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 Monday 30 November 2020.

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**Strategy and Strategic Planning**

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<td>Board Committee Dates for January Cycle</td>
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<td>433/20</td>
<td>Date of next meeting: Tuesday 2 February 2021 No meeting to be held in January 2021</td>
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1100 Close of meeting.

*In accordance with §152(4) of the Health and Social Care Act, 2012, a copy of this agenda has been provided to Governors prior to the Board Meeting*
MINUTES OF THE PUBLIC BOARD OF DIRECTORS MEETING HELD VIRTUALLY ON TUESDAY 3 NOVEMBER 2020

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

In attendance: Ms J Dentith, Corporate Governance Consultant
               Mr I Hinitt, Director of Estates and Facilities
               Ms E Parkes, Director of Communications
               Mr J Rawlinson, Director of Health Informatics
               Miss D Stewart, Corporate Governance Manager (minutes)

Apologies: Mrs H Craven, Non-Executive Director

365/20 CHAIRMAN’S WELCOME AND APOLOGIES FOR ABSENCE

The Chairman welcomed all present, including Operational Director colleagues as attendees to the board. Apologies for absence were noted.

366/20 QUORACY CHECK

The meeting was confirmed to be quorate.

367/20 DECLARATIONS OF CONFLICTS OF INTERESTS

Dr Jenkins’ interest in terms of his joint role as Chief Executive of both the Trust and 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.

Mr Hackett’s interest, in terms of his joint role as interim Director of Finance at the Trust and substantive Director of Finance at Rotherham Doncaster and South Humber (RDaSH) NHS Foundation Trust, was noted.
Ms Hagger declared an interest with regard to the Chairman’s Report which detailed the extension to her current term of office.

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

368/20 **PATIENT STORY**

The Chief Nurse presented the patient story, which outlined the service improvements resulting from a complaint received in late 2019.

The complaint had related to the provision of care for a patient with a hearing impairment who had attended the Urgent and Emergency Care Centre and the Acute Medical Unit. The specific concerns raised had been the difficulty in accessing a British sign language interpreter in a timely manner in order to support provision of care. Utilising official interpreters rather than family members, was important particularly in circumstances of difficult conversations between a clinician and a patient.

In responding to the matters raised from the complaint, the Chief Nurse had led wider discussions with the local hearing impaired community to identify further actions, across a range of areas such as the scheduling of appointments, to support those with such impairments. Due to COVID-19, some actions had been able to be implemented and others such as a drop in clinic/support meetings had been paused.

Whilst disappointing that a complaint had been received in the first instance, it had resulted in a number of positive actions, which Ms Wood was requested to communicate to Rotherham Healthwatch who had expressed an interest in provision of care for this patient group. **ACTION – Chief Nurse**

The Board of Directors noted the patient story.

**PROCEDURAL ITEMS**

369/20 **MINUTES OF THE PREVIOUS MEETING**

The minutes of the previous meeting held on 6 October 2020 were agreed as a correct record.

370/20 **MATTERS ARISING FROM THE PREVIOUS MEETING**

There were no matters arising which were not either covered by the action log or agenda items.

371/20 **ACTION LOG**

The Board of Directors reviewed the action log and agreed that log numbers 46, 48, 49, 50, 51, 52, 53, 54, 55, 57 and 58, would be closed.

With regard to log number 56 relating to access to IT for junior doctors, Dr Gardner confirmed that the matter would be added to the risk register. However, he took the opportunity to assure the Board that he did not consider the matter
to be a material risk. It was specific to certain areas of the Trust, infrequent in occurrence and mitigating actions had been established until a permanent solution was in place. The action would remain open.

**STRATEGY AND STRATEGIC PLANNING**

**372/20 REPORT FROM THE CHAIRMAN**

The Board of Directors received the Chairman’s Report.

Mr Havenhand highlighted that eight new Public Governors had been recently elected and started their duties from 1st November and, a virtual joint session of the Board and Council of Governors would be held on 11 November 2020, to facilitate general introductions and consider how communication could be enhanced.

It was noted that the Council of Governors at its recent meeting had approved a one-year extension to Ms Hagger’s term of office to 30 September 2022, subject to satisfactory performance review in 2021.

Details of the NHS Providers Community Network Forum were documented within the report, with it suggested that consideration be given to including the digital board development programme as part of a future Board Seminar.

**ACTION – Chairman**

The Board of Directors noted the Chairman’s Report.

**373/20 REPORT FROM THE CHIEF EXECUTIVE**

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

Dr Jenkins highlighted the section detailing changes to the Executive Team, specifically asking the Board to note that the Deputy Chief Executive, having undertaken the role at a previous organisation and being already trained, would assume the role of Senior Information Risk Owner (SIRO). This arrangement would be reviewed once ongoing recruitment to the Executive Team was complete.

With regard to COVID-19, cases continued to rise in South Yorkshire resulting in increased bed pressures across all organisations. Public Health data suggested that the pressures in this second wave were for general and adult beds rather than critical care beds. Increased knowledge of the virus and known treatment pathways was seeing improved survival rates compared to wave one.

It was expected that the number of cases would further rise before the impact of any local or national lockdown measures were seen. Regrettably, it had been necessary to review and cease some areas of activity at the Trust, with a decision taken across the South Yorkshire and Bassetlaw Integrated Care System to recommence centralisation of some emergency surgery for children at Sheffield Children’s Hospital as in wave one.

Staff morale remained challenged, more as a result of fatigue, due to the numbers of patients being admitted compared to wave one.
As there were no other matters to be considered from the Chief Executive’s report, at this point the Chairman moved the discussion to the later COVID-19 report from the Chief Operating Officer. The detail of the discussion recorded in minute 376/20.

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

374/20  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 from the Deputy Chief Executive.

Mr Wright highlighted a number of specific matters from the report, indicating that focus across the sector remained on COVID-19 and health inequalities. The system wide Winter and Surge Plan for 2020-21 had been formally signed off by the A&E Delivery Board. Additionally, the Rotherham Flu Vaccination Plan had been signed off for implementation.

As requested at the previous meeting, the Place governance structure was detailed within the report.

The Board of Directors noted the update report.

375/20  QUARTERLY REVIEW OF PROGRESS AGAINST OBJECTIVES

The Board of Directors received the quarterly review of progress against the Trust’s objectives presented by the Deputy Chief Executive.

Mr Wright reported that of the twenty projects, five were rated as on plan (green) and fifteen as behind plan with mitigation or actions in place to support recovery (amber). No projects were rated as behind plan (red).

The report detailed each project, including the milestones; however, this level of detail was deemed not necessary when presented to the Board, as information was considered by each Board Assurance Committee. Mr Smith additionally commented that there was duplication across a number of reports which could result in confusion. Mr Wright agreed to review the position.

**ACTION – Deputy Chief Executive**

Mr Edgell questioned whether, based upon current capacity and challenges, the operational objectives would be achieved, or whether consideration should be given to focusing on those projects which would have significant benefits.

Whilst the Executive Directors continued to monitor progress against the milestones, Mr Wright stated the four 2020/21 Operational Objectives, as agreed by the Board, had been developed to reflect the constraints resulting from COVID-19. At this time, he did not consider there was a requirement for any changes. In acknowledging this comment, Mr Havenhand confirmed that any revisions to the operational objectives, should they be proposed by the Executive’s, would be discussed by the Board with decisions to be risk based.
It was noted that the regulator remained satisfied with regards to the progress being made by the Trust against the Improvement Plan.

The Board of Directors noted the report and were assured that progress continued to be made in achieving the operational objectives.

**OPERATIONAL PERFORMANCE**

**376/20 COVID-19 REPORT**

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

It was reported that admissions continued to rise, with an increase in staff being absent either due to themselves being confirmed positive or where required to self-isolate.

Although staffing was proving to be challenging, Ms Wood confirmed that safe staffing levels were constantly under review to avoid any never event. Staff were being redeployed as appropriate, including midwifery colleagues who were actively supporting other areas of the Trust. Dr Gardner added that significant focus was also being given in supporting colleagues health and wellbeing.

Due to patient numbers it had been necessary to open the winter ward earlier than planned, with additional critical care beds also available. However, to support the additional critical care beds these would need to be staffed from areas, such as theatres, with the necessary clinical expertise.

Other than complex or cancer cases, elective inpatient admissions had been cancelled. In the main Outpatient and day case activities would continue, unless COVID-19 inpatient numbers reached 150 which would see a shift to a major incident approach to provision of services.

Bronze, Silver and Gold Command continued to address matters as they arose, with it being confirmed that the actions taken to date were in line with a predetermined approach based upon the number of COVID-19 inpatients at any one time. Any decisions to cease activities had been discussed with the ICS to ensure they were cognisant of the reasons why.

The COVID response room, which linked to the national team and provides situation reports, had been re-established and would operate seven days a week.

In terms of staff absence levels Mr Ned indicated that testing for all staff, including those asymptomatic, would be rolled out as quickly as possible, starting in critical services. It was anticipated that the staffing position would worsen further before it started to improve.

In response to a question from Dr Shah, it was confirmed that unlike wave one when all activities ceased, there was an expectation that diagnostics and cancer services would continue to be provided. However, as stated earlier should there be 150 plus cases, the position may change.
Ms Hagger highlighted a recent article in the national press in relation to the response by the NHS in wave one and the use of the triage tool to determine how a patient would be treated, with it potentially weighted against those in an older age group.

Dr Jenkins agreed that this had been a concerning article, with a lengthy and reasoned response from NHS England. The issues raised had been discussed by the Executive Team who considered that patients treated at the Trust had not been denied clinical treatment based on their age. Decisions had been taken on the factors which would have been used pre-COVID, this was further supported by Dr Gardner.

In terms of the deaths to date associated with COVID-19, it was reported that at a Place level Rotherham was similar to other Trusts, with any death at the Trust being the subject of review to determine any learning.

The Board noted that compared with wave one, there was now increased knowledge in terms of treatment, and although the second wave so far showed greater patient acuity, the outcomes were improved.

Dr Jenkins commented that as it may be some weeks before any impact from the national lockdown was seen, the length of this second wave would inevitably result in the Trust’s recovery taking longer than originally planned. Potentially it could be the end of 2021 before pre-COVID performance returned.

Before concluding the discussion, Mr Briggs expressed his gratitude to staff for once again being adaptable to the requirements, and their continued positivity in the challenges over recent weeks. These comments were endorsed by the Board.

The Board of Directors noted the report.

377/20 MONTHLY INTEGRATED PERFORMANCE REPORT

The Board of Directors received and noted the Integrated Performance Report (IPR), with detailed information on a number of matters contained within subsequent reports.

377/20(a) QUALITY REPORT

The Board of Directors received the Quality Report presented by the Chief Nurse and Executive Medical Director.

Ms Wood confirmed that with regards to harm free care, the focus remained on pressure ulcers and falls with actions continuing to be taken in each area to improve quality of care.

Whilst overall performance against the looked after children target continued to improve, there had been a number of recent cases requiring further collaborative action with external agencies to address issues identified in month.
For the third consecutive month, complaints had been responded to within the agreed timescales showing 100% compliance. In noting the position, Ms Hagger questioned if complaints, as an important source of information in triangulating the position, had been received relating to COVID-19. Ms Wood confirmed that there had, with Dr Jenkins reporting that they mainly related to delayed treatment and claims that patient had acquired COVID-19 whilst in hospital. It was agreed that further thematic information in this area would be detailed in the next report.

**ACTION – Chief Nurse**

The second cohort of overseas nurses had arrived at the Trust, once they had completed 14 days’ isolation they would commence duties. Additionally, a number of Return to Practice candidates had joined the Trust and similar to the overseas nurses would be required to complete their Objective Structured Clinical Examination before they would be able to register with the Nursing and Midwifery Council (NMC). In terms of the latter, clarification was being sought from the NMC if, as in the first wave of the pandemic, temporary registration would be available as a means to support staffing levels during the second wave.

The 2020/21 Quality priorities continued to be discussed by both the Clinical Governance Committee and Quality Committee.

Members of the Board highlighted the limited value from the patient feedback section of the Integrated Performance Report (IPR). Ms Wood concurred with this statement and would discuss with the author the possibility of it either being removed or replaced with more relevant information.

**ACTION – Chief Nurse**

Although the national trajectory had yet to be received with regards to hospital acquired infections, Dr Jenkins indicated that it would be prudent for the Trust to establish its own interim performance targets.

**ACTION – Chief Nurse**

Dr Jenkins highlighted the Venous Thrombus Embolism (VTE) compliance rates. He advised that it was important that additional focus and scrutiny be given in this area as performance had significantly deteriorated since March 2019. Whilst Dr Gardner indicated he considered this to be a data quality issue, he acknowledged that assurance in this area was required by the Board.

**ACTION – Executive Medical Director**

The Board of Directors noted the Quality Report.

**377/20(b) OPERATIONAL PERFORMANCE REPORT**

The Board of Directors received the Operational Performance Report presented by the Chief Operating Officer.

Mr Briggs reported that whilst the Trust had maintained improvements across the urgent and emergency care standards, challenges were being seen in terms of staffing levels and longer waiting times as a result of increased activity. Flow and access to beds had been maintained, with wards having being reconfigured and extra beds created.
Ms Wood highlighted that flow out of the hospital had also recently been challenging, particularly for COVID-19 positive patients no longer requiring acute hospital care. The Trust had worked closely with the Local Authority and Rotherham Clinical Commissioning Group to improve patient flow, with Mr Briggs providing additional information as to the actions being taken to enable access to additional beds within the community.

The report further detailed the position with regards to the referral to treatment time, which would be further impacted by the increasing number of COVID-19 cases, subsequent decisions made by the Trust and any emerging national guidance.

In terms of Dermatology performance, which had been a matter raised at the previous meeting, it was noted that performance had improved with Dr Gardner confirming that the service had expanded the number of virtual clinic appointments.

Cancer performance continued to be below pre-COVID-19 levels, with current focus being on 2-week waits. Although slow improvement was being seen against other cancer metrics, it may be six to nine months before performance significantly improved.

The Board of Directors noted the Operational Report.

377/20(c) WORKFORCE REPORT

The Board of Directors received the Workforce Report presented by the Director of Workforce.

Mr Ned highlighted a number of key matters including performance against the “recruitment time to clear” standing at 41 days compared with the target 34 and the continued rise in sickness absence.

Mandatory and Statutory Training (MAST) compliance rates stood at 91%, with significant improvement having been seen across the Medical and Dental staff group. However, Corporate Operations had a number of areas of low compliance currently standing at 84%.

Mr Havenhand indicated that focus should be given to improving MAST compliance across Corporate Operations. Additionally, similar focus should also be given to completion of personal development reviews for Corporate Operations and Corporate Services which, as documented within the report, was below the required standard. ACTION - Deputy Chief Executive

A significant amount of work continued to be undertaken across the organisation with regards to equality, diversity and inclusion, including specific activities with the Board.

Ms Hagger commented that nationally there was growing criticism of the use of the term of Black, Asian, and Minority Ethnic (BAME) resulting in a less inclusive approach. Whilst Mr Ned indicated that the Trust should be mindful of the local
and national language, he agreed to ask the Equality and Diversity Steering Group to look at alternative options.  

**ACTION – Director of Workforce**

Provision of health and wellbeing support to staff continued to be offered through a number of services. To strengthen the importance of health and wellbeing, the NHS People Plan recommended the appointment of a Health and Wellbeing Guardian. When considered by the People Committee it was suggested that this role should be undertaken by a Board member to ensure sufficient prominence of the requirements in Board debates. The Chairman would give consideration to identification of a Non-Executive Director to undertake the role.  

**ACTION – Chairman**

Following comments from one of the Non-Executive Directors based upon a recent interview panel, Mr Ned was requested to review the Consultant interview process.  

**ACTION – Director of Workforce**

The Board of Directors noted the Workforce Report.

### 377/20(d)  
**FINANCE REPORT**

The Board of Directors received the month six Finance Report presented by the interim Director of Finance.

Mr Hackett reported that the key financial matters were:

- £20K deficit position as at 30 September 2020, as required by NHS England /Improvement;
- After accounting for £8,259K COVID-19 expenditure; and
- Additional Top-Up income of £19,529K.
- Capital programme; £2,593K expenditure incurred in month and £7,473K year to date, which was £1K above plan;
- Cash position stood at £28,247K

The Board noted that the Trust continued to work on the assumption that notice would be given two months in advance of the requirement to recover the £19m allocated at the beginning of the financial year.

Mr Hackett informed the Board that months 7 -12 would return to traditional financial reporting.

The Board of Directors noted the month six Finance Report.

### 378/20  
**ASSURANCE COMMITTEE UPDATES**

The Board noted the verbal update provided by each of the Non-Executive Director Chairs following the Board Assurance Committee meetings held in October 2020.

i. **Finance and Performance Committee**

Miss Bancroft reported that the Committee had undertaken a deep dive into its assigned Board Assurance Framework risks.
The Committee had been assured on financial delivery for the first six months and had considered a number of business cases and financial governance matters.

Key matters going forward would be achievement of operational priorities, delivery of the phase three recovery plan and continued scrutiny of income, expenditure and capital.

ii. **People Committee**

Ms Hagger reported that the Family Health Division had attended the Committee and served as a useful reminder as to the number of safeguarding matters the division had to deal with.

Whilst not assured by the number of completed personal development reviews, a report on the proposed talent management approach had outlined provision of higher quality reviews including issues such as succession planning.

On other matters, the Committee had been informed of the internal Audit Review relating to E-rostering. Additionally, consideration would be given to operational risks from the risk register which should be assigned to this Committee for review.

iii. **Quality Committee**

Dr Shah reported that the Committee continued to review the Quality Improvement Plan and give focus to harm free care.

The Committee had been informed of the changes to the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme and had been assured by the actions being taken.

However, the Committee had not been assured with regards to National Institute for Health and Care Excellence (NICE) compliance and would be monitoring the position.

iv. **Audit Committee**

Mr Barnes highlighted a matter to the Board regarding compliance with the Standing Financial Instructions (SFIs), with three recent breaches having related to senior interim appointments undertaken outside of the SFIs by Executive Directors.

A representative from the newly appointed External Auditor had attended their first meeting. It was noted that further discussions with the External Auditors would take place relating to the interim appointments and end of year external auditors plan.

**SAFER NURSE STAFFING REVIEW**

The Board of Directors received the report presented by the Chief Nurse which outlined the outcome of the bi-annual safer staffing review across the acute medical and surgical bed base.
Ms Wood indicated that the outcome of the review, which ensured that current patient acuity was supported by appropriate staffing levels, was documented within the report. Proposed changes to establishment had also been discussed by the Executive Directors and were documented. A number of the requirements had been supported and those which had not would be considered at the next review.

The Board of Directors noted the report detailing the six-month review of nurse staffing levels.

REGULATORY AND STATUTORY REPORTING

380/20  ANNUAL QUALITY ACCOUNT

The Board of Directors received the final draft of the 2019/20 Quality Account presented by the Chief Nurse.

Ms Wood explained that the process to finalise the Quality Account/Report had been paused due to COVID-19, with the Quality Report not being required as part of the Annual Report and Accounts.

The external auditors would normally provide an assurance opinion on the outturn of chosen ‘indicators’, however this work had not been undertaken other than assurance provided on the processes to develop the Quality Account.

The revised timetable for production of the Quality Account was for it to be approved by the Board and published by 15 December 2020.

Ms Wood confirmed that the Quality Account had been considered by the Quality Committee.

The Board of Directors approved the 2019/20 Quality Account, recognising that there were a small number of areas which would be finalised by the end of the week.

381/20  FREEDOM TO SPEAK UP GUARDIANS QUARTERLY REPORT

The Board of Directors received the quarter two Freedom to Speak Up Guardian’s report presented by the Chief Nurse.

Ms Wood reported that there had been seven concerns raised during the quarter. These related to areas such as attitudes and behaviours, policy and procedure, staffing levels and patient safety. Four concerns had been closed with the remaining three being progressed through the appropriate channels.

It was noted that no concerns had been raised in relation to the Trust’s response to COVID-19.

Ms Wood provided further detail into the concern raised by the Urgent and Emergency Care Centre staff, with it being confirmed that open discussion had been held with the team with productive joint resolution to the issue raised.
Freedom to Speak Up training was mandatory for all Trust staff and overall compliance rate stood at 98.17%.

Dr Gardner reminded the Board that the Freedom to Speak Up Guardians were one of a number of opportunities available to staff to speak up about concerns.

The Board of Directors noted the report.

382/20

**HOW WE LEARN FROM DEATHS REPORT**

The Board of Directors received the quarterly “How We Learn from Deaths Report” presented by the Executive Medical Director.

Dr Gardner indicated that the report demonstrated progress with regards to mortality, against the background of the challenges presented by COVID-19, being driven by the Medical Examiner and supported by the Divisions.

Mr Edgell indicated that it was important that the focus remained on improving the quality of care, and sought assurance that cases were progressed to structured reviews, with appropriate learning or changes in clinical practice being disseminated.

Dr Gardner confirmed that the Medical Examiner when reviewing stage one reviews, ensured where necessary that structured judgement reviews were undertaken, or referred them to the Harm Free meeting. All deaths for patients with a learning disability received a structured judgement review. However, there were areas where dissemination of learning could be improved. To support this a Learning from Deaths newsletter was being developed.

The input from the Palliative Care team, from the reviews undertaken had been excellent, with the service provision being expanded through a number of business cases.

In concluding the discussion, Dr Jenkins considered that the report as currently presented to the Board was process driven and was not providing assurance to the Board as to improvements in the provision of care. Capacity constraints should not impede progress in this critical area, and Mr Wright would discuss the position further with Dr Gardner outside the meeting.

**ACTION – Deputy Chief Executive**

The Board of Directors received the report.

382/20

**EMERGENCY PREPARDNESS RESILIENCE AND RESPONSE ASSURANCE PROCESS**

The Board of Directors received the Emergency Preparedness Resilience and Response (EPRR) assurance report presented by the Chief Operating Officer.

All NHS organisations were required to complete a self-assessment process of compliance with regards EPRR core standards. Whilst there was no formal requirement for Boards to approve this year’s assurance return, it was noted that
Mr Briggs, as the Accountable Emergency Officer, would be required to submit a return to the regional EPRR Director.

Mr Briggs indicated that the report detailed the EPRR improvement plan from the 2019/20 self-assessment, and the actions taken against the two core standards at that time which had been assessed as partially compliant.

The report also detailed the interim COVID-19 review action plan and progress in winter planning preparations.

The information contained within the report had been considered by both the Business Resilience Group and the Executive Directors. Additionally, Mr Havenhand, as Non-Executive Director lead for EPRR had also reviewed the information and took the opportunity to emphasise that, as demonstrated during the pandemic, it was vital for up to date continuity plans to be readily available. In addition, Mr Havenhand commented on the importance of all senior colleagues responding in a timely way to requests for maintaining and updating the EPRR plan.

The Board of Directors noted the report.

ASSURANCE FRAMEWORK
384/20 GOVERNANCE REPORT

The Board of Directors received and noted the Governance Report presented by the Corporate Governance Consultant.

385/20 BOARD ASSURANCE FRAMEWORK

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

Ms Dentith confirmed that the BAF had been updated during quarter two, to include the Trust’s Operational Objectives milestones. Additionally, the process of BAF deep dives had commenced, with the first having been at the Finance and Performance Committee.

Discussions had taken place at each assurance committee, with the full BAF having been discussed at the Audit Committee, who had also considered their own assigned BAF risks, prior to submission to the Board.

The Audit Committee had considered it important that timings for the Board assurance committee meetings facilitated suitable feedback of the BAF discussions to the Audit Committee, as stipulated by the Internal Auditors.

Of the two BAF risks directly assigned to the Board of Directors, there were no proposed changes to the risk scores for B11 or B12.

The Board of Directors noted the report and approved the BAF risk scores in relation to B11 and B12. In addition, the Board approved the risk scores as determined by the Board Assurance Committees.
RISK MANAGEMENT REPORT

The Board of Directors received the Risk Management Report presented by the Chief Nurse detailing matters on the risk register rated 15 and above.

Ms Wood indicated that the report had been considered by the Risk Management Committee, in addition to each Board Assurance Committee reviewing specific risks assigned to them.

When discussed by the Audit Committee it had been noted that there were relatively few risks associated with staff. Following those discussions Ms Wood had agreed to review the risk register and ensure that appropriate risks were allocated to the People Committee.

In addition, the Audit Committee had requested that the review dates for two specific risks were updated, although Ms Wood confirmed for the Board that one had been a typographical error.

Work continued in a number of areas to ensure robust systems were in place to ensure the Board had assurance on such areas as timeframes to reduce the risk and identification of barriers preventing achievement. Due to work constraints in other areas it had not been possible to include the planned level of detailed reporting, this would be rectified for future reports.

The Board of Directors noted the Risk Management Report.

RISK MANAGEMENT STRATEGY AND POLICY

The Board of Directors received the revised Risk Management Strategy and revised Risk Management Policy.

Ms Wood reported that both documents had been reviewed following the Internal Auditors’ review of governance and risk management arrangements. The main changes had been in relation to the risk appetite statement, duties and accountabilities and ensuring that both documents were user friendly.

It was confirmed that both documents had been considered and supported by the Risk Management Committee.

Ms Dentith indicated that it was important that the risk appetite also reflect the Board Assurance Framework risk appetite and the linkages to the committee structure.

In terms of the content of the Risk Management Policy, Ms Dentith suggested a change in emphasis with regards to the duties of the Director of Corporate Affairs. Rather than ‘being responsible for the management of the Board Assurance Framework (BAF), ensuring it is robust and effective’ the role should be one of co-ordination of the BAF. This amendment was supported by the Board.

In addition, Miss Bancroft suggested a change to the target risk section of the Risk Management Strategy where it was stated that ‘the target risk is provided
as a guide and not an absolute expectation’ suggesting that it should state that it was an absolute expectation. Ms Wood confirmed that discussion on this had been held prior to the meeting and would support the suggested amendment.

The Board of Directors approved the Risk Management Strategy and Risk Management Policy, subject to the two amendments suggested by the Board.

**ACTION – Chief Nurse.**

Dr Shah commented that he considered both documents should be included as part of the induction material for any new Non-Executive Director.

**ACTION – Corporate Governance Consultant**

**388/20 UPDATE ON CLINICAL CHEMOTHERAPY SERVICES AND ONCOLOGY**

The Board of Directors received the report from the Chief Operating Officer which outlined the action taken by the Trust to resolve the two concerns raised following a peer review undertaken in 2019 on the Trust’s ability to support the Chemotherapy Service.

Mr Briggs confirmed that the Trust had advised the national team that the identified actions had been completed.

The Board of Directors noted the report.

**389/20 ANNUAL BOARD MEETING DATES**

The Board of Directors received and noted the report which detailed that a comprehensive planner for 2021 meetings would be presented to the December 2020 Board meeting.

**ACTION – Corporate Governance Consultant**

**BOARD GOVERNANCE**

**390/20 ANY OTHER BUSINESS**

i. Interim Director of Finance

Mr Havenhand noted that this would be the last meeting Mr Hackett would attend as interim Director of Finance. The current arrangements would cease on 14 November 2020. He wished to place on record the Board’s appreciation that Mr Hackett has been able to undertake this role in addition to maintaining his substantive duties. He had been invaluable in providing assurance to the Board on a number of matters.

In addition, the Board wished to acknowledge the collaborative approach taken by Rotherham Doncaster and South Humber (RDaSH) NHS Foundation Trust in enabling Mr Hackett to support the Trust.

**391/20 DATE OF NEXT MEETING**

The next meeting of the Board of Directors would be held on 1 December 2020.

Martin Havenhand  
Chairman  

[Signature]

[Date]
### Board Meeting; Public action log

<table>
<thead>
<tr>
<th>Log No</th>
<th>Meeting Date</th>
<th>Report/Agenda title</th>
<th>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>56</td>
<td>06-Oct-20</td>
<td>Guardian of Safe Working Report</td>
<td>332/20</td>
<td>Access to IT for junior doctors to be added to the risk register if it was not already</td>
<td>EMD</td>
<td>01-Dec-20</td>
<td>This action is actually about IT access for locum doctors, not junior doctors per se; it is now added to the Risk Register.</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>59</td>
<td>03-Nov-20</td>
<td>Patient Story</td>
<td>368/20</td>
<td>To communicate to Rotherham Healthwatch the actions taken to address concerns raised by a patient with a hearing impairment</td>
<td>CN</td>
<td></td>
<td>The Engagement and Inclusion Officer is in communication with Healthwatch and the local Deaf Community as part of the engagement sessions and has fed this information back.</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>60</td>
<td>03-Nov-20</td>
<td>Chairman's Report</td>
<td>372/20</td>
<td>Digital board development programme as part of future Board Seminar.</td>
<td>Chair</td>
<td></td>
<td>Added to Seminar forward planner.</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>61</td>
<td>03-Nov-20</td>
<td>Quarterly review of progress against objectives</td>
<td>375/20</td>
<td>consolidation of reports</td>
<td>DCEO</td>
<td></td>
<td>Will ensure that the progress report reflects on other related papers within the Board pack</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>62</td>
<td>03-Nov-20</td>
<td>Quality Report</td>
<td>377/20 (a)</td>
<td>Report to include thematic around COVID-19 related complaints</td>
<td>CN</td>
<td></td>
<td>Will be included in next Quality Report</td>
<td>Open</td>
</tr>
<tr>
<td>63</td>
<td>03-Nov-20</td>
<td>Quality Report</td>
<td>377/20 (a)</td>
<td>To consider removing the Patient Feedback section of the IPR, or replace with alternative information</td>
<td>CN</td>
<td></td>
<td>Section removed</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>64</td>
<td>03-Nov-20</td>
<td>Quality Report</td>
<td>377/20 (a)</td>
<td>Establish interim performance targets for hospital acquired infections pending receipt of national trajectories</td>
<td>CN</td>
<td></td>
<td>Interim targets to be discussed at next Infection Control Committee</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>65</td>
<td>03-Nov-20</td>
<td>Quality Report</td>
<td>377/20 (a)</td>
<td>Detailed analysis of VTE performance to be undertaken to ascertain reason for deterioration in performance</td>
<td>EMD</td>
<td></td>
<td>Detailed analysis ongoing; update will be incorporated into Quality Report</td>
<td>Open</td>
</tr>
<tr>
<td>Log No</td>
<td>Meeting</td>
<td>Report/Agenda title</td>
<td>Minute Ref</td>
<td>Agenda item and Action</td>
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<tr>
<td>66</td>
<td>03-Nov-20</td>
<td>Workforce Report</td>
<td>377/20 (c)</td>
<td>To improve MAST and PDR compliance rates in Corporate Operations and Corporate Services</td>
<td>DCEO</td>
<td></td>
<td>Reminder issued to Executive colleagues and CEO will discuss compliance/completion rates of teams with each ED at monthly 1:1s</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>67</td>
<td>03-Nov-20</td>
<td>Workforce Report</td>
<td>377/20 (c)</td>
<td>Equality and Diversity Group to consider alternatives to the use of BAME terminology</td>
<td>DoW</td>
<td></td>
<td>Head of Diversity and Inclusion will discuss with members of the EDI Steering Group and take forward.</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>68</td>
<td>03-Nov-20</td>
<td>Workforce Report</td>
<td>377/20 (c)</td>
<td>To consider and identify NED to undertake the role of Health and Wellbeing Guardian</td>
<td>Chair</td>
<td></td>
<td>Chairman's Report agenda item 423/20</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>69</td>
<td>03-Nov-20</td>
<td>Workforce Report</td>
<td>377/20 (c)</td>
<td>To review Consultant interview panel process</td>
<td>DoW</td>
<td></td>
<td>Mr Ned has met with Mr Thomas (Head of Medical Workforce) and a review of consultant process has commenced.</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>70</td>
<td>03-Nov-20</td>
<td>How do we learn from deaths' Report</td>
<td>382/20</td>
<td>To discuss required resources with Dr Gardner</td>
<td>DCEO</td>
<td></td>
<td>New Mortality Group to commence in December 2020</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>71</td>
<td>03-Nov-20</td>
<td>Risk Management Strategy &amp; Policy</td>
<td>387/20</td>
<td>Amendment to a section in each of the Policy and Strategy</td>
<td>CN</td>
<td></td>
<td>Amendments undertaken</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>72</td>
<td>03-Nov-20</td>
<td>Risk Management Strategy &amp; Policy</td>
<td>387/20</td>
<td>Both Policy and Strategy to be included in documents issued to new future NED</td>
<td>CGC</td>
<td></td>
<td>Copies placed in induction folder</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>73</td>
<td>03-Nov-20</td>
<td>Annual Board Meeting dates</td>
<td>389/20</td>
<td>Dates for 2021 meeting to be presented to December meeting</td>
<td>CGC</td>
<td></td>
<td>Agenda item 451/20</td>
<td>Recommend to close</td>
</tr>
</tbody>
</table>
# Board of Directors’ Meeting
## 1 December 2020

<table>
<thead>
<tr>
<th>Agenda item</th>
<th>423/20</th>
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</thead>
<tbody>
<tr>
<td>Report</td>
<td>Public Report from the Chairman</td>
</tr>
<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>
</tbody>
</table>

### Purpose

<table>
<thead>
<tr>
<th>Decision</th>
<th>To note</th>
<th>Approval</th>
<th>For information</th>
</tr>
</thead>
</table>

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

- Board of Directors and Council of Governors meeting
- Board Code of Conduct
- Board Seminar 11 November 2020
- Governors Member Engagement Group
- 2020 Board Membership and Diversity Survey (England)
- Health and Wellbeing Guardian
- Lead Non-Executive Director Updates
- Proud Awards 2020
- Memorial Garden
- NHS Confederation Reset meeting

### Recommendations

The Board is asked to note this report and to approve:

- The addition of an item to the Board Code of Conduct (section 3.2)
- The proposed appointment of a Health and Wellbeing Guardian (section 7.2)

### Appendices

None
1.0 Introduction

1.1 This report provides an update since the last Board Meeting on 3 November 2020.

2.0 Board of Directors and Council of Governors meeting

2.1 The Board of Directors and the Council of Governors met virtually on 11 November 2020. The aim of the meeting was for all Governors and Directors to get to know each other and to brief Governors on the training sessions and meetings that were taking place up until the February 2021 Council of Governors’ meeting.

3.0 Board Code of Conduct

3.1 As Board colleagues are aware our Code of Conduct was recently circulated for Board members to sign and return by end November 2020. In the future the Code of Conduct will be circulated for signature in April every year to align it with the declaration of interest process.

3.2 The Board of Directors is asked to agree an additional item to the Code of Conduct as follows: ‘that for virtual Board meetings, the same standards of professional attire should apply as for meetings in person’.

4.0 Board Seminar 11 November 2020

4.1 The Safeguarding Children Team delivered mandatory training to the Board members at this seminar session. The training covered the additional Board requirements related to safeguarding children who may have contact with Trust staff. The team described the requirements set out by the local, regional and national guidance and gave a summary of actions being taken by the team to ensure that the Trust is able to meet its responsibilities in safeguarding and achieve good outcomes for vulnerable children.

5.0 Governors Member Engagement Group

5.1 The Governors Member Engagement Group met on 17 November 2020. The main item on their agenda was the potential Governor involvement within the Trust’s Strategic Patient Engagement Group which is being established as part of the Trust’s improved working with our patients and the public.

6.0 2020 Board Membership and Diversity Survey (England)

6.1 All Board members are currently participating in this survey being run by NHS England / NHS Improvement. The survey opened on Monday 16 November and runs until Wednesday 16 December 2020. Each Board member has been sent a link to the survey which will enable them to provide their feedback anonymously.

6.2 The aim of the survey is to collect data on the membership of NHS Trust and Clinical Commissioning Groups (CCGs) boards, including their diversity data across the protected characteristics and it is designed to assist the NHS in achieving its commitment to improve equality, diversity and inclusion.

7.0 Health and Wellbeing Guardian

7.1 The NHS People Plan recommended the appointment of a Health and Wellbeing Guardian. The People Committee recommended that this role should be undertaken by a Board member to ensure sufficient prominence.
7.2 The Board is asked to agree that Lynn Hagger be our Health and Wellbeing Guardian.

8.0 Lead Non-Executive Director (Mike Smith)

8.1 Mike Smith, Non-Executive Director, attended the senior Learning & Development team meeting in November as part of his development plan where the following items were discussed: apprenticeships and trainee posts; the Learning & Development contribution to the CQC safeguarding action plan; and the Trust’s appraisal process.

9.0 Lead Non-Executive Director (Rumit Shah)

9.1 Dr Rumit Shah, Non-Executive Director, attended the Resuscitation Committee meeting on 19 November 2020 at which the following issues were discussed: emergency equipment audits; significant improvement in compliance on AMU with Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms; defibrillation operational checks evidencing that all areas had passed; arrangements for responding to emergency allergic reactions occurring in portable CT scanner unit and training mannequins.

10.0 Lead Non-Executive Director (Heather Craven)

10.1 Heather Craven, Non-Executive Director, met with Richard Jenkins, Chief Executive and Angela Wood, Chief Nurse to establish a common understanding of expectations about the new role of lead Non-Executive Director for Safeguarding and have developed a description of the role which will be shared with the CQC.

10.2 Mrs Craven has met with a number of colleagues across Urgent & Emergency Care, Integrated Medicine, Family Health and Clinical Support Services Divisions as well as the Head of Safeguarding in order to understand how safeguarding is managed in their areas and any issues and concerns. She has plans to meet with colleagues across the remaining Divisions.

10.3 Feedback on themes and issues from the above meetings has been provided to the Chief Nurse. Mrs Craven will be attending the monthly safeguarding governance meetings to observe and provide independent feedback to the Chief Nurse around governance issues. In addition, Mrs Craven has met with the Quality Governance Compliance & Risk Manager to discuss the role and the CQC’s approach.

10.4 Mrs Craven met with the Chief Operating Officer, Director of Recovery and Director of Strategy, Planning & Performance to understand how the Trust’s recovery plan has been constructed, how it is being managed and the roles of the team charged with delivery of the plan.

10.5 Mrs Craven will attend the monthly review meeting led by the Chief Operating Officer to provide independent challenge and a more detailed understanding of the issues as part of the process of providing assurance to the board.

11.0 Lead Non-Executive Director (Mark Edgell)

11.1 Mark Edgell, Non-Executive Director lead for mortality, is arranging to meet with the Medical Director to go through the steps being taken to ensure the data presents the correct picture and to ensure that the mortality reviews and other evidence is being used effectively to change practice where it needs to be changed in order to reduce the risk and level of mortality.
12.0 Proud Awards

12.1 During the week commencing 23 November 2020 the Trust held a week-long celebration of our colleagues achievements with the Recognition of Learning event on Monday and the Long Service Awards on Wednesday culminating on the Friday evening with the annual Proud Awards ceremony.

13.0 New memorial garden at Rotherham Hospital

13.1 The memory of loved ones who have sadly died will live on thanks to a new memorial garden at Rotherham Hospital. After months of planning and a generous £11,500 donation from national charity 4 Louis as well as support from our Hospital and Community Charity, a disused patch of land in the grounds of Rotherham Hospital has been transformed into a beautiful, peaceful and calming space.

13.2 The project has been spearheaded by midwives Shahida Mehrban and Hayley Lea who aspired to provide a tranquil space for parents who have sadly lost a baby. However, the garden will be open for all colleagues, patients, families and members of the community who need it.

13.3 This memorial garden is one of just two in Yorkshire funded by 4 Louis, which works nationally to support anyone affected by miscarriage, the death of a baby or child. Harry, the grandson of a Trustee of the charity, Sharon Abbotts, was sadly stillborn at our hospital on 15 May 2013.

13.4 The concept design for the garden was created by Sam Cartwright, Senior Site Manager at Killingley, who was inspired by the Rotherham Hospital and Community Charity’s children’s appeal mascot Dr Ted: the outline shape of the garden looks like a teddy bear’s head.

13.5 The garden includes a hornbeam hedge around the exterior to provide privacy, a weeping willow memorial tree in the centre, benches, flowering shrubs, flowers and plants.

13.6 On Tuesday 17th November I was joined by our midwifery colleagues, Director of Estates & facilities and Simon Loukes, our Project Manager for this scheme, when we received the cheque from 4 Louis and had an opportunity to see the transformation that has taken place.

14.0 NHS Confederation Reset meeting 24th November 2020

14.1 Lynn Hagger and Michael Smith (Non-Executive Directors) attended this meeting on behalf of the Trust and they have highlighted the following key points:

14.2 Matt Hancock, Secretary of State for Health and Social Care, made a presentation and focussed on:

- Busting bureaucracy and retaining the innovation that arose from dealing with the pandemic. He highlighted the use of data and the need to collect it once for multiple uses using the Data Alliance Partnership approach
- Working with the General Medical Council (GMC) to streamline the registering of overseas doctors; establishing more meaningful appraisals that reduce in duration from circa 3 hours down to 30 minutes
- Proportionate regulation and ensuring health and social care integration becomes a reality avoiding the silos of the past
14.3 Anita Charlesworth, Director of Research at the Health Foundation

- Investment is required for health and social care. The Long Term Plan intended to provide more funding for primary care (including mental health), addressing the 18-week target and to stabilise Trusts’ finances.
- We also now have new demands such as Long Covid patients, increased mental health challenges in the acute and community settings. Workforce capacity is as important as appropriate funding to address this issue

Martin Havenhand
Chairman
November 2020
### Agenda item 424/20

#### Report
- **Report from the Chief Executive**

#### Executive Lead
- Presenter: Dr Richard Jenkins, Chief Executive

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

#### Purpose
- Decision [ ]  To note ✓  Approval [ ]  For information [ ]

#### Executive Summary (including reason for the report, background, key issues and risks)
- This report addresses the following issues:
  
  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.

#### Recommendations
- The Board is asked to note this report.

#### Appendices
- 1. Integrated Care System CEO Update Report for November 2020
- 2. Establishing and Implementing Diagnostic Imaging Networks Across England
1.0 COVID-19

1.1 The pandemic impact on the Trust has continued to be a huge challenge with the proportion of beds occupied by patients being the third highest in England and approximately double the peak activity in Wave 1. The latest data indicates that the prevalence of Covid-19 in the Rotherham population is falling and the numbers of positive inpatients has plateaued. Other South Yorkshire Trusts have seen a fall in cases recently so it is likely Rotherham will see this pattern over the next 1-2 weeks.

1.2 The roll out of lateral flow testing is underway and the Trust is also developing readiness for the Covid-19 vaccination programme which is anticipated to start in December. This will accelerate through the first few months of 2021, giving some hope that an end to the pandemic may be in sight.

1.3 Recovery of waiting times and activity delayed in Wave 1 has been further compromised by the need to prioritise the response to Wave 2. As activity subsides through December, the recovery programme will be stepped up again.

1.4 A fourth letter is expected from Sir Simon Stevens and Amanda Pritchard in the near future, which is anticipated to outline the NHS priorities for the rest of this year and is expected to clarify financial arrangements.

2.0 Staff Survey

2.1 The staff survey completion rate so far has been disappointing but discussions with other Trusts suggest this is a more generalised challenge, likely related to the pandemic. Additional measures and encouragement are being put in place over the last week or so of the staff survey window to maximise numbers received.

3.0 Influenza Vaccination

3.1 Further progress has been made with the latest figure for front line staff at 74.5% and for staff overall at 72.5%. When looked at across the region, the Trust is one of the highest performing organisations in this and credit needs to go to Sarah Newbold, Head of Engagement, and her team for leading this work.

4.0 PROUD Week

4.1 I was delighted to be part of the virtual Recognition of Learning event on 23rd November, along with the Chairman. Despite Covid-19, our staff have continued to develop their expertise across a broad range of disciplines and through partnership with a wide range of academic institutions. James Short, Learning and Development Manager, did an excellent job of organising the event.

4.2 On Friday 27th November, the week ends with the flagship PROUD Awards ceremony which will be carried out virtually for the first time. Damian Staples from the Communications team has organised the event.

5.0 Imaging Network

5.1 NHSEI have written to all Trusts to require the development of imaging networks based on natural clusters of organisations. Trusts have been allocated to a proposed network and requested to respond by 30th November 2020 should the Trust not agree that the allocation is appropriate. The South Yorkshire acute Trusts have all been allocated to the same cluster and the attached letter describes the proposals in more detail. Given that
the South Yorkshire Trusts have been working together for some years on collaborative approaches to imaging, the proposed approach seems consistent with our existing direction of travel and it is recommended that the Trust supports the allocation.

Dr Richard Jenkins
Interim Chief Executive
November 2020
CHIEF EXECUTIVE REPORT

November 2020

Author(s)  Andrew Cash, System Lead

Sponsor

Is your report for Approval / Consideration / Noting

For noting and discussion

Links to the STP (please tick)

- Reduce inequalities
- Join up health and care
- Invest and grow primary and community care
- Treat the whole person, mental and physical
- Standardise acute hospital care
- Simplify urgent and emergency care
- Develop our workforce
- Use the best technology
- Create financial sustainability
- Work with patients and the public to do

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 (SYB ICS) provides a summary update on the work of the SYB ICS for the month of October 2020.

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.
South Yorkshire and Bassetlaw Integrated Care System CEO Report

CHIEF EXECUTIVE REPORT

November 2020

1. Purpose

This paper from the South Yorkshire and Bassetlaw Integrated Care System System Lead provides an update on the work of the South Yorkshire and Bassetlaw Integrated Care System for the month of October 2020.

2. Summary update for activity during October 2020

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

The North East, Yorkshire and the Humber have been disproportionately affected by high levels of community transmission of Covid-19 and particularly so in our own regional system of South Yorkshire and Bassetlaw (SYB). This has led to increasing healthcare demand and a massive collective effort. SYB’s primary, community, mental health, social care and secondary care teams are working extremely hard within this pressurised context but are continuing to cope.

As outlined in previous updates, all SYB health and care organisations have collectively planned for a second wave and thanks to the fantastic efforts of all staff and the measures that were put in place earlier in the year, patients are continuing to receive the care they need.

What is different this time is that GPs, community, mental health and acute hospital services are also trying to provide as much non Covid-19 care as they can, where it is safe and appropriate to do so. They are also very mindful of the demands that will be placed on their staff in the coming months given this is the second time they have dealt with a surge in Covid-19 cases.

The figures for deaths in hospitals remain low overall. Similarly, deaths in care homes also remain low, and have done since August, which is attributable to the much-enhanced infection control measures enacted by Local Authorities and care home providers.

Regional public health experts forecast that SYB will likely see a peak in new Covid-19 cases mid to late November which would then translate into hospital admissions and, sadly, some deaths.

More will be known about SYBs future approach once the national position on the lockdown restrictions is reviewed (2 December). It is currently thought that if the lockdown ends on schedule, regions would revert back to their original Regional Covid Alert Level restrictions, which for SYB, would be ‘Very High’ (Tier Three).

2.2 National Update

In response to increasing coronavirus infections the Government and Parliament enacted a further set of national Covid-19 measures on 4th November. On the same day, the NHS reported projections for increased Covid-19 demand which led NHS England and Improvement Chief Executive Sir Simon Stevens to announce that the health service in England would be returning to its highest level of emergency preparedness, Incident Level 4, from 5 November.

This means the NHS has now moved from a regionally managed but nationally supported incident under Level 3, returning for the time being to one that is co-ordinated nationally.

2.3 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 October focused on the ongoing extensive seasonal flu vaccination programme, planning for a Covid-19 vaccination programme, and preparations for asymptomatic testing of the health and care workforce. National priorities such as improving BAME inclusion, the People Plan and digital progress were also discussed.

2.4 Local Authorities

Discussions with Local Authority Chief Executives have been taking place on working together to tackle health inequalities in SYB. The initial focus for the work is to identify some system-wide priorities with a particular focus on Covid-19, the most vulnerable and the widened health inequalities as a result of the pandemic.

It has been agreed to hold a workshop early in the New Year to share initiatives and examples of good practice in tackling health inequalities from the first wave of the pandemic from each place. This will enable partners to learn from each other about how they supported vulnerable populations, shielding, and what data and tools were used to best understand needs and respond to them.

This will hopefully lead to opportunities at scale across the ICS footprint and a SYB Health Inequalities Network of key people across the system who will continue to meet during the year to carry on the learning and sharing and identify work to take forward.

2.5 Sheffield City Region

Mayor Dan Jarvis and the four South Yorkshire Local Authority Leaders negotiated an economic package of £41m for the region as part of the Tier Three discussions. £30m is to be allocated to support businesses and £11m to support ongoing public health requirements.

The new funding is in addition to the government schemes that are already providing some financial support to business and individuals that are temporarily out of employment. The agreed economic package will provide a range of vital resources to support our regional NHS partners and the local economy.

2.6 Wave Two Planning

The SYB Wave 2 Plan is built on the Phase 3 Recovery Plan and therefore starts from a robust position thanks to the extensive testing that has been done.

In addition to managing the ongoing Covid-19 incident, the Plan also takes into consideration the management of non-Covid casework. In contrast to the first wave, partners have been maintaining as much elective work as possible and patients advised to attend for appointments or operations unless they are informed otherwise. The resurgence in Covid-19 cases is more complex and challenging this time round as partners extremely hard to deliver routine care and treatment alongside Covid-19 care.

2.7 Long Covid

An additional £10 million in funding towards long Covid-19 clinics across England was announced at the beginning of October and discussions are now underway to establish what the support should look like for the SYB population. The support will complement existing primary, community and rehabilitation care to ensure that patients get the best possible holistic care.

Increasing medical evidence and patient testimony is showing that a small but significant minority of people who contract Covid-19 cannot shake off the effects of the virus months after initially falling ill. Some estimates suggest that 10% of Covid-19 patients may still be experiencing
symptoms more than three weeks after infection, and perhaps 60,000 people nationally could be suffering from long Covid-19 symptoms after more than three months.

2.8 Flu vaccination programme

SYB’s delivery plans for the mass flu immunisation programme are progressing well. The immunisation of health and care workers has been a key priority with programmes well underway across SYB organisations.

Targeted communications have been taking place across social media starting with two-to-three year olds, followed by the Year Seven school age group and pregnant women. Radio advertising across SYB has focused on at-risk groups but with flexibility built into the approach to take account of the insight from the SYB Flu Board and alter messaging as appropriate.

Public Health England has published a leaflet to help explain the flu immunisation delivery process to the public. It aims to address questions around supply, staggered delivery and why some eligible individuals may be asked to wait or get their vaccine in another setting. Professor Stephen Powis has also sent a letter to Trust chief executives outlining some initial expectations around staff uptake.

2.9 Covid-19 vaccination programme

The infrastructure for the national Covid-19 vaccination programme continues to be developed. SYB is expecting one regional vaccine hub for storage and distribution and which will be integral to implementation. Plans also include three levels of vaccination sites – fixed mass (big venues near major transport routes such as motorways), semi-fixed (reminiscent of mobile CT scanner sites) and mobile units. Early discussions suggest that SYB could have two fixed mass, 16 semi-fixed and 130 mobile sites across the patch. An SYB immunisation programme would span 10 months to cover all of the targeted population with an estimate of around 5000 vaccines being administered a day.

There are encouraging signs that a vaccine could be made available by late-December 2020. Should this be the case then SYB would follow the Joint Committee on Vaccination and Immunisation (JCVI) guidelines which currently recommend frontline health and care staff and care homes (residents and staff) would likely be among the first to receive the vaccine.

2.10 Workforce Testing

SYB is likely to shortly receive several saliva testing facilities which will be able to deliver around 42,000 tests a week.

The initial focus will likely be in acute hospital settings (all hospital services, maternity, cancer-protected surgery hubs), and then mental health, community care, and primary care. The details of the logistical operations are being finalised but it is likely that the new facilities will be able to deliver asymptomatic testing of health and care workers in SYB.

Saliva testing can be delivered at pace, provide quicker results and in administered in much greater volumes than the Polymerase Chain Reaction (PCR) swab tests; public testing at-scale has already taken place in China and Slovakia on millions of people. Liverpool is to be the first UK city to use saliva tests for mass-testing of public groups as part of the Governments Operation Moonshot programme.

The availability and proximity of saliva testing among health and care workers will undoubtedly support those who are self-isolating to safely return to work, where otherwise, they are unable to do so, enabling Trusts to manage staff absences more effectively.
2.8 ICS Governance Review

Following the Health Executive Group (HEG) support for proposals to review and refresh governance within the ICS, several next steps were outlined. These were: first, to seek feedback from partners; second, to co-produce the governance and an operating model; and third, to review and seek support from partners to adopt a model to be in place by April 2021.

The first step has been completed and Chief Executives and Accountable Officers discussed the feedback at a workshop on 13 October 2020. The insights and feedback from the first stage will now inform the co-production of governance and operating model with SYB leaders.

2.9 Brexit

The UK exited the EU on 31 Jan 2020 and is now in a transition period until 31 December 2020. The government recently confirmed that the transition period will cease as planned on 31 December 2020 and there will be no extension.

The NHS will manage its operational readiness response to the EU Exit alongside the ongoing Covid-19 response and restoration of services, through established national and regional incident coordination centres.

2.11 Equality, Diversity and Inclusion

SYB is advancing with commitments to improve leadership representations, career progression and workplace culture in the area of equality, diversity and inclusion (EDI).

The EDI leads in partner organisations met recently to share their approaches and initiatives that are already underway and discussed working together to take forward a set of agreed priorities from the collective promise that SYB leaders made. There are also early discussions taking place to form a network of BAME Network chairs from across the organisations.

In addition, there will be an increased focus on talent management pathways to support BAME staff to develop and progress into senior positions.

2.12 National AHPs Day – 14 October 2020

Allied Health Professions (AHP) across SYB celebrated National AHPs Day on Wednesday 14 October, 2020. SYB is one of the first areas in the country to establish an AHP Council and partners took the opportunity to raise awareness of AHPs on the day to improve understanding of the different roles, the achievements made and the significant opportunities AHPs have to support integrated care.

3. Finance update

The final ICS plan for Months 7 to 12 of 20/21 was submitted on 22 October and showed a significant reduction in the gap against the system financial envelope from £49.3m in the draft plan to £6.9m in the final plan. However there are significant risks within the plan that will need to be managed. There are a number of anomalies in the national financial framework that are currently being discussed with NHSE/I at a regional level.

A group has been set up to help inform the central team in their design of the 21/22 financial framework. This could involve ‘road testing’ the framework at a future point in time. The group includes Directors of Finance and Chief Finance Officers from partner organisations.

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

Date: 6 November 2020
27 October 2020

To:
Sir Andrew Cash, South Yorkshire & Bassetlaw ICS

Cc:
Trust and FT CEOs and Medical Directors via their proposed network
Radiology Clinical Leads and Radiology Services Managers

ESTABLISHING AND IMPLEMENTING DIAGNOSTIC IMAGING NETWORKS ACROSS ENGLAND

Dear Sir Andrew,

The NHS Long Term Plan sets out a clear commitment\(^1\) to transform the delivery of diagnostic services to patients through networks. Specifically, the commitment that “By 2023, diagnostic imaging networks will enable the rapid transfer of clinical images from care settings close to the patient to the relevant specialist clinician to interpret”. We are writing to highlight the actions required to enable the system to realise these benefits. The Operational Planning & Commissioning Guidance for 2020/21 indicates that the delivery of imaging networks should be prioritised, and the Richards’ Review emphasises the primary role of networks in service transformation. Feedback from recent Adopt & Adapt programme workshops across all Regions have emphasised the desirability of accelerating this work.

We have been working with your Trusts to collect and validate a comprehensive national imaging data set which reveals significant unwarranted variations across England in how rapidly and efficiently services are delivered to patients and how productively imaging services are run; and therefore how much they cost. These findings, together with an extensive engagement process with front line service leads and national bodies, have enabled the development of the National Imaging Strategy published on 5th November 2019. We should now take action together to create and deliver the Imaging Networks to ensure we utilise a scarce workforce to best effect,

\(^1\) NHS Long Term Plan paras 3.60, 5.28 and 6.17 (iii)
deliver services that are sustainable, and that provide better value, high-quality care for patients.

Using the national data from imaging service providers we have identified 21 potential diagnostic imaging networks across England – recognising established clinical flows between organisations already working in clinical networks for delivery of cancer, stroke, cardiac, trauma and maternity services. Such a structure will support the decoupling of image reporting from image acquisition, and the pooling of the available reporting workforce capacity to serve a larger population. High quality image acquisition will remain available locally for patients, whilst digital technology will enable equity of access, faster turnaround, and improved access to sub-speciality expertise in image reporting. The modern digital infrastructure required to enable image sharing for reporting will also facilitate the rapid introduction of a new generation of AI and machine learning applications to augment clinical practice, when this technology is clinically validated for use within the NHS.

What your system needs to do by the end of November 2020:

- We would be grateful if your system could review with your Trusts your proposed network configuration (details in the attached data pack). Please can you then confirm the ICS’ commitment to the proposed network model and that your Trusts have formally signed this off with their boards. Please could this be confirmed in a letter to Warren Brown, SRO for diagnostics copied to nhsi.imageservices@nhs.net by 30 November 2020.

- If you disagree with your proposed network and would like to be considered as part of a different cluster, please contact NHS England & Improvement urgently, setting out your rationale for this alternative. We will help work towards your proposed network as long as there is a strong rationale that services to patients will thereby be improved including improved quality and enhanced value as compared with the suggested configuration. The criteria that we will use to assess requests are attached at appendix A

- Please provide reassurance that commitment to any agreement relating to, for example, initiation or renewal of an outsourcing or managed equipment service contract, will be postponed pending review and agreement with NHS England & NHS Improvement, if these will run beyond 31st March 2021.

What your agreed network needs to do following confirmation of network configurations:

Newly formed imaging networks will need to progress rapidly with the following workplan:

- A commitment from all network partners to a timetable for achieving formal board agreement on a partnership model with the aim of networking imaging services;

- The formation of a leadership team and the necessary commitment to deploy project resources in order to deliver: a strategic outline business case approved by all partnership boards; a governance structure, timetable and deliverables for
an inter-trust Steering Group to oversee these processes; a workforce plan that identifies the workforce capacity and skill mix required; a digital technology plan to deliver real-time digital image sharing; and a capital equipment plan.

**Our support offer to your network**

We recognise that a programme of this scale delivered at pace requires guidance and support, and we will ensure you are helped at every phase. There will be a series of activities over the coming months to ensure your network is learning from our early adopters as well as being supported with the latest evidence and a toolkit ([https://future.nhs.uk/Imaging/grouphome](https://future.nhs.uk/Imaging/grouphome)) so you do not have to start this process with a blank page. Enclosed with this letter is NHSE/I’s Implementation Guide ([https://future.nhs.uk/Imaging/grouphome](https://future.nhs.uk/Imaging/grouphome)) highlighting the key aspects involved in developing an imaging network.

We recognise that the availability of resources, including capital and change management capacity, are important enablers for the implementation of imaging networks. Bids for both capital and revenue programme funding to support imaging networks have been submitted to the government Comprehensive Spending Review process. ICS should prioritise resources already available to them to support delivery of network formation and service transformation as an investment in recurrent benefits for patients and the NHS’s finances. NHS England & NHS Improvement will ensure that business cases that are aligned with the National imaging strategy objectives are prioritised for approval where NHS England & NHS Improvement sign-off is necessary.

We are happy to offer facilitated workshops for each proposed network between now and the end of October. Please indicate if your network would like to take up that offer. In order to continuously support you throughout the implementation phase, each NHS Region has appointed an SRO for Diagnostics (Warren Brown for North East & Yorkshire) who has access to subject-matter expertise in diagnostic network formation and service transformation, which can be made available to provide guidance.

We are grateful for your ongoing commitment in making the 21 diagnostic imaging networks a reality for the NHS and its patients.

Yours sincerely

Richard Barker
Regional Director – North East and Yorkshire
NHS England & NHS Improvement

Cc: Andy Howlett, Director of Diagnostics, Medicines & Pharmacy Improvement
### Board of Directors’ Meeting
1 December 2020

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<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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<tr>
<td>Link with the BAF</td>
<td>B11, B12</td>
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<tr>
<td>Purpose</td>
<td>Decision [ ] To note [✓] Approval [ ] For information [ ]</td>
</tr>
<tr>
<td>Executive Summary (including reason for the report, background, key issues and risks)</td>
<td>The purpose of this report is to provide the Trust Board with an update on national developments and also developments across the South Yorkshire and Bassetlaw Integrated Care System (SYB ICS) and Integrated Care Partnership (Rotherham Place). The focus through November has, unfortunately, needed to move back to the response to the 2nd peak in COVID-19 cases across South Yorkshire and the subsequent admissions into the Trust.</td>
</tr>
<tr>
<td>Recommendations</td>
<td>The Board is asked to note the content of this paper.</td>
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<td>Appendices</td>
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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). The focus through November has unfortunately needed to refocus back to the response to the 2nd peak in COVID-19 cases across South Yorkshire and the subsequent admissions into the Trust.

2.0. National Update

2.1. In response to the increase in new COVID-19 cases in the UK, the Government announced a new England wide ‘lockdown’ from the 1st November to the 2nd December. Unlike previous lockdowns, schools and other educational facilities have remained open. The current intention is that after 2nd December, England will return to the 3-Tier regional system (South Yorkshire was in Tier-3, Very High Alert).

2.2. At the start of November cases continued to rise. They appeared to peak on 12th November with over 33,000 new cases diagnosed. However, cases nationally now appear to be flattening and possibly declining (though quite significant variation in day to day figures make trends difficult to confirm).

2.3. The increase in cases has been matched by increased number of patients in hospitals. Nationally there were over 16,000 patients in Hospitals with COVID-19 on 20th November 2020 and this is expected to increase further in the short term.

2.4. In response to this pressure NHSE/I announced on 4th November that it would return to a Level 4 incident. This moves the response to the pandemic back to national coordination rather than regional, as it had been under level 3 through the summer.

2.5. NHSE/I announced the creation of 40 ‘Long COVID-19 clinics. These are designed to help the thousands of patients who are suffering from long term effects of COVID-19, a condition which can include continued fatigue, brain fog, breathlessness, and pain.

2.6. There has been some positive news through November as multiple pharmaceutical companies who are developing vaccines start to release stage 3 results. While this is undoubtedly positive news, the Deputy Chief Medical Officer in England has asked for caution. However, the NHS is nationally stepping up plans for how a vaccine would be distributed and administered as quickly and effectively as possible.

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

3.1. South Yorkshire and Bassetlaw remains one of the hardest hit regions for COVID-19 in the country. Analysis undertaken by the Health Service Journal in mid-November showed that the system had three of the highest five hospitals for COVID-19 patients in beds as a percentage of general bed stock. These being Barnsley, Rotherham, and Doncaster with Sheffield at 14th highest.

3.2. At the end of October 2020, the Chief Executives of Barnsley, Rotherham and Doncaster requested that the Children’s Emergency Surgery pathway be stepped back up due to the ongoing COVID-19 pressures. The lessons learnt from Wave 1 will be incorporated into a revised pathway and transfer protocol for the service.

3.3. The seasonal flu vaccination programme remains of critical importance to the system, both through reduction in flu cases through winter and as preparation for any potential
COVID-19 vaccine. SYB ICS have a fortnightly flu board that has been meeting since 4th August (though this has moved to monthly as programs of work are now established). In late October and November, the Ministry of Defence provided independent validation of the regions flu plans and feedback from this was positive and recognised the comprehensive detail of the plans.

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

4.1. Where possible Business and usual Place Governance has continued. However, the significant resurgence of COVID-19 has had an impact on this through November with several meetings having been stepped down.

4.2. Place Gold Command continues to meet weekly with its key objective to oversee and co-ordinate the strategic response to COVID-19 across Rotherham. This includes the identification and solution to any blockages across the Rotherham system.

4.3. The Flu vaccination programme within Rotherham continues. Midway through November 72% of the 75% target to vaccinate over 65s had been achieved. The next focus group will be 2-3yr olds.

Michael Wright
Deputy Chief Executive
November 2020
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<th>Agenda item</th>
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<tr>
<td>Report</td>
<td>COVID-19 Report</td>
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<tr>
<td>Executive Lead</td>
<td>George Briggs, Chief Operating Officer</td>
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<tr>
<td>Link with the BAF</td>
<td>B1, B2</td>
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<tr>
<td>Risk scores have slightly increased from the previous quarter on the basis of the Trust having increased pressure from numbers of COVID-19 positive patients</td>
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<tr>
<td>Purpose</td>
<td>Decision [ ] To note [✓] Approval [ ] For information [ ]</td>
</tr>
<tr>
<td>Executive Summary (including reason for the report, background, key issues and risks)</td>
<td>This report summarises operational pressures from the COVID-19 pandemic and updates the Board of Directors on the Rotherham NHS Foundation Trust’s specific responses for the month of November 2020. It highlights some of the key issues and actions going forward to maintain patient and staff safety.</td>
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<tr>
<td>2020/21 continues to be a difficult year for the NHS. We are well into our response to the COVID-19 pandemic which is described as the most severe such episode in the history of the NHS:</td>
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<tr>
<td>• The Trust initially in February-March focussed all of its efforts on preparation for the influx of COVID-19 patients to the acute sector</td>
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<tr>
<td>o Clearing non-essential services</td>
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<td>o Manning help and support lines</td>
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<td>• Stopping elective services to free up personnel and reduce risks to patients and staff</td>
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<tr>
<td>• Then developing a recovery programme</td>
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<td>• In Phase 2 of the pandemic we are implementing the above actions as well as balancing essential services and a focused recovery programme. The recovery from the effects of the pandemic is complex and reliant upon a number of facets</td>
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<td>o Staffing absence levels have risen again to numbers similar to April in Phase 1. In September we had under 70 staff absent this has risen to 160-180 in October</td>
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<td>o Access and maintenance of Personal Protective Equipment (PPE) continues</td>
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<td>o Patient compliance with national guidance and local guidance is ongoing</td>
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<tr>
<td>o Maintaining Diagnostics and Urgent Care services</td>
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<td>o Treating Phases 1 and 2 patients whilst maintaining critical functions</td>
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<td>o Surge management of Critical Care</td>
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<td>o Daily management and review of oxygen supplies and usage</td>
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<td>o National guidance and directives</td>
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<tr>
<td>This paper sets out an ongoing updated summary of the COVID-19 actions. The ongoing challenge, and our response to such as a Trust.</td>
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<tr>
<td>Recommendations</td>
<td>It is recommended that the Board of Directors note the report.</td>
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<td>Appendices</td>
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</table>
1.0 **COVID-19 Response**

1.1 This paper covers key operational indicators, during the pandemic and shows an overview of our position, headline progress and actions being taken to address areas of risk and concern as required.

1.2 Healthcare in the UK is operating in a second wave of the COVID-19 pandemic and the Trust is managing patient flow and demand within significant staffing and capacity concerns.

1.3 The trust has produced a Phase 3 recovery plan which has been in operation since August and has appointed Mr J Garner as Recovery Director to support the recovery plan. The plan is being monitored by the Director of Strategy and Performance. The recovery has stalled during October and this is linked to higher numbers of positive COVID-19 patients, an increase in emergency care and staffing shortages due to COVID-19.

1.4 We saw recovery above plan in August and early September. The increase in COVID-19 patients circa 30% of our available bed capacity and staff availability has decreased our general and acute capacity. We have created 5 COVID-19 positive wards and have plans to create further COVID-19 wards if demand continues to increase. This has put an end to our general patient recovery plan and reduced our out-patient and day case activity with only complex urgent and cancer patients being brought in.

1.5 Latest guidance on full PPE is being adhered to and we are not seeing significant shortages of PPE across any areas. Staff are utilising full PPE as required which is also affecting efficiency and the ability to maintain capacity in diagnostics and outpatient areas.

1.6 We have closed our ring-fenced orthopaedic ward and this has become a general ward for non COVID-19 patients. The other surgical ward is being used to support medical COVID-19 patients with the orthopaedic trauma ward supporting all surgical emergency admissions. Gynaecology electives have been cancelled and we are using the ward to support medical and surgical patients.

1.7 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 team has escalated into Ward A3 at times when demand has exceeded the available capacity and we are actively engaged in daily network discussions regarding supporting South Yorkshire Critical Care capacity. The team has an agreed short term escalation plan which entails the use of theatres and Ward A3 and will flex as required. The key area of concern is staffing across critical care and theatres, which has reduced our ability to flex at times.

1.8 The number of COVID-19 positive patients has exceeded 35% of our general bed base and is making normal flow very difficult during the last 2 weeks we have had to cancel all urgent and cancer surgery at times due to no critical care capacity and utilising theatre staff to support critical areas.

George Briggs  
Chief Operating Officer  
November 2020
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<td>Report</td>
<td>Integrated Performance Report</td>
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<tr>
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<td>Michael Wright, Deputy Chief Executive</td>
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<td>B1, B2, B10</td>
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<tr>
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<tr>
<td>Executive Summary (including reason for the report, background, key issues and risks)</td>
<td>This Integrated Performance Report (IPR) for October 2020 brings together the key monthly data for the organisation, across the domains of Quality, Operational Performance, Workforce and Finance. Dashboards are included for each of these areas, alongside Statistical Process Control (SPC) charts, and summary commentary. There are 4 escalation reports provided for the metrics which are currently the most concerning. Each of the Board Committees have received Integrated Performance Reports for their areas of focus, in order to be sighted on the issues identified in this report in advance of the Board meeting.</td>
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<tr>
<td>Recommendations</td>
<td>The Board is asked to note the contents of the report.</td>
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<td>Appendices</td>
<td>Integrated Performance Report – October 2020</td>
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Integrated Performance Report - October 2020

Provided by

Business Engagement Team, Health Informatics
## Integrated Performance Report

### PERFORMANCE SUMMARY

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<td>Maternity</td>
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<td>Community Care</td>
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### CQC DOMAINS

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Operational Delivery

Urgent & Emergency Care:
- Attendances in October dropped steadily throughout the month, averaging approximately 22% below 2019 volumes across the month, although the increasing acuity of patients arriving at the front door and within the hospital led to challenges in consistently delivering the key access metrics. Site pressures increased given the growth in Covid-19 positive patients, requiring a significant number of ward changes through the month, and the utilisation of the newly-created additional critical care capacity on B6. There were increased numbers of super-stranded patients across the month (21 day+ length of stay) and the capacity constraints meant flow was challenged, with an increase in ambulance handover delays over 60 minutes as a result. The number of patients waiting 12 hours in the department increased to 41, although this was still a 71% reduction on the equivalent figures in 2019.

Elective Care:
- The size of the waiting list grew further in October, with elective activity having to be pulled back in the second half of the month to manage the non-elective Covid-19 demand. However, the growth was within patients waiting under 18 weeks, with patients waiting over 18 weeks falling by over 560 in-month, representing over 10% of this cohort. In addition, the number of overdue follow-ups increased significantly again in-month, with our Patient Initiated Follow-Ups work moving forward at pace, particularly within our most challenged services - Sleep Studies and Ophthalmology.
- Whilst the number of patients waiting with a decision to admit fell slightly in month, and the reported RTT percentage improved, there are 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 plans need revising based on the reduced availability of theatres, and this work is underway, led by the Director of Recovery and Director of Strategy, Planning and Performance. The new national independent sector framework is due to be published in late November, at which point the Trust will work with the system to define our requirements in Q4 2020/21, when the new contract will go live.

Cancer:
- The size of the Cancer Patient Tracking List (PTL) remained relatively flat during October, in part driven by sickness in the Cancer Services Team, as well as increased volumes of referrals, particularly within Breast Cancer (October was Breast Cancer Awareness month).
- 62-day performance was well below the national standard again, with 22.5 breaches in the month (of which 6 were in Breast, 5.5 in Lower GI and 4 in Urological cancers). 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 offered an external review of our Colorectal Cancer Pathway by the Cancer Alliance, which will begin in November.

Outpatient care:
- The DNA rate has continued to rise, and it is thought that this may be linked to the poor performance around clinic outcomes, which may mean patients are being automatically recorded as a DNA on Meditech after 90 days, where an outcome has not been recorded. A full review of the particularly challenged specialties is underway, so that an improvement action plan can be quickly developed to ensure appropriate management of patients.

Quality Summary

Mortality:
The HSMR rose again in the July data, with the Trust continuing to outlie in a key number of diagnosis groups. 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. Respiratory disease groups, including Pneumonia, COPD and Other Lower Respiratory disease, continue to be outlying areas. The Community Acquired Pneumonia care bundle is now live, with one of the key risk stratification tools within this framework - CURB65 - built into Meditech for use by clinicians. Fortnightly Insight and Analysis sessions have been setup with Dr Foster to ensure thorough interrogation of the mortality data on a regular basis, with a specific focus on activity recording and coding benchmarking.

Infection Prevention & Control:
- There were four clostridium-difficile infections in the month which takes the year-to-date number to 12. A target trajectory has not been received from NHSEI; however, the year-to-date figure compare similarly to local peers.

Patient Safety:
- There were 11 potential incidents of severe harm or death reported internally in October, of which 6 related to severe harm and 5 to death. Given the significant increase of reporting internally, further scrutiny of the increase has been applied at the Executive Team Meeting. As per the standard Trust process, all moderate and more severe incidents are discussed weekly at Harm Free Care and where necessary given further scrutiny at the weekly Serious Incident panel. As a consequence, 5 of these incidents were deemed to meet the criteria for a Serious Incident and have therefore been reported externally on STEIS and in reporting papers to CGC, QC and Board of Directors. The reasons for the incidents were wide-ranging but included possible delays or failure to monitor patients adequately, communication failures and failure of a device or equipment. A review of the incidents does not demonstrate any one specific reason for the increase.

Maternity:
The number of emergency Caesarean sections rose by 1 in month, and this took performance to worse than the expected target. The Trust experienced a similar increase in wave 1 of the pandemic, where clinicians are potentially having to make slightly earlier decisions given the time required to don and doff for such procedures. Unfortunately there was 1 stillbirth in the month, of a baby born at 26 weeks. Given the relatively low numbers of births each month, this took the Trust above the target percentage. This picture is similarly being seen both regionally and nationally, and TRFT is not an outlier in this area.
Trust Integrated Performance Dashboard - Commentary

### Workforce Summary

**Recruitment:**
The number of new starters has decreased (45.25 WTE) compared to the previous month (67.96 WTE), however this is an increase of 19.41 WTE, compared to October 2019. Nursing & Midwifery staff are the group with the highest number of new starters with 18 (16.24 WTE).

**Retention:**
The month of October 2020 saw a decrease in leavers (33.93 WTE) compared to previous month, although this was an increase of 6.91 WTE compared to October 2019. Further analysis shows of the 27 leavers who left voluntarily in October 2020, 10 (7.70 WTE) had the leaving reason of 'Relocation' (5.33 WTE). 56% (15, 11.73 WTE) had less than 5 years service at the date of termination, with 6 of these staff being within Nursing & Midwifery (of whom 3 stated 'Work Life Balance' as their reason for leaving).

**Sickness:**
12 month rolling sickness absence for October 2020 was 4.28% and represents a 0.07% improvement from the previous month (4.35%). Compared with October 2019, the 12-month rolling sickness absence rate has improved by 0.43%. Short term and long term absence have both increased by 0.18% compared to previous month. There has been an increase in Short Term absence cases in October 2020 (389) compared to previous month (372). However, Long Term absence cases have decreased in October 2020 (30) compared to previous month (34). The Trust sickness rate including COVID-19 is 5.54% October 2020, an increase of 1.06% compared to previous month. In late October, we had just under 190 staff who were reported as off sick for COVID-19 related reasons. The impact of Test & Trace activity within staff cohorts during this second wave has been significant, and has led to a number of staff needing to self-isolate due to close contact. Staff are receiving frequent reminders of the need to ensure we all abide by the necessary social distancing and PPE guidelines to minimise these instances.

**Mandatory and Statutory Training (MAST):**
MAST compliance remains above target at 92%, with only three services out of 32 not meeting the 85% standard. In addition, Medical & Dental Core MAST compliance remains at 91% compared to previous month and remains above Trust target by 6%.

**Personal Development Reviews:**
Overall Personal Development Review (PDR) rolling 12 month compliance rate for the organisation is 76%, an increase of 7 percentage points on September. The rolling 12 month PDR rate has decreased by 13% compared to October 2019. The UECC Division has the highest rolling 12 month PDR compliance rate at 89%. The Trust continues to encourage colleagues to ensure PDR information is entered into ESR as soon as possible after PDR discussions take place. Given the second wave of COVID-19, there is less opportunity currently to ensure clinical staff can be released from duties where PDRs have not yet taken place. This will become a priority when the position stabilises on site.

### Finance Summary

**I&E Position:**
The latest position ending 31st October 2020 shows a £165K surplus to plan in month and £145K year to date. The forecast out-turn results for the full financial year show a deficit to plan of £20K which, after adjusting for donated assets, will result in £7,673K which was presented to, and approved by the Board of Directors at its meeting held on 3rd November 2020. The plan has previously been submitted via the South Yorkshire & Bassetlaw Integrated Care System to NHSE/I on 22nd October 2020, but as yet no formal feedback has been received and hence, it is unclear whether the plan will be accepted.

**Capital Expenditure:**
The latest forecast out-turn position as at 31st March 2021 is showing a gross overspend of £8,017K after bringing the anticipated costs of the Carbon and Energy Fund scheme (£9,513K) into account which is due to complete in the final quarter of the financial year. The Trust has been informed that this forecast over-spend can be absorbed by SYB ICS through slippage from other providers, but this will then need to be reinstated to those providers in due course during the next or subsequent financial years, thereby reducing the overall capital spending power of the Trust in those years.

**Cash position:**
Significant closing cash balance as at 31st October of £25,492K which results mainly from the current payment arrangements which have one month’s payment in advance from commissioners. 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.
### 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 (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>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mortality</strong></td>
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<tr>
<td>M1 Mortality index - SHMI</td>
<td>May-20</td>
<td>B</td>
<td>100</td>
<td>119.4</td>
<td>120.0</td>
<td>120.2</td>
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<td>120.9</td>
<td>113.8</td>
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<tr>
<td>M2 Mortality index - HSMR (Rolling 12 months)</td>
<td>Jul-20</td>
<td>B</td>
<td>100</td>
<td>118.6</td>
<td>121.3</td>
<td>121.7</td>
<td>122.6</td>
<td>121.3</td>
<td>113.0</td>
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<tr>
<td>M3 Number of deaths (crude mortality)</td>
<td>Oct-20</td>
<td>-</td>
<td>-</td>
<td>70</td>
<td>61</td>
<td>63</td>
<td>93</td>
<td>663</td>
<td>89</td>
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<tr>
<td><strong>Infection, Prevention and Control</strong></td>
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<tr>
<td>In1 Clostridium-difficile Infections</td>
<td>Oct-20</td>
<td>L</td>
<td>TBC - not yet received</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>12</td>
<td>1</td>
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<tr>
<td>In2 MRSA Infections (Methicillin-resistant Staphylococcus Aureus)</td>
<td>Oct-20</td>
<td>L</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>In3 In-Hospital Mortality - Infectious Diseases</td>
<td>Jul-20</td>
<td>CQC</td>
<td>100</td>
<td>250.4</td>
<td>298.3</td>
<td>170.9</td>
<td>121.8</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>Oct-20</td>
<td>L</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>11</td>
<td>26</td>
<td>3</td>
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<tr>
<td>PS2 Never Events</td>
<td>Oct-20</td>
<td>L</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
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<td>3</td>
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<tr>
<td>PS3 Number of Patient Harms</td>
<td>Oct-20</td>
<td>-</td>
<td>-</td>
<td>489</td>
<td>548</td>
<td>476</td>
<td>550</td>
<td>3188</td>
<td>588</td>
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<tr>
<td>PS4 Readmission Rates</td>
<td>Q2 20/21</td>
<td>B</td>
<td>9.04%</td>
<td>12.9%</td>
<td>88.7%</td>
<td>85.6%</td>
<td>85.9%</td>
<td>85.9%</td>
<td>9.6%</td>
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<tr>
<td>PS5 Venous Thromboembolism (VTE) Risk Assessment</td>
<td>Aug-20</td>
<td>N</td>
<td>95%</td>
<td>82.6%</td>
<td>88.7%</td>
<td>85.6%</td>
<td>88.8%</td>
<td>84.5%</td>
<td>79%</td>
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<tr>
<td>PS6 Number of complaints per 10,000 patient contacts</td>
<td>Oct-20</td>
<td>L</td>
<td>8</td>
<td>10.2</td>
<td>9.2</td>
<td>10.2</td>
<td>8.7</td>
<td>7.4</td>
<td>7.9</td>
<td></td>
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</tr>
<tr>
<td>PS7 Proportion of complaints closed within 30 days</td>
<td>Oct-20</td>
<td>L</td>
<td>100%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>84.9%</td>
<td>46.2%</td>
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<tr>
<td>PS8 Care Hours per Patient Day</td>
<td>Oct-20</td>
<td>B</td>
<td>7.3</td>
<td>7.1</td>
<td>8.5</td>
<td>7.9</td>
<td>7.5</td>
<td>7.5</td>
<td>7.3</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>Oct-20</td>
<td>N</td>
<td>90%</td>
<td>94.0%</td>
<td>93.7%</td>
<td>90.3%</td>
<td>93.0%</td>
<td>93.0%</td>
<td>93.9%</td>
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<tr>
<td>Ma2 % of emergency Caesarean-sections</td>
<td>Oct-20</td>
<td>L</td>
<td>16.5%</td>
<td>20.5%</td>
<td>13.2%</td>
<td>15.9%</td>
<td>17.6%</td>
<td>17.1%</td>
<td>9.7%</td>
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<tr>
<td>Ma3 Breast Feeding Initiation Rate</td>
<td>Oct-20</td>
<td>N</td>
<td>66%</td>
<td>71.2%</td>
<td>63.9%</td>
<td>62.1%</td>
<td>66.3%</td>
<td>67.5%</td>
<td>64.3%</td>
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<tr>
<td>Ma4 Stillbirths per 1000 live births</td>
<td>Oct-20</td>
<td>L</td>
<td>4.46</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4.8</td>
<td>4.1</td>
<td>4.4</td>
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<td></td>
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<tr>
<td>Ma5 1:1 care in labour</td>
<td>Oct-20</td>
<td>-</td>
<td>75%</td>
<td>91.0%</td>
<td>93.8%</td>
<td>93.3%</td>
<td>93.7%</td>
<td>86.3%</td>
<td>78.4%</td>
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<td>KPI</td>
<td>Reporting Period</td>
<td>Type of Standard</td>
<td>Target</td>
<td>Previous Month (1)</td>
<td>Previous Month (2)</td>
<td>Previous Month (3)</td>
<td>Current Month</td>
<td>YTD 20/21</td>
<td>Same Month Prev. Yr</td>
<td>Forecast - Year End</td>
<td>Trend</td>
<td>Data Quality</td>
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<tr>
<td><strong>Planned Patient Care</strong></td>
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<tr>
<td>P1 Waiting List Size</td>
<td>Oct-20</td>
<td>L</td>
<td>13,700</td>
<td>13,381</td>
<td>13,439</td>
<td>14,634</td>
<td>15,085</td>
<td>15,085</td>
<td>15,444</td>
<td>14,594</td>
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<tr>
<td>P1A Number of RTT Patients with a Decision to Admit</td>
<td>Oct-20</td>
<td>-</td>
<td>-</td>
<td>4,111</td>
<td>3,998</td>
<td>3,870</td>
<td>3,821</td>
<td>3,821</td>
<td>1,661</td>
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<tr>
<td>P2 Referral to Treatment (RTT) Performance</td>
<td>Oct-20</td>
<td>N</td>
<td>92%</td>
<td>46.8%</td>
<td>53.3%</td>
<td>61.5%</td>
<td>66.4%</td>
<td>60.8%</td>
<td>92.0%</td>
<td>75%</td>
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<tr>
<td>P3 Overdue Follow-Ups</td>
<td>Oct-20</td>
<td>L</td>
<td>6,658</td>
<td>8,238</td>
<td>9,078</td>
<td>10,518</td>
<td>11,416</td>
<td>11,416</td>
<td>9,719</td>
<td>6,325</td>
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<tr>
<td>P4 First to follow-up ratio</td>
<td>Oct-20</td>
<td>B</td>
<td>2.5</td>
<td>3.0</td>
<td>3.7</td>
<td>3.6</td>
<td>3.3</td>
<td>3.2</td>
<td>2.6</td>
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<tr>
<td>P5 Day case rate (%)</td>
<td>Oct-20</td>
<td>B</td>
<td>80%</td>
<td>89.4%</td>
<td>85.7%</td>
<td>84.6%</td>
<td>85.6%</td>
<td>85.0%</td>
<td>77.9%</td>
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<tr>
<td>P6 Diagnostic Waiting Times (DM01)</td>
<td>Oct-20</td>
<td>N</td>
<td>1%</td>
<td>49.0%</td>
<td>47.5%</td>
<td>39.6%</td>
<td>41.6%</td>
<td>53.8%</td>
<td>0.0%</td>
<td>1%</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>Oct-20</td>
<td>CQC</td>
<td>0</td>
<td>0</td>
<td>8</td>
<td>7</td>
<td>32</td>
<td>54</td>
<td>59</td>
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<tr>
<td>E2 Number of 12 hour trolley waits</td>
<td>Oct-20</td>
<td>N</td>
<td>0</td>
<td>0</td>
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<td>0</td>
<td>0</td>
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<tr>
<td>E3 Conversion rate from A&amp;E (not including Observations)</td>
<td>Oct-20</td>
<td>-</td>
<td>-</td>
<td>24.6%</td>
<td>24.7%</td>
<td>25.8%</td>
<td>27.1%</td>
<td>26%</td>
<td>19%</td>
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<td>E4 Proportion of same day emergency care</td>
<td>Oct-20</td>
<td>L</td>
<td>33%</td>
<td>44.1%</td>
<td>39.8%</td>
<td>39.2%</td>
<td>36.7%</td>
<td>41.0%</td>
<td>29.4%</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>Sep-20</td>
<td>N</td>
<td>93%</td>
<td>96.2%</td>
<td>96.8%</td>
<td>84.8%</td>
<td>95.3%</td>
<td>90.7%</td>
<td>91.1%</td>
<td>93%</td>
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<td>Ca2 2 Week Wait Breast Symptoms</td>
<td>Sep-20</td>
<td>N</td>
<td>93%</td>
<td>92.9%</td>
<td>74.5%</td>
<td>76.5%</td>
<td>75.5%</td>
<td>80.5%</td>
<td>91.8%</td>
<td>90%</td>
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</tr>
<tr>
<td>Ca3 31 day First treatment</td>
<td>Sep-20</td>
<td>N</td>
<td>96%</td>
<td>98.3%</td>
<td>94.7%</td>
<td>89.9%</td>
<td>92.9%</td>
<td>98%</td>
<td>96.7%</td>
<td>100%</td>
<td></td>
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</tr>
<tr>
<td>Ca4 62 Day Performance</td>
<td>Sep-20</td>
<td>N</td>
<td>85%</td>
<td>64.6%</td>
<td>63.7%</td>
<td>58.0%</td>
<td>57.9%</td>
<td>66.7%</td>
<td>74.8%</td>
<td>80%</td>
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</tr>
<tr>
<td>Ca5 62 day Patient Tracking List Size</td>
<td>Oct-20</td>
<td>L</td>
<td>1,071</td>
<td>992</td>
<td>1052</td>
<td>1036</td>
<td>1015</td>
<td>1015</td>
<td>801</td>
<td>800</td>
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</tr>
<tr>
<td>Ca6 28 day faster diagnosis standard</td>
<td>Sep-20</td>
<td>N</td>
<td>75%</td>
<td>49.5%</td>
<td>48.9%</td>
<td>50.9%</td>
<td>48.6%</td>
<td>54.4%</td>
<td>74%</td>
<td>75%</td>
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<tr>
<td><strong>Inpatient Care</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>I1 Mean Length of Stay - Elective</td>
<td>Oct-20</td>
<td>-</td>
<td>-</td>
<td>0.3</td>
<td>0.4</td>
<td>0.4</td>
<td>0.4</td>
<td>0.4</td>
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<tr>
<td>I2 Mean Length of Stay - Non-Elective</td>
<td>Oct-20</td>
<td>-</td>
<td>-</td>
<td>4.7</td>
<td>4.4</td>
<td>4.6</td>
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<td>4.5</td>
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<tr>
<td>I3 Length of Stay &gt; 7 days (Proportion discharged)</td>
<td>Oct-20</td>
<td>L</td>
<td>21%</td>
<td>22.8%</td>
<td>22.1%</td>
<td>21.6%</td>
<td>23.6%</td>
<td>21.9%</td>
<td>21.9%</td>
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<tr>
<td>I4 Length of Stay &gt; 21 days (Proportion discharged)</td>
<td>Oct-20</td>
<td>L</td>
<td>3.5%</td>
<td>3.1%</td>
<td>2.1%</td>
<td>3.6%</td>
<td>4.1%</td>
<td>2.9%</td>
<td>3.6%</td>
<td></td>
<td></td>
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<tr>
<td>I5 Length of Stay &gt; 21 days (Snapshot Numbers)</td>
<td>Oct-20</td>
<td>L</td>
<td>20</td>
<td>20</td>
<td>25</td>
<td>36</td>
<td>35</td>
<td>35</td>
<td>40</td>
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<tr>
<td>I6 Right to Reside - % not recorded</td>
<td>Oct-20</td>
<td>-</td>
<td>-</td>
<td>34.7%</td>
<td>17.6%</td>
<td>25.2%</td>
<td>25.2%</td>
<td>-</td>
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<tr>
<td>I7 Discharges before midday</td>
<td>Oct-20</td>
<td>L</td>
<td>20%</td>
<td>14.1%</td>
<td>12.0%</td>
<td>13.1%</td>
<td>10.7%</td>
<td>12.2%</td>
<td>8.0%</td>
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<tr>
<td><strong>Outpatient Care</strong></td>
<td></td>
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</tr>
<tr>
<td>O1 Did Not Attend Rate (OutPatients)</td>
<td>Oct-20</td>
<td>B</td>
<td>8.0%</td>
<td>6.9%</td>
<td>8.2%</td>
<td>8.3%</td>
<td>8.6%</td>
<td>8.6%</td>
<td>9.1%</td>
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<tr>
<td>O2 Appointment Slot Issues</td>
<td>Sep-20</td>
<td>N</td>
<td>4%</td>
<td>65%</td>
<td>63%</td>
<td>88%</td>
<td>66%</td>
<td>66%</td>
<td>36%</td>
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<tr>
<td>O3 % of missing outcomes</td>
<td>Oct-20</td>
<td>L</td>
<td>20%</td>
<td>24.0%</td>
<td>25.1%</td>
<td>23.7%</td>
<td>23.0%</td>
<td>23.2%</td>
<td>19%</td>
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<tr>
<td><strong>Community Care</strong></td>
<td></td>
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<tr>
<td>CC1 MusculoSkeletal Physio &lt;4 weeks</td>
<td>Oct-20</td>
<td>L</td>
<td>80%</td>
<td>94%</td>
<td>78%</td>
<td>17%</td>
<td>20%</td>
<td>48%</td>
<td>37%</td>
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<tr>
<td>CC2 % urgent referrals contacted within 2 working days by specialist nurse (Continued)</td>
<td>Oct-20</td>
<td>L</td>
<td>95%</td>
<td>92%</td>
<td>87%</td>
<td>83%</td>
<td>90%</td>
<td>84%</td>
<td>84%</td>
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<tr>
<td>CC3 A&amp;E attendances from Care Homes</td>
<td>Oct-20</td>
<td>L</td>
<td>153</td>
<td>107</td>
<td>97</td>
<td>106</td>
<td>135</td>
<td>718</td>
<td>145</td>
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<tr>
<td>CC4 Admissions from Care Homes</td>
<td>Oct-20</td>
<td>L</td>
<td>72</td>
<td>81</td>
<td>74</td>
<td>74</td>
<td>70</td>
<td>514</td>
<td>76</td>
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<tr>
<td>CC6 Patients assessed within 5 working days from referral (Diabetes)</td>
<td>Oct-20</td>
<td>L</td>
<td>95%</td>
<td>98%</td>
<td>98%</td>
<td>99%</td>
<td>98%</td>
<td>94%</td>
<td>100%</td>
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### Trust Integrated Performance Dashboard - Finance

<table>
<thead>
<tr>
<th></th>
<th>In Month Plan £000s</th>
<th>In Month Actual £000s</th>
<th>YTD Plan £000s</th>
<th>YTD Actual £000s</th>
<th>YTD Variance £000s</th>
<th>Forecast Variance £000s</th>
<th>Prior Month Forecast Variance £000s</th>
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<tbody>
<tr>
<td>I&amp;E Performance (Actual)</td>
<td>(683)</td>
<td>(518)</td>
<td>(683)</td>
<td>(538)</td>
<td>145</td>
<td>(20)</td>
<td>0</td>
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<tr>
<td>I&amp;E Performance (Control Total)</td>
<td>(683)</td>
<td>(515)</td>
<td>(683)</td>
<td>(515)</td>
<td>169</td>
<td>21</td>
<td>0</td>
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<tr>
<td>Agency Spend</td>
<td>683</td>
<td>866</td>
<td>4,780</td>
<td>6,040</td>
<td>(1,260)</td>
<td>(1,594)</td>
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<tr>
<td>Efficiency Programme (CIP)</td>
<td>256</td>
<td>0</td>
<td>336</td>
<td>0</td>
<td>(336)</td>
<td>(415)</td>
<td>0</td>
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<tr>
<td>Capital Expenditure</td>
<td>1,720</td>
<td>945</td>
<td>9,192</td>
<td>8,418</td>
<td>774</td>
<td>(8,017)</td>
<td>0</td>
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<tr>
<td>Capital Expenditure (Excl. Covid-19)</td>
<td>1,720</td>
<td>944</td>
<td>9,192</td>
<td>7,114</td>
<td>2,078</td>
<td>(8,017)</td>
<td>0</td>
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<tr>
<td>Cash Balance</td>
<td>0</td>
<td>(2,756)</td>
<td>1,357</td>
<td>25,492</td>
<td>24,135</td>
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</tbody>
</table>

### Trust Integrated Performance Dashboard - Activity

#### UECC Attendances

![Graph showing UECC Attendances](#)

#### Inpatient Admissions (including Observations)

![Graph showing Inpatient Admissions](#)

#### Total Outpatients

![Graph showing Total Outpatients](#)

#### Inpatient Admissions (excluding Observations)

![Graph showing Inpatient Admissions](#)

#### Total Referrals (Acute)

![Graph showing Total Referrals](#)

#### 2ww Referrals

![Graph showing 2ww Referrals](#)
<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>Workforce</td>
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<tr>
<td>W1 Whole Time Equivalent against plan - Total</td>
<td>Oct-20</td>
<td>L</td>
<td>-204</td>
<td>-227</td>
<td>-250</td>
<td>-258</td>
<td>-245</td>
<td>-245</td>
<td>-265</td>
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<tr>
<td>W2 Whole Time Equivalent plan - Nursing</td>
<td>Oct-20</td>
<td>L</td>
<td>-97</td>
<td>-137</td>
<td>-144</td>
<td>-149</td>
<td>-123</td>
<td>-123</td>
<td>-138</td>
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<td></td>
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<tr>
<td>W3 Total Headcount</td>
<td>Oct-20</td>
<td>-</td>
<td>4,790</td>
<td>4,768</td>
<td>4,754</td>
<td>4,778</td>
<td>4,778</td>
<td>4,673</td>
<td>6,5%</td>
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<tr>
<td>W4 Vacancy Rate - TOTAL</td>
<td>Oct-20</td>
<td>B</td>
<td>4.9%</td>
<td>5.4%</td>
<td>6.0%</td>
<td>6.2%</td>
<td>5.9%</td>
<td>4.4%</td>
<td>6.5%</td>
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<tr>
<td>W5 Vacancy Rate - Nursing</td>
<td>Oct-20</td>
<td>B</td>
<td>7.6%</td>
<td>10.7%</td>
<td>11.3%</td>
<td>11.7%</td>
<td>9.6%</td>
<td>10.2%</td>
<td>10.9%</td>
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<tr>
<td>W6 Time to Recruit</td>
<td>Oct-20</td>
<td>L</td>
<td>34</td>
<td>48</td>
<td>39</td>
<td>41</td>
<td>34</td>
<td>34</td>
<td>38</td>
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<tr>
<td>W7 Sickness Rates (%) - exc COVID related</td>
<td>Oct-20</td>
<td>L</td>
<td>3.95%</td>
<td>3.3%</td>
<td>3.5%</td>
<td>4.0%</td>
<td>4.4%</td>
<td>3.7%</td>
<td>5.2%</td>
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</tr>
<tr>
<td>W8 Sickness Rates (%) - inc COVID related</td>
<td>Oct-20</td>
<td>-</td>
<td>4.6%</td>
<td>4.1%</td>
<td>4.5%</td>
<td>5.5%</td>
<td>5.4%</td>
<td>5.2%</td>
<td>5.2%</td>
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</tr>
<tr>
<td>W9 Turnover</td>
<td>Oct-20</td>
<td>L</td>
<td>0.63%</td>
<td>0.81%</td>
<td>0.72%</td>
<td>0.76%</td>
<td>0.54%</td>
<td>0.66%</td>
<td>0.5%</td>
<td>0.63%</td>
<td></td>
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</tr>
<tr>
<td>W10 Appraisals complete (%)</td>
<td>Oct-20</td>
<td>L</td>
<td>90%</td>
<td>56.2%</td>
<td>61.3%</td>
<td>69.5%</td>
<td>76.0%</td>
<td>76.0%</td>
<td>89.4%</td>
<td>90%</td>
<td></td>
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</tr>
<tr>
<td>W11 MAST (% of staff up to date)</td>
<td>Oct-20</td>
<td>L</td>
<td>85%</td>
<td>92.1%</td>
<td>92.9%</td>
<td>92.4%</td>
<td>91.7%</td>
<td>91.7%</td>
<td>91.1%</td>
<td>90%</td>
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</table>
Covid-19 pandemic peaked in Rotherham in April, leading to higher numbers of deaths than otherwise expected.
The readmissions metric is now reported quarterly, via the Model Hospital benchmarking tool. A replacement metric for this SPC chart will be identified for the M8 IPR report.

Covid-19 pandemic has meant the closure of a number of beds and significantly lower bed occupancy figures, meaning nurse:patient ratios have improved.
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.
Covid-19 pandemic has introduced significant additional short-term (self-isolation) and long-term (shielding) sickness.

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

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

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

#### Performance:

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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>
<td>115.0</td>
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<td>116.8</td>
<td>114.0</td>
<td>116.9</td>
<td>116.1</td>
<td>118.6</td>
</tr>
<tr>
<td>2020/21</td>
<td>120.7</td>
<td>121.3</td>
<td>121.7</td>
<td>122.6</td>
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<td><strong>Target</strong></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, with estimates suggesting it could have an 8-12 point impact on our HSMR (full-year impact).
- **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.

#### 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. In addition, a Mortality Insights Task & Finish Group has been set up for the next 3 months, to ensure appropriate insight and intelligence is drawn from our latest data. Both will complement the Trust’s monthly Mortality Group meeting, being led by the Trust’s Medical Director.
- Inpatient Observation activity is now flowing to the activity submission as non-elective admitted activity. This will have a gradual impact from April data onwards given the time lag for receipt of data and the rolling 12-month nature of the metric.
- The Medical Examiner (ME) is reviewing all deaths with a Stage 1 review, and co-ordinating any Stage 2 reviews which are required. Furthermore, 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.
- The Community Acquired Pneumonia care bundle is now live, with one of the key risk stratification tools within this framework - CURB65 - built into Meditech for use by clinicians.

#### Expected Trajectory/forecast:
- The Improvement Plan target is for an HSMR of less than 110 by the time of the March data 2021. However, the impact of Covid-19 is likely to be significant and unpredictable, with the recent rebasing of the Dr Foster HSMR not appearing to have led to a noticeable shift in the figures for April and May. Fortnightly insight and analysis sessions have been established with Dr Foster, to better understand the impact of the change to recording and Covid-19.

---

**Lead Executive Director:**
Callum Gardner, Executive Medical Director

**Lead Senior Manager:**
Carrie Kelly, Medical Examiner

**Lead Analyst:**
Lisa Fox
### Escalation/Accruals

<table>
<thead>
<tr>
<th>Metric:</th>
<th>Type of Standard</th>
<th>Assurance Committee:</th>
<th>Report Period:</th>
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<tr>
<td>62 Day Performance</td>
<td>National Constitutional Standard</td>
<td>FPC</td>
<td>August 2020</td>
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#### Performance:

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<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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<tbody>
<tr>
<td>2019/20</td>
<td>85.00%</td>
<td>74.20%</td>
<td>77.20%</td>
<td>78.50%</td>
<td>77.30%</td>
<td>74.80%</td>
<td>73.83%</td>
<td>66.15%</td>
<td>84.25%</td>
<td>79.03%</td>
<td>71.15%</td>
<td>80.67%</td>
</tr>
<tr>
<td>2020/21</td>
<td>78.26%</td>
<td>60.78%</td>
<td>64.56%</td>
<td>63.73%</td>
<td>58.02%</td>
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</table>

**Target:** 62% 62% 62% 62% 62% 62% 62% 62% 62% 62% 62% 62%

#### Driver for Underperformance:

- **Diagnostic Activity:** At the start of the pandemic, there was a national dictat around reducing endoscopy activity to almost minimal levels, which meant a lot of cancer 2ww referrals were deferred for several weeks. The patients within this cohort who do have cancer are now breaching the 62 day standard.

- **Patient Choice:** Over the last 6 months we have had significant numbers of patients not wanting to attend hospital for appointments, particularly for diagnostics, despite them being on a cancer pathway. Some of these patients are now being found to have cancer, at a point when they have breached the 62-day standard.

- **Pathway management:** Historically, the Trust has struggled to deliver an effective 62-day pathway within Urology, and this remains a challenge. Considerable work has gone on to identify areas of improvement, as noted.

- **Patient Illness:** 16% of our patients who have not yet received treatment for Cancer but have been waiting over 62 days, are currently unfit for treatment (e.g. recent heart attack). We are seeing a higher number of patients with pathways extended due to Covid-19 issues (e.g., self-isolating for 2 weeks/COVID-19+ so cannot receive endoscopy for 6 weeks afterwards). If these patients do have cancer, when they receive their treatment they will breach the 62-day standard.

#### Actions to Deliver Improvement:

- **Urology Pathway Improvement:** An improvement project is underway within Urology to identify the necessary changes to the pathway. The Clinical Lead has agreed to implement a straight-to-test model which should significantly improve the efficiency at the front end of the pathway, with further discussions on the back-end of the pathway ongoing. Urology breaches can account for 40-50% of all breaches across all tumour groups, so improvement in this area will have a significant impact.

- **Lower GI Pathway Development:** We have been successful in our bid for £204k of funding from the Cancer Alliance to support clinical and operational leadership capacity to deliver an improved Lower GI pathway, in line with Rapid Diagnostic principles. We have also been offered the opportunity to work with an external company to review our pathway as part of this, and ensure opportunities for improvement are identified and implemented.

- **Endoscopy activity:** Endoscopy activity has been increasing over the last few weeks, with a series of Sunday lists now planned until January, in order to ensure the backlog can be reduced and straight-to-test activity for appropriate Lower and Upper GI referrals can be re-instated.

- **Primary Care Involvement:** Where patients have not wanted to attend hospital for critical appointments, we have involved their primary care doctors where appropriate, as GPs often have a long-standing relationship with patients.

#### Escalation/Assurance

- **Metric:** 62 Day performance
- **Type of Standard:** National Constitutional Standard
- **Report Period:** August 2020

**Expected Trajectory/Forecast:**

- The 62 day standard has been a challenge for the Trust for some time. With the improvements to the Urology pathway and the increased activity within endoscopy, it is hoped that the Trust can bring performance back to 80% by the end of the year. We continue to aim for the 85% figure, but given the increasing Covid prevalence at the moment and related increasing levels of staff sickness, it is likely this will remain a significant challenge to deliver this year.

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

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

**Lead Analyst:**
Roberto Juan-Martin
Performance:

Covid restrictions and operational impact has led to difficulty in achieving the target by the August deadline. It is also clear that whilst some PDRs have been completed, the information has not been entered into the electronic system, meaning they are being recorded as not complete.

- There has been Executive Team agreement to focus on plans to complete within each of their respective functions.
- HRBPs continue to work with the Divisional leadership teams and their respective CSUs, highlighting the gaps and working with managers to support completion of all PDRs.
- Regular communications have been sent out across the organisation as reminder(s) and the Learning and Development team have adapted all the training courses/materials in order to continue to deliver the relevant training throughout the pandemic.
- PDR compliance rates have been discussed at every monthly Divisional performance meeting with the Executive Team and there has been assurance that plans are in place to achieve target as soon as possible. However, given the second wave of Covid, additional levels of sickness, self-isolation and shielding over the last few weeks have exacerbated some of the challenges. We are keen to balance the need to ensure completion of colleagues’ performance development reviews with the need for clinical staff to be focussed on the front line over the next several weeks.

Given the increasing levels of Covid in the Trust at present, HRBPs will focus on ensuring that all completed PDRs have been entered into the system so that we can ensure an accurate record is being presented. This work will continue through October and November. However, given the second wave that we are managing at present, we do not expect to achieve the standard until Q4 2020/21.

Driver for Underperformance:

Actions to Deliver Improvement:

Expected Trajectory/forecast:

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<th>Jun</th>
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### 2019/20

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### 2020/21

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**Target:**

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**Driver for Underperformance:**

- There were 11 potential incidents of severe harm or death reported internally in October, of which 6 related to severe harm and 5 to death. Given the significant increase of reporting internally, further scrutiny of the increase has been applied at the Executive Team Meeting. As per the standard Trust process, all moderate and more severe incidents are discussed weekly at Harm Free Care and where necessary given further scrutiny at the weekly Serious Incident panel. As a consequence, 5 of these incidents were deemed to meet the criteria for a Serious Incident and have therefore been reported externally on STEIS and in reporting papers to CGC, QC and Board of Directors. Some examples of specific actions taken include:

  - Full review of the outlier process within the Trust
  - The Trust has seconded a Sepsis lead nurse, whose focus will include improvement of the Trust Sepsis training.
  - Project underway to improve the recording of fluid balance, in collaboration with Meditech team
  - Staff reminded of correct processes for escalation and obtaining help.

**Actions to Deliver Improvement:**

- As per the standard Trust process, all moderate and more severe incidents are discussed weekly at Harm Free Care and where necessary given further scrutiny at the weekly Serious Incident panel. At a consequence, 5 of these incidents were deemed to meet the criteria for a Serious Incident and have therefore been reported externally on STEIS and in reporting papers to CGC, QC and Board of Directors. Some examples of specific actions taken include:

**Expected Trajectory/Forecast:**

- Review of these incidents does not suggest any one specific reason for the in-month increase. It is therefore expected to be a one-off increase, with reported incidents returning to normal from November.

---

**Lead Executive Director:**

Angela Wood, Chief Nurse

**Lead Senior Manager:**

Alison Walker, Head of Patient Safety

**Lead Analyst:**

Darren Burkitt
The below summary sets out the proposed methodology and colouring we will use at TRFT, noting the different trends that will be shown as special cause variation or out of control.

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

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

1) A single point outside the control limits

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

3) Six consecutive points increasing or decreasing

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

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

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

In addition, we will annotate any reasons for special cause variation which we are aware of.
### Board of Directors’ Meeting
1 December 2020

<table>
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<th>Agenda item</th>
<th>428/20</th>
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<tr>
<td>Report</td>
<td>European Union Transition Report</td>
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<tr>
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<td>George Briggs, Chief Operating Officer</td>
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<td>B1, B2</td>
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<th>To note</th>
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### Executive Summary (including reason for the report, background, key issues and risks)

The United Kingdom left the European Union (EU) at 23.00 on 31 January 2020. We are now in the official transition period a 11-month phase which finishes on 31 December 2020 and it cannot be extended beyond this period.

During transition most things have remained the same:

- Travelling to and from the EU
- Per passports
- Driving licences
- Freedom of movement
- The right to live and work in the EU
- UK EU trade no extra charges or checks.

When transition ends on 31 December, the UK will automatically drop out of the EU's main trading arrangements (the single market and the customs union). If a new UK-EU trade deal is not agreed in time then tariffs and border checks would be applied to UK goods travelling to the EU. The UK also decides what tariffs and checks to impose on EU goods.

Full border checks could cause long delays at airports and ports.

Failure to reach a deal would also result in the UK service industry losing its guaranteed access to the EU. Even if a trade deal is reached, it would not eliminate all checks - so the UK and the NHS will need to prepare.

During the period to support this, the EU Exit Team, led by Professor Keith Willett, EU Exit Strategic Commander Medical Director for Acute Care and Emergency preparedness, has continued in shadow form ramping up during the last quarter of the year.

The Team has been holding a series of webinar briefings and a number of non-face to face briefings. The Rotherham NHS Foundation Trust (TRFT) has created an EU working party and has been represented at all of these briefings, and the focus has been:

- The NHS role will be non-political, focussed on co-ordinating the best possible operational response for patients and the public
- National procurement of alternative routes and express freight channels has occurred – two separate procurements from Department for Transport and Department of Health and Social Care
- Engagement with key suppliers maintained nationally; greater autonomy
- Continuity of supply – much more supplier routing information, smarter call-off procurements framework, tight schedules
- Winter pressures – workforce capacity; Urgent and Emergency Care demand; adverse weather; seasonal flu and changes to supply requirements increased freight capacity
- COVID-19 preparedness
- Awareness of system risks in supply of non-clinical goods and services – data audit; system risks; Estates and Facilities
- Further updates of Government planning assumption

**Rotherham Place**

We are members of a fortnightly EU Planning Group, Chaired by Jackie Mould, Head of Service, Performance, Intelligence & Improvement. Other members include:

- Rotherham Metropolitan Borough Council Heads of Service
- Rotherham Chamber of Commerce
- Police
- Voluntary Action Rotherham (VAR) and Other Voluntary Groups
- Clinical Commissioning Group
- Rotherham and Doncaster, South Humber NHS Foundation Trust
- The Rotherham NHS Foundation Trust

Our Critical Incident Room is now in place and responding to all EU sitrep requests and information sharing

**Recommendations**

It is recommended that the Board of Directors note the information.

**Appendices**

None
## Agenda item
430/20

## Report
**Governance Report**

## Executive Lead
Jill Dentith, Corporate Governance Consultant

## Link with the BAF
B8

## Purpose

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### Executive Summary
**(including reason for the report, background, key issues and risks)**
- BAME inequalities inquiry in health and social care
- NHS England returns to highest level of alert
- Hospital Food Standards to be inspected by the Care Quality Commission
- COVID-19 – Key legal considerations arising from the pandemic
- How many terms should Foundation Trust Governors serve?
- Preparations for EU Exit
- Patients no longer need to sign prescriptions in measure to reduce spread of COVID-19
- CQC to review use of DNACPR during pandemic
- NHSX Information Governance portal

## Recommendations
This report is provided to the Board for information

## Appendices
None
1.0 Introduction

1.1 This report provides an update on governance matters since the last Board meeting on 3 November 2020.

2.0 BAME inequalities inquiry in health and social care

2.1 The Equality and Human Rights Commission has launched an inquiry into the inequalities experienced by those employed in the health and social care sector with a Black, Asian and minority ethnic heritage. The inquiry intends to consider the structural issues that mean that people from these backgrounds are at greater risk across England, Scotland and Wales. More information is available here: https://www.equalityhumanrights.com/en/our-work/news/equality-body-scrutinise-racial-inequality-workers-health-and-social-care

3.0 NHS England returns to highest level of alert


4.0 Hospital Food Standards to be inspected by the Care Quality Commission

4.1 The report from the NHS Food Review, commissioned by the government in the wake of the deaths of seven hospital patients after they ate sandwiches contaminated with Listeria monocytogenes in 2019, has recommended that that food standards for hospitals should become enshrined in statute and compliance with them monitored by the CQC.


5.0 COVID-19 – Key legal considerations arising from the pandemic

5.1 NHS Providers and Hempsons solicitors have created a briefing document focussing on the legal liabilities which could arise as a result of the pandemic and suggesting ways in which Boards could look to respond. It covers areas such as clinical negligence, employment and workforce, governance and Board liability and health and safety and is available here: https://nhsproviders.org/media/690301/nhs-providers-and-hempsons-brochure.pdf

6.0 How many terms should Foundation Trust Governors serve?

6.1 In answer to this commonly posed question, NHS Providers have produced an analysis of the key statutory duties of Governors which benefit from a ‘fresh pair of eyes’ and independence of thought. The publication advises that good governance practice for Foundation Trusts includes limiting the number of consecutive terms which may be served by a Governor to a maximum of three and seeking to refresh their Council of Governors periodically.
6.2 In addition, it is suggested that should a Governor wish to return after a period of absence there should ideally be a gap of at least three years before they do so. The analysis is available here: https://nhsproviders.org/media/690452/how-many-terms-should-foundation-trust-governors-serve.pdf

7.0 Preparations for EU Exit

7.1 On 4 November 2020 Professor Keith Willett, Strategic Incident Director for EU Exit at NHS England / Improvement, wrote to all Trust Chief Executives to ask that they begin to prepare for the end of the transition period on 31 December 2020. The letter also stated that guidance on the mitigations that should be put in place by NHS organisations would be published during November. The letter is available here: https://www.england.nhs.uk/wp-content/uploads/2020/11/BE279-eu-exits-sytem-stand-up-letter.pdf

7.2 An update on the Trust’s preparations for EU exit will also be provided by the Chief Operating Officer to the public session of the Board of Directors’ December 2020.

8.0 Patients no longer need to sign prescriptions in measure to reduce spread of COVID-19

8.1 The Secretary of State for Health and Social Care has temporarily approved that until end March 2021 the requirement for patients to sign prescriptions, dental and ophthalmic forms is removed. This decision has been taken to try to prevent the spread of COVID-19.

9.0 CQC to review use of DNACPR during pandemic

9.1 As a result of concerns reported earlier in 2020, the CQC has been asked by the Department of Health and Social Care to look at the use of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders during the COVID-19 pandemic. Whilst the scope of the review is currently being agreed, it is likely that it will include care homes, primary care and hospitals. The final report is expected in early 2021 although interim findings are likely to be published in late 2020. Further information is available here: https://www.cqc.org.uk/news/stories/cqc-review-use-dnacpr-during-pandemic

10.0 NHSX Information Governance portal

10.1 NHSX has launched an Information Governance portal which brings together clear and consistent guidance and advice for all NHS colleagues to access. The aim of the portal is to facilitate NHS staff to share information securely in order to provide high quality care. The portal is available here: https://www.nhsx.nhs.uk/information-governance/

11.0 Consultations

11.1 Public Health England is seeking feedback on the way in which the UK National Screening Committee involves patients and stakeholder in its work. The consultation closes on Sunday 13 December 2020 and can be accessed here: https://forms.office.com/Pages/ResponsePage.aspx?id=mRRO7jVKLkutR188-d6GZgL_DULZuYNAj6UDFO5VpGxUNE83R09OTTk3NDZLSTk5N0MyQ0lWOEE3Ti4u

Lisa Reid, Head of Governance, November 2020
**Board of Directors’ Meeting**  
1 December 2020

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<td>Report</td>
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**Executive Summary** (including reason for the report, background, key issues and risks)

The date of assurance committees in January 2021 are as follows:
People Committee: 22 January  
Finance & Performance Committee: 27 January  
Quality Committee: 27 January  

The date of future Board and assurance committee meetings are currently being reviewed and will be presented to the February 2020 Board meeting.

In the months in which the Board Assurance Framework is received the Audit Committee meeting must come after the other Board Assurance Committees to meet the requirements of the Trust’s Internal Auditors relating to good corporate governance. The Internal Auditors monitor whether or not this requirement is achieved as part of their Head of Internal Audit Opinion.

Following consultation with the Board Chairman and the Chairman of the Audit Committee it is proposed that the date of the Audit Committee in January 2021 is changed to Friday 29 January 2021. The proposed change will facilitate review of the relevant sections of the Board Assurance Framework (BAF) by each assurance committee of the Board, followed by a review of the full BAF by Audit Committee prior to the document being presented to the February 2021 Board.

**Recommendations**
The Board of Directors is recommended to:  
- Agree that the Audit Committee is held on Friday 29 January 2021

**Appendices**
There are no appendices to this paper