriately with local partners at place and to strengthen the resilience, efficiency and quality of services delivered at-scale, including across multiple ICSs.

**Clinical and professional leadership** will be enhanced, connecting the primary care voice that has been a strong feature of PCNs and CCGs, to clinical and professional leadership from community, acute and mental health providers, public health and social care teams.

### 2.3 Implementation and development in 2021-22

System Development Plans (SDPs) should be updated and agreed between system partners and with NHSEI regional teams by the end of Q1, to set out how each ICS will develop the leadership, capabilities and governance required to take on their anticipated statutory responsibilities from April 2022. SDPs should refer to the core components of system arrangements set out in section 2.4 and should indicate what they expect their arrangements to be from that point, as agreed collaboratively between the NHS, local government and other system partners.

Each system should also have an implementation plan in preparation for managing their organisational and people transition into the future arrangements. This should take into account the anticipated process and timetable for ICS establishment set out in section 2.5, any potential changes to ICS boundaries and the need to streamline commissioning functions across the ICS footprint. They should include public, staff and other stakeholder communications and engagement plans.

SDPs should be agreed with NHSEI regional teams and regularly reviewed and updated throughout the year. By the end of Q4, we expect each ICS’s operating plans to be included in an ICS “Memorandum of Understanding” (MoU) for 2022/23.

Alongside national and regional partners, NHSEI will work with each ICS to support their ongoing development and to ensure that they are in a position to discharge their statutory duties and functions (as well as having the necessary technical infrastructure in place, notably data and financial systems) to operate once the new ICS NHS body is established. This will include a peer review and co-development process during Q1 to take stock of initial plans, share good practice and identify support needs.

In line with previous guidance, all ICSs should confirm plans to ensure that commissioning functions are organised across the ICS footprint during 2021/22. Where an ICS has multiple CCGs they must confirm governance and resourcing arrangements that ensure that a single commissioning decision can be made (where appropriate) and that they operate effectively as a single management team at ICS-level. By Q3 CCG teams should only operate at sub-ICS level where the System Development Plan confirms that the ICS plans to establish a significant place-based function at that footprint.

A new System Oversight Framework is being published for 2021/22. It will set consistent expectations of systems and their constituent organisations and match accountability for results with improvement support. There will be a partnership approach between regional teams and ICSs in the oversight process and in support of individual organisations, linked to system development.

All ICSs should implement the arrangements described in the System Oversight Framework. This will include agreeing, and reviewing on a quarterly basis, an oversight MOU with regional teams that sets out:
2. System development and ICS establishment

• the delivery and governance arrangements, including financial governance across the ICS and the role of place-based partnerships and provider collaboratives in delivering the priorities set out in the 2021/22 planning guidance

• the oversight mechanisms and structures that reflect these delivery and governance arrangements, including the respective roles of the ICS and regional NHSEI team

• the local strategic priorities that the ICS has committed to deliver in 2021/22 as a partnership that complements the national priorities set out in the 2021/22 planning guidance and align to the four fundamental purposes of an ICS.

NHSEI is preparing to shift some of its direct commissioning functions to ICS bodies and we are currently developing the details of these plans. Subject to the proposed changes in legislation, discussions with systems and regions and further work on HR, our initial intention is to enable ICSs to take on responsibility as soon as they are ready to do so from 1st April 2022 onwards.

Commissioning of primary medical services is currently delegated to CGGs and will move automatically into ICS NHS bodies when they are established. We anticipate that ICSs will also take on dental services, general ophthalmic and community pharmacy commissioning from this point onwards.

Further work is taking place at the national and regional levels to explore how the commissioning model for specialised services could evolve in the context of ICSs becoming statutory bodies, in line with the safeguards and four principles set out in Integrating Care: Next steps to building strong and effective integrated care systems across England.

NHSEI has a range of other direct commissioning functions including health and justice, armed forces and aspects of public health, and we will continue to engage with ICSs as we consider how they could take on greater responsibility for these services in future.

2.4 Planning for implementing new statutory arrangements

If, as expected, legislation is introduced into Parliament later this year, we expect to ask systems to start formally preparing to establish these statutory arrangements during Q1 2021/22. Preparations, informed by guidance, may include:

• running a process to appoint an ICS chair, accountable officer and chief financial officer

• development of an ICS NHS body constitution, involving system partners, to be agreed by NHSEI (the constitution will be formally agreed by the Board of the ICS NHS body upon establishment)

• establishing shadow arrangements for the system’s ICS NHS body and health and care partnership, including related governance arrangements (such as joint committees and other arrangements for the exercise of functions) that they wish to deploy locally as and when legislation permits

• agreeing an ICS “MOU” for 2022/23 and the associated regional support offer.

The indicative process to be undertaken in every ICS over the course of 2021/22 is set out below. This is subject to legislation and other factors (including pending decisions on ICS boundaries in some areas) and must be viewed as indicative at this stage.

Accountability for managing this process will remain with the current ICS leadership until such time as the new leaders (designated chair, chief executive and others at Board level) may be appointed (subject to legislation). Implementation plans should be agreed with regional teams.
### System development and ICS establishment

<table>
<thead>
<tr>
<th>By end Q1</th>
<th>Update SDPs and confirm proposed boundaries, constituent partner organisations and place-based arrangements.</th>
</tr>
</thead>
<tbody>
<tr>
<td>By end Q2</td>
<td>Confirm designate appointments to ICS chair and chief executive positions (following the second reading of the Bill and in line with senior appointments guidance to be issued by NHSEI). Confirm proposed governance arrangements for health and care partnership and NHS ICS body.</td>
</tr>
<tr>
<td>By end Q3</td>
<td>Confirm designate appointments to other ICS NHS body executive leadership roles, including place-level leaders, and non-executive roles.</td>
</tr>
<tr>
<td>By end Q4</td>
<td>Confirm designate appointments to any remaining senior ICS roles. Complete due diligence and preparations for staff and property (assets and liabilities) transfers from CCGs to new ICS bodies. Submit ICS NHS body Constitution for approval and agree “MOU” with NHS England and NHS Improvement</td>
</tr>
<tr>
<td>1 April</td>
<td>Establish new ICS NHS body; with staff and property (assets and liabilities) transferred and boards in place.</td>
</tr>
</tbody>
</table>

During 2021/22 we will also update guidance on provider governance (to support providers to work collaboratively), including:

- Updated FT Code of Governance
- Updated guidance on the duties of FT council of governors
- Updated memorandums for accounting officers of FTs and NHS trusts
- New guidance issued under the NHS Provider Licence that good governance for NHS providers includes a requirement to collaborate.
3. Elective recovery framework

Systems will coordinate the production of plans for elective activity, including cancer, that can be delivered through core funding and the extended funding that is available via the Elective Recovery Fund (ERF). Plans should make full use of available NHS and Independent Sector (IS) capacity through the new IS contract framework (the ‘NHS Increasing Capacity Framework’), while demonstrating the steps being taken to eliminate unnecessary activity.

The ERF is designed to ensure that systems receive appropriate funding to deliver the highest possible levels of recovery activity. Systems will be paid through the ERF for activity delivered above nationally set thresholds as compared to 2019/20 activity levels, which will be an aggregate of inpatient and outpatient activity delivered by both NHS and IS providers and will include both CCG and specialised activity.

The baseline will be calculated using a £ value based on tariff prices. Activity delivered will be calculated on the same basis to ensure that more complex activity is given full value and there is no incentive to deliver higher volumes of simpler activity to achieve the baseline. The baseline and value of activity delivered will be calculated using data submitted to SUS+.

The scheme will operate on an individual month basis, rather than cumulatively, to provide a continued incentive for systems that do not achieve the baseline in the first part of the year.

Systems will need to decide how to allocate additional funding to providers and commissioners and how this will operate alongside the variable payment for elective activity in the aligned payment model for 2021/22 when the national tariff becomes operational.

For activity delivered between the target thresholds and the estimated funded activity within envelopes (set at 85%), systems will receive an additional payment at 100% of tariff. Additional activity above 85% will receive the equivalent of 120% of tariff to take into account additional pathway costs that are not funded by published tariff prices (for example, critical care costs for some elective procedures).

There are no downside adjustments; activity delivered below the lower thresholds will not result in any adjustments to system envelopes.

To access the additional funding, systems will need to demonstrate that their elective recovery plan is consistent with some wider objectives, described in section 3.3.

Thresholds

Thresholds have been set nationally, measured against the value of total activity delivered in 2019/20, and taking into account productivity constraints due to infection prevention and control (IPC) measures.

There will be a staged increased in thresholds, recognising the ongoing challenges in re-establishing affected services and workforce recovery. The thresholds, as a percentage of the value of the 2019/20 activity, will be:

- 70% for April 2021
- 75% for May 2021
- 80% for June 2021
- then 85% from July to September 2021

These thresholds will be applied to all NHS-commissioned activity, whether delivered in the NHS, the IS or insourced). Each provider’s activity will count towards their system threshold, irrespective of the patient’s CCG. Activity delivered by IS providers will count towards the system threshold of the patient’s CCG.

The scope of the activity covered is:
• elective activity (ordinary or day case), including cancer, with a published tariff price
• outpatient procedures with a published tariff price
• outpatient attendances for all treatment function codes (TFCs) apart from mental health, maternity and diagnostic imaging, whether consultant-led, non-consultant-led or non-face-to-face.

The threshold will be calculated using a £ value based on tariff prices based on the 2021/22 tariff consultation, specifically:

• published tariff prices for elective and outpatient procedures
• published consultant led tariff prices for outpatient attendances with a published price. For these TFCs, non-consultant led and non-face to face will be given the consultant led price
• the average of the published consultant-led tariff prices for outpatient attendances that do not have a published price. For these TFCs, non-consultant-led and non-face-to-face will be given the consultant-led price
• other tariff adjustments such as market forces facto (MFF), specialist top-ups and excess bed days will be applied as per the 2021/22 tariff consultation.

Actual activity delivered will be calculated on the same basis. An adjustment will be made to thresholds to reflect any differences in the number of working days between 2019/20 and 2021/22.

Where there are likely to be systematic differences to the counting and coding of activity in 2021/22 compared to the baseline activity from 2019/20, we will be asking systems to provide us with that information in order to adjust the threshold values. The only categories of change we will implement are:

• where a service has shifted across system boundaries, an adjustment will be made to both systems on a net neutral (apart from MFF) basis
• where a service has shifted to a provider that cannot submit the data to SUS+
• significant counting and coding changes (for example where an SDEC service was coded as an outpatient service in 2019/20 but as an emergency service in 2021/22)
• where an error has been identified in the 2019/20 data (for example incorrect coding leading to the activity having been rejected)

Worked example

<table>
<thead>
<tr>
<th>2019/20 activity baseline</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
</tr>
</thead>
<tbody>
<tr>
<td>£ 30,000,000</td>
<td>£ 30,000,000</td>
<td>£ 30,000,000</td>
<td>£ 30,000,000</td>
<td>£ 30,000,000</td>
</tr>
<tr>
<td>Baseline adjustments (70%/75%/80%/85%)</td>
<td>£ 21,000,000</td>
<td>£ 22,500,000</td>
<td>£ 24,000,000</td>
<td>£ 25,500,000</td>
</tr>
<tr>
<td>WD adjustment</td>
<td>100%</td>
<td>90%</td>
<td>110%</td>
<td>96%</td>
</tr>
<tr>
<td>Threshold value of activity (LOWER THRESHOLD)</td>
<td>£ 20,500,000</td>
<td>£ 19,857,143</td>
<td>£ 25,900,000</td>
<td>£ 23,891,304</td>
</tr>
<tr>
<td>Threshold value of activity at 85% (UPPER THRESHOLD)</td>
<td>£ 25,000,000</td>
<td>£ 22,571,429</td>
<td>£ 27,550,000</td>
<td>£ 23,891,304</td>
</tr>
<tr>
<td>Actual Activity (Example 1 - System delivers activity below LOWER THRESHOLD)</td>
<td>£ 20,000,000</td>
<td>£ 20,000,000</td>
<td>£ 20,000,000</td>
<td>£ 20,000,000</td>
</tr>
<tr>
<td>Actual Activity (Example 2 - System delivers activity above UPPER THRESHOLD)</td>
<td>£ 26,000,000</td>
<td>£ 26,000,000</td>
<td>£ 28,000,000</td>
<td>£ 25,000,000</td>
</tr>
<tr>
<td>Actual Activity (Example 3 - System delivers activity between LOWER and UPPER THRESHOLDS)</td>
<td>£ 23,000,000</td>
<td>£ 22,000,000</td>
<td>£ 28,000,000</td>
<td>£ 20,000,000</td>
</tr>
</tbody>
</table>

(Example 1 - System delivers activity below LOWER THRESHOLD)
Amount above UPPER THRESHOLD | £ - | £ - | £ - | £ - |
Amount above LOWER THRESHOLD but below UPPER THRESHOLD | £ - | £ - | £ - | £ - |
Total Additional Funding | £ - | £ - | £ - | £ - |

(Example 2 - System delivers activity above UPPER THRESHOLD)
Amount above UPPER THRESHOLD | £ 1,000,000 | £ 3,428,571 | £ 450,000 | £ 1,108,696 |
Amount above LOWER THRESHOLD but below UPPER THRESHOLD | £ 4,500,000 | £ 2,714,286 | £ 1,650,000 | £ - |
Total Additional Funding | £ 5,700,000 | £ 6,226,271 | £ 2,190,000 | £ 1,330,435 |

(Example 3 - System delivers activity between LOWER and UPPER THRESHOLDS)
Amount above UPPER THRESHOLD | £ - | £ - | £ 450,000 | £ - |
Amount above LOWER THRESHOLD but below UPPER THRESHOLD | £ 2,500,000 | £ 2,142,857 | £ 1,650,000 | £ - |
Total Additional Funding | £ 2,500,000 | £ 2,142,857 | £ 2,190,000 | £ - |
3.2 Gateway criteria and monitoring

To qualify for ERF funding, systems are required to demonstrate their elective recovery plan supports the requirements set out in sections C1 and C2 of the planning guidance and the five objectives listed below, with tangible deliverables and milestones where possible. Regional teams will review progress against the agreed deliverables on a monthly basis to determine if the gateway criteria are being met.

1. **Addressing health inequalities**

   Systems are required to demonstrate that plans for elective recovery will:
   - Use waiting list data (pre and during pandemic), including for clinically prioritised cohorts, to identify disparities in relation to the bottom 20% by Index of Multiple Deprivation (IMD) and black and minority ethnic populations
   - Prioritise service delivery by taking account of the bottom 20% by IMD and black and minority ethnic populations for patients on the waiting list and not on the waiting list, including through proactive case finding
   - Use system performance frameworks to measure access, experience and outcomes for black and minority ethnic populations and those in the bottom 20% of IMD scores
   - Evaluate the impact of elective recovery plans on addressing pre-pandemic and pandemic-related disparities in waiting lists, including for clinically prioritised cohorts
   - Demonstrate how the ICS’s SRO for health inequalities will work with the Board and partner organisations to use local population data to identify the needs of communities experiencing inequalities in access, experience and outcomes and ensure that performance reporting allows monitoring of progress in addressing these inequalities.

2. **Transforming outpatient services**

   Systems are expected to take all possible steps to avoid outpatient attendances of low clinical value and redeploy that capacity where it is needed. Where outpatient attendances are clinically necessary, at least 25% should be delivered remotely by telephone or video consultation.

   Systems are required to demonstrate progress in the following, with routine data capture in place by the end of Q2:
   - Introducing Patient-Initiated Follow-up (PIFU), or similar alternative, in at least three major outpatient specialties per provider; including personalised stratified follow-up for cancer patients, avoiding unnecessary follow-up attendances, and providing faster access to follow-up appointments where clinically necessary
   - Collaborating across primary and secondary care to treat more patients without the need for an onward referral, including increasing the uptake of Advice and Guidance or other measures such as referral triage to avoid unnecessary first attendances.

3. **System-led recovery**

   Systems are required to set out how management of Patient Tracking Lists (PTLs), including for cancer patients, will be undertaken at a system level and how NHS and IS capacity will be used to the benefit of the whole system population. This will be supported through the ongoing mobilisation of Elective Activity Coordination Hubs.

4. **Clinical validation, waiting list data quality and reducing long waits**

   Plans should be built on robust, system-level processes, including:
• shared decision making and treatment reviews between patients and clinicians, keeping waiting patients informed of next steps in their treatment, including discussion of alternative treatment options.

• maintaining waiting list data quality through close interrogation of patient-level PTL data and the application of system-wide data review processes, including close partnership working with primary care and adherence to guidance on Evidence Based Interventions.

• detailed validation, by providers, of the weekly Waiting List Minimum Dataset (MDS) uploads, to ensure waiting list data are complete and accurate.

• clinical validation, focusing on diagnostic and non-admitted pathways, providing evidence of how long-waiting patients will be regularly reviewed and risk assessed.

5. People recovery

Systems are required to demonstrate how they will monitor and safeguard staff health and wellbeing, using an appropriate set of staff experience measures, to ensure people recovery is taken into account when considering available workforce capacity.

3.3 High impact service models

Diagnostic activity volumes are critical to elective recovery, and additional capacity and efficiency should be maximised through new Community Diagnostic Hubs (CDHs) and pathology and imaging networks, as set out in the planning guidance.

Systems will be supported to accelerate high volume low complexity (HVLC) surgery in specialties targeted according to local needs, including orthopaedics, ophthalmology, urology, ENT, gynaecology and general surgery, including theatre productivity, where HVLC typically represents over half of surgical waiting lists, and day case maximisation.

Systems will be required to continue the development of Elective Activity Coordination Hubs, which support patient choice and maximise the available NHS and IS capacity.
4. Health inequalities

COVID-19 has highlighted the urgent need to prevent and manage ill health in groups that experience health inequalities, as outlined in the [NHS Long Term Plan](https://www.england.nhs.uk/wp-content/uploads/2021/05/long-term-plan.pdf).

To help achieve this, NHS England and NHS Improvement issued guidance as part of its ‘phase 3’ response to the COVID-19 pandemic, setting out eight urgent actions for tackling health inequalities. Systems are now asked to focus on five priority areas in the first half of 2021/22, distilled from the eight actions.

The effective use of data is central to tackling health inequalities including delineation of our waiting list and performance data by deprivation and ethnicity as set out in section 3.2.

**Priority 1: Restore NHS services inclusively**

At national level, the decline in access amongst some groups during the first wave of the pandemic broadly recovered in later months. Insight work has, however, highlighted that in some cases pre-existing disparities in access, experience, and outcomes, have been exacerbated by the pandemic.

It is therefore critical that systems use their data to plan the inclusive restoration of services, guided by local evidence. This approach should be informed by NHS performance reports that are delineated by ethnicity and deprivation, as evidence suggests these are the areas where health inequalities have widened during the pandemic.

**Priority 2: Mitigate against digital exclusion**

Systems are asked to ensure that:

- providers offer face-to-face care to patients who cannot use remote services
- more complete data collection is carried out, to identify who is accessing face-to-face, telephone, or video consultations, broken down by relevant protected characteristic and health inclusion groups
- they take account of their assessment of the impact of digital consultation channels on patient access.

**Priority 3: Ensure datasets are complete and timely**

Systems are asked to continue to improve the collection and recording of ethnicity data across primary care, outpatients, A&E, mental health, community services, and specialised commissioning.

NHS England and NHS Improvement will support the improvement of data collection across all settings, including through the development of the Health Inequalities Improvement Dashboard, which will contain expanded datasets where there is currently a relative scarcity of intelligence, e.g. for people experiencing post-COVID syndrome.

Systems should also implement mandatory ethnicity data reporting in primary care, to enable demographic data to be linked with other datasets and support an integrated approach to performance monitoring for improvement.

**Priority 4: Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes**

Uptake of the COVID and flu vaccination has increased significantly across all groups, but inequality has also widened, particularly by deprivation and ethnicity. Systems and providers should take a culturally competent approach to increasing vaccination uptake in groups that had a lower uptake than the overall average as of March 2021.
Preventative programmes and proactive health management for groups at greatest risk of poor health outcomes should be accelerated, as set out in the main 2021/22 planning guidance, including:

- Ongoing management of long-term conditions
- **Annual health checks for people with a learning disability** This example from Herefordshire and Worcestershire CCG, shows an approach tailored to the local population.
- **Annual health checks for people with serious mental illness**, learning from proven delivery models such as the approach taken by City and Hackney CCG.
- In maternity care, implementing continuity of carer for at least 35% of women, with the proportion of Black and Asian women and those from the most deprived neighbourhoods meeting and preferably exceeding the proportion in the population as a whole.

**Priority 5: Strengthen leadership and accountability**

Systems and providers should have a named executive board-level lead for tackling health inequalities, and should access training made available by the Health Equity Partnership Programme.
5. Maternity and Neonatal transformation priorities

NHS England and NHS Improvement are committed to working with regions, systems and partners to implement the actions from Donna Ockenden's initial report: Emerging findings and recommendations from the independent review of maternity services at the Shrewsbury and Telford Hospitals NHS Trust.

In the letter of 14 December systems were asked to implement the seven Immediate and Essential Actions in the Ockenden Report, identifying 12 clinically urgent priorities. An assurance assessment tool has been used by all trusts, reported to Local Maternity Systems and shared with regional teams. This section sets out the next steps for transforming maternity services in light of the Ockenden report.

5.1 Additional support for systems and providers in 21/22 for improvements to maternity services

For 2021/22, we will invest more than £80m of additional funding in systems to help deliver more midwives, more consultant obstetrician time and more multi-disciplinary training in maternity services. Arrangements are set out in section 5.4 below.

5.2 Pandemic recovery

The NHS in England has put enormous effort into maintaining safe and personalised care for women and their babies despite the challenges of the pandemic. In recovering the full maternity care pathway LMSs are asked to oversee and support trusts to:

- Reopen any services that have been suspended as a result of COVID-19.
- Remove restrictions on women’s access to support, on the basis of a risk assessment and in line with Supporting pregnant women using maternity services during the coronavirus pandemic: Actions for NHS providers.
- Take active steps to help maternity staff recover from the pressures of the pandemic.

Whilst COVID-19 remains a risk to pregnant women and their babies, the NHS in England must continue to implement the four actions to minimise the additional risk of COVID-19 for Black, Asian and minority ethnic women and their babies.

5.3 Transformation – priorities for 2021/22

LMSs are expected to move back to delivering a more complete range of transformation objectives to make maternity care safer, more personalised and more equitable. In light of the variation in implementation highlighted by the Ockenden report, we will be putting a greater emphasis on universal implementation. We will expect LMSs to take responsibility for this, with accountability to ICSs.

We remain committed to women receiving continuity of carer as set out in the NHS Long Term Plan. Some potential barriers need tackling at the outset, including putting adequate staffing in place, ensuring that the model is based on a team approach with a named obstetrician
attached, and capturing the right information electronically so that progress can more easily be measured. We will therefore focus on addressing these issues during 2021/22.

The full range of objectives is:

I. Ensure every woman is offered a **Personalised Care and Support Plan**, underpinned by a risk assessment and in line with national guidance, by March 2022.

II. Implement the five elements of the **Saving Babies’ Lives** care bundle, and in particular ensure that:
   a) Every provider has a pre-term birth clinic.
   b) At least 85% of women who are expected to give birth at less than 27 weeks’ gestation are able to do so in a hospital with appropriate on site neonatal care.

III. Make new **NHS smoke free pregnancy pathways** available for up to 40% of maternal smokers by March 2022.

IV. Embed **maternal medicine networks** so that women with acute and chronic medical problems have timely access to specialist advice and care at all stages of pregnancy from the start of the 2021/22 planning year.

V. Embed the offer to all women with type 1 diabetes of **continuous glucose monitoring** fully during 2021/22.

VI. Work with neonatal Operational Delivery Networks to implement local **neonatal improvement plans**.

VII. Implement the Core Competency Framework and ensure all maternity staff receive **multi-disciplinary training** – in line with the Ockenden report this must be validated by the LMS three times over the course of the year.

VIII. Put in place the building blocks by March 2022 so that **continuity of carer** is the default model of care offered to all women by March 2023, specifically:
   a) Undertake a Birth-rate Plus assessment to understand the current midwifery workforce required and follow this through with recruitment.
   b) Co-design a plan by July 2021 with local midwives, obstetricians and service users for implementation of continuity of carer teams in compliance with national principles and standards, and phased alongside the fulfilment of required staffing levels. This plan should also take into account the need for maternity staff to be supported to recover from the challenges of the pandemic.
   c) Prioritise those most likely to experience poorer outcomes first, including ensuring most women from Black, Asian and mixed ethnicity backgrounds and also from the most deprived areas are placed on a continuity of carer pathway by March 2022.
   d) Develop the ability to measure progress electronically and report it to the Maternity Services Dataset.
   e) Develop an enhanced model of continuity of carer which provides for extra midwifery time for women from the most deprived areas for implementation from April 2022.

IX. Following the publication of a national **Perinatal Equity Strategy**, LMSs will be asked to submit an equity analysis (covering health outcomes, community assets and staff experience) and a coproduction plan by 30 September 2021. LMSs will then co-produce Equity Action Plans by 31 December 2021.
5.4 Support and funding available

Ockenden Immediate and Essential Actions

Alongside this guidance, Ruth May- Chief Nursing Officer, Jacqueline Dunkley-Bent- Chief Midwifery Officer and Matthew Jolly- National Clinical Director for the Maternity Review and Women’s Health, will write to systems to set out the next steps. In parallel to system planning, we are asking systems or providers (with system endorsement) to set out by 6 May their current performance and plan to meet Birth-rate Plus and the Ockenden actions.

Regional teams will review and assure all submissions and confirm funding allocations to systems and providers by the end of May to inform final workforce planning submissions. We will also be strengthening the support available to systems by expanding the team of Maternity Improvement Advisers and providing additional consultant and midwifery leadership to regional teams.

Transformation Funding

As well as continued funding for existing Maternity Transformation Programme priorities we will provide funding on a targeted basis for two new service models included in the NHS Long Term Plan which are still at the pilot stage and not yet suitable for wider rollout: Maternal Mental Health Services (through the Mental Health Programme) and Postnatal Pelvic Health Services. We have also commissioned UNICEF to support trusts that are not accredited with its Baby Friendly Initiative (on infant feeding) to achieve accreditation. We will write to LMSs individually to confirm allocations. Funding will also be made available for Operational Delivery Network and LMS plans to implement the Neonatal Critical Care Review.

5.5 Ockenden report and the role and governance of Local Maternity Systems

The 14 December letter included the expectation that LMSs would oversee implementation of the Ockenden report. LMSs must continue to oversee implementation of the initial report, working in collaboration with the relevant Regional Chief Midwife. The actions regarding the governance of LMSs should be taken forward in a way that positions LMSs as the maternity arm of ICSs in line with Integrating care: Next steps to building strong and effective integrated care systems across England. The actions are:

I. “LMS must be given greater accountability and responsibility so that they can ensure the maternity services they represent provide safe services for all who access them.”

Those LMSs that have not already done so should now also take on full and ongoing oversight of quality, ensuring that an understanding of the quality of maternity and neonatal services informs transformation. We are therefore asking all LMSs to review their terms of reference and work programme by 3 June 2021 and to ensure that the LMS purpose specifically includes all of the following:

- To oversee quality in line with Implementing a revised perinatal quality surveillance model.
- To share information and learning in a structured and systematic way, working with partners to turn learning into service improvement.
- To oversee local trust actions to implement the seven immediate and essential actions from the Ockenden report.
- To ensure action is taken to improve the culture of maternity and neonatal services as a building block for safe, personal and more equitable care.
• To co-design and implement a vision for local maternity and neonatal services with local women through Maternity Voices Partnerships.

• To implement shared solutions wherever possible through shared clinical and operational governance.

Alongside this, there must be clear routes of accountability. We are therefore asking existing ICSs to take on formal, structured and systematic oversight of how their LMS delivers its functions. ICSs should set out a plan by 3 June 2021 outlining how this will be delivered with implementation no later than 1 April 2022.

II. “An LMS cannot function as one maternity service only.”

Donna Ockenden pointed out that independent scrutiny and challenge through peer review alongside peer support are fundamental to LMS operations and this can only be done when multiple trusts come together. However, providers are moving towards greater collaboration on ICS footprints with shared responsibilities and accountabilities through provider collaboratives. At the same time, as set out above, we need to strengthen LMS accountability through ICSs. In this context a sustainable approach ensuring there is ongoing shared learning and critical challenge is to buddy up LMSs as learning partners to undertake this function. We are therefore asking all LMSs, in consultation with regional teams, to identify a buddy LMS and implement processes for peer review and support by 3 June 2021.

III. “The LMS Chair must hold CCG Board level membership so that they can directly represent their local maternity services which will include giving assurances regarding the maternity safety agenda.”

To future proof implementation of this recommendation LMS governance must be aligned with ICSs (see section 2). We therefore expect ICSs to ensure the LMS Board is part of governance arrangements for 2021/22, and ensure that future arrangements maintain direct line of sight from the statutory ICS Board to the LMS Board, although there may be a period of transition during 2021/22 where existing arrangements are already planned to come to an end during this period. This will further support accountability and responsibility of the LMS as set out above.
6. Submission Guidance

6.1 Submission requirements

Systems (and where appropriate individual providers) are asked to submit plans covering activity and performance, workforce and finances that reflect the priorities set out in 2021/22 priorities and operational planning guidance. A set of linked collection templates are being made available to support plan submission. The individual elements and submission process for each of these is summarised below. Detailed guidance to support completion of each template can be found on the NHS Planning FutureNHS collaboration platform (see section 7.3) and/or within the collection template itself. The individual collection templates are:

- **Activity and performance**
  - Single system level collection incorporating CCG and provider level breakdowns as appropriate

- **Workforce**
  - Single system level collection across acute, community and primary care, incorporating provider level breakdown
  - Dedicated mental health collection at system and provider level

- **Finance**
  - System financial planning template
  - Provider financial planning template (issued 22 March)
  - Mental health CCG financial planning template

- **Supporting narrative**
  - A single system level template covering:
    - the actions and assumptions that underpin the trajectories within the activity and workforce numerical submission; and
    - other critical actions that systems will take over the next 6 months to address the priorities set out in 2021/22 operational planning guidance and in section 3 (elective recovery), section 4 (health inequalities) and section 5 (maternity) of this document

The collection mechanism for each template is set out in section 6.3

6.2 Planning assumptions

As set out in 2021/22 priorities and operational planning guidance, we do not yet know what the pattern of COVID-19 transmission will look like over the next 6-12 months and there also remains uncertainty over the pattern of non-COVID demand. To provide a consistent basis for planning systems should assume that over the first half of the year:

- Overall non-elective demand from COVID and non-COVID returns to pre-pandemic (2019/20) levels from the beginning of the 2021/22, subject to the impact of any planned service developments.
- COVID general and acute bed occupancy remains <5% between April and September 2021.
• Infection Prevention Control: All NHS organisations should ensure continued reliable application of the recommendations in the UK Infection Prevention and Control guidance. Individual organisations should make an assessment of the productivity impact based on local mitigation plans.

These planning assumptions are not a forecast and are provided as a consistent basis for planning only. As set out in 2021/22 priorities and operational planning guidance, systems should continue to prepare for possible future surge requirements for COVID patients.

6.3 Submission portals

Activity and performance

The activity and performance collection will be conducted through SDCS which can be accessed here. Submitters from each system will be contacted and invited to sign up to the SDCS collection system if they do not already have an account. Once the planning collection opens, submitters will be able to download the template from SDCS before completing and resubmitting through SDCS.

Full user guidance for accessing and using the SDCS collection system is available here and any queries regarding the system itself should be directed to the Data Collections team at NHS Digital; data.collections@nhs.net. Any other queries including those regarding the templates themselves should be directed to the NHS planning mailbox; england.nhs-planning@nhs.net.

For mental health there is no requirement to submit activity plans. The focus for this submission is on finance and workforce planning to mitigate risks to LTP delivery. The trajectories communicated in the Mental Health LTP Analytical Tool remain for 2021/22, with the exception of Children and Young People’s access, which reflects the additional activity funded through the Spending Review settlement (further information can be found in the Mental Health LTP Analytical Tool). Systems should use the information in the Mental Health LTP Analytical Tool, in conjunction with finance and workforce planning inputs to plan for delivery in 2021/22.

Workforce

The Acute, Primary care and community workforce collection will be conducted through SDCS in the same way as for activity and performance.

The Mental Health Workforce element of the collection will be carried out separately through the HEE eCollections portal. Mental Health Trusts will be responsible for the completion of their Provider-level Mental Health Workforce Collection submission. ICSs will be responsible for the system level Mental Health Workforce Collection submission. The nominated ICS and mental health trust leads will receive access to the tool via an email from HEE providing details to create an account. If you have not received a login by 6th April or if you have any issues accessing the portal, please contact DataService@hee.nhs.uk

Finance

System financial planning templates

System financial planning templates will be issued by email to system leads, along with supporting technical guidance. System leads will then be required to submit their completed system financial planning templates into NHSI.finplan@nhs.net by noon on the submission deadline. All templates should be submitted with all validation errors cleared. Please send any queries regarding the system financial planning collection to NHSI.finplan@nhs.net.

Provider financial planning templates

Provider financial planning templates and supporting technical guidance were issued on 22nd March for the capital and cash collection. After the systems have submitted their system financial plans, a macro fix will be issued to cascade the agreed provider amendments to the
subsequent Provider Income and Expenditure planning collection and there will then be a small window of opportunity for provider’s to amend their phasing and breakdown of their H1 plans. These templates, macro fixes and supporting technical guidance are published through the Provider Financial Monitoring System provider portals. The financial planning team will contact regions asking them to cascade to systems when the subsequent macro fixes are available to download from the system. Providers will be required to submit their templates via their portals by noon on the respective submission deadlines for capital and revenue with all validation errors cleared.

If you are a new user requiring log-in details, contact our IT Support team at Itservicedesk@NHSeandi.nhs.uk. Any other queries, including any regarding the template itself should be directed to NHSI.finplan@nhs.net.

**Mental Health financial planning templates**

Mental Health financial planning templates will be issued through the lead CCG SharePoint portals, along with supporting technical guidance. Systems will then be required to submit their completed mental health financial planning templates into the lead CCG who will upload them onto SharePoint by noon on the submission deadline. All templates should be submitted with all validation errors cleared. Please send any queries regarding the mental health financial planning collection to NHSI.finplan@nhs.net.

**Narrative**

Plans should be submitted using the template made available on the NHS Planning FutureNHS collaboration platform (see section 7.2) and submitted to the appropriate regional planning mailbox (see section 7.1) in line with the draft and final planning submission dates.

### 6.4 Sign Off

The templates do not include details of the internal sign off process within each ICS. It is assumed that by submitting the return the ICS confirms that the plan is a reflection of the collective intentions of the system for the rest of the year, that activity and workforce plans align and that the plan is agreed by all ICS partners.
7. Key planning contacts and resources

7.1 Regional contacts
ICSs should initially contact their region for advice on planning, using the contact details below:

<table>
<thead>
<tr>
<th>Location</th>
<th>Contact information</th>
</tr>
</thead>
<tbody>
<tr>
<td>North East and Yorkshire</td>
<td><a href="mailto:england.nhs-NEYplanning@nhs.net">england.nhs-NEYplanning@nhs.net</a></td>
</tr>
<tr>
<td>North West</td>
<td><a href="mailto:england.nhs-NWplanning@nhs.net">england.nhs-NWplanning@nhs.net</a></td>
</tr>
<tr>
<td>East of England</td>
<td><a href="mailto:england.eoe2021operplan@nhs.net">england.eoe2021operplan@nhs.net</a></td>
</tr>
<tr>
<td>Midlands</td>
<td><a href="mailto:england.midlandsplanning@nhs.net">england.midlandsplanning@nhs.net</a></td>
</tr>
<tr>
<td>South East</td>
<td><a href="mailto:england.planning-south@nhs.net">england.planning-south@nhs.net</a></td>
</tr>
<tr>
<td>South West</td>
<td><a href="mailto:england.southwestplanning@nhs.net">england.southwestplanning@nhs.net</a></td>
</tr>
<tr>
<td>London</td>
<td><a href="mailto:england.london-co-planning@nhs.net">england.london-co-planning@nhs.net</a></td>
</tr>
</tbody>
</table>

7.2 National and wider technical issues

<table>
<thead>
<tr>
<th>Subject area</th>
<th>Contact information</th>
</tr>
</thead>
<tbody>
<tr>
<td>SDCS collection portal</td>
<td><a href="mailto:data.collections@nhs.net">data.collections@nhs.net</a></td>
</tr>
<tr>
<td>NHS National Planning Team – activity, workforce</td>
<td><a href="mailto:england.nhs-planning@nhs.net">england.nhs-planning@nhs.net</a></td>
</tr>
<tr>
<td>MH workforce and general planning queries</td>
<td></td>
</tr>
<tr>
<td>Integrated Planning Tool</td>
<td><a href="mailto:england.covid-ipt@nhs.net">england.covid-ipt@nhs.net</a></td>
</tr>
<tr>
<td><a href="mailto:NHSI.finplan@nhs.net">NHSI.finplan@nhs.net</a></td>
<td><a href="mailto:NHSI.finplan@nhs.net">NHSI.finplan@nhs.net</a></td>
</tr>
<tr>
<td>Capital and Cash</td>
<td><a href="mailto:NHSI.CapitalCashQueries@nhs.net">NHSI.CapitalCashQueries@nhs.net</a></td>
</tr>
</tbody>
</table>

7.3 FutureNHS collaboration platform
General updates and resources will be provided on the [NHS Planning FutureNHS collaboration platform](https://future.nhs.uk/connect.ti/system/home) throughout the planning round.
You will need a FutureNHS account to access pages, and can get this at: [https://future.nhs.uk/connect.ti/system/home](https://future.nhs.uk/connect.ti/system/home) following the registration process outlined.
Guidance on finance and contracting arrangements for H1 2021/22

March 2021
Overview

1. This document sets out the details of the finance and contracting arrangements for the six-month period from 1 April 2021 to 30 September 2021 (‘H1 2021/22’ or ‘H1’). These arrangements are supported by an additional £8.1bn of funding provided by government, of which £7.4bn is available over the first half of 2021/22 to reflect the on-going impact of COVID-19.

2. In addition, the government has provided £1.0bn for elective recovery and £0.5bn for mental health recovery across 2021/22. Full details of these are included in the Elective Recovery section of the H1 implementation guidance, and Appendix 1 of this guidance.

3. The H1 arrangements are:

   • System funding envelope, comprising adjusted CCG allocations, system top-up and COVID-19 fixed allocation, based on the H2 2020/21 envelopes adjusted for known pressures and policy priorities.

   • Block payment arrangements will remain in place for relationships between NHS commissioners (comprising NHS England and CCGs) and NHS providers (comprising NHS foundation trusts and NHS trusts). Signed contracts between NHS commissioners and NHS providers are not required for the H1 2021/22 period.

   • H1 block payments with NHS providers should be amended to reflect the changes to system funding envelopes, eg application of inflation and distribution of additional funding. Block payments with CCGs outside the system (‘inter-system’) and NHS England contracts for directly commissioned services (specialised and other directly commissioned services) will be uplifted by 0.5%. National approval will continue to be required to action changes to these contracts.

   • Payment timelines will return to pre-COVID timelines as set out in the NHS Standard Contract terms; the payment for April 2021 will be due on 8 April 2021.
• Where non-NHS providers are being commissioned to provide services (other than core primary care) from 1 April 2021 onwards, a written contract in the form of the 2021/22 NHS Standard Contract must be in place and signed. This includes putting in place contracts for acute independent sector (IS) services which were covered by the national IS contract during 2020/21.

• Through the H1 financial regime, systems will have access to the following additional growth funding:

  i. acute services – access to additional funding through the Elective Recovery Fund

  ii. mental health services – additional CCG programme funding and service development funding (SDF) to enable delivery of the Mental Health Investment Standard (MHIS) and Long Term Plan (LTP) priorities

  iii. primary medical care services – additional primary care growth has been issued in line with the 2021/22 published CCG primary medical care allocations and additional agreed allocations as outlined in this document

  iv. community services – funding for demographic growth has been included within system funding envelopes. Access to additional non-demographic growth will be available through SDF for transforming community services, including for accelerating the rollout of the two-hour crisis community health response at home.

• In recognition of the impact of the COVID-19 pandemic on services funded through non-NHS income streams, we will be issuing additional fixed income support in H1 2021/22 through the COVID-19 allocation. The COVID-19 allocation will continue to be distributed to the lead CCG for the system and transacted to NHS providers, where relevant, through amendments to their block payment arrangements. The funding provided will represent the totality of funding available for systems in relation to non-NHS income support. With this income, systems will be expected to fully recover their positions.
• The financial arrangements include efficiency requirements for NHS and non-NHS providers. For non-NHS providers of services within the scope of the National Tariff Payment System (NTPS), an annualised efficiency requirement of 1.1% has been set in the NTPS 2021/22 consultation prices.

• For NHS providers, a general efficiency requirement of 0.28% for the six-month H1 period has been applied to the growth in NHS provider block payments and feeds through to CCG programme envelope growth and inflation on the system top-up and COVID-19 allocation. In addition to the general efficiency factor applied to all NHS providers, targeted reductions in system top-up funding will be applied to those systems with carry-forward 2019/20 financial trajectory gaps which were funded through the H2 2020/21 arrangements. Through this mechanism, we will begin to recover the positions of those systems funded in excess of a sustainable position and support overall financial recovery. There will be a continued efficiency requirement into the second half of 2021/22.

H1 financial planning process

4. NHS England and NHS Improvement have nationally calculated CCG and NHS provider organisational plans for the H1 period as a default position for systems and organisations to adopt. The intention in calculating these is that organisations have a starting point for budget management without needing to complete an extensive planning process.

5. Default organisational plans have been generated based on Q3 2020/21 actuals. Q3 actuals generate affordable positions for most systems and therefore minimise the extent of local planning required to set affordable organisational-level budgets. We have not actioned adjustments to organisational positions to reflect 2021/22 new items, ie no adjustment has been made for inflation or distribution of growth funding. Systems will need to plan collaboratively to determine the distribution of these resources.

6. By generating organisational positions based on Q3 actuals, the plans will implicitly assume the continuation of the Q3 distribution of system funding (comprising allocations, system top-up, COVID-19 allocation and SDF) to organisations and will not include the distribution of new funding.
7. Systems, by mutual agreement and on a net neutral basis within their system funding envelope, will be able to amend the default organisational positions, to reflect an alternative distribution of current resources and the impact of new resources, pressures and policy priorities. These changes should be reported on the system plan template.

8. All systems will be expected to report a balanced position on the system plan template. Those systems where the aggregate organisational plan position based on Q3 actuals is a deficit will be required to submit a system plan template showing an improvement to a breakeven position. If a system does not submit a balanced position, regions will be asked to assess the causes and will work with systems to develop a balanced plan.

9. As part of setting plans, CCGs are advised to set aside a contingency of up to 0.5% of their allocation to support risks to expenditure that may not otherwise be mitigated. Where setting of a contingency fund is neither considered affordable nor required – for example, where financial risks are fully mitigated – it is allowable to not set a contingency; this will be subject to regional assurance.

10. Where the submitted system plan template shows a change to an organisation’s surplus/deficit position for the period (referred to as Local Organisation Contribution in the system plan template), we will action a one-line adjustment to the nationally generated organisational plan such that the final position reconciles to the system plan template.

11. In constructing organisational plans, we will assume an equal profile across each month. NHS providers will have the opportunity, during a short window in advance of M2 reporting, to make net neutral amendments to their plans to reflect an alternative distribution between detailed plan categories and an alternative monthly profile to the default position. However, the plan surplus/deficit for the period must remain consistent with the system plan template.

12. Organisations will be monitored against the final positions reported on the system plan template, including any agreed amendments.
H1 system envelope and organisational plans

13. System funding envelopes comprise adjusted CCG allocations, system top-up and COVID-19 fixed allocation.

14. The system top-up and COVID-19 allocation will be distributed to a lead CCG for the system. By mutual agreement within a system, changes in funding should be transacted to NHS providers through amendments to their block payment arrangements.

15. Further detail on the construction of H1 system envelopes and organisational plans, including further information on the inflation and efficiency calculations, will be available through regional teams.

16. Except for the items identified in this section, system funding envelopes and block payment arrangements with CCGs outside of the system and NHS England commissioners, represent the totality of NHS funding available in H1 2021/22.

17. The following services will continue to be funded outside of system funding envelopes, and the funding terms are outlined in further detail in this document.

   • specialised high cost drugs and devices – refer to the ‘Specialised services’ section

   • specific COVID-19 services – refer to the ‘Funding for COVID-19 services’ section

   • non-clinical services contracted by NHS England and NHS Improvement that are transacted via invoicing – refer to the H2 2020/21 guidance¹

   • allocations of national SDF – refer to the ‘National service development funding’ section.

18. In addition, systems will have access to elective recovery funding. Full details are set out in the Elective Recovery section of the H1 implementation guidance.

Contracts

19. Signed 2021/22 contracts between NHS commissioners and NHS providers (NHS trusts and NHS foundation trusts) are not required for the H1 2021/22 period. Where services continue to be provided, the nationally mandated terms of the NHS Standard Contract for 2021/22\(^2\) will apply from 1 April 2021 onwards, and a contract incorporating those nationally mandated terms will be implied as being in place between the parties.

20. Where non-NHS providers are being commissioned to provide services (other than core primary care) from 1 April 2021 onwards, a written contract in the form of the 2021/22 NHS Standard Contract must be in place and signed.

21. The national Q4 2020/21 contracts between NHS England and 14 IS providers of acute services will expire on 31 March 2021. Commissioners, NHS providers and IS providers should take action to ensure that local contracts and subcontracts are in place to meet each system’s needs for IS acute capacity from 1 April 2021 onwards.

22. H1 system envelopes have been adjusted to move funding for IS services contracted by CCGs back to historical levels. All IS provision will therefore be locally managed and funded. Access to additional reimbursements from NHS England and NHS Improvement will exclusively be through the Elective Recovery Fund arrangements per the terms set out in the ERF section of the H1 2021/22 implementation guidance.

23. Systems should continue to make best use of the NHS Increasing Capacity Framework (the ‘Framework’). The Framework covers over 90 providers of acute elective services at present and allows a commissioner to put in place a contract, or a trust to put in place a subcontract, with one of the identified providers, either by a direct award (in the circumstances described in the Framework documentation) or by undertaking a mini-competition. Contracts and subcontracts awarded under the Framework must always be in the form of the current NHS Standard Contract or template NHS Standard Subcontract (full-length in each case).

\(^2\) https://www.england.nhs.uk/nhs-standard-contract/21-22/
24. The consultation notice for the *2021/22 National Tariff Payment System (NTPS) statutory consultation*³ has been published. The 2020/21 NTPS remains in place from 1 April until the new 2021/22 NTPS comes into force. The NTPS should continue to be the basis of contracting and payment arrangements with non-NHS providers for services within the scope of the NTPS. NHS providers will continue to be paid under the block payment arrangements (outlined in the ‘NHS provider block payments arrangements’ section), which involve variation from the national pricing arrangements in the NTPS.

25. System funding envelopes continue to contain an allowance for low-volume activity (NCA) flows from distant CCGs and remove the need for separate invoicing to CCGs outside the block payment arrangements. We are continuing to consider changes to streamline the way in which payment is managed for low-volume activity flows after the interim framework ends.

26. There will be no 2021/22 CQUIN scheme (either CCG or specialised) published at this stage. The NTPS consultation document and NHS Standard Contract propose that CQUIN will be brought within the scope of the NTPS. Block payments to NHS providers are deemed to include CQUIN. Commissioners must not withhold funding from NHS providers or non-NHS providers in relation to failure to meet CQUIN requirements during H1.

27. Further detail on contracting arrangements are set out in the technical guidance of the NHS Standard Contract. Where this contracting guidance refers to the “first part of 2021/22” this is now confirmed to be H1 2021/22.

**NHS provider block payment arrangements**

28. The block payments approach for arrangements between NHS commissioners and NHS providers in England will remain in place in H1. Where there was already a signed multi-year contract in place with an NHS provider, extending into 2021/22, the payment terms of this contract must be set aside for the rollover period, and payment must instead be made in accordance with the block payment arrangements. The local variations from national pricing

arrangements agreed last year in accordance with NTPS rules will remain in effect.\(^4\)

29. All commissioner to provider invoicing has been suspended (except for specific NHS England and NHS Improvement non-healthcare activity transactions) and therefore amendments to funding must be actioned through variations to the block payments.

30. For H1, block payment values should be set based on:

- Contracts between CCGs and NHS providers within the same system (‘intra-system contracts’) – systems are advised to roll over their latest intra-system contract value (subject to affordability) and uplift them by the H1 provider inflation factor (0.5%) but may opt for an alternative distribution of inflation funding based on knowledge of local pressures.

- Contracts between CCGs and NHS providers in different systems (‘inter-system contracts’) – will be issued with the latest CCG inter-system contract values (based on the national contract tracker) uplifted for the H1 provider inflation factor (0.5%).

- NHS England directly commissioned service contracts – systems will be issued with the latest contract values (based on the national contract tracker) uplifted for the H1 provider inflation factor (0.5%).

31. As with the H2 2020/21 framework, systems may, through agreement across their relevant organisations adjust the block payment values with NHS providers within their system to support matching resources to their system delivery model.

32. The H2 2020/21 process for amending block payment between organisations within different systems (inter-system and NHS England contracts) will continue to operate. This process was designed to support organisations to amend contract values while enabling NHS England and NHS Improvement to steward the utilisation of system funding which has been distributed on the basis of enabling all systems to achieve a breakeven position. Requests to change inter-system block payments should be made on the block contracts

amendment template (available in the CCG portal of the lead CCG) by the lead CCG for each system. Changes should be agreed with the relevant NHS England and NHS Improvement regional teams before being submitted for national approval. Queries on this process and template submissions should be addressed to: nhsi.blockamendments@nhs.net.

NHS provider other income

33. During 2020/21, NHS England and NHS Improvement provided additional income support to NHS providers to recognise the impact of COVID-19 on non-NHS income streams. In 2021/22, NHS providers need to take actions to recover their positions – either through recovery of non-NHS income streams, utilisation of capacity for NHS activity to be funded through the Elective Recovery Fund or decommissioning of costs associated with these income streams.

34. To support NHS providers to recover their positions, we will be issuing additional fixed income support in H1 2021/22 through the COVID-19 allocation. The funding provided will represent the totality of funding available for systems, and systems will need to plan for and deliver a breakeven position including this funding. No additional income support will be available.

35. NHS hospitals are required to provide free car parking for disabled people, frequent outpatient attenders, parents of sick children staying overnight and staff working night shifts. In addition, the government committed to provide free car parking for NHS staff for the duration of the pandemic. H2 2020/21 system funding envelopes included funding for free NHS staff car parking. This funding will continue into H1 2021/22 while the policy remains in place. Additional funding has been issued in the H1 2021/22 envelopes for free car parking for the eligible patient groups.

36. Contract arrangements with NHS Wales commissioners should be rolled over into H1 with inflationary increases in line with NHS England contracts. Additional inflationary uplifts for pay agreements will be actioned during the

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financial year. Arrangements for elective recovery for Welsh commissioners are under discussion and will be communicated in due course.

37. NHS providers should agree contracts with local authorities based on the appropriate funding for services. Once the government’s response to the recommendations of the pay review bodies is announced, contracts should be updated accordingly. Arrangements for the funding of core services should not overrule separate arrangements in place for the Hospital Discharge Programme and Better Care Fund (BCF).

38. Health Education England (HEE) arrangements will continue to be funded on an activity basis by reference to the healthcare education and training tariffs.

**Mental health services**

39. CCGs must continue to meet the Mental Health Investment Standard (MHIS) as a minimum in 2021/22. For 2021/22, the MHIS requires CCGs to increase their spend on mental health services by at least 2021/22 published allocation growth.

40. In addition, systems must progress towards their LTP goals through use of their available SDF and additional funding secured through the Spending Review to aid recovery of services from COVID-19.

41. To support achievement of these objectives, a full-year planning process supported by full-year funding information has been initiated. Guidance on the 2021/22 financial planning process for mental health services is outlined in Appendix 1.

42. Systems should ensure that their system plan template and mental health planning return are aligned.
Primary medical care services

43. CCG allocations will be uplifted to fund the growth between 2020/21 and 2021/22 published primary care allocations\(^6\) and the additional allocations described in this section.

Funding for the updated GP contract for 2021/22

44. Additional allocations for the GP contract, on top of the published primary medical allocations, will be issued to fund:

- £20m practice contract funding, continuing to fund the impact of changes in the 2020/21 GP contract

- £24m for the new QOF indicator for mental health – severe mental illness (new for 2020/21)

- £58m for the new QOF indicators for vaccinations and immunisations, previously funded from public health budgets (new for 2020/21)

- the first tranche of the Impact and Investment Fund (IIF) indicators are introduced in April, valued at £50.7m.

45. In addition to the £50.7m above, we expect to fund CCGs up to a further £99.3m for the IIF during 2021/22. The profile of this funding will be subject to further discussions on the IIF indicators. We will adjust CCG allocations to reflect the outcome of these discussions and communicate the detail of the indicators as they are agreed.

46. Allocations for Improving Access funding will continue to be transacted through the same mechanism as in 2020/21, which comprised funding already embedded in CCG core allocations and additional SDF allocations to give a total of £6 per head. This is a change from the approach previously anticipated.\(^7\) They will include allocations made directly to CCGs in London and Greater Manchester.

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Primary care network funding

47. This section details the funding available in respect of primary care networks (PCNs). In 2021/22, funding will comprise the following elements:

- £746m for the Additional Roles Reimbursement Scheme (ARRS):
  
  i. published primary medical care allocations already include £415m of the total £746m funding available for ARRS
  
  ii. the remaining £331m will be held centrally by NHS England and NHS Improvement. Once the PCNs in a CCG area have claimed the total of the CCG’s allocated share of the £415m, and ongoing claims will cause the CCG to exceed this amount, a CCG can access additional funding based on need. The process for this was set out in the 9 October 2020 communication to commissioners

- £134m support for PCNs, comprising:
  
  iii. £91m for the £1.50 per head from published CCG core allocations
  
  iv. £43m for the clinical director roles from CCG primary medical care allocations

- £55m Care Home Premium funding to support PCN delivery of the Enhanced Health in Care Homes services – to be allocated to CCGs separately

- £87m for the PCN Extended Access DES from CCG primary medical care allocations.

Primary care system development funding (SDF) for 2021/22

48. A full analysis of the SDF funding supporting primary care transformation programmes will be issued before 31 March 2021.

National service development funding (SDF)

49. Schedules will be issued detailing the funding available to systems in 2021/22, including 2020/21 funding which continues into 2021/22, and separately identifying H1 and H2 funding. The schedules will outline funding split by national programme and scheme (where relevant): for example, the schedules will identify the funding related to cancer alliances and targeted lung health checks, among other schemes.

50. SDF will be funded through two routes:

- historic SDF embedded in block payments and adjusted CCG allocations in respect of funding for 2019/20, which will remain within block payments and adjusted CCG allocations in H1 2021/22
- additional allocations for 2020/21 and 2021/22 which will be transacted as separately notified allocations.

51. To simplify the transaction of SDF arrangements, we have actioned a net neutral adjustment to transfer historic primary care SDF embedded within adjusted CCG allocations to the separately notified primary care SDF allocations. We have processed this adjustment for primary care SDF for improved transparency of funding and because there is limited interaction with the NHS provider block payment arrangements.

52. For historic SDF embedded in block payments and recurrent SDF issued in 2020/21, the funding should continue to be utilised for the purposes for which the allocation was made (without further planning requirements or reporting processes, unless specifically notified) and commissioners should ensure that funding continues to flow to the relevant organisations to enable them to continue these activities and cover their cost base.

53. The non-recurrent additional funding for flash glucose monitors issued through SDF in 2020/21 will end. These services should continue and should be funded from system envelopes, which include growth funding for prescribing services.

54. To minimise the immediate requirements on systems during Q1, a limited number of further SDF allocations will be issued at 1 April 2021. These
instances are identified in the section below. Additional SDF allocations will be available throughout the course of the year.

H1 2021/22 additional SDF allocations

55. Additional funding will be available from 1 April 2021 for the areas listed in Table 1 below.

Table 1. Further areas of SDF funding from 1 April 2021

<table>
<thead>
<tr>
<th>Programme</th>
<th>Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health</td>
<td>Refer to the ‘Mental health services’ section</td>
</tr>
<tr>
<td>Primary care</td>
<td>Refer to the ‘Primary medical care services’ section</td>
</tr>
<tr>
<td>Community</td>
<td>Funding will be available through SDF for transforming community services, including for accelerating the rollout of the two-hour crisis community health response at home. This transformation funding will be released subject to receipt of plans to accelerate the two-hour rollout in line with planning guidance and a commitment by all community service providers to provide complete, timely and accurate data to the Community Services Dataset (CSDS) throughout 2021/22.</td>
</tr>
<tr>
<td>Long COVID services</td>
<td>Funding will be distributed to regions on the same basis as in 2020/21 to maintain support for the initial assessment services established in 2020/21.</td>
</tr>
<tr>
<td>Outpatient video consultation (VC)</td>
<td>Nationally £10m of funding is available in 2021/22 for the local procurement of outpatient VC capability, to ensure the continued and further adoption of VC to support frontline care delivery. VC is a key enabler in the delivery of the LTP objective to reduce the number of face-to-face outpatient appointments. Regional teams are working with systems to agree procurement arrangements. Further guidance will be issued on the distribution of funding.</td>
</tr>
<tr>
<td>Learning disability and autism</td>
<td>To maintain progress on transformation of learning disabilities and autism services, the H1 proportion of fair share funding and agreed targeted schemes will be distributed to lead CCGs for Transforming Care Partnerships (TCPs).</td>
</tr>
<tr>
<td>Ockenden review of</td>
<td>More than £80m of additional SDF funding will be available to improve the safety of maternity services and to progress implementation of the Immediate and Essential Actions from</td>
</tr>
</tbody>
</table>
maternity services | the Ockenden Review. More detail on how this funding will be distributed is set out in the Maternity section of the H1 2021/22 implementation guidance.

Armed forces | SDF allocations will be distributed to regional commissioners.

Health and justice | SDF allocations will be distributed to regional commissioners.

**H2 2021/22**

56. When we exit the COVID-19 financial framework for H2, the process of transacting SDF for the totality of funding will return to the 'usual' process. SDF allocations (covering historic allocations and additional 2021/22 allocations) will be issued as a separately notified allocation and will be transacted on a programme/scheme basis at relevant periods during the year.

57. To prepare for this change, systems should ensure that they are reviewing their contract arrangements to understand where historic SDF is embedded into block payments and how the transition back to separately notified allocations will need to be managed through amended contracting arrangements from H2.

**Better Care Fund**

58. The government has confirmed that the Better Care Fund (BCF) will continue in 2021/22 and that the CCG minimum contribution will grow (in line with the planned Long Term Plan settlement) by 5.3% to £4.26bn. As part of the H1 arrangements, CCGs’ envelopes include funding for growth to enable CCGs to meet their 2021/22 BCF commitments. Details of the national conditions and processes for the BCF will be set out in due course in the BCF policy and planning guidance.

**MedTech mandate**

59. The MedTech Funding Mandate (MTFM) policy was published in January 2021 and is effective from 1 April 2021. This policy requires NHS providers to make four technologies available to patients: HeartFlow, Placental Growth Factor Based Testing, SecurAcath and gammaCore. These technologies are supported by NICE guidance, deliver cost savings within 12 months, and
reduce hospital visits and clinical interventions, which is vital in the current COVID-19 pandemic.

60. Where NHS providers have already implemented these technologies, providers and commissioners should work together to ensure a continuation of service to patients from 1 April 2021 and make adjustment to contract values as may be necessary to support this. Systems will be expected to fund these technologies from within the system funding envelopes allocated and from core allocations thereafter.

61. New site implementation will need to be managed alongside pandemic activity and recovery. The Academic Health Science Networks (AHSNs) and the technology suppliers are on hand to assist systems. Details of how to contact the AHSNs and additional implementation support is contained in the policy guidance on the NHS England and NHS Improvement website.

Specialised services

62. Arrangements for specialised services will align with the H1 arrangements across the rest of NHS commissioning, with the following areas of note or exception.

63. Systems should be mindful that the system top-up is partly funded from resource which would normally have funded growth in the value of specialised commissioning contracts. This funding will remain within system funding envelopes on a non-recurrent basis during H1 except for the adjustments described below.

Specialised high cost drugs

64. The reimbursement process for specialised high cost drugs in H2 2020/21 will continue as part of the H1 arrangements.

65. The block payments will fund a notional baseline for high cost drugs subject to cost and volume arrangements, and a single block value for other high cost drugs. The notional baselines for 2020/21 will roll into H1 2021/22 at the same level.
66. The H1 provider block payments with specialised commissioners will be updated to transfer any amounts related to the high cost drugs baseline funded in the system top-up value in H2 2020/21 to the specialised block payments. System top-ups included funding for part of the baseline where there were differences between 2019/20 M9 AoB value and rate of spend during M8-M10. This adjustment will have a net neutral impact to system funding envelopes but will simplify funding arrangements such that all funding for specialised high cost drugs will be within the specialised element of block funding in H1 2021/22.

67. Due to the delay between source data for high cost drug reimbursement and payment, prospective payments-on-account will continue as part of the H1 arrangements for Cancer Drugs Fund (CDF), hepatitis C (hep C) and other cost and volume high cost drugs. This will be based on the prospective payment-on-account for M10-M12 included in the 15 March 2021 payment run. Provider block payment values will include these values on top of the notional baselines.

68. The notional baseline for high cost drugs expenditure included in block payments will continue to be trued-up based on actual drugs spend. The reimbursement of CDF, hep C and cost and volume high cost drugs will continue to depend on the provision of accurate data submitted through existing systems, ie complete and accurate information in the provider’s drugs patient-level contract monitoring data submission (DrPLCM) and Blueteq if relevant.

69. There are opportunities for significant drugs savings within high cost drugs. More detail on how commissioners will work with systems to release these will be communicated for implementation in H1 where possible.

Specialised high cost devices

70. The notional baseline for high cost devices expenditure included in block payments will continue to be trued-up based on actual devices spend.

71. As part of the High Cost Tariff Excluded Devices Programme (HCTED), the move to the central procurement route for high cost excluded devices was mandated for all providers by 31 March 2021. In recognition of the impact of responding to COVID-19, the programme team has allowed for slippage in these timescales. However, it is intended that there will be no reimbursement of any devices outside of the NHS Supply Chain route from 1 July 2021. Exceptions to this include the continuing work on the external fixation category,
and devices which are not currently available through the NHS Supply Chain catalogues.

72. To support this process, all providers should have agreed plans for outstanding migrations in place. Where it is believed that there are exceptional circumstances which would require an extension beyond these dates, these must be formally agreed with the national HCTED programme director via regional teams.

Specialised mental health, learning disability and autism provider collaboratives

73. There are currently 10 live NHS-led provider collaboratives (PCs) for specialised mental health, learning disability and autism services in 2020/21. It is expected that more PCs will go live from April 2021. Their scope and remit will be the same as for the first set of PCs, with the extension to cover more geographies than has been the case this financial year.

74. Under these arrangements, identified lead providers take clinical pathway and financial responsibility for the delivery of in-scope services for specific populations. The lead provider (LP) for each PC going live will receive a budget to commission services for their population. Those providers who previously held contracts with specialised commissioning for services within the scope of the PCs will see a reduction in their contract value with specialised commissioning and this value will be transferred to the LP of the PC. LPs will subcontract with other providers to deliver the services in scope.

75. For PCs as they go live, the starting expectation is that LPs will subcontract with NHS providers at the same contract value as the reduction from their block payments, to maintain system financial stability through the transition, although the contract terms may differ as appropriate.

76. For all PCs, it continues to be the expectation that any commissioning intention changes will be carefully managed, jointly agreed, be in line with contractual notice requirements and pay due attention to system financial stability.

77. Any changes to NHS contract values in 2021/22 because of commissioning decisions and service changes are expected to be agreed locally. In any instance where this would materially affect an individual systems’ ability to meet
their system envelope in year, this will be expected to be agreed with the relevant regional team(s) before being enacted.

**Other specialised mental health services**

78. In line with the commitment to fund growth on CCG-commissioned mental health services, additional growth funding will be available in H1 2021/22 for specialised mental health contracts.

**Other adjustments to specialised commissioning block payments**

79. The national and regional specialised commissioning teams will update the H1 specialised commissioning block payment values to reflect agreed values for service changes and clinical priorities, including genomic testing and complex knees services.

80. The implementation of the revised funding models for genomic testing and complex knees services in 2020/21 resulted in funding for services previously within the scope of the NTPS being transferred from system funding envelopes and funded through specialised commissioning contracts with the directly commissioned providers. In H1 2021/22, a further adjustment has been processed to update the 2020/21 adjustment for the latest estimate. Supporting information will be available to providers via regional teams.

**Funding for COVID-19 services**

81. Systems will continue to receive a fixed system envelope for COVID-19 services.

82. Systems should continue to review the utilisation of their system COVID-19 allocation as part of determining the optimal service design for their system. Amendments to the implied distribution should be reported through the system plan template. Changes in NHS provider funding should be transacted as block payment amendments per the guidelines outlined in the ‘NHS provider block payment arrangements’ section.

83. A full list of the COVID-19 items which are eligible to be funded outside of the system funding envelopes in H1 will be issued. For clarity, a table of items
where eligibility has been removed between H2 2020/21 and H1 2021/22 will also be available.

84. For the Hospital Discharge Programme, Scheme 2 costs will be covered for patients discharged up to 31 March 2021 and for the first six weeks of their care, so some costs may continue into H1. Further detail will be issued in relation to the reimbursement arrangements for the Hospital Discharge Programme for patients discharged from 1 April 2021.

85. PPE will continue to be procured nationally, funded and overseen by DHSC until at least the end of June 2021. A decision will be made in April 2021 about arrangements from June 2021 and will be communicated in due course.

86. The Nightingale sites are due to close as acute care facilities. Where sites continue to be utilised in 2021/22 to deliver other COVID-19 services which are funded outside of system envelopes – for example, as part of the COVID-19 vaccination programme – the costs of these facilities should be recorded against the cost category related to their current use. Where regions and systems are approved to use sites as part of services funded from within system funding envelopes, including as part of elective recovery plans, the costs should be borne by the relevant region or system and will need to be managed within their existing funding streams.

**CCG drawdown**

87. The default position for all CCGs continues to be the delivery of a breakeven position.

88. We do not expect to make any drawdown of historic underspends available during the H1 period. This position will be reviewed for H2 2021/22 and will remain subject to affordability.

89. Cumulative historic under and overspends will continue to be reported at a CCG level; however, any future access to historic underspends will additionally take into consideration the net position of the system.
Cash regime

90. The block payment arrangements will be rolled forward for H1 2021/22. There will not be a block payment from commissioners for April 2021 in March. Instead block payments for April 2021 will be paid in April and the in-month pattern will continue with the May block being paid in May, and so on.

91. The method of payment for block payments will remain through invoice payment file (IPF) and payment requests. Detailed guidance outlining the governance arrangements for payment requests and IPF have been issued. Provider invoicing to commissioners should occur in limited instances related to NHS England and NHS Improvement non-healthcare items.

92. Commissioners will continue to pay the NHS provider block on the 15th of the month (or closest working day) until further notice, except for April when payment should be made on the 8 April to support provider cash needs.

93. For funded COVID-19 programmes, NHS providers will continue to be reimbursed in arrears by NHS England and NHS Improvement and CCGs will be reimbursed by allocation adjustment following a process of validation of reported costs.

94. The system top-up and COVID-19 allocation will be distributed to a lead CCG for the system by allocation adjustment. By mutual agreement within a system, funding should be transacted to NHS providers, where relevant, through amendments to their block payment arrangements.

95. Amendments to NHS provider funding for specialised high cost drugs and devices will be reimbursed in arrears through amendments to the specialised block payment values.

96. It remains important that providers and commissioners pay promptly during this time, so that cash flow for NHS and non-NHS suppliers of goods and services (including, for example, NHS Supply Chain) does not become a barrier to service provision.

97. In the context of the expected overall cash mandate for 2020/21 and H1 funding, it is expected that provider net cash borrowing requirements will remain low. Where providers do require supplementary revenue cash support,
providers will be able to apply for revenue cash support from the Department of Health and Social Care (DHSC) via the NHS England and NHS Improvement Capital and Cash team. Communication of the process to access revenue cash financing from DHSC will be issued per normal processes.

Capital regime

98. Guidance on system capital allocations and the 2021/22 capital planning process was published on 16 March 2021.9

99. Systems should consider the revenue impacts of their capital plans when completing their system plan template, including considering the impacts of depreciation on COVID capital assets but excluding the impact on PDC dividend for COVID capital assets that are exempt from the calculation.

Queries and FAQs

100. Unless specified otherwise, queries on the H1 financial arrangements should be directed to NHSI.FinPlan@nhs.net. FAQs will be issued to CCGs (through the SharePoint Planning Library) and to providers (through the additional documents section of provider portals).

101. Queries on the process to amend NHS provider block payment arrangements and template submissions should be directed to: nhsi.blockamendments@nhs.net

102. FAQs in relation to the mental health financial planning process will be available via the NHS Futures Collaboration Platform.

Appendix 1. Mental health financial planning guidance

Introduction

1. It is anticipated that the impact of COVID-19 will lead to a significant increase in demand for mental health services, with evidence of services already seeing increased referral rates. The NHS Long Term Plan (LTP) for Mental Health and the ambitions outlined in the Mental Health Implementation Plan 2019/20 - 2023/24 (the implementation plan) remain solid foundations to deliver mental health services in the context of COVID-19 and respond to the growing mental health needs of the population in the future.

2. We therefore confirm that for 2021/22:
   - all CCGs are individually required to meet the Mental Health Investment Standard (MHIS)
   - service development funding (SDF) will flow in line with the implementation plan
   - additional funding from the £500m announced at the Spending Review has been provided by HM Treasury in 2021/22 to accelerate recovery from COVID-19 and to bring forward elements of the LTP
   - mental health support hubs for staff will continue to be funded in 2021/22 through additional SDF funding.

3. Mental health financial planning will be undertaken once in relation to minimum investment requirements. In undertaking the annual mental health financial planning process, CCGs and systems need to plan for the minimum investment to meet the MHIS. Additional investment in mental health services above the minimum can be included in the wider system financial planning process for April to September 2021 (H2).

4. In 2021/22, all systems must invest the full amounts available to them, recovering activity lost during the pandemic and locking in beneficial changes made throughout the COVID-19 response. Amounts allocated in this planning round must not cover COVID-19 costs such as personal protective equipment. Systems are encouraged to work together to flow available
funding at the earliest opportunity to enable investment to be delivered throughout the financial year.

1. Timeline and process

5. The **Mental Health Finance Planning 2021/22 template** (the template) will be issued separately. Systems are required to complete their template in accordance with this guidance and submit to NHS England and NHS Improvement. **Systems should implement their plans as soon as they have been agreed locally. Submission should be made by 6 May 2021.**

6. NHS England and NHS Improvement will seek assurance that funding is flowing to providers, to enable the greatest opportunity for investment. **CCGs should flow agreed funding to providers equally throughout the year (on a monthly basis) and not withhold funding until later in the financial year.**

7. Submissions will be reviewed against the cumulative growth in the **LTP analytical tool (see para 25).** These findings will be shared back to regional finance and mental health teams, to enable CCGs and providers to explain any major divergences, and where it is required, to establish recovery plans where investment will not deliver the commitments set out in the Long Term Plan.

2. Governance arrangements

8. ICSs/STPs are asked to lead mental health finance planning to agree an investment plan at system and CCG level. The template should be signed off by:

   • the ICS CFO
   • each CCG CFO
   • each NHS mental health provider trust CFO listed in the template.

9. By signing off the template, each party is confirming that the agreed plan is the best way to deploy the resources available within the Mental Health Investment Standard, to deliver the Long Term Plan objectives for mental health and that the SDF and Spending Review funding is being spent for the purposes for which it was allocated, as detailed in this document.
3. Elements of the mental health finance planning process

3.1 Meeting the Mental Health Investment Standard (MHIS)

10. The minimum spend to meet the MHIS is based on forecast outturn at month 11 of 2020/21 from CCGs’ non-ISFE returns, increased by the allocation growth for each CCG. Where a CCG is forecasting to not meet the MHIS in 2020/21, the shortfall will be added to the 2021/22 minimum. During 2021/22 the minimum spend to meet the MHIS will be reviewed and adjusted to reflect outturn and any shortfalls discovered through the independent review of 2019/20 MHIS performance.

11. Systems and CCGs should note that as the Agenda for Change (AfC) settlement has not been confirmed, CCGs should hold the amount of the minimum spend estimated for pay inflation in a tariff adjustment reserve. This is calculated within the template for each CCG and each CCG must agree to hold a reserve.

12. The categories of spend included in the MHIS are set out here. While we expect some minimal growth in mental health continuing health care (CHC) and prescribing, this growth is not expected to exceed 20/21 FOT add inflation. We expect growth in core mental health services will be equal to or greater than the overall growth in mental health spend.

13. CCGs will also need to demonstrate an increase in the percentage of their total mental health spend that is spent with NHS mental health providers and non-NHS providers that provide core and specialist mental health services. Where there are exceptions to this increase, this should be agreed with ICS/STP leadership.

14. As part of the mental health LTP ambition, CYP mental health investment will increase faster than overall mental health investment and overall NHS funding.

15. Investment in learning disability, autism and dementia should not be included in the MHIS, unless investment is for services for mental health and learning disability where the primary aim is to treat someone’s mental health condition.

16. From 2021/22, most physical health checks for people with SMI and follow-up actions should take place within primary care, and these will be funded via the
GP Contract and the Quality Outcomes Framework (QOF) incentive scheme for primary care. Any MHIS spend noted here should be on top of national level investment into QOF to support PH SMI checks.

Supporting Information to meet the MHIS in 2021/22

17. To support with planning the following information is provided:

*Indicative CCG funding profile for 2021/22*

18. A supporting schedule will be provided to regional finance teams, which will provide each CCG with an indicative breakdown of investments across each mental health programme area to maintain progress on the LTP in 2021/22.

19. This profile has been calculated by first providing pay and non-pay growth on 2020/21 outturn. The remaining proportion of each CCG’s allocation growth has then been apportioned based on the programme breakdown provided by the LTP analytical tool. This funding profile should provide a blueprint for how MHIS funding could be spent where systems may not have the usual capacity to undertake a full financial planning process but will always need local review as it is based on national assumptions.

*The LTP analytical tool*

20. The LTP analytical tool provides an indicative baseline increment for programmes where the LTP has committed further investment and should be used as a check against local plans. This is particularly relevant for community SMI where CCGs should continue to invest CCG baseline MHIS funding growth in 2021/22 in community mental health services broadly in line with the LTP analytical tool, with funding flowing to providers as soon as possible.

21. CCGs may be starting from different points in terms of level of investment, which will affect investment decisions, but a large variance from the analytical tool may indicate a problem and should be investigated to be sure that local plans will deliver on the LTP ambitions:

- Amounts detailed in the LTP analytical tool may differ from those in the 'Indicative CCG funding profile for 2021/22' as the LTP analytical tool sets out the indicative cumulative baseline growth from the start of the LTP.
• The LTP analytical tool nationally apportions LTP growth using target allocations. STPs'/ICSs' resource will vary depending on distance from target, previous mental health spending and other priorities.

• The new and expanded services being introduced as outlined in the Mental Health Implementation Plan 2019/20 - 2023/24 have been assumed to cover all demographic and non-demographic growth for mental health, including on services in the pre-2019/20 baseline.

22. FAQs in relation to the mental health financial planning process will be updated and made available via the NHS Futures Collaboration Platform.

3.2 Service development funding and Spending Review funding

Service Development Funding (SDF)

23. In 2021/22 allocated SDF funding is included in the mental health finance planning template (separately to the MHIS). Funding that has been agreed as part of SDF or transformation funding does not contribute towards delivery of the MHIS.

24. SDF (and Spending Review funding) has been allocated to all programmes excluding the following:

• MHST 2021/22 sites wave 5 and 6 (MHST2021/22)

• rough sleeping 2021/22 sites

• problem gambling – 2021/22 sites

• specified sites for community SMI and perinatal MMS (new sites for 21/22)

• children and young people (four-week wait sites), Spending Review only.

25. The allocation process for these programmes will be undertaken separately to allow release of funding from July 2021.

26. The funding for Department for Work and Pensions (DWP) employment advisors in IAPT services is pass-through from DWP to CCGs. There are
memorandums of understanding in place between DWP and CCGs which detail the values. Allocations will be included in the template as notified by DWP.

27. We will review CCGs’ delivery of submitted plans over the first half of the year with regional teams. Where performance is poor and there are no plans to ensure recovery to full delivery, further SDF funding may not be released in full during quarters 3 and 4.

**Spending Review funding**

28. CCG Spending Review allocations have been included where these are on a fair share basis across CCGs. This funding does **not** contribute towards the delivery of the MHIS; where the Spending Review investment allows an early start on investments planned for 2022/23, these will be included in the MHIS in 2022/23, when they become recurrent. CCGs will need to allocate this funding to providers as part of the mental health finance planning process and include in the total provider contracts.

**3.3 NHS provider contract summary**

29. CCGs are required to show NHS providers which they are contracting with as part of the minimum spend to meet the MHIS, SDF and Spending Review investments where total investment is £500,000 or greater. The planning template calculates a monthly amount expected to flow from CCGs to NHS providers, with investment expected to be made equally throughout the year.

**3.4 Mental health community realignment**

30. Significant investment from CCG baselines is expected as part of the community transformation (about £1 billion by 2023/24). The MHIS categories were updated in 2020/21 to align them better to the mental health LTP and capture this investment. Community and crisis outturn for 2018/19 and 2019/20 should now be recategorised, at CCG level, to enable historical comparison.

31. CCGs and STPs/ICSs may need to work with their mental health providers to recategorise contracted services in 2018/19 and 2019/20. CCGs are **only** expected to recategorise adult community and crisis categories that are no longer in use to the 2020/21 adult community and crisis categories. If
necessary, spend against old categories can be recategorised against other MHIS categories, but it is expected that this will only happen by exception.
<table>
<thead>
<tr>
<th>Agenda item</th>
<th>P71/21</th>
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<tbody>
<tr>
<td>Report</td>
<td>National, Integrated Care System and Integrated Care Partnership Report</td>
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<tr>
<td>Executive Lead</td>
<td>Michael Wright, Deputy Chief Executive</td>
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<td>Link with the BAF</td>
<td>B11, B12</td>
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<td>How does this paper support Trust Values</td>
<td>N/A</td>
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<td>Purpose</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 Board with an update on national developments and developments across the South Yorkshire and Bassetlaw Integrated Care System (SYB ICS) and Integrated Care Partnership (Rotherham Place).

Key points to note from the report are:

1. The chancellor delivered his budget on 3rd March 2021. On 18th March a further £6.6bn was made available to the NHS to cope with the impact of the Covid-19 pandemic.

2. A letter from was sent from NHSE/I to national leaders warning of a significant slowdown in vaccine supply from April.

3. The ICS Collaborative Partnership Board held a session on ‘Developing a Population Health Led ICS and Addressing Health Inequalities’ in early March.

4. Rotherham Place continues to make exceptional progress with its Covid-19 vaccination program and as at 17th March there has been over 90% take up for the over 70s and the clinically extremely vulnerable.

5. A review has taken place of the gap in provision for Covid-19 patients who are not admitted to hospital but continue to experience issues related to ‘long Covid’ |
<p>| 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 |</p>
<table>
<thead>
<tr>
<th>Who, What and When</th>
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<tr>
<td>(what action is required, who is the lead and when should it be completed?)</td>
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<tr>
<td>Recommendations</td>
<td>It is recommended that the Board note the information in this paper.</td>
</tr>
<tr>
<td>Appendices</td>
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</tbody>
</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 Chancellor delivered his budget to Parliament on 3rd March 2021. On 18th March the Government announced that a further £6.6bn would be available to the NHS to help with the impact of the Covid-19 pandemic for the first six months of the new financial year.

2.2. The Government has made a recommendation of a 1% pay rise to the independent panel which makes decisions on Agenda for Change pay increases.

2.3. NHS England reported that NHS staff had cared for 50% more non-covid patients during the winter peak with 1.3million patients benefitting from non-covid care in January 2021 compared to 847,000 in April 2020. This includes around 70,000 more emergency admissions in January than in April.

2.4. The national vaccine programme continued its rollout. On 6th March invites were sent out to people aged 56-59 (approximately 1.7m people) who were now eligible for their vaccine. This follows high take up in older groups.

2.5. A letter sent to NHS Leaders on 17th March warned that vaccine supply may be significantly reduced in April and that no further bookings are uploaded onto the national system. While the Government remain confident the roll out will still meet the deadlines set, this will undoubtable have an effect, particularly in roll out of the under 50s.

2.6. Many EU countries paused the roll out of the AstraZeneca vaccine, raising concerns over its potential to cause blood clots. There has been significant push back from within the UK with many independent scientist questioning the rationale for this ‘pause’. On 18th March the UK medicines regulator said that after review there was no evidence that the vaccine causes blood clots. This was also confirmed by the EU medicines regulator on 19th March with many countries now planning to restart use of the vaccine.

2.7. The fallout from Covid-19 on the NHS elective care programme continue to emerge. In early March it was reported that over 300,000 patients had waited over a year for the start of treatment and the overall waiting list was at 4.6m, a record high.

2.8. The national NHSE/I planning guidance was issued on the 25th March 2021 (at the time of drafting this report). Organisational, Place and ICS plans will need to be developed at pace.

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

3.1. The ICS Collaborative Partnership Board held a session on ‘Developing a Population Health Led ICS and Addressing Health Inequalities’ in early March. This was following a development session with the Health Executive Group (HEG), which looked to re-energise this focus as we exit Covid-19. As part of its aim to ‘build back fairer in 2021/22’ it set out the following principles:

a) Improve the health of the SYB population and improve the health of those with worst health fastest.

b) Understand need and assets across SYB using data and intelligence ‘one version of the truth’.

c) Allocate resource in response to need and assets, with a premium on prevention / upstream interventions.
d) Support Places to deliver place strategies using Marmot principles to improve health outcomes and address Health Inequalities particularly for the most vulnerable and deprived populations.

e) Levelling up of outcomes and a ‘Shift left’ (£investment and focus into primary care at scale over time).

f) Build system capacity and capability for population health management and addressing health inequalities.

3.2. Providers across SYB ICS continued to make good progress in bringing elective services back online. Despite having the highest Covid-19 occupancy in the North East region through February, all acute providers were at or above the regional average for day case work and all (with just one exception) were above for elective inpatients.

3.3. While Covid-19 has continued to decline within SYB in line with the national picture, in the wider region, this fall as not been as steep as elsewhere. On March 10th, Yorkshire and the Humber had the highest Covid-19 prevalence in the country with 103.4 cases per 100,000. The 2nd highest region was the East Midlands at 82.3 cases per 100,000.

4.0. Rotherham Integrated Care Partnership (Place)

4.1. Rotherham Place continues to make exceptional progress with its Covid-19 vaccination program and as at 17th March there has been over 90% take up for the over 70s and the clinically extremely vulnerable. Over 90,000 people in Rotherham have been vaccinated across the five Primary Care led vaccination centres and the hub at TRFT.

4.2. Evaluation of the Rotherham Social Prescribing Service highlighted that take up of social prescriptions from the BAME community was under 3%. The more recent Primary Care Network Link Worker scheme also highlighted lower access from BAME patients. Between January and March 2021 there was a deep dive into the evaluation findings, and to explore causes and offer solutions. The report details the findings of the work carried out by Voluntary Action Rotherham, You Asked We Responded Services and Rotherham Ethnic Minority Alliance as part of efforts to promote equality of access to social prescribing and respond to a perception that BAME communities are underrepresented amongst patients accessing the services.

4.3. A multi-agency Health Inequalities Data group has been established with the initial focus being to map current workstreams across the system to better understand health inequalities and the impact of Covid-19 on different groups and to support the articulation of the health inequalities picture. Linked workstreams include population health management, risk stratification, new data collections (particularly relating to Covid-19) and ICS networks. A workshop was held and an analysis undertook of the key themes.

4.4. A review has taken place of the gap in provision for Covid-19 patients who are not admitted to hospital (there is already a recognised pathway for these patients) but continue to experience issues related to ‘long Covid’ i.e. those with issues 12 weeks after diagnosis. The proposal will utilise the Social Prescribing resource to support GP practices with the initial assessment of patients and to identify the appropriate services for referral. Once referred by the GP practice, the social prescribers will then follow up with the patients to ensure they are receiving relevant appointments and do not require any additional support. In essence, the service will acknowledge Covid-19 as a ‘long term condition’ for normal management.

4.5. The process has commenced once again to reaffirm the place priorities and set out performance as at the end of March 2021, to provide a shared understanding at system level of the position going into 2021/22 and to support the requirements of the forthcoming planning guidance.
## Agenda item
P72/21

## Report
Approval of Trust Operational Plan 2021/2022

## Executive Lead
Michael Wright, Deputy Chief Executive

## Link with the BAF
B1, B2, B10

### How does this paper support Trust Values
The Trust Operational Plan for 2021/22 incorporates the Trust's values into the priority areas – it contains ambitious plans around delivery of our services to patients; it reflects a need to focus on caring across the organisation, and it puts our colleagues working together and looking after our own health and wellbeing at the heart of the priorities.

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

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

The Operational Plan for 2021/22 has been developed through a period of internal engagement over the last few months, alongside development of divisional priorities for next year. Following the publication on Thursday 25th March 2021 of the national planning guidance, we are now in a position to approve the final version of our Trust Operational Plan for 2021/22, which sets out the key priorities we will be focussing on delivering as an organisation.

This paper therefore seeks approval of the priorities and deliverables within the Trust Operational Plan for 2021/22. Following Board approval of these focus areas, Executive Team Leads and SROs will be identified for each of the six priorities, with action plans and key success metrics established in April, to enable monitoring of progress going forward through appropriate internal forums.

A summary of the planning guidance is also included within the appendix for reference. The publication of the guidance did not fundamentally change the priorities within our draft operational plan, but we have highlighted key elements which we will need to build into the more detailed action plans that are developed in the coming weeks.

## Due Diligence
This plan has been discussed as part of the series of Board Seminars in Q4 on three occasions as it has been developed, and has also received review prior to these discussions at the Executive Team meeting.
<table>
<thead>
<tr>
<th>Board powers to make this decision</th>
<th>In order to be assured of the appropriateness of the Trust’s plan for 2021/22, the Board needs to approve the organisation’s priorities for next year.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who, What and When</td>
<td>The Deputy Chief Executive is the Lead Executive Director for the development of the operational plan, supported by the Director of Strategy, Planning and Performance.</td>
</tr>
<tr>
<td>Recommendations</td>
<td>It is recommended that the Board of Directors approve the key priorities and deliverables set out below as the Trust Operational Plan for 2021/22.</td>
</tr>
<tr>
<td>Appendices</td>
<td>Trust Operational Plan 2021/22</td>
</tr>
</tbody>
</table>
Trust Operational Plan
2021-22

Board of Directors

April 2020

The Rotherham NHS Foundation Trust
Contents

• Trust Organisational Plan 2021/22

• National Planning Guidance 2021/22
  Summary
Development of the Operational Plan 2021/22

**Divisional Input**
- Divisions were asked to provide **high level summaries** of their expected priorities for 2021/22
- The request was for the response to be what the divisions realistically think is **deliverable within 2021/22**
- Generally the focus for 2021/22 is on ‘**BAU**’ improvements rather than large scale transformational change

**Board Workshops**
- Three **Board Seminars** held in January, February and March, with focus on the operational plan
- **Breakout sessions** to agree high-level priorities and underlying objectives
- Draft outputs shared for further review and refinement at subsequent discussions
- **Six priorities** agreed

**Senior Leadership Engagement**
- Executive Team discussions focussing on potential **key success metrics** and outcomes to confirm completeness of proposal
- Summary outputs shared with General Managers and Divisional Directors for further input/comment
- Planning Guidance reviewed to ensure no additional priorities required
Trust Operational Plan 2021-22 – FOR APPROVAL

Safely exit the Covid-19 Pandemic
- Deliver full programme of Health and Wellbeing initiatives for staff
- Identify new practices from Covid-19 to embed in the long-term and implement new ways of working

Focus on the fundamentals of care
- Embed agreed standards of care and support teams to deliver and embed quality improvement
- Embed effective learning from deaths practices and deliver improved mortality rate

Deliver elective recovery for patients
- Plan the long-term recovery of elective care and deliver 2021/22 recovery plan
- Implement programme of ensuring operational excellence in elective care

Empower and enable staff to deliver
- Design and launch organisational development programme for divisional teams
- Build a culture so the Trust is seen as an employer of choice, appointing to key clinical leadership vacancies

Deliver a step change improvement in flow
- Implement best practise discharge processes across the organisation to support stronger flow
- Focus on admission avoidance through implementing effective ambulatory and frailty pathways

Drive the organisation forwards
- Deliver on our financial commitments, and ensure removal of breach of licence
- Publish a new five year strategy, and support partners with re-organisation
Contents

• Trust Organisational Plan 2021/22

• National Planning Guidance 2021/22 Summary
Planning Guidance - Five Core Themes

1. Supporting the **health and wellbeing of staff** and taking action on recruitment and retention

2. Delivering the **NHS COVID vaccination programme** and continuing to meet the needs of patients with COVID-19

3. Building on what we have learned during the pandemic to transform the delivery of services, accelerate the **restoration of elective and cancer care** and manage the increasing demand on mental health services

4. **Expanding primary care capacity** to improve access, local health outcomes and address health inequalities

5. Transforming community and urgent and emergency care to **prevent inappropriate attendance at emergency departments** (ED), improve **timely admission to hospital** for ED patients and **reduce length of stay**
Supporting the health and wellbeing of staff and taking action on recruitment and retention

Looking after our people and helping them to recover

- Trusts to allow staff to carry over all unused annual leave and offer flexibility for staff to take or buyback unused leave
- Individual health and wellbeing conversations should take place over the course of first half of the year
- Occupational health and wellbeing support should be available to all staff, including rapid access to psychological and specialist support

Belonging in the NHS and addressing inequalities

- Develop improvement plans based on the latest WRES findings, including to improve diversity through recruitment and promotion practices
- Accelerate the delivery of the model employer goals.

Embed new ways of working and delivering care

- Providers should maximise the use of and potential benefits of e-rostering
- Providers are asked to show how they intend to meet the highest level of attainment as set out by our ‘meaningful use standards’ for e-job planning and e-rostering

Grow for the future

- Ensure system plans draw on national interventions to introduce medical support workers (MSWs), and make use of associated national funding, increase health care support workers (HCSWs) and international recruitment of nursing staff.
- Develop and implement robust postgraduate (medical and dental) training recovery plans
Covid-19 Vaccination Programme

• Offer first dose to entire adult population by end of July. Delivered through implementing a mixed model of vaccine delivery through vaccination centres, hospital hubs, general practice and community pharmacy capacity

• Systems will need to consider:
  • being prepared for a COVID-19 re-vaccination programme from autumn, with high uptake ambitions for seasonal flu vaccination, alongside:
  • the possibility of COVID-19 vaccination of children, should vaccines be authorised for use in under 18s and recommended by the JCVI in this population.

• All systems to provide timely and equitable access to Post COVID Syndrome (‘Long COVID’) assessment services. We will continue national funding to maintain the dedicated Post COVID Assessment clinics.

• All NHS organisations should ensure continued reliable application of the recommendations in the UK Infection Prevention and Control guidance
Elective Recovery Plans must meet five objectives:

- **Addressing health inequalities**
  - Use waiting list data to identify disparities in relation to the bottom 20% by Index of Multiple Deprivation (IMD) and black and minority ethnic populations
  - Prioritise service delivery by taking account of the bottom 20% by IMD and black and minority ethnic populations for patients on the waiting list and not on the waiting list

- **Transforming Outpatient Services**
  - At least 25% of OP appointments should be delivered remotely by telephone or video consultation.
  - Introduce Patient-Initiated Follow-up (PIFU), or similar alternative, in at least three major outpatient specialties per provider
  - Increase the uptake of Advice and Guidance or other measures such as referral triage to avoid unnecessary first attendances.
  - Implement whole pathway transformations and improve performance in 3 specialties: cardiac, musculoskeletal (MSK) and eye care with support via the National Pathway Improvement Programme

- **System-led Recovery**
  - Set out how management of Patient Tracking Lists (PTLs), including for cancer patients, will be undertaken at a system level
  - How NHS and IS capacity will be used to the benefit of the whole system population

- **Waiting Lists**
  - Shared decision making and treatment reviews between patients and clinicians
  - Maintain waiting list data quality, including detailed provider validation, of the weekly Waiting List uploads
  - Clinical validation, focusing on diagnostic and non-admitted pathways, providing evidence of how long-waiting patients will be regularly reviewed and risk assessed.

- **People Recovery**
  - Demonstrate how systems will monitor and safeguard staff health and wellbeing, using an appropriate set of staff experience measures
Elective Recovery Fund

Scheme Overview

• Systems will be paid through the Elective Recovery Fund for activity delivered above nationally set thresholds as compared to 2019/20 activity levels, which will be an aggregate of inpatient and outpatient activity delivered by both NHS and IS providers and will include both CCG and specialised activity.

• Baseline will be calculated using a £ value based on tariff prices. The baseline and value of activity delivered will be calculated using data submitted to SUS+.

• The scheme will operate on an individual month basis.

• For activity delivered between the target thresholds and the estimated funded activity within envelopes (set at 85%), systems will receive an additional payment at 100% of tariff. Additional activity above 85% will receive the equivalent of 120% of tariff.

Scheme Scope

• The thresholds, as a percentage of the value of the 2019/20 activity, will be:
  • 70% for April 2021
  • 75% for May 2021
  • 80% for June 2021
  • 85% from July to September 2021

• Scope of the activity covered is:
  ✓ elective activity (ordinary or day case), including cancer, with a published tariff price.
  ✓ outpatient procedures with a published tariff price.
  ✓ outpatient attendances for all treatment function codes (TFCs) apart from mental health, maternity and diagnostic imaging, whether consultant-led, non-consultant-led or non face-to-face.
**Cancer Services**

**Targets**
- Return the *number of people waiting for longer than 62 days* to the level we saw in February 2020.
- Meet the increased level of referrals and treatment required to address the shortfall in *number of first treatments* by March 2022.
- Systems will be expected to meet the new *Faster Diagnosis Standard from Q3*, to be introduced initially at a level of 75%.

**Getting patients to come forward**
- Increase the number of people coming forward and being referred with suspected cancer.
- Restore all cancer screening programmes – extend bowel cancer screening to include 50-60 year olds, with rollout to 56 year olds from April 2021.

**Investigate and Diagnose**
- Extend the centralised clinical prioritisation and hub model.
- Increase take up of innovations like colon capsule endoscopy and Cytosponge.
- Accelerate the development of Rapid Diagnostic Centre pathways.
- Restore first phase Targeted Lung Health Check projects.

**Treat**
- Embed the system-first approach to collaboration established during the pandemic, including centralised clinical triage and centralised surgical hubs.
- Agree personalised stratified follow up (PSFU) pathways in three additional cancer types and implement one by March 2022.
Expanding primary care capacity

Restoring and increasing access to primary care services

- All systems are expected to support their PCNs to:
  - achieve share of 15,500 FTE PCN roles to be in place by March 2022, in line with the target of 26,000 by 2023/24
  - expand the number of GPs towards the 6,000 target
  - continue to make progress towards delivering 50 million more appointments in general practice by 2024
- All practices offering face-to-face consultations; Support practices to increase significantly the use of online consultations
- Work with local communities to address health inequalities
- Community Pharmacy Consultation Service extended to include the ability to receive referrals from General Practice
- Dental services should maximise clinically appropriate activity and target capacity to minimise deterioration in oral health and reduce health inequalities.

Implementing population health management and personalised care to address health inequalities

- Adopt population health management techniques
- Apply person-centred segmentation and risk stratification to identify at-risk groups
- Develop robust plans for the prevention of ill-health, covering both primary and secondary prevention deliverables as outlined in the Long Term Plan (including expansion of smoking cessation services, improved uptake of the NHS diabetes prevention programme and CVD prevention)
- Deliver the NHS Comprehensive Model for Personalised Care; Accelerate the delivery of existing requirements, including personal health budgets, social prescribing referrals and personalised care and support plans
### Prevent inappropriate attendances, improve timely admission and reduce length of stay

<table>
<thead>
<tr>
<th>Transforming community services and improve discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Set out plans to accelerate the rollout of the 2-hour crisis community health response at home to provide consistent national cover (8am-8pm, seven days a week) by April 2022</td>
</tr>
<tr>
<td>• All providers should seek to deliver an improvement in average length of stay with a particular focus on stays of more than 14 and 21 days</td>
</tr>
<tr>
<td>• We will continue to fund the first six weeks of additional care after discharge from an NHS setting during the first quarter and first four weeks from the beginning of July</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ensuring the use of NHS111 as the primary route to access urgent care and the timely admission of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Promote the use of NHS 111 as a primary route into all urgent care services</td>
</tr>
<tr>
<td>• Maximise the use of booked time slots in A&amp;E with an expectation that at least 70% of all patients referred to an emergency department by NHS 111 receive a booked time slot to attend</td>
</tr>
<tr>
<td>• Maximise the utilisation of direct referral from NHS 111 to other hospital services</td>
</tr>
<tr>
<td>• Adopt a consistent, expanded, model of SDEC provision, including associated acute frailty services</td>
</tr>
</tbody>
</table>
## Submission Requirements

**Activity and Performance:**
Single system level collection incorporating CCG and provider level breakdowns as appropriate

**Workforce:**
Single system level collection across acute, community and primary care, incorporating provider level breakdown

**Finance:**
System financial planning template Provider financial planning template

**Supporting Narrative:**
A single system level template covering the actions and assumptions that underpin the trajectories and other critical actions that systems will take over the next 6 months to address the priorities set out

## Planning Assumptions

- **Overall non-elective demand** from COVID and non-COVID returns to pre-pandemic (2019/20) levels from the beginning of the 2021/22
- **COVID general and acute bed occupancy** remains <5% between April and September 2021
- All NHS organisations should ensure continued reliable application of the recommendations in the UK **Infection Prevention and Control** guidance. Individual organisations should make an assessment of the productivity impact based on local mitigation plans
# Planning Guidance - Timetable

<table>
<thead>
<tr>
<th>Task</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Templates issued</td>
<td></td>
</tr>
<tr>
<td>- Non-functional activity and workforce</td>
<td>26th March</td>
</tr>
<tr>
<td>- Narratives</td>
<td></td>
</tr>
<tr>
<td>System financial templates issued</td>
<td>29th March</td>
</tr>
<tr>
<td>Organisational (provider) capital and cash plan submissions</td>
<td>12th April</td>
</tr>
<tr>
<td>System finance plan submission</td>
<td>6th May</td>
</tr>
<tr>
<td>Draft plan submission</td>
<td></td>
</tr>
<tr>
<td>- activity, workforce, narrative plan</td>
<td></td>
</tr>
<tr>
<td>Non-mandated provider organisation final finance plan submission</td>
<td>24th May</td>
</tr>
<tr>
<td>Final plan submission deadline</td>
<td>3rd June</td>
</tr>
<tr>
<td>- activity, workforce, narrative plan</td>
<td></td>
</tr>
</tbody>
</table>
Further Detail

• System Development
• Health inequalities
• Maternity Priorities
System Developments

ICSs - 4 core purposes

1) Improving outcomes
2) Tackling inequalities
3) Enhancing productivity
4) Social and economic development

Expectations around system progression 21/22:

1) One Statutory NHS body and one statutory ICS health and care partnership per ICS from April 22
2) CCG functions subsumed into ICS NHS body. Some NHSE direct commissioning functions transferred to ICSs
3) Staff below Board level affected will have employment commitment. Local administrative running costs will not be cut
4) NHS organisations to continue to forge relationships with local government.
5) Development of primary and community services, implementation of population health management
6) Every acute or mental health FT will be part of at least one provider collaborative
7) Clinical and professional leadership will be enhanced
System Development - Implementation in 2021/22

**Update System Development Plans**
- Updated by end Q1 to set out how ICSs will take on statutory responsibilities
- Implementation plan for managing people transition
- Confirm plans for ensuring commissioning functions organised across ICS footprint

**Establish shadow arrangements**
- Establish shadow arrangements for the system’s ICS NHS body and health and care partnership, including related governance arrangements
- Agree ICS ‘MOU’ for 2022/23

**Confirm ICS Leadership**
- Confirm designate appointments to ICS Chair and Chief Executive roles
- Confirm designate appointments to other ICS leadership roles

**Establish new ICS body**
- Staff and property (assets and liabilities) transferred to new body, and boards in place

End Q1
- From Q1
- Q2/Q3
- 1st April 2022
Health Inequalities

Systems are now asked to focus on **five priority areas** in the first half of 2021/22:

<table>
<thead>
<tr>
<th>Restore NHS services inclusively</th>
<th>Mitigate against digital exclusion</th>
<th>Ensure datasets are complete and timely</th>
<th>Accelerate preventative programmes</th>
<th>Strengthen leadership and accountability</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Plan the inclusive restoration of services, guided by local evidence</td>
<td>• Providers offer face-to-face care to patients who cannot use remote service</td>
<td>• Improve the collection and recording of ethnicity data across primary care, outpatients, A&amp;E, mental health, community services, and specialised commissioning</td>
<td>• Increase vaccination uptake in groups that had a lower uptake than the overall average as of March 2021</td>
<td>• Named executive board-level lead for tackling health inequalities</td>
</tr>
<tr>
<td>• Informed by NHS performance reports that are delineated by ethnicity and deprivation</td>
<td>• Identify who is accessing face-to-face, telephone, or video consultations, broken down by relevant protected characteristic and health inclusion groups</td>
<td></td>
<td>• Accelerate preventative programmes and proactive health management for groups at greatest risk of poor health outcomes</td>
<td>• Access training made available by the Health Equity Partnership Programme</td>
</tr>
</tbody>
</table>
### Pandemic Recovery

LMSs need to oversee and support trusts to:
- Reopen any services that have been suspended due to Covid-19
- Remove restrictions on women’s access to support
- Take active steps to help maternity staff recover from the pressures of the pandemic
- Continue to implement the four actions to minimise the additional risk of COVID-19 for Black, Asian and minority ethnic women and their babies.

### Ockenden and the governance of LMSs

The actions regarding the governance of LMSs should be taken forward in a way that positions LMSs as the maternity arm of ICSs in line with Integrating Care:

1. LMS must be given greater accountability and responsibility so that they can ensure the maternity services they represent provide safe services for all who access them.
   - All LMSs to review their terms of reference and work programme by 3 June 2021
   - ICSs should set out how they will take on formal, structured and systematic oversight of how their LMS delivers its functions
2. An LMS cannot function as one maternity service only
   - All LMSs, in consultation with regional teams, to identify a buddy LMS and implement processes for peer review and support by 3 June 2021
3. The LMS Chair must hold CCG Board level membership
Maternity and Neonatal – Transformation Priorities

LMSs are expected to move back to delivering a more complete range of transformation objectives to make maternity care safer, more personalised and more equitable:

1. Ensure every woman is offered a Personalised Care and Support Plan
2. Implement the five elements of the Saving Babies’ Lives care bundle
3. Make new NHS smoke free pregnancy pathways available for up to 40% of maternal smokers
4. Embed maternal medicine networks so that women with acute and chronic medical problems have timely access to specialist advice and care at all stages of pregnancy
5. Embed the offer to all women with type 1 diabetes of continuous glucose monitoring
6. Work with neonatal Operational Delivery Networks to implement local neonatal improvement plans
7. Implement the Core Competency Framework and ensure all maternity staff receive multi-disciplinary training
8. Put in place the building blocks by March 2022 so that continuity of carer is the default model of care
9. LMSs will be asked to submit an equity analysis (covering health outcomes, community assets and staff experience) and a coproduction plan
**Executive Summary (including reason for the report, background, key issues and risks)**

This purpose of this report is to provide an overview of the mechanisms in place to ensure the effective oversight of the delivery of the Operational Plan. It should however be noted that COVID-19 has continued to impact the NHS and will continue to do so over the coming months. The pandemic has impacted on the routine planning processes and the Trust has reacted accordingly.

Key points to note from the report are:

- The Board of Directors has fully considered and had input into the development of the Operational Plan for 2021/22. The Board of Directors will monitor progress throughout the year.
- There is framework put in place by the Executive Team to ensure effective oversight and delivery of the Operational Plan, demonstrating clear accountabilities and corporate responsibility for the delivery of the plan.
- Executive led performance management has continued throughout the pandemic and will continue through 2021/22.
- The Quality Committee will monitor progress on the delivery of the Quality agenda throughout 2021/22.
- The Finance and Performance Committee has monitored the financial plan throughout 2020/21 and the changes made to functioning of the Committee following the financial challenges of 2019/20 are now embedded.
- The People Committee effectively oversees the Trusts workforce challenges and the progression of our people agenda.
| **Due Diligence**  
| (include the process the paper has gone through prior to presentation at Board of Directors' meeting) | N/A |
| **Board powers to make this decision** | N/A |
| **Who, What and When**  
| (what action is required, who is the lead and when should it be completed?) | N/A |
| **Recommendations** | The Board of Directors is asked to note the paper, and through the Board and its assurance committees, seek an appropriate level of assurance in relation to the delivery of the 2021/22 Operational Plan. |
| **Appendices** |  |
1.0 Introduction

1.1 The Board of Directors is expected to approve the Operational Plan for 2021/22 at their meeting in April. The Plan builds on the planning approach utilised for 2020/21, which was significantly different from the documents drafted in previous years. This is a direct result of the Covid-19 pandemic. This paper provides an overview of the mechanisms in place to ensure effective oversight of the delivery of the Operational Plan 2021/22.

1.2 During 2019/20, the Performance Management Framework was revised. In 2020/21, performance management continued, with a significant focus on the management of Covid-19. This will continue through 2021/22, although the management of recovery will be a key theme.

2.0 The Role of the Board of Directors

2.1 Having agreed the process and timeline to renew the strategy and having produced the Operational Plan for 2021/22, it is important that there is an effective functioning unitary Board in place to ensure the effective oversight and delivery of the Operational Plan. The Trust has participated in an externally facilitated Board development programme in the second half of 2020/21 and this will continue into 2021/22.

2.2 It is imperative that all Directors of the Board are clear about the objectives and deliverables set out in the Operational Plan, both individually to enable them to fulfil their duties as a member of the Board which include:

- Holding the Executive to account for the performance of the Trust through seeking assurance that systems of control are robust and reliable;
- Setting, and leading, a positive culture in the organisation; and
- Being accountable to stakeholders, particularly the Trust’s Governors, for outcomes delivered.

2.3 The Board Assurance Committees play a key role in obtaining evidence to help the Board gain assurance that the Trust’s strategic objectives are being delivered as outlined in the Operational Plan. Each Committee has a Non-Executive Director Chair and Lead Executive Director who will work together, on behalf of the Board of Directors, with guidance from the Company Secretary, to agree the detailed work programme for the committee, obtain evidence to support assurance on the key aspects of Operational Plan delivery, in accordance with the Terms of Reference approved by the Board, with attention to ensuring effective management of risk through the Board Assurance Framework (BAF) and wider risk management framework.

2.4 A key point to highlight is the membership rotation and expanded attendee lists of Assurance Committees, allied with a chairs log reporting mechanism through to the Board which was adopted in the final months of 2020/21. The People Committee was initiated in 2020/21 and is now embedded.

2.5 The Audit Committee will continue to focus on seeking assurance that financial reporting is accurate, that internal controls are robust, and maintaining strong relationships with Internal and External Auditors and Counter Fraud. The audit plan for 2021/22 is currently being drafted and is scheduled to approved at the Audit Committee in April 2021.
3.0 **Role of the Non-Executive Directors**

3.1 A key part of the assurance framework is the role undertaken by the Non-Executive Directors, who are responsible for scrutinising the performance of management, seeking evidence in relation to the achievement of the objectives of the organisation, satisfying themselves as to the integrity of performance information and that internal controls and systems of risk management are robust.

3.2 One of the most critical and important dimensions of the role of Non-Executive Directors on Board Assurance Committees, is to ensure objectivity and perspective, without being drawn into unnecessary operational detail or directing the work of the Executives. Impartiality is a vital aspect of effective assurance, generating valued insights, and providing challenge and support for Executive colleagues, to improve Trust performance for the benefit of patients.

4.0 **The Role of the Chief Executive**

4.1 Reporting to the Chairman and to the Board directly, the Chief Executive is responsible for leading the Executive Team and the organisation to deliver the Operational Plan. All members of the management structure report either directly or indirectly to the Chief Executive.

4.2 The Chief Executive is also the Accounting Officer of the organisation.

5.0 **The Role of the Executive Directors**

5.1 The Executive Team is accountable for ensuring the delivery of the Operational Plan. Furthermore, the Executive Team is collectively responsible for all aspects of plan delivery and individual Executive Directors are responsible for ensuring that the elements of the plan which they are leading, are achieved to the required outcome and timescale.

5.2 Each Executive Director is responsible for identifying and escalating risks to the Executive Team (and the CEO) that might impact the delivery of planned objectives and for ensuring mitigating action is taken as required.

5.3 All individual Executive Directors are responsible for championing and supporting the delivery of the Trust’s Operational Objectives and a culture of continuous quality improvement throughout the Trust. Each Executive Director is responsible and collectively accountable for the delivery of the Operational Plan.

5.4 Monthly performance meetings are an integral part of the Performance Management Framework and have been chaired by the Deputy CEO, focused on effective review of actions that underpin the overall delivery of the Operational Plan. The impact of Covid-19 did necessitate changes to the routine performance management agenda. The performance meetings were brought forwards so that issues could be escalated to the Finance and Performance Committee on a timelier basis.

5.5 The Executive Team Meetings have, throughout 2020/21, operated with more formal arrangements and will continue to play a vital role in ensuring that senior divisional leaders are engaged and clear about the direction, priorities and targets set out in the Operational Plan and are fully committed to delivery.
6.0 **Performance Reporting**

6.1 The Integrated Performance Report (IPR), was revised during 2020/21. The IPR reflects the key deliverables that the Trust must focus on and makes reference to areas of escalation for the Trust Board to note.

6.2 Divisional performance dashboards remain in place, although a process to further develop these by division was initiated during 2020/21 which will conclude in 2021/22.

6.3 The reporting of financial performance has been improved with a new dashboard developed in the final quarter of 2020/21 and this will be further developed and embedded through 2021/22.

7.0 **Quality Performance Assurance**

7.1 It is clear that the Trust needs to continue the focus on Quality Improvement. The Care Quality Commission (CQC) suspended inspections in light of Covid-19, although have continued to engage with the Trust during 2020/21. It is likely that the Trust will be inspected in early 2021/22.

7.2 The Quality Committee has the responsibility to monitor progress against the Quality Objectives and remains focused on quality improvement.

8.0 **Financial Performance Assurance**

8.1 The Financial Assurance process for the Trust was reviewed and improved early in 2020/21, following an unplanned significant variance to plan late in 2019/20. A key area of focus has been on how the Trust can produce more robust forecasts earlier in the financial year. An independent review of the Trust’s financial governance processes was undertaken, which identified a number of recommendations with the vast majority now implemented.

8.2 The Finance and Performance Committee has monitored progress against the financial plan during the year. The Committee has been presented with robust data supporting financial forecasting and has enhanced its membership.

8.3 The Covid-19 central response did suspend the usual financial arrangements for 2020/21 and this is planned to continue through the first six months of 2021/22.

9.0 **Five Year Plan**

9.1 A 5-year plan was developed by the Executive Team and discussed by the Board. The plan was supported by the Board of Directors in February 2020. However, the launch of the plan was paused in line with national guidance released in relation to Covid-19. Consequently, the Trust focussed on its one year operational plan during 2020/21. A one year operational plan has also been developed for 2021/22. During 2021/22, the Trust will also develop a new Strategy which will be drafted and presented to an extraordinary Trust Board meeting in September 2021.

10.0 **Conclusion**

10.1 The Board of Directors has fully considered the Operational Plan for 2021/22 and this is provided to the Board of Directors this month for final approval. It should be noted that the Trust has reacted appropriately to the challenges associated with Covid-19.
Accordingly, the Operational Plan is significantly amended from what would otherwise be classed as the normal course of business.

10.2 This paper sets out the framework put in place by the Executive Team to ensure effective oversight and delivery of the Operational Plan, demonstrating clear accountabilities and corporate responsibility for the delivery of the plan.

10.3 The Quality Committee will monitor progress on the delivery of the Quality agenda throughout 2021/22.

10.4 The Finance and Performance Committee has monitored the financial plan throughout 2020/21 and the changes made following the financial challenges of 2019/20 are now embedded.

10.5 The People Committee is now embedded and actively challenging progress against our people agenda.

Dr Richard Jenkins
Chief Executive
April 2021
### Agenda item
P74/21(i)

### Report
Chair's Assurance Log Part 1 agenda
Finance and Performance Committee (FPC)

### Executive Leads
Stuart Diggles, Interim Director of Finance
George Briggs, Chief Operating Officer

### Link with the BAF
B9: The financial plan is not delivered.
B10: The lack of capital investment may affect the delivery of some services.

### How does this paper 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 and verbal updates received at the FPC meeting on 31 March 2021:

1. Financial performance continues to be favourable to plan, with careful management of significant capital expenditure ongoing in month 12;
2. Robust processes in place for year end balance sheet review;
3. Recent 360 Assurance Internal Audit has given a ‘significant assurance’ rating to the review of the Trust’s financial systems;
4. A challenging process is ahead to pull together an agreed budget for 2021/22, supported by robust action plans.

### 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 Director of Finance 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.
| **Who, What and When**  
(what action is required, who is the lead and when should it be completed?) | 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. |
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<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 |
CHAIR’S LOG: Chair’s Key Issues and Assurance Model

<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>
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<tbody>
<tr>
<td>1</td>
<td>Integrated Financial Performance Report</td>
<td>The Committee received an update on month 11 financial performance and year to date, along with the latest year end forecast position. Key headlines on actual performance: • Income and Expenditure (I&amp;E) Account: on track. £2,014k surplus to plan in month, £3,876k year to date; • Capital expenditure £3,083k underspend versus plan year to date; • Closing cash as at the end of February: £36,512k. Forecast out-turn is showing: • An improving position I&amp;E position month on month, £4,360k favourable to plan for the 12 months; • Capital Expenditure £10,615k agreed overspend versus plan, after accounting for the impact of the Carbon Energy Fund Scheme of £9,513k; • Cash £1,367k as at 31 March 2021 as reported to NHSE/I. From a Trust perspective, the forecast is estimated at £25,914k, which reflects the latest view on capital creditors and working capital at the year end. A detailed cash flow analysis was discussed and assured – on track financial performance.</td>
<td>Board of Directors</td>
<td>Assured – on track financial performance</td>
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<tr>
<td>Ref</td>
<td>Agenda Item</td>
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<td>forecast will be completed for quarter 1 2021/22 as part of the Half 1 2021/22 planning process to ensure control over and understanding of the expected significant level of cash outflows. The Committee reviewed the activity on major accruals and provisions, the key forecast assumptions in month 12 and the risks and mitigating actions. The Committee was assured with the results to date and the approach being taken for year end. In reviewing the significant amount of capital spend in month 12, the Committee recognised the tremendous work being undertaken to deliver the key schemes by the end of the financial year and minimise and limit any carry-over. However, it was recognised that a higher depreciation charge resulting from this ‘exceptional’ level of spending will need to be managed in future years. The Committee requested a review of the forecasting process to ensure key learning points are factored into the ways of working for the new financial year noting that due to the current favourable financial position that potentially overly prudent forecasting had not been challenged as much as it might be in other circumstances. Lead: Stuart Diggles.</td>
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<td>2</td>
<td>Balance Sheet Update</td>
<td>A verbal update was provided on the processes in place to verify the closing balance sheet at the end of month 12. The Committee was informed of the outcome of the recent Internal Audit by 360 Assurance on the Trust’s Financial Systems. Their review resulted in a ‘significant assurance’ rating (finalised report to be received).</td>
<td>Board of Directors</td>
<td>Assured</td>
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<td>Ref</td>
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<td>Mazars, the Trust’s External Auditors have undertaken their interim audit and to date have not flagged any areas of concern. Lead: Stuart Diggles.</td>
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<td>3</td>
<td>Budget 2021/22 Update</td>
<td>The Committee received a verbal update on the status of the planning guidance received from NHSE/I and the key steps in the process to deliver an agreed Trust budget for 2021/22. A detailed timetable is being pulled together by Finance to capture the key steps in the process, including the required reviews by FPC and the Board of Directors. It was noted that flexibility on meeting dates is likely to be required given the submission dates to the ICS, the first of which being a draft plan position by 29 April 2021. The Committee recognised limited assurance at this stage given the volume of work still required to deliver a robust plan for the new financial year (noting all necessary information was still not available to complete a budget e.g. income envelope) along with managing the 2020/21 year end accounts process. Lead: Stuart Diggles.</td>
<td>Board of Directors</td>
<td>Limited assurance – at this stage of the process</td>
</tr>
<tr>
<td>4</td>
<td>Capital Monitoring Group: Minutes &amp; Chair Assurance Log</td>
<td>As part of the FPC Terms of Reference, it was agreed that three specific operational groups would report to the Committee, via their respective Chair issuing a report and approved minutes. The first of these reports was received from the Capital Monitoring Group. Reports from the CIP Board and the Divisional Performance Meetings are to follow. Lead: Michael Wright.</td>
<td>Board of Directors</td>
<td>Assured – quality of current report</td>
</tr>
</tbody>
</table>
Finance and Performance Committee

Meeting Agenda – Papers for Assurance, Information and Decision

31 March 2021

1. Integrated Financial Performance Report
2. Balance Sheet Update (Verbal)
3. Budget 2021/22 Update (Verbal)
4. Capital Programme 2021/22
5. Capital Monitoring Group – Minutes and Chair’s Assurance Log
6. Committee Annual Report to Board of Directors – Template
<table>
<thead>
<tr>
<th>Agenda item</th>
<th>P74/21(ii)</th>
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<tbody>
<tr>
<td>Report</td>
<td>Chair's Assurance Log – Part 1 Agenda People Committee</td>
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<tr>
<td>Chair</td>
<td>Lynn Hagger, Non-Executive Director</td>
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<tr>
<td>Executive Lead</td>
<td>Steven Ned, Director of Workforce</td>
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**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 an 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 26th March 2021 were:
- Health Informatics have plans to address their MAST/PDR shortfalls; engagement/communication amongst teams is good and staff have responded well to the huge increase in demand during the pandemic
- limited assurance re PDRs but good compliance with other KPIs and further improvement in international nurse recruitment
- 2nd dose Covid-19 vaccination programme continues to maintain its success and is currently unaffected by national constraints of vaccine supply. Work is underway to liaise with vaccine hesitant staff
- the Health and Wellbeing programme continues to develop with encouraging signs of it becoming ‘business as usual'
- Covid-19 challenges means that not all the Committee’s operational objectives will be met in their entirety but there will be renewed focus on work that remains to be instigated
- the Committee were assured as to the breadth/depth of work undertaken by the Learning and Development team
- further work required to address Model Employer targets

<table>
<thead>
<tr>
<th>Due Diligence (include the process the paper has gone to prior to presentation at Board of Directors Meeting)</th>
<th>The content of this report was agreed at the People Committee held on 26th March 2021 and is presented to the Board of Directors for assurance.</th>
</tr>
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<tbody>
<tr>
<td>Who, what and when (what action is required, who is the lead and when should it be completed?)</td>
<td>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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<tr>
<td>Recommendations</td>
<td>It is recommended that the Board of Directors receive this report and consider the assurance presented as detailed in the attached report.</td>
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</table>
| Appendices | Appendix One – Chair’s Assurance Log
Appendix Two – Agenda items from People Committee held on the 26 March February 2021. |
CHAIR’S LOG: Chair’s Key Issues and Assurance Model

Committee / Group: People Committee (PC)  Date: 19th February 2021  Chair: Lynn Hagger

<table>
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<tr>
<th>Ref</th>
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<tbody>
<tr>
<td>1</td>
<td>Divisional Performance – Corporate area (Health Informatics)</td>
<td>The Director of Health Informatics, Carl Wilson (Interim HR Business Partner), Laura Mumby (Head of EPR), Lisa Fox (Associate Director of Information Services) and Ms W Herman (IT Training Manager) provided a presentation of People matters. The Department recognised the challenges related to delivering against PDR and MAST targets and have plans to address this. The response rate to the National Staff Survey (NSS) has improved as have a number of the responses themselves especially in relation to management. Work will continue to improve the scores further in the next NSS. The Department has deployed a number of initiatives to ensure the engagement of staff including newsletters, a blog and virtual coffee catch-ups for colleagues who are working from home. There are a number of training courses for colleagues to achieve accreditation and pursue career development. There are key risks in relation to maintaining the IT response to Covid-19 and homeworking as well as the need to address succession planning by creating deputy roles. There are plans to streamline the Department and improve the production/alignment of information. The Committee were impressed by how well the Department appeared to work together during a period of unprecedented limitation.</td>
<td>Board of Directors</td>
<td>Assured</td>
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<td>demand and the support that was given to the vaccination and lateral flow test programmes. The future focus will be on the Health and Wellbeing of the staff using the Trust’s offers and ensuring an appropriate balance of home and office working. Lead Officer: James Rawlinson</td>
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<td></td>
<td></td>
<td>Workforce Report</td>
<td>Board of Directors</td>
<td>Assured</td>
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| 2   | Workforce report (inc. Covid-19 update) and Integrated Performance Report | - Sickness absence has increased by 0.48% compared to last month at 4.34% but this represents a 0.47% decrease compared to February 2020  
- MAST (91%) and Job Specific training (85%) are above target with IG compliance at 91% against a target of 95% but the Deputy CEO was confident that the target would be reached in time  
- PDR compliance is at 82% so below the 90% target; the focus now will be on rolling out the new appraisal process from April 2021 and on areas with low compliance in this area  
- sixth consecutive month of reduced vacancies in Nursing and Midwifery not least because of the international recruitment of nurses (6 during February 2021)  

Covid-19 Vaccination Programme  
The Trust continues with its successful programme although supplies may be interrupted during April. A FAQ poster and a video of a BAME colleague who has had the vaccination have been produced and line managers are undertaking discussions to encourage further staff to have a vaccination. | | |
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<td><strong>Health and Wellbeing</strong></td>
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<td>• the revised Our People Pack which sets out all the health and wellbeing offers at a local, regional and national level has been cascaded</td>
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<td>• the number of colleagues accessing the EAP service has risen over the last few months</td>
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<td>• ‘Approachable Team Time’ is being developed and will be available to all staff to help with emotional support</td>
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<td>• the People Pulse Survey will be launched and it will allow the Trust to assess the results on a quarterly basis</td>
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<td>The Chairperson highlighted the fact that it became clear in her catch-up meeting with the Surgery Division leadership team in her capacity as Health and Wellbeing Guardian that they had seized this agenda and it is rapidly becoming ‘business as usual’.</td>
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<td>The national Toolkit devised following the Ockenden Report contains a recommendation to develop a Behavioural Standards Framework which the two Maternity and Neonatal Champions present thought would be relevant for all staff. The Chief Nurse and Deputy Director of Workforce will consider this further and bring a proposal to the May meeting.</td>
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<td>Lead Officer: Steve Ned</td>
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<td>3</td>
<td>Operational Objectives 2020/21</td>
<td>While there has been an increase in staff engagement activity that has been positively received, this objective is rated amber because the pandemic has meant that it was not possible to hold Together We Can sessions nor the staff led quality improvement programme (QSIR certification sessions). The main reason the maximising of the effectiveness of senior leadership in the Trust remains amber is because of the failure to reach PDR targets also due to the effects of the pandemic. There has been significant success in increasing our substantive workforce, reducing vacancies and reducing agency costs so this objective is rated green.</td>
<td>Board of Directors</td>
<td>Limited Assurance</td>
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<td>Ref</td>
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<td>The Committee was assured that all efforts had been made to meet the relevant targets and that the reasons for not doing so were entirely understandable. With the plans to introduce a new improved appraisal process and a renewed focus on other engagement and development initiatives the Committee was assured that the appropriate steps are being taken. Lead Officer: Steve Ned</td>
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<td>4</td>
<td>Covid-19 risk register re: workforce risks</td>
<td>The Chief Nurse will ensure this is now combined with the main Risk Register and made more 'useable' with risks scoring over 15 relating to workforce matters coming to this Committee. Risks scoring under 15 will be managed by the usual risk management processes. Significant 'cleansing' of the risks has taken place. The Committee were assured as to the management of the risks. Lead Officer: Steve Ned</td>
<td>Board of Directors</td>
<td>Assured</td>
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<td>5</td>
<td>National Staff Survey update</td>
<td>The Divisions have developed action plans to address areas that the Survey highlighted as requiring improvement and these will be monitored during routine performance meetings. Staff side, the CEO and DoW are meeting to discuss this further. Colleagues are enthusiastic to ensure positive changes take place. The Health Service Journal highlighted that our Trust was one of the most improved surveys and this has been acknowledged by external colleagues. The Committee were assured as to the approach taken to the Survey results. Lead Officer: Steve Ned</td>
<td>Board of Directors</td>
<td>Assured</td>
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<td>The Committee welcomed Mrs Helen Thomas to the meeting and she highlighted the following points:</td>
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<th>Ref</th>
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| 6   | Learning and Development – Quarterly Report | - there is a new process for the removal and approval of MAST subjects which will report into the Operational Workforce Group  
- documentation for the new appraisal process has been tested to ensure it is fit for purpose, will be supported by videos/other sources with feedback on a quarterly basis and will include a health and wellbeing conversation  
- Corporate Induction will have a strengthened focus on safeguarding  
- there will be an increased focus on leadership/management next year  
- DCEO to explore whether unspent (due to Covid-19) CPD monies (£504k) can be accrued for next year which the Trust is in a better position to utilise  
- completion of improvement work to support the CQC Action Plan and continue to respond to requests  
- very successful apprenticeship programme with a number of awards  
- have received ICS funding for professional filming of the careers opportunities at the Trust  
- the People Pack will be updated twice a year  
- a group will be established to drive improvements as a result of the NSS and Pulse surveys | | Assured |
| 7   | Model Employer – Recruitment Targets | This initiative aims to increase black and minority ethnic representation at senior levels across the NHS so that it is more reflective of its workforce and local communities. A range of interventions will be used to reach relevant targets and the next PC meeting’s Deep Dive into recruitment and retention will include consideration of links with the community/schools as well as our recruitment practices. Given the amount of work that needs to be | Board of Directors | Limited Assurance |

Lead Officer: Helen Thomas
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<td>8</td>
<td>Gender Pay Gap Report</td>
<td>undertaken the Committee had limited assurance overall but were assured as to the steps being taken to improve our position. Lead Officer: Emily Wraw</td>
<td>Board of Directors</td>
<td>Assured</td>
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<td>Although there has been a deterioration in the Trust’s Gender Pay Gap, the Committee was assured that the Executive Team have given this issue significant attention through detailed analysis of the complex contributory factors and the steps that will be taken to improve the position including having more female members on the Clinical Excellence Award panels and encouraging the female medical workforce to be more forthcoming about their achievements. Lead Officer: Emily Wraw</td>
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Appendix Two

People Committee

Meeting Agenda – Papers for Assurance, Information and Decision

26 March 2021

- Divisional Performance: Corporate Area – Health Informatics
- Workforce Report - Inc. Covid – 19 Update and Health & Wellbeing
- Integrated Performance Report Monthly update
- Operational Objectives 2020/21
- Covid-19 risk register re workforce risks
- National Staff Survey Update
- Learning & Development Report – Quarterly
- Model Employer – Recruitment Targets
- Operational Workforce Group minutes
- Gender Pay Gap - annual report + data submission - pay equality
- Committee Annual Report to Board of Directors – template
- Committee Annual Planner
Board of Directors Meeting
09 April 2021

Agenda item | P75/21
---|---
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 (including reason for the report, background, key issues and risks)

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 February 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
- Overdue Reviews
- DM01 Performance
- Nursing Vacancy Rate

### 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 – February 2021
### PERFORMANCE SUMMARY

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

Urgent & Emergency Care:
- Attendances in January continued to be significantly lower than the previous year, 24% below 2019 volumes, although the increasing acuity of patients arriving at the front door and within the hospital led to a 9% increase in the numbers of patients admitted. Site pressures were high despite the reduction in Covid-19 positive patients given the ongoing challenges around cohorting on wards. The ‘Rotherham Reset’ week demonstrated some changes that can be made to improve flow through the organisation going forward, and led to some really positive impacts on overall emergency performance and flow. Numbers of super-stranded patients (21 day+ length of stay) remained high in month but were still well above the target set over a year ago, although are below the new national target that is due to be implemented in 2021/22. Ambulance handover delays over 60 minutes reduced to 18, a 62% reduction on the same month last year, and meant the Trust was the top performer in the SYB area for ambulance handovers. The number of patients waiting 12 hours in the department fell to 81, an 81% reduction on the equivalent figures in 2019 and a 73% reduction on the prior month.

Elective Care:
- The size of the waiting list reduced to below target in February, despite the continued reduction in elective activity. There was a reduction of over 500 pathways over 18 weeks in the month, although 52+ week wait patient volumes increased further to 763 patients (from 721 patients in January). Over 130 of these patients are choosing not to be treated during Covid-19 (either for Covid-19 reasons, or for other reasons), but the majority are patients who have been unable to treat to date due to the limited elective bed base (and particularly the lack of an Orthopaedic ward). From the second week in March when our elective wards re-open, we will be able to focus on treating those long waiters.
- The number of patients waiting with a decision to admit remained relatively stable in the month, with a slight improvement in the reported RTT percentage. Despite this, the January national data shows that compared to pre-pandemic performance, the Trust has seen a more significant deterioration on elective care performance than other trusts when benchmarked nationally. In part this is driven by the significant performance challenges within a few surgical specialties where activity has been well below previous levels for several months now, particularly Ear, Nose & Throat, Oral and Maxillo-Facial Surgery, Trauma and Orthopaedics and Gynaecology.
- Recovery trajectories have been developed for all specialties by the divisional teams, with monthly Recovery meetings taking place to help drive the Trust’s Recovery programme. Q4 activity in the Independent Sector is increasing, although the planned activity will not be fully delivered due to the extent of the exclusions and allowable procedures in the independent sector sites. The additional Q4 activity which was agreed by the Executive Team has started, with weekend clinics taking place in Paediatric Cardiology, ENT and OMF5. Weekend theatre lists have been running since early February across Gynaecology and General Surgery, and these will continue through March, depending on the availability of theatre staff.

Outpatient care:
- The DNA rate was below target for the third consecutive month, which is likely to be in large part due to the switching back on of the text message reminders, although some technical issues unfortunately meant that these were failing to send in the latter part of the month. As mentioned in November, internal review of the number of DNAs has identified an issue around poor recording of clinic attendances, in part driven by the new ways of working and increase in virtual consultations. This has meant significant numbers of patients (~9,500) have been automatically recorded as a DNA on Meditech after 90 days if an outcome has not been recorded in the system. Full patient-level validation of these patients is almost complete, the latter part of the month. As mentioned in November, internal review of the number of DNAs has identified an issue around poor recording of clinic attendances, in part driven by the new ways of working and increase in virtual consultations.
- The size of the Cancer Patient Tracking List (PTL) continued to fall in January, and this will remain a key focus for the rest of Q4.
- 62-day performance was well below the national standard again, with 18 breaches in the month (of which 7 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 now has the lowest number and proportion of over 62-day waiters on the PTL of any SYB Trust. Additional focus is now being given to all patients at risk of breaching 62 days, and a deep dive has been undertaken into the Urology cancer pathways, to identify a series of actions for implementation. In addition, the Trust has been successful in its bid for support to establish a Cancer Improvement Programme to focus on improvements within the Lower GI and Urology pathway in particular, and recruitment is underway for 3 new Cancer Navigator posts.

Quality Summary

Mortality:
- The Trust HSMR fell slightly further this month (0.4 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 respectively (108.0, 96.2, 98.1) suggest positive movement in the right direction, with a crude rate of 2.8% over that period. However, based on the impact of Covid-19 on the HSMR in Q1, the October position has started to show signs of deterioration as the Dr Foster re-basing does not appear to take full account of the increased crude rate relating to Covid-19 deaths. An escalation report is enclosed which goes into further detail on the actions underway to recover Trust mortality performance.

Infection Prevention & Control:
- There were no Clostridiodes difficile infections in the month, taking the year-to-date total to 21. This is in line with benchmarking and not a concern. Significant infection prevention and control measures are in place to manage the Covid-19 pandemic and the Trust is reporting nationally against all the required metrics relating to our IPC performance.

Patient Safety:
- There were 2 potential incidents of severe harm or death reported in February As per the standard Trust process, all moderate and severe incidents are discussed weekly at Harm Free Care meetings and, where necessary, given further scrutiny at the weekly Serious Incident panel. Readmission rates have increased since April 2020, in large part due to the amendment to the recording of assessments through ASU and AMU as admissions. It is worth noting that the national methodology for calculating readmissions does not exclude readmissions to different specialties. VTE assessment compliance rose to its highest level in almost two years, with just 11 further assessments required (out of over 2,100) to meet the standard. The Executive Medical Director continues to drive delivery of this through the Clinical Governance Committee and monthly Safe and Sound Internal Professional Standards meetings, with patient-level detail available to clinicians where specialties are not meeting the 95% standard.

Maternity:
- There was sadly one stillbirth in the month, which translates to above the proportionate target, although year-to-date the figure is still achieving the target. Emergency Caesarean-sections were above target in month, with 37 emergency Caesarean-sections performed in month. In part this recent trend has been driven by higher numbers of patients requiring inducing, which is more likely to lead to a Caesarean-section. The proportion of antenatal bookings within 12 weeks and 6 days improved in-month, with only 17 patients not being seen within the set timescale.
Financial Position

I&E Position:
- The Trust has delivered a surplus to plan in February 2021 (Month 11) of £2,014K, which builds upon the previous four months’ performance to produce a £3,896K surplus to plan for the first five months of the Trust’s plan for the second half of the financial year. Clinical income is being boosted in month by additional income from Rotherham CCG to cover various one-off initiatives/projects (£85K); Recovery of both revenue and capital costs incurred to support the national testing and vaccination programmes (£168K);
- Recovery of costs for treating patients in the independent sector (£144K). Other operating income is better than plan in month due to receipt of central funding of £798K (£958K for the second half) for the planned loss of non-NHS income, mainly being driven by the loss of car parking receipts. Pay budgets are under-spending despite continued staff absence but there has been £600K released in month equally from the balance sheet and reserves regarding cancellation of any penalties to be incurred linked to slower than required activity recovery under the Elective Incentive Scheme; and release of provision for further COVID-19 expenditure, which is no longer required. Non-pay costs continue to under-spend (although at lower levels than some previous months) linked to reduced levels of activity.
- The Trust is forecasting to deliver a further £1,344K surplus to plan in the final two months of the year adding to positive year to date performance, which gives a final forecast out-turn position as at 31st March 2021 of £3,206K favourable to plan. The current trends are expected to continue for other operating income although there is a slow down in real terms for education and training income. Pay costs are forecast to decrease during March as COVID-19 pressures start to continue to reduce in real terms normal business starts to get reinstated. Equally there is also a continued expectation of an under-spend against the Winter Plan.

Capital Expenditure:
- In month expenditure is £1,716K compared to a plan of £1,615K. Most of this variance has been caused by expenditure not being incurred as profiled. This has particularly been the case with regards to the UEC Public Dividend Capital funded scheme, where delays have resulted from limited access during the second wave of the COVID-19 pandemic to carry out the planned works. Year to date expenditure is £11,964K compared to a plan of £15,045K – an under-spend of £3,082K. The Estates Strategy schemes which have been funded nationally in year from additional Public Dividend Capital will be drawn down in cash terms prior to 31st March 2021, in line with expenditure incurred.
- The forecast out-turn is showing an over-spend of £10,615K. 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 Trust of c. £1.5million on medical equipment, for which CDEL cover has been approved by STB ICS in order to reduce underspend and utilise CDEL across the whole system.

Cash position:
- Significant closing cash balance as at 31st January of £36,512K, 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 is as a result of payment due for non recurrent financial support monies due from quarter 4 of 2019-20 financial year totalling £10,190K and additional COVID 19 revenue and capital expenditure funding of £1,382K for 2019-20. A significant cash outflow from paying off trade and other payables is a direct consequence of the cash received above. Despite having a substantial cash balance, the Trust does not benefit from interest receivable as the government banking service and other government agencies are not paying any interest on cash deposits, which is understandable given the unprecedented low Bank of England base rate. A forecast cash position of £1,367K as at 31st March 2021 is in anticipation of upfront receipts for block contract and incentive payments having to be repaid in the current financial year.
**Trust Integrated Performance Dashboard - Operations**

<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 - Year End</th>
<th>Trend</th>
<th>Data Quality</th>
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<tbody>
<tr>
<td><strong>Planned Patient Care</strong></td>
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<tr>
<td>P1 Waiting List Size</td>
<td>Feb-21</td>
<td>L</td>
<td>14,400</td>
<td>13,993</td>
<td>14,605</td>
<td>14,012</td>
<td>13,254</td>
<td>13,254</td>
<td>15,384</td>
<td>14,594</td>
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<td>P1A Number of RTT Patients with a Decision to Admit</td>
<td>Feb-21</td>
<td>-</td>
<td>-</td>
<td>3,719</td>
<td>3,755</td>
<td>3,738</td>
<td>3,561</td>
<td>3,561</td>
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<tr>
<td>P2 Referral to Treatment (RTT) Performance</td>
<td>Feb-21</td>
<td>N</td>
<td>92%</td>
<td>68.6%</td>
<td>69.2%</td>
<td>70.2%</td>
<td>72.4%</td>
<td>64.3%</td>
<td>91.0%</td>
<td>75%</td>
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<tr>
<td>P3 Overdue Follow-Ups</td>
<td>Feb-21</td>
<td>L</td>
<td>5,007</td>
<td>12,512</td>
<td>13,223</td>
<td>12,449</td>
<td>11,939</td>
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<td>10,637</td>
<td>6,325</td>
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<tr>
<td>P4 First to follow-up ratio</td>
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<td>B</td>
<td>2.5</td>
<td>3.3</td>
<td>3.3</td>
<td>3.4</td>
<td>3.1</td>
<td>3.2</td>
<td>2.5</td>
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<tr>
<td>P5 Day case rate (%)</td>
<td>Feb-21</td>
<td>B</td>
<td>80%</td>
<td>89.9%</td>
<td>89.1%</td>
<td>89.7%</td>
<td>87.8%</td>
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<td>77.4%</td>
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<td>P6 Diagnostic Waiting Times (DM01)</td>
<td>Feb-21</td>
<td>N</td>
<td>1%</td>
<td>37.0%</td>
<td>39.3%</td>
<td>39.2%</td>
<td>28.7%</td>
<td>48.0%</td>
<td>0.0%</td>
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<td><strong>Emergency Performance</strong></td>
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<tr>
<td>E1 Number of Ambulance Handovers &gt; 60 mins</td>
<td>Feb-21</td>
<td>CQC</td>
<td>0</td>
<td>62</td>
<td>107</td>
<td>72</td>
<td>18</td>
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<tr>
<td>E2 Number of 12 hour trolley waits</td>
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<td>N</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>15</td>
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<tr>
<td>E3 Conversion rate from A&amp;E (not including Observations)</td>
<td>Feb-21</td>
<td>-</td>
<td>-</td>
<td>26.8%</td>
<td>26.5%</td>
<td>29.0%</td>
<td>27.5%</td>
<td>26%</td>
<td>21%</td>
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<tr>
<td>E4 Proportion of same day emergency care</td>
<td>Feb-21</td>
<td>L</td>
<td>33%</td>
<td>34.2%</td>
<td>33.8%</td>
<td>30.2%</td>
<td>39.3%</td>
<td>38.8%</td>
<td>26.6%</td>
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<tr>
<td><strong>Cancer Care</strong></td>
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<tr>
<td>Ca1 2 Week Wait Cancer Performance</td>
<td>Jan-21</td>
<td>N</td>
<td>93%</td>
<td>97.7%</td>
<td>92.9%</td>
<td>96.0%</td>
<td>83.1%</td>
<td>91.7%</td>
<td>93.6%</td>
<td>93%</td>
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<tr>
<td>Ca2 2 Week Wait Breast Symptoms</td>
<td>Jan-21</td>
<td>N</td>
<td>93%</td>
<td>86.1%</td>
<td>45.7%</td>
<td>81.8%</td>
<td>34.3%</td>
<td>70.8%</td>
<td>90.3%</td>
<td>90%</td>
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<tr>
<td>Ca3 31 day First treatment</td>
<td>Jan-21</td>
<td>N</td>
<td>96%</td>
<td>96.7%</td>
<td>91.0%</td>
<td>98.6%</td>
<td>95.8%</td>
<td>95%</td>
<td>96.2%</td>
<td>100%</td>
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<tr>
<td>Ca4 62 Day Performance</td>
<td>Jan-21</td>
<td>N</td>
<td>85%</td>
<td>62.3%</td>
<td>62.6%</td>
<td>65.6%</td>
<td>57.8%</td>
<td>61.0%</td>
<td>79.0%</td>
<td>80%</td>
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<tr>
<td>Ca5 62 day Patient Tracking List Size</td>
<td>Feb-21</td>
<td>L</td>
<td>814</td>
<td>1075</td>
<td>981</td>
<td>861</td>
<td>857</td>
<td>857</td>
<td>602</td>
<td>800</td>
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<tr>
<td>Ca6 28 day faster diagnosis standard</td>
<td>Jan-21</td>
<td>N</td>
<td>75%</td>
<td>56.1%</td>
<td>56.5%</td>
<td>58.4%</td>
<td>57.7%</td>
<td>54.1%</td>
<td>74%</td>
<td>75%</td>
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<tr>
<td><strong>Inpatient Care</strong></td>
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<tr>
<td>I1 Mean Length of Stay - Elective (excluding Day Cases)</td>
<td>Feb-21</td>
<td>-</td>
<td>-</td>
<td>2.9</td>
<td>2.2</td>
<td>2.8</td>
<td>2.6</td>
<td>2.8</td>
<td>2.9</td>
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<tr>
<td>I2 Mean Length of Stay - Non-Elective</td>
<td>Feb-21</td>
<td>-</td>
<td>-</td>
<td>5.7</td>
<td>5.9</td>
<td>6.3</td>
<td>5.6</td>
<td>5.0</td>
<td>5.8</td>
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<tr>
<td>I3 Length of Stay &gt; 7 days (Proportion discharged)</td>
<td>Feb-21</td>
<td>L</td>
<td>21%</td>
<td>27.4%</td>
<td>28.6%</td>
<td>31.4%</td>
<td>28.1%</td>
<td>24.5%</td>
<td>27.1%</td>
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<tr>
<td>I4 Length of Stay &gt; 21 days (Proportion discharged)</td>
<td>Feb-21</td>
<td>L</td>
<td>35%</td>
<td>5.5%</td>
<td>5.6%</td>
<td>6.2%</td>
<td>4.9%</td>
<td>3.9%</td>
<td>5.9%</td>
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<tr>
<td>I5 Length of Stay &gt; 21 days (Snapshot Numbers)</td>
<td>Feb-21</td>
<td>L</td>
<td>20</td>
<td>44</td>
<td>52</td>
<td>44</td>
<td>41</td>
<td>41</td>
<td>55</td>
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<tr>
<td>I6 Right to Reside - % not recorded</td>
<td>Feb-21</td>
<td>B</td>
<td>0.0%</td>
<td>22.6%</td>
<td>31.3%</td>
<td>13.3%</td>
<td>21.4%</td>
<td>13.3%</td>
<td>-</td>
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<tr>
<td>I7 Discharges before midday</td>
<td>Feb-21</td>
<td>L</td>
<td>20%</td>
<td>10.0%</td>
<td>9.9%</td>
<td>9.6%</td>
<td>11.6%</td>
<td>11.5%</td>
<td>11.0%</td>
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<td><strong>Outpatient Care</strong></td>
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<tr>
<td>O1 Did Not Attend Rate (OutPatients)</td>
<td>Feb-21</td>
<td>B</td>
<td>8.0%</td>
<td>8.8%</td>
<td>7.7%</td>
<td>7.5%</td>
<td>7.9%</td>
<td>9.7%</td>
<td>9.0%</td>
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<tr>
<td>O2 Appointment Slot Issues</td>
<td>Dec-20</td>
<td>N</td>
<td>4%</td>
<td>89%</td>
<td>66%</td>
<td>80%</td>
<td>76%</td>
<td>76%</td>
<td>24%</td>
<td></td>
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<tr>
<td>O3 % of missing outcomes</td>
<td>Feb-21</td>
<td>L</td>
<td>20%</td>
<td>24.8%</td>
<td>24.0%</td>
<td>23.9%</td>
<td>24.0%</td>
<td>23.9%</td>
<td>19%</td>
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<tr>
<td><strong>Community Care</strong></td>
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<tr>
<td>CC1 MusculoSkeletal Physio &lt;4 weeks</td>
<td>Feb-21</td>
<td>L</td>
<td>80%</td>
<td>19%</td>
<td>18%</td>
<td>11%</td>
<td>9%</td>
<td>32%</td>
<td>36%</td>
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<td>CC2 % urgent referrals contacted within 2 working days by specialist nurse (Continued)</td>
<td>Feb-21</td>
<td>L</td>
<td>95%</td>
<td>89%</td>
<td>88%</td>
<td>92%</td>
<td>82%</td>
<td>85%</td>
<td>81%</td>
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<tr>
<td>CC3 A&amp;E attendances from Care Homes</td>
<td>Feb-21</td>
<td>L</td>
<td>176</td>
<td>116</td>
<td>107</td>
<td>107</td>
<td>105</td>
<td>1153</td>
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<tr>
<td>CC4 Admissions from Care Homes</td>
<td>Feb-21</td>
<td>L</td>
<td>85</td>
<td>78</td>
<td>83</td>
<td>57</td>
<td>56</td>
<td>788</td>
<td>89</td>
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<tr>
<td>CC6 Patients assessed within 5 working days from referral (Diabetes)</td>
<td>Feb-21</td>
<td>L</td>
<td>95%</td>
<td>96%</td>
<td>97%</td>
<td>98%</td>
<td>94%</td>
<td>95%</td>
<td>99%</td>
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</table>
# Trust Integrated Performance Dashboard - Quality

<table>
<thead>
<tr>
<th>KPI</th>
<th>Reporting Period</th>
<th>Type of Standard</th>
<th>Target</th>
<th>Previous Month</th>
<th>Previous Month</th>
<th>Previous Month</th>
<th>Previous Month</th>
<th>Current Month</th>
<th>YTD 20/21</th>
<th>Same Month Prev. Yr</th>
<th>Forecast - Year End</th>
<th>Trend</th>
<th>Data Quality</th>
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<tr>
<td>M1 Mortality index - SHMI</td>
<td>Sep-20</td>
<td>B</td>
<td>100</td>
<td>120.7</td>
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<td>M2 Mortality index - HSMR (Rolling 12 months)</td>
<td>Oct-20</td>
<td>B</td>
<td>100</td>
<td>122.6</td>
<td>118.5</td>
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<td>115.3</td>
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<tr>
<td>M3 Number of deaths (crude mortality)</td>
<td>Feb-21</td>
<td>-</td>
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<td>157</td>
<td>141</td>
<td>157</td>
<td>105</td>
<td>1223</td>
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<tr>
<td><strong>Infection, Prevention and Control</strong></td>
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<tr>
<td>In1 Clostridiodies difficile Infections</td>
<td>Feb-21</td>
<td>L</td>
<td>TBC - not yet received</td>
<td>3</td>
<td>4</td>
<td>2</td>
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<td>In2 MRSA Infections (Methicillin-resistant Staphylococcus Aureus)</td>
<td>Feb-21</td>
<td>L</td>
<td>-</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>0</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>Feb-21</td>
<td>L</td>
<td>0</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>2</td>
<td>30</td>
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<td>PS2 Never Events</td>
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<tr>
<td>PS3 Number of Patient Harms</td>
<td>Feb-21</td>
<td>-</td>
<td>-</td>
<td>551</td>
<td>582</td>
<td>558</td>
<td>506</td>
<td>5385</td>
<td>665</td>
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<td>PS4 Readmission Rates</td>
<td>Feb-21</td>
<td>B</td>
<td>9.04%</td>
<td>12.7%</td>
<td>11.0%</td>
<td>11.8%</td>
<td>11.4%</td>
<td>13.8%</td>
<td>9.8%</td>
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<tr>
<td>PS5 Venous Thromboembolism (VTE) Risk Assessment</td>
<td>Feb-21</td>
<td>N</td>
<td>95%</td>
<td>92.2%</td>
<td>92.6%</td>
<td>94.4%</td>
<td>94.5%</td>
<td>90.6%</td>
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<tr>
<td>PS6 Number of complaints per 10,000 patient contacts</td>
<td>Feb-21</td>
<td>L</td>
<td>8</td>
<td>12.3</td>
<td>10.4</td>
<td>9.2</td>
<td>6.7</td>
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<tr>
<td>PS7 Proportion of complaints closed within 30 days</td>
<td>Feb-21</td>
<td>L</td>
<td>100%</td>
<td>#</td>
<td>#</td>
<td>#</td>
<td>#</td>
<td>#</td>
<td>91.8%</td>
<td>75.0%</td>
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<tr>
<td>PS8 Care Hours per Patient Day</td>
<td>Feb-21</td>
<td>B</td>
<td>7.3</td>
<td>6.7</td>
<td>6.7</td>
<td>6.3</td>
<td>7.2</td>
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<td>6.8</td>
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<tr>
<td><strong>Maternity</strong></td>
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<tr>
<td>Ma1 Bookings by 12 Week 6 Days</td>
<td>Feb-21</td>
<td>N</td>
<td>90%</td>
<td>91.1%</td>
<td>95.1%</td>
<td>91.3%</td>
<td>93.0%</td>
<td>92.8%</td>
<td>92.9%</td>
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<tr>
<td>Ma2 % of emergency Caesarean-sections</td>
<td>Feb-21</td>
<td>L</td>
<td>16.3%</td>
<td>16.3%</td>
<td>16.2%</td>
<td>18.6%</td>
<td>19.9%</td>
<td>17.3%</td>
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<tr>
<td>Ma3 Breast Feeding Initiation Rate</td>
<td>Feb-21</td>
<td>N</td>
<td>66%</td>
<td>67.4%</td>
<td>66.5%</td>
<td>63.1%</td>
<td>64.3%</td>
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<tr>
<td>Ma4 Stillbirths per 1000 live births</td>
<td>Feb-21</td>
<td>L</td>
<td>4.46</td>
<td>5.5</td>
<td>5.3</td>
<td>4.9</td>
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<td>4.5</td>
<td>4.8</td>
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<tr>
<td>Ma5 1:1 care in labour</td>
<td>Feb-21</td>
<td>-</td>
<td>75%</td>
<td>96.2%</td>
<td>94.2%</td>
<td>95.5%</td>
<td>94.1%</td>
<td>89.3%</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><strong>For Workforce</strong></td>
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<tr>
<td>W1</td>
<td>Whole Time Equivalent against plan - Total</td>
<td>Feb-21</td>
<td>L</td>
<td>-178</td>
<td>-225</td>
<td>-224</td>
<td>-226</td>
<td>-208</td>
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<td>-272</td>
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<tr>
<td>W2</td>
<td>Whole Time Equivalent plan - Nursing</td>
<td>Feb-21</td>
<td>L</td>
<td>-94</td>
<td>-119</td>
<td>-116</td>
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<td>-124</td>
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<tr>
<td>W3</td>
<td>Total Headcount</td>
<td>Feb-21</td>
<td>-</td>
<td>-</td>
<td>4,794</td>
<td>4,794</td>
<td>4,825</td>
<td>4,841</td>
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<td>4,696</td>
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<tr>
<td>W4</td>
<td>Vacancy Rate - TOTAL</td>
<td>Feb-21</td>
<td>B</td>
<td>4.3%</td>
<td>5.38%</td>
<td>5.37%</td>
<td>5.38%</td>
<td>4.95%</td>
<td>4.95%</td>
<td>6.6%</td>
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<tr>
<td>W5</td>
<td>Vacancy Rate - Nursing</td>
<td>Feb-21</td>
<td>B</td>
<td>7.4%</td>
<td>9.2%</td>
<td>9.1%</td>
<td>8.6%</td>
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<td>8.1%</td>
<td>9.8%</td>
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<tr>
<td>W6</td>
<td>Time to Recruit</td>
<td>Feb-21</td>
<td>L</td>
<td>34</td>
<td>36</td>
<td>27</td>
<td>32</td>
<td>30</td>
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<td>31</td>
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<tr>
<td>W7</td>
<td>Sickness Rates (%) - exc COVID related</td>
<td>Feb-21</td>
<td>L</td>
<td>3.95%</td>
<td>4.5%</td>
<td>4.3%</td>
<td>3.9%</td>
<td>4.3%</td>
<td>3.9%</td>
<td>4.8%</td>
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<tr>
<td>W8</td>
<td>Sickness Rates (%) - inc COVID related</td>
<td>Feb-21</td>
<td>-</td>
<td>-</td>
<td>6.5%</td>
<td>6.0%</td>
<td>5.2%</td>
<td>5.4%</td>
<td>5.6%</td>
<td>4.8%</td>
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<tr>
<td>W9</td>
<td>Turnover</td>
<td>Feb-21</td>
<td>L</td>
<td>0.63%</td>
<td>0.59%</td>
<td>0.65%</td>
<td>0.80%</td>
<td>0.52%</td>
<td>0.64%</td>
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<td>0.63%</td>
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<tr>
<td>W10</td>
<td>Appraisals complete (%)</td>
<td>Feb-21</td>
<td>L</td>
<td>90%</td>
<td>79.1%</td>
<td>81.6%</td>
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<td>89.4%</td>
<td>90%</td>
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<tr>
<td>W11</td>
<td>MAST (% of staff up to date)</td>
<td>Feb-21</td>
<td>L</td>
<td>85%</td>
<td>91.7%</td>
<td>91.5%</td>
<td>90.8%</td>
<td>90.8%</td>
<td>90.8%</td>
<td>92.2%</td>
<td>90%</td>
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</tbody>
</table>
## Trust Integrated Performance Dashboard - Finance

### I&E Performance
- **Actual**: (1,538) £000s, 476, 2,014 £000s, (6,205) £000s, 2,329 £000s, 3,876 £000s, 4,360 £000s
- **Control Total**: (1,535) £000s, 479, 2,014 £000s, (6,167) £000s, 2,291 £000s, 3,876 £000s, 4,401 £000s

### Agency Spend
- 683 £000s, 574 £000s, 109 £000s, 7,511 £000s, 8,739 £000s, (1,228) £000s, (1,230) £000s

### Efficiency Programme (CIP)
- 242 £000s, 339 £000s, 97 £000s, 1,211 £000s, 1,007 £000s, (204) £000s, 127 £000s

### Capital Expenditure
- 996 £000s, 1,716 £000s, (720) £000s, 15,047 £000s, 11,964 £000s, 3,083 £000s, (10,615) £000s

### Cash Balance
- 0 £000s, 3,360 £000s, 3,360 £000s, 0 £000s, 35,155 £000s, 0 £000s

## Trust Integrated Performance Dashboard - Activity

### UECC Attendances

### Inpatient Admissions (including Observations)

### Total Referrals (Acute)

### Total Outpatients

### Inpatient Admissions (excluding Observations)

### 2ww Referrals
Trust Integrated Performance Dashboard - SPC Charts - Operational Performance (1)

Ambulance Handovers - % of handovers > 60 minutes

Referral to Treatment - % of patients waiting less than 18 weeks for treatment

12 hour trolley waits - per month

Delayed Transfers of Care - average % of patients with delayed transfer in month

Did Not Attends (DNAs) % of appointments

Length of Stay > 21 days (proportion of patients discharged)

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

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.

Zero tolerance communicated.
Cancer 2 week wait standard

Cancer 2 week wait breast symptoms standard

Cancer 62 day first treatment standard

Diagnostics - % of breaches over 6 weeks (DM01)

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.
<table>
<thead>
<tr>
<th>Clostridium difficile infections (number)</th>
<th>Readmissions (%)</th>
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</thead>
<tbody>
<tr>
<td>0%</td>
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<td>1%</td>
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<td>2%</td>
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<td>18%</td>
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<td>19%</td>
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<tr>
<td>20%</td>
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</tbody>
</table>

Venous Thrombous Embolism compliance (%)

<table>
<thead>
<tr>
<th>Care Hours per Patient Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covid-19 pandemic has meant the closure of a number of beds and significantly lower bed occupancy figures, meaning nurse:patient ratios have improved</td>
</tr>
</tbody>
</table>

| Covid-19 pandemic has meant the closure of a number of beds and significantly lower bed occupancy figures, meaning nurse:patient ratios have improved |

219
Aspirant nurses working at the Trust as part of Covid-19 response included in Trust overall workforce figures

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

<table>
<thead>
<tr>
<th>Sickness (%)</th>
<th>Turnover (%)</th>
<th>Mandatory and Statutory Training (MAST)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time to Recruit - days</td>
<td>Vacancy Rate (TOTAL)</td>
<td>Vacancy Rate (Nursing)</td>
</tr>
</tbody>
</table>

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: October 2020

Performance:

<table>
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<tr>
<th></th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
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</thead>
<tbody>
<tr>
<td>2019/20</td>
<td>112.4</td>
<td>113.8</td>
<td>115.0</td>
<td>113.0</td>
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<td>115.3</td>
<td>116.8</td>
<td>114.0</td>
<td>116.9</td>
<td>116.1</td>
<td>118.6</td>
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<tr>
<td>2020/21</td>
<td>120.70</td>
<td>121.30</td>
<td>121.70</td>
<td>122.60</td>
<td>118.50</td>
<td>118.30</td>
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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 rebasing 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.
- 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 with the second wave of Covid-19 arriving from October, it is likely that 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
**Escalation/Accuracy**

**Metric:** Diagnostic Waiting Times (DM01)  
**Type of Standard:** National Constitutional Standard  
**Assurance Committee:** FPC  
**Report Period:** May 2020

**Performance:**

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<td>0.02%</td>
<td>0.00%</td>
<td>0.02%</td>
<td>0.00%</td>
<td>0.02%</td>
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<tr>
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<td>39.3%</td>
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<td>1%</td>
</tr>
</tbody>
</table>

**Target:** 1%  
**2019/20:** 8.65%  
**2020/21:** 1%  

**Driver for Underperformance:**

- Covid-19 has led to a significant reduction in diagnostic capacity, for similar reasons to those described in the 18 Weeks Referral to Treatment escalation report. PPE and necessary infection control for COVID have reduced capacity by 25-50% dependent on the examination being carried out. In addition, if a patient is intubated, the air filtration is not of a high enough standard in the CT scanners so the room has to be left for 3 hours in-between appointments which significantly impacts on our capacity. 3 CT staff have been shielding, which has reduced opportunities for extended days or additional weekend activity.
- There are some specific tests (such as MRI Small Bowel) where capacity has been significantly reduced, mainly due to the length of time of the test (and therefore the opportunity cost). These backlogs have built up over the last year, and are difficult to clear quickly given the resource requirements for each diagnostic.
- Endoscopy activity had to be reduced to life and limb only for several weeks given national and British Society guidance, which created a significant backlog of patients. This has now changed and activity is above pre-Covid levels, with DM01 within Endoscopy alone expected to be met from the end of March 2021.

**Actions to Deliver Improvement:**

- **Mobile MRI:** We have access to a mobile MRI scanner on site at RCHC, 6 times a month. This will only be able to do certain procedures but will still make some inroads into reducing the backlog. We have recently approved an additional 10 days of this scanner, in order to increase the speed of the backlog reduction.
- **Temporary CT:** The Trust has received a portable CT scanner, to be located on site, which will be staffed utilising locums and will be in operation 5 days a week.
- **Barnsley SLA:** The Trust is in the process of agreeing an SLA with Barnsley, for 20-25 CT slots a week at their site. The challenge will be patient resistance to travel, but the team are identifying patients who live closer to Barnsley to help mitigate this.
- **Recruitment:** 5 new radiographers have been appointed, with staggered starts from March over the next 6 months. This will support our ability to run extra sessions and weekend activity on site.
- **Independent Sector:** Currently, one all-day endoscopy list a week is currently being carried out in the Independent Sector. Our colposcopy and hysteroscopy activity was relocated to at Kinvara Hospital in Rotherham in the summer, and the colposcopy backlog has now been cleared.
- **Shift Patterns:** Shift patterns are being amended to ensure we are utilising all of our staff as effectively as possible, including when staff sickness occurs due to Covid-19.
- **Ultrasound:** The Ultrasound backlog has now been cleared to fewer than 100 patients (it was at over 2,000 patients earlier in the pandemic) and the CT and MRI backlogs are less than half what they were several months ago, although have increased in the last few weeks. The endoscopy backlog recovery is ahead of trajectory against a plan to clear it by mid-March, and DM01 will be met in Endoscopy from the end of March.
- Initially, the Trust was forecasting to be meeting the DM01 standard within the year-end forecast, but due to the impact of wave 2 of the pandemic, we have had to review expectations. Given the numbers of patients over 6 weeks still awaiting MRI, CT and DEXA scans, achievement of the full DM01 standard is not now expected until at least the end of Q1 2021/22. However, within this, the DM01 standard for Endoscopy will be met by the end of March.

**Lead Executive Director:** George Briggs, Chief Operating Officer  
**Lead Senior Manager:** Kevin Wilkinson, General Manager, Clinical Support Services  
**Lead Analyst:** Catherine Dixon
### Escalation/Assurance

**Metric:** Overdue Follow-Ups  
**Type of Standard:** Local  
**Assurance Committee:** FPC  
**Report Period:** February 2021

#### Performance:

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**Driver for Underperformance:**
- Consultation mediums: The move to virtual appointments at the start of the pandemic has been positive for many reasons, but it can be more difficult for a clinician to discharge patients following a virtual follow-up appointment compared to previously when the majority of appointments were face-to-face.
- Covid-19 Impact: The stopping of significant volumes of outpatient activity through 2020/21 to support Covid-19 demand, and also given increased staff absence throughout the year, has led to an increase in the numbers of overdue reviews in some specialties (e.g., sleep studies with nearly 1,800 overdue reviews alone). In addition, IPC rules have reduced OP clinic capacity where face-to-face appointments are required, which is having a continued impact on our OP capacity in certain specialties.

**Actions to Deliver Improvement:**
- Patient Initiated Follow Ups: The Trust has begun a programme of work around implementation of patient-initiated follow ups (PIFU), which is being rolled out in Sleep Studies in March, with discussions also underway in Ophthalmology, Gynaecology and Gastroenterology.
- Clinic Booking Rules: Service Managers regularly review the clinic booking rules to see if the balance of new to follow-up appointments needs amending, in order to ensure we are meeting the demand from new referrals whilst continuing to manage patients requiring follow-up care. A review of this in the face of the data around likelihood of discharge is also being fed in.
- Performance Meetings: Fortnightly divisional Elective Review meetings are held to review elective care performance, during which the overdue review numbers are scrutinised and specialty-level actions agreed. Some of these have included clinical review of the proposed appointment timescales and where these can be safely extended without compromising patient care.
- Trajectories: All specialties have developed recovery trajectories for overdue reviews for Q1 2021/22, and these are tracked via a live Power BI app to identify where we are behind plan.

**Expected Trajectory/Forecast:**
- The focus is currently on reducing the number of patients whose reviews are overdue by 3 months or more, which requires us to reduce the number of overdue reviews to approximately 6,000. The current trajectories from the divisions will see overdue reviews fall to 9,300 by the end of June. It is likely to be Q4 until we are able to ensure that overdue reviews do not exceed 6,000, and this will be dependent on potential new waves of Covid-19 affecting our capacity as well.

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**Lead Executive Director:** George Briggs, Chief Operating Officer  
**Lead Senior Manager:** Louise Tuckett, Director of Strategy, Planning & Performance  
**Lead Analyst:** Ruth Gallagher
Escalation/Accrual

<table>
<thead>
<tr>
<th>Metric:</th>
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<th>Assurance Committee:</th>
<th>Report Period:</th>
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<td>Vacancy Rate - Nursing</td>
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<td>February 2021</td>
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**Performance:**

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<td>2020/21</td>
<td>9.5%</td>
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**Driver for Underperformance:**
There has been a further positive shift in qualified nurse vacancy rates this month, with vacancies now close to the regional benchmark and at the lowest levels for over 2 years, which is a fantastic achievement and demonstrates the impact of the ongoing recruitment efforts. There are also a further 24.5 WTE qualified nurses going through the recruitment process who are joining us from organisations external to the Trust. The increased number of substantive nursing staff will support our focus on improving the quality of care across the organisation.

On a daily basis this is currently being offset by the high sickness and Covid related absence rates, combined with low fill rates for Bank and Agency shifts meaning that shift fill rates are adversely affected.

**Actions to Deliver Improvement:**

Ongoing Recruitment: We continue to advertise for and recruit to nursing positions on a rolling basis, with recruitment campaigns targeted at universities for newly qualified nurses. Four newly qualified nurses are due to commence in March 2021.

International Recruitment: 17 international recruits from the first 2 cohorts are now registered nurses with PIN numbers. A further 11 from cohort 3 are in the process of joining the temporary register awaiting examination dates. The fourth cohort of 6 international recruits arrived in February 2021 and are following the fast-track process to join the temporary register, providing their clinical skills are deemed suitable. The next cohort of 6 nurses are due to arrive in April.

Nursing Associates: 8 places have been offered to existing Support Workers to commence as Trainee Nursing Associates in April 2021.

**Expected Trajectory/Forecast:**
The trajectory for end of March is for a further vacancy decrease (of 5-10 WTE) if temporary NMC registrations are completed as planned. A monthly pipeline supply of 10 WTE international nurses per month will commence in April (with transfer to RN status 8-12 weeks later) from April onwards following approval of the business case.

**Lead Executive Director:** Angela Wood, Chief Nurse

**Lead Senior Manager:** Helen Dobson, Deputy Chief Nurse

**Lead Analyst:** Danielle Hardy
Safer Staffing

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<td>96.11%</td>
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<td>Daily staffing - actual HCA v planned (Nights)</td>
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<td>6.3</td>
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There has been a slight increase in registered staff fill rates on days and a reduction on nights when compared to those for January. Non-Registered shift fill rates reduced on days and increased on nights in February 2021.

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. During February the CHPPD for Registered staff was 4.3 and 2.9 for non-registered staff, resulting in an overall increased actual CHPPD of 7.2.

Increased sickness and a significant number of vacancies, poses a daily challenge in ensuring safe and effective staffing across the divisions. Nurse staffing remains on the Trust risk register (5442), with a score of 20.
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.
<table>
<thead>
<tr>
<th>Agenda item</th>
<th>P76 /21</th>
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</thead>
<tbody>
<tr>
<td>Report</td>
<td>Covid-19 Update and Recovery Report</td>
</tr>
<tr>
<td>Executive Lead</td>
<td>Mr George Briggs, Chief Operating Officer</td>
</tr>
<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>
<tr>
<td>Executive Summary</td>
<td>This report is presented to the board for information and assurance that the Trust is managing the pandemic under challenging circumstances and:</td>
</tr>
<tr>
<td></td>
<td>• provides an update on the Rotherham NHS Foundations Trust’s (TRFT’s) response to the Covid-19 pandemic.</td>
</tr>
<tr>
<td></td>
<td>• describes the activity and actions the Trust has taken to deal with the pandemic, up to the month of February 2020.</td>
</tr>
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<td>• updates the trajectories we have developed.</td>
</tr>
<tr>
<td>Due Diligence</td>
<td>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</td>
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<tr>
<td>Board powers to make this decision</td>
<td>N/A</td>
</tr>
<tr>
<td>Who, what and when</td>
<td>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.</td>
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<tr>
<td>Recommendations</td>
<td>It is recommended that: The Board note the report.</td>
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<tr>
<td>Appendices</td>
<td>1. Covid-19 Response and Recovery</td>
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</table>
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 February 2021.

1.2 Healthcare in the UK has been in a Covid-19 pandemic for 12 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 updated the initial recovery plan and the new plan as discussed at the Finance and Performance Committee Meeting and Board of Directors’ Meeting last month, and has been in operation since December 2020. The plan is being monitored by the Director of Strategy and Performance. The initial recovery has been complex and prolonged due to higher numbers of positive Covid-19 patients, an increase in emergency care and staffing shortages due to Covid-19.

1.4 We have agreed elective care trajectories until the end of Q1 2021/22. These are based on specialty-level plans, which have been developed by divisional teams.

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. Critical care has now moved back to the main Critical Care Unit, which is allowing for the finishing of essential estates work on Ward B6.

2.0 Elective Care position

2.1 Referral to Treatment

2.2 Referral to Treatment performance has improved slightly in February to 72.4% (up from 70.2% in January). 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.

2.3 In the February data, we are seeing a high number of over 52 week waiters, with 765 such patients still waiting at the end of February 2021 (721 in January). The majority of these patients are within surgical specialties, given the reduction in theatre and diagnostic activity over the last 12 months.

- Total incomplete PTL size 13254

2.4 Trauma and Orthopaedics has the highest number of long waiting patients 730 over 18 weeks closely followed by ophthalmology at 620 against 3600 patients at 18 weeks or more.

2.5 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 recovery plan
was to have an Orthopaedic ward running again at TRFT in March / April, following the ring fencing of a general elective ward in March.

2.6 I am pleased to say as of the middle of March both the elective and orthopaedic ward are fully open and being ring-fenced for elective capacity.

3.0 Cancer Recovery Performance

3.1 The ongoing reductions in elective and diagnostic capacity, has led to the deterioration in performance against the 62-day standard; with Q4 performance initially unvalidated at 68.1%, (Q3 was 63.9%) against an 85% target.

3.2 2 week waits numbers are recovering as per plan and on track to be sustained January performance was 83.1% with Februarys at 96.3% validated against a 93% target.

3.3 Referral volumes are now the same as the previous year’s numbers, and so services have to manage a similar number of patients with reduced capacity, as well as patient engagement challenges and infection prevention and control measures.

3.4 In particular, the endoscopy team have shown a recovering position and are now on plan to recover in the next month to pre pandemic performance levels.

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

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<thead>
<tr>
<th>Provider</th>
<th>63-103 day</th>
<th>104+ day</th>
<th>ALL 63+ day</th>
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<tr>
<td>The Rotherham NHS FT</td>
<td>73</td>
<td>18</td>
<td>91</td>
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<tr>
<td>Barnsley Hospital NHS FT</td>
<td>124</td>
<td>16</td>
<td>140</td>
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<tr>
<td>Doncaster &amp; Bassetlaw Teaching Hospitals NHS FT</td>
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<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>

3.5 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 plans take a measured approach to delivering improvement through these plans, which is appropriate given the historic challenges with achieving the 62-day standard at the Trust.

3.6 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.
3.7 Cancer 62-day performance trajectory, January 2021 – June 2021

4.0 DM01 Performance

4.1 DM01 diagnostic performance has remained challenged throughout the pandemic. Despite additional capacity through the CT scanner in a box and the mobile MRI unit, linked to a lack of sufficient workforce to utilise these. It is worth noting that NHSE have now confirmed the Trust will be able to keep the CT in a box permanently and the team have formally accepted this, which will provide additional support and capacity.

4.2 The formal performance is 28.7% against a pre pandemic performance of under 1% this is an improving position.

4.3 Key areas of compromised performance are:

- Computed Tomography CT
- Magnetic Resonance Imaging MRI
- Dexa scans
- Audiology assessments

With 1,238 patients waiting over 6 weeks (out of a total1368 patients waiting over 6 weeks)

5.0 Emergency Performance

5.1 The care of our elective and emergency patients is balanced between demand capacity and available resources we are reviewing emergency performance on a daily basis with performance remaining complex but improved the latest position for February shows an average of 1 patient waiting in the department over 12 hours a improvement on the previous year’s performance.

5.2 Initial assessment times and time to see a clinician are variable and have remained similar to previous performance. Although the time to be seen has shown an improvement.
<table>
<thead>
<tr>
<th></th>
<th>Rolling Time to Initial Assessment (Mins)</th>
<th>Time to be seen by a Clinician (Mins)</th>
<th>Mean Total Wait (Mins)</th>
<th>12hrs in Department</th>
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</thead>
<tbody>
<tr>
<td>Standard</td>
<td>15</td>
<td>60</td>
<td>200</td>
<td>0</td>
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<tr>
<td>Pre-Field Test (6wks)</td>
<td>15</td>
<td>93</td>
<td>189</td>
<td>3 (per day)</td>
</tr>
<tr>
<td>Mon</td>
<td>22/02/2021</td>
<td>24</td>
<td>89</td>
<td>226</td>
</tr>
<tr>
<td>Tue</td>
<td>23/02/2021</td>
<td>24</td>
<td>91</td>
<td>243</td>
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<td>Wed</td>
<td>24/02/2021</td>
<td>18</td>
<td>84</td>
<td>222</td>
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<tr>
<td>Thu</td>
<td>25/02/2021</td>
<td>17</td>
<td>89</td>
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<td>26/02/2021</td>
<td>13</td>
<td>83</td>
<td>217</td>
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<td>Sat</td>
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<td>121</td>
<td>257</td>
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<tr>
<td>Sun</td>
<td>28/02/2021</td>
<td>13</td>
<td>62</td>
<td>189</td>
</tr>
<tr>
<td>Rolling 7 Days</td>
<td>18</td>
<td>89</td>
<td>225</td>
<td>0 (0 per day)</td>
</tr>
<tr>
<td>Year to Date (20/21)</td>
<td>16</td>
<td>81</td>
<td>201</td>
<td>1 (per day)</td>
</tr>
</tbody>
</table>

6.0 Ongoing Recovery

6.1 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,

- Additional capacity (e.g., weekend theatres, extended clinics)
- Clinical and administrative validation of patients.
- Increase in face-to-face activity.
- First 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) Complete.
- Two elective surgical wards available from April (Sitwell) Complete.
- ICU demands reduce mid-February and additional capacity released back to divisions. This did not happen out since these assumptions were derived in January but happened March 21.
- Independent Sector capacity was available in January at Kinvara Thornbury/Claremont from 1st Feb. Latest activity figures shows the IS delivery is 50% of planned volumes.
- Referral volumes are moving back to pre-pandemic volumes.
- We built in increased annual leave provision between March and September 2021 due to carry over.

7.0 RTT Patient Tracking List from April 2021

7.1 National guidance relating to the treatment and recording of patients who become ‘Appointment Slot Issues’ (ASIs) following a referral is now clear. Best practice dictates that all patients waiting for consultant-led care at the Trust should be counted within the Patient Tracking List (PTL).
7.2 As mentioned last month our reporting practices will ensure all patients (including those awaiting a first appointment) are counted within our full waiting list from April 2021.

7.3 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.

8.0 RTT Trajectory

8.1 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. As can be seen we are slightly below trajectory at the end of February 0.9%.

9.0 RTT Incomplete Standard Trajectory

9.1 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.

9.2 As outlined above, the recovery trajectories are now being 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.

9.3 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.

10.0 Conclusion

10.1 The recovery of performance will take many months, and in some services up to a year or more, the developments in the last month shows recovery in RTT Diagnostics and cancer.

10.2 The ring-fenced elective ward on Keppel, and the Orthopaedic ward Sitwell both opened ahead of plan.

G Briggs
March 2021
<table>
<thead>
<tr>
<th>Agenda item</th>
<th>P77/21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report</td>
<td>Care Quality Commission Report</td>
</tr>
<tr>
<td>Executive Lead</td>
<td>Angela Wood, Chief Nurse</td>
</tr>
<tr>
<td>Link with the BAF</td>
<td>B1</td>
</tr>
<tr>
<td>How does this paper support Trust Values</td>
<td>Demonstrates the ambition to manage quality of standards and delivery of good care. Working together to reduce poor standards for patients and staff.</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 presented to the Board to provide an update on CQC Compliance. The Trust has developed action plans to address specific concerns raised by the CQC. The action plans are updated regularly, with regular submissions to the CQC. The actions identified as outstanding and updates that were submitted to CQC on 5 March 2021 are attached in the Appendices.</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 report was presented to the Quality Committee on 31 March 2021 and the CQC Delivery Group on 23 March 2021.</td>
</tr>
<tr>
<td>Powers to make this decision</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Who, What and When (what action is required, who is the lead and when should it be completed?)</td>
<td>Once presented, the Chief Nurse, as Executive Lead for CQC will continue to monitor compliance with the CQC actions.</td>
</tr>
<tr>
<td>Recommendations</td>
<td>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.</td>
</tr>
</tbody>
</table>
| Appendices | 1. CQC Action Plan  
2. Safeguarding Quality Improvement Action Plan  
3. AMU Improvement Action Plan |
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 (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 actions.

2.2 **2020 CQC Inspections**

2.2.1 **Safeguarding**

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

A showcase event is being developed currently to enable the services involved in the action plan to be able to demonstrate their improvements to the Executive Management Team and identify how the actions have been embedded and are being sustained.

2.2.2 **Warning Notice (AMU)**

Following publication of the Section 29a Warning Notice, an action plan was submitted to the CQC on 19 February 2021, identifying all the actions required to address the issues raised, and with longer term actions identified to enhance these actions further. This plan was reviewed and updated further, to identify the evidence and assurance level of the actions, and was resubmitted to the CQC on 22 March 2021 (see Appendix 3). This plan is monitored internally in the Trust in a number of forums.

3. **Enquiries**

3.1 The following enquiries have been received from the CQC between 4 February 2021 to 11 March 2021
### CQC Reference Number and Date Received

<table>
<thead>
<tr>
<th>Reference</th>
<th>Subject of Enquiry</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSIB Referrals 5/2/21</td>
<td>The number of HSIB referrals in the last 2 years and with each one a brief outline of the incident and where in the process the investigation is.</td>
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<tr>
<td>MRR1-9068205392 4/2/21</td>
<td>NEW REQUEST - Request for information in relation to safeguarding</td>
</tr>
<tr>
<td>ENQ1-10256440082 NRLS ID 51630196 Local ID 117720 14/2/21</td>
<td>Theme: Speciality review Assessment and discharge</td>
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</tbody>
</table>

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. **Preparation for Future CQC Inspection**

4.1 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.

4.2 Although the CQCs 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.

4.3 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.

5. **Conclusion**

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

Anne Rolfe  
Quality Governance, Compliance and Risk Manager  
March 2021
## AGENDA ITEM 42/21 OFF-PLAN ACTIONS

<table>
<thead>
<tr>
<th>AI No.</th>
<th>Area for Improvement</th>
<th>Core Service</th>
<th>Regulation Progress Status</th>
<th>Exception Commentary</th>
</tr>
</thead>
</table>
| 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 | Acute - Urgent & Emergency Care | Off-Plan                  | Three audits were completed (data submitted and action plans developed) in 2018/19:  
1. Vital signs in adults (care in emergency departments). Observational audit took place in early November. The action plan has been completed and initialised. A presentation will be given at Nursing/Doctors CE Days.  
2. VTE risk in lower limb immobilisation (care in emergency departments). This action plan has been completed. VTE leaflets are in situ in UECC.  
3. Feverish Children (care in emergency departments). This action plan is part completed. Due to COVID the feverish children pathway was changed so the audit couldn’t be completed. As children are now going through UECC this audit has commenced. Awaiting audit results: based Nov to Feb following previous RCEM audit – pops introduced.  
RCEM reports from 2019/20 audits:  
Assessing cognitive impairment in older people (Care in Emergency Departments). Action plans for cognitive impairment for older people are written. Meditech adaptions will be required.  
Care of Children (Care in Emergency Departments). Action plans for care of children- data poor as number of patients included very few. Need to introduce a psych social assessment. 12-17 year olds. Discussions with Paeds UECC team commencing.  
Mental Health (Care in Emergency Departments). Data submitted for these and the reports with actions should have been available in Spring 2020. The local and national reports for Assessing cognitive impairment in older people and Care of Children have recently been published. The results and recommendations from the audits are being reviewed. 18/3/21 - No result as yet.  
The Mental Health local and national reports will be released in the following weeks.  
The audits for 2020/21 are Fractured neck of femur and Infection control & pain in children which were due to commence in August 2020. Registration is currently open for the 2020-21 audits, with data collection commencing in October 2020 until April 2021. Data collection was due to start on 12th |
October, but the information packs for the 2020-2021 audits were only published on 3 November 2020. These audits have now commenced. Pain in children will run until October 2021- allow for full QUIP plans to introduce pain score on discharge-education and posters being written.

Clinical Audit plan in place, with action plans being developed. The discussion of these at the UECC Divisional Governance Meeting and the embedding of the actions requires further review.

A quarterly report was presented to CGC and QC in December 2020 on UECC compliance against the RCEM audits. A further report will be presented in March 21. A review of all the previous RCEM audits has been undertaken and a RAG rated action plan has been developed.

Regarding the RAG rating older audits- asthma discharge documents looking at we can adapt to Meditech/use originals.

Vital signs re-audited and closed

Frailty nurse loss- intro of 4AT assessment on Meditech (see audit 2020)

There is no separate action plan for this action as there are appropriate mitigating reasons for non-completion.

<table>
<thead>
<tr>
<th>037</th>
<th>The Trust must ensure that oxygen is appropriately prescribed including the documentation of target blood oxygen levels.</th>
<th>Acute - Medical Care (Inc. Older People)</th>
<th>Off-Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>VERBAL UPDATE TO BE PROVIDED AT THE MARCH CQC DELIVERY GROUP MEETING</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A task and finish group has been established, which is being led by the Medical Director. Meetings took place in September, November 2020 and January 2021.

A detailed action plan is being developed and progress will be monitored through the Patient Safety Group.

Progress is being made in relation to a locally agreed protocol and training. The PCM Inpatient Admission Summary now includes a mandatory question on the VTE Assessment Tab asking whether an oxygen prescription is required. If yes, the user will be prompted to include the oxygen target saturations range and then prompted to prescribe the oxygen. If oxygen has not been prescribed, the electronic observation chart will generate a pop up informing nursing staff of this when they select a method of oxygen administration. It will prompt the nurse to ensure a clinician prescribes the oxygen within the hour. The nurses will have to make sure the clinician prescribes there is no auto prompt to clinicians at this point. The MAR Chart – Oxygen will now be prescribed once daily at 8am therefore nurses will be required to document given or not given on a
It has been agreed that the KPI will be that where applicable 98% of patients will have their target blood levels documented and oxygen prescribed as necessary. Achievement targets of 75% by the end of Q3 and 98% by the end of Q4 have been agreed. The current achievement level is 68.17% for November and 64.85% for December (awaiting validation).

See separate action plan for further detail.

| 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. |
| Acute - Services for Children & Young People | Off-Plan |
| The target is 70%, and as at 15/9/2020 a total of 56% of SCBU staff are QIS qualified (note: Band 6 vacancies and above in SCBU require the applicant to be QIS trained). The plan to achieve the target is: |
| Establish Control Panel have approved the conversion of 1.86 FTE Band 5 to Band 6 – these vacancies have now been recruited to and once they are in post this will lift the total to 62% (anticipated to be in post Jan 21). Since then there has been an additional conversion of 1FTE equivalent Band 5 to Band 6 0.8 FTE (anticipated to be in post Feb 21) this will increase compliance to 63%. |
| 1 x member of staff will attend QIS training from Sept 20 and will be qualified by Sept 21, lifting the total to 67% |
| 1 x member of staff will attend QIS training Sept 21 and will be qualified by Feb 22, lifting the total to 69% |
| 1 x member of staff will attend QIS training Feb 22 and be qualified by Sept 22, lifting the total to 72%. |
| The CQC are aware that this action will remain off plan until September 2022. This has also been discussed at the Board of Directors. |
| There is no separate action plan for this action as there are appropriate mitigating reasons for non-completion. |
The Trust must provide assurance for safeguarding children and adults is such a way that they are safe to access and are a priority to promptly build up a comprehensive picture of a child's needs.

2. The Trust must ensure that records maintained for safeguarding children and adults is such a way that they are safe to access and are a priority to promptly build up a comprehensive picture of a child's needs.

The Board of Directors have agreed that one of the 9 Quality Priorities for 2021 will be leaving from incidents, they enhance all systems:.

- To build a range of methods to disseminate learning and knowledge to all members of the organisation, including staff, emerging themes and trends on a quarterly basis.
- To ensure that the Learning from Incidents Quality Priority is captured and evidenced literally at all levels, including regular “Learning from the Incident” events across the Trust.
- To build a range of methods to engage and engage and engage...
<table>
<thead>
<tr>
<th>Ref No.</th>
<th>Task/Description</th>
<th>Completion Date</th>
<th>Progress Status as at 3 March 2021</th>
<th>Commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>Lead</td>
<td>30 September 2020 (soft-launch)</td>
<td>On-plan In January / February 2021 the developed appraisal conversation and career conversation paperwork (underpinned by significant input from the BEL Leadership Academy Task &amp; Finish that was agreed by the Task &amp; Finish group) was with Graphics for branding - draft evidence provided. In support of these, an appraisal and career conversations guidance document and flowcharts have been produced - draft evidence provided. In addition, a video is available on the HUB which outlines the journey of the soft launch, plus current and future plans. The second edition of Our People Pack was launched on the 29th January 2021 in PROUD (evidence provided) as part of the &quot;Trees to Talk&quot; initiative and also included in the TRFT Team Brief on the 5th February 2021 (evidence provided) which supports employees with their wellbeing conversations (which will be actively used during appraisal). The launch of the new Appraisal conversation is being fully operational from April 2021. The Trust must ensure that the culture and ethos within the organisation supports safeguarding being everyone's business. The Trust’s People Strategy (Build, Engage, Lead, Learn) has just been approved, there is opportunity to align the safeguarding actors with this.</td>
<td></td>
</tr>
<tr>
<td>2.2</td>
<td>Task</td>
<td>30 September 2020 (soft-launch)</td>
<td>On-plan In January / February 2021 the developed appraisal conversation and career conversation paperwork (underpinned by significant input from the BEL Leadership Academy Task &amp; Finish that was agreed by the Task &amp; Finish group) was with Graphics for branding - draft evidence provided. In support of these, an appraisal and career conversations guidance document and flowcharts have been produced - draft evidence provided. In addition, a video is available on the HUB which outlines the journey of the soft launch, plus current and future plans. The second edition of Our People Pack was launched on the 29th January 2021 in PROUD (evidence provided) as part of the &quot;Trees to Talk&quot; initiative and also included in the TRFT Team Brief on the 5th February 2021 (evidence provided) which supports employees with their wellbeing conversations (which will be actively used during appraisal). The launch of the new Appraisal conversation is being fully operational from April 2021. The Trust must ensure that the culture and ethos within the organisation supports safeguarding being everyone's business. The Trust’s People Strategy (Build, Engage, Lead, Learn) has just been approved, there is opportunity to align the safeguarding actors with this.</td>
<td></td>
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<tr>
<td>3.2</td>
<td>Task</td>
<td>30 September 2020 (soft-launch)</td>
<td>On-plan In January / February 2021 the developed appraisal conversation and career conversation paperwork (underpinned by significant input from the BEL Leadership Academy Task &amp; Finish that was agreed by the Task &amp; Finish group) was with Graphics for branding - draft evidence provided. In support of these, an appraisal and career conversations guidance document and flowcharts have been produced - draft evidence provided. In addition, a video is available on the HUB which outlines the journey of the soft launch, plus current and future plans. The second edition of Our People Pack was launched on the 29th January 2021 in PROUD (evidence provided) as part of the &quot;Trees to Talk&quot; initiative and also included in the TRFT Team Brief on the 5th February 2021 (evidence provided) which supports employees with their wellbeing conversations (which will be actively used during appraisal). The launch of the new Appraisal conversation is being fully operational from April 2021. The Trust must ensure that the culture and ethos within the organisation supports safeguarding being everyone's business. The Trust’s People Strategy (Build, Engage, Lead, Learn) has just been approved, there is opportunity to align the safeguarding actors with this.</td>
<td></td>
</tr>
<tr>
<td>Action</td>
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<td>Trust Wide</td>
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<td>Statement</td>
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<td>-------------</td>
<td>-------------</td>
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</tr>
<tr>
<td>2.2.1</td>
<td>Natalie Zuber - AMU</td>
<td>AMU</td>
<td>22 Feb 21</td>
<td>There is an overarching mortality improvement action plan which includes and addresses themes identified from learning from deaths. Mortality also forms a standing agenda item for the MD fortnightly Clinical Leads' meeting, which Dr Jahangir, AMU Clinical Lead, attends.</td>
</tr>
<tr>
<td>2.2.3</td>
<td>Natalie Zuber - AMU</td>
<td>AMU</td>
<td>30 Sep 21</td>
<td>To ensure that there is adherence to processes and procedures for the preparation/storage/administration of medications on AMU.</td>
</tr>
<tr>
<td>1.3.1</td>
<td>Natalie Zuber - AMU</td>
<td>TRFT</td>
<td>19 Feb 21</td>
<td>To ensure that the Trust learning from deaths process is fully embedded within the Trust and Clinical Divisions, and that learning from incidents reduces the pravalence going forward.</td>
</tr>
<tr>
<td>1.3.2</td>
<td>Natalie Zuber - AMU</td>
<td>TRFT</td>
<td>30 Sep 21</td>
<td>To enable the Trust to ensure consistent reporting of important safety events, and improve compliance and the reduction in incident reporting of patients and patient harm.</td>
</tr>
</tbody>
</table>

**Reference**

1. The Trust has a policy and procedure to ensure proactive management of areas to ensure the safe storage and preparation of medication environments on AMU.
2. To ensure that there is adherence to processes and procedures for the preparation/storage/administration of medications on AMU.
3. To enable the Trust to ensure consistent reporting of important safety events, and improve compliance and the reduction in incident reporting of patients and patient harm.

**Conclusion**

- Natalie Zuber - AMU
- TRFT

**Supporting Documents**

- P77.21iii CQC Report - appendix 3 AMU Section 29a Improvement Plan March 21
- RDGH B3 ROOM ALTERATIONS PLAN
- Weekly Briefing 11 Jan 2021
- NMC Code of Practice
- Letter to Registered Nurses and Associates 261120
- Pressure Ulcer Action plan
- Patient Safety Bulletin Issue 3
- TRFT Falls Audit October 20 Presentation
- TRFT Falls Audit October 20 PowerPoint
- TRFT Falls Audit October 20 PDF
- TRFT Falls Audit October 20 Word

**Appendices**

- TRFT Falls Audit October 20 Presentation
- TRFT Falls Audit October 20 PowerPoint
- TRFT Falls Audit October 20 PDF
- TRFT Falls Audit October 20 Word

**Supporting Figures**

- TRFT Falls Audit October 20 Presentation
- TRFT Falls Audit October 20 PowerPoint
- TRFT Falls Audit October 20 PDF
- TRFT Falls Audit October 20 Word
<table>
<thead>
<tr>
<th>Action</th>
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<th>Description</th>
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<th>Report Date</th>
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<tbody>
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<td>Jenny Benton - AMU</td>
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<td>AMU</td>
<td>31-Jan-21</td>
<td>Evidence listing</td>
<td>Natalie Zuber - AMU</td>
<td>AMU - Matron Assurance Audit 24 Jan 21</td>
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<td>Jenny Benton - AMU</td>
<td>Not known</td>
<td>AMU</td>
<td>31-Jan-21</td>
<td>Evidence listing</td>
<td>Natalie Zuber - AMU</td>
<td>AMU - Matron Assurance Audit 14 Jan 22</td>
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<tr>
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<td>Jenny Benton - AMU</td>
<td>Not known</td>
<td>AMU</td>
<td>31-Jan-21</td>
<td>Evidence listing</td>
<td>Natalie Zuber - AMU</td>
<td>AMU Staffing Audit 23 Feb 21</td>
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<td>Evidence listing</td>
<td>Natalie Zuber - AMU</td>
<td>Nursing - Medicine 31-Jan-21</td>
</tr>
</tbody>
</table>
### Recommendation

- **To improve communication between Trust and AMU**
  - Facilitate a monthly meeting between Trust and AMU to discuss recommendations and updates.

### Action

- Regular communication meetings between Trust and AMU.

### Area of Assurance

- Communication

### Key Dates

- **March 2021**: Initial meeting to discuss recommendations.
- **June 2021**: Second meeting to review progress.

### Performance Standards

- Regular monitoring of communication outcomes.

### Commentaries

- Continuous improvement in communication practices.

---

### 3.5.1

**To ensure that all patients in AMU have access to appropriate and competent staff**

- Regular monitoring of staffing levels.
- Review of staff deployment to ensure adequate coverage.

### Action

- Weekly review of staffing levels and deployment.

### Area of Assurance

- Staffing

### Key Dates

- **February 2021**: Initial review of staffing levels.
- **April 2021**: Review of staffing deployment.

### Performance Standards

- Staffing levels meeting target.
- Adequate staff deployment.

### Commentaries

- Continuous improvement in staffing practices.

---

### 4.1.3

**Governance processes, skills and competencies of staff are assessed and improved**

- Regular audit of governance processes.
- Staff skills and competencies assessed.

### Action

- Monthly audit of governance processes.

### Area of Assurance

- Governance

### Key Dates

- **March 2021**: Initial audit of governance processes.
- **May 2021**: Review of governance processes.

### Performance Standards

- Processes meeting target.
- Staff skills and competencies improved.

### Commentaries

- Continuous improvement in governance practices.

---

### 3.3.1

**AMU actions**

- Specific actions for AMU.

### Action

- AMU-specific actions.

### Area of Assurance

- AMU

### Key Dates

- **April 2021**: Initial actions.
- **June 2021**: Review of actions.

### Performance Standards

- Actions meeting target.
- AMU meeting target.

### Commentaries

- Continuous improvement in AMU practices.

---

### 3.6.4

**AMU actions**

- Specific actions for AMU.

### Action

- AMU-specific actions.

### Area of Assurance

- AMU

### Key Dates

- **April 2021**: Initial actions.
- **June 2021**: Review of actions.

### Performance Standards

- Actions meeting target.
- AMU meeting target.

### Commentaries

- Continuous improvement in AMU practices.
<table>
<thead>
<tr>
<th>Action</th>
<th>Notes</th>
<th>Area of Application</th>
<th>Deficiency Description</th>
<th>Task</th>
<th>Operational Level</th>
<th>负责人</th>
<th>Recommended Action</th>
<th>Anticipated Outcome</th>
<th>Status</th>
<th>Technical</th>
<th>Evaluation</th>
<th>Operating</th>
<th>Ongoing Management Strategy</th>
<th>Conclusion</th>
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<tr>
<td>4.3.2</td>
<td>Patient safety Teams to identify isolation and training needs for staff to improve quality of care in hospital.</td>
<td>1-1.1, 1.4, 1.5, 1.6</td>
<td>Team to identify and develop training programmes for adequate care in hospital.</td>
<td>Senior Executive</td>
<td>Senior Leadership</td>
<td>Chief Nurse Safety</td>
<td>Team to develop training programmes for adequate care in hospital.</td>
<td>To improve quality of care in hospital.</td>
<td>On-plan</td>
<td>30-Jun-21</td>
<td>30-Aug-21</td>
<td>30-Sep-21</td>
<td>30-Oct-21</td>
<td>Improvemnt of training for staff to improve quality of care in hospital.</td>
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<td>4.4.2</td>
<td>Enhanced process for reporting nurse staffing concerns to be in identified and escalated through the escalation process.</td>
<td>Senior Executive</td>
<td>Process to be identified and escalated through the escalation process.</td>
<td>Team to develop training programmes for adequate care in hospital.</td>
<td>Team to develop training programmes for adequate care in hospital.</td>
<td>To improve quality of care in hospital.</td>
<td></td>
<td>On-plan</td>
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<td>30-Aug-21</td>
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<td>30-Oct-21</td>
<td>Improvemnt of training for staff to improve quality of care in hospital.</td>
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<tr>
<td>4.5.1</td>
<td>Implement the organisational learning and action forum (OLAF) to ensure all actions have been completed and evidence submitted.</td>
<td>Senior Executive</td>
<td>OLAF to be implemented and evidence submitted.</td>
<td>Team to develop training programmes for adequate care in hospital.</td>
<td>Team to develop training programmes for adequate care in hospital.</td>
<td>To improve quality of care in hospital.</td>
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<td>On-plan</td>
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<td>30-Sep-21</td>
<td>30-Oct-21</td>
<td>Improvemnt of training for staff to improve quality of care in hospital.</td>
<td>Complete</td>
</tr>
<tr>
<td>4.5.2</td>
<td>Ensure individualised goals are documented in daily staff handover.</td>
<td>Senior Executive</td>
<td>Individualised goals to be documented in daily staff handover.</td>
<td>Team to develop training programmes for adequate care in hospital.</td>
<td>Team to develop training programmes for adequate care in hospital.</td>
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<td></td>
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<td>30-Sep-21</td>
<td>30-Oct-21</td>
<td>Improvemnt of training for staff to improve quality of care in hospital.</td>
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<tr>
<td>4.5.3</td>
<td>Develop an electronic staffing escalation log to support the Duty Matron role.</td>
<td>Senior Executive</td>
<td>Electronic staffing escalation log to support the Duty Matron role.</td>
<td>Team to develop training programmes for adequate care in hospital.</td>
<td>Team to develop training programmes for adequate care in hospital.</td>
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<td>Executive Lead</td>
<td>Dr Callum Gardner, Executive Medical Director</td>
<td></td>
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| 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 ☐ |

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 October 2020.

Summary of key points:

**HSMR: 117.9** - statistically significantly higher than expected. However, it represents a stability in the Trust position with a downward trend. The in-month graph shows progress achieved in August and September, with the HSMR being below 100.

**SHMI: 117.7** - statistically significantly higher than expected. This again shows a considerable improvement. The alert on Dr Foster for intestinal hernia without obstruction has reduced but this remains a high relative risk.

Diagnosis code alerts:

There are 3 outlying groups attracting significantly higher than expected deaths remain as:
- Pneumonia
- Acute Bronchitis
- Cancer of Ovary
<table>
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<th>Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors’ meeting)</th>
<th>This data has been presented to the Trust’s Safe &amp; Sound Mortality Group, Mortality Analytics Group and Clinical Governance Committee, and was presented to the Quality Committee on 31st March.</th>
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<tr>
<td>Board powers to make this decision</td>
<td>N/A</td>
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<tr>
<td>Who, What and When (what action is required, who is the lead and when should it be completed?)</td>
<td>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. The intention is to keep this group in place until the HSMR and SHMI are less than 110.</td>
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<tr>
<td>Recommendations</td>
<td>It is recommended that the Board notes the mortality position and the significant actions being taken to make improvements.</td>
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</tbody>
</table>
| 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 of 117, and the Trust continues to be 1 of 6 within the regional peer group of 13 with this rating. However, this represents a stability within the Trust and the 1-month delay has given the confidence that this figure will not change in-month.

1.2 There have been 814 deaths within the cohort of patients versus 690 expected.

1.3 There are only 3 diagnosis codes alerting at present; all the others have dropped off, however it is still worthy of note that they remain statistically high but not significant.

1.4 HSMR and SHMI are 12-month rolling averages, and therefore it will take time for them to drop below the initial target of under 110. Nevertheless, the latest data point in the rolling 12-month HSMR trend shows a downward trend:

1.5 Furthermore, although individual ‘in-month’ figures should not be interpreted in isolation due to natural variation, the graph below shows in-month trends as an example of HSMR being below 100 for the months of August and September. This suggests that the improvement actions being taken by the Trust are having a positive impact and is an encouraging sign. However, it should be noted that it is anticipated that the HSMR will rise again next month (November 2020 data) due to the indirect impact of Covid-19.

1.6 The Trust Crude rate within HSMR basket sits at 4%, with the peer group at 3.4%.
1.7 Whilst the Medical Director is awaiting the final reports from each of the case-note reviews of a sample of deaths falling within each of the diagnostic codes triggering mortality alerts, including pneumonia, COPD and intestinal obstruction without hemia, initial feedback is that no significant concerns and/or avoidable deaths have been identified. However, themes and trends are being collated in order to further enrich the Trust’s overall Mortality Improvement Action Plan. Furthermore, whilst this review did not undergo the new enhanced process as it was commissioned prior to the new process being agreed, the Medical Director has been working with colleagues in order to introduce new ‘Stage 3’ (Structured Judgement Review/SJR+) and ‘Stage 4’ review forms, which will be used for in-depth reviews following this enhanced process moving forward.

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 The next instalment of the Mortality Matters bulletin will focus on a case going to inquest and the lessons learned in advance of the coronial process.

1.10 A review into the cancer of the ovary alert will be brought back to the Safe & Sound Mortality Group next month; this alert consists of 6 superspells and 2 deaths.

1.11 The Medical Director is currently out to advert internally for a new Associate Medical Director – Mortality and Learning from Deaths, with a view to putting greater resource into the learning from deaths, as this is recognised as being a key area requiring significant strengthening in the Trust. This post will also enable the separation of the learning from deaths from the Medical Examiner’s service, thus strengthening this service’s independency.

1.12 As part of a new Clinical Effectiveness Business Case, the Medical Director is also looking to introduce a new Learning from Deaths Manager, following feedback from the Kettering General Hospital, who have made significant progress around mortality, having historically been in a similar position to the Trust.

1.13 The Mortality Improvement Group, chaired by the Chief Executive, continues to meet regularly, in order to ensure drive and pace around the key actions identified in the Mortality Improvement Action Plan (Appendix 3). This Group has external representation and support by Professor Chris Welsh, an experienced clinician and retired Medical Director, who is now an acute Trust Non-Executive Director; this ensures external scrutiny and a ‘fresh look’ approach to the significant work being undertaken by the Trust around mortality and learning from deaths.

2.0 Coding

2.1 Following the clinical review of pneumonia, a coding review is now in train in order to triangulate where improvements can be made within this diagnosis code, as it is still featuring as an alert.

2.2 The urosepsis/urinary tract infection review will be discussed at the next month’s Safe & Sound Mortality Group meeting. The provisional findings show that there is a mixture of issues where cases documented as urosepsis were not coded as such and where clinical documentation has not allowed the coding of urosepsis. These cases were managed as urosepsis, where there is a higher relative risk of mortality.

2.3 In light of the new diagnosis code of acute bronchitis alerting, the Safe & Sound Mortality Group will be discussing issues around this. This appears to be more of a historical term.
and is felt likely to relate to issues with documentation, as the term ‘acute bronchitis’ is a term generally used only in primary care and comes with a low expected mortality rate. Furthermore, it is felt likely that such patients coded as having had ‘acute bronchitis’ are much likely in fact to have had ‘pneumonia’, which carries a higher expected mortality rate.

2.4 Ongoing communication, led by the Medical Director and Lead Medical Examiner, continues to reiterate the importance of clear documentation. Furthermore, coding cards have again been distributed and are to be given out at all future inductions for medical staff. Furthermore, the Trust will be introducing ‘3M’ coding software in the near future, following a successful trial which identified significant opportunities to improve the depth of clinical coding; it is anticipated that this will also have a positive impact of the Trust’s HSMR and SHMI.

3.0 Case-mix

3.1 The community team has conducted a review of patients in the care homes and an update was provided to the Safe & Sound Mortality Group. The review concluded that patients received good care, as it was a Consultant-led service. All patients have DNACPR discussed with them and their wishes to return to hospital if necessary. This is documented within the care notes as advanced care planning.

3.2 The case where a return to hospital was inappropriate was due to locum staffing covering annual leave.

3.3 There is an ongoing review of palliative care services within the Trust and the Trust is currently actively recruiting to the increased nursing establishment approved through a successful Business Case. The process for recruitment to the increased medical resource approved is currently in train, with a view to expansion of acute palliative care services. Once in place, this will enable the Trust to focus more on end of life training and recognition.

3.4 Palliative care coding rate (HSMR basket) for the rolling 12-month position is 3.3%, vs an increased national rate of 4.4%, again suggesting opportunities to improve both clinical documentation and clinical coding.

3.5 The Medical Director is in the process of setting up a new ReSPECT Implementation Task & Finish Group. This is a nationally recognised form, which will seek to replace the current Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) form, as well as incorporating detailed decision-making around ceilings of care. This Implementation Group will include partners from across Rotherham Place, including colleagues from primary care and the hospice.

4.0 Conclusion

4.1 A significant amount of work and effort is being focussed on improving mortality and the learning from deaths within the Trust. Whilst there is some way to go, the current mortality figures suggest that the Trust is moving in a positive direction. The Chief Executive and Medical Director continue to drive improvements around mortality and the learning from deaths, which remain one of the Trust’s top improvement priorities.

Dr Carrie Kelly
Medical Examiner
March 2021
SHMI: Last update on NHS Digital: 11 Feb 2021

Data has been released in February for SHMI incorporating performance data up to September 2020.
Looking at the rolling 12-month SHMI Oct 2019 – Sept 2020 the score is 117.8, in line with the previous score of 117.3 (worse than expected category).
SHMI excludes Covid as part of their standard modelling.

HSMR: Last update on Dr Foster: 06/02/2020

The HSMR is based on a subset of diagnoses which give rise to around 80% of in-hospital deaths, aka as the Basket of 56.

Data has been released in February for HSMR incorporating performance data up to October 2020.
Looking at the rolling 12-month HSMR Nov 2019 – October 2020 the score is 117.9 (higher than expected category).
With Covid excluded the rolling 12-month HSMR November 2019 – October 2020 the score is 113 (higher than expected category).
TRFT is 118 out of 125 Trusts (117th if covid activity is excluded).
MORTALITY SUMMARY REPORT

THE ROTHERHAM NHS FOUNDATION TRUST

TRUST LEVEL – FEBRUARY 2021

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<th>Report Date</th>
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<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>November 2019 to October 2020 (Unless otherwise stated)</td>
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HOSPITAL STANDARDISED MORTALITY RATIOS (HSMR)

TRENDS IN CODING & CASEMIX

HSMR INFLUENCERS

STANDARDISED MORTALITY RATIOS (SMR) ANALYSIS

CUSUM ALERTS @ 99% & 99.9% (NOVEMBER 20)

SHMI (DATA PERIOD: OCTOBER 2019 TO SEPTEMBER 2020)

RECOMMENDATIONS FOR FURTHER ANALYSIS

APPENDIX

REFERENCES

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### EXECUTIVE SUMMARY

<table>
<thead>
<tr>
<th>Metric</th>
<th>Result: Data Period: November 2019 to October 2020 (1 month time lag included)</th>
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</thead>
<tbody>
<tr>
<td><strong>HSMR</strong></td>
<td>117.9 statistically significantly higher than expected</td>
</tr>
<tr>
<td><strong>HSMR position vs. peers</strong></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&lt;br&gt;Crude rate within HSMR basket = 4.0% (Peer group rate = 3.4%)</td>
</tr>
<tr>
<td><strong>HSMR outlying groups</strong></td>
<td>There are 3 outlying groups attracting significantly higher than expected deaths remain as:&lt;br&gt;• Pneumonia&lt;br&gt;• Acute Bronchitis&lt;br&gt;• Cancer of ovary</td>
</tr>
<tr>
<td><strong>Coding and Case-mix</strong></td>
<td>• Palliative care coding rate (HSMR basket) for the rolling 12 month position is 3.3% vs. an increased national rate of 4.4%&lt;br&gt;  - This will continue to be impacted by the increase in O day emergency admissions and changing case-mix during the COVID-19 pandemic?&lt;br&gt;  - However, as per previous reports when reviewing 1+ the rate is low relative to peer.&lt;br&gt;• The proportion of superspells within the Non-elective HSMR basket with a 20+ score remains low at 12.6% compared to a national rate of 14.3%&lt;br&gt;• The Trust retains the highest proportion of 0 day Abdominal pain admissions nationally, if not correct this will potentially be having an impact on the expected rate. 9.7% of all 0 day admissions v 4.7% nationally.&lt;br&gt;• 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.</td>
</tr>
<tr>
<td><strong>All Diagnosis SMR</strong></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.&lt;br&gt;  - SMR excluding COVID-19 = 110.3 as at September 2020.&lt;br&gt;• There are no further outlying groups (outside of the HSMR)</td>
</tr>
<tr>
<td><strong>New CUSUM alerts this month</strong></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.&lt;br&gt;• 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><strong>SHMI (Oct 2019 to Sept 2020)</strong></td>
<td>• SHMI = 117.76 significantly higher than expected but again does represent a material reduction in point vale interestingly with only one common diagnosis group.&lt;br&gt;  - Key outlying groups include&lt;br&gt;    - Fluid &amp; Electrolytes&lt;br&gt;      - Not significant within the Dr Foster model and the SHMI significance is being driven by the &quot;out of hospital&quot; element.&lt;br&gt;    - Other Connective tissue disease&lt;br&gt;    - Intestinal obstruction without hernia&lt;br&gt;      - No longer significant within the Dr Foster model but retains a raised standardised and high crude rate&lt;br&gt;    - Intracranial Injury&lt;br&gt;    - Joint Disorders&lt;br&gt;    - Other Gastrointestinal disorders&lt;br&gt;    - Aspiration pneumonitis (In Hospital)</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 November 2019 to October 2020. Although Dr Foster does have access to data up until November 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 August 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 October 2019 to September 2020 was obtained from NHS Digital’s Indicator Portal. SHMI is updated and rebased monthly.

• No longer significant within the Dr Foster model but remains raised
  • Acute Myocardial Infarction (In Hospital)
  • As discussed in the previous month’s report not significant within the Dr Foster model, however the key cohort of activity is the cohort which is neither transferred in or out of the Trust.
HOSPITAL STANDARDISED MORTALITY RATIOS (HSMR)

Key Highlights:

- HSMR = 117.9 statistically significantly high and has been for the last 12 data points.
- Crude rate within HSMR basket = 4.0% (Peer group rate = 3.4%)

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 now only 3 outlying groups:

- Pneumonia
- Cancer of ovary
- Acute Bronchitis
HSMR Trends

Fig 1.0 HSMR Trend (month)

As can be seen from Fig 1.0 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.

August and September both saw HSMR in month point values below 100 with October at 110.6.
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 or subsequent primary diagnosis of U07.1 or U07.2 (The nominated COVID19 ICD10 codes)

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 4.0% (vs 3.4% for the peer group)

In terms of activity, The Rotherham NHS Foundation Trust retains the second lowest volume of HSMR activity across the Acute providers within 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

<table>
<thead>
<tr>
<th>REGION (acute)</th>
<th>Super spells</th>
<th>% of Ad</th>
<th>Spite</th>
<th>Observed events</th>
<th>Trend observed</th>
<th>Trend expected</th>
<th>Relative risk</th>
<th>95% Issure confidence limit</th>
<th>95% upper confidence limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>THE ROTHERHAM NHS FOUNDATION TRUST</td>
<td>62,294</td>
<td>4.2%</td>
<td>30,280</td>
<td>1,811</td>
<td>3.0%</td>
<td>1,642.2</td>
<td>3.5%</td>
<td>172.8</td>
<td>159.0</td>
</tr>
<tr>
<td>HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST</td>
<td>51,320</td>
<td>9.0%</td>
<td>49,850</td>
<td>1,871</td>
<td>3.5%</td>
<td>1,410.2</td>
<td>3.1%</td>
<td>154.1</td>
<td>131.9</td>
</tr>
<tr>
<td>MID YORKS HOSPITALS NHS TRUST</td>
<td>50,620</td>
<td>9.4%</td>
<td>45,840</td>
<td>1,581</td>
<td>3.3%</td>
<td>1,410.2</td>
<td>3.1%</td>
<td>154.1</td>
<td>131.9</td>
</tr>
<tr>
<td>LEEDS TEACHING HOSPITALS NHS TRUST</td>
<td>48,720</td>
<td>10.3%</td>
<td>30,925</td>
<td>2,218</td>
<td>4.2%</td>
<td>1,629.3</td>
<td>3.9%</td>
<td>180.7</td>
<td>159.4</td>
</tr>
<tr>
<td>SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST</td>
<td>73,880</td>
<td>15.5%</td>
<td>74,590</td>
<td>1,645</td>
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<td>1,553</td>
<td>2.2%</td>
<td>190.0</td>
<td>158.0</td>
</tr>
<tr>
<td>BARKING SAILORS HOSPITALS &amp; BRIGHTON HOSPITALS NHS FOUNDATION TRUST</td>
<td>18,940</td>
<td>4.1%</td>
<td>20,235</td>
<td>825</td>
<td>4.2%</td>
<td>755.7</td>
<td>3.8%</td>
<td>60.2</td>
<td>109.3</td>
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<tr>
<td>DONCASTER &amp; Bassetlaw Teaching Hospitals NHS Foundation Trust</td>
<td>31,670</td>
<td>6.5%</td>
<td>31,760</td>
<td>1,558</td>
<td>4.9%</td>
<td>1,612.2</td>
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<td>68.8</td>
<td>150.6</td>
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<tr>
<td>NORTH LANCASHIRE AND OGLE HOSPITALS NHS FOUNDATION TRUST</td>
<td>50,640</td>
<td>6.3%</td>
<td>30,770</td>
<td>1,213</td>
<td>4.0%</td>
<td>1,517.1</td>
<td>3.6%</td>
<td>43.3</td>
<td>103.7</td>
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<tr>
<td>BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST</td>
<td>32,130</td>
<td>6.7%</td>
<td>32,535</td>
<td>891</td>
<td>2.8%</td>
<td>887.1</td>
<td>2.8%</td>
<td>7.7</td>
<td>100.0</td>
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<tr>
<td>YORK TEACHING HOSPITALS NHS FOUNDATION TRUST</td>
<td>31,400</td>
<td>10.3%</td>
<td>31,950</td>
<td>1,487</td>
<td>2.6%</td>
<td>1,486.9</td>
<td>3.0%</td>
<td>41.8</td>
<td>97.4</td>
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<td>RUGBY &amp; DISTRICT HOSPITALS NHS FOUNDATION TRUST</td>
<td>12,185</td>
<td>3.8%</td>
<td>16,420</td>
<td>450</td>
<td>2.5%</td>
<td>444.9</td>
<td>2.4%</td>
<td>5.1</td>
<td>100.0</td>
</tr>
<tr>
<td>ABERDEEN HOSPITALS FOUNDATION TRUST</td>
<td>20,430</td>
<td>4.5%</td>
<td>20,895</td>
<td>535</td>
<td>2.4%</td>
<td>323.3</td>
<td>2.5%</td>
<td>17.9</td>
<td>46.9</td>
</tr>
<tr>
<td>CALDRENDON AND WORCESTERSHIRE HOSPITALS FOUNDATION TRUST</td>
<td>26,360</td>
<td>7.6%</td>
<td>37,660</td>
<td>1,255</td>
<td>3.4%</td>
<td>1179.0</td>
<td>3.9%</td>
<td>140.0</td>
<td>95.0</td>
</tr>
<tr>
<td>SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST</td>
<td>3,050</td>
<td>0.6%</td>
<td>4,040</td>
<td>10</td>
<td>0.3%</td>
<td>9.6</td>
<td>0.3%</td>
<td>0.2</td>
<td>9.2</td>
</tr>
</tbody>
</table>

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

Figure 2.2: HSMR Non-elective 0 day Peer comparison (FYTD)
HSMR TRACKING BY KEY DIAGNOSIS GROUPS

There are now only three significantly high diagnosis groups within the HSMR, however it may be prudent to continue to monitor a number of the existing groups?

- Pneumonia
- Acute Bronchitis (NEW)
- Cancer of ovary (6 superspells, 2 deaths: https://one.drfoster.com/Query/?id=1978322)

Initial basic analysis has been completed below and does include the 3 diagnosis groups that were significant in September 2020 but are no longer significantly high within October 2020.

- Intestinal obstruction without hernia (Significant within the SHMI)
- Chronic obstructive pulmonary disease and bronchiectasis
- Aspiration Pneumonitis (Significant within the SHMI – in hospital)

Figure 3.0 – HSMR by diagnosis group
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

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### Figure 3.3 Key diagnosis impact of COVID-19

**Diagnosis group**
- Acute bronchitis
- Aspiration pneumonia, food/vomitus
- Cancer of ovary
- Chronic obstructive pulmonary disease and bronchitis
- Intestinal obstruction without hernia
- Pneumonia
- All

<table>
<thead>
<tr>
<th>Diagnosis group</th>
<th>COVID-19 T/F</th>
<th>Otopnea</th>
<th>% of All</th>
<th>Spikes Observed</th>
<th>Crude rate (%)</th>
<th>Expected rate (%)</th>
<th>Expected rate</th>
<th>Relative risk</th>
<th>95% lower confidence limit</th>
<th>95% upper confidence limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>3,352</td>
<td>100.0%</td>
<td>3,355</td>
<td>381</td>
<td>10.5%</td>
<td>270.0</td>
<td>8.3%</td>
<td>3.3</td>
<td>73.1</td>
<td>113.4</td>
</tr>
<tr>
<td>Cancer of ovary</td>
<td>1</td>
<td>0.1%</td>
<td>1</td>
<td>0.1</td>
<td>2.5%</td>
<td>1.1</td>
<td>197.2</td>
<td>0.3</td>
<td>0.9</td>
<td>6.8</td>
</tr>
<tr>
<td>No</td>
<td>5</td>
<td>0.1%</td>
<td>1</td>
<td>20.0%</td>
<td>0.1</td>
<td>2.5%</td>
<td>197.2</td>
<td>0.3</td>
<td>0.9</td>
<td>6.8</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>1,495</td>
<td>45.0%</td>
<td>805</td>
<td>239</td>
<td>14.4%</td>
<td>261.4</td>
<td>12.5%</td>
<td>33.8</td>
<td>113.4</td>
<td>152.2</td>
</tr>
<tr>
<td>No</td>
<td>1,600</td>
<td>47.5%</td>
<td>555</td>
<td>216</td>
<td>13.6%</td>
<td>263.2</td>
<td>12.5%</td>
<td>33.8</td>
<td>113.4</td>
<td>152.2</td>
</tr>
<tr>
<td>Acute bronchitis</td>
<td>805</td>
<td>24.0%</td>
<td>605</td>
<td>34</td>
<td>5.3%</td>
<td>265</td>
<td>3.3%</td>
<td>7.5</td>
<td>128.1</td>
<td>179.1</td>
</tr>
<tr>
<td>No</td>
<td>805</td>
<td>24.0%</td>
<td>605</td>
<td>34</td>
<td>5.3%</td>
<td>265</td>
<td>3.3%</td>
<td>7.5</td>
<td>128.1</td>
<td>179.1</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease and bronchitis</td>
<td>406</td>
<td>24.0%</td>
<td>606</td>
<td>35</td>
<td>4.3%</td>
<td>27.6</td>
<td>3.3%</td>
<td>8.1</td>
<td>129.7</td>
<td>199.3</td>
</tr>
<tr>
<td>No</td>
<td>805</td>
<td>24.0%</td>
<td>605</td>
<td>34</td>
<td>5.3%</td>
<td>265</td>
<td>3.3%</td>
<td>7.5</td>
<td>128.1</td>
<td>179.1</td>
</tr>
<tr>
<td>Aspiration pneumonia, food/vomitus</td>
<td>65</td>
<td>1.9%</td>
<td>25</td>
<td>62</td>
<td>24.0%</td>
<td>16.1</td>
<td>20.9%</td>
<td>0.2</td>
<td>146.1</td>
<td>95.4</td>
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<tr>
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<td>10</td>
<td>0.3%</td>
<td>10</td>
<td>0.1</td>
<td>2.5%</td>
<td>1.1</td>
<td>197.2</td>
<td>0.3</td>
<td>0.9</td>
<td>6.8</td>
</tr>
<tr>
<td>Intestinal obstruction without hernia</td>
<td>185</td>
<td>5.5%</td>
<td>105</td>
<td>35</td>
<td>10.3%</td>
<td>12.3</td>
<td>6.9%</td>
<td>7.8</td>
<td>118.5</td>
<td>95.4</td>
</tr>
<tr>
<td>No</td>
<td>185</td>
<td>5.5%</td>
<td>105</td>
<td>35</td>
<td>10.3%</td>
<td>12.3</td>
<td>6.9%</td>
<td>7.8</td>
<td>118.5</td>
<td>95.4</td>
</tr>
<tr>
<td>Yes</td>
<td>2</td>
<td>0.1%</td>
<td>2</td>
<td>1</td>
<td>50.0%</td>
<td>0.4</td>
<td>22.0%</td>
<td>0.6</td>
<td>226.9</td>
<td>3.0</td>
</tr>
</tbody>
</table>

**Based on: NRHE Notes: Mortality (in-hospital) Time period: Nov 19 - Oct 20**

- Diagnosis groups: Acute bronchitis, Aspiration pneumonia, food/vomitus, Cancer of ovary, Chronic obstructive pulmonary disease and bronchitis, Intestinal obstruction without hernia, Pneumonia
- Patients: 2,668
- Sex: Male 51.0%, Female 49.0%
- Relative Risk: 2.5 (1.2 - 5.0)
ACUTE BRONCHITIS

- As can be seen from Fig 3.2 there was a significant spike in mortality in October without the associated increase in expected mortality
  - However it is worthy of note that the Trust does have the second highest expected rate across the regional peer group.
- The age cohort 85+ is significant despite Age being a variable within the model
- As per previous month’s report the LOS profile is variant to the national and regional position with a higher proportion of 2, 3 & 4 day LOS a similar pattern to that which is being seen within both Pneumonia and COPD.
- Furthermore the Trust retains the highest crude rate nationally: https://one.drfoster.com/Query/?id=2001833
  - It is worthy of note that Barnsley have circa 300 more superspells that Rotherham but with a comparable observed mortality.
- There was only one of the seven deaths in October that had a secondary or subsequent primary diagnosis of COVID-19: https://one.drfoster.com/Query/?id=2001345
- **RECOMMENDATION:**
  - **Initial review of the October mortality because of the spike.**
  - Discuss additional analysis with Dr Foster re possible low denominator value and differing LOS profile?

Fig 3.4 Acute Bronchitis Age breakdown

<table>
<thead>
<tr>
<th>Age (Years)</th>
<th>Observed % of All Deaths</th>
<th>Expected % of All Deaths</th>
<th>Crude rate (Per 1000)</th>
<th>Expected rate (Per 1000)</th>
<th>Relative Risk</th>
<th>95% lower confidence limit</th>
<th>95% upper confidence limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;17</td>
<td>174</td>
<td>0.04%</td>
<td>0.32</td>
<td>0.01</td>
<td>0.1</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>18-24</td>
<td>15</td>
<td>0.00%</td>
<td>0.84</td>
<td>0.84</td>
<td>1.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>25-64</td>
<td>13</td>
<td>0.00%</td>
<td>1.33</td>
<td>1.66</td>
<td>1.3</td>
<td>2.7</td>
<td>311.3</td>
</tr>
<tr>
<td>65-74</td>
<td>12</td>
<td>0.00%</td>
<td>1.11</td>
<td>1.11</td>
<td>1.0</td>
<td>1.2</td>
<td>175.5</td>
</tr>
<tr>
<td>75+</td>
<td>11</td>
<td>0.00%</td>
<td>1.37</td>
<td>1.37</td>
<td>1.0</td>
<td>1.3</td>
<td>158.3</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>0.71</td>
<td>0.48</td>
<td>1.5</td>
<td>2.6</td>
<td>167.4</td>
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<td></td>
<td></td>
<td></td>
<td>0.54</td>
<td>0.68</td>
<td>1.0</td>
<td>0.8</td>
<td>179.4</td>
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<td></td>
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<td></td>
<td>0.48</td>
<td>0.84</td>
<td>1.0</td>
<td>0.8</td>
<td>184.5</td>
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<td></td>
<td></td>
<td></td>
<td>0.65</td>
<td>0.70</td>
<td>1.0</td>
<td>0.7</td>
<td>270.7</td>
</tr>
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</table>

Fig 3.5 Acute Bronchitis LOS profile
TRENDS IN CODING & CASEMIX

Key Highlights:

- Palliative care coding rate (HSMR basket) for the rolling 12 month position is 3.3% vs. an increased national rate of 4.4%
  - This will continue to be impacted by the increase in O day emergency admissions and changing case-mix during the COVID-19 pandemic?
  - However, as per previous reports when reviewing 1+ the rate is low relative to peer.
- The proportion of superspells within the Non-elective HSMR basket with a 20+ score remains low at 12.6% compared to a national rate of 14.3%
- The Trust retains the highest proportion of 0 day Abdominal pain admissions nationally, if not correct this will potentially be having an impact on the expected rate. 9.7% of all 0 day admissions v 4.7% nationally.
  - 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</th>
<th>Site</th>
<th>Trust</th>
<th>Peer</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSMR</td>
<td>117.9</td>
<td>105.0</td>
<td>95.9</td>
<td></td>
</tr>
<tr>
<td>SMR</td>
<td>113.9</td>
<td>106.0</td>
<td>100.8</td>
<td></td>
</tr>
<tr>
<td>Non-elective (HSMR)</td>
<td>116.9</td>
<td>104.6</td>
<td>99.7</td>
<td></td>
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<tr>
<td>Weekday, emergency (HSMR)</td>
<td>118.9</td>
<td>103.3</td>
<td>98.2</td>
<td></td>
</tr>
<tr>
<td>Weekend, emergency (HSMR)</td>
<td>114.5</td>
<td>109.3</td>
<td>104.8</td>
<td></td>
</tr>
<tr>
<td>Saturday, emergency (HSMR)</td>
<td>98.6</td>
<td>107.1</td>
<td>104.5</td>
<td></td>
</tr>
<tr>
<td>Sunday, emergency (HSMR)</td>
<td>131.2</td>
<td>111.7</td>
<td>104.8</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Coding/Casemix</th>
<th>Site</th>
<th>Trust</th>
<th>Peer</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Non-elective deaths with palliative care (HSMR)</td>
<td>32.9%</td>
<td>26.8%</td>
<td>33.7%</td>
<td></td>
</tr>
<tr>
<td>% Non-elective spells with palliative care (HSMR)</td>
<td>3.3%</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>6.4%</td>
<td></td>
</tr>
<tr>
<td>% Non-elective spells with Charlson comorbidity score = 0 (HSMR)</td>
<td>43.4%</td>
<td>39.8%</td>
<td>41.8%</td>
<td></td>
</tr>
<tr>
<td>% Non-elective spells with Charlson comorbidity score = 20+ (HSMR)</td>
<td>12.6%</td>
<td>15.2%</td>
<td>14.3%</td>
<td></td>
</tr>
<tr>
<td>% Non-elective spells in Risk Band (0-10%) (HSMR)</td>
<td>85.8%</td>
<td>83.4%</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 Abdominal Pain activity relative to the national rate (0 days)

Figure 7.0 – 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 2nd highest volume regionally which primarily relates to November 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 7.1 – Non-elective Residual Codes – 12 months to November 2020
Figure 7.2 – Residual Codes – Regional Trend

**November 20**

<table>
<thead>
<tr>
<th>REGION (county)</th>
<th>Superscript</th>
<th>% of All</th>
<th>Deaths Observed</th>
<th>Crude rate (%)</th>
<th>Expected</th>
<th>Expected rate (%)</th>
<th>Observed</th>
<th>Relative risk</th>
<th>95% lower confidence limit</th>
<th>95% upper confidence limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>York Teaching Hospital NHS Foundation Trust</td>
<td>1,275</td>
<td>12.7</td>
<td>19</td>
<td>9.5</td>
<td>1.2</td>
<td>-5.9</td>
<td>78.7</td>
<td>57.7</td>
<td>144.0</td>
<td></td>
</tr>
<tr>
<td>Leeds Teaching Hospitals NHS Trust</td>
<td>935</td>
<td>9.5</td>
<td>58</td>
<td>6.5</td>
<td>12.5</td>
<td>2.3</td>
<td>37.5</td>
<td>396.7</td>
<td>249.9</td>
<td>515.1</td>
</tr>
<tr>
<td>NYP Yorkshire Hospitals NHS Trust</td>
<td>525</td>
<td>5.2</td>
<td>33</td>
<td>3</td>
<td>0.5</td>
<td>-</td>
<td>-</td>
<td>0.0</td>
<td>0.0</td>
<td>249.9</td>
</tr>
<tr>
<td>Barnsley Hospital NHS Foundation Trust</td>
<td>345</td>
<td>3.4</td>
<td>15</td>
<td>4.3</td>
<td>1.2</td>
<td>10.7</td>
<td>374.6</td>
<td>239.5</td>
<td>617.9</td>
<td></td>
</tr>
<tr>
<td>Sheffield Teaching Hospitals NHS Foundation Trust</td>
<td>160</td>
<td>1.6</td>
<td>18</td>
<td>1.0</td>
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<td>-</td>
<td>0.0</td>
<td>0.0</td>
<td>2361.0</td>
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</tr>
<tr>
<td>Calderdale and Huddersfield NHS Foundation Trust</td>
<td>120</td>
<td>1.2</td>
<td>10</td>
<td>0.8</td>
<td>-</td>
<td>-</td>
<td>0.0</td>
<td>0.0</td>
<td>499.3</td>
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<tr>
<td>Northern Lincolnshire and Goole NHS Foundation Trust</td>
<td>120</td>
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<td>10</td>
<td>0.8</td>
<td>-</td>
<td>-</td>
<td>0.0</td>
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<tr>
<td>Harrogate and District NHS Foundation Trust</td>
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<td>-</td>
<td>0.0</td>
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</tr>
<tr>
<td>Hull University Teaching Hospitals NHS Trust</td>
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<td>0.9</td>
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<td>0.8</td>
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<td>-</td>
<td>0.0</td>
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<td>248.7</td>
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<tr>
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<tr>
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<td>-</td>
<td>-</td>
<td>0.0</td>
<td>0.0</td>
<td>248.7</td>
<td></td>
</tr>
</tbody>
</table>

**October 20**

<table>
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<tr>
<th>REGION (county)</th>
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<td>0.0</td>
<td>0.0</td>
<td>248.7</td>
<td></td>
</tr>
</tbody>
</table>
STANDARDISED MORTALITY RATIOS (SMR) ANALYSIS

Key Highlights:

- SMR = 113.9 and remains statistically significantly high but represents a continued stable point value.
  - Fig 11.0 shows the SMR excluding COVID-19 activity with the point value being 108.9 as at October 2020.
- There are no further outlying groups (outside of the HSMR)

Figure 8.0 – SMR All Diagnosis trend (month)

Figure 8.1 – SMR All Diagnosis trend (rolling 12 month) – last 24 months

Figure 8.2 – Potential impact of COVID-19.

COVID activity and mortality removed – October – 108.9
CUSUM ALERTS @ 99% & 99.9% (NOVEMBER 20)

Key Highlights:

- At 99% across the 12 months there are 11 diagnosis groups with CUSUM breaches, notably Acute Bronchitis and Viral Infection (COVID) breaching in month.
- Using a 99.9% threshold as per CQC there are 5 diagnosis groups alerting over the 12 month period with, Intestinal obstruction without Hernia, Pneumonia & Acute Bronchitis breaching using both thresholds.

Figure 9.0 – CUSUM Alerts at 99% & 99.9%

Over the 12 month period there have been 11 diagnosis groups with a CUSUM trigger at 99% as highlighted below (Including Viral Infection):
<table>
<thead>
<tr>
<th>Condition</th>
<th>Graph</th>
<th>Graph</th>
<th>Graph</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intestinal obstruction without hernia</td>
<td><img src="image1" alt="Graph" /></td>
<td><img src="image2" alt="Graph" /></td>
<td><img src="image3" alt="Graph" /></td>
</tr>
<tr>
<td>Other connective tissue disease</td>
<td><img src="image4" alt="Graph" /></td>
<td><img src="image5" alt="Graph" /></td>
<td><img src="image6" alt="Graph" /></td>
</tr>
<tr>
<td>Residual codes, undiagnosed</td>
<td><img src="image7" alt="Graph" /></td>
<td><img src="image8" alt="Graph" /></td>
<td><img src="image9" alt="Graph" /></td>
</tr>
<tr>
<td>Cancer of ovary</td>
<td><img src="image10" alt="Graph" /></td>
<td><img src="image11" alt="Graph" /></td>
<td><img src="image12" alt="Graph" /></td>
</tr>
<tr>
<td>Gout and other crystal arthropathies</td>
<td><img src="image13" alt="Graph" /></td>
<td><img src="image14" alt="Graph" /></td>
<td><img src="image15" alt="Graph" /></td>
</tr>
<tr>
<td>Viral infection</td>
<td><img src="image16" alt="Graph" /></td>
<td><img src="image17" alt="Graph" /></td>
<td><img src="image18" alt="Graph" /></td>
</tr>
</tbody>
</table>
SHMI (DATA PERIOD: OCTOBER 2019 TO SEPTEMBER 2020)

Key Highlights:

- SHMI = **117.76** 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
      - Not significant within the Dr Foster model and the SHMI significance is being driven by the “out of hospital” element with a significantly high post discharge crude rate. Fig 12.0
    - Other Connective tissue disease
    - Intestinal obstruction without hernia
      - No longer significant within the Dr Foster model but retains a raised standardised and high crude rate
    - Intracranial Injury
    - Joint Disorders
    - Other Gastrointestinal disorders
    - Aspiration pneumonitis (In Hospital)
      - No longer significant within the Dr Foster model but remains raised
    - Acute Myocardial Infarction (In Hospital)
      - As discussed in the previous month’s report not significant within the Dr Foster model, however the key cohort of activity is the cohort which is neither transferred in or out of the Trust.

Figure 10.0 – SHMI Summary
SHMI analysis – September 2020

Figure 11.0 – SHMI key diagnosis groups

**FLUID & ELECTROLYTE DISORDERS**

The has a significantly high crude rate post discharge: 7.49% v 3.26% nationally and within the in hospital element a materially different LOS profile compared to peers regionally and nationally.

Figure 12.0 Fluid & Electrolyte disorders – Out of Hospital

| Mortality rate (yrs/100) where patient died for St. Bede’s NHS Foundation Trust vs all non-specialist acute providers in Oct 2019 to Sep 2020 |
|---|---|---|---|---|---|---|---|
| All deaths | Cases | Deaths | Rate | Cases | Deaths | Rate |
| All deaths | 227 | 28 | 12.33 | 53030 | 1816 | 3.39 |
| In-hospital deaths | 227 | 11 | 4.85 | 53030 | 1746 | 3.26 |
| Post discharge deaths | 227 | 17 | 7.49 | 53030 | 1816 | 3.39 |

**Figure 12.1 Fluid & Electrolyte disorder LOS profile**
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 the current and historical significance including Acute Bronchitis and Pneumonias
  - Further analysis should be completed to understand the Acute Myocardial Infarction significant SHMI value in conjunction with Dr Foster.

- Review internally the Abdominal pain activity volumes particularly the 0 day cohort.

- Utilise the early warning mortality tool to analyse and review November 20’s data including key diagnosis and analysis on COVID-19 activity (See appendix)
APPENDIX

Figure 13.0 Early Warning HSMR Trend

It is apparent from local data within the Early Warning Mortality tool that the HSMR has increased significantly in both November and December 20. This will result in an HSMR or approximately 125 at December.

This is not apparent to the same degree within the HIP because of the nature of the time lag associated with the HES data and the current coding backlog at the Trust.

Figure 14.0 HSMR basket only – COVID activity / mortality trend

Although COVID as a primary diagnosis will not be included within the HSMR any activity where a superspell has a primary diagnosis in the first episode of care within the HSMR basket but a secondary diagnosis or subsequent primary diagnosis in any further episode of COVID then this activity will be included.

As previously mention and can be seen within Fig 13.0 the in month HSMR increased significantly in November and December 20 which is driven in part by the increase in COVID related mortality.
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>W'Stream</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>02/03/2021</th>
<th>23/03/2021 Update</th>
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<tbody>
<tr>
<td>1</td>
<td>C1 OUTPUT CARE</td>
<td>Investigation into Dr Foster Alerts (Backlog and BAU Process)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>C1.1 TASK</td>
<td></td>
<td>Confirmation of SOP for this process based around clinical notes and coding reviews</td>
<td>Improvement Group</td>
<td>Richard J Ben G</td>
<td>18/03/2021</td>
<td>On Track</td>
<td></td>
<td>SOP updated to version 2 to incorporate learnings from initial reviews</td>
<td>Internal SOP Approved. Learning from initial reviews to be built into version 2 of the review.</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>C1.2 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></td>
<td>Identification of high impact areas - Waterfall Completed</td>
<td>Draft outputs presented to MIG on 02/03/21. Dave Hatting asked to complete a 1 page summary. Will come back to MIG and S&amp;S Mortality Group for any learnings. Clinical review has taken place - a SJR per case. This is being summarized. Dave Hatting has agreed to do a summary of the cases over the next couple of weeks.</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>C1.3 TASK</td>
<td></td>
<td>Review of Pneumonia</td>
<td>Improvement Group</td>
<td>Callum G Lisa F</td>
<td>18/03/2021</td>
<td>On Track</td>
<td></td>
<td>To confirm if any further actions required at next MIG</td>
<td>Initial review of data shows this is a very small number of deaths. Still need to undertake the clinical review.</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>C1.4 TASK</td>
<td></td>
<td>Review of COPD and Bronchiectasis</td>
<td>Improvement Group</td>
<td>Callum G Lisa F</td>
<td>18/03/2021</td>
<td>On Track</td>
<td></td>
<td>Share of Coding timeline / schedule</td>
<td>Coding reviews are scheduled in. Will start with Pneumonia given it's the largest area of excess deaths.</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>C1.5 TASK</td>
<td></td>
<td>Review of Aspiration pneumonia</td>
<td>Improvement Group</td>
<td>Callum G Lisa F</td>
<td>18/03/2021</td>
<td>On Track</td>
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<tr>
<td>7</td>
<td>C1.6 TASK</td>
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<td>Review of Skin and subcutaneous tissue infections</td>
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<td></td>
<td>Not Started</td>
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<tr>
<td>8</td>
<td>C1.7 TASK</td>
<td></td>
<td>Review of Intestinal obstruction without hernia</td>
<td>TBC</td>
<td></td>
<td></td>
<td>On Track</td>
<td></td>
<td></td>
<td>See action c1.1 - review has taken place at the same time. As above - SJR's complete.</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>C1.8 TASK</td>
<td></td>
<td>Development of ProForma for Dr Foster Reviews - Coding and Notes</td>
<td>Improvement Group</td>
<td></td>
<td>Complete</td>
<td></td>
<td></td>
<td>Required move into action c1.1. So this action moved to complete.</td>
<td>Merged with Output C1.1 as proforma will form part of the SOP. Need to take learnings from the reviews taking place. Potential to need to ask specific questions of the reviews and build beyond the SJR structure.</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>C1.9 TASK</td>
<td></td>
<td>Review of Cancer of ovary (Feb Alert)</td>
<td>TBC</td>
<td></td>
<td></td>
<td>On Track</td>
<td></td>
<td></td>
<td>Lesely Crosby undertaking the review. This is 27 patients. Report expected. Ex Chief Nurse undertaking the review. Will be done for end March.</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>C2.0 TASK</td>
<td></td>
<td>Review of Acute Bronchitis (March Alert)</td>
<td></td>
<td></td>
<td></td>
<td>On Track</td>
<td></td>
<td></td>
<td>Present at Safe and Sound Mortality and allocate a clinician to undertake a review. Initial information review suggests this may be an issue of classification - as many may be Pneumonia patients.</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>C2 OUTPUT CARE</td>
<td>Investigation into quality of care in areas with high avoidable deaths</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>13</td>
<td>C2.1 TASK</td>
<td></td>
<td>Thematic review of last 12 months of avoidable deaths from SfAs, Riads and Inquests (expected to be 170 reviews) to confirm high impact areas</td>
<td>Improvement Group</td>
<td>Callum G Richard J Susan D</td>
<td>16/03/2021</td>
<td>On Track</td>
<td></td>
<td>Findings to come to MIG on the 16th March</td>
<td>Lesely Crosby undertaking the review. This is 27 patients. Report expected.</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>C2.2 TASK</td>
<td></td>
<td>Collection of baseline 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></td>
<td></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 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;DSP&amp;S Group</td>
<td>Managed through S&amp;DSP&amp;S Group - update requested by MIG at next meeting. Next S&amp;DSP&amp;S group on the 12/03/21 - update at 16/03/21 at MIG.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>C2.4 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>16/03/2021</td>
<td>On Track</td>
<td></td>
<td>Update on progress of work between Dr Arefin and Helen Canning.</td>
<td>Managed through S&amp;DSP&amp;S Group - update requested by MIG at next meeting. Next S&amp;DSP&amp;S group on the 12/03/21 - update at 16/03/21 at MIG.</td>
<td></td>
</tr>
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</table>

Total: 276
<table>
<thead>
<tr>
<th>Task Code</th>
<th>Task Description</th>
<th>Improvement Group</th>
<th>Start Date</th>
<th>Status</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>C2.5</td>
<td>Improvement in management of deteriorating patients</td>
<td>Deteriorating Patient and Sepsis</td>
<td>TBC</td>
<td>TBC</td>
<td>Not Started</td>
</tr>
<tr>
<td>C2.6</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>
</tr>
<tr>
<td>C2.7</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>11/03/2021</td>
<td>On Track</td>
</tr>
<tr>
<td>C3.1</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>Not Started</td>
<td>No current actions</td>
<td>Within the divisional governance structure of Mortality and Governance discussions. Will update actions as needed following Internal Audit governance review.</td>
</tr>
<tr>
<td>C3.2</td>
<td>Have an up to date, approved mortality policy which captures all elements</td>
<td>Safe &amp; Sound Mortality</td>
<td>Callum G</td>
<td>01/04/2021</td>
<td>On Track</td>
</tr>
<tr>
<td>C3.3</td>
<td>Review external Mortality review for areas of additional focus</td>
<td>Improvement Group</td>
<td>Callum G / Ben G</td>
<td>08/10/2021</td>
<td>Complete</td>
</tr>
<tr>
<td>C3.4</td>
<td>Understand process for Elective Care Deaths and monitoring</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
<td>Not Started</td>
</tr>
<tr>
<td>C3.5</td>
<td>Continuous care improvements in AMU</td>
<td>Security and Governance</td>
<td>T&amp;F</td>
<td>Complete</td>
<td>No current actions - AMU improvement group has commenced - update by exception. No longer managed by MIG</td>
</tr>
<tr>
<td>M1.1</td>
<td>Palliative Care Coding review - looking at Specialist V Generalist in particular</td>
<td>Analytical Group</td>
<td>Lisa F</td>
<td>31/03/2021</td>
<td>Not Started</td>
</tr>
<tr>
<td>M1.2</td>
<td>Ensure every palliative care patient is coded as palliative</td>
<td>Analytical Group</td>
<td>Michael W</td>
<td>31/03/2021</td>
<td>Not Started</td>
</tr>
<tr>
<td>M1.3 TASK</td>
<td>Joint Audit with Primary Care of known palliative care patients who came into Hospital and Died</td>
<td>Callum G</td>
<td>16/03/2021</td>
<td>On Track</td>
<td>To confirm if audit going ahead at MIG on 16th March. Audit may take place in April to coincide with the focus on Palliative Care. Lower priority work than 'Care aspects'. Though have now confirmed that we have sufficient patients for a audit to be undertaken. Need to confirm time line / TRFT lead etc. If this could be Rod R?</td>
</tr>
<tr>
<td>M1.4 TASK</td>
<td>Ensure that ReSPECT documentation is in place and being used</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
<td>not started</td>
</tr>
<tr>
<td>M1.5 TASK</td>
<td>Review of hospice capacity or primary care</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
<td>not started</td>
</tr>
<tr>
<td>M1.6 TASK</td>
<td>DNACPR Decision Making / Planning</td>
<td>Not Started</td>
<td></td>
<td></td>
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<tr>
<td>D1 OUTPUT CODING</td>
<td>Improved quality and depth of coding (i.e. comorbidities)</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>D1.1 TASK</td>
<td>Review Charleton Index Score and evidence if this is an concern / issue</td>
<td>Analytical Group</td>
<td>Lisa F</td>
<td>05/01/2021</td>
<td>Complete</td>
</tr>
<tr>
<td>D1.2 TASK</td>
<td>Coding team member to be collocated with ME</td>
<td>Analytical Group</td>
<td>Lisa F</td>
<td>05/01/2021</td>
<td>complete</td>
</tr>
<tr>
<td>D1.4 TASK</td>
<td>Explore the &quot;2 FCE&quot; coding rule and consider options for resolution if an issue</td>
<td>Analytical Group</td>
<td></td>
<td></td>
<td>not started</td>
</tr>
<tr>
<td>D1.5 TASK</td>
<td>External coding review from 3M / IQVIA</td>
<td>Analytical Group</td>
<td>Lisa F</td>
<td>TBC</td>
<td>On Track</td>
</tr>
<tr>
<td>D1.6 TASK</td>
<td>'R' codes and issues with coding completeness</td>
<td>Analytical Group</td>
<td>Lisa F</td>
<td>07/01/2021</td>
<td>Complete</td>
</tr>
<tr>
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<tr>
<td>D2 OUTPUT CODING</td>
<td>Improve documentation in notes to enable accurate coding</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2.1 TASK</td>
<td>Confirm that 'treat as' is in place within Meditech and is being used</td>
<td>Improvement Group</td>
<td>Ben G</td>
<td>05/02/2021</td>
<td>Complete</td>
</tr>
<tr>
<td>D2.2 TASK</td>
<td>Improve the process of asking for notes reviews on deaths by coding team to consultant</td>
<td>Analytical Group</td>
<td>Ben G</td>
<td>16/03/2021</td>
<td>On track</td>
</tr>
<tr>
<td>D2.3 TASK</td>
<td>Establish training / refresh programme for documentation and coding for clinical teams</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
<td>Not Started</td>
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<tr>
<td>S1 OUTPUT COMMS</td>
<td>Implement Regular Mortality / Learning fromDeaths Bulletin</td>
<td></td>
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</tbody>
</table>
| **S1.1 TASK** | Confirm layout / input / distribution list (Inc methodology - i.e. WhatsApp) and branding | Improvement Group | Carrie K. | Complete | No further actions - though need to confirm regular publications. | 1st edition has been sent. Need to be go out on a regular basis.

| **S2 OUTPUT COMM** | Increase awareness of mortality and mortality issues across the Trust |  |

| **S2.1 TASK** | Undertake meeting with Respiratory medical teams to increase awareness of current situation | Not Started | No current actions - not considered useful currently |

| **S2.2 TASK** | Chief Executive Messages on Mortality | Improvement Group | Richard J | 16/02/2021 | On Track | CEO Mortality Message | Updated timeline as need to manage the messages along with staff moral and existing COVID. Need to provide a draft message for review. |

| **G1 OUTPUT GOVERNANCE** | Ensure governance arrangements are fit for purpose for both Rapid Improvement and BAU mortality work |  |

| **G1.1 TASK** | Review current governance through service, division and corporate where mortality is considered and reviewed | Improvement Group | Ben G | 31/03/2021 | On Track | Confirm actions following Internal Audit Review | Updated timeline Internal Audit review needed by end of March. Sue Wake has undertaken governance ‘check’ in each division and collected minutes from governance meetings. Medicine to hold their 1st meeting by end of March. 360 Assurance undertaking a audit into the Governance with a specific focus on Medicine. Report due in Late Feb / Early March. Work also being undertaken by Sue Wake to collect governance. Suggest wait until 360 work complete and build action plan from that. |

| **G1.2 TASK** | Confirm Medical input into Rapid Improvement Group | Improvement Group | Callum G | ASAP | Behind | Have medical leadership represented on the MIG | Ongoing challenges with medical leadership. Ongoing. |

| **G1.3 TASK** | Appoint Learning from Deaths Nurse / Manager | Improvement Group | Callum G | 15/03/2021 | On Track | Confirm if this will be a nurse or manager and complete a JD | There is a vacant learning from deaths nurse within the medical director structure. Discussions with Kettering hospital have indicated that a ‘manager’ is more useful (could be clinical - but focus isn’t on clinical knowledge, but organisational / management skills). Need to confirm approach and move to appointment |

| **G2 OUTPUT GOVERNANCE** | Separation of mortality lead from ME role |  |

| **G2.1 TASK** | Appoint mortality lead for the Trust - separate v part of the role | Callum G | ASAP | Behind | Appoint Trust Mortality and Learning from Deaths Lead | No interest internally. Job Description created, will need to go external. Ongoing challenges with recruitment. Ongoing |

| **G3 OUTPUT GOVERNANCE** | Ensure that reporting and assurance on mortality within the Trust and to Board of Directors is effective |  |

| **G3.1 TASK** | Ensure information is consistent, shared and accessible from Ward to Board on mortality | TBC | TBC | TBC | Not Started | Review and update (if necessary) mortality dashboard and information flows | Medicine having the 1st Safe&Sound mortality group at end of March. Surgery held Mortality as part of there wider Clinical Governance meeting. Family Health, only gynea deaths reporting through this mechanism - no a一事無base Community DD and ME/Mortality Lead meeting to review community reporting |

| **G3.2 TASK** | Local discussion to be taking place of learning from deaths / mortality to improve practice | Safe and Sound Mortality Group | TBC | TBC | Not Started | Moved to a collective action within G3.1 | |

| **G4 OUTPUT GOVERNANCE** | Confirmation that weekly Medicine MDT SJRs are timetabled in the diary |  |

| **G4.1 TASK** | Evidence of MDT SJRs within medicine are timetabled in weekly and that actions are in place | Improvement Group | Callum G | 05/02/2021 | Complete | Confirm SJRs are taking place in medicine in line with guidance | SJRs are scheduled in. Further work will drop out of G1.1. |
### Agenda item
P79/21

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<tr>
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</thead>
<tbody>
<tr>
<td>Executive Lead</td>
<td>Jill Dentith, Corporate Governance Consultant</td>
</tr>
<tr>
<td>Link with the BAF</td>
<td>The contents of the report are associated with all BAF risks</td>
</tr>
<tr>
<td>How does this paper support Trust values</td>
<td>Good corporate governance underpins achievement of the Trust 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) | This paper provides an outline of the Board Governance Framework which underpins the Rotherham NHS Foundation Trust’s (“the Trust”) strategic and operational systems to ensure that the Trust complies with legal and statutory requirements.  
The systems and processes established by the Board of Directors support the achievement of our organisation’s vision, mission, strategic and operational plans. |
| Due Diligence (include the process the paper has gone to prior to presentation at Board of Directors Meeting) | This paper has been developed in consultation with the Chair of the Board, Interim Chief Executive, Deputy Chief Executive and the Director of Strategy, Planning and Performance. |
| Who, what and when (what action is required, who is the lead and when should it be completed?) | The requirements and regulations outlined in the paper should be enacted by the relevant individuals who hold the roles detailed in the paper |
| Recommendations | It is recommended that the Board gain assurance from the information provided in the report relating to the Trust’s Board Governance. |
| Appendices | • Appendix A – Board Governance Framework 2021/22  
• Appendix 1 – Role of Directors  
• Appendix 2 – The duties of the Accounting Officer  
• Appendix 3 – Duties and Responsibilities of the Company Secretary with regard to Corporate Governance |
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 This document provides details of the Governance Framework which will support the delivery of the Trust’s Operational Plan for 2021/22 and longer term Strategic Plan.

2.0 The Coronavirus Pandemic

2.1 At the start of 2020/21, the Trust was dealing with the coronavirus pandemic. It had to respond on an operational and strategic level to these challenges. The situation continues into 2021/22 and the Trust is reviewing its governance arrangements accordingly.

2.2 The Board’s leadership role at this time continues to be crucial. The governance arrangements around the Trust’s Board, its committees and Council of Governors, continue to be managed in a way which is proportionate to the current position, responding to national guidance, and taking account of the Board’s legal responsibilities for the management of a public organisation.

3.0 The Board Governance Framework

3.1 Details of the Board’s Governance Framework were first set out in a document to the Board, in March 2017 and a refreshed version of this for 2021/22, has been produced (Appendix A).

3.2 In addition, a number of the governance documents, which were included in the original report, have been updated, and further updates are provided within this document.

3.3 Regular assurance reports, required by statute, regulation, or simply best practice guidance, are also received by the Board, including:

- Reports from the Guardian of Safe Working;
- Reports from the Responsible Officer;
- Complaints Annual Report;
- Health and Safety Annual Report;
- Freedom to Speak up Annual Report;
- How we learn from deaths report;
- Employment Exclusions and Restrictions Report;
- Audit Committee Annual Report;
- Medical Examiner; and
- Freedom to Speak Up Guardian
3.4 Planned risk based reports are presented to the Board on a quarterly basis:
- Board Assurance Framework Report; and

3.5 Monthly use of action trackers, declarations of conflicts of interest, board planner, Chair’s Assurance Logs, and board review feedback at each meeting from one of the members of the board, provides transparency and consistency.

3.6 In addition, at year-end 2020/21 an annual report from all of the Board Committees will also be received by the Board of Directors following governance best practice advice from the Trust’s Internal Auditors.

Jill Dentith
Corporate Governance Consultant
March 2021
Appendix A

Board Governance Framework 2021/22

Supporting: Governance: Trusted Open Governance

1.0 Introduction

1.1 Whilst written in 2019, the sentiments of Chris Hopson (Chief Executive of NHS Providers) below, remain valid today as we enter a further period of change and new ways of working. However, the need for effective board and executive leadership remains crucial, supported by appropriate performance management and governance systems.

1.2 “The NHS has entered a period of unprecedented change. What the shape and extent of the NHS provider sector will be in five years’ time is largely unknown as new care models evolve and as devolution begins in earnest. At the same time, the NHS continues to face tightening resources alongside a requirement to improve or at least maintain, quality of care for patients and service users.

The choice facing NHS provider organisations is to be part of the changes taking place, to lead, contribute or influence developments - or to be swept up by the change taking place around them.

In these circumstances, strong and effective leadership will be indispensable. While being no guarantor, the disciplines of corporate governance provide a methodology for dynamic leadership that is capable of delivering change and long term sustainability.

We know that good governance does not happen spontaneously and that it takes hard work, vigilance and frequent attention to maintain it.

What is certain is that sustainable organisations led by capable boards delivering effective high quality services will be central to autonomy and to the concept of board leadership.”

Chris Hopson, Chief Executive NHS Providers, 2019

2.0 The Rotherham NHS Foundation Trust

2.1 The Board of Directors is critical to the success of The Rotherham NHS Foundation Trust and for achieving its vision of becoming “an outstanding Trust, delivering excellent healthcare at home, in our community and in hospital”. The elements of the Trust’s five strategic themes will support delivery of this vision:

- Patients: Excellence in Healthcare
- Colleagues: Engaged Accountable Colleagues
- Governance: Trusted Open Governance
- Finance: Sound Financial Foundations
- Partners: Securing Our Future Together
2.2 This document sets out how our trusted, open governance systems and processes established by the Board, and delivered through the leadership of the Executive, will support achievement of the organisation’s vision, mission and strategic objectives 2017 – 2022, and the objectives for 2021/22.

2.3 One of our operational objectives for 2021-22 is to develop a new Trust Five Year Strategy. This is an ideal time to produce a new strategy as the landscape within the NHS has changed so significantly over the last 12 months due to the COVID-19 pandemic and the likely changes to national legislation around NHS structures and the changes to regional systems.

3.0 The Golden Thread

3.1 The ‘golden thread’ is essential to hold together the purpose, values, strategy and culture of an organisation. It is precious and valuable, and getting it wrong could be expensive, not just in financial terms, but also in terms of reputation and staff morale.

3.2 The ‘golden thread’ can be easily broken, as can our journey to achieving delivery of our objectives. For example, get the organisation’s values wrong, or fail to live by them, and trust will be broken.

3.3 The ‘golden thread’ should be clear from board to ward and board to front line community services through our governance arrangements.

3.4 The five elements of the ‘golden thread’;

a. Vision: The Trust’s vision is to become “an outstanding Trust, delivering excellent healthcare at home, in our community and in hospital”.

   It communicates the Trust’s aspirations to the highest level and is important because our colleagues need to know where they are going and more importantly, how they fit into that vision.

b. Mission: The mission statement covers the who, what and how of the organisation and describes the impact that the Trust has on the lives of stakeholders: To improve the health and wellbeing of the population we serve, building a healthier future together.

   To get the ‘golden thread’ right, colleagues need to understand what we are trying to do for our patients and other key stakeholders – it is the real motivator for colleagues who want to be informed and recognised for their achievements.

c. Engagement: This is the best way to secure buy-in; to guide the ‘golden thread’ is to consult and action what we hear, and it needs to be genuinely two-way. Colleagues need to feel that they are part of the process of strategy development and visioning.

   If it listens, the Board can reflect on what is discovered and consider questions such as ‘how can we track actions at ward level right back to decisions made in the boardroom?’ and ‘how will this impact the vision?’.

d. Integrity: As leaders, we have to practice what we preach. And for the ‘golden thread’ to stay in place, there is a need to develop trust with all colleagues. It is essential that we ‘walk the walk’ as well as ‘talk the talk’. We must be seen to living
by the values *(ambitious, caring, together)* we set and by committing to the Trust’s vision and mission.

e. Governance: The final element needs the right processes and structures in place to act as a framework for consistency and fairness. Colleagues must be able to speak out or whistle-blow when they see things go wrong, without the fear of being punished. A culture of hiding bad news and bad practice can lead to disaster, and good leadership can prevent this.

The ‘golden thread’ of governance will bring all of this together so that targets that line up with our strategic objectives, are achieved – with the right engagement framework and the right authority and performance framework.

### 4.0 The Board of Directors

4.1 The Board of Directors will continue to meet on a monthly basis (except for September and January). For 2021/22 it was agreed to move Board meetings to the first or second Friday in each month. Details of the timing for Board meetings can be found in the corporate calendar which was agreed by the Board at its meeting in February 2021. There has been a subsequent review of the timing of Board Committees, in response to a review of governance during the ongoing pandemic, and these are detailed in the report from the Chair of the Board to the Board in April 2021.

4.2 Due to the continuing coronavirus pandemic, Board Meetings will continue to be held remotely. This will be reviewed each month with the decision being taken by the Chair of the Board, following national guidance and advice taken on the current operational situation, from the Interim Chief Executive.

4.3 The majority of business will continue to be discussed in ‘public’. Until such times as the Board meets in person the following will ensure that Governors, members of the public and press will be able to:

- Access the agenda and Board papers for the meeting usually held in public from the Trust’s website on the Monday before the meeting is held;
- Governors and members of the public will be invited to submit questions (up until lunchtime on the day before the meeting) to be addressed at the meeting. These will be co-ordinated by the Company Secretary with the Executive Directors;
- The meetings will be livestreamed on YouTube; and
- The Lead Governor will be invited to attend (remotely) the Board meeting held in public.

### 5.0 Board Committee Structure

5.1 The Board undertook an externally facilitated Well Led review which completed with governance accreditation from The Chartered Governance Institute in November 2019. The Board conducted a further internal review of its committee structure and assurance processes October 2020 – March 2021.

5.2 The following Committees report to the Board of Directors:

- Audit Committee;
- Remuneration Committee;

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

5.4 As part of a wider review of its governance arrangements 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.

5.5 A thorough review of terms of reference for each committee followed. A standard template was used and specific text added which related to each committee. As part of the Committee’s annual review of effectiveness each committee reviewed its terms of reference, taking account of recommendations relating to membership, attendees and reporting arrangements. The revised terms of reference were then recommended to the Board of Directors at the meeting in March 2021, where they were approved.

5.6 With the continued response to the coronavirus pandemic it has been necessary to revise the frequency, length of agendas and attendance at committee meetings for the first quarter of 2021/22. Details of the revised dates can be found in the Chair of the Board’s report in April 2021. The position will be reviewed at the Board meeting in June 2021.

5.7 In light of the coronavirus pandemic, committee meetings will continue to take place remotely at present.

6.0 Board Committee administration

6.1 As a reminder, Standing Order 6.1.f states that "such terms of reference¹ shall have effect as if incorporated into the Standing Orders" of the Trust.

6.2 Board committee packs will be prepared and distributed as detailed in the section “Meeting administration” in the terms of reference.

7.0 Board Committees Support Accountability

7.1 Board committees have delegated powers as prescribed by the Trust’s Standing Orders, and provide the basis of the assurance framework through which the Board operates. It is not the role of the committee to substitute themselves for the Board, but rather, to obtain evidence to help the Board gain oversight and assurance, and to manage risk within the committee’s terms of reference.

7.2 The Audit Committee is established under Board delegation with approved terms of reference that are aligned with the Audit Committee Handbook published by the Healthcare Financial Management Association (HFMA) and the Department of Health and Social Care. Its focus is to seek assurance that financial reporting and internal control principles are applied, and to maintain a relationship with the internal and external auditors.

¹ Of board committees
7.3 The Remuneration Committee aims to ensure that executive remuneration is set at an appropriate rate, taking into account the relevant market conditions and needs of the organisation. The committee is also responsible for deciding if a proportion of Executive Directors’ remuneration should be structured so as to link reward to corporate and / or individual performance.

7.4 The Trust has two Nomination Committees, one led by Governors which deals with the appointment of Non-Executive Directors. This committee reports to the Council of Governors. The other is the Board of Directors’ Nomination Committee, made up of Non-Executive Directors, which is responsible for the identification and appointment of Executive Directors. The committee also considers the size and composition of the Board, and the skills and experience that may be required to fill any gaps.

7.5 The Finance and Performance Committee provides the Board with an objective review of the financial position of the Trust and seeks assurance as to the delivery of strategic objectives relating to the financial performance, which includes contractual performance and operational performance.

7.6 The Quality Committee seeks assurance that there is an effective system of quality governance, risk management and internal control in place with regard to patient safety, patient experience and clinical effectiveness. In doing so, the Trust’s ongoing compliance with applicable statutory and regulatory standards, in particular, those of the Care Quality Commission and NHS England / Improvement, are also monitored.

7.7 The People Committee seeks assurance that any risks that may jeopardise achievement of the Trust’s strategic objectives relating to workforce and colleagues, are managed appropriately.

7.8 The Rotherham NHS Foundation Trust Committee in Common is established as a committee in common between Acute Trusts working across South Yorkshire and Bassetlaw to improve quality, safety and the patient experience; delivering safe and sustainable new models of care; and making collective efficiencies operating within the South Yorkshire and Bassetlaw Integrated Care System.

8.0 Board and Committee Minutes

8.1 As under the Companies Acts, the format of Board meetings of public benefit corporations is not set in legislation even though they form part of the organisation’s formal records – that is, save for the requirement to hold meetings in public.

8.2 The format of minutes used at the Trust follows guidance issued by The Chartered Governance Institute (ICAS) which states that “the purpose of minutes is to provide an accurate, impartial and balanced internal record of the business transacted at a meeting.”

8.3 The format of minute writing at The Rotherham NHS Foundation Trust has been agreed by the Board and broadly follows the views of ICSA as above, with one exception relating to names of directors appearing in minutes. Whilst ICSA advise that “the board has collective responsibility for its decisions, therefore, the naming of individuals should be avoided wherever possible” the Board accepts that it may be necessary from time to time, to name individuals in the Board and committee minutes, although the reasoning for this can be varied and should not detract from the principal purpose of the minutes.

[2] ICSA Guidance Note: Minute Taking, September 2016, Pg7
[3] ICSA Guidance Note: Minute Taking, September 2016, Pg7

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9.0 The Council of Governors

9.1 The Trust will put in place arrangements to ensure that the Council is able to fulfil its duties and to be effectively engaged and informed. Council of Governors will meet on a quarterly basis.

9.2 Due to the continuing coronavirus pandemic, Council of Governor meetings will continue to be held remotely. This will be reviewed in July 2021 with the decision being taken by the Chair of the Board in consultation with the Lead Governor, following national guidance and advice taken on the current operational situation, from the Interim Chief Executive.

9.3 Alternative arrangements have been made in the interim for the Council of Governor meeting:
- The agendas and Council papers for the meeting (usually held in public), will continue to be sent out to Governors and put onto the Trust website no later than the Friday before the meeting is held; and
- Governors and members of the public will be invited to submit questions (up until lunchtime on the day before the meeting). These will be co-ordinated by the Company Secretary with the executive directors.

9.4 Governors will continue to be kept informed of developments at the Trust via their usual, weekly news email from the Corporate Governance Manager.

9.5 The Chair of the Board will continue to brief the Lead Governor on a regular basis.

9.6 At the time of writing, the nomination period for the 2021 Governor Elections will close on 31 March 2021. Depending upon the number of nominations submitted will determine if a vote will be required.

10.0 The Role of Board of Directors

10.1 The duties of the directors of The Rotherham NHS Foundation Trust are statutorily provided. Schedule 7 of the National Health Service Act 2006 lays out the initial requirements:
- The organisation must have a Board of Directors⁴;
- The Constitution of the organisation must provide for all the powers of the organisation to be exercisable by the Board of Directors⁵;
- Powers of the Board may be delegated to Board committees⁶.

10.2 The composition of the Board is also provided for through the same legislation:
- There must be Executive Directors, one of whom must be a chief executive (and accounting officer), one a finance director, one a registered medical practitioner or registered dentist, and another must be a registered nurse or a registered midwife.
- There must also be Non-Executive Directors, one of whom is the Chair.⁷

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⁴ National Health Service Act 2006, Schedule 7, §15(1)
⁵ Ditto, §15(2)
⁶ Ditto, §15(3)
⁷ Ditto, §16(1) and (2)
Section 152 of the Health and Social Care Act 2012 provides more detail as to the statutory role of the Board of Directors:

“The general duty of the Board of Directors, and of each director individually, is to act with a view to promoting the success of the corporation so as to maximise the benefits for the members of the corporation as a whole and for the public.”

In this context, “the members” refer to the members of the Trust.

Section 152 aforesaid, also provides specific statutory requirements for directors to avoid conflicts of interest, and statutory requirements for the copy of the agenda of board meetings to be provided to the Council of Governors prior to the meeting taking place, and for minutes to be sent to Governors thereafter.

From these sources, it can be ascertained that the role of the unitary Board of Directors provides the following duties:

a) Setting the strategic direction of the Trust;

b) Holding the executive to account for the performance of the Trust through seeking assurance that systems of control are robust and reliable;

c) Setting, and leading, a positive culture in the organisation; and

d) Being accountable to stakeholders, particularly the Trust’s Governors, for outcomes delivered.

Other directors’ duties can be inferred from common law, such as:

- to act within their powers: this means Boards must comply with all relevant legislation and regulation;
- to exercise independent judgement: in their Board capacity Executive Directors are directors, not part of the Chief Executive’s team; and
- to use reasonable care, skill and diligence: this means using the skills and knowledge necessary to carry out the role as well as using any other relevant skills and knowledge that the individual director may have.

Directors must meet the “fit and proper” person test, described in the provider licence and by the CQC in their regulations relating to appointments of senior positions in organisations.

More detailed information can be found in Appendix 1.

11.0 The Role of the Chair of the Board

“The Chairperson is responsible for the leadership of the Board of Directors and the Council of Governors, ensuring their effectiveness on all aspects of their role and leading on setting the agenda for meetings.”

The Chairperson is responsible for ensuring that the Board develops vision, strategies and clear objectives, and they hold the Chief Executive to account for delivery of the Trust Strategy.

Board culture is led by the Chairperson, who supports a constructive dynamic in which all directors are able to contribute and challenge.

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8 Health and Social Care Act 2012, §152 (1)
9 To aid effectiveness, a new timetable for submission of board papers has been devised, at Appendix B and will be applicable from 1 April 2017.
10 The NHS Foundation Trust Code of Governance, Main Principle, A.3.a., pg 19
11.4 The Chairperson will also ensure that Board committees support accountability and are properly constituted.

11.5 Playing a key role as an ambassador, the Chairperson builds strong relationships with patients and the public, members and Governors, regulators and institutional stakeholders.

12.0 The Role of the Non-Executive Directors

12.1 As part of the unitary board, Non-Executive Directors should constructively challenge and help develop proposals on strategy. They should also promote the functioning of the Board as a unitary board.\(^{11}\)

12.2 Non-Executive Directors will scrutinise the performance of management in achieving the objectives of the organisation, and satisfy themselves as to the integrity of financial information and that financial controls and systems of risk management are robust. They are also responsible for determining the levels of remuneration of executive directors and have a prime role in appointing Executive Directors.

12.3 The board will appoint one of the Non-Executive Directors to be a Senior Independent Director (SID) to act as intermediate for other directors when necessary. Governors may also require to consult the SID, particularly in circumstances where it may not be appropriate to consult with the Chairperson.

12.4 The Chairperson and Chief Executive have roles in Board leadership that complement each other, but which are distinctly different. The Chairperson leads the Board and ensures its effectiveness, whilst the Chief Executive leads the executive and the organisation. The Chairperson and Chief Executive cannot be the same person.

13.0 The Role of the Associate Non-Executive Director

13.9 In 2021/22 the Trust is introducing the position of Associate Non-Executive Director. The Associate Non-Executive Director (Associate NED) role is used successfully in the NHS to support Board succession strategy and achieve a balance of Board level skills. The Associate NED role is a ‘step up’ role aimed to attract potential Non-Executive Director candidates who do not yet have (sufficient) Board-level experience, or currently do not have the required availability. However, they do possess the ability and potential to succeed in an NHS Trust Board-level role. The position of Associate NED will be for a period of 12 months until 31 March 2022.

14.0 The Role of the Chief Executive

14.1 Reporting to the Chairman and to the Board directly, the Chief Executive is ultimately responsible for ensuring that the decisions of the Board and its committees are implemented. All members of the management structure report either directly or indirectly to the Chief Executive.

14.2 The Chief Executive is responsible for ensuring that the executive has the right balance of skills, knowledge and perspectives, and uses performance evaluations as the basis for determining individual and collective development needs of the Executive Directors, relevant to their duties as Board members.\(^{12}\)

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\(^{11}\) Ditto, Main Principle, A.4.a., pg. 20

\(^{12}\) The Healthy NHS Board, Principles for Good Governance, 2013, pg38
15.0 The Role of the Chief Executive as Accounting Officer

15.1 The Chief Executive is also the Accounting Officer of the organisation and as such, is accountable to Parliament and has a duty of being witness before the Public Accounts Committee to answer questions regarding the Trust’s accounts, or more commonly, to answer to reports made to Parliament by the Comptroller and Auditor General under the National Audit Act 1983.

15.2 As Accounting Officer, the individual is responsible for ensuring that effective management systems for achievement of the Trust’s objectives have been put in place, and is also responsible for ensuring that managers at all levels have a clear view of their objectives and the means to assess and measure outputs or performance.

15.3 There is a particular responsibility to ensure that appropriate advice is provided to the Board of Directors and to the Council of Governors on all matters of financial propriety and regularity, and to all considerations economical, efficient and effective. See Appendix 2 for more details.

16.0 The Role of the Executive Directors

16.1 In addition to, and separate from, the management of their functional areas, Executive Directors also have duties as board members, which are the same as their Non-Executive director colleagues, and cover all aspects of the board’s business, i.e. not only their own functional area. Executive Directors share the Board’s individual and collective responsibility for the decisions of the Board.

16.2 Executives draw on their professional expertise in assisting the development of the Trust’s strategy. As part of their functional role, they lead implementation of the strategy within their own functional areas. They take principal responsibility for the provision of accurate and timely information to the Board members.

16.3 As highlighted above, one of the roles of the Board of Directors (i.e. both Non-Executive Directors and Executive Directors together) is to hold the executive team to account, individually and collectively, for delivery of the Trust’s strategic objectives.

16.4 In order to be effective in this role and to provide leadership to the organisation, the Executive team members meet once a week in order to discuss and assess the risks which may affect delivery of the strategic objectives.

17.0 The Role of the Company Secretary

17.1 The Company Secretary is responsible for advising the Board of Directors through the Chair on all governance matters, including that the organisation complies with relevant legislation and regulations (via the Terms of Authorisation / Provider Licence). They assist with professional development of Board members\(^\text{13}\) and facilitate induction. They ensure good information flows within the board and its committees.

17.2 Whilst some NHS governance manuals cite that the Company Secretary is accountable to the Chairperson\(^\text{14}\), at The Rotherham NHS Foundation Trust, in common with many other FTs, the Company Secretary is accountable for Board governance to the

\(^{13}\) See appendix D for revised dates of board development sessions 2017/18

\(^{14}\) The Healthy NHS Board, Principles for Good Governance, 2013, pg39
Chairperson, but accountable to the Chief Executive for day-to-day purposes and as support to the executive and senior management teams in governance matters.

17.3 The Company Secretary’s roles (see Appendix 3) are carried out via the structure of the board assurance framework (which describes the strategic objectives, identifies potential risks to their achievement and gaps in assurance) upon which the Board relies.

18.0 The Role of the Senior Management Team

18.1 Whilst the Board is accountable for oversight of the governance process, management is responsible for implementing the policies and procedures through which governance occurs within the organisation. The Board is responsible for understanding — and for advising management on — the processes through which governance occurs within the organisation, and is accountable for the results of those processes. Management is responsible for the governance processes and their workings, and for their results.\textsuperscript{15}

19.0 Governing documentation

19.1 The Board is supported in carrying out its duties by a library of formal documentation; The Trust Constitution, Provider Licence, Standing Orders, Matters Reserved to the Board, Standing Financial Instructions and Scheme of Delegation, together with the Board Assurance Framework document.

19.2 These documents help to ensure that Board processes are sufficiently robust to support, not only the internal governance processes, but that they will safeguard the organisation in its collaborative and partnership work with others too.

20.0 Urgent Actions

20.1 Board of Directors has emergency powers within the Standing Orders (5.1) which may be exercised by the Chair, after having consulted at least two Non-Executive Directors and an Executive Director. The exercise of such powers by the Chair shall be reported to the next formal meeting of the Board of Directors for ratification.

21.0 COVID-19 – corporate and financial governance

21.1 During the period of the pandemic the Trust have been kept abreast of legislation and guidance within which it should operate. Legislation and guidance continues to be updated to reflect the response to the pandemic. The Chief Executive, Executive Director of Finance and Company Secretary, supported by the other Executive Directors will keep the Board appraised of any changes and will ensure that the Trust works within the requirements at the relevant times.

22.0 Comply or Explain

22.1 Comply or explain has been part of the UK corporate governance framework since it was introduced with the Cadbury Code in 1992 and has also been introduced into NHS governance.

\textsuperscript{15} Deloitte: Developing an effective governance operating model, pg1
22.2 Each year the Trust provides an explanation of its compliance with the NHS Foundation Trust Code of Governance, or explain why it does not. This is formally documented at the Board of Directors through the annual corporate governance statement, and through the Annual Report (and accounts) submitted to Parliament.

Jill Dentith
Corporate Governance Consultant
March 2021
Appendix 1
Role of the Directors

From the NHS Foundation Trust Code of Governance:

Main principles
A.1.a. Every NHS foundation trust should be headed by an effective board of directors. The board is collectively responsible for the performance of the NHS foundation trust.

A.1.b. The general duty of the board of directors, and of each director individually, is to act with a view to promoting the success of the organisation so as to maximise the benefits for the members of the trust as a whole and for the public.

Supporting principles
A.1.c The role of the board of directors is to provide entrepreneurial leadership of the NHS foundation trust within a framework of prudent and effective controls, which enables risk to be assessed and managed.

A.1.d The board of directors is responsible for ensuring compliance by the NHS foundation trust with its licence, its constitution, mandatory guidance issued by Monitor, relevant statutory requirements and contractual obligations.

A.1.e The board of directors should develop and articulate a clear “vision” for the trust. This should be a formally agreed statement of the organisation’s purpose and intended outcomes which can be used as a basis for the organisation’s overall strategy, planning and other decisions.

A.1.f The board of directors should set the NHS foundation trust’s strategic aims at least annually taking into consideration the views of the council of governors, ensuring that the necessary financial and human resources are in place for the NHS foundation trust to meet its priorities and objectives and, then, periodically reviewing progress and management performance.

A.1.g The board of directors as a whole is responsible for ensuring the quality and safety of health care services, education, training and research delivered by the NHS foundation trust and applying the principles and standards of clinical governance set out by the Department of Health (DH), NHS England, the Care Quality Commission (CQC) and other relevant NHS bodies.

A.1.h The board of directors should also ensure that the NHS foundation trust functions effectively, efficiently and economically.

A.1.i The board of directors should set the NHS foundation trust’s vision, values and standards of conduct and ensure that its obligations to its members are understood, clearly communicated and met.

A.1.j All directors must take decisions objectively in the best interests of the NHS foundation trust and avoid conflicts of interest.

A.1.k All members of the board of directors have joint responsibility for every decision of the board regardless of their individual skills or status. This does not impact upon the particular responsibilities of the chief executive as the accounting officer.
A.1.l All directors, executive and Non-Executive, have a responsibility to constructively challenge during board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy.

A.1.m As part of their role as members of a unitary board, all directors have a duty to ensure appropriate challenge is made. In particular, Non-Executive directors should scrutinise the performance of the executive management in meeting agreed goals and objectives, receive adequate information and monitor the reporting of performance. They should satisfy themselves as to the integrity of financial, clinical and other information, and make sure that financial and clinical quality controls, and systems of risk management and governance, are robust and implemented. Non-Executive directors are responsible for determining appropriate levels of remuneration of executive directors and have a prime role in appointing and, where necessary, removing executive directors, and in succession planning.

**Code provisions**

A.1.1. The board of directors should meet sufficiently regularly to discharge its duties effectively. There should be a schedule of matters specifically reserved for its decision. The schedule of matters reserved for the board of directors should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the board of directors. These arrangements should be kept under review at least annually.

A.1.2. The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director and the chairperson and members of the nominations, audit and remuneration committees. It should also set out the number of meetings of the board and those committees and individual attendance by directors.

A.1.3. The board of directors should make available a statement of the objectives of the NHS foundation trust showing how it intends to balance the interests of patients, the local community and other stakeholders, and use this as the basis for its decision-making and forward planning.

A.1.4. The board of directors should ensure that adequate systems and processes are maintained to measure and monitor the NHS foundation trust’s effectiveness, efficiency and economy as well as the quality of its health care delivery. The board should regularly review the performance of the NHS foundation trust in these areas against regulatory and contractual obligations, and approved plans and objectives.

A.1.5 The board of directors should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and delivery of performance. Where appropriate and, in particular, in high risk or complex areas, independent advice, for example, from the internal audit function, should be commissioned by the board of directors to provide an adequate and reliable level of assurance.

A.1.6. The board of directors should report on its approach to clinical governance and its plan for the improvement of clinical quality in accordance with guidance set out by the DH, NHS England, the CQC and Monitor. The board should record where, within the structure of the organisation, consideration of clinical governance matters occurs.
A.1.7. The chief executive as the accounting officer should follow the procedure set out by Monitor for advising the board of directors and the council of governors and for recording and submitting objections to decisions considered or taken by the board of directors in matters of propriety or regularity, and on issues relating to the wider responsibilities of the accounting officer for economy, efficiency and effectiveness.

A.1.8. The board of directors should establish the constitution and standards of conduct for the NHS foundation trust and its staff in accordance with NHS values and accepted standards of behaviour in public life, which includes the principles of selflessness, integrity, objectivity, accountability, openness, honesty and leadership (The Nolan Principles).

A.1.9. The board of directors should operate a code of conduct that builds on the values of the NHS foundation trust and reflect high standards of probity and responsibility. The board of directors should follow a policy of openness and transparency in its proceedings and decision-making unless this is in conflict with a need to protect the wider interests of the public or the NHS foundation trust (including commercial-in-confidence matters) and make clear how potential conflicts of interest are dealt with.

A.1.10. The NHS foundation trust should arrange appropriate insurance to cover the risk of legal action against its directors. Assuming the governors have acted in good faith and in accordance with their duties, and proper process has been followed, the potential for liability for the council should be negligible. Governors may have the benefit of an indemnity and/or insurance from the trust. While there is no legal requirement for trusts to provide an indemnity or insurance for governors to cover their service on the council of governors, where an indemnity or insurance policy is given, this can be detailed in the trust’s constitution.
The duties of the Accounting Officer

The essence of the accounting officer's role is a personal responsibility for:
• the propriety and regularity of the public finances for which he or she is answerable
• the keeping of proper accounts
• prudent and economical administration in line with the principles set out in Managing public money
• the avoidance of waste and extravagance
• the efficient and effective use of all the resources in their charge.

An accounting officer must:
• personally sign the accounts and, in doing, so accept personal responsibility for ensuring their proper form and content as prescribed by Monitor in accordance with the Act;
• comply with the financial requirements of the NHS provider licence;
• ensure that proper financial procedures are followed and that accounting records are maintained in a form suited to the requirements of management, as well as in the form prescribed for published accounts (so that they disclose with reasonably accuracy, at any time, the financial position of the NHS foundation Trust);
• ensure that the resources for which they are responsible as accounting officer are properly and well managed and safeguarded, with independent and effective checks of cash balances in the hands of any official;
• ensure that assets for which they are responsible such as land, buildings or other property, including stores and equipment, are controlled and safeguarded with similar care, and with checks as appropriate;
• ensure that any protected property (or interest in) is not disposed of without the consent of Monitor;
• ensure that conflicts of interest are avoided, whether in the proceedings of the board of directors, or council of governors or in the actions or advice of the NHS foundation trust’s staff;
• ensure that, in the consideration of policy proposals relating to the expenditure for which you are responsible as accounting officer, all relevant financial considerations, including any issues of propriety, regularity or value for money, are taken into account, and brought to the attention of the board of directors.

An accounting officer should also ensure that managers at all levels:
• have a clear view of their objectives, and the means to assess and, wherever possible, measure outputs or performance in relation to those objectives
• are assigned well-defined responsibilities for making the best use of resources (both those consumed by their own commands and any made available to organisations or individuals outside the NHS foundation trust), including a critical scrutiny of output and value for money
• have the information (particularly about costs), training and access to the expert advice which they need to exercise their responsibilities effectively.
Duties and Responsibilities of the Company Secretary with regard to Corporate Governance

• Support the chair and chief executive in ensuring that the trust has a robust governance infrastructure that complies with Monitor’s licence conditions as relate to governance, and takes account of Monitor’s code of governance and other relevant best practice recommendations in corporate governance.

• Provide advice to the board, council of governors, their committees, directors, on all governance matters.

• With the chair, ensure that the board, council of governors and their committees are properly constituted, operated and supported, according to the standing orders and the regulatory framework.

• Ensure there is appropriate coordination and good information flows between the board, the council of governors, their committees and executive management.

• Establish and monitor procedures to ensure that the trust is able to comply with the requirements of the legislative and regulatory framework.

• Ensure that the foundation trust complies with its constitution, and review, propose and implement approved changes to the constitution.

• Provide advice to chair, chief executive, board, and council of governors on legal and constitutional matters and the correct and proper conduct of business and meetings.

• Commission and provide briefings for external legal advice where necessary to ensure the efficient and effective resolution of issues.

• Scrutinise and report to the board and council of governors’ new regulatory developments.

• Ensure all registers required by the constitution or relevant legislation are established and maintained, and made available for public inspection in line with statutory requirements.

• Ensure standing orders are in place, acted upon and reviewed as necessary, and with the chief financial officer, ensure standing financial instructions are similarly in place, reviewed and acted upon by the board.

• With the chief executive and chief financial officer, take a leading role in the preparation and publication of the annual report and accounts and ensure it is properly submitted to Monitor and laid before Parliament.

• Coordinate and assist with the production/ submission of all appropriate returns, reports and plans to regulatory bodies.

• Contribute to the development of systems, controls and risk management arrangements that comply with internal and external governance and best practice requirements.

16 NHSP / DAC Beachcroft, The Foundations of Good Governance, 2015, appendix 14
• Act as the key point of contact between the board, council of governors and Monitor.

• Ensure reporting arrangements enable the board and council of governors (to the extent applicable) to focus on those goals and objectives in the corporate plan that are at risk of not being delivered.

• With the chief executive, executive directors and next in line managers reporting to executive directors, ensure effective risk management and reporting for the trust, including the submission of quarterly reports to the board.

• Support the chief executive, executive directors and other senior managers in the development of an effective performance management framework that facilitates effective delivery of the trust’s strategy and agreed performance standards.
<table>
<thead>
<tr>
<th>Agenda item</th>
<th>P80/21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report</td>
<td>Board Assurance Framework 2021/22</td>
</tr>
<tr>
<td>Executive Lead</td>
<td>Jill Dentith, Corporate Governance Consultant / Julie Dawes, Interim Company Secretary</td>
</tr>
<tr>
<td>Link with the BAF</td>
<td>All BAF items, especially B8 re: corporate governance</td>
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<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>
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<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)

In the context of the Trust’s five year strategy being reviewed with the final version due for approval in September 2021, and the necessity to agree the BAF for the new financial year as soon as possible after the start of April 2021, this proposal is presented to the Board of Directors’ meeting.

It is proposed that:
- The majority of the 2020/21 BAF is rolled forward for quarters (Q) 1 and 2 in 2021/22;
- The target risk scores for each BAF item to be achieved by end Q2 2021/22 will be reviewed as part of the Q4 2020/21 process; and
- A revised BAF will be created for Q3 and Q4 2021/22 (October 2021 to March 2022) based on an assessment of the risks to the achievement of the strategic objectives contained within the Trust’s revised strategy.

There is an opportunity to review the current BAF risks and their identifiers. Hence Appendix 1 details the current BAF risks and proposes some changes for consideration by the Board of Directors.

**Due Diligence**

This proposal was considered by the Executive Team (ETM) on 18 March 2021. ETM approved the proposal, the deletion of item B6 and proposed the rewording of items B2, B8, B11 and B12. Based on the discussion at ETM a further version of the BAF was shared via email and final comments received.

The proposed BAF indicators for 2021/22 were then emailed to the Non-Executive Directors for review and comment. These comments have been included in Appendix 1.

**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)*

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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 to APPROVE:
- The proposal to roll over the majority of the 2020/21 BAF for Q1 and Q2 2021/22;
- The proposal to delete BAF item B6; and
- The proposed rewording of the BAF risk identifiers for B2, B8, B11 and B12

Appendices

1. 2021/22 BAF risks and identifiers
## Proposed BAF identifiers for Q1 and Q2 2021/22 based on BAF 2020/21 [draft v5]

<table>
<thead>
<tr>
<th>ID</th>
<th>Risk title</th>
<th>Risk Owner</th>
<th>Oversight Committee</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 for 2020/21</th>
<th>ETM Recommend</th>
<th>ETM Rationale for Recommendation</th>
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<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>
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<td>Demand for care exceeds the resources available, leading to failure to achieve recognised healthcare standards</td>
<td>COO QC</td>
<td>QC</td>
<td>4x4</td>
<td>3x4</td>
<td>5x4</td>
<td>TBC</td>
<td>3x4</td>
<td>Rewording of risk</td>
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<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>QC</td>
<td>4x4</td>
<td>4x4</td>
<td>4x4</td>
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<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>PC</td>
<td>4x4</td>
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<td>2x4</td>
<td>Roll over</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>PC</td>
<td>4x4</td>
<td>4x4</td>
<td>3x4</td>
<td>TBC</td>
<td>2x4</td>
<td>Roll over</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>PC</td>
<td>4x4</td>
<td>3x4</td>
<td>3x4</td>
<td>TBC</td>
<td>2x4</td>
<td>Delete</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>QC</td>
<td>3x5</td>
<td>3x5</td>
<td>4x4</td>
<td>TBC</td>
<td>2x5</td>
<td>Roll over</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 Audi</td>
<td>4x5</td>
<td>4x5</td>
<td>4x4</td>
<td>TBC</td>
<td>3x5</td>
<td>Rewording of risk</td>
<td>Positive assurances on addressing this risk in 2020/21 including the Financial Governance Report and Action Plan, quarterly review of licence condition, Chair’s Assurance Logs and general improvements in assurance processes in 2020/21. It is therefore suggested that B8 is reworded such that it is focused on licence condition issues rather than the wider risk as currently described.</td>
</tr>
<tr>
<td>B9</td>
<td>The financial plan is not delivered</td>
<td>DoF F&amp;PC</td>
<td>F&amp;PC</td>
<td>4x5</td>
<td>4x5</td>
<td>2x3</td>
<td>TBC</td>
<td>3x5</td>
<td>Roll over</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>F&amp;PC</td>
<td>4x5</td>
<td>4x5</td>
<td>3x5</td>
<td>TBC</td>
<td>3x5</td>
<td>Roll over</td>
</tr>
<tr>
<td>B11</td>
<td>Mismatched governance and decision-making may arise from divergent Trust and ICS interests and objectives</td>
<td>DCE BoD</td>
<td>BoD</td>
<td>3x4</td>
<td>3x4</td>
<td>3x4</td>
<td>TBC</td>
<td>2x4</td>
<td>Rewording of risk</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>BoD</td>
<td>2x4</td>
<td>2x4</td>
<td>2x4</td>
<td>TBC</td>
<td>2x4</td>
<td>Rewording of risk</td>
</tr>
</tbody>
</table>
## Board of Directors’ Meeting
### 09 April 2021

<table>
<thead>
<tr>
<th>Agenda item</th>
<th>P81/21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report</td>
<td>Governance 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: this report provides a horizon scan of regulatory, statutory or legislative reviews, updates and changes</td>
</tr>
<tr>
<td>How does this paper support Trust Values</td>
<td>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</td>
</tr>
<tr>
<td>Purpose</td>
<td>For information</td>
</tr>
</tbody>
</table>

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

The report includes sections on:

- Implementation guidance relating to the 2021/22 priorities and operational planning guidance;
- CQC Duty of Candour guidance;
- Implementing the overseas visitor charging regulations;
- NICE consultation – better communications about healthcare for babies, children, young people and shared decisions; and
- EU settlement deadline - advise for employers.

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

This report has not been received elsewhere prior to its presentation to the Board of Directors.

### Board powers to make this decision

No decisions are required by this paper.

### 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**

This report provides an update on governance matters since the last Board meeting in March 2021.

2 **2021/22 priorities and operational planning guidance: Implementation guidance**

NHS EI have issued the above implementation guidance in relation to the 2021/22 priorities and operational planning guidance. The implementation guidance provides further detailed policy and technical information to enable Integrated Care Systems (ICSs) and their constituent organisations to develop and agree operational plans. Plans should summarise how, as systems, the priorities set out in 2021/22 priorities and operational planning guidance will be delivered, with a focus on the six months to the end of September 2021 for most areas.

Section 2.2 states that:

“Every acute (non-specialist) and mental health NHS trust and FT will be part of at least one provider collaborative, allowing them to integrate services appropriately with local partners at place and to strengthen the resilience, efficiency and quality of services delivered at-scale, including across multiple ICSs.”

Section 2.4 “Planning for implementing new statutory arrangements” states that:

“During 2021/22 we will also update guidance on provider governance (to support providers to work collaboratively), including:

- Updated FT Code of Governance;
- Updated guidance on the duties of FT council of governors;
- Updated memorandums for accounting officers of FTs and NHS trusts; [and]
- New guidance issued under the NHS Provider Licence that good governance for NHS providers includes a requirement to collaborate.”

A copy of the guidance can be found using the following link:

3 **CQC Duty of Candour guidance**

In March 2021 the Care Quality Commission (CQC) have updated the guidance for providers on Regulation 20 - the duty of candour.

This is to make it clear what providers must do to meet the requirements of the regulation and the circumstances in which it must be applied.

The duty of candour was introduced in 2014 in response to concerns raised following investigations into Mid Staffordshire NHS Foundation Trust. It also followed a tireless campaign by the parents of Robbie Powell who sadly died in 1990 and whose case highlighted the need for a statutory duty of candour.

The regulation puts a legal duty on all health and social care providers to be open and transparent with people using services, and their families, in relation to their treatment and care.

Details of the updated guidance can be found at Updated guidance on meeting the duty of candour | Care Quality Commission (cqc.org.uk)
4 Implementing the overseas visitor charging regulations

Following the outcome of the UK-EU negotiations and the implementation of the Trade and Cooperation Agreement, the Department of Health and Social Care have updated the information for NHS bodies who need to make and recover hospital charges from overseas visitors.

Details of the information can be found at Guidance on implementing the overseas visitors charging regulations (publishing.service.gov.uk)

5 NICE consultation

NICE is currently consulting on draft guidance to support better communication with and about healthcare for babies, children and young people and shared decision-making. The consultation closes at 17.00 on Friday 16 April 2021.

Details of the consultation can be found by following the link Consultation | Babies, children and young people's experience of healthcare | Guidance | NICE

6 EU Settlement Scheme deadline – advice for employers

NHS Employers has produced guidance on supporting individuals to sign up to the EU Settlement Scheme before the deadline on 30 June 2021.

The EU Settlement Scheme allows EU citizens living in the UK before 31 December 2020 to retain their and their family member's rights to continue to live, work and study in the UK beyond 30 June 2021.

Details of the guidance can be found by following the link Preparing for the EU Settlement Scheme deadline - NHS Employers

7 Recommendations

It is recommended that the Board of Directors received this report for information.

Produced by: Jill Dentith, Corporate Governance Consultant
March 2021