The Rotherham NHS Foundation Trust

Board of Directors
Public AGENDA

Date: **Friday 07 January 2022**
Time: **0900hrs – 1130hrs**

The Trust's Constitution states that:

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

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

However, should members of the public have any questions relating to the items on the agenda, please forward these to dawn.stewart4@nhs.net by 1pm on Thursday 06 January 2022

Time	Item no.			Page	Required Actions	Lead
		Procedural Items				
0900	*P01/22*	*Chairman's welcome and apologies for absence*	*Verbal*	*-*	*For information*	*Martin Havenhand, Chairman*
	P02/22	*Quoracy Check*	*Verbal*	*-*	*For assurance*	*Martin Havenhand, Chairman*
	P03/22	*Declaration of conflicts of interest*	*Verbal*	*-*	*For assurance*	*Martin Havenhand, Chairman*
	P04/22	*Minutes of the previous meeting held on 05 November 2021*	*Enc.*	*4*	*For decision*	*Martin Havenhand, Chairman*
	P05/22	*Matters arising from the previous minutes (not covered elsewhere on the agenda)*	*Verbal*	*-*	*For assurance*	*Martin Havenhand, Chairman*
	P06/22	*Action Log*	*Enc.*	*20*	*For assurance*	*Martin Havenhand, Chairman*
		Overview and Context				
0910	*P07/22*	***Staff** Story*	*Pres*	*-*	*For information*	*Steve Ned, Director of Workforce*
0920	*P08/22*	*Report from the Chairman*	*Enc.*	*22*	*For information*	*Martin Havenhand, Chairman*
0925	*P09/22*	*Report from the Interim Chief Executive*	*Enc.*	*28*	*For information*	*Dr Richard Jenkins, Interim Chief Executive*
		Strategy				
0930	*P10/22*	*Operational Objectives 2021/22 Review*	*Enc*	*47*	*For assurance*	*Michael Wright, Deputy Chief Executive*
0940	*P11/22*	*Council of Governors Approved Membership and Engagement Strategy*	*Enc.*	*69*	*For decision*	*Angela Wendzicha, Director of Corporate Affairs*

0945	*P12/22*	*National, Integrated Care System and Integrated Care Partnership Report*	*Enc.*	*81*	*For assurance*	*Michael Wright, Deputy Chief Executive*
		Assurance				
0950	*P13/22*	*Board Committees Chairs Assurance Logs* *i. Finance and Performance Committee (24/11/21 & 22/12/21)* *ii. Quality Committee (24/11/21 & 22/12/21)* *iii. People Committee (19/11/21 & 17/12/21)* *iv. Audit Committee (30/12/21)*	*Enc.*	*85 & 90* *95 & 99* *103*	*For assurance*	*Committee Chairs and Lead Executives*
1000	*P14/22*	*Care Quality Commission Report*	*Enc.*	*108*	*For assurance*	*Helen Dobson, Interim Chief Nurse*
1005	*P15/22*	*Monthly Integrated Performance Report*	*Enc.*	*114*	*For assurance*	*Michael Wright, Deputy Chief Executive*
1015	*P16/22*	*Reset and Recovery Operational Report*	*Enc.*	*134*	*For assurance*	*George Briggs, Chief Operating Officer*
1025	*Break*					
1030	*P17/22*	*Finance Report*	*Enc.*	*151*	*For assurance*	*Steven Hackett, Director of Finance*
1040	*P18/22*	*Ockenden Monthly Report*	*Enc.*	*163*	*For assurance*	*Helen Dobson, Interim Chief Nurse*
1045	*P19/22*	*Default Midwifery Continuity of Carer (MCoC)*	*Enc.*	*166*	*For assurance*	*Helen Dobson, Interim Chief Nurse*
1050	*P20/22*	*Mortality and Learning From Deaths Report*	*Enc.*	*182*	*For assurance*	*Dr Callum Gardner, Executive Medical Director*
1055	*P21/22*	*Health Inequalities Task and Finish Group*	*Enc.*	*191*	*For assurance*	*Michael Wright, Deputy Chief Executive*
1100	*P22/22*	*National CQC Patient Experience Surveys*	*Enc.*	*197*	*For information*	*Helen Dobson, Interim Chief Nurse*
		Regulatory Compliance Risk and Assurance				
1105	*P23/21*	*Health and Safety Annual Report 2020/21*	*Enc.*	*204*	*For assurance*	*George Briggs, Chief Operating Officer*
		Board Governance				
1110	*P24/22*	*Board Assurance Framework: Quarter 3*	*Enc.*	*250*	*For decision*	*Angela Wendzicha, Director of Corporate Affairs*
1120	*P25/22*	*Enhancing Board Oversight: A New Approach to Non-Executive Director Champion Roles*	*Enc.*	*277*	*For decision*	*Angela Wendzicha, Director of Corporate Affairs*

1125	*P26/22*	*Escalations from Council of Governors – 10/11/2021 meeting*	*verbal*	*-*	*For noting*	*Martin Havenhand, Chairman*
		For Information				
	P27/22	*Any other business*	*-*	*-*	*For noting*	*Martin Havenhand, Chairman*
	P28/22	*Date of next meeting:* *04 March 2022*	*-*	*-*	*For noting*	*Martin Havenhand, Chairman*
1130	*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

The Rotherham NHS Foundation Trust

MINUTES OF THE PUBLIC BOARD OF DIRECTORS MEETING HELD VIRTUALLY ON FRIDAY 05 NOVEMBER 2021

Present:
Mr M Havenhand, Chairman
Miss N Bancroft, Non-Executive Director
Dr J Bibby, Non-Executive Director
Mrs H Dobson, Interim Chief Nurse
Dr C Gardner, Executive Medical Director
Mr S Hackett, Director of Finance
Ms L Hagger, Non-Executive Director
Dr R Jenkins, Interim Chief Executive
Mr K Malik, Non-Executive Director
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:
Mr A Bennett, Lead Freedom to Speak Up Guardian (minute P214/21)
Mr M Hill, Head of Nursing (minute P209/21)
Mr I Hinitt, Director of Estates and Facilities
Ms S Hooper, Ward Manager (minute P209/21)
Ms E Jones, Deputy Ward Manager (minute P209/21)
Mrs S Kilgariff, Director of Operations / Deputy Chief Operating Officer
Dr G Lynch, Guardian of Safe Working (minute P213/21)
Mr J Rawlinson, Director of Health Informatics
Miss D Stewart, Corporate Governance Manager (minutes)
Mrs L Tuckett, Director of Strategy Planning and Performance
Ms A Wendzicha, Director of Corporate Affairs

Apologies:
Mr G Briggs, Chief Operating Officer
Mrs H Craven, Non-Executive Director

PROCEDURAL ITEMS

P203/21 CHAIRMAN'S WELCOME AND APOLOGIES FOR ABSENCE

The Chairman welcomed all present, with Mrs Dobson attending her first meeting as Interim Chief Nurse. Apologies for absence were noted.

P204/21 QUORACY CHECK

The meeting was confirmed to be quorate.

P205/21 DECLARATIONS OF CONFLICTS OF INTERESTS

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

Mr Ned's interest, in terms of his joint role as Director of Workforce of both the Trust and Barnsley Hospital NHS Foundation Trust, was noted.

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

P206/21 MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting held on 10 September 2021 were agreed as a correct record.

P207/21 MATTERS ARISING FROM THE PREVIOUS MEETING

There were no matters arising from the previous meeting not covered by the action log or items for discussion.

P208/21 ACTION LOG

The Board of Directors reviewed the action log and agreed that log numbers 43, 45 and 46 would be closed. The remaining open actions were 35, 41 and 44 which were scheduled to be reported to future meetings.

OVERVIEW AND CONTEXT

P209/21 PATIENT STORY

The Board of Directors welcomed to the meeting Mr Hill, Head of Nursing and colleagues Ms Hooper, Ward A1 Manager and Ms Jones, Deputy Ward A1 Manager, to present the Patient Story.

Although Ward A1 was a General Medicine Ward, which specialised in Cardiology and Health Care for the Older Person, during 2021 it had also cared for a number of patients with eating disorders.

Working as an extended multi-disciplinary team, a blended approach of physical, mental and psychological support, care treatment and interventions were provided to patients following approved protocols.

Debriefs, including the patient, had been provided throughout the journey and post discharge. At all times patients were treated with respect, with staff being responsive to their needs and preferences. Feedback on the quality of care and patient experience had been positive

In terms of the ward team, it had been a journey of new learning, with staff continuing their education and training in this area. Opportunities to share learning have been taken forward with such as Family Health. Dr Gardner confirmed that until a clinical lead was identified, Adult Physicians continued to offer support to adults and adolescents (16 to 18 year olds) on the paediatric wards.

Mr Havenhand thanked colleagues for their story and the tremendous work they and their teams were doing in support of our patients.

The Board of Directors noted the Patient Story.

P210/21 **REPORT FROM THE CHAIRMAN**

The Board of Directors received the Chairman's Report.

Mr Havenhand highlighted one matter, confirming that Dr Jenkins secondment as joint interim Chief Executive at Rotherham and substantive Chief Executive at Barnsley Hospital NHS Foundation Trust had been extended until March 2022. Both organisations continued discussions in relation to a substantive joint appointment.

Ms Hagger took the opportunity to highlight a number of matters in relation to her lead Non-Executive Director portfolio, including the challenges in terms of organ donation ambassadors, the ability to access documents as part of her Maternity and Neonatal Safety Champion role and attendance by Obstetric Consultants at a number of meetings. These matters would be discussed outside the meeting.

In terms of the outputs from the Health Inequalities Board Task and Finish Group, it was confirmed that a report from the Group would be provided to the January 2022 Board of Directors meeting.

ACTION – Deputy Chief Executive

The Board of Directors noted the Chairman's Report.

P211/21 **REPORT FROM THE INTERIM CHIEF EXECUTIVE**

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

Dr Jenkins wished to draw the Board's attention to the continuing pressures and challenges, resulting in the organisation having been at internal escalation level 4 for a protracted period. Rotherham and the wider Integrated Care System continued to see rising COVID cases, staffing challenges, ambulance diverts and emerging pressures in relation to maternity services.

Rotherham had been able to maintain its elective activities, however, a decision had now been made to cease elective orthopaedic cases for a short period in order to support the non-elective position. The pressures on staff in managing the competing demands, was recognised and commended by the Board.

It was noted that the Care Quality Commission had published their report following the Trust's inspection in May/June 2021. The overall rating remained one of Requires Improvement. In terms of individual services, there had been positive progress in relation to Maternity Services which had been upgraded to Good. However, Medicine and Urgent and Emergency Care would require focussed attention to address the findings relating to their services.

Dr Jenkins reported that the Trust would be one of twenty Trusts to be inspected by the Health and Safety Executive, with the three day inspection planned to take place from 29 November 2021 and would be focussed around

three specific employee related areas of violence and aggression, Covid-19 and musculoskeletal matters.
In terms of the new NHS System Oversight Framework for 2021/22, as detailed in the letter appended to the report from NHS England / Improvement, Rotherham had been confirmed in Segment[1] 3. Other than Sheffield Children's Hospital, all other Trusts in South Yorkshire had been placed in Segment 2.

Segmentation 3 would enable the Trust to access additional support and resources to drive forward quality improvements at an accelerated rate. Dr Jenkins indicated that discussions were underway with NHSE/I regarding the support which would be made available, with the Executive Team considering the requirements, particularly in relation to quality improvement and quality governance matters.

The Board of Directors noted the report.

CULTURE

P212/21 RESPONSIBLE OFFICER'S REPORT Q1 2021/22 REVIEW

The Board of Directors received the quarter two report from the Responsible Officer.

Dr Gardener reported that Dr Shekar, Consultant Anaesthetist, had been appointed as Medical Appraisal Lead, with interviews to be held shortly for the final appraisers.

In noting the establishment of a dedicated appraisal room to facilitate medical appraisals, Mrs Kilgariff considered such a facility would be worth exploring for other services.

Consideration was being given to the development of an appraisal data pack for all doctors, incorporating such as complaints and Serious Incident information to support reflective learning and training. Provision of patient feedback for revalidation continued to be challenging due to the pandemic, this was recognised nationally.

The Board of Directors noted the Responsible Officer Report.

P213/21 GUARDIAN OF SAFE WORKING REPORT Q1 2021/22 REVIEW

The Board of Directors welcomed to the meeting Dr Lynch, Guardian of Safe Working, to present the quarter two Guardian of Safe Working Report.

The Executive Medical Director took the opportunity in introducing the report to highlight the increased number of exception reports received from Foundation Year 1 Doctors working in General Surgery due to staffing challenges.

[1] Segmentation indicated the scale and general nature of support needs, from no specific support needs (segment 1) to a requirement for mandated intensive support (segment 4).

Dr Lynch explained that exception reports were the mechanism for junior doctors to highlight matters where other channels had not resolved issues and junior doctors were encouraged to complete them. As the Guardian of Safe Working he considered that the Trust had good processes in place and other opportunities for open communication between the junior doctors and Trust officers.

There remained a feeling of goodwill and cooperation from the junior doctors; however, there were concerns regarding potential forthcoming challenges during the winter period.

As it was unusual for the junior doctors in surgery to submit exception reports clarification was sought as to the circumstances for the increase, particularly the comments that they felt unsupported. Dr Lynch explained that a change in the rota and a number of gaps had resulted in the support normally able to be accessed not being available. The matter had been escalated to the Division, who had taken prompt action to resolve the rota issues, including provision of new doctors and redistribution of the workload. It was anticipated that future reports would reflect the action taken.

Seven of the exception reports had been defined as immediate risk to safety, with three not being able to be investigated due to the absence of the Guardian of Safe Working, as such Mr Ned questioned future arrangements to ensure the issues were reviewed and action taken during any absence. Dr Lynch explained that there were other routes available to junior doctors in such circumstances, such as speaking to the educational leads, highlighting the matter to the Consultant or completion of Datix reports.

In seeking availability of comparative data, Dr Lynch informed the Board that there was no real time data available; however when reviewing retrospective reports available through Health Education England, reporting at Rotherham was similar other Trusts of an equitable size.

Dr Lynch also confirmed in response to a question, that as the Trust had maintained training and supervision during the pandemic, there had been a limited number of educational exception reports submitted.

The Board of Directors noted the Guardian of Safe Working quarter two report.

P214/21 **FREEDOM TO SPEAK UP GUARDIAN REPORT Q1 2021/22 REVIEW**

The Board of Directors welcomed to the meeting Mr Bennett, Lead Freedom to Speak Up Guardian to present the quarter two Freedom to Speak Up Guardian (FTSU) Report.

The Interim Chief Nurse in introducing the item took the opportunity to highlight the increased number of concerns raised during the quarter, which demonstrated staff confidence in the processes of being able to raise concerns. The important matter was to ensure that the issues raised were addressed.

Mr Bennett confirmed that nineteen concerns had been raised during quarter two, of which thirteen related to attitudes and behaviours. Nine had been raised by international nurses and escalated to the Chief Nurse and Heads of Nursing to address. Improvements had been seen, with positive feedback from the nurses that they were being supported. Regular contact was being maintained by the Freedom to Speak Up Guardian and Equality, Diversity and Inclusion leads. The intention was that future cohorts of overseas recruits would be introduced directly to the Freedom to Speak Up Guardians.

Mrs Dobson indicated that she had been disappointed from the feedback received by the international nurses. However, in working with the Heads of Nursing, she was assured of the position. Retention levels amongst overseas recruits remained good, with only one nurse having left the Trust due to relocation.

In terms of Mandatory and Statutory Training, it was noted that there was overall compliance of 97.06% for FTSU e-learning training, with every Division being above the 85% target.

The Board of Directors received and noted the Freedom to Speak Up Guardian quarter two report.

STRATEGY

P215/21 **NATIONAL, INTEGRATED CARE SYSTEM AND INTEGRATED CARE PARTNERSHIP REPORT**

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

Mr Wright reported that the Office for Standards in Education, Children's Services and Skills (OFSTED) and the Care Quality Commission (CQC) joint inspection to assess the effectiveness of Rotherham in implementing the Special Educational Needs and/or Disabilities (SEND) reforms set out in the Children's and Families Act 2014 report had been published. The Trust would support the Local Authority and Clinical Commissioning Group in implementation of the required improvements.

The report also detailed the COVID vaccination rates from 12 years and over to 80 years and over.

It was noted that the ICS had secured £3m of national capital funding to support accelerated recovery in relation to diagnostics, and would be developing two new community diagnostic hubs. The initial sites identified were The Glass Works in Barnsley and Montagu Hospital in Mexborough.

The Board of Directors noted the report.

P216/21 **TARGET OPERATING MODEL SOUTH YORKSHIRE AND BASSETLAW – OUTLINE BUSINESS CASE**

The Board of Directors received the Outline Business Case (OBC) to transform pathology services across South Yorkshire and Bassetlaw (SYB).

Dr Jenkins reported that Rotherham was the final Trust within the SYB Integrated Care System to consider the OBC. For Rotherham there was a further matter to be considered as part of the OBC, which was the implications to the Barnsley and Rotherham Integrated Laboratory Service (BRILS).

Pursuing the OBC would result in significant changes to the BRILS, compared to other laboratory services. Staff would need to be supported through the transition, as staff choosing to leave in advance of the reconfiguration could result in significant challenges to staffing the BRILS. Dr Jenkins had raised the matter with Chief Executive colleagues within the network, who had given their commitment to supports the BRILS as required.

It was confirmed that the OBC had been considered in detail by the Finance and Performance Committee, who were supportive of the OBC being approved by the Board.

The Board of Directors supported the decision for the OBC to proceed to the Full Business Case and in doing so approved and noted the following:

- The proposed Target Operating Model;
- That the SYB Pathology Service would be established between the five partner Trusts as a Hosted Network, operating as a single service, with Sheffield Teaching Hospitals NHS Foundation Trust as the Host;
- That a Pathology Partnership Board and Operational Team should be appointed to lead delivery of the substantial reconfiguration of services as described in the recommended target operating model of the OBC;
- Support to be provided from network colleagues in relation to the BRILS.

P217/21 **OPERATIONAL OBJECTIVES 2021/22 REVIEW**

The Board of Directors received the report from the Deputy Chief Executive reviewing progress against the ten 2021/22 Operational Plan Priorities.

Mr Wright reported that at the end of month six, two of the operational priorities were rated Green (on plan) and eight rated Amber (behind plan with mitigation or actions in place to recover).

As progress against each operational priority had been considered by the relevant Board Assurance Committee, there were no further questions from the Board of Directors.

The Board of Directors noted the report.

ASSURANCE

P218/21 BOARD COMMITTEE CHAIRS ASSURANCE LOGS

The Board of Directors received and noted the Chairs logs from the following Board Assurance Committees held in September and October 2021:

i. Finance and Performance Committee

Miss Bancroft took the opportunity to highlight a number of matters from the two recent meetings as detailed within the reports.

The Winter Plan had been considered, with the Committee having been assured that it built upon learning from previous years and was aligned to the financial plan.

Operational priorities and recovery had been considered, currently the organisation was benchmarking positively against other Trust's; however, it was recognised that H2 may require different targets.

The financial position remained positive moving into H2. Whilst there had been good progress in terms of the cost improvement programme, there remained further actions to be taken.

In terms of the outpatient transformation programme, Miss Bancroft confirmed that the Committee had received a presentation on the findings and resulting recommendations following the external review. The next stages of the work would be taken forward by the Executive Team, with Dr Jenkins indicating that once considered and agreed, this information would be submitted to the Finance and Performance Committee.

ii. Quality Committee

Dr Shah took the opportunity to raise a number of matters detailed within the Chairs log, where the Committee had received limited assurance. However, it was acknowledged that the position may reflect current operational challenges and pressures. Moving forward the focus of the Committee would be to assess if plans and processes were resulting in the required outputs.

With regards to attendance at the Strategic Safeguarding Meeting by the named doctor and general quoracy of the meeting, it was noted that the matter would be addressed by the Executive Medical Director. However, Dr Jenkins added that in reviewing the attendance levels, although not ideal the position may not be as first thought, and quoracy was set unrealistically high. The matters raised would be addressed in revising the terms of reference and ensuring escalation processes were in place for non-attendance.

It was noted that no named doctor on some sample requests had been addressed through a task and finish group ensuring strengthened systems and processes.

In response to a comment from Mr Smith relating to the assurance ratings for the Chairs logs, Ms Wendzicha explained that a review was being undertaken as to the assurance rating descriptions, with the proposals to be considered at the Strategic Board meeting in December 2021.

Mr Havenhand concluded the discussion in that there were a number areas of concern regarding quality assurance which were matters for the whole Board to address which and they would be included in future quality governance improvement reports.

iii. People Committee

The Board received and noted the Chair Assurance Logs, with Ms Hagger indicating that there were no matters she specifically wished to bring to the Board's attention.

iv. Audit Committee

Mr Malik indicated that the October meeting had been his first as Chair of the Committee.

He took the opportunity to highlight the review of the Committee's terms of reference which would be formally considered by the Board in due course, and the enhanced focus to be given to colleagues within the organisation who had yet to complete their annual standards of business conduct declarations.

Performance in implementation of recommendations following reviews by the Internal Auditors currently stood at 77%, with completion within the agreed deadlines being one of the factors in deciding the Head of Internal Audit Opinion.

P219/21 CARE QUALITY COMMISSION REPORT

The Board of Directors received the Care Quality Commission (CQC) Report presented by the Interim Chief Nurse.

Mrs Dobson indicated that the 2021 CQC inspection had not resulted in any change to the overall Requires Improvement rating. Whilst Maternity Core service had seen its overall rating change from Requires Improvement to Good, a number of other services had seen a downgraded rating for specific domains, as detailed within the report.

The CQC had identified 54 must do and 28 should do actions following their review. These actions formed the basis for the action plan, which was required to be submitted to the CQC by 18 November 2021. Implementation of the recommendations would be monitored by the CQC Delivery Group.

Dr Bibby commented that the action plan had been considered by the Quality Committee, however she questioned as the how such matters as behaviours, culture and embedding action would be addressed as these matters would be important in taking forward the must do and should do actions.

Mrs Dobson confirmed that going forward the Divisions would be required to own each action and the leadership team from each Division would be required to present to the CQC Delivery Group on a monthly basis progress being made. The more challenging element would be monitoring embeddedness of actions taken.

The Board of Directors noted the report, welcomed the improvement in rating for the Maternity Service and noted the ongoing progress monitoring the assurance of delivery through the CQC Delivery Group.

P220/21 **MONTHLY INTEGRATED PERFORMANCE REPORT**

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

Mr Wright reported that new and extensive narrative had been included within the report, which he anticipated would add value when considered by the Board.

In terms of the content of the report, Dr Shah questioned the Trust's position with regards to utilisation of the independent sector. The Director of Strategy Planning and Performance indicated that as there was now clarity on the H2 financial position continued utilisation of the independent sector would be revisited. This would be particularly relevant in light of the continued operational pressures.

The Board of Directors noted the Integrated Performance Report.

P221/21 **RESET AND RECOVERY OPERATIONAL REPORT (INCLUDING COVID-19 UPDATE)**

The Board of Directors received and noted for assurance the Reset and Recovery Operational Report which included an update on COVID-19 presented by the Director of Operations/ Deputy Chief Operating Officer.

The report detailed progress made to date, the areas of challenge and the regional task force supporting recovery across all organisations.

Dr Jenkins highlighted the elective recovery event, attended by North East and Yorkshire Chairs and Chief Executive's, with the key messages and priority actions for the Acute Federation appended to the report. A further session was planned for the beginning of December 2021, following which an update would be provided to the Board.

In terms of staff, it was noted that there was a high level of staff absence, including COVID related, which was placing additional pressures on the teams. The Division of Surgery, who were one of the primary contributors to recovery, were implementing additional mechanisms to support their staff.

The Board of Directors noted the report.

P222/21 **WINTER PLAN**

The Board of Directors received the Winter Plan (Demand Management/Surge Plan 2021-22) presented by the Director of Operations/deputy Chief Operating Officer.

Mrs Kilgariff confirmed that the plan was a collective approach from key organisations across Rotherham, with a strong focus on community care over what would undoubtedly be a challenging winter period. Financial aspects of the plan had been allocated and would be closely monitored.

It was additionally noted that the Plan had been reviewed and supported by the Finance and Performance Committee.

The Board of Directors noted for assurance the Winter Plan.

P223/21 **FINANCE REPORT**

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

Mr Hackett reported that in month there had been a deficit to plan of £157K, which had been forecasted, with a £250K surplus to plan year to date.

In terms of the capital position, there had been expenditure of £529K in month and £2,694K year to date representing an under-spend of £557K in month and an under-spend of £2,388K year to date. This in the main was due to slippage in the new MRI scanner and had been acknowledged by the Capital Monitoring Group and the Finance and Performance Committee.

It was confirmed that the Trust continued to be in a position to contribute £1,000k to a SYB ICS potential over-commitment of £12,400K.

The cash position as at 30 September 2021 stood at £26,641K.

It was confirmed that the Finance and Performance Committee had discussed the position in detail, with any matters of note detailed within Chairs Assurance Log.

The Board of Directors noted the month six finance report.

P224/21 **MEDICAL WORKFORCE REPORT Q2 2021/22 REVIEW**

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

Dr Gardner explained that the report provided an update in terms of progress to complete job planning and consultant level recruitment.

In terms of job planning, progress had not been as anticipated in signing off job plans, with Dr Gardner continuing to work with the Divisions and the Head of Medical and Dental Workforce to establish mechanisms to ensure there was engagement to complete the process.

Mechanisms were already in place that without a completed job plan, there would be no access to any additional clinical excellence awards for medical staff. There could also be further opportunities in terms of pay increments to incentivise completion of job plans.

In order to ensure job planning was undertaken thoroughly, particularly in light of the new Divisional leadership, it was noted that training at a national level would be provided, which would be widened to senior managers.

There had been a number of appointments across a number of specialities following recruitment activities; however challenges continued in the specialities of Acute Medicine, Gastro and Rheumatology resulting in engagement with contracted agencies to identify potential candidates.

Whilst there had been improvements in terms of recruitment, equally important would be maximising retention of current staff, key to which would be supporting their health and wellbeing.

The Board of Directors noted the Medical Workforce Report.

P225/21 **NURSING SAFER STAFFING – SIX MONTH REVIEW OCTOBER 2021**

The Board of Directors received the report from the Interim Chief Nurse detailing the six-monthly review of nurse and midwifery staffing levels to ensure that they were appropriate based upon establishment levels.

Mrs Dobson reported that following the review the Division of Surgery would be seeking changes to their establishment with a Business Case to be developed for consideration through the governance processes.

In terms of Urgent and Emergency Care, it was confirmed that no changes to the funded establishment were proposed at this time. Instead, in January 2022 the Division would undertake a review of pathways utilising the recently launched Emergency Department Safer Nursing Care Tool (SNCT). The findings from the evidence based tool would inform the next six month review in April 2022. Until that time the Division had indicated that they were assured of their current staffing establishments.

Mrs Tuckett would further discuss the specific ward data outside the meeting to ensure that it correlated with the Operational Plan.

ACTION – Director of Strategy, Planning and Performance

Dr Jenkins commented that in reviewing the staffing position, there was also a requirement to understand the full position when taking into consideration sickness and planned absence to understand how staff may be feeling.

The Board of Directors noted the report which concluded the review of current staffing levels of the nurse and midwifery establishment and the Trust position in relation to adherence to the monitored metrics on nurse / midwife staffing levels. The Board further noted the development of a business case for the Division of Surgery.

P226/21 **OCKENDEN MONTHLY REPORT**

The Board of Directors received a report which provided oversight and assurance on the Maternity Service's compliance with the Ockenden

Independent Review into Maternity Services required actions and mandated clinical priorities.

In terms of the Regional Perinatal Quality Oversight Group Dashboard appended to the report, Ms Hagger questioned the red rating for Safety Champions. Mrs Dobson confirmed that the position had significantly improved, with the position in the report reflecting the Trust's historical low starting point.

Dr Shah indicated that the report identified a number of areas to be considered, when the next update report was presented to the Quality Committee.

The Board of Directors noted the report and compliance to date.

P227/21 **DIGITAL STRATEGY AND DATA QUALITY REPORT**

The Board of Directors received the report presented by the Director of Health Informatics providing an update on progress towards the delivery of the Trust's Digital Strategy.

Mr Rawlinson took the opportunity to highlight a number of areas from the report, including the progress being made across the digital aspirant programme. However; operational challenges were resulting in access to some clinical areas being delayed. Good progress continued in relation to cyber security activities, with the position having been formally reported to the October 2021 Audit Committee meeting.

Advances continued in relation to the accessibility of the Rotherham Health App to a number of systems across primary care and hospital settings.

In support of earlier discussions, Mr Rawlinson indicated Rotherham was the only Trust in the North of England that operated an electronic ambulance handover process.

It was noted that NHSX had published 'what good looks like' guidance across seven domains. This would be the template against which the Trust would assess itself.

The Board of Directors noted the report and in doing so acknowledged there may be a timing mismatch between NHSX framework guidance and production of the updated Digital Strategy. The Board further recognised that there may be a delay in go-live of certain programmes due to operational pressures.

P228/21 **RISK MANAGEMENT REPORT Q2 2021/22 REVIEW**

The Board of Directors received the Risk Management Report which detailed the risks on the corporate risk register scoring 15 and above.

Mrs Dobson reported that one new risk had been added to the register relating to lack of adherence to processes and governance in relation to Inquest

management affecting the Trusts ability to present findings (risk register 5832). The report further detailed that one risk had been closed and one risk had had its score reduced to 12.

In terms of risk 6226 relating to COVID-19 Organisational Recovery, Miss Bancroft indicated that the Finance and Performance Committee had requested that this risk be further reviewed as although the risk score had reduced from 20 to 15, the organisation still had significant challenges, which most recently had impacted upon recovery.

Dr Jenkins highlighted that the risk title and risk score for 6545 and 6546 would need to be revisited as they were identical.

ACTION – Interim Chief Nurse

The Board of Directors noted the Risk Management Report.

P229/21 **MORTALITY AND LEARNING FROM DEATHS REPORT**

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

Dr Gardner reported that Hospital Standardised Mortality Ratio (HSMR) stood at 112.2 for the rolling twelve month period (March 2020 to February 2021). This demonstrated a significant improvement, and when secondary COVID-19 codes were excluded, the position was 98.5. In addition, the latest month's in-month rate (May 2021) stood at 93.5, not 98.5 as documented within the report and banded as statistically 'within expected'.

The Summary Hospital-level Mortality Indicator (SHMI) stood at 111.33 for the period May 2020 - April 2021. This was a slight increase for the figure of 109.72 for the period March 2020 – February 2021 but remained within the 'as expected' group.

The Board of Directors noted the report which provided assurance on the significant actions being taken to address the Trust's mortality position.

REGULATORY COMPLIANCE RISK AND ASSURANCE

P230/21 **REVISED STANDING FINANCIAL INSTRUCTIONS**

The Board of Directors received the revised Standing Financial Instructions presented by the Director of Finance.

Mr Hackett indicated that the report provided the background to the revisions and detailed all the proposed changes. The most significant amendments he wished to highlight to the Board were:

- The budget holder authorisation levels had been reduced from £10,000 to £5,000, with budgetary management training to be provided by the Divisional Finance Managers to all new budget holders
- The appendices detailed the budget delegation and financial limits for authorised signatories in terms of capital, revenue and in year changes to budgets

- Detailed information, clarification and streamlining of processes in relation to contracts and specifically for renewal of existing contracts.

It was confirmed that the proposed revisions had been considered by both the Finance and Performance Committee and Audit Committees, who would recommend approval by the Board.

Miss Bancroft added that when the proposed revisions had been discussed at the Audit Committee, both the Internal and External Auditors had been supportive of the way forward.

The Board of Directors approved the revised Standing Financial Instructions.

P231/21 **REVIEW OF STANDING ORDERS**

The Board of Directors received the revised Standing Orders presented by the Director of Corporate Affairs.

Ms Wendzicha indicated that the Standing Orders (SOs) complimented the Standing Financial Instructions. The SOs would normally be reviewed on an annual basis, but had not been updated since 2018. However, anticipating that a comprehensive review of all constitutional documents would be required in early 2022 due to enactment of the Health and Care Act, the SOs had at this time undergone a minimal review.

It was noted that the Audit Committee had considered the revisions and would recommend approval by the Board of Directors.

It was commented that section 3.20a relating to the frequency of Board meetings and section 3.14h which referenced Clinical Divisional Directors who no longer attended the Board meeting, would need to be updated.

ACTION – Director of Corporate Affairs

The Board of Directors approved the revised Standing Orders and noted that the outcome of a more comprehensive review would be considered in early 2022.

P232/21 **REVIEW OF MATTERS RESERVED TO THE BOARD**

The Board of Directors received the revised Matters Reserved to the Board presented by the Director of Corporate Affairs.

Similar to the previous agenda item the Matters Reserved complimented the Standing Financial Instructions and had been considered by the Audit Committee who would recommend they be approved.

Ms Wendzicha indicated that the contracts section of the Matters Reserved would need to be aligned to the Standing Financial Instructions.

ACTION – Director of Corporate Affairs

The Board of Directors approved the revised Matters Reserved to the Board.

BOARD GOVERNANCE

P233/21 EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR) ANNUAL ASSURANCE PROCESS 2021/2022

The Board of Directors received the Emergency Preparedness, Resilience and Response (EPRR) Annual Assurance Process – 2021/22 report.

Mr Smith, as Non-Executive Director lead for Emergency Preparedness, confirmed that he had met with both the Chief Operating Officer and the Emergency Planning and Business Resilience Manager to discuss in detail the self-assessment against the standards.

The Board of Directors noted the Emergency Preparedness, Resilience and Response statement of compliance, including the improvement plan and deep dive review.

P234/21 GOVERNANCE REPORT

The Board of Directors received and noted the Governance Report.

Ms Wendzicha highlighted a number of reports published by the Care Quality Commission, and the publications from NHS Providers relating to the evolving regulation and oversight framework, and health inequalities. The latter two matters would be factored into the ongoing work of the Trust.

FOR INFORMATION

P235/21 BOARD ASSURANCE COMMITTEE MEETING DATES 2022

The Board of Directors received and noted the Board Assurance Committee meeting dates for 2022.

P236/21 REGISTER OF INTEREST (BI-ANNUAL REVIEW)

The Board of Directors received and noted the report which detailed the bi-annual review of the Register of Interest for Board members.

P237/21 ANY OTHER BUSINESS

There were no items of any other business.

P238/21 DATE OF NEXT MEETING

The next meeting of the Board of Directors would be held on Friday, 7 January 2022, commencing at 9am.

The meeting was declared closed.

Martin Havenhand
Chair Date

Board Meeting; Public action log

Log No	Meeting	Report/Agenda title	Minute Ref	Agenda item and Action	Lead Officer	Timescale/ Deadline	Comment/ Feedback from Lead Officer(s)	Open /Close
		2021						
35	09-Jul-21	National ICS and ICP Report	P154/21	Rotherham Place Development Plan, The Rotherham Integrated Care Agreement and Rotherham Place Plan to be submitted to Board when finalised	DCEO	Dec-21	The Rotherham Place Development Plan and the Rotherham Integrated Care Agreement will be included in the Deputy CEO's report to Board in September 2021 (P181/21). The Place Plan however is going to the Place Board week commencing 30/08/21 and therefore will not be available for the Board of Directors until the November 2021 Board meeting. The Rotherham Place Development Plan and the Rotherham Integrated Care Agreement were included in the Deputy CEO's report to Board in September 2021 (P181/21). October 2021: The Place Priorities have been agreed by Place Board colleagues and are included within the Deputy CEOs report. There is action plan for quarter 2 that supports the priorities. This is currently being reviewed and updated with a view to being presented to the confidential Place Board in November and public Place Board in December. December 2021 - Place Objectives yet to be considered by Place Board. Current version circulated to Board members for information at this time.	Open
41	09-Jul-21	Governance Report	P161/21	Core Trust governing documents requiring review in light of the Health and Care Bill to be documented within Board forward work plan	DoCA	Apr-22	The forward planner will be updated as and when further ICS guidance is issued. It is anticipated that key governance documents will be revised by end of Q3 beg Q4.	Open
44	10-Sep-21	Five Year Strategy	P180/21	Analysis of the risks to be undertaken in parallel to the next stages, with these to be presented to the November 2021 Board meeting.	DoCA	~~01/12/2021~~ 01/02/2022	This matter will be considered as part of the ~~December~~ February Strategic Board meeting	Open
47	05-Nov-21	Chairs Report	P210/21	Outputs from the Health Inequalities Board Task and Finish Group to be provided to the January 2022 meeting.	DCEO	Jan-22	Agenda item P21/22	Recommend to close

Log No	Meeting	Report/Agenda title	Minute Ref	Agenda item and Action	Lead Officer	Timescale/ Deadline	Comment/ Feedback from Lead Officer(s)	Open /Close
48	05-Nov-21	Nursing Safer Staffing Six month Review	P225/21	To discuss the specific ward data outside the meeting to ensure that it correlated with the Operational Plan.	DoSPP		DoSPP and CN have discussed the challenges with the current presentation of staffing data and a further conversation is planned to ensure that any operational plan and performance reports use the same measurement tools as the staffing updates, in advance of the next report's submission in Q1 2022/23.	Recommend to close
49	05-Nov-21	Risk Management Report	P228/21	Risk title and score for 6545 and 6546 to be revisited as they were identical.	DoCA		Complete	Recommend to close
50	05-Nov-21	Standing Orders	P231/21	Section 3.20a relating to the frequency of Board meetings and section 3.14h which referenced Clinical Divisional Directors to be upated	DoCA		Complete	Recommend to close
51	05-Nov-21	Matters Reseverd to the Board	P232/21	Contracts section to be aligned to the Standing Financial Instructions.	DoCA		Complete	Recommend to close

Open
Recommend to close
Complete

Board of Directors' Meeting
07 January 2022

The Rotherham NHS Foundation Trust

Agenda item	P08/22
Report	**Chairman's Report**
Executive Lead	Presenter: Martin Havenhand, Chairman
Link with the BAF	The Chairman's report reflects various elements of the BAF
How does this paper support Trust Values	This report supports the core values of Ambitious and Together through the various updates included relating to improving corporate governance and working collaboratively with key partners
Purpose	**For decision** ☐ **For assurance** ☐ **For information** ☒
Executive Summary (including reason for the report, background, key issues and risks)	This report provides an update on a number of issues for the Board. In particular I would like to highlight the following: **PROUD Awards** - The Rotherham NHS Foundation Trust annual PROUD Awards were held virtually on 19 November 2021. Although it was a virtual event, everyone who was able to participate had a great evening. There was an award given in thirteen categories: **Recognition of Learning awards** - The Chairman and Interim Chief Executive attended the Recognition of Learning event on the 19 November and the Interim Chief Executive distributed certificates to a number of colleagues who had been successful in their training and academic and vocational qualifications. **Council of Governors** - Met on 10th November and appointed Geoff Berry as Deputy Lead Governor following an election. **Appointment of Chief Operating Officer** - Following a national recruitment process Sally Kilgariff our Director of Operations and Deputy Chief Operating Officer has been appointed Chief Operating Officer. **Yorkshire and Humber Chairs meeting 8 Dec 2021** - Chairs were particularly asked about ambulance handovers at their Urgent Emergency Care Centres.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	This report has not been received elsewhere prior to its presentation to the Board of Directors
Board powers to make this decision	The Trust's Matters Reserved document details that approving the membership and Chairmanship of Board Committees is a matter which it has reserved unto itself.
Who, What and When	Actions required will be led by the relevant Executive or Non-Executive Director.
Recommendations	It is recommended that: The Board of Directors notes the report.

1.0 Introduction

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

2.0 PROUD Awards

2.1 The Rotherham NHS Foundation Trust annual PROUD Awards were held virtually on 19 November 2021. Although it was a virtual event, everyone who was able to participate had a great evening. There was an award given in thirteen categories:

Values Award: Tony Bennett – Security
Governor's Award for Outstanding Colleagues: Sheron Ducker – Therapy Services
Safe and Sound Award: Security and Children's Ward
Diversity and Inclusion Award: Paul Stewart and Gail Smith – Medicine
Innovation and Improvement Award: Hip and Knee School
Clinical Team of the Year: Supportive / Palliative Care Team
Non-Clinical Team of the Year: Isolation and Curtain Team
Public Recognition Award: John Brammer – Theatres
Inspiring Leader Award: Sarah Newbold – Staff Engagement
Apprentice of the Year Award: Claire Wilson – Estates
Unsung Hero Award: Lisa Kerry – Stroke
Chief Executive's Award: Critical Care
Chairman's Award: Maternity Services

There was also special recognition award for Thunder the Therapy Dog who is a regular visitor to the Trust and brings joy to colleagues and patients with his kind, calm and loving nature.

2.2 It was very humbling to hear individual stories about our colleague's significant contributions to patient care in the face of unprecedented challenges caused by the covid-19 pandemic. The Board all attended the event and want to place on record our appreciation to all of the winners and all of those who were nominated.

3.0 Recognition of Learning Awards

3.1 The Chairman and Interim Chief Executive attended the Recognition of Learning event on the 19 November and the Interim Chief Executive distributed certificates to a number of colleagues who had been successful in their training and academic and vocational qualifications.

4.0 Council of Governors

4.1 The Council of Governors held its public meeting virtually on 10 November and welcomed Councillor Eve Keenan representing Rotherham Metropolitan Borough Council to her first meeting.

4.2 Key issues addressed at the meeting were:

- The appointment of Geoff Berry as the Deputy Lead Governor following election.
- The Council of Governors also approved a new Member Engagement Strategy which will shape how the Governors work on increasing the number of members and how they engage with them in the future.
- The Council of Governors endorsed the Trusts Five Year Strategy which runs from 2022-2027.

- The Council of Governors received a report from the Executive Team showing the elective recovery programme and the continuing impact of covid-19 on the operation of the Trust.

5.0 NHS Providers Conference

5.1 The NHS Providers Conference was held virtually again this year over three days from 16 November and the Chairman and Interim Chief Executive attended a number of the conference sessions.

6.0 Ambition Rotherham Board

6.1 The Chairman chaired a meeting of the Rotherham Together Partnership, Ambition Rotherham Board on 17 November which focused on the positive messaging about Rotherham and the approach of 'Rotherham a place to be proud of'.

6.2 Rotherham will be hosting three Women's European football matches in 2022 and preparations are starting in earnest for Rotherham becoming the 'children's capital of culture' in 2025.

6.3 Everyone was pleased to know that Julie Dalton, Managing Director of Gulliver's in Rotherham has been appointed the Chair of the organising committee.

7.0 Meeting with Pearse Butler, Chair Designate of the South Yorkshire Integrated Care Board

7.1 The Chairman and Interim Chief Executive welcomed Pearse Butler on a visit to Rotherham Hospital as part of his 'getting to know' the NHS facilities across South Yorkshire. It was a good opportunity for the Trust to inform Pearse of some significant developments that have taken place within the hospital over the last few years including the urgent and emergency care centre, discharge lounge and the central control centre.

8.0 NHS providers Chairs and CEO Network

8.1 On the 2 December the Chairman attended this event where an update was received from the Chief Executive of NHS England, Amanda Pritchard, who highlighted the key issues being faced by the NHS, covid-19, elective recovery and winter. The Chief Executive of NHS Providers, Chris Hopson gave a strategic overview of the challenges facing the NHS and explained how NHS Providers were supporting and representing NHS provider Trusts in discussions at a national level and particularly around the health and care bill progressing through parliament.

9.0 Appointment of Chief Operating Officer

9.1 Following a national recruitment process Sally Kilgariff our Director of Operations and Deputy Chief Operating Officer has been appointed Chief Operating Officer. She will take up the role in June 2022 on the retirement of George Briggs.

10.0 Yorkshire and Humber Chairs meeting 8 Dec 2021

10.1 The Chairman attended this meeting which included presentations from the NHSE/I Chief Finance Officer, Julian Kelly, Richard Barker Regional Director of NHSE/I and Chris Hopson, Chief Executive of NHS Providers.

10.2 Chairs were particularly asked about their knowledge regarding ambulance handovers and the challenges ambulance handovers are having at their Urgent Emergency Care Centres.

11.0 Strategic Board Meeting 10 Dec 2021

11.1 All Board directors attended an extremely valuable NHS cyber security training session presented by Templar Executives Ltd.

11.2 The second part of the Board session included a presentation by Robert McGough, a partner with Hill Dickinson Solicitors, who provided an up-to-date overview of the development of the Integrated Care Board and the Trusts involvement in the South Yorkshire system Provider Collaborative and our engagement within Rotherham Place and Rotherham Place Provider collaborative.

12.0 Lead Non-Executive Director (Nicola Bancroft)

12.1 On the 4 November 2021, Nicola attended the Chief Executive Development Network Dialogue for Change. The Chief Executive Development Network is uniquely positioned as a confidential and non-political, peer development network that offers reflection, renewal, regeneration and community. The specific Dialogue for Change was an online event to have a mutually informative and developmental conversation with Julian Kelly, Chief Financial Officer for NHS England and Improvement. It offered the opportunity to network with NHS Chairs, Chief Executives and fellow Non-Executive Directors and inform national thinking.

12.2 On 3 December 2021, Nicola (on behalf of the Chairman) joined the North East and Yorkshire Elective Recovery Task Force follow-up event alongside Richard Jenkins. It was a valuable opportunity to focus on elective recovery as a region and reinforce the following priorities:

1. To deliver on reducing 104-week elective waiters with no increase and see a reduction in 52-week waiters whilst maintaining cancer performance and reductions.

2. 2021/22 – To get as much activity out as possible over the next 3 months. This will involve being smart on what we do, making the most of Targeted Investment Fund (TIF) schemes, and breeding confidence.

3. 2022/23 – To start seeing a step change in activity growth, up to 10% above pre-COVID levels. This will need to be delivered through focused, dedicated and innovative approaches. Systems should begin planning for this to hit the ground running.

13.0 Lead Non-Executive Director (Michael Smith)

13.1 As Chair of the Charitable Funds Committee, Mike attended the second meeting of the charity fundraising group which involves staff, Unison and a representative from the Clinical Commissioning Group. We discussed and agreed actions on how to publicise and take a forward Christmas related activities including the Christmas Grotto, Santa

13.2 As chair of Charitable Funds Committee, and, along with 2 other NEDs, (Heather Craven and Nicola Bancroft) he attended the opening of the Christmas Grotto. Mike spoke to attendees from various departments and to those who had kindly contributed their time or produce (cakes, crocheted seasonal items, reindeer food packs etc).

Heather was delighted to judge the excellent cakes for the Charity Christmas bake off alongside Helen Dobson, Interim Chief Nurse, in the well-being garden.

13.3 Mike visited UECC and was briefed on and visited the new Command Centre where activity is both monitored and responded to in real time. The information on display makes use of both current activity and historical data so as to be able to predict and plan activity.

13.4 Mike met with Anthony Bennett, Trust Security Lead, and visited the CCTV monitoring room and spoke to staff. He met with the external provider's new contract manager and discussed operational issues. He was informed about potential changes to the placement of staff and monitoring equipment to improve the response time for incidents.

14.0 Lead Non-Executive Director (Heather Craven)

14.1 As lead NED for the community division Heather attended the NHS Providers Trust wide Improvement seminar hosted by Miriam Deakin, Director of Policy and Strategy for NHS Providers. This was a deep dive into the Quality Improvement journey undertaken by Central London Community Healthcare NHS Trust. The Trusts board shared their experiences of instilling a trust wide QI methodology linked to governance and highlighted what had worked, and what they had learnt from the things that hadn't. Some key messages were around consistent QI methodology, board support, data and KPI's. Heather will be meeting with Elaine Jeffers in January to discuss the points raised.

14.2 In her role as lead safeguarding NED Heather visited UECC and met with Fiona Middleton to discuss the challenges in safeguarding and improvements made and still being worked on.

15.0 Lead Non-Executive Director (Lynn Hagger)

15.1 Organ Donation Committee - A site visit was undertaken with Heather Craven, Suzanne Rutter, Ian Hinnitt and Simon Loukes to consider areas where the Charity and organ donation could be better promoted.

15.2 Lynn attended a Maternity Voices Partnership (MVP) meeting where the tongue tie service was discussed together with how the proposed 15 steps challenge could be conducted in the current environment. A survey undertaken by REMA to canvass views from ethnic minorities and to understand how a more systematic approach needs to be taken in addressing MVP views and then feeding back what has been done.

15.3 On 25th November Lynn joined a Y & H MIS Safety Champions Workshop which included a discussion about MVP. NED Champions shared their different approaches to the role.

15.4 On 26th November Lynn attended a Labour Ward walk round during which staff explained how they worked cohesively, including with medical staff colleagues, and explained the challenges in moving towards the Continuity of Carer targets.

15.5 On 7th December Lynn attended the Leadership Framework – Health Inequalities Improvement Programme where there was a strong message that recovery needs to include a re-set that addresses the issue of health inequalities: the horizon needs to be scanned, there needs to be diversity of thought that reflects the needs of the local community, NHS funds should be used effectively and we should act now to realise opportunities. The Health Inequalities Improvement Programme's vision is of exceptional quality healthcare for all through equitable access, excellent experience and optimal outcomes. There needs to be a positive legacy from the pandemic and of the many policy

questions to ask digital exclusion, completed data sets with ethnicity coding and preventative programmes (annual mental health checks, continuity of carer and long term conditions) are key. The Health Inequality Academy in W. Yorkshire is a useful resource and, increasingly, the ICS will be offering support and resources. As a starting point, the Board could consider the use of the Board Assurance Tool to map where we are and where we want to go on this issue.

Martin Havenhand
Chairman
December 2021

Board of Directors' Meeting
07 January 2021

The Rotherham NHS Foundation Trust

Agenda item	P09/22
Report	**Chief Executive Report**
Executive Lead	Dr Richard Jenkins, Interim Chief Executive
Link with the BAF	The Chief Executive's report reflects various elements of the BAF
How does this paper support Trust Values	The contents of the report have bearing on all three Trust values.
Purpose	**For decision** ☐ **For assurance** ☐ **For information** ☒
Executive Summary (including reason for the report, background, key issues and risks)	This report is intended to give a brief outline of some of the key activities undertaken as Chief Executive since the last meeting and highlight a number of items of interest including: • Covid-19/Recovery • ICS and Rotherham Place • CQC • Staffing The items are not reported in any order of priority
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	This paper reports directly to the Board of Directors.
Board powers to make this decision	No decision is required.
Who, What and When (what action is required, who is the lead and when should it be completed?)	No action is required.
Recommendations	It is recommended that: The Board note the contents of the report.
Appendices	1. Updates from ICS CEO for November and December 2021

1.0 Covid-19

1.1 **Activity:** Through December, the Trust saw a reduction in the number of Covid-19 positive cases as per the national picture, however over the last few weeks, there has been an increase in admissions and higher inpatient numbers related to the new Omicron variant which is now the dominant virus. So far, this has not manifested in a rise in critically ill patients. Infection rates in the community have become very high in the pre-Christmas period, currently circa 1000/100,000 and likely to rise further through early January. Public Health advice is that the pressure on hospitals will likely peak in early to mid-January but there is understandably some uncertainty in the timing and scale of the peak.

1.1.1 Covid-19 related staff absence has increased dramatically and is being managed on a shift by shift basis daily. Testing capacity for staff has been ramped up accordingly. Contingency surge plans are in place to safeguard minimum staffing levels across inpatient and other frontline areas. In line with recent national guidance, non-essential meetings will be scaled back in January to allow staff to focus on managing the Omicron wave.

1.1.2 The Chief Executive of the NHS has written to all Health Providers regarding preparing the NHS for the potential impact of the omicron variant and other winter pressures. A Trust response has been prepared and further detail is available in the Chief Operating Officers board report.

1.2 **Vaccination:** The Trust has agreed to support Rotherham CCG with the ongoing public booster programme, including offering vaccinations to 12-15yr olds. This created circa 6000 appointment slots until mid-December 2022, and the programme has been extended until the end of December to support the national ambition to offer a booster to all adults aged over 18. A working group had been established in order to work with Divisions to understand the vaccination status of our front-line colleagues in readiness for when Covid-19 vaccination becomes mandated on 1st April 2022. Workshops will be organised with the Medical Director, Interim Chief Nurse and Chief Pharmacist to enable colleagues to have an opportunity to discuss any concerns.

1.3 **Recovery:** The work to recover the accumulated long waiting times is well underway within the Trust and across the system. SYB providers have made a decision to not anticipate any additional Elective Recovery Funding (ERF) within H2, given the increased expectation of 95% delivery against 2019/20 baselines. Provisional data shows that TRFT exceeded the new 89% ERF threshold in September, but given the overall SYB position, we will not receive any ERF funding relating to this. The growth in our overall waiting list has stabilised, although the number of 18+ week waiters continues to increase, with 5 specialties accounting for two-thirds of the long waiters. Increased referral volumes since March 2021, ongoing Infection Prevention and Control requirements and increased staff absence are all contributing to the growth. We are maximising opportunities to introduce new ways of working in order to better manage the demand and to maximise our capacity, and this should support some of the most challenged specialties in Q4. Whilst all Trusts are facing similar elective care challenges, TRFT is in the top ten acute or combined Trusts in the country for overall Referral to Treatment (RTT) performance in October (latest national data), and has delivered the best rate of improvement in this key elective care metric over the 12 months to August 2021. The number of year-long waiters is under 40 as of mid-December, which is a more than 95% reduction on the peak of February 2021. Further information is provided to Board in a separate paper.

1.4 **Urgent and Emergency Care Activity:** The Trust continues to see and treat a consistent number of attendances through our Urgent and Emergency Care Centre (UECC) showing an increase in ambulance dispositions since my last update in October, the ambulance service and other local Trusts have experienced significant pressures over the last few month. The effects of increased long length of stay and complexity of patients has caused difficulties and long waits within our emergency pathways. We have commenced focused planning in preparation for an increase in cases due to the Omicron variant.

1.5 **Acute Care Transformation (ACT) programme**: A new CEO and COO-led programme has been commenced to systematically deliver improvements across the Trust's internal acute pathways. This has been informed by staff engagement and comprises five key workstreams, each with an executive lead and a divisional lead. A full description of this work will be reported through the Finance and Performance Committee in due course.

2.0 Integrated Care System (ICS) and Rotherham Place Development

2.1 Appendix one is the usual update from the ICS Chief Executive System Leader, which is provided for information and covers the months of November and December 2021.

2.2 Rotherham Place continues to focus on the Rotherham Health and Social Care Partnership and the Rotherham Place Plan. It has also re-instated its weekly gold command meetings in the light of the increased threat from the new Omicron variant.

2.3 The new ICB Chief Executive (Designate) has now been announced and Mr Gavin Boyle will take up the role formally at the beginning of February 2022.

3.0 Care Quality Commission Update

3.1 The focus on improvement work to address the CQC findings following the inspection in summer continues and is being led by the Interim Chief Nurse. Work continues on the application process for removal of the Section 31 for paediatrics. Further detail on the work associated with the CQC can be found in the Interim Chief Nurse's report.

4.0 Infection Prevention and Control

4.1 In response to a number of healthcare associated infections, the Trust invited NHSEI in to walk the patient journey and this took place on 10th December 2021. Whilst there were a small number of issues that remain unresolved and are being addressed, overall the review was positive with no significant concerns.

5.0 Staffing

5.1 I am pleased to report that, following an interview process, Sally Kilgariff, our current Director of Operations has been successful in being appointed as the Chief Operating Officer and will take over from George Briggs when he retires in June 2022.

5.2 The staff survey had now closed with the final overall response rate being 59.6% (2779 respondents from an eligible sample of 4661 staff). This is a further improvement on the 2020 response rate of 52.2% and compares favourably with the average this year for Acute and Community Trusts of 51.1%. The Trust will carefully consider the results, which it is anticipated will be published in February 2022, to identify areas of good practice and opportunities for improvement.

6.0 Cyber Vulnerability

6.1 Late on Friday 10th December 2021, a cyber vulnerability was detected globally relating to a component of many software systems called “log4j” which is used by software developers as they create applications. As it is deeply embedded into many software systems, it is difficult to find. On Saturday 11th December the Government Security Group initiated work across government and sectoral cyber teams to understand potential risks and exposure. NHS Digital issued an urgent CareCert notice which was responded to promptly and as further information was shared globally and across the NHS, our IT team started a process to assess and individually contact our 142 software suppliers, an internal group has been stood up which meets every 2 days. In advance of software suppliers issuing patches, they disabled the vulnerability on effect external facing systems on Tuesday (14/12/21) night. So far the NHS has not seen any evidence of this vulnerability being used against any NHS organisation, and many of the software suppliers contacted have confirmed their software is not affected. Our IT server team will apply software vendor patches as they are made available.

Dr Richard Jenkins
Interim Chief Executive
January 2022

South Yorkshire and Bassetlaw Integrated Care System

Chief Executive Report

Health Executive Group

9th November 2021

Author(s)	**Andrew Cash**
Sponsor	

Is your report for Approval / Consideration / Noting

For noting and discussion

Links to the ICS Five Year Plan (please tick)

Developing a population health system

- ☑ Understanding health in SYB including prevention, health inequalities and population health management
- ☑ Getting the best start in life
- ☑ Better care for major health conditions
- ☑ Reshaping and rethinking how we flex resources

Strengthening our foundations

- ☑ Working with patients and the public
- ☑ Empowering our workforce
- ☑ Digitally enabling our system
- ☑ Innovation and improvement

Building a sustainable health and care system

- ☑ Delivering a new service model
- ☑ Transforming care
- ☑ Making the best use of resources

Broadening and strengthening our partnerships to increase our opportunity

- ☑ Partnership with the Sheffield City Region
- ☑ Anchor institutions and wider contributions
- ☑ Partnership with the voluntary sector
- ☑ Committment to work together

Where has the paper already been discussed?	
Sub groups reporting to the HEG:	**System governance groups:**
☐ **Quality Group**	☐ **Joint Committee CCGs**
☐ **Strategic Workforce Group**	☐ **Acute Federation**
☐ **Performance Group**	☐ **Mental Health Alliance**
	☐ **Place Partnership**
☐ **Finance and Activity Group**	
☐ **Transformation and Delivery Group**	

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 provides a summary update on the work of the South Yorkshire and Bassetlaw health and care partners for the month of October 2021.

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

Chief Executive Report

SOUTH YORKSHIRE AND BASSETLAW
INTEGRATED CARE SYSTEM

Health Executive Group

9th November 2021

1. Purpose

This paper from the South Yorkshire and Bassetlaw (SYB) Integrated Care System (ICS) System Lead provides an update on the work of the South Yorkshire and Bassetlaw health and care partners for the month of October 2021.

2. Summary update for activity during October

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

After a slight reduction in new Covid cases over recent weeks there are now signs of small increases detected across SYB. This coincides with the end of the Half-Term Holiday as children return to schools and colleges combined with the resumption of regular Covid testing.

The majority of Covid cases remain across younger age groups (under 18s) but there are signs that cases in the over 70s are flattening and declining in some areas. There is a rise within the 50-69 year-old age group which could translate into more hospitalisations.

Regionally, SYB remains in the middle of the pack across the wider region - South West, North East, South East, East of England all showing higher cases – and within Yorkshire and The Humber with County Durham, North Yorkshire/York and Cumbria are all showing higher rates.

Public health teams continue to provide robust support to prevent large-scale outbreaks which are typically confined and isolated to smaller group settings. It is highly likely that Covid cases will continue to rise as we head into the Winter and contingency plans are being developed with our health and care partners to manage system pressures, promote public health messaging and support the Covid vaccination and booster campaign.

SYB's Covid Vaccination Programme continues to provide oversight for the regional roll-out of both the boosters and the primary vaccination offer, including third doses for eligible groups. The focus remains on protecting care homes, the health and care workforce and supporting the School Age Immunisation Service (SAIS) with the 12-15 year-old single vaccination offer.The SYB programme is progressing well against the deadlines for these priority areas.

2.2 Regional update

2.2.1 Leaders meeting

The North East and Yorkshire (NEY) Regional ICS Leaders meet weekly with the NHS England and Improvement Regional Director. During October, discussions focused on emergency care and winter resilience, planning and recovery, health inequalities and ICS development and the ongoing response to Covid..

2.3 National update

2.3.1 Comprehensive Spending Review

The Comprehensive Spending Review (Autumn Budget 2021) outlined a range of new investments that will support SYB's health and care system to improve waiting lists, reduce health inequalities and invigorate SY's transport infrastructure.

Our health and care system will receive a share of £5.9 billion of new funding which is being allocated to support the NHS' COVID-19 (Covid) recovery. With the main aim of reducing waiting lists and speeding up diagnostics, the Spending Review committed towards the purchasing of new hospital beds, equipment, estate developments, improving digital technology/connectivity and the launch of new community-based diagnostic 'hubs' (as recently reported for The Glass Works in Barnsley and the Montagu Hospital site in Mexborough).

The Spending Review also announced a range of investments that will provide a boost towards levelling-up across SYB; a planned increase of 6.6 per cent on the National Living Wage (up to £9.50 an hour), a Covid recovery fund of £2 billion pounds for schools/colleges and £640m annual funding to be allocated to address rough sleeping and homelessness. Regionally, £570 million will also be made available to fast-track transport infrastructure projects including active and green travel schemes in South Yorkshire.

2.3.2 Winter preparedness funding

SYB health and care partners have been allocated £8 million pounds of dedicated new funding to directly address winter preparedness plans.

The NHS continues to experience significant levels of pressure. The continued impact of managing Covid, plus the recovery of services and return to usual activity levels has led to a challenging summer; especially in the context of constrained capacity due to Covid related infection prevention and control (IPC) and workforce issues.

As partners move into the winter months with more unknowns than usual, we need to plan to manage capacity to respond to demand that may be fuelled by further waves of Covid and/or severe outbreaks of respiratory and other illness. Resilience over winter can only be achieved through taking a system led approach and through detailed scenario planning, at both system and Place, we are developing robust strategies to alleviate system pressures.

Partners are continuing to work collaboratively on the consistent and coordinated deployment of public health messaging, led through South Yorkshire's Local Resilience Forum (LRF) - which includes the NHS, local authorities, public health teams and police, fire and rescue services.

Thanks are extended to all colleagues in the health and care system for their ongoing hard work and dedication through this very busy time

2.4 Integrated Care System update

There have been a number of developments relating to our transitional journey into becoming the South Yorkshire Integrated Care Board (SYICB) by April 2022.

At the end of September, colleagues across our four Clinical Commissioning Groups (CCGs) in Barnsley, Doncaster, Rotherham and Sheffield alongside our current ICS-based teams, were given letters that provided greater clarity over future employment statuses.

We shortly hope to have appointed SY's future designate Chief Executive Officer (CEO) for the SYICB. The designate Chair, Pearse Butler, has been overseeing the selection process alongside a system-representative panel, including colleagues from Healthwatch, Local Authorities and the

NHS.

We have been working on the refreshed System Development Plan and working with our regional NHS team in the North East and Yorkshire (NEY) to develop a '4+1' process to review our systems' Readiness to Operate Statement (ROS) assessments; this is a structured framework that requires evidence of SYB's ability to start working as an ICB. The checklist criteria include the appointment of leadership roles, financial planning requirements and information governance processes, to name a few. The expectation is that the ROS outputs will be agreed with the regional team and shared with the National Director of System Transformation in November.

A wide-range of published guidance about the development of national integrated care systems continues to be uploaded to the NHS Futures website. Most recently, partners have been discussing our transition and development journey and starting to put a structure around the future board/core requirements as we move closer towards the national deadline in April 2022.

This has included engaging with partners on two key aspects of the ICB Constitution - its composition and how partners will be nominated. This work is being led by SYB's designate leaders, Pearse Butler, Independent Chair and Chair Designate of the future SY ICB organisation. It is hoped that the Chief Executive Officer (CEO), which is now in the latter stages of the interview process, will join the ICB development work shortly.

South Yorkshire's four clinical commissioning groups (CCGs) in Barnsley, Doncaster, Rotherham and Sheffield, will present the final proposals for the future board make up and process for appointment to it at the Joint Committee of Clinical Commissioning Groups (JCCCG).

2.5 Launch of Digital North Accelerator Programme

A new digital accelerator programme, co-developed by four regional Academic Health Science Networks (AHSN's), has been launched with the aim to support national health challenges exacerbated by the pandemic.

Yorkshire & Humber AHSN, Health Innovation Manchester, Innovation Agency (AHSN for the North West Coast) and AHSN North East and North Cumbria are leading the new programme, enabling the most successful regional solutions to be guided towards national adoption through the Innovation Exchange programme.

The 2021 "Restore, Reset and Recover" programme will deliver digital innovations which meet the recovery priorities of our NHS partners as they respond to the continuing impact of Covid.

2.6 Children's Hospital Charity

Outstanding fundraising efforts by colleagues at The Children's Hospital Charity's has raised more than £750,000 from the Bears of Sheffield auction. This successfully completes their three-year appeal to transform the Cancer and Leukaemia ward at Sheffield Children's Hospital NHS Foundation Trust.

2.7 Partner organisation appointments

Dr Graeme Tosh has been appointed as the new Executive Medical Director of the Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) and will replace the current Medical Director, Dr Nav Ahluwalia, in spring next year.

Tracey Wrench, the Executive Director of Nursing and Allied Health Professionals and Deputy Chief Executive, has also announced her retirement and will leave RDaSH on March 22 next year.

2.8 British Medical Association recognition for SYB health equality and prevention schemes

The British Medical Association (BMA) has referenced a number of SYB's health equality and prevention schemes as exemplary case studies in its most recent toolkit for clinicians; the QUIT Programme (treating tobacco addiction) with Yorkshire Cancer Research, The SOAR community regeneration project (chronic pain support group, North Sheffield) and Page Hall Medical Centre's translated public health videos (into different languages).

3. Finance

The revenue surplus at Month 6 (H1 – first half of the year) is £26.6m which is an increase of £4.1m on the forecast surplus reported at Month 5 of £22.5m. This surplus relates to Providers only. CCGs have reported a break even position at Month 6. Capital spend reported at Month 6 is £28.4m which is £1.9m under spend against plan at Month 6.

Plans are currently being agreed for the second half of 2021/22 now that the system envelope has been announced. Submission of the system plan is due on 16th November.

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

Date: 4th November 2021

South Yorkshire and Bassetlaw Integrated Care System

Chief Executive Report

Health Executive Group

14th December 2021

Author(s)	**Andrew Cash**
Sponsor	

Is your report for Approval / Consideration / Noting

For noting and discussion

Links to the ICS Five Year Plan (please tick)

Developing a population health system

- ☑ Understanding health in SYB including prevention, health inequalities and population health management
- ☑ Getting the best start in life
- ☑ Better care for major health conditions
- ☑ Reshaping and rethinking how we flex resources

Strengthening our foundations

- ☑ Working with patients and the public
- ☑ Empowering our workforce
- ☑ Digitally enabling our system
- ☑ Innovation and improvement

Building a sustainable health and care system

- ☑ Delivering a new service model
- ☑ Transforming care
- ☑ Making the best use of resources

Broadening and strengthening our partnerships to increase our opportunity

- ☑ Partnership with the Sheffield City Region
- ☑ Anchor institutions and wider contributions
- ☑ Partnership with the voluntary sector
- ☑ Committment to work together

Where has the paper already been discussed?

Sub groups reporting to the HEG:

- ☐ **Quality Group**
- ☐ **Strategic Workforce Group**
- ☐ **Performance Group**
- ☐ **Finance and Activity Group**
- ☐ **Transformation and Delivery Group**

System governance groups:

- ☐ **Joint Committee CCGs**
- ☐ **Acute Federation**
- ☐ **Mental Health Alliance**
- ☐ **Place Partnership**

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 provides a summary update on the work of the South Yorkshire and Bassetlaw health and care partners for the month of November 2021.

Recommendations

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

Chief Executive Report

SOUTH YORKSHIRE AND BASSETLAW
INTEGRATED CARE SYSTEM

Health Executive Group

14th December 2021

1. Purpose

This paper from the South Yorkshire and Bassetlaw (SYB) Integrated Care System (ICS) System Lead provides an update on the work of the South Yorkshire and Bassetlaw health and care partners for the month of November 2021.

2. Summary update for activity during November

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

SYB has between 300-400 cases of Covid across the patch and is faring better than regional counterparts in The Humber, North York/Yorkshire and County Durham.

As reported last week, previous high case rates across under-18s are starting to move in closer range of other age groups. This same downward trend continues across our other, more vulnerable, age groups (particularly the over-60's cohorts), which is due to the excellent uptake of the Covid vaccine boosters so far.

In terms of system pressures, Covid-related hospital bed occupancy is at just over 250 patients; it's a slight drop compared with previous weeks but not necessarily a downward trend and likely to rise again soon given that attendances at SYB's emergency departments are already very high.

We also heard about a new Variant of Concern called Omicron (B.1.1.529) which was identified as a significant threat to public health by the World Health Organisation (WHO) due to its higher transmissibility and larger number of mutations to its spike protein (compared with other strains such as Delta). At the time of writing (6th December) there are no cases of Omicron in SYB but its highly probable that there will be given its detection in the North West and East Midlands.

To counteract this, SYB's Covid Vaccination Programme is undertaking a ramped-up booster programme between now and the end of January 2022 to support the immunization of all over-18's in the region.

2.2 Regional update

2.2.1 Leaders meeting

The North East and Yorkshire (NEY) Regional ICS Leaders meet weekly with the NHS England and Improvement Regional Director. During November, discussions focused on the ongoing Covid response and vaccination programme, urgent and emergency care, winter resilience, planning and recovery and ICS development (including feedback from the NEY transition oversight group).

2.3 National updates

2.3.1 Core20PLUS5 – reducing health inequalities across systems

The Core20PLUS5 is a national NHS England and NHS Improvement (NHE E/I) approach to support the reduction of health inequalities at both national and system level.

The new scheme aims to accelerate clinical improvements in five crucial areas – maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis and hypertension – and is calling on ICSs to lead the way in progressing with this agenda.

With health inequalities permeating all aspects of health and care recovery, it's recognised that health inequalities tend to affect the most deprived 20 per cent of the national population (identified by the Index of Deprivation).

The first action was for systems to call on partners to complete a national survey (closed 19th November) in which SYB supported on several occasions with regional partners.

This specifically includes partnering with the Yorkshire & Humber Academic Health Science Network (Yorkshire & Humber AHSN) to call for regional case studies.
.

2.3.2 Health and Care Bill – third reading

The Health and Care Bill continues its passage through Parliament (18th November) having reached the 'Report Stage' and has since passed with a majority (294 to 244) to ensure this will continue to make its way into the House of Lords.

This coincided with policy publication, 'Build Back Better: Our Plan for Health and Social Care' (19th November) which detailed the Governments plans to address the challenges in adult social care.

Alongside the announcement of the £86,000 personal care cap from October 2023 (over a person' lifetime) includes further details about the proposed Health and Social Care Levy; this UK-wide tax increase of 1.25 per cent will be funded through National Insurance contributions (NICs) and will be fully reinvested back into the health and care system.

The NHS Confederation, broadly supportive of the Bill measures, has also been expressed concern over some aspects of the proposals – particularly the proposed (new) powers for the SoS to become lawfully responsible for local service reconfigurations and the implications these will have on local intelligence/decisions around future workforce demands.

2.3.3 Social care white paper

The 'People at the Heart of Care: adult social care reform' report (published 1st December) sets out the ambitions for the next decade to address financial and geographical imbalances of social care provided across England.

This includes major announcements on new investments, integrating care with other agencies (social housing), digital innovations and staffing, there are areas that have been scrutinised for not addressing the immediate needs across the sector.

There are public responses to the white paper by NHS Confederation and the Local Government Association.

On a related subject, South Yorkshire became the first region in England to implement the

proposed salary increase for adult social care workers before Christmas and the official proposed date of April 2022.

2.3.4 **New merger announced across NHS digital and training organisations**

Health Education England (HEE), NHSX and NHS Digital are to merge with NHS E/I as part of a new strategy to align recruitment, training and retention functions across the NHS (and social care) under the same umbrella organisation.

These separate organisations are work towards Covid recovery transformation and this new integration is a further development towards system working/a 'one workforce' approach to tackle the enormous challenges that lie ahead across health and care.

2.3.5 **NHS Confederations (annual) ICS Conference**

The NHS Confederation's ICS Conference (10th November) provided a number of useful discussion points for system preparations as they prepare for the transition to become NHS statutory bodies.

A consistent theme throughout the event was exploring how ICS' can address the pressing needs of today (reducing waiting lists, supporting our workforce, improving patient-flow) whilst also accelerating with pre-pandemic rapid transformation priorities to reduce health inequalities.

In short, there was broad consensus that the strength of Place-based partnerships was integral in developing systems that responded adeptly to 'local' population health needs.

Amanda Pritchard acknowledged that this has had been an "extraordinarily challenging couple of years for the NHS" before explaining how ICSs have been central in underpinning the considerable benefits of collaborative working at Place-level (referencing PCNs as a key enabler across systems).

Dr Claire Fuller, Senior Responsible Officer (SRO) of the Surrey Heartlands ICS, who will oversee this specific collaboration between PCNs, ICSs and NHS E/I that will ensure health inequalities are focused-in on local population health needs.

There was strong encouragement for regional systems to continue to innovate, do things differently and share best practice/learning with national partners.

2.3.6 Net zero campaign and regional action plan

The 'Healthier Planet, Healthier People' staff campaign is NHS E/I's response to the climate crisis. The Conference of the Parties (COP26) highlighted the enormous threat posed by inactivity and this new workforce-focused campaign puts a spotlight on the progress made one year on since the pledge was first made.

Closer to home, the newly formed Yorkshire & Humber Climate Commission, an independent advisory body with members from the public, private and third sectors (including South Yorkshire Mayor, Dan Jarvis MP), has developed a 50-point action plan to address climate change in the region.

2.3.7 Round-up of national system pressures

A range of new reports have been published which highlight the exceptional system demands faced across health and care systems in England and the UK.

These include:

- NHS E/I - NHS responds to highest number of 999 calls on record
- The British Red Cross - people who frequently attend accident and emergency (A&E) services make up less than one per cent of the population - yet account for a significant proportion of all A&E attendances, ambulance journeys and hospital admissions
- Association of Ambulance Chief Executives (AACE) – delayed hospital handovers: impact assessment of patient harm
- Royal College of Nursing (RCN) - New analysis confirms RCN warnings that current pressures on the NHS in England are unsustainable
- NHS Confederation - Under pressure: NHS priorities this winter

2.4 Integrated Care System update

2.4.1 New CEO designate for SYICB appointed

Following an extensive recruitment process, Gavin Boyle has been appointed as the new Chief Executive designate of the South Yorkshire Integrated Care Board (SYICB).

Gavin has over 30 years' experience of working within NHS organisations having held several Board-level posts and more recently has been a Chief Executive Officer (CEO) at Yeovil Hospital, Chesterfield Royal Hospital and will leave University Hospitals of Derby and Burton in January 2022.

This senior appointment is aligned with the Government's Health and Care Bill, which aims to ensure all parts of the country host an Integrated Care System (ICS) by April 2022.

The South Yorkshire and Bassetlaw Integrated Care System (SYB ICS) is working on enacting the local arrangements set out in the Bill to support the formation of a new statutory NHS body – the South Yorkshire Integrated Care Board (SY ICB) – which will come into effect from the 1st April 2022.

The confirmation of senior leaders within these new NHS statutory bodies is a key element of the ICB transition.

2.4.2 System Development Plans

There are new documents relating to the ICB development (6th December); the Board Level Consultation Document, Proposed Job Descriptions for South Yorkshire ICS Executive roles and Equality and Diversity (EDI) Demographics of the South Yorkshire CCGs and ICS PMO Executive Boards and Governing Bodies. These are all available to view on the People's Hub within the Board Consultation folder.

2.4.3 System Lead retirement

As per my message (19th October) to all staff across the Programme Management Office (PMO) and publicly (3rd November), I will retire as System Lead at the end of December 2021.

I will continue to support the new designate Chair, Pearse Butler, and ensure a smooth handover to the newly appointed designate CEO, Gavin Boyle, once in post.

2.5 National award win for SYB

SYB's Primary Care Workforce and Training Hub won 'Preceptorship of the Year - Under 1,500 Nursing Staff' at the Times Workforce Summit and Awards ceremony (17th November).

The Vocational Training Scheme (VTS) was praised by judges as being an "excellent submission" that responded to "workforce need with excellent multi stakeholder engagement across the system… a clear winner".

SYB was also a runner-up within the 'Best International Recruitment Experience' category. This was recognition of a partnership between SYB ICS and the NHS Professionals International (NHSPI), which saw hundreds of international nurses arrive safely in the region during 2020/21 despite the challenges of the pandemic.

2.6 SYB selected to pilot new childhood obesity programme

SYB has been selected to host a new centre that will provide specialist multidisciplinary wrap-around support for obese children (and their families) to support weight loss.

Sheffield Children's Hospital NHS Foundation Trust will host the new centre as part of a new NHS E/I programme, joining 14 other specialist clinics nationally that will provide intensive support to children that are referred into the programme.

This new comprehensive support package will help to combat a range of illnesses caused by obesity which affects one in five children in the UK and can increase the likelihood of a child developing serious health issues; Type 2 diabetes, liver conditions, early heart disease, breathing difficulties, sleeping problems and mental health issues – all of which can dramatically impact on quality of life.

2.7 Barnsley's Covid Memorial Project

The Covid Memorial Project launched in Barnsley (18th November) with the unveiling of a bronze sculpture to commemorate the 900 who have sadly lost their lives during the pandemic. As part of the Project, health and care partners across Barnsley produced a short, poignant documentary film.

The ceremony was covered in mainstream media by BBC News, ITV and Channel 4 alongside local news agencies.

2.8 The NHS Digital Weight Management Programme (NHS DWMP) Launches in SYB

SYB has joined up with NHSE/I to boost the number of patients and staff referred into the new NHS Digital Weight Management Programme.

This dedicated programme provides a 12-week online behavioural and lifestyle online course to individuals living with obesity who also have either diabetes, hypertension, or both.

We have started targeted staff communications to utilise key practitioners across the system – such as Allied Health Professionals (AHP's) to increasing the level of referrals across SYB.

There are national targets and local performance monitoring by North East and Yorkshire and for each region.

SYB is currently falling short on weight management referrals – there's been a 36% decrease since in the volume of Tier 3 referrals compared with pre-Covid numbers.

2.9 Well Rotherham Project - exemplary new physical and social regeneration programme

The Well Rotherham programme, one of 10 national innovation platforms funded by Public Health England (PHE), produced its first report to summarise the transformative impact that co-production between Place-partners and local communities has had on the town.

The programme delivers a range of socio-economic improvements that are helping to reduce health inequalities in Rotherham (and surrounding areas) but also connect local communities with a range of impressive new entrepreneurial, educational and social engagement prospects - including a guide to getting active.

One of the key findings from the report was identifying influential people in these communities with great ideas - and backing them. Key achievements from the programme include micro-funding £374,000 of grants for community projects, developing a new social space at Waverley and launching a new science and educational annual event via the North Star Science School.

2.10 QUIT stop smoking programme appoints more than 200 NHS 'champions'

More than 200 NHS staff have become 'QUIT Champions' as part of their role to help hospital patients and staff give up smoking.

As part of the line of the non-clinical workforce support for the QUIT Programme, 222 QUIT Champions to encourage hospital patients and staff to give up smoking.

The QUIT Champions support smokers to quit, highlighting the health benefits of stopping and encourage them to take advantage of the support offered by the innovative Programme. Patients are then referred for ongoing support with the Tobacco Treatment Advisors as part of routine care during their time in hospital.

2.11 Children and Young People's Mental Health Strategic Plan (2021)

The NHS Long-Term Plan sets out a commitment to improving children and young people's mental health services and as part of this, South Yorkshire & Bassetlaw ICS is required to publish a Children and Young People's Mental Health Strategic Plan for 2020 – 2023 which is now available

Transformation will take place locally across partnerships across SYB, in which the ICS will facilitate a joint approach to transformation seeking out feedback on the proposed improvements for all those with a mental health need aged 0 -25.

Areas of focus include access to community mental health services, eating disorder services, crisis services, Mental Health School Teams [MHSTs], young adult 18-25 services and bereavement and suicide prevention services.

Members of the ICS's Children and Young People's Mental Health Steering Group have considered the case for change and agreed a number of priorities. Children and young people supported by Chilypep have also created some infographics to summarise South Yorkshire & Bassetlaw ICS's Strategic Plan.

3. Finance

As the financial plans have only recently been submitted there is limited financial reporting available for Month 7. NHSE/I has asked that the Month 7 reported financial position is the same as Month 6, which was a favourable variance against plan of £26.6m. The system submitted a balanced plan for the year, which would result in a planned deficit of £26.6m for the second six months.

The forecast for capital remains unchanged, which is break even against plan after allowing for the allowable overspend of £1.5m for the Accelerator schemes.

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

Date: 8th December 2021

Board of Directors' Meeting
07 January 2022

The Rotherham NHS Foundation Trust

Agenda item	P10/22
Report	**Operational Objectives 2020/21 Review**
Executive Lead	Michael Wright, Deputy Chief Executive
Link with the BAF	B1, B4, B5, B7, B8, B9, B10, B12
How does this paper support Trust Values	Ambitious – The paper provides detail of the delivery of the ambitious operational objectives for 2021/22 as at the end of Month 8. Together – colleagues work together to ensure that the continual monitoring and assurance of operational objectives is underpinned by robust governance arrangements.
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary	The purpose of this paper is to present to the Board of Directors a review of progress against the 2021/22 Operational Plan priorities and associated programmes as at Month 8. At the end of Month 8, one of the ten programmes is rag rated Blue (completed) one is rag rated Green (on plan), seven are rag rated Amber (behind plan with mitigation or actions in place to recover) and one is rag rated Red (behind plan with more significant action required). Mitigation and recommendations for action against programmes that are rag rated amber and/or red are described in the body of the report.
Due Diligence	The content of individual monthly highlight reports has been presented to Board Assurance Committees.
Board powers to make this decision	The principal purpose of the Board is to support the timely delivery of the Trust's strategic objectives / Annual Operational Plan, whilst being assured as to compliance with appropriate statutory and legislative requirements, such as those determined, inter alia, by the Care Quality Commission (CQC).
Who, What and When	Individual Executive Directors act as Executive SROs (Senior Responsible Officers) for each area for ensuring achievement of the Operational Objectives and priorities and are responsible for realising the relevant milestones.
Recommendations	It is recommended that Board consider any actions or additional assurance required as a result of this report.
Appendices	1: Operational Objectives 2021-22 Programme Highlight Reports (October - November 2021)

1.0 Introduction

1.1. The Operational Plan for 2021/22 is built around six key themes:-

- Safely exit the Covid-19 pandemic
- Focus on the fundamentals of care
- Deliver elective recovery for patients
- Empower and enable staff to deliver
- Deliver a step change improvement in flow
- Drive the organisation forwards

1.2. The ten priorities that derive from the above themes are supported by 10 operational programmes that are set out to deliver the organisational objectives for the Trust this year.

1.3. The delivery and monitoring of the programmes utilises a standardised Highlight Report (see Appendix 1) so that the Trust can maintain a clear line of sight on progress.

1.4. The Highlight Reports incorporate two Red, Amber, Green (RAG) indicators to assist assurance. The first looking at the progress of the plan of delivery (achievement of milestones) and the second examining the impact of that progress (realisation of the metrics).

1.5. This paper presents a high level update on progress during Months 7 and 8, against each of the programmes of work and reports, by exception, any areas of concern with recommendations for continuance into the next planning cycle.

2.0 Progress against Operational Objectives and Priorities

2.1 Each of the programmes supporting the delivery of the Trust's Operational Objectives and Priorities have been BRAG (Blue, Red, Amber, Green) rated as to their status at the end of September 2021 as illustrated below:

- Completed
- On plan
- Behind plan with mitigation or actions in place to recover
- Behind plan, no mitigation or more significant action required

2.2 The following tables provide the summary position at Months 7 and 8 on each of the programmes of work with their respective BRAG rating. More detailed highlight reports are attached at Appendix 1.

Theme: Safely Exit the Covid-19 Pandemic

Programme	Scope	Summary Position	Status
01.1 Health and Wellbeing (Executive Director of Workforce and Organisational Development)	To deliver the full programme of health and wellbeing initiatives for staff	Covid booster and flu campaigns successfully completed. Occupational Health tender evaluated with a decision on a new provider to be made by year end. NHS Wellbeing framework launched. Staff Survey completed with an improvement on the previous year's response rate (provisionally reported as 58%).	Green
01.2 Identify new practices to embed (Director of Strategy, Planning and Performance)	Support to clinical and corporate areas to understand what positive changes made through Covid-19 would want to be maintained / developed / embedded	Decision made to undertake this work as part of the Operational Plan 2022/23 process during quarter four.	Amber

Theme: Focus on the Fundamentals of Care

Programme	Scope	Summary Position	Status
02.1 Standards of Care and Quality Improvement (Executive Chief Nurse and Director of Infection, Prevention, Control (DIPC)	Embed agreed standards of care and support teams to deliver and embed quality improvement	Quality Improvement projects are having a positive impact on performance notably in relation to falls and pressure ulcers. The relaunch of the Quality Strategy is delayed until next year to allow time to develop proposals to include a Quality Academy function.	Amber
02.2 Learning from Deaths (Executive Medical Director)	Embed effective learning from deaths practices and deliver improved mortality rate	The new Mortality and Learning from Deaths Manager commenced in November. Their priority will be to work closely with divisions to review internal processes and make recommendations for improvements that will further reduce HSMR.	Amber

Theme: Deliver Elective Recovery for Patients

Programme	Scope	Summary Position	Status
03 Plan the long-term recovery of Elective Care / Operational Excellence (Chief Operating Officer)	Achieve nationally defined targets and requirements with access to Elective Recovery funds, provide staff training on recording elective care pathways	Cancellation of clinics due to site pressures and staff absence resulted in activity levels below plan in November. Referral to treatment (RTT) training tool expected to be rolled out in January. Orthopaedic Planned Care Citizens Panel meetings now scheduled to take place monthly to make recommendations for action.	Amber

Theme: Empower and Enable Staff to Deliver

Programme	Scope	Summary Position	Status
04.1 Organisational Development Programme (Director of Workforce and Organisational Development)	Design and launch organisational development programme for divisional teams	New behavioural framework launched. Divisional leadership programme to continue first phase with existing provider. 360 appraisal facilitators appointed. General Managers completed new psychometric profile analysis "PRINT" ©.	Amber
04.2 Employer of Choice (Director of Workforce and Organisational Development)	Build a culture so the Trust is seen as an employer of choice, appointing to key clinical leadership vacancies	Review of the Medical and Dental recruitment strategy has been delayed further. Medical and non-medical recruitment packs updated but not ready for publication due to set backs in graphics.	Amber

Theme: Deliver a Step Change Improvement in Flow

Programme	Scope	Summary Position	Status
05.1 Best Practice Discharge Processes (Deputy Chief Operating Officer/Director of Operations)	Ensure best practice discharge solutions. Includes digital patient flow/command centre	Mixture of results in October/November affecting the achievement of targets e.g. length of stay has increased due to high patient acuity and pressures on discharging patients. Discharge lounge is being under-utilised which is also affecting targets, but is on an improving trajectory. Best practice discharge process mapping workshops not yet completed due to site pressures and staff absence. Positive progress has been made in relation to new OPEL (Operational Pressures Escalations Levels) escalation tool roll out.	Amber

Theme: Deliver a Step Change Improvement in Flow (continued)

Programme	Scope	Summary Position	Status
05.2 Admission Avoidance (Deputy Chief Operating Officer/Director of Operations)	Implementation of an appropriate Same Day Emergency Care (SDEC) service at acute site and ensure effective ambulatory frailty pathways are in place	Same Day Emergency Care (SDEC) business case has not been finalised despite an extension to timeline. The frailty pathway and model is under review with a decision expected in January. We are working with Rotherham Clinical Commission Group and Rotherham Metropolitan Borough Council to update the local Directory of Services.	**Red**

Theme: Drive the Organisation Forwards

Programme	Scope	Summary Position	Status
06 Removal of Breach of Licence/5 Year Strategy (Deputy Chief Executive)	To have long standing breach of license lifted by March 2022 and to publish a new 5 Year Trust Strategy by the end of September 2021	The new 5 Year Strategy has been launched in December, and as such this programme will be closed.	**Completed**

3.0 Conclusions

3.1 The Board Assurance Committees play a key role in ensuring effective oversight and delivery of the Operational Plan. In December, the Committees considered reports on progress in all areas and confirmed the following assertions with recommendations for action as deemed applicable.

4.0 Quality Committee

4.1 The quality improvement projects taking place across the trust are progressing well and are achieving the objectives as set out in the original mandate. This is reflected in the outcome metrics in that there have been no falls resulting in the death of a patient and the number of pressure ulcers graded 3 and 4 has also improved when compared to the same period last year. Both the Acute Medical Unit and Urgent and Emergency Care services are seeing a reduction in deep tissue injuries and unstageable pressure ulcers. The review and data interrogation of pressure ulcers graded 2 has been completed and is on track to deliver.

4.2 The Frailty Quality Improvement Week successfully completed in October. An action plan is in implementation with delegated activity and timescales for completion set between 30 and 90 days. The quality improvement methodology deployed during the QI week followed the “Plan, Do, Study, Act” (PDSA) approach. The teams involved have been fully engaged in the process

4.3 An internal decision has been taken to postpone the relaunch of the Safe and Sound Quality Strategy until next year to allow time to fully consider the resource and timeline implications of introducing a Quality Academy which could take up to two years to establish. For this reason the programme is rated amber status. The Standards of Care and Quality Improvement programme will however continue to deliver against the remainder of its objectives (see bullet points below) and the associated metrics will be monitored in order to measure the programme's overall success.

- Articulate and embed agreed standards of care across the organisation
- Identify clear quality improvement methodology and resources
- Support teams to deliver and embed continuous quality improvement

4.4 On 22nd December, the Quality Committee questioned the amber rag status of the Standards of Care and Quality Improvement programme due to the significant delay in plans to relaunch the Safe and Sound Quality Strategy. The Senior Responsible Officer confirmed that, in accordance with this year's programme mandate and milestone plans, the refinements to the existing strategy have already been completed and having worked alongside NHS Improvement a standardised approach is now in place. However, now that the proposal to establish a Quality Improvement Faculty has been stated, the Quality Strategy will require a re-write next year albeit subject to Trust Board approval and development of any associated business case. An outline strategy is planned for completion by the end of the year which will then be presented to Trust Board stating the reasons behind the proposal to make such a fundamental change that has ultimately affected delivery of this year's plans to relaunch an updated version of the existing strategy. The Quality Committee therefore assigned limited assurance to the programme accepting that work will continue as planned this year but with a view to continuation into next year due to proposals to develop a Quality Improvement Faculty and the impact that its development will have on trust quality priorities and next year's plans.

4.4 The Learning from Deaths Programme requires monthly updates from the contracted data provider, Dr Foster, in order to measure ongoing improvements aligned to programme delivery. However, due to ongoing national data issues Dr Foster reports are not being published on a monthly basis. This is due to a national decision and part of a process of regular changes that are being made by Dr Foster to ensure that the most accurate data is in use. Nonetheless, the data presented to the Quality Committee in December shows clear evidence that sustained progress is being made across the trust and this is having a positive impact on mortality indicators for example, without Covid HSMR (Hospital Standardised Mortality Ratio) has fallen within the expected category at 93.5 which is below the trust's internal KPI of 100. It will take some months before the data finally stabilises, however, and a true picture of HSMR can be presented.

4.5 The Medical Examiner has raised a concern at the Safe and Sound Mortality and Learning from Deaths group following publication of the National Medical Examiner's directive relating to Medical Examiner's independent scrutiny of deaths. The directive states that Stage 1/Medical Examiner independent 'scrutiny' reviews should not form part of patient records (i.e. Meditech) and as a result the trust's Medical Examiner's processing of Stage 1/scrutiny documentation has reverted to a paper-based system.

This will cause an issue with the reporting of Stage 1 reviews as the trust can no longer automatically pull the data from Meditech. The information available on Stage 1's completed will therefore be inaccurate until a workaround is confirmed. The potential change in process will have a greater impact on Medicine division due to the number of deaths occurring there and also due to capacity across the wider trust to complete mortality reviews in a timely manner. This topic was therefore highlighted to Quality Committee as a risk to programme delivery and its negative impact on the achievement of key performance indicators.

4.6 Divisional Mortality and Learning from Deaths Sub Groups have continued to provide inconsistent information to the Safe and Safe Mortality and Learning from Deaths Group which has compromised the ability of the group to undertake appropriate discussions. This is preceded by lack of quoracy at divisional mortality meetings where key themes and trends are therefore not sufficiently discussed and decisions and learning from deaths are being deferred. The newly appointed Mortality and Learning from Deaths Manager will be working closely with Divisions during the coming weeks to review internal governance processes and make recommendations to improve their effectiveness which will in turn impact positively on hospital mortality indicators and quality of patient care provision. This topic was also highlighted to Quality Committee as an overall risk to programme delivery.

4.7 No further progress has been made to commence mandatory training for Sepsis due to the delayed installation of the relevant training course into the Electronic Staff Records. It is anticipated that the work will be completed by the end of December, however, the target to achieve 85% compliance by November has therefore not been achieved. This is also highlighted as a risk to programme delivery.

4.8 The overall rag rating of the Learning from Deaths Programme is at amber status despite completing over 80% of its milestones. This is due to the number of metrics that are not consistently achieving target and the increasing level of risk this presents to overall delivery.

4.9 The Quality Committee held on 22nd December assigned limited assurance to the Learning from Deaths Programme due to ongoing technical challenges which is adversely impacting on the production of metrics.

5.0 People Committee

5.1 The Health and Wellbeing programme is delivering on all key objectives as set out in the original mandate as described below and with milestones and metrics consistently on track:-

- **Maintain national health and wellbeing offer and access regional mental health hubs/access to psychological and physical support** – Staff across the trust have access to a number of support systems including counselling and various pilot initiatives relating to healthy minds, health eating, healthy body.

- **Review Occupational Health Service Specification** – the review identified new requirements which resulted in the service going out to tender. A decision will be made on the new provider before the end of the year.

- **Encourage and embed health and wellbeing conversations** – training is available for managers on how to conduct the new appraisal process launched earlier this year. Health and wellbeing conversations are recorded in conjunction with the appraisal and career conversation elements of the discussion. The target to achieve 80% completed appraisals was exceeded in November.

- **Facilitate the process for COVID and flu vaccinations/booster jabs** – the trust is the highest performing in the region for rolling out its COVID and Flu vaccination campaigns. This is evident from the number of jabs carried out (4,016 COVID boosters – includes Rotherham Metropolitan Borough Council) and 3,003 flu vaccinations (trust staff only).

- **Improve usage of effective e-rostering to support flexibility/work life balance** – The number of rosters approved 42 days in advance is above internal target levels. Line Manager training has continued to ensure rosters are published in good time and this will ultimately support staff in achieving their work life balance goals.

5.2 The rag status of the Organisational Development Programme has been under review in recent weeks due to the delay in selecting a suitable provider to deliver the Leadership Development Programme. The Executive Management Team has now agreed to retain its Amber rag status as the decision has been taken to continue the work already started earlier this year with an existing provider. A benefits review will be undertaken in early 2022 to determine any further requirements. To support the leadership development work a new psychometric profiling tool has been introduced and there is now a full cohort of trained, 360 appraisal facilitators who will also assist leaders and their teams. This activity will support delivery of one of the key objectives of this programme which is to sustain improvements in individual and team performance and effectiveness.

5.3 The Employer of Choice programme has been set back again due reduced capacity issues. This has further delayed achievement of the key milestone (previously deferred) regarding updating the Medical and Dental Recruitment Strategy.

5.4 Progress around publication of the revamped recruitment packs (medical and non-medical) is impacted by low capacity within graphics services. However, a recruitment campaign is due to commence in December to appoint a Digital Communications Assistant. The new post holder will commence work on refreshing the Trust's website (including our recruitment pages), which will subsequently help improve our candidate attraction rates.

5.5 Medical staffing recruitment remains challenging with Acute Medicine posts being re-advertised in the British Medical Journal. Discussions are also taking place to consider possible new roles such as joint posts with Urgent and Emergency Care specialists.

5.6 The People Committee held on 17th December found limited assurance on progress due to the amber rating of two out of three programmes, however, the Committee recognised that progress is being made in relation to the Employer of Choice programme in order to restore its rag status back to Green (on track).

6.0 Finance and Performance Committee

6.1 Good progress is being made to deliver the "Plan the Long-term Recovery of Elective Care / Operational Excellence" Programme. Setbacks in achieving locally agreed targets based on the ICS Recovery Programme are attributed in part to cancellation of clinics and theatre sessions on account of prolonged periods of high escalation across the trust and also due to the impact that high levels of sickness absence within anaesthetics is having on cancellation of theatre lists. In addition, key medical workforce vacancies in some specialties is affecting our ability to manage demand coming into the trust.

6.2 As part of elective care recovery efforts nationally, the trust is expected to implement "patient initiated follow-up pathways (PIFU) across at least five major outpatient specialties before the end of March 2022. Sleep Studies and Ophthalmology are now in implementation with Gastroenterology, Ear Nose and Throat (ENT) and General Surgery in the pipeline for implementation by the end of the year (subject to internal governance approval to changes in clinical practice and processes). The development of PIFU pathways in Ophthalmology will contribute to the wider discussions taking place across the system aimed at reducing the backlog. Outcomes from the monthly Planned Care Citizens Panel meetings will also be factored into recommendations and actions to reduce backlog and overdue reviews.

6.3 One of the key objectives of the Elective Care/Operational Excellence programme is to ensure that a robust training package and clear guidance is in place to support operational managers and planning teams to record elective care pathways appropriately in systems. In order to achieve this objective the trust has worked closely with Barnsley Hospital NHS Foundation Trust to develop a bespoke Referral to Treatment (RTT) training tool. This activity is now completed. The associated training package – which is expected to be rolled out in the new year – will support the achievement of the trust's internal performance metric that 50% of all relevant staff will complete the training by February 2022, with up to 90% completed by the end of March. RTT training will then form part of a full induction package for all relevant new starters in order to further embed standard working practices across the elective care function, and also to achieve targets relating to the RTT Incomplete Standard.

6.4 Discussions scheduled to take place with divisional and corporate teams around new ways of working post-COVID and the distribution of COVID packs were not completed in October as planned due the decision taken to move this work into the 2022/23 Operational Planning process. These discussions can then incorporate the essential topics aligned to the programme around operational performance, financial and workforce sustainability and quality of service provision. However, as there is still uncertainty around the national operational planning guidance at this stage, the programme is rag rated Amber due to the potential risk this may cause to programme delivery.

6.5 The Best Practice Discharge Processes programme has two key objectives namely:

- Ensure best practice discharge processes are implemented, and
- Ensure appropriate digital solutions and processes are implemented

Unfortunately due to site pressures and continuing absence of key staff members, the workshop organised to identify improvements and develop an action plan to make changes in discharge pathways and processes has not yet taken place.

A further attempt will be made in December to complete the task; however, the delay will undoubtedly impact negatively on the likelihood of this programme achieving performance targets this year and slow down the practical application of any changes in pathways and processes identified that would otherwise improve the flow of patients through the organisation.

The movement of patients to the Discharge Lounge is intended to optimise discharge processes and improve patient flow by releasing time to care for acutely ill patients that have been admitted in an emergency or following elective treatment. However the Discharge Lounge remains under-utilised (around 20% patients discharged via the discharge lounge against a target of 40%). In order to take action to improve usage, discussions are taking place at ward level and with the Discharge Lounge team to identify the reasons behind its decline and with a view to preparing an engagement and communication campaign that will better market the service and its benefits across the Trust.

The digitisation of patient flow is progressing well through the operational control centre based on D level. The Operational Pressures Escalation Levels (OPEL) management solution will provide visibility from the control centre and across the site. Solution testing and roll out is on track for completion in December.

The number of inaccurate medicines to take out (TTOs) received by Pharmacy remains challenging and is contributing to delays in discharging patients. In response to this, Pharmacy will be prioritising services to undertake a training and education programme aimed at significantly reducing inaccuracies. The success of the training scheme will be evaluated to ensure that the desired changes in working practices are embedded.

6.6 The Same Day Emergency Care business case has not been approved despite an extension to timescales for completion. This lead to a review of the rag status of this programme. The Executive Management Team decided that more significant action would need to be taken to bring the programme back on track and as such it is now rag rated Red It is expected that the parameters of the business case will be made clear following further discussions in December and following a tour of the location by Executives.

6.7 The Frailty pilot ended in October following the planned Quality Improvement week. Lessons learned and outstanding issues have been factored into a 30, 60, 90 day transition plan along with supporting actions and delegated responsibilities for delivery. The frailty pathway model, based on the quick turnaround concept tested during the pilot phase, will continue for the foreseeable future. Patients will be assessed by frailty specialist nurses and therapists with support from the Consultant Geriatrician/frailty specialist in the emergency department or short stay area with a view to patients returning home either on the same day or within 72 hours of admission. Discussions are taking place within the Division of Medicine around the future of the frailty model and its possible configuration and specification. The next key milestone within the programme is to make the decision on the proposed clinical pathway and model by the end of January 2022.

6.8 The Breach of Licence/5 Year Strategy programme is now completed.

6.9 The Finance and Performance Committee held on 22nd December assigned limited assurance to all programmes within their remit with the exception of Removal of the Breach of Licence/5 Year Strategy which was completed ahead of plan.

The Finance and Performance Committee discussed the likelihood of achieving programme delivery across all areas by the end of the year in the light of significant operational pressures and the changing status of the pandemic. The rag status of the programmes will be updated to reflect the realistic prospect of full or partial delivery during quarter four. Where necessary papers will be presented to the Executive Management Team in order to decide on significant changes required to this year's plan and where delays may result in deferment to next year.

6.10 The Board of Directors is asked to note the content of this report.

Michael Wright
Deputy Chief Executive
January 2022

Operational Objectives 2021-22

October - November 2021

Appendix 1: Programme Highlight Reports

Board of Directors Meeting

7th January 2022

Operational Plan 21/22 Programme Highlight Report – Oct - Nov 2021

NHS The Rotherham NHS Foundation Trust

Programme: O1.1	Health & Well Being (HWB)		R
Exec Lead:	Director of Workforce & OD	**Impact**	A
SRO:	Deputy Director of HR	People	G

Current ↓

Progress Red Amber Green

Previous ↑

Overview:	To deliver a full programme of HWB initiatives available for all TRFT staff to access. This will include key priorities contained in the NHS People Plan /P&PG :- Maintain national HWB offer and access regional mental health hubs (SYB); Enhanced OH & HWB offer (review of OH service specification); Encourage and embed health and wellbeing conversations (including training and support to line managers and a means of tracking delivery); Continue to offer colleagues risk assessments; Facilitate the process for Covid (and flu) vaccinations / booster jabs in line with national guidance; Access to psychological and physical support for colleagues; Improve usage of effective e-rostering to support flexibility, planning annual leave, work-life balance.
Summary Position:	The flu and Covid vaccination programme ended on 14th November after a successful roll out of 4016 Covid booster vaccinations (Trust and RMBC combined) and 3003 flu vaccinations (Trust only). The Trust has been the best performing Trust in the region for delivering Covid vaccinations. The contract with the Trust's employee assistance provider is due to be replaced at the beginning of December. The new service will provide free, confidential advice to staff looking for mental health support. The Occupational Health Tender has been evaluated with a view to a decision being made on the new provider by the end of the year. The NHS Wellbeing Framework launched at the beginning of November. This framework will provide detailed oversight of organisational wellbeing. The national staff survey closed at the end of November.
Activities completed October/November	▪ Mental Health Awareness Day – 10th October 2021 ▪ Menopause Awareness Day – 18th October 2021 ▪ Stress Awareness Week – 1 – 5th October 2021 ▪ COVID Booster and annual Flu vaccination programmes ▪ Evaluate responses to occupational health tender ▪ Launched NHS Wellbeing Framework ▪ Closure of the national staff survey
Activities planned for December/January	▪ Develop plans to complete NHS Wellbeing Framework (by end of Quarter 4) to include staff engagement, people pulse data and staff survey information (key milestone to implement quarterly staff survey tracker moved to February 2021) ▪ Continue to seek out opportunities to bid for a variety of wellbeing opportunities such as complimentary therapies and weight loss ▪ Continue to work with ICS partners to evaluate the healthy minds, health eating, healthy body pilot
Key risks to overall delivery	▪ None

Operational Plan 21/22 Programme Highlight Report – Oct - Nov 2021

The Rotherham NHS Foundation Trust

Programme: O1.2	Identify new practices to embed		
Exec Lead:	Director of Strategy, Planning & Performance	**Impact**	R / A / G
SRO:	Assistant Director of Strategy, Planning & Delivery	F&PC	

Current Progress: Red – Amber – Green

Previous

Overview:	Understand the current sustainability of services post COVID. Identify key actions / areas for focus for unsustainable services Identification of changes made through COVID which services / corporate teams want / hope to maintain Support services / corporate teams to maintain the positive changes made through COVID
Summary Position:	A decision has been made to move this work to within the Operational Planning 2022/23 process which will commence in the new year therefore planned discussions with General Management have been postponed along with distribution of the COVID packs.
Activities completed October/November	▪ None
Activities planned for December/January	▪ Commencement of operational planning cycle
Key risks to overall delivery	▪ Continued uncertainty around national operational planning guidance
Key issues	▪ None

Blue – Achieved / Completed

Green – On Target / Plan

Amber – Behind plan with mitigation or actions in place to recover

Red – Behind plan no mitigation or more significant action required

Operational Plan 21/22 Programme Highlight Report – Oct - Nov 2021

The Rotherham NHS Foundation Trust

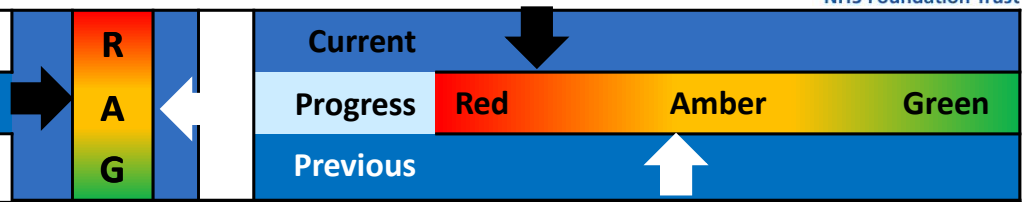
Programme: O2.1	Standards of Care & Quality Improvement		R	Current
Exec Lead:	Executive Chief Nurse & DIPC	**Impact**	A	**Progress** Red Amber Green
SRO:	Dep. Chief Nurse (Safety, Safeguarding, Risk Management)	Quality	G	**Previous**

Overview:	Review and relaunch the Safe and Sound Quality Strategy. Articulate and embed agreed standards of care across the organisation consistently. Identify clear quality improvement methodology and resources. Support teams to deliver and embed continuous quality improvement
Summary Position:	Falls data has been mapped against the new national guidelines and is being measured against 1000 bed days. Latest falls data indicates the trust is consistently below moderate harm and above lower/no harm levels nationally. Education work is continuing across divisions to reduce falls in high risk areas such falls at the bedside and toilet areas. Category 2 Pressure ulcers data has been reviewed and is on track to deliver. The Frailty QI week completed in October as planned. A 30/60/90 day action plan is in place to support teams to embed identified improvements. An internal decision has been made to postpone the re-launch of the Safe and Sound Quality Strategy until the new financial year to allow time to consider the possible establishment of a Quality Improvement Faculty. A QI Faculty will require specific funding and could take up to two years to establish. The relaunch of the Quality Improvement toolkit aligned to the strategy relaunch will also need to be postponed following this decision, however, the Quality Matrons will continue to support teams to utilise improvement methodology currently in place until the toolkit can be launched.
Activities completed October/November	▪ Conduct data quality checks via Datix to reflect National Falls Network national averages ▪ Implement escalation plan and proforma for deteriorating patients on Meditech ▪ Review Category 2 Pressure ulcers ▪ Commence Quality Dashboard refresh ▪ Update Standards of Care and Quality Improvement milestone plan for Q4 (requires Executive approval) ▪ Commence Frailty quality improvement week and progress Falls EPIQ into ward areas as listed in the above summary
Activities planned for December/January	▪ Seek Executive approval to close the programme two months early (end January) due to postponement of the re-launch of the quality strategy and associated toolkit until next year ▪ Continue to embed improvements identified during implementation of the 5 Quality Improvement Projects already started this year
Key risks to overall delivery	▪ Insufficient time to prepare the updated strategy in full and present to Trust Board during quarter four.
Key issues	▪ None

Operational Plan 21/22 Programme Highlight Report – Oct - Nov 2021

The Rotherham NHS Foundation Trust

Programme: O2.2	Learning from Deaths		
Exec Lead:	Executive Medical Director	**Impact**	
SRO:	Deputy Medical Director for Professional Standards	Quality	



Overview:	Improve the quality of care provided within the Trust. Reduce the level of excess mortality within the Trust. Improve the quality and accuracy of our clinical coding (including documentation) so that it fully reflects our patient cohort and standard of care provided. Support the clinical, quality and operational governance structures to support and promote learning and improvements in the quality of care.
Summary Position:	The investigation into palliative care processes and coding has been achieved ahead of plan and the updated Mortality Coding Process is now in place. A training video is in development to support end users. The new Sepsis e-learning package has not yet been installed in ESR therefore the 85% compliance target has not been achieved. The new Mortality and Learning from Deaths Policy is in implementation. Actions identified by 360 Assurance have been uploaded to the on line tracker with evidence. 360 Assurance will conduct their follow up review during quarter 4. The new Mortality and Learning from Deaths Manager joined the trust in November. Their priority will be to work closely with divisions to review internal processes and make recommendations for improvements.
Activities completed October/November	▪ Full revision and approval of the Trust's Mortality Policy, now updated in line with new mortality review process. ▪ New Mortality and Learning from Deaths Manager appointed and commenced in post ▪ Terms of Reference for Safe and Sound Mortality Group and Sub-Groups reviewed to re-align membership and purpose to the LfD agenda ▪ Updated Mortality Coding Process approved and implemented with appropriate communication plan in place ▪ 360 Assurance Audit required actions completed and uploaded with evidence.
Activities planned for December/January	▪ Identify divisional learning and actions associated with Dr Foster alerts for alcoholic liver disease and congestive heart failure ▪ Strengthen SJR review process in line with Trust KPIs and presentation of themes/trends within Divisional Sub-Groups. ▪ New Mortality & LFD Manager to begin to review processes and make recommendations for further improvements. ▪ Clinical coding training video in place
Key risks to overall delivery	▪ Clinician capacity and operational pressures leads to non-quorate mortality meetings where key decisions are then deferred ▪ 85% compliance target at risk due to installation issues related to Sepsis e-learning training package ▪ Timeliness of junior doctors attending bereavement centre to complete death certificates impacts on S1 and SJR KPIs (30, 60 days). ▪ National ME directive that Stage 1/ME 'scrutiny' reviews should not form part of Meditech/patient records.
Key issues	▪ Mortality lead for medicine not in place ▪ HSMR data impacted by COVID ▪ Dr Foster database issues continuing to cause late data submission (national data/system problem, in the process of being rectified)

Operational Plan 21/22 Programme Highlight Report – Oct - Nov 2021

The Rotherham NHS Foundation Trust

Programme: O3	Plan the long-term recovery of Elective Care / Operational Excellence		
Exec Lead:	Chief Operating Officer	**Impact**	
SRO:	Director of Strategy, Planning and Performance	F&PC	

R A G

Current ↓

Progress Red Amber Green

Previous ↑

Overview:	**Elective Care Recovery** will aim to achieve a) a set of defined targets against the national constitutional standards b) adherence to the key requirements in the national planning guidance, relating to a system's ability to access the Elective Recovery Fund. **Operational Excellence** will aim to achieve a) a robust and accessible package of training for colleagues around elective care and b) clear guidance for staff on how to record elective care pathways in our systems.
Summary Position:	**Elective Recovery** – activity levels were above plan in October, but below plan in November across Outpatients and inpatient activity, due in part to the cancellation of clinics and theatres due to non-elective pressures, as well as anaesthetic sickness forcing list cancellations. **PIFU** - the national expectation is that the Trust will have PIFU in place for at least 5 major outpatient specialties, moving or discharging 1.5% of all outpatient attendances to PIFU pathways by December 2021, and 2% by March 2022. Sleep Studies (CPAP) continues to progress well and Ophthalmology went live on 22nd November. Work is now progressing with Gastro with Phase 1 being the IBD Nurse pathway which will go live on 23rd Dec, and Phase 2 (rest of Gastro) by end of Feb 22. Q4 will see ENT and General Surgery initiate their PIFU pathways once clinical protocols/standard operating procedures have been approved. **Orthopaedic Planned Care Citizens Panel** - the first meeting took place on the 4th November, with further monthly meetings scheduled through to April 22. Following initial patient feedback, an action plan is under development to progress agreed patient feedback. **Operational Excellence –** we are working with Barnsley to deliver a bespoke TRFT RTT training tool. The RTT training is designed, and internal trainers have been identified and trained. The content of the training will be taken to the Validators meeting in January where training roll-out will be discussed and agreed. To be rolled-out across the organisation by March 22.
Activities completed October/November	▪ Waiting list analysis based on deprivation and BAME built into PowerBI ▪ RTT – train the trainer session 26th November
Activities planned for December/January	▪ Orthopaedic Planned Care Patient Panel – December and January meetings ▪ PIFU – Gastro phase 1 roll-out ▪ RTT training roll-out – Validators Meeting (January)
Key risks to overall delivery	▪ Winter pressures are likely to make increases in activity more challenging, especially if the ring-fenced bed base is lost at any future point. ▪ Future Covid waves will also impact on recovery as activity levels will fall with increased sickness from clinical teams.
Key issues	▪ Elective Recovery efforts have been hampered by non-elective pressures, leading to cancellation of significant activity in Q3

Operational Plan 21/22 Programme Highlight Report – Oct – Nov 2021

The Rotherham NHS Foundation Trust

Programme: O4.1	Organisational Development Programme		
Exec Lead:	Director of Workforce & OD	**Impact**	R / A / G
SRO:	Deputy Director of HR	People	

Current Progress: Red | Amber | Green — **Previous**

Overview:	Ascertain how Divisions operate: challenges, successes, areas for continuous improvement; Look at ways to improve effectiveness of Divisional management and leadership; Generate rich picture of good stories and not-so-good stories; Improve senior leadership teams' integrated performance; Develop and integrate effective coaching and mentoring framework to improve individual and team performance and effectiveness; Enhance leadership behaviours and safe practice intentions and actions; Further improve patient care, safe practice, safe and effective management and leadership; Develop far-reaching OD Plan that aids the sustained improvement of the Divisions operating principles; Further embed The Trust's values, mission and strategy; Increase levels of Transparency, Communication and Participation.
Summary Position:	The new behavioural framework was successfully launched at the beginning of October. The existing provider will continue to roll out the first piece of work associated with the Divisional Leadership programme. A review of the benefits will be undertaken in the new financial year in order to identify any further requirements. Eleven 360 appraisal facilitators are now in place to support the Divisional Leadership Programme, however, due to unforeseen delays the process has not yet started and this now places the target to achieve 80% in January at risk. The trust has looked at improving the effectiveness of divisional management and leadership further by introducing a new psychometric profiling tool, namely "PRINT". So far all General Managers have completed the profiling exercise.
Activities completed October/November	▪ Complete 360 appraisal facilitator training (passed by NHS Leadership Academy) ▪ Launch new behavioural framework
Activities planned December/January	▪ Existing provider to continue roll out of existing leadership programme ▪ Facilitate 360 appraisals
Key risks to overall delivery	▪ 360 appraisals delayed therefore target to complete 80% by January 2022 is at risk
Key issues	▪ None

Blue – Achieved / Completed

Green – On Target / Plan

Amber – Behind plan with mitigation or actions in place to recover

Red – Behind plan no mitigation or more significant action required

Operational Plan 21/22 Programme Highlight Report – Oct - Nov 2021

NHS The Rotherham NHS Foundation Trust

Programme: O4.2	Employer of Choice		
Exec Lead:	Director of Workforce & OD	**Impact**	R A G
SRO:	Deputy Director of HR	People	

Current Progress — Red / Amber / Green — **Previous**

Overview:	Identify and recruit to key posts, including through the exploration of alternative markets & new roles and have mitigation plans in place if roles not filled. Build and maintain our reputation externally, improving our brand as an employer of choice. Review of how we sell TRFT as a place to work, such as an updated website. Develop our own M&D staff to become Clinical Leaders. Attract external applicants to undertake leadership roles. Encourage trainees to apply for consultant posts upon completion of training. Retain staff once recruited. Recruitment strategy of direct advertisement, liaising with recruitment agencies when this route has been unsuccessful or a dual strategy of both concurrently.
Summary Position:	Recruitment remains challenging in Acute Medicine, Gastroenterology and Rheumatology, however, the number of consultant vacancies (25.9) remains lower overall than the original base line identified at the start of this programme (27.4). Acute Medical posts are to be re-advertised in the British Medical Journal. Suggestions around joint posts with UECC are under consideration. Recruitment packs for medical and non-medical staff have been updated, however, the re-design and graphics work required to overhaul the packs and potentially increase our candidate attraction rates has been significantly delayed in the last few months due to capacity issues both within the medical staffing service and Trust graphics. A recruitment campaign is due to commence in December to appoint a Digital Communications Assistant who will revamp the recruitment pages on the trust web site, ultimately improving our employer brand. Reduced capacity within the medical staffing service has also resulted in a further delay in finalising the Medical and Dental recruitment strategy.
Activities completed October/November	▪ Improvements/enhancements to recruitment packs/web site/branding materials (medical and non-medical vacancies)
Activities planned for December/January	▪ Medical and Dental recruitment strategy updated (key milestone) ▪ Commence Digital Communications Assistant recruitment
Key risks to overall delivery	▪ Candidates once interviewed are not appointable ▪ COVID continues to impact on international recruitment ▪ Capacity to overhaul job packs (medical & non-medical) in graphics design services and medical staffing team
Key issues	▪ Cost of advertisement in professional journals exceeds divisional budgets normally covered by unfilled vacancies

Blue	Achieved / Completed	Green	On Target / Plan	Amber	Behind plan with mitigation or actions in place to recover	Red	Behind plan no mitigation or more significant action required

Operational Plan 21/22 Programme Highlight Report – Oct - Nov 2021

The Rotherham NHS Foundation Trust

Programme: O5.1	Best Practice Discharge Processes		
Exec Lead:	Deputy Chief Operating Officer / Director of Operations	**Impact**	R A G
SRO:	Associate Director of Operations	F&PC	

Current Progress: Red / Amber / Green

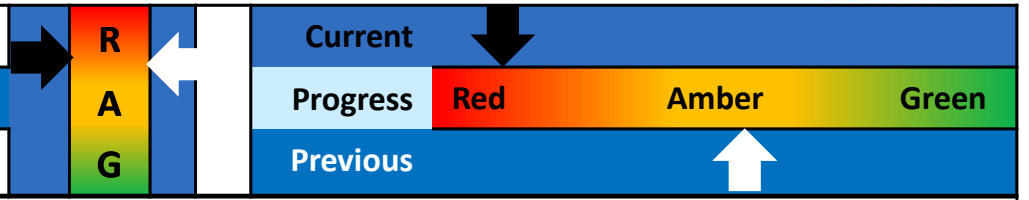
Previous

Overview:	Ensure best practice discharge processes are implemented. Ensure appropriate digital solutions and processes are implemented (to include escalation system, teletracking, command centre).
Summary Position:	The **LoS** position on patients occupying a bed for more than 7 and 21 days has worsened from September to November (this is a reflection of the increased level of acuity of patients that are admitted and pressures in discharging on Pathways 1, 2 and 3). Whilst below target, both **Right to Reside not recorded** and **Discharge Lounge Utilisation** metrics are showing an improving position. **Discharge Lounge utilisation** has plateaued at 21%. To address this, engagement with ward teams is being undertaken to understand what the blockages are to using the lounge, and with the Discharge Lounge itself to promote the new facility and the service it offers. Review of weekend utilisation in progress. **Trust Escalation Management Tool (Escalation Wheel)** – Phase 1 testing complete. Phase 2 OPEL level of the wheel complete. Phase 3 is the ability of the system to send notifications in regards to OPEL, escalation and de-escalation alongside category and metric level notification. This is on track for completion by early December (date TBC). **TTOs** - Pharmacy have reported that 25% of TTOs they receive are incorrect, and there are ongoing challenges around communicating the required changes to clinical teams. Pharmacy to deliver prioritised TTO training, piloting on 2 wards initially, and review the impact to ensure the training package has the desired effect. CCU training delivered for those routinely writing TTO's, and training for Fitzwilliam ward arranged for the 8th Dec. **IDT Review** – workshop to commence process mapping of the current and future state cancelled twice due to staff leave/sickness/operational pressures in IDT. To be rearranged in December.
Activities completed October/November	▪ Discharge Co-ordinators Workshop 18th October ▪ Ward by Ward Programme for Improvement - in progress with reviews of Wards A3, A4, A5 and A7 completed ▪ Trust Escalation Management Tool (Escalation Wheel) – Phase 2 completion
Activities planned for December/January	▪ Ongoing ward by ward improvement reviews ▪ Discharge Focus Week on A4 – commencing 13th December ▪ IDT Review - process mapping of the current and future state to commence (1st December session cancelled) ▪ Escalation Management Tool – Phase 3 scheduled for early December ▪ Review of Surgery Discharge Co-ordinator requirements

Operational Plan 21/22 Programme Highlight Report – Oct-Nov 2021

The Rotherham NHS Foundation Trust

Programme: O5.2	Admission Avoidance		
Exec Lead:	Chief Operating Officer	**Impact**	
SRO:	General Manager Medicine	F&PC	



Overview:	Implementation of an appropriate SDEC service at acute site. Ensure effective ambulatory and frailty pathways are in place.
Summary Position:	**SDEC** - the SDEC/AMU business case was issued to the Exec Team for their comments, and following this a meeting is planned in on the 7th Dec for the Exec Team to have a walk round the unit followed by a Q&A session. **Frailty pathway -** The Frailty Quality Improvement week completed in early October as planned and this has now brought the pilot phase to a close. Agreed next steps are in place to transition the identified changes in working practices into business as usual during the next 30 – 90 days. For the foreseeable future the frailty pathway/model will continue to be based on the quick turnaround concept as executed during the pilot (i.e. with a view to patients returning home either on the same day or within three days). Discussions are taking place within the Division of Medicine to determine whether any further enhancements can be made to the frailty pathway/model before the end of this financial year.
Activities completed October/November	▪ Frailty Pilot completion ▪ Frailty Assessment Pro-forma go-live 11th October ▪ Frailty Quality Improvement Week ▪ Draft SDEC/AMU business case issued to the Exec Team
Activities planned for December/January	▪ SDEC business case – Exec Team walk around and Q&A session 7th December, followed by meetings with the Exec Team on the 13th and 17th December to agree clear parameters of the business case ▪ Determination of any further enhancements to the frailty pathway/model
Key risks to overall delivery	▪ Cannot deliver an appropriate model of SDEC/proposed model is unaffordable
Key issues	▪ Delays to SDEC/AMU business case approval

Blue – Achieved / Completed

Green – On Target / Plan

Amber – Behind plan with mitigation or actions in place to recover

Red – Behind plan no mitigation or more significant action required

Operational Plan 21/22 Programme Highlight Report – Oct – Nov 2021

The Rotherham NHS Foundation Trust

Programme: O6	Removal of Breach of Licence / Five Year Strategy		**Completed**	**Current**
Exec Lead:	Deputy Chief Executive	**Impact**		**Progress** Red / Amber / Green
SRO:	Dir. of Finance / Dir. of Strategy, Planning & Performance	F&PC		**Previous**
Overview:	To have the longstanding breach of licence lifted by March 2022 and to publish a new Trust Strategy by the end of September 2021.			
Summary Position:	As reported in the last report Breach of of licence and undertakings have been removed ahead of plan. The Trust Strategy was approved at the Trust Board in September subject to minor amendments and will now be published slightly later than planned in December. This will complete the activities aligned to the programme which is therefore recommended for closure once the strategy has been launched.			
Activities completed October/ November	▪ Minor amendments made and strategy finalised ready for publication ▪ Senior leaders workshop held on strategy delivery plan			
Activities planned for December/ January	▪ Board development session on Trust's strategy delivery plan 10/12/21 ▪ New Trust Strategy published			
Key risks to overall delivery	▪ None			
Key issues	▪ None			

Board of Directors' Meeting
07 January 2022

The Rotherham NHS Foundation Trust

Agenda item	P11/22
Report	**Council of Governor Approved Membership & Engagement Strategy**
Executive Lead	Angela Wendzicha, Director of Corporate Affairs
Link with the BAF	BAF3: Should the Trust fail to actively engage with, or listen to the experience of service users, there is a risk that the organisation will not learn or improve the quality of care (experience, quality and outcomes) for those who use our services.
How does this paper support Trust Values	The paper spans all Trust values; Ambitious: We are striving to increase our current membership numbers and increase engagement Caring: We care about the communities we serve and want to include them in the development of our services Together: We want to work with the communities we serve to actively encourage them to engage with the Trust.
Purpose	**For decision** ☒ **For assurance** ☐ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	The Board will recall that following their meeting on 11 August 2021, the Council of Governors formally escalated their ongoing concern in relation to the level of proactive membership engagement within the Trust to the Board of Directors. The purpose of the paper is to provide an update on the progress to date relating to the cleansing of the membership database, plan to increase membership engagement and dedicated resources to assist with progressing the engagement offer. The Board is asked to note the update provided therein and approve the Council of Governors Membership and Engagement Strategy.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	The Membership and Engagement Strategy has been developed in conjunction with the Governor Membership and Engagement Group and approved at the Council of Governors on 10 November 2021.
Board powers to make this decision	In accordance with the Trust Matters Reserved to the Board, the Trust Board is responsible for final approval of all Strategy documents
Who, What and When (what action is required, who is the lead and when should it be completed?)	The implementation plan associated with the Strategy will continue to be developed and implemented in conjunction with the Governor Membership and Engagement Group.

Recommendations	It is recommended that: the Board of Directors approve the Council of Governors Membership and Engagement Strategy and note the ongoing work in relation to increased membership engagement.
Appendices	Appendix 1: Council of Governors Membership and Engagement Strategy.

1. Introduction

1.1 The Council of Governors escalated their continuing concern that the Trust was not carrying out sufficient engagement with our current membership. In addition, concern was raised that since the establishment of our membership database, this had not been cleansed and updated since inception in 2005. Furthermore, there was concern around the current lack of resource to support the necessary membership engagement activity and production of an appropriate Membership and Engagement Strategy.

1.2 The Board discussed the aforementioned concerns at the public Board meeting held on 10 September 2021. The following illustrates the progress to date on agreed actions from the September Board meeting.

2. Membership Database

2.1 A programme of work commenced in early September 2021 whereby all members on the current Trust membership database were contacted by letter requesting updated information with a deadline of the end December 2021. This has resulted in approximately 300 members requesting removal of their details from our membership database.

2.2 Work continued until the end December 2021 in cleaning the current database.

3. Membership and Engagement Strategy

3.1 A new Membership and Engagement Strategy has been developed in consultation with the Governor Membership and Engagement Group and subsequently approved by the Council of Governors on 10 November 2021. The Council of Governors subsequently confirmed they were content their concerns had been fully addressed. The Strategy can be found at Appendix 1 and is currently with the graphics team for formatting and inclusion of appropriate photographs.

3.2 The Director of Corporate Affairs has been working in conjunction with the Governors to develop an implementation plan in order to commence engagement work during January 2022. Additional meetings have been held to facilitate progress. The progress and success of the implementation plan will be monitored by the Governor Membership and Engagement Group and ultimately the Council of Governors.

4. Resources to Support Membership Engagement

4.1 The programme of work relating to membership engagement is currently led by the Director of Corporate Affairs. Additional dedicated resource has been source with interim support commencing on 17 January 2022.

5. Recommendations

5.1 The Trust Board is asked to:

a) Note the progress made to date in cleansing the membership database;
b) Note the position in relation to dedicated resource and
c) Approve the Council of Governors Membership and Engagement Strategy.

Angela Wendzicha
Director of Corporate Affairs
December 2021.

The Rotherham NHS Foundation Trust

Council of Governors

Membership & Engagement Strategy

2022-2025

Contents

1. Introduction

1.1 As a Foundation Trust, The Rotherham NHS Foundation Trust (TRFT) is accountable to the local community, the patients it cares for and the people it employs through its membership. Furthermore, there is a duty on the Trust to engage with our local community and encourage local people to become members of the organisation thereby ensuring the membership is representative of the community we serve.

1.2 By becoming members, local people, patients, carers and our staff can have a say in how services will be designed and delivered; this is ever more important given we are evolving into greater collaborative and system working.

1.3 Public and staff members elect representatives to the Council of Governors who are the voices of the members they represent. Governors are also responsible for engaging with members within their respective constituencies about the future strategy of the Trust. By doing this, the Trust engages and involves the people they serve in shaping the direction of activities.

1.4 TRFT is committed to being a successful membership organisation including strengthening the links with our local communities. An involved, informed representative and vibrant membership is integral to delivery of outstanding services that listen to and respond to the needs of the community.

2. Purpose of the Strategy

2.1 The purpose of our Membership and Engagement Strategy is to outline the vision and aims for our membership and the methods we intend to use to identify and build an effective, responsive and representative membership. It also outlines our future plans in terms of recruitment and engagement and how we will measure the success of our implementation of our Membership and Engagement Strategy.

2.2 The Membership and Engagement Strategy aims to ensure that TRFT membership is representative of the community it serves in addition to ensuring a continuous approach to developing a membership based on active engagement targeting staff groups or services.

3. What Does Membership Mean to Us?

3.1 Membership is our way of developing closer relationships with our local communities. It provides the Trust with an opportunity to engage with our members on matters they consider important in relation to our services and their development.

3.2 Membership is free and there is no obligation for members to get involved but we would want to encourage this as part of our engagement strategy. The Trust has a database supplier that provides the ability to deliver messages to our membership base in addition to the expectation that our communication team will be an integral part of the implementation of this Strategy.

3.3 As a Trust, we recognise that if our membership scheme is to be successful and effective, we must ensure that our members know that their views are listened to and give our potential members a reason to want to take part. As such we need to ensure that all our current and potential members know they can:

- Help in improving the quality of our services or the patient/visitor experience
- Provide their views on the future plans of the Trust
- Vote and stand in elections for the Council of Governors
- Attend the Annual Members' meeting
- Attend events at the Trust that are open to the public
- Suggest events/fora at which health or Trust information could be shared
- Receive information on the Trust and its services

4. Vison and Aim for Membership

4.1 Our vision is for TRFT's membership to be active, engaged, involved and representative of local communities, staff and the wider population that the Trust serves in order to support the delivery of the highest quality of care and experience for our patients. Membership activity will be compatible with involvement by people within groups with any of the protected characteristics in line with the values of the NHS.

4.2 Our aim is to:

- build a substantial and representative membership;
- support our members in being well-informed, motivated and engaged; and
- provide our members with opportunities to help shape how our services develop.

4.3 The Trust's members are an essential part of our future development with many of those living in the communities served by TRFT becoming involved with or taking an interest in the following:

- Receiving information about the Trust and its activities
- Attending events such as open days (subject to Covid restrictions)
- Taking part in focus groups, consultations or other work to support service development
- Becoming a Governor or Non-Executive Director
- Voting in Governor elections
- Expressing views and opinions about the services provided by TRFT

4.4 TRFT will aim to have a membership that is representative and in doing so we will take into account factors but not limited to:

- Whether members are public or staff
- Whether particular groups of staff have higher opt-out rates
- Geographical location of public members
- Age and gender of public members
- Ethnic origin of public members
- Socio-economic profile of the membership
- Lifestyle profile.

4.5 Age and gender balance of public members: The Trust will seek to achieve a balance between adult public members and younger public members. In addition we will seek to achieve greater gender balance within our membership cohort.

4.6 Ethnic origin of public members: We will aim to align our membership as closely as possible with the ethnic breakdown of Rotherham.

4.7 Socio-economic background of public members: we will aim to have a membership as close as possible to the socio-economic background of the wider population.

5. Recruitment of Members

5.1 Our members currently fall into two constituencies, Public and Staff. The following table illustrates the minimum membership required for each constituency as per our Constitution:

Insert graphic of relevant map to illustrate all constituencies

Name of Public Constituency	For Residents of	Minimum Number of Members	Seats on the Council of Governors
Rotherham South	Boston, Castle, Rotherham East, Sitwell	10	2
Rotherham North	Kepple, Rotherham West, Wingfield	10	2
Wentworth South	Rawmarsh, Silverwood, Valley	10	2
Rother Valley West	Brinsworth & Catcliffe, Holderness, Rother Vale	10	2
Wentworth Valley	Hellaby, Maltby, Wickersley	10	2
Rother Valley South	Anston & Woodsetts, Dinnington, Wales	10	2
All England	The rest of England	10	2

5.2 Our staff constituency comprises staff employed under a contract of employment which has no fixed term or a fixed term of at least 12 months. The minimum number of staff members is five.

5.3 As at 02 November 2021 the Trust had just over 10,000 members.

5.4 Analysis of our current membership will be an important aspect of this Strategy and the associated implementation plan. The Director of Corporate Affairs has lead responsibility for the development of the implementation plan that will support this Strategy and will develop this in conjunction with the Governor Membership Group.

5.5 The Trust will carry out a range of activities which involve local communities, businesses and staff, including but not limited to:

- Holding engagement events at TRFT
- Having representation at other events held such as health awareness campaigns
- Attending public meetings and events
- Promoting membership through social media and the media
- Membership materials in departments across the Trust and community locations
- Target recruitment

5.6 The recruitment plan will be developed by the Corporate Governance Department in collaboration with the Governor Membership Group in response to current membership activity levels.

6. Membership Objectives 2022-25 and Delivery of the Strategy

6.1 The Trust will develop an effective 'Membership Office' with the recruitment of a new Governor and Membership Officer within the Corporate Governance Department. The Membership Office, for the purpose of this Strategy, will communicate effectively with members and support potential new governors in preparation for first elections.

The following illustrates the key objectives for 2022-25.

Objective 1: To build and maintain our membership numbers by actively recruiting and retaining our members.

- **Maintain an accurate membership database**
- **Successfully recruit and retain membership numbers**
- **To take steps to ensure our membership is representative of the diversity of the population that we serve**
- **Have planned, targeted recruitment drives**
- **Link with the Trust Patient and Public Involvement Team**

Objective 2: To effectively engage and communicate with members

- **Promote the work of the Governors and the Trust**
- **Engage the expertise of the Trust communications department**
- **Identify opportunities for two way communication between Members and Governors**
- **To ensure that the views of the members are heard, understood and acted upon**
- **To ensure that a wide range of communication media and methods are explored to aid effectiveness.**

6.2 The objectives will be delivered as part of the Implementation Plan that will include the following actions;

6.2.1 **Recruiting and Retaining Members** - This will include:

- Analysis of current membership
- Develop recruitment material
- Undertake targeted recruitment drives
- Utilise Governors to recruit at key location and consider developing membership champions from within our existing volunteer group.

- Identify initiatives to raise the profile of membership in our local communities e.g. advertising in local parish publications
- Develop a process of identifying and addressing under-representation, working with existing equality and diversity organisations
- Support Governors to engage with community groups to attract new members
- Develop processes of engaging with younger members by holding specific events that maybe of interest to them.

6.2.2 **Communicating with Members** – This will include:

- Designing a members' specific webpage
- Development of an events calendar hosted by Governors
- Utilisation of social media to communicate with members
- Work with our Patient Experience Team

6.2.3 **Effectively Engaging with Members –** This will include:

- Promoting the work of the Trust on the website and through member newsletters
- Facilitate opportunities for the membership to meet the Governors
- Provide all new members with relevant information about the Trust
- Provide opportunities for members to give their views on a range of issues
- Identify with the Patient and Public Involvement Team initiatives where members can be a source of feedback on patient and quality issues.
- Invite members to engage in patient experience programmes within the Trust
- Survey the members for their views.

7. Approval Process

7.1 The draft Strategy will be considered by the Governor Membership Group and once agreed, will be submitted for approval to the Council of Governors and Trust Board.

8. Monitoring Success

8.1 The success of the implementation plan associated with the Strategy will be measured through the Governor Membership Group who will consider the effectiveness of each objective.

8.2 Recruitment of our membership will be measured by achievement of any recruitment targets set in accordance with the Implementation Plan and benchmarking across the system with comparable organisations.

8.3 The success of member engagement will be measured by feedback from members involved in the engagement and attendance at membership events.

Board of Directors' Meeting
07 January 2022

The Rotherham NHS Foundation Trust

Agenda item	P12/22
Report	**National, Integrated Care System and Integrated Care Partnership Report**
Executive Lead	Michael Wright, Deputy Chief Executive
Link with the BAF	B11, B12
How does this paper support Trust Values	Together – the paper demonstrates how the Trust and partners across both Rotherham Place and the wider ICS work together in providing patient care and also providing mutual support in response to the COVID-19 pandemic.
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	The purpose of this report is to provide the Trust Board with an update on national developments, developments across the South Yorkshire and Bassetlaw Integrated Care System (SYB ICS) and also the Integrated Care Partnership (Rotherham Place). Key points to note from the report are: 1. National health news has been dominated by the Omicron COVID variant with concerns raised on the impact it will have on demand for services and staff absences. 2. Sir David Sloman was appointed as NHS England's Chief Operating Officer 3. Gavin Boyle has been appointed as Chief Executive designate of the South Yorkshire Integrated Care Board. 4. Ruth Brown has been appointed as Chief Executive of Sheffield Children's Hospital. 5. Rotherham Place continues to hold weekly Gold Command meetings to work collectively in managing and providing mutual support as the pandemic continues. 6. Rotherham Place is working collectively to support COVID-19 booster vaccinations, with progress date being really positive.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	The Executive Team receives a weekly verbal update covering key Place level activities in addition to specific papers periodically, as and when required.
Board powers to make this decision	N/A

Who, What and When (what action is required, who is the lead and when should it be completed?)	N/A
Recommendations	It is recommended that the Board note the content of this paper
Appendices	N/A

1.0 Introduction

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

2.0 National Update

2.1 National health news has been dominated by the emergence of the Omicron COVID-19 variant and the impact that is having across the globe and the UK in particular. The rapid rise in cases in early December led to the Government introducing 'Plan B' restrictions from 10 December. These included:

- Face masks to be worn in more public settings.
- People asked to work from home where possible.
- 'Covid Passports' introduced to some large venues.

2.2 There are growing concerns within the NHS about the impact that Omicron will have on services. On 17 December the 'daily +ve cases' set a new high and therefore has the potential to have a significant impact on hospital admissions. Additionally, the impact on staff availability presents a concern for many Trusts with the number of staff with COVID related absence increasing by 144% from 1,926 on 12 December to 4,695 on the 16th December. The local infection rate for Rotherham as at 24 December 2021 was 587.6 / 100,000 with the position for England being 915.3 / 100,000.

2.3 The pressure on urgent care pathways was evident with October figures (published in November) being confirmed as the busiest month on record for 999 calls with over one million calls. Ambulance teams also responded to more than 82,000 life threatening call outs – an increase of over 20,000 from the previous high for October.

2.4 Sir David Sloman was appointed to the role of Chief Operating Officer of NHS England on 14 December. He had previously been the London Regional Director and Group Chief Executive for the Royal Free London NHS Foundation Trust. Sir David is the substantive appointment to the role which became vacant when Amanda Pritchard was appointed as NHS Chief Executive.

3.0 South Yorkshire & Bassetlaw Integrated Care System (SYB ICS)

3.1 Gavin Boyle has been appointed as the new Chief Executive designate of the South Yorkshire Integrated Care Board. Gavin has worked at a variety of Trusts across a 30+ year carer including Oxford University Hospitals and Leeds Teaching Hospitals. Since 2007 he has been the Chief Executive of Yeovil Hospital, Chesterfield Royal Hospital and most recently at University Hospitals of Derby and Burton.

3.2 Doncaster Royal Infirmary opened a new inpatient facility in mid-December. The development, which is part of a £12.4m investment, will house paediatric services and contains a modern surgical theatre. The investment is also supporting the repairs to the main Women and Children's hospital which suffered significant damage from a major water leak in April 2021.

3.3 Ruth Brown was appointed as the Chief Executive of Sheffield Children's NHS Foundation Trust. Ruth has worked at the Trust since 2017 and had been the Executive Director of Strategy and Operations, Deputy Chief Executive and more recently acting Chief Executive.

4.0 Rotherham Integrated Care Partnership (ICP)

4.1 At the 8 December System Gold meeting Brigitte Kaviani, Head of Health & Wellbeing at SYB ICS, gave members an overview of the offer available via the SYB Heath & Wellbeing hub (https://sybics.co.uk/workforce-wellbeing). This is for everyone in SY&B including social care, the voluntary sector, health students, and primary including opticians, dentists and pharmacists, free of charge, 24/7 and 365 days of the year.
It includes counselling and specialist accredited mental health support, wellbeing webinars, podcasts, self-help workbooks and a variety or workshops. Mental health support is available, via vivup mental health specialist partners, 24/7 which includes self-help information and fast track access to therapy.

4.2 The spotlight presentations for each of the transformation groups continued at public Place Board, November presentations were:

- Children & Young People - Mental Health & Emotional Wellbeing
- Mental Health & Neurodevelopmental - Suicide Prevention
- Urgent & Community Care - Sustainable Discharge

4.3 During December, members of the Rotherham Place Board met with Pearse Butler, SY ICB Chair. The session commenced with a presentation explaining the Place level challenges and priorities as well as how Rotherham sees the future operating model post April 2022. Members of the Place Board reflected on the strengths and maturity of the Rotherham partnership.

4.5 Rotherham Place continues to hold weekly Gold Command meetings to work collectively in managing and providing mutual support as the pandemic continues. Significant work has been undertaken to secure beds in the community to support discharge from the Trust.

4.6 COVID vaccinations rates as at 19 December across Rotherham are provided below. The Rotherham NHS Foundation Trust has made a significant contribution to the successful booster roll-out, led by the Executive Place Director for Rotherham CCG. In addition, colleagues from the Family Health Division are planning to continue the 12-15 vaccination service following their successful delivery of the programme during the autumn.

Cohort	% Total Booster & 2 Doses
All those 80 years of age and over	**93.63%**
All those 75 years of age and over (75-79)	**95.99%**
All those 70 years of age and over (70-74)	**95.33%**
All those 65 years of age and over (65-69)	**92.92%**
All those 60 years of age and over (60-64)	**86.52%**
All those 55 years of age and over (55-59)	**81.52%**
All those 50 years of age and over (50-54)	**76.95%**
All those 40 years of age and over (40-49)	**62.23%**
All those 30 years of age and over (30-39)	**39.45%**
All those 18 years of age and over (18-29)	**23.60%**

Michael Wright
Deputy Chief Executive
January 2021

Subject:	**Finance and Performance Committee 24 November 2021 CHAIR'S ASSURANCE LOG – PART 1 AGENDA** **Quorate: Yes**	**Ref:P13/22(i)**	**BoD:07/02/2022**

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

Committee / Group: Finance and Performance Committee	**Date:** 24 November 2021	**Chair:** Nicola Bancroft

Ref		Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
1	Divisional Performance Update: Medicine	The Committee welcomed representatives from the Senior Management Team from the Medicine Division who provided an overview of the Divisional structure and further highlighted the following: • At Month 7 the Division was carrying a pay surplus of £170K which was due in part to an underspend in the nursing pay budget of £80K. In addition, due to a reduction in locum spend within the Division, underspend for medical staffing was £105K. • Cost Improvement Programme (CIP): The current target for Medicine is £715K with recurrent schemes worth £614K identified. • The Division had agreed a 'control total' for the full year, £100k surplus. • Operational Performance: Challenges have been recognised within Dermatology and Gastroenterology, resulting in increased waiting lists and overdue follow-ups increasing. In addition, the emergency pathway has been extremely challenging, directly impacting on referral response times.	Board of Directors	Assured

Ref		Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
		• There has been an improvement in cancer performance with all targets met except for the 2 week wait – this was due to patient choice on six occasions and capacity issues due to short notice sickness on seven occasions. The Committee was assured that the Division had delivered on its operational and financial performance targets but was mindful of the issues raised around winter pressures.		
2	Risk and Assurance: Board Assurance Framework (BAF) and Risk Register	The Committee received and discussed the position for quarter 2 acknowledging the ongoing work around the BAF. The Committee discussed the two BAF risks aligned to the Committee noting they are currently managed risks and discussed reducing the score for BAF Risk 9 to 4 (L1xC4) due to the change in the capital position since the report was published. The Committee discussed the three risks rated 15 and above assigned to the Finance and Performance Committee and requested sight of the action plans that support the gaps in controls to provide assurance the target scores would be met. The Committee noted the plan to receive both the BAF and the Risk Register on a monthly basis to ensure the Committee remains sighted on the risk profile. In addition, operational risks would be part of the review at the next Committee.	Board of Directors	Assured – BAF assessment as at Quarter 2 Limited Assurance – Risk Register (lack of visibility of action plans)
3	Integrated Performance Report	The Committee received and discussed the Integrated Performance Report noting the addition of two new metrics to reflect the NHS Half 2 (H2) Planning Guidance and the System oversight Framework; targets and trajectories are currently in development. The Committee further noted the following:	Board of Directors	Limited Assurance

Ref		Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
	Recovery and Winter Update	• Some deterioration has been seen in the waiting list position with further work ongoing at speciality level with reviews being undertaken in relation to any harm as a result of the long wait for cancer patients. • Challenges remain in the increasing numbers of patients that are being seen thorough our system. The Committee noted that the winter plan had been enacted with variable rates of COVID positive in-patients. Pressures continue to be seen within Critical Care which in turn affects the number of available critical care beds for elective procedures. Increasing staff sickness absence adds to the operational pressures. A further 'reset week' is planned for November, the outcome of which will be presented to the next Committee in December.		
4	Integrated Financial Performance Report Half 2 (H2) Financial Plan	The Committee received and discussed the financial position noting the following: • Good financial position with a surplus to plan of £150K in month and £400K surplus to plan year to date. • CIP Performance remains positive with risk adjusted schemes identified. • Given the overall performance relating to income and expenditure, no changes are required to the financial forecasting. • All Divisions have agreed a control total for the remainder of the year which has supported the ability to release winter plan monies and invest in recovery. The Committee further received and discussed the H2 financial plan update, noting the expected elective recovery fund allocation. The Committee agreed to continue with the H2 plan,	Board of Directors	Assured (Both financial performance to date and the H2 Plan)

Ref		Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
		acknowledging that this was a low risk plan which had prior approval by the Board. The Committee requested that the finance team commence planning now for the next financial year,		
5	Carbon Energy Fund	The Committee received an update on the Carbon Energy Fund scheme noting that practical completion had been delayed due to COVID-19 and the impact on the replacement Combined Heat and Power Plant. The Committee was informed of the assurance processes in place to support implementation of the business case and an update will be provided in three months (February 2022) relating to the audit of the programme in addition to commentary on the working relationship with the main contractor.	Board of Directors	Assured (process and governance to date) Update on Veolia – February 2022.
6	E-Rostering / Pay Controls	The Committee discussed the detail within the report noting the increase in agency spend due to the need for additional agency spend and increased medical locum expenditure. The Committee agreed that the pay cost analysis would be included in the Integrated Financial Performance Report and that the People Committee would review assurance on the workforce metrics and governance process.	Board of Directors	Assured (visibility of spend)

Finance and Performance Committee held on 24 November 2021 considered the following agenda items:

- Divisional Performance Update: Medicine
- Quarterly Board Assurance Framework Review
- Risk Register
- Integrated Performance Report
- Recovery and Winter Update
- Integrated Financial Report
- Half 2 Financial Plan Update
- HealthCare Executive Group Finance Report
- Carbon Energy Fund Update
- E-Rostering/Pay Controls Update

Subject:	**Finance and Performance Committee 22 December 2021 CHAIR'S ASSURANCE LOG – PART 1 AGENDA** **Quorate: Yes**	Ref:P13/22(i)	**BoD: 07/01/2022**

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

Committee / Group: Finance and Performance Committee	**Date:** 22 December 2022	**Chair:** Nicola Bancroft

Ref		Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
1	Divisional Performance Update: Clinical Support Services	The Committee welcomed representatives from the Senior Management Team from the Clinical Support Services who provided an overview of the Divisional management structure. The Senior Management Team highlighted the following: • The financial position within the Division in Month 8 was a surplus of £59K and £306K Year to Date. The forecast outturn position is £74K surplus against an agreed control total of £100K. • Pressures remain within Pharmacy in relation to staffing and recruitment with a plan in place for ongoing recruitment and increased visibility from the Pharmacy management team. • Establishment control and exceptional spend panel meeting now takes place on a weekly basis for additional scrutiny and challenge for all requested posts. • The South Yorkshire & Bassetlaw (SYB) Pathology Network Business Case carries the ongoing retention and recruitment risks which are being managed with regular drop in sessions for staff.	Board of Directors	Assured.

Ref		Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
		• Cost Improvement Programme (CIP): The Division forecasted a gap of £75K with confidence from the Leadership Team that the gap will be closed by the end of the year. The main risk is that the majority of schemes are non-recurrent and the Division are aware of the financial risk potentially carried forward into the next year. • Support had been given in relation to the Divisional Capital Plan with approval for the second MRI Scanner, replacement autoclaves and replacement general X-ray room. In addition there has been some targeted investment funding via South Yorkshire ICS to replace the Pharmacy Robot. The Committee agreed there was assurance in that the Division had clarity on their performance with assurance they will deliver on their plans. In addition there was confidence within the Leadership Team that they will meet their control total with a clear articulation of their risks and the plans in place to mitigate.		
2	Risk and Assurance: Board Assurance Framework (BAF) and Risk Register	The Committee received and discussed the position for Q3 acknowledging the ongoing work around the BAF. The Committee discussed the three BAF risks aligned to the Committee noting that the movement of a level of assurance in BAF 2 relating to right to reside to a gap in control. In addition the Committee noted that three gaps in controls had been closed for BAF 8. The Committee further discussed the target scores for the year end and the rationale for those noting that due to the current position relating to the pandemic, the target score for BAF2 is likely to remain at 16. The Committee further discussed and	Board of Directors	Assured – BAF assessment at Quarter 3 with agreement in relation to target scores for year end. Limited Assurance - Risk Register with assurance around the process in place to strengthen the risk register.

Ref		Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
		agreed the target scores for both BAF 8 and BAF 9 are expected to remain the same until the year end. The Committee discussed the three risks on the Trust Risk Register rated 15 and above assigned to the Finance and Performance Committee noting the review carried out by the newly appointed Quality, Governance and Risk Manager concluding that action plans to support mitigation of risks are not widely available on the Datix system. A detailed piece of work has begun to address the gaps within the Risk Register and support end users in utilising the system effectively. The Committee noted the work required and requested sight of the implementation plan at the January 2022 meeting.		
3	Operational Plan: Update	The Committee received and discussed the update on progress against the 2021/22 Operational Priorities noting the one programme that is currently behind plan relates to Admission Avoidance and completion of the associated Business Case relating to SDEC. The Committee noted the ongoing work and significant operational pressures due to the pandemic, clarity was therefore sought as to the potential effect on completion of those programmes with an Amber status. The Committee concluded there was Limited Assurance and requested a realistic updated plan for Quarter 4.	Board of Directors	Limited Assurance
4	Integrated Performance Report	The Committee received and discussed the Integrated Performance Report noting the following key issues: • Increasing waiting lists continue to be a concern with the additional problem with access to ENT in Doncaster. • Increasing demand within UECC with the associated increase in waiting times.	Board of Directors	Limited Assurance

Ref		Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
	Recovery and Winter Update	• Improvement has been seen in cancer waits overall but some issues around capacity remain in general surgery and urology. Discussions are ongoing in how the Trust manages cancer in the future with the assistance of a focused management team. • The Community teams remain under pressure from a staffing perspective. The Committee discussed how we know what 'good' looks like in terms of compliance against national standards and requested the inclusion of benchmarking into the next reiteration of the report. The Committee noted the improvements made as a result of the recovery plan but concern remained around waits in UECC. All 'winter beds' had been opened and staffing levels remain of most concern with the anticipated impact of the new variant still fully unknown. Daily calls continue within the system.		
5	Integrated Financial Performance Report	The Committee received and discussed the financial position as at Month 8 noting the following: • Good financial position with a surplus to plan of £630K and £1,030K to plan year to date • Some non-recurrent allocations have been assigned to the Trust but not yet received • The Trust does not foresee any difficulty in signing off as a Going Concern at the end of the year. • Work remains ongoing to provide further clarity on our performance against the Better Payments Practice Code. • Discussion took place in relation to the Carbon Energy Fund Scheme in particular the use of the contingency fund which was deemed to have been appropriately managed.	Board of Directors	Assured in relation to the financial performance to date.

Ref		Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
		• Committee noted that a further meeting was scheduled with the Chair of the Finance and Performance Committee and Finance colleagues, one area to discuss was Carbon Energy scheme.		
6	Cost Improvement Programme (CIP)	The Committee received and noted the updated position noting the challenges associated with non-recurrent savings delivered.	Board of Directors	Assured - on delivery of the £5m in year. Limited Assurance on the impact of competing demands for future CIP delivery but assured on the approach being taken.

Finance and Performance Committee held on 22 December 2021 considered the following agenda items:

- Divisional Update: Clinical Support Services
- Quarterly BAF Review
- Risk Register
- Integrated Performance Report
- Recovery and Winter Update
- Integrated Financial Report
- HealthCare Executive Group Finance Report
- CIP Update
- Refurbishment of Kepple Ward

Subject:	**Quality Committee 24 November 2021 CHAIR'S ASSURANCE LOG – PART 1 AGENDA** **Quorate: Yes (not quorate for the period of time one Non-Executive Director left the meeting for a short time).**	Ref: P13/22(ii)	**BoD: 07/01/2022**

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

Committee / Group: Quality Committee	**Date:** 24 November 2021	**Chair:** Rumit Shah

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
1	Divisional Attendance: Medicine	The Committee welcomed the first Divisional presentation from Medicine and received an overview of the senior management team in addition to an overview of the metrics relating to the quality agenda. The Committee noted and discussed the following: • Challenges remain within the Division around staffing levels and the Committee noted the ongoing work to support recruitment and retention in addition to health and wellbeing for staff. • The Committee welcomed the information relating to quality improvement, in particular around falls in addition to the outcome approach of the Perfect Ward audit Programme.	Board of Directors	Assured
2	Risk Register	The Committee reviewed the risk register and received limited assurance in relation to this as work remains ongoing in correctly aligning the risks to the Board Assurance Framework. In addition,	Board of Directors	Limited Assurance

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
		the Committee sought clarity on the actions taken to close the gaps in controls for individual risks.		
3	Board Assurance Framework	The Committee discussed in detail the BAF Risks and agreed the proposed risk scores for Quarter 2. The Committee discussed the need to realign the Board Assurance Framework with the new 5 Year Strategy in addition to the ongoing work to align the current risk register with the existing BAF risks.	Board of Directors	Limited Assurance
4	Strategic Safeguarding Chair's Log	The Committee noted the report noting there were no items for escalation to the Committee.	Board of Directors	Assured
5	CQC Delivery Group Chair's Log	The Committee discussed the report noting the new arrangements for each Division presenting progress on the relevant action plans leading to constructive challenge. The Committee noted the ongoing gaps in the action plans due to operational pressures.	Board of Directors	Assured on the revised process for the CQC Delivery Group but Limited Assurance due to gaps in the timely completion of the action plans.
6	Infection Control Committee Chair's Log	The Committee noted a number of areas of limited assurance relating to single room isolation availability, compliance with Level 2 Infection Prevention and Control mandatory training and antimicrobial Stewardship. Assurance was provided to the Committee that improvements are expected to be seen in due course.	Board of Directors	Limited Assurance
7	Performance Update	The Committee received and discussed the report noting that performance had been sustained despite operational pressures. The Committee discussed the current position in relation to nurse staffing and requested a deep dive into nurse staffing to be included in the report for the December meeting.	Board of Directors	Assured in relation to the performance dashboard.
8	Safeguarding Quarterly Report	The Committee received and discussed the report noting the compliance with Adult Safeguarding Training has now become 'green'.	Board of Directors	Assured on some progress made but Limited Assurance on the

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
		The Quality Committee was assured in relation to the ongoing activity in relation to safeguarding but there was limited assurance around the booking system for the Think Family training.		booking system for Think Family training.
9	Looked After Children Quarterly Report	The Committee received and discussed the report noting that compliance for the Initial Health Assessment had decreased in Quarter 1 and the Committee sought clarity on the procedure agreed with Rotherham Council in relation to this.	Board of Directors	Limited Assurance due to a reduction in compliance rates.
10	Learning from Deaths Report	The Committee received the monthly Mortality Report noting the Hospital Standardised Mortality Ratio (HSMR) and the Summary Hospital-level Mortality Indicator (SHMI) remained unchanged. The Committee heard that the Learning from Deaths Manager had commenced in post and would be working in conjunction with the Divisions around the areas that required strengthening. The Committee discussed the learning from deaths process and agreed there was limited assurance around learning from deaths that involve Serious Incident investigation and that there are outstanding actions from an Internal Audit report around learning from deaths.	Board of Directors	Assurance in relation to the processes around HSMR and SHMI and Limited Assurance around learning from deaths due to outstanding actions from the Internal Audit Report.
11	Serious Incident Report	The Committee received an updated position in relation to ongoing Serious Incident investigations and was assured in relation to this process. The Committee expressed Limited Assurance in relation to the implementation and oversight of action plans generated as a result of the investigation.	Board of Directors	Assured on the investigation process but limited assurance in relation to action plan implementation.
12	Patient Experience Quarterly Report	The Committee received and discussed the report highlighting that the Trust had been classified as one of the 10 Trusts achieving worse than expected and that this report should be escalated to the Trust Board at the next meeting in January.	Board of Directors	Not Assured.

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
13	Health and Safety Annual Report	The Committee received the annual Health and Safety Report in addition to information around the forthcoming inspection by the Health and Safety Executive.	Board of Directors	Assured
14	NHSI/E Appreciative Review of Medicines Management	The Committee discussed the outcome of the review noting the overarching improvement plan in relation to medicine management. The Committee agreed it was assured around the process that had been undertaken but until evidence of outcomes were presented, limited assurance remained in this area.	Board of Directors	Limited Assurance

The Quality Committee met on 24 November 2021 and considered the following agenda items:

- Divisional update from Medicine
- Risk Register and BAF
- Performance update
- Safeguarding Quarterly update
- Looked After Children update
- CNST Maternity update
- Serious Incident Report
- RCEN Standards
- Patient Experience
- Infection Prevention and Control
- Health and Safety Report
- Safer Staffing Report

Subject:	**Quality Committee 22 December 2021 CHAIR'S ASSURANCE LOG – PART 1 AGENDA** **Quorate: Yes**	Ref:P13/22(ii)	**BoD:07/01/2022**

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

Committee / Group: Quality Committee	**Date:** 22 December 2021	**Chair: Dr Jo Bibby**

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
1	Risk Register	The Committee reviewed the risk register aligned to the Quality Committee concluding there was limited assurance due to the overall lack of visibility of actions to mitigate the risks. The Committee acknowledged the planned work required on the risk register and noted the implementation plan will be presented to the Committee in January 2022 by the Director of Corporate Affairs.	Board of Directors	Limited Assurance
2	Board Assurance Framework (BAF) Quarter 3.	The Committee discussed in detail the BAF Risks and agreed the proposed risk scores for Quarter 3 noting the target scores for the end of the first half of the year have not been met. The Committee further noted the rationale for the target scores to remain the same until the year end. The Committee agreed that overall the BAF has been strengthened insofar as how the risks are reviewed and updated acknowledging the ongoing work to align with the risk register.	Board of Directors	Assured on the process of reviewing the BAF.
3	Infection, Prevention and Control Monthly Report	The Committee received and discussed the report noting the reduction in Covid-19 within Rotherham which, at the date of the	Board of Directors	Assured in terms of process acknowledging

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
		report is below the national average with the expectation that cases will rise due to the new Omicron variant. Mitigating actions are in place including testing of non-elective patients on admission and at 3 day intervals.		the limitation of the unknown impact of the Omicron variant.
4	Health and Safety Executive: Notified Inspection	The Committee received and noted the outcome of the recent Inspection by the Health and Safety Executive resulting in some improvements required to our overarching risk assessment relating to violence and aggression, risk assessments and training relating to moving and handling and the requirement to carry out risk assessment training. The Committee noted the overall positive response from the Health and Safety Executive around the Trust's management response to Covid-19.	Board of Directors	Assured that progress will be made to complete the action plan by the required date of 28 February 2022.
5	Operational Plan 2021/22: Update	The Committee received and discussed the report noting the amber status of the two programmes aligned to the Quality Committee. The Committee expressed concern around the decision made to postpone the relaunch of the Quality Strategy. In addition, the Committee discussed the challenges for mortality reviews and in particular in relation to the lack of data received via Dr Foster. In addition, changes to the way in which Stage 1 reviews are carried out following receipt of a National Medical Examiner's Directive resulting in this process reverting back to a paper-based system has in itself highlighted a risk to the delivery of the programme.	Board of Directors	Limited Assurance.
6	Quality Score Card	The Committee received and discussed the Quality Scorecard and concluded that whilst there is a recognition of the ongoing work on the Quality Dashboard, clarity was required in terms of where the Trust is in comparison to the national position. In addition, challenges remain in relation to care hours per patient per day and	Board of Directors	Limited Assurance

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
		work remains ongoing to ensure we are responsive to service users from a patient experience perspective. As a result, the Committee agreed there was limited assurance received.		
7	Mortality and Learning from Deaths Report	The Committee received and discussed the monthly report noting the content of the Summary Hospital-level Mortality Indicator (SHMI) data published, with the Trust remaining within the 'As Expected' banding. The Committee agreed that given there continues to be challenges around the process of learning from deaths, there was limited assurance in relation to this acknowledging the programme of work commenced by the new in post Learning from Deaths Manager to strengthen this process.	Board of Directors	Limited Assurance
8	Clinical Effectiveness Quarterly Report	The Committee received and discussed the report concluded there was limited assurance due to the inability to make progress on a number of audits in addition to the lack of submission of TARN data in a timely manner. The Committee further noted that a number of National Audits have been abandoned during 2021/22. The Committee acknowledged that a review of all audits is currently in progress with an update on the position to be included in the next report to the Committee.	Board of Directors	Limited Assurance
9	Management of Sepsis: Update	The Committee received and discussed the report noting the ongoing challenges in relation to the management of Sepsis within the Trust concluding there was limited assurance from the discussion that the Trust had the correct measures in place to deliver sepsis care to our patients. The Committee noted the plans in place to mitigate the current gaps in sepsis management.	Board of Directors	Limited Assurance

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
10	Serious Incident Report	The Committee received and discussed the report relating to the current position around Serious Incident Management noting there was assurance that the appropriate level of incidents are being reported highlighting a positive reporting culture within the Trust.	Board of Directors	Assured in relation to the reporting of Serious Incidents.
11	Medication Safety Report	The Committee welcomed the revised report and was assured that the Committee will be in a position to see where improvements are required and where improvements have been made.	Board of Directors	Assured.
12	Safer Staffing Reports	The Committee received and discussed two separate reports relating to Allied Health Professional and Medical staffing and was assured by the detail in both reports that the Trust is meeting safer staffing levels and where there are gaps in the medical workforce, work remains ongoing to recruit to those posts.	Board of Directors	Assured.
13	CQC Progress against Action Plans	The Committee was assured on the progress made in relation to the process to complete the action plans as a result of the last CQC Inspection.	Board of Directors	Assured

The Quality Committee met on 22 December 2021 and considered the following agenda items:

- Risk Register and BAF
- Performance update
- Health and Safety Executive Inspection update
- Operational Update
- Safe and Sound Quality Scorecard
- Serious Incident Report
- Patient Safety Report
- Sepsis Report: Update
- Infection Prevention and Control Report
- CQC: Progress on action plans
- Safer Staffing Report

Subject:	**People Committee 19 November 2021 CHAIR'S ASSURANCE LOG – PART 1 AGENDA** **Quorate: Yes**	Ref:P13/22(iii)	**BoD: 07/01/2022**

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

Committee / Group: People Committee	**Date:** 19 November 2021	**Chair:** Lynn Hagger

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
1	Divisional Attendance- Medicine	The Committee welcomed a presentation from the leadership team within Medicine who shared the strengthened leadership structure, including the new operational team structure. The Committee heard about some of the key successes within the Division relating to increased recruitment to both nursing vacancies and medical consultant vacancies in addition to the positive responsiveness of colleagues to the continuing Covid-19 pandemic. The new Divisional Director has been in place for 6 months and the Committee were informed the Triumvirate is working well. Conversely, the positive response to the pandemic also created sustained pressures that impacted on the health and wellbeing of staff – this has resulted in the Divisional focus around health and wellbeing as follows: • Psychological support • Team time sessions • Promotion of health and wellbeing services • Increased use of the Trust therapy dog	Board of Directors	The Committee acknowledged the achievements and hard work within the Division but concluded there was Limited Assurance due to challenges around KPI compliance and the low return for staff survey but was Assured around the plans in place to mitigate the above.

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
		• Conversation Café's • Rewarding and acknowledging colleagues • Challenging behaviours and ensuring kindness, care and compassion to each other The Committee further heard of the work the Division are undertaking with regard to Equality, Diversity and Inclusion including training across the wards and departments from the Equality and Diversity Team on how the team support staff and patients to bring their whole self to hospital in addition to race, religion in healthcare and understanding disability. The Committee noted the challenges in relation to the Key Performance Indicators in relation to sickness and compliance with PDRs commending the ongoing work within the Division.		
2	Board Assurance Framework and Risk Register	The Committee discussed the Board Assurance Framework risks aligned to the People Committee noting the significant amount of work ongoing to align the risk register to the Board Assurance Framework. The Committee reviewed the BAF risk scores and approved as recommended.	Board of Directors	Assured in relation to the process and assessment of the BAF risks as appropriate.
3	Risk Register	The Committee received the full risk register relating to risks scored over 15 noting only one risk was aligned to the Committee. The Committee discussed the limited number of risks on the risk register relating to workforce noting that this will be reviewed with an update to the December meeting.	Board of Directors	Assured in relation to the rating of the risk on the risk register.

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
4	Workforce Report	The Committee discussed the Workforce Report highlighting the following: • Sickness absence currently at 6.84% which is a concern and is higher than target; the Trust is becoming an outlier within the system and a detailed piece of work is required around this. • MAST training compliance is 4% above target at 89% • Recruitment time to clear is performing well at 31 days against a target of 34 days. • The target around PDRs has been reset due to organisational challenges; the target for the end November is 80% and the Trust is currently at 79% • Incentives have been put in place to encourage staff to complete the staff survey The Committee further discussed the pressures staff are currently experiencing and the importance of staff taking annual leave to support health and wellbeing.	Board of Directors	Limited Assurance due to the pressures experienced by the workforce but Assured in relation to the steps that are being taken to support.
5	Flu and Covid Vaccination: Update	The Committee received and commended the updated position in relation to the Flu and Covid Vaccination programme noting that the Trust had experienced a very successful campaign to date. The Committee noted the national average for Covid booster vaccinations is 70% with the Trust currently at 88%. Due to external recognition of our successful vaccination Hub, the CCG have requested we support the 14+ years vaccination programme in addition to providing support for the 40+ booster and child vaccinations.	Board of Directors	Assured

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
6	Medical and Dental CPD Update	The Committee received an overview of what constitutes Continuing Professional Development (CPD) for medical and dental staff which should be discussed as part of the job planning process. The Committee requested sight of additional information around what clinicians are doing for their CPD.	Board of Directors	Limited Assurance with a recognition of the ongoing work around this.
7	Equality, Diversity and Inclusion: Update	The Committee received and discussed the update noting the following: • An EDI lead for health and wellbeing has been appointed and will commence in post shortly. • Recent international recruits are being supported by the team. • The work carried out by the Engagement and Inclusion Lead in relation to highlighting gaps around Health Inequalities was commended. • Divisional work was beginning to start again but staff networks have been challenged due to operational pressures. • The Committee welcomed the introduction of interns and welcomed the news that we have an individual working within our gardening service who is a very welcome addition to the team.	Board of Directors	Assured.

People Committee held on Friday 19 November 2021

- Divisional Attendance – Medicine
- BAF and Risk Register
- Workforce Report
- HR Systems Update
- Proud Award Update
- Flu/Covid Vaccination Update
- Medical Workforce Report
- Medical and Dental CPD Update
- Equality, Diversity and Inclusion Update

Board of Directors' Meeting
07 January 2022

The Rotherham NHS Foundation Trust

Agenda item	P14/22
Report	**Care Quality Commission Report**
Executive Lead	Helen Dobson, Interim Chief Nurse
Link with the BAF	B1, B2, B3, B6
How does this paper support Trust Values	Ambitious – The Trust is working to achieve a CQC rating of Good and beyond. Caring – The Trust is working to achieve a CQC rating of Outstanding for the Caring Domain Together – The Trust is working together with senior leaders, clinical teams and external stakeholders to deliver safe, high quality care for the population of Rotherham
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	This paper provides a brief overview of the activity in relation to compliance and regulation. This includes: • Performance against the CQC Action Plans – November Cycle 2021 • CQC Assurance - December 2021 • The launch of the CQC Strategy – '*A new strategy for the changing world of health and social care'*
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	Iterations of this Report have been presented to: • Quality Committee 22 December 2021 • CQC Delivery Group 23 December 2021 • Executive Management Team 23 December 2021
Board powers to make this decision	N/A
Who, What and When (what action is required, who is the lead and when should it be completed?)	The action is for the Board of Directors to note the content of the Report and be assured that robust plans are in place to ensure sufficient and timely progress is being made to address the issues identified through the 2021 Inspection process. The Interim Chief Nurse is the Board lead for Regulatory Compliance.

Recommendations	It is recommended that the Board of Directors: • Note the content of the Report • Note the submission of the CQC Action Plans on 1 December 2021 • Note the decision to close the Section 29a Warning Notification for the Acute Medical Unit • Note the ongoing requirements for monitoring the CQC Action Plans • Note the launch of the new CQC Strategy and early indications of changes to the current assurance model
Appendices	N/A

1. CQC Action Plans 2018-2021

1.1 The Trust is currently managing a number of retrospective Action Plans relating to each of the CQC Inspections that occurred between 2018 and 2021. This report provides an update on progress being made. The Action Plans are set out below:

- Section 31 Action Plan (October 2018) – Urgent and Emergency Care
- Section 29a Action Plan – (November 2020) – Acute Medical Unit
- Must/Should take Action Plan – (September 2021) CQC Inspection
- Section 29a Action Plan – (August 2021) – Urgent and Emergency Care

1.2 To provide sufficient assurance to the CQC, in particular in relation to the Section 29a Warning Notification received by Urgent and Emergency Care (UECC) and the Must and Should take concerns identified within the 2021 Inspection Report the Trust submitted the following plans to the CQC within their agreed timeframe on 1 December 2021:

- Section 29a Acute Medical Unit
- Section 29a Urgent and Emergency Care
- Must/Should Take Action Plan from the 2021 CQC Report

1.3 The core services of Urgent and Emergency Care, Medical Care, Maternity and Children and Young People presented their sections of the Action Plans to the CQC Delivery Group on 23 November, following which the agreed updates were made and signed off by the Executive prior to submission to CQC.

1.4 CQC acknowledged receipt of the Action Plans confirming they are satisfied that all necessary concerns have been identified and the actions in place are appropriate to drive the necessary improvement.

2. Section 31 (2018) - Urgent and Emergency Care (UECC)

2.1 As reported previously the Section 31, received by UECC following the 2018 Comprehensive Inspection CQC raised concerns around the ongoing safe care and treatment of children attending the paediatric emergency department. Consequently, two conditions were imposed on the Trust's Certificate of Registration. The two conditions set out the requirement to ensure the provision of two sick children's nurses and oversight by a medical consultant 24 hours a day, seven days per week.

2.2 Although, as with all District General Hospitals, this provision will continue to pose staffing challenges, the Trust can now demonstrate there are robust systems and processes in place to identify and escalate any staffing shortfalls in this area and take appropriate and timely remedial action.

2.3 There has been a consistent recruitment programme in place since 2018, which is further enhanced by a closer working relationship with the Children's Ward and an increase in the number of adult nurses with paediatric competencies.

2.4 To further strengthen the department the line management will change from January 2022 to formally integrate the paediatric emergency service with the overall Children and Young People's Core Service. This will facilitate greater flexibility, skills and competencies of the workforce, leading to increased recruitment, staff satisfaction and patient safety.

2.5 Again, as previously reported, the Trust plans to formally apply to have the conditions of the Section 31 lifted through quarter four with submission of the application scheduled for

January 2022. UECC staff are currently collating the supporting evidence for approval by the CQC Delivery Group on 11 January.

3. Section 29a (2020) - Acute Medical Unit (AMU)

3.1 Following receipt of the AMU Section 29a Action Plan on 1 December CQC visited the Unit as part of their routine Engagement meeting on 8 December. They met with a number of staff, including the Medicine Triumvirate, the Matron and Ward Manager and spoke to a number of staff. The Trust has been submitting progress against the Section 29a actions each month since December 2020. The Unit was included in the inspection of the Medical Care Core Service in May 2021 where no further concerns were raised.

3.2 CQC colleagues confirmed that the Section 29a is now closed. Continued monitoring of the improvements made will be via periodic reporting through to CQC Delivery Group to ensure the Unit maintains their improved position. This is a very positive position for the Trust, but in particular is testament to the commitment and engagement of the AMU team to deliver consistently safe, high quality care.

4. The MUST take Action Plan (2021)

4.1 As reported to the November Board meeting, 82 Must and Should take issues have been identified within the 2021 Inspection Report. In order to fully address each concern a number of sub-actions (229) have been agreed to ensure delivery of the required improvements. Table 1 indicates the total number of actions per core service area and it is against this number that progress will be monitored via the CQC Delivery Group going forward. The table illustrates progress against the actions as of 23 December.

4.2 The one 'off track' (Red) action relates to the transition of young adults from the paediatric service to adult services. This is a multiagency issue and as such, a wider piece of work is underway to develop appropriate transitional pathways.

Core Service Area	No of issues	No of actions	R	A	G	B
Trustwide	4	9			9 (100%)	
Urgent and Emergency Care	30	93		17 (18.3%)	76 (81.7%)	
Medical Care	18	72		1(1.4%)	71 (98.6%)	
Maternity	6	10			10 (100%)	
Children and Young People	24	45	1(2.2%)	27 (60%)	17 (37.8%)	
Total	82	229	1 (0.4%)	45 (19.7%)	183 (79.9%)	0(0%)

Table 1

5. Urgent and Emergency Care - Section 29a warning Notice (2021)

Core Service Area	No of issues	No of actions	R	A	G	B
Within the UECC, there was evidence that patients were not always receiving safe care and treatment.	21	62		2 (3.2%)	60 (96.8%)	
There were issues around the safeguarding processes for both adults and children, which could increase the risk of harm.	7	18		4 (22.2%)	14 (77.8%)	
There was evidence to show that not all patients received appropriate patient centred care.	8	14		2 (14.2%)	12 (85.8%)	
Leadership, systems and processes were in place within the Department that were not being consistently applied. Audits were not consistently completed appropriately. Issues, whilst identified were not being addressed in a timely manner	12	12			12 (100%)	
Total	48	106	0 (0%)	8 (7.5%)	98 (92.5%)	0 (0%)

Table 2

5.1 UECC received a Section 29a Warning notification as part of the 2021 Inspection cycle, raising 48 individual concerns. As with the Must and Should take Action Plan a number of sub-actions (106) have been identified against each of the elements of the Warning Notice. Table 2 above illustrates progress to date as of 23 December.

5.2 During the on-site CQC Engagement meeting on 8 December, CQC colleagues visited the UECC and met with a number of staff. They were pleased to note the work that is being undertaken and in particular, the specific focus on staff engagement demonstrating that the concerns raised during the May/June visit are being addressed and that staff across the department are being actively encouraged to be fully involved in the improvement journey.

6. Progress Monitoring

6.1 A formal 'Confirm and Challenge' meeting is held with each core service in the last week of the month, although regular meetings take place throughout the month. The purpose of the confirm and challenge meeting is to provide support, advice and guidance to the clinical teams with regards to progress against their actions and collation of supporting evidence.

6.2 The Plan is updated after each final confirm and challenge session prior to submission to the CQC Delivery Group.

6.3 From November, each core service presents the current position to the CQC Delivery Group, with a specific focus on actions that are off track and mitigation plans.

6.4 Should a core service feel that sufficient evidence has been collated to demonstrate the concern has been fully addressed and is sustained into business as usual, then this will be

presented to CQC Delivery Group for approval. If the Delivery Group is in agreement the action will be BRAG-rated 'Blue' – achieved and embedded into business as usual.

6.5 The Action Plan will be locked down after each CQC Delivery Group and filed as the final version for the month.

7. CQC Assurance

7.1 At the CQC Engagement meeting on 8 December, it has been agreed that in order to provide ongoing assurance the Trust will submit to CQC, the Minutes of each CQC Delivery Group, the CQC Delivery Group Chair's Log for Quality Committee and the CQC Assurance Report to Quality Committee each month.

7.2 The Must/Should take Action Plan will be submitted to CQC each quarter for additional assurance on progress. It is proposed that this submission will be via a CQC Engagement meeting where core service representatives will be invited to attend and discuss the work they are undertaking.

7.3 It is expected that over time additional actions will be included within this plan as it transforms into a proactive, forward-looking Quality Improvement Plan.

8. CQC Strategy

8.1 CQC launched *'A new strategy for the changing world of health and social care'* at the end of May 2021

8.2 The CQC are changing how they regulate to improve care and services for everyone; there will be changes to how they conduct inspections and to the well-led element.

8.3 Regulation will be more relevant to how care is delivered, and more flexible to manage risk and uncertainty

8.4 There will be changes to the operating model and assessment framework from 2022:

- The 5 key domains will remain
- Inspections will be risk-based and focussed
- A 'quality statement' from the Trust will be introduced
- A process of continuous intelligence gathering
- Ratings will be driven by the change in quality
- Improved inspection reports

8.5 The details of the new operating model will become clearer through quarter four with a full explanation provided to the Board of Directors in March 2022.

Elaine Jeffers
Deputy Director of Quality Assurance
December 2021

Board of Directors Meeting
07 January 2022

The Rotherham NHS Foundation Trust

Agenda item	P15/22
Report	**Integrated Performance Report – November 2021**
Executive Lead	Michael Wright, Deputy Chief Executive
Link with the BAF	B1, B2, B9
How does this paper support Trust Values	The Integrated Performance Report supports the Trust's *Ambitious* value in ensuring we are constantly striving to deliver stronger performance across all of the core domains.
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	The Integrated Performance Report is the monthly summary of Trust performance across the four domains of Operational Delivery, Quality, Finance and Workforce. This month's report relates to November 2021 data wherever it is available. It highlights performance against agreed national, local or benchmarked targets. Statistical Process Control charts are included against key metrics.
Due Diligence	Each of the Assurance Committees have received the relevant elements of the Integrated Performance Report or identical information, with the Executive Directors approving the content for their domain.
Board powers to make this decision	In order to be assured of the performance of the organisation, the Board needs to have visibility of the Trust's performance against core metrics.
Who, What and When	The Deputy Chief Executive is the Lead Executive for reporting on the performance of the organisation through the Integrated Performance Report on a monthly basis.
Recommendations	It is recommended that the Board of Directors note the Trust's performance against the metrics presented in the Integrated Performance Report and receive assurance on the basis of this report.
Appendices	Integrated Performance Report – November 2021 Integrated Performance Report Commentary – November 2021

Board of Directors

Integrated Performance Report - November 2021

Provided by

Business Intelligence Analytics, Health Informatics

PERFORMANCE SUMMARY

Quality	Operational Delivery	Finance	Workforce	Activity
Mortality	Planned Patient Care	Financial Position	Workforce Position	Acute
Infection Prevention & Control	Emergency Performance			Community Services
Patient Safety	Cancer Care			
Maternity	Inpatient Care			
Patient Feedback	Community Care			

CQC DOMAINS

Responsive	Effective	Safe	Caring	Well Led
Planned Patient Care	Mortality	Infection Prevention & Control	Patient Feedback	Workforce position
Emergency Performance	Inpatient Care	Patient Safety		Financial Position
Cancer Care		Maternity		
Community Care				

The Rotherham NHS
NHS Foundation Trust

Trust Integrated Performance Dashboard - Operations

KPI		Reporting Period	Type of Standard	Target	Previous Month (3)	Previous Month (2)	Previous Month (1)	Current Month	YTD 21/22	Same Month Prev. Yr	Trend	Data Quality
Planned Patient Care												
P1	Waiting List Size	Nov 2021	L	**19,705**	19,765	19,705	20,478	20,489	20,489	13,993		
P1A	Number of RTT Patients with a Decision to Admit	Nov 2021			2,644	2,773	2,914	3,038	3,038	3,719		
P2	Referral to Treatment (RTT) Performance	Nov 2021	N	**92%**	83.2%	82.5%	83.2%	81.9%	83.4%	69%		
P3	Number of 52+ Weeks	Nov 2021	L	**48**	124	67	47	44	44	445		
P3A	Number of 104+ Weeks	Nov 2021	N	**0**	0	0	0	0	0	0		
P4	Overdue Follow-Ups	Nov 2021	L	**8,700**	9,510	9,393	9,754	10,340	10,340	12,512		
P5	First to follow-up ratio	Nov 2021			2.99	3.05	2.97	2.88	2.98	3.27		
P6	Day case rate (%)	Nov 2021	B	**80%**	83.7%	85.2%	85.1%	87.7%	83.4%	90%		
P7	Diagnostic Waiting Times (DM01)	Oct 2021	N	**1%**	24.2%	23.8%	19.1%	17.4%	23.8%	42%		
P8	Diagnostic Activity Levels											
Emergency Performance												
E1	Number of Ambulance Handovers > 60 mins	Nov 2021	CQC	**0**	178	206	190	307	1,326	62		
E1A	Number of Ambulance Handovers > 30 mins	Nov 2021	CQC	**0**	384	441	438	579	3,038	211		
E2	Average Time to Initial Assesment in ED (Mins)	Nov 2021	N	**15**	23	27	25	28	23	16		
E3	Proportion of patients spending more than 12 hours in A&E from time of arrival	Nov 2021			6.74%	6.86%	7.89%	10.06%	7.87%			
E4	Number of 12 hour trolley waits	Nov 2021	N	**0**	0	0	0	0	0	0		
E5	Conversion rate from A&E (not including Observations)	Nov 2021			22.8%	21.9%	22.1%	21.5%	21.2%	27%		
E6	Proportion of same day emergency care	Nov 2021	L	**33%**	37.8%	41.0%	39.4%	41.6%	40.4%	34%		
Cancer Care												
Ca1	2 Week Wait Cancer Performance	Oct 2021	N	**93%**	95.2%	93.4%	92.4%	94.2%	94.4%	98%		
Ca2	2 Week Wait Breast Symptoms	Oct 2021	N	**93%**	92.0%	92.5%	96.2%	94.7%	91.3%	86%		
Ca3	31 day first treatment	Oct 2021	N	**96%**	93.8%	94.6%	95.6%	96.9%	95.9%	97%		
Ca4	62 Day Performance	Oct 2021	N	**85%**	78.2%	71.3%	67.9%	75.2%	73.9%	62%		
Ca5	Patients waiting longer than 62 days on the PTL	Nov 2021	L	**75**	87	90	86	70	70			
Ca6	28 day faster diagnosis standard	Oct 2021	N	**75%**	72.6%	74.8%	71.0%	73.0%	72.8%	56%		
Inpatient Care												
I1	Mean Length of Stay - Elective (excluding Day Cases)	Nov 2021			3.00	2.70	3.10	3.06	3.10	2.88		
I2	Mean Length of Stay - Non-Elective	Nov 2021			5.29	5.46	5.46	5.52	5.25	5.67		
I3	Length of Stay > 7 days (Snapshot Numbers)	Nov 2021	L	**142**	195	167	192	204	204	177		
I4	Length of Stay > 21 days (Snapshot Numbers)	Nov 2021	L	**42**	64	61	51	66	66	44		
I5	Right to Reside - % not recorded (Internal Performance from May)	Nov 2021	B	**0%**	15.3%	10.2%	11.7%	9.2%	9.2%	23%		
I6	Discharges before 5pm (inc transfers to Dis Lounge)	Nov 2021	L	**70%**	60.6%	60.5%	53.7%	54.8%	56.7%	53%		
Outpatient Care												
O1	Did Not Attend Rate (OutPatients)	Nov 2021	B	**7%**	8.6%	8.0%	8.7%	8.4%	8.1%	10%		
O4	% of all Outpatient activity delivered remotely via telephone or video consultation	Nov 2021	N	**25%**	18.4%	19.0%	15.6%	17.0%	17.7%			
O6	Number of patient pathways moved or discharged to PIFU, expressed as a proportion of all outpatient activity.	Nov 2021			0.18%	0.10%	0.03%	0.14%	0.09%			
Community Care												
CC1	MusculoSkeletal Physio <4 weeks	Nov 2021	L	**80%**	14.8%	13.7%	11.4%	16.4%	15.4%	19%		
CC2	% urgent referrals contacted within 2 working days by specialist nurse (Continence)	Nov 2021	L	**95%**	56.3%	58.8%	65.1%	79.2%	64.9%	89%		
CC3	A&E attendances from Care Homes	Nov 2021	L	**144**	119	144	143	159	159	116		
CC4	Admissions from Care Homes	Nov 2021	L	**74**	56	62	62	72	72	78		
CC5	Patients assessed within 5 working days from referral (Diabetes)	Oct 2021	L	**95%**	100.0%	70.6%	92.9%	100.0%	89.9%	98%		

The Rotherham NHS
NHS Foundation Trust

Trust Integrated Performance Dashboard - Quality

KPI		Reporting Period	Type of Standard	Target	Previous Month (3)	Previous Month (2)	Previous Month (1)	Current Month	YTD 21/22	Same Month Prev. Yr	Forecast - Year End	Trend	Data Quality
Mortality													
M1	Mortality index - SHMI	Apr 2021	B	**100**	111.0	109.7	109.6	111.3	--	120.2			
M2	Mortality index - HSMR (Rolling 12 months)	May 2021	B	**100**	120.4	121.6	114.0	112.2	--	121.3			
M3	Number of deaths (crude mortality)	Nov 2021		-	92	90	84	110	659	157			
Infection, Prevention and Control													
In1	Clostridium-difficile Infections	Nov 2021		-	0	1	2	2	13	3			
In1a	Clostridium-difficile Infections (rate)	Nov 2021			32.9	32.8	29.2	27.4	0	0	**0**		
In2	MRSA Infections (Methicillin-resistant Staphylococcus Aureus)	Nov 2021	L	**0**	0	0	0	0	1	0			
In2a	MRSA Infections (Methicillin-resistant Staphylococcus Aureus) (Rate)	Nov 2021			1.4	1.4	1.4	1.4	0.0	0	**0**		
In3	E.coli blood bactertaemica, hospital acquired	Nov 2021			4	1	4	6	0	0	**0**		
Patient Safety													
PS1	Incidents - severe or above (one month behind)	Oct 2021	L	**0**	4	6	3	3	30	4			
PS2	% Potential of Under Reporting of Pt Safety Incidents	Nov 2021			51.4	51.9	51.2	51.7	49.8	0			
PS3	Never Events	Nov 2021	L	**0**	0	0	0	0	0	0			
PS4	Number of Patient Harms	Nov 2021		-	671	602	588	633	4,860	550			
PS5	Number of Patient Harms (Moderate and above)	Nov 2021		-	26	24	20	33	196	19			
PS6	Number of Patient Falls	Nov 2021		-	104	85	91	83	711	103			
PS7	Number of Pressure Ulcers (G3 and above)	Nov 2021		-	1	1	0	4	7	1			
PS8	Medication Incidents	Nov 2021		-	93	123	114	96	842	93			
PS9	Readmission Rates (one month behind)	Oct 2021	L	**7.6%**	8.0%	7.9%	6.8%	8.6%	8.0%	8.3%			
PS10	Venous Thromboembolism (VTE) Risk Assessment	Nov 2021	N	**95.0%**	96.9%	95.9%	95.4%	92.0%	95.7%	92.2%			
PS11	Number of complaints per 10,000 patient contacts	Nov 2021	L	**8**	9.9	5.2	9.3	10.4	7.9	12.3			
PS12	Proportion of complaints closed within 30 days	Nov 2021	L	**100.0%**	91.3%	100.0%	100.0%	100.0%	97.9%	100.0%			
PS13	Hip Fracture Best Compliance	Nov 2021	L	**65.0%**	79.2%	73.3%	74.1%	79.2%	75.5%	88.2%			
PS14	F&F Postive Score - Inpatients & Day Cases	Nov 2021	N	**95.0%**	99.1%	97.3%	98.0%	97.6%	97.9%	97.9%			
PS15	F&F Postive Score - Outpatients	Nov 2021	N	**95.0%**	97.6%	94.9%	98.7%	98.1%	97.9%	97.9%			
PS16	F&F Postive Score - Maternity	Nov 2021	N	**95.0%**	95.0%	100.0%	100.0%	96.9%	98.6%	98.9%			
PS17	Care Hours per Patient Day	Nov 2021	L	**7.3**	6.60	6.70	6.50	6.40	6.40	6.7			
Maternity													
Ma1	Bookings by 12 Week 6 Days	Nov 2021	N	**90.0%**	93.4%	93.8%	91.0%	92.5%	93.6%	91.1%			
Ma2	% of emergency Caesarean-sections	Nov 2021	L	**16.5%**	17.1%	19.3%	20.2%	14.8%	17.4%	17.4%			
Ma3	Breast Feeding Initiation Rate	Nov 2021	N	**66.0%**	67.5%	67.5%	67.1%	70.5%	68.9%	67.4%			
Ma4	Stillbirth Rate per 1000 live births (Rolling 12 months)	Nov 2021	L	**4.66**	4.11	4.50	4.08	3.62	3.62	4.87			
Ma4a	Number of Stillbirths	Nov 2021		-	0	1	0	0	1	1			
Ma5	1:1 care in labour	Nov 2021	L	**75.0%**	95.4%	97.9%	95.4%	96.4%	95.9%	96.2%			
Ma6	Serious Incidents (Maternity)	Oct 2021	L	**0**	0	3	0	0	4	0			
Ma7	Moderate and above Incidents (Harm Free)	Oct 2021		-	0	0	0	0	0				
Ma8	Cases Referred to HSIB	Nov 2021	L	**0**	0	0	0	0	1				
Ma9	Consultants on labour (Hours on Ward)	Nov 2021		-	62.5	62.5	62.5	62.5	62.5	--			

The Rotherham NHS
NHS Foundation Trust

Trust Integrated Performance Dashboard - Workforce

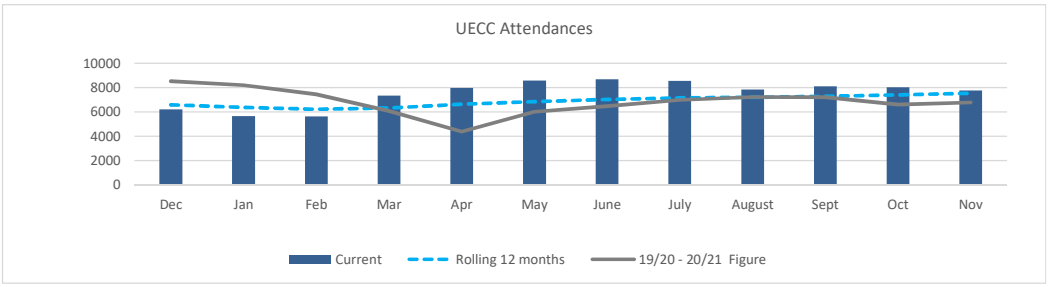
KPI		Reporting Period	Type of Standard	Target	Previous Month (3)	Previous Month (2)	Previous Month (1)	Current Month	YTD 20/21	Same Month Prev. Yr	Forecast - Year End	Trend	Data Quality
Workforce													
W1	Whole Time Equivalent against plan - Total	Nov 2021	L	**-236**	-199	-243	-285	-279	-279	-225			
W2	Whole Time Equivalent plan - Nursing	Nov 2021	L	**-106**	-42	-57	-39	-23	-23	-119			
W3	Total Headcount	Nov 2021		-	4,881	4,892	4,911	4,905	4,905	4,794			
W4	Vacancy Rate - TOTAL	Nov 2021	B	**5.40%**	4.66%	5.65%	6.51%	6.39%	6.39%	5.38%			
W5	Vacancy Rate - Nursing	Nov 2021	B	**8.10%**	3.25%	4.36%	2.93%	1.79%	1.79%	9.23%			
W6	Time to Recruit	Nov 2021	L	**34**	28	31	31	30	30	36			
W8	Sickness Rates (%) - inc COVID related	Nov 2021	L	**3.95%**	6.68%	6.95%	6.84%	6.83%	5.91%	6.47%			
W9	Turnover	Nov 2021		**0.63%**	1.04%	1.20%	0.90%	0.80%	0.86%	0.59%			
W10	Appraisals complete (%)	Nov 2021	L	**90.00%**	65.00%	68.00%	79.00%	82.00%	82.00%	79.06%			
W11	MAST (% of staff up to date)	Nov 2021	L	**85.00%**	90.00%	89.00%	89.00%	88.00%	88.00%	91.66%			

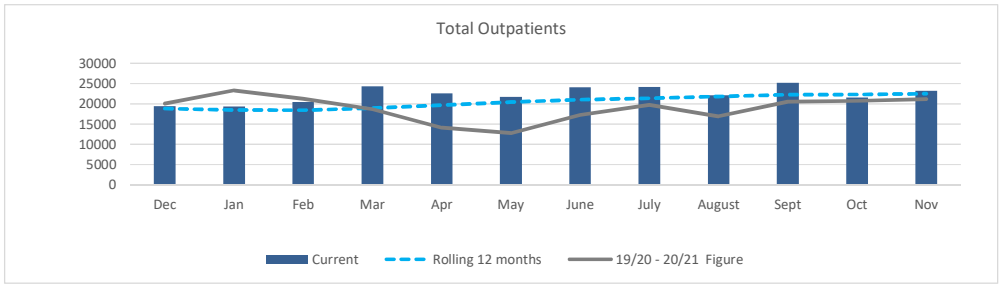
The Rotherham NHS
NHS Foundation Trust

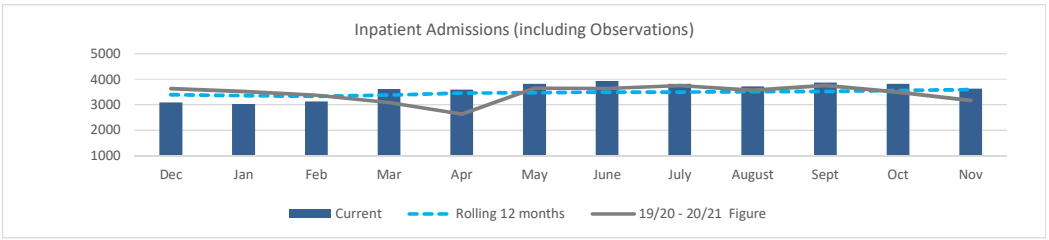
Trust Integrated Performance Dashboard - Finance

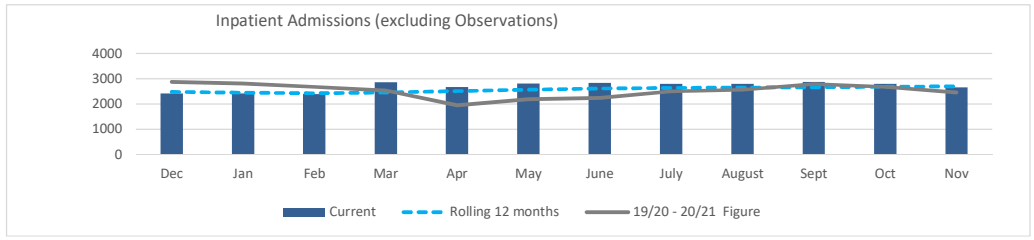
	In Month Plan £000s	In Month Actual £000s		In Month Variance £000s	YTD Plan £000s	YTD Actual £000s		YTD Variance £000s		Forecast Variance £000s		Prior Month Forecast £000s
I&E Performance (Actual)	(78)	552		630	(381)	649		1,030		512		108
I&E Performance (Control Total)	(41)	589		630	(83)	946		1,029		513		109
ciency Programme (CIP) - Risk Adjusted	503	1,501		998	2,762	3,567		805		157		(378)
Capital Expenditure	1,224	1,105		119	7,334	4,517		2,817		1,077		1,000
Cash Balance	0	1,242		1,242	1,357	30,197		28,840		14,363		13,006

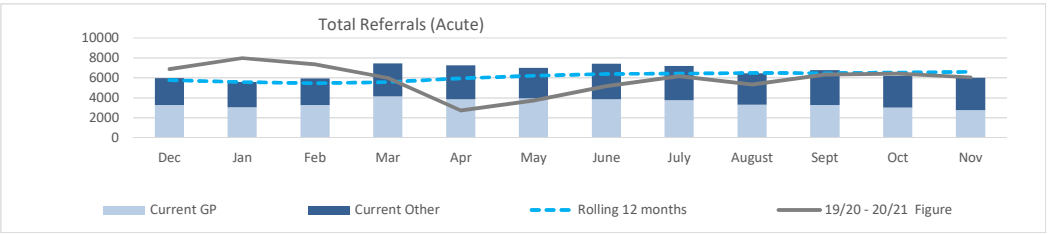
Trust Integrated Performance Dashboard - Activity

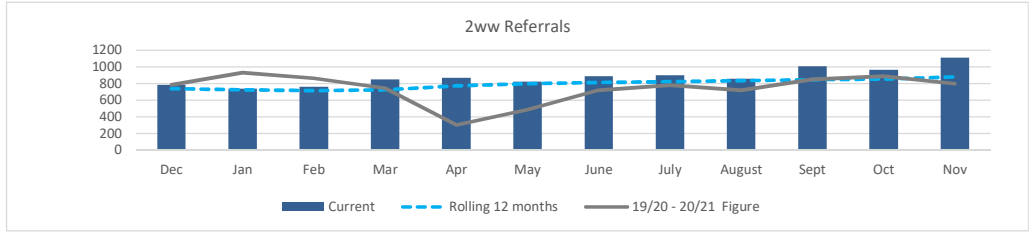












The Rotherham NHS
NHS Foundation Trust

Trust Integrated Performance Dashboard - Activity

ACTIVITY

OUTPATIENTS

	Activity 2021	Activity 2019 (WDA)	As % of 2019/20 WDA
November	19,666	21,934	-10.3%
M7-12 YTD monthly average	40,253	46,763	-13.9%

DAYCASES

	Activity 2021	Activity 2019 (WDA)	As % of 2019/20 WDA
November	1,990	2,061	-3.4%
M7-12 YTD monthly average	3,830	4,237	-9.6%

ELECTIVE ACTIVITY

	Activity 2021	Activity 2019 (WDA)	As % of 2019/20 WDA
November	286	423	-32.4%
M7-12 YTD monthly average	606	841	-27.9%

CLOCK STOPS - RTT

Clock Starts

	Clock Starts 2021* includes ASIs	Clock Starts 2019	As % of 2019/20 WDA
November	7,228	6,530	10.70%
M7-12 YTD monthly average	7,089	6,998	1.30%

Clock Stops Admitted

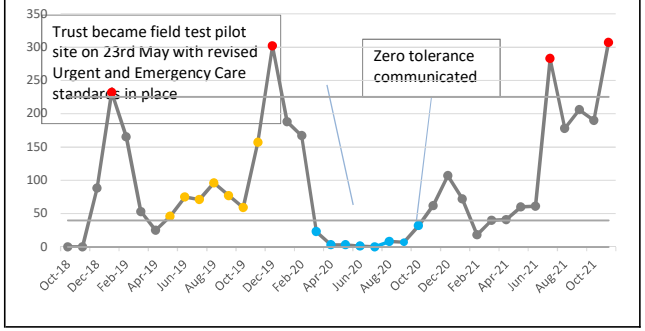
	Clock Stops 2021	Clock Stops 2019	As % of 2019/20 WDA
November	1,385	1,518	-8.80%
M7-12 YTD monthly average	1,295	1,590	-18.60%

Clock Stops Non-Admitted

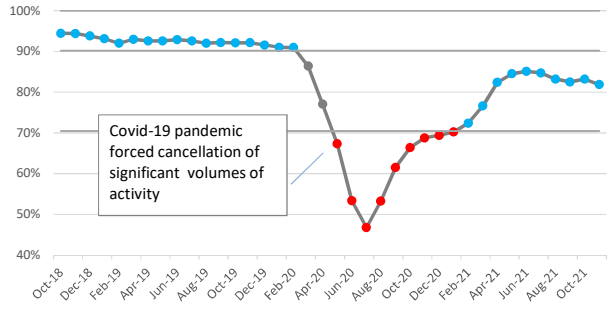
	Clock Stops 2021	Clock Stops 2019	As % of 2019/20 WDA
November	3,912	4,093	-4.40%
M7-12 YTD monthly average	3,777	4,296	-12.10%

Trust Integrated Performance Dashboard - SPC Charts - Operational Performance (1)

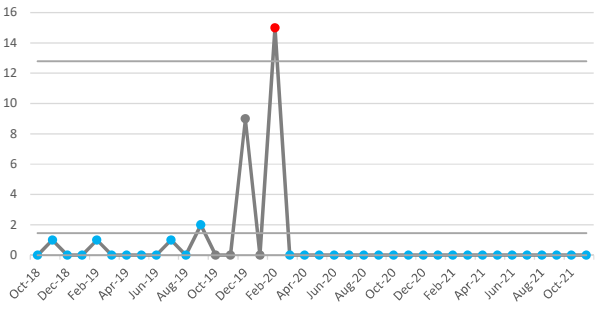
Ambulance Handovers - % of handovers > 60 minutes



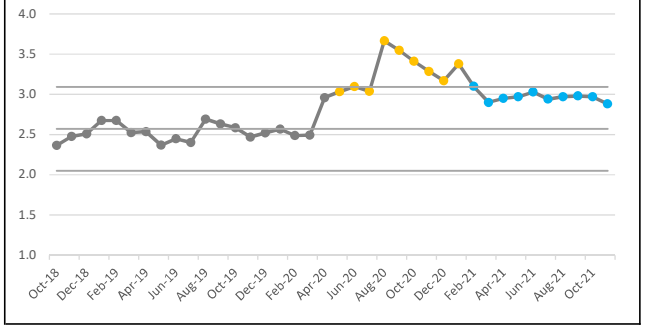
Referral to Treatment - % of patients waiting less than 18 weeks for treatment



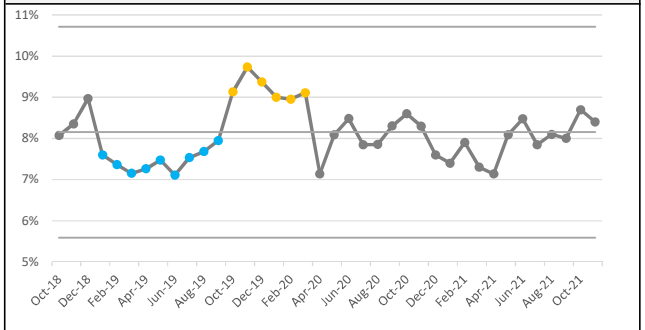
12 hour trolley waits - per month



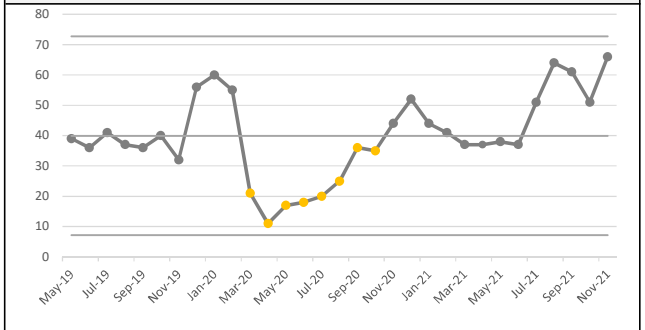
First to Follow-Up Ratio



Did Not Attends (DNAs) % of appointments

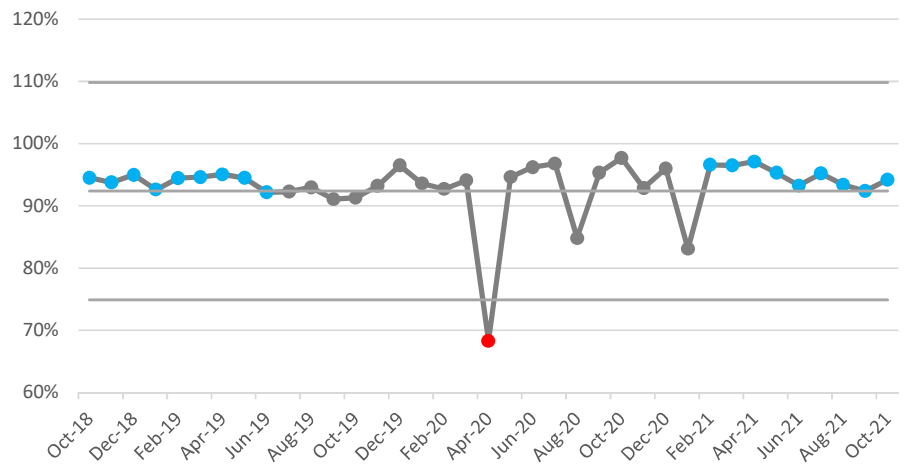


Length of Stay > 21 days (Snapshot Numbers)

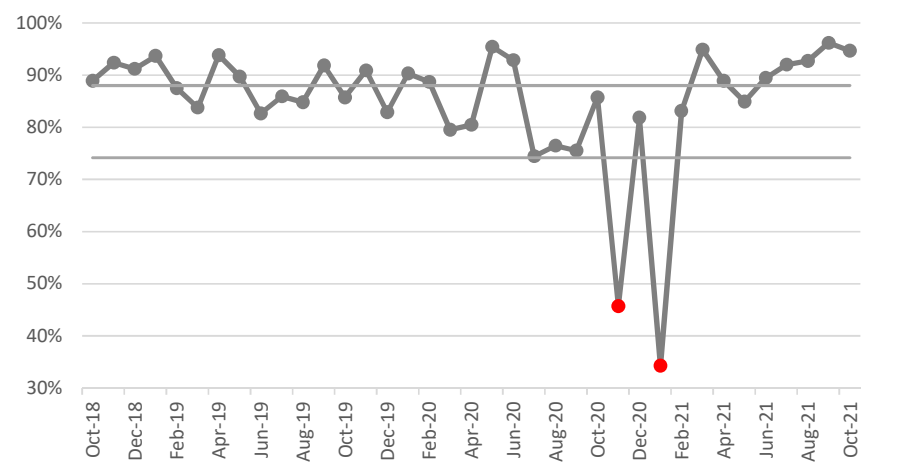


Trust Integrated Performance Dashboard - SPC Charts - Operational Performance (2)

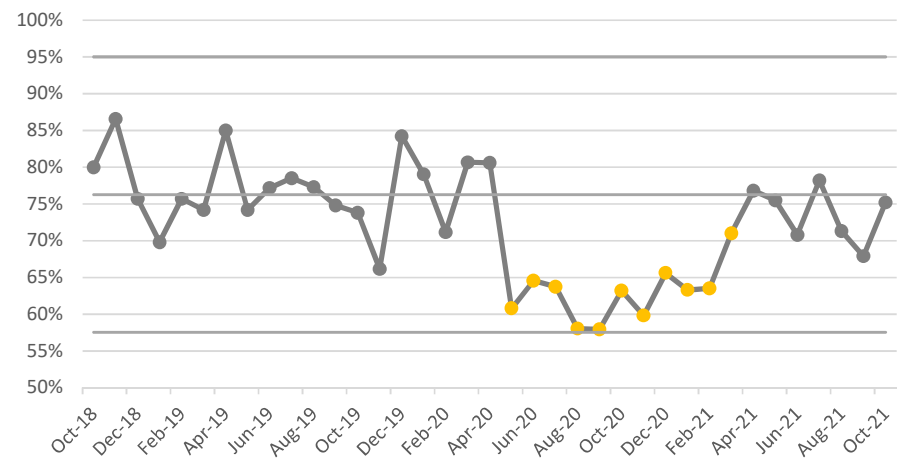
Cancer 2 week wait standard



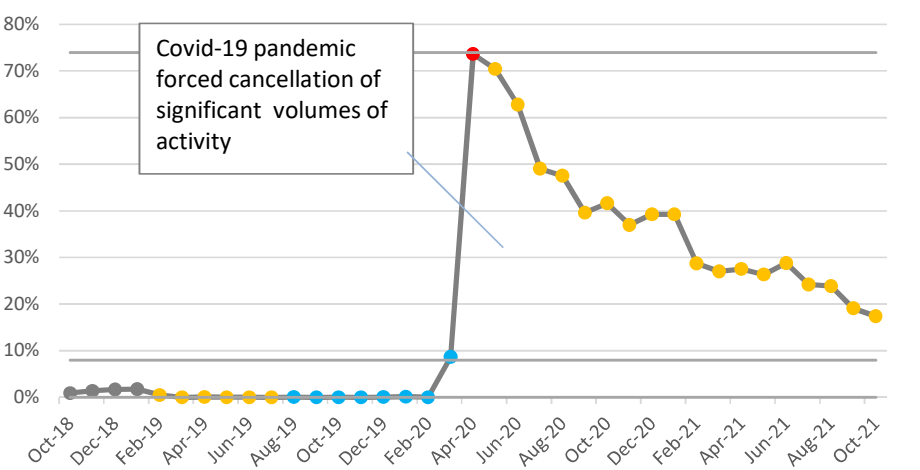
Cancer 2 week wait breast symptoms standard



Cancer 62 day first treatment standard

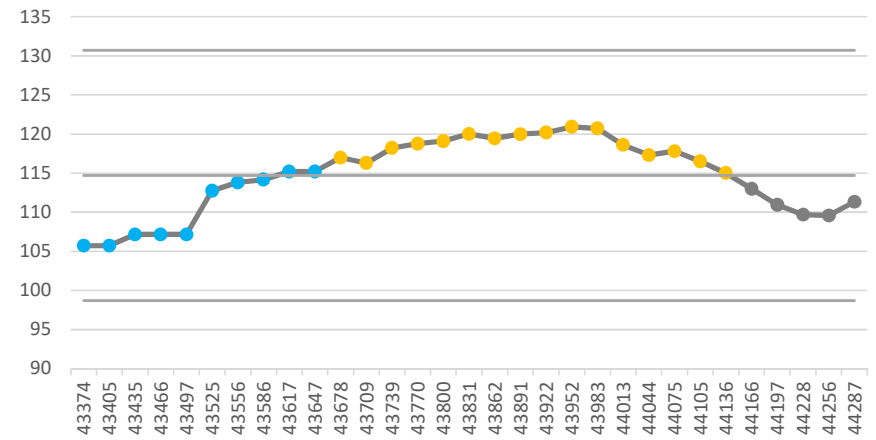


Diagnostics - % of breaches over 6 weeks (DM01)

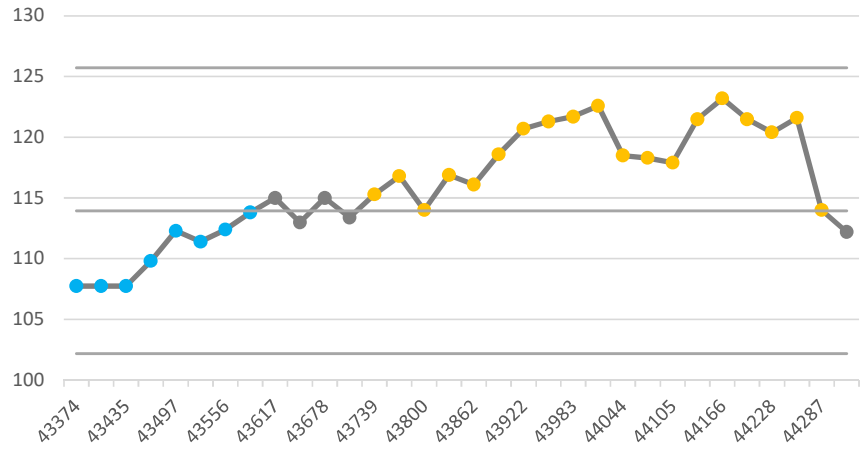


Trust Integrated Performance Dashboard - SPC Charts - Quality (1)

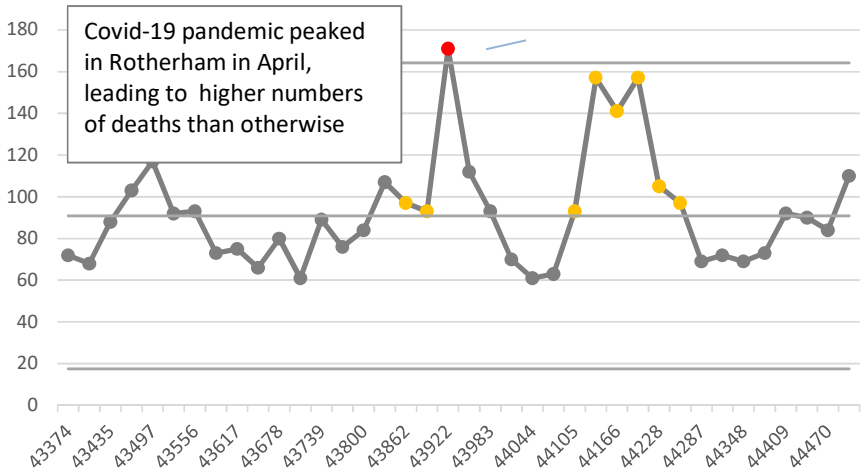
Standardised Hospital Mortality Indicator (SHMI)



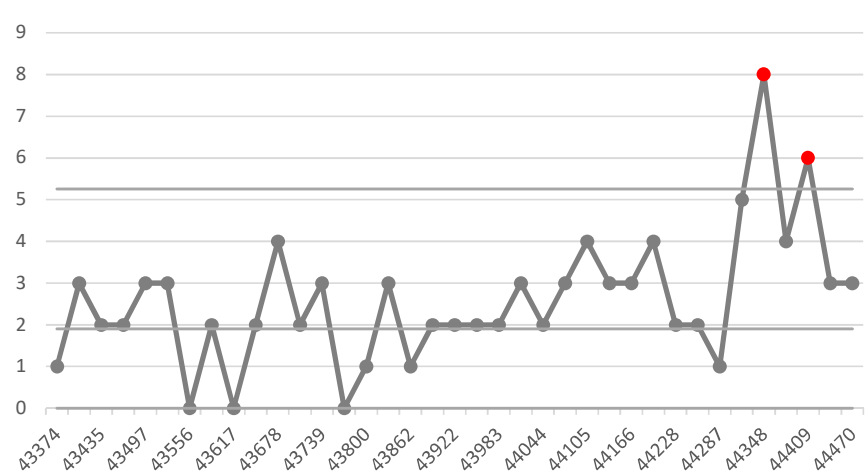
Hospital Standardised Mortality Ratio (HSMR)



Crude Mortality (number of deaths)

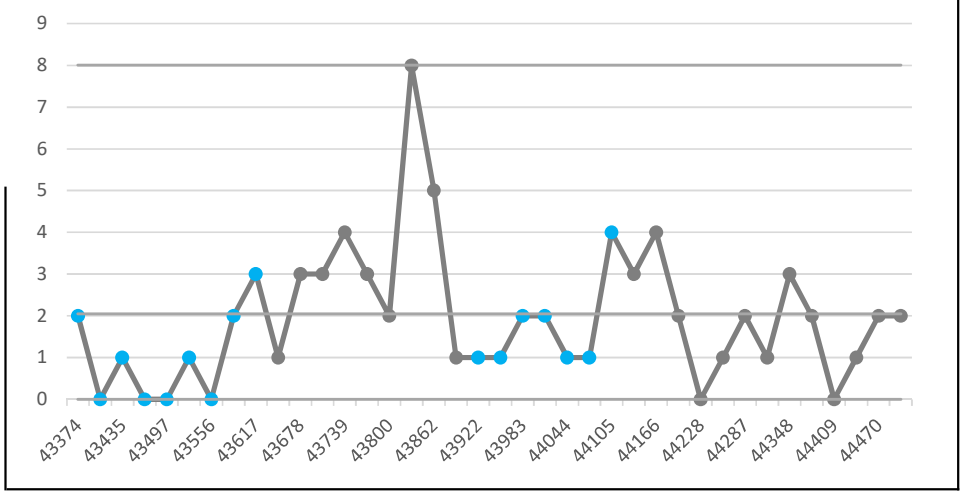


Incidents (severe or above)

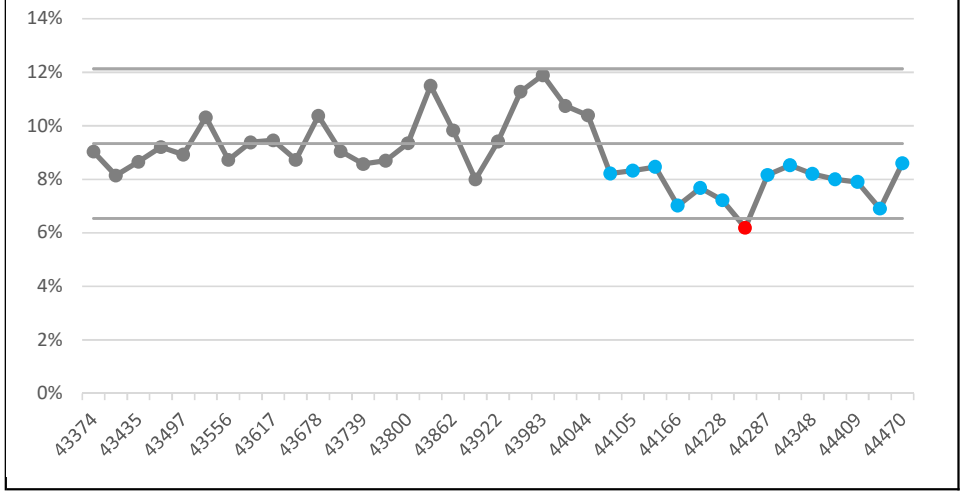


Trust Integrated Performance Dashboard - SPC Charts - Quality (2)

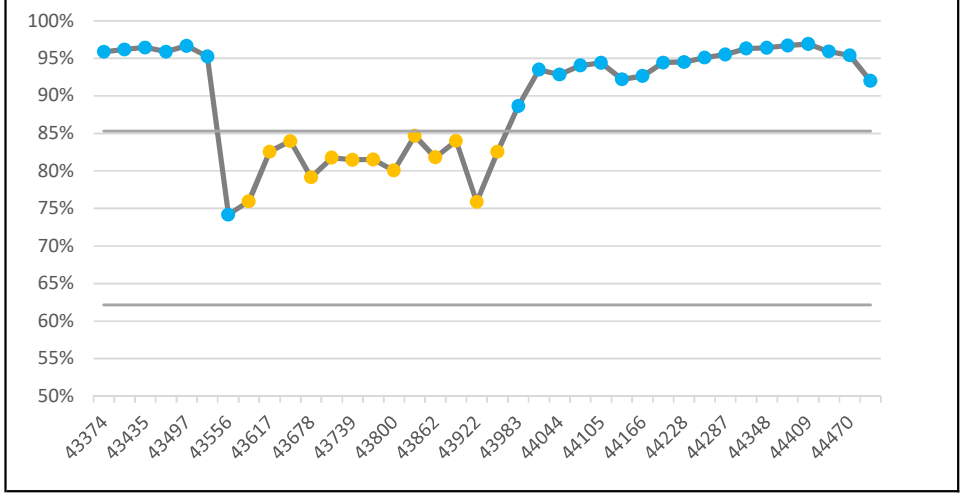
Clostridium difficile infections (number)



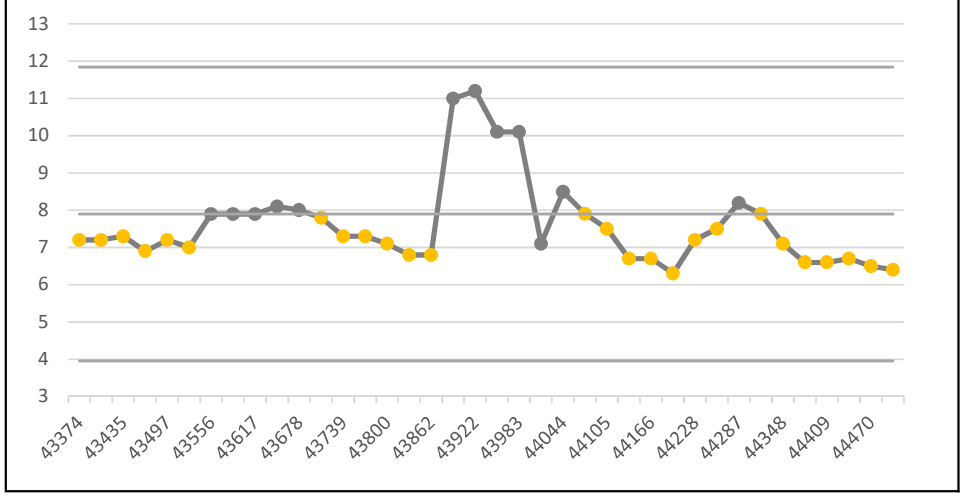
Readmissions (%)



Venous Thrombous Embolism compliance (%)

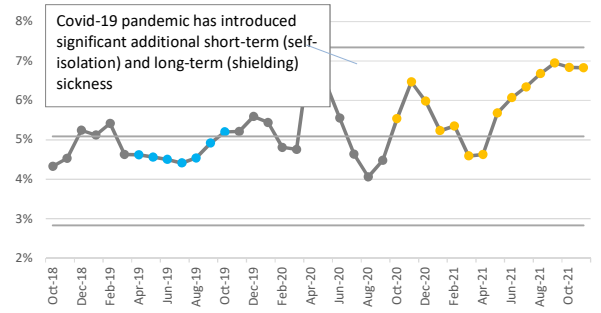


Care Hours per Patient Day

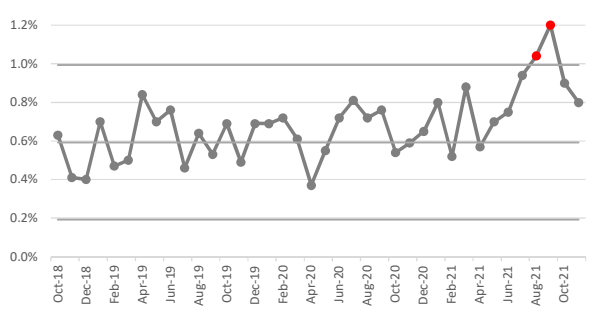


Trust Integrated Performance Dashboard - SPC Charts - Workforce

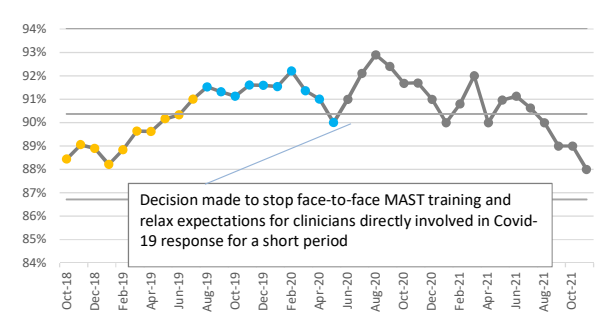
Sickness (%)



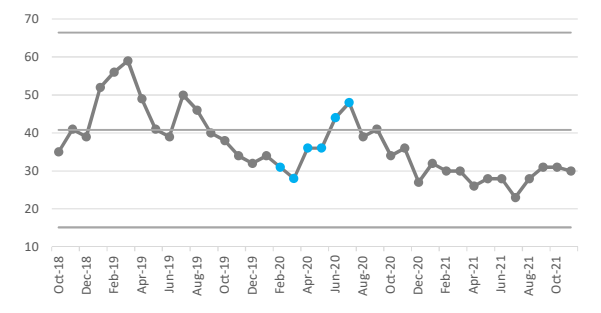
Turnover (%)



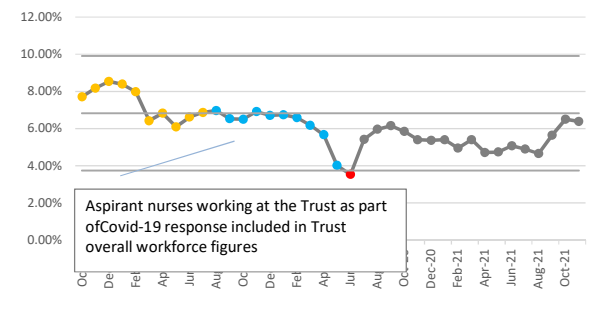
Mandatory and Statutory Training (MAST)



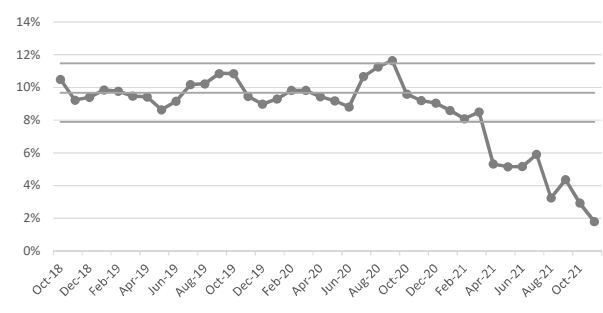
Time to Recruit - days



Vacancy Rate (TOTAL)



Vacancy Rate (Nursing)



Safer Staffing

Trust Wide Scorecard Rolling 12 Months & Year End position 20/21	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
Daily staffing -actual trained staff v planned (Days)	85.42%	89.00%	88.00%	88.25%	86.51%	87.67%	89.80%	85.40%	82.55%	84.17%	87.39%	85.51%	86.74%
Daily staffing -actual trained staff v planned (Nights)	85.50%	89.70%	87.21%	85.24%	85.30%	88.23%	87.10%	89.95%	86.37%	83.00%	83.93%	82.94%	86.32%
Daily staffing - actual HCA v planned (Days)	91.79%	92.00%	101.69%	102.86%	105.41%	111.97%	129.70%	108.39%	104.30%	103.18%	100.43%	99.16%	101.90%
Daily staffing - actual HCA v planned (Nights)	89.44%	89.19%	99.1`%	1.0071	120.72%	108.47%	113.20%	105.09%	101.02%	101.69%	98.49%	89.90%	95.29%
Care Hours per Patient per Day (CHPPD)	6.7	6.7	6.3	7.2	7.5	8.2	7.9	7.1	6.6	6.6	6.7	6.5	6.4

Integrated Performance Report Commentary

OPERATIONAL PERFORMANCE

Urgent & Emergency Care and Flow

- Site pressures increased in November, despite Covid-19 positive patients falling to the lowest level since July, in part due to significant demand at the front door with a high acuity of patients. UECC Attendances were above the previous year, 27% above November 2020 volumes and 3% above November 2019 volumes. In addition, admissions were 13% above 2019 volumes for the same month.
- The number of super-stranded patients (21 day+ length of stay) rose again in November and is well above the new national target that has been implemented in 2021/22, with a new peak for the highest numbers of 21+ day length of stay patients in the Trust.
- The increased challenges with flow through the organisation led to another difficult month regarding ambulance handover delays over 60 minutes, with over 300 recorded 'black breaches' in the month. In a further sign of the pressures in the site, 1 in 10 patients waited 12 hours in the department.
- These figures demonstrate the intense challenges experienced in the Trust in this month, through the combination of high demand at the front door, difficulties in flow out of the organisation, as well as the ongoing need to cohort Covid-19 patients appropriately.

Elective Care

- The size of the waiting list remained relatively stable in month, with referrals now close to pre-pandemic levels but capacity constrained by IPC requirements, sickness absence and workforce challenges. However, the RTT position deteriorated, driven by significant capacity challenges within a couple of the larger specialties. Inpatient activity was affected by the closure of one of the elective wards given the site pressures, with comparisons to volumes in 2019/20 significantly reduced.
- The drive to reduce the number of patients waiting over a year continued, and we have now seen over a 95% reduction since the peak in February 2021. Plans are in place to treat all the remaining patients by the end of March 2021. However, the recent developments around a further wave of Covid-19 and the Omicron variant is likely to lead to further cancellations of elective activity in Q4.
- From a benchmarking perspective, the October national data shows that the Trust's recovery around Referral to Treatment performance has been the

fastest of any acute or combined Trust nationally, with the Trust delivering the 7th best performance in the country. This is a particularly impressive achievement given how affected the Trust has been by Covid-19 compared to other trusts.

Cancer

- The size of the Cancer Patient Tracking List (PTL) returned to end of September levels following a reduction in October. However, the PTL has fallen by 10% over the most recent weeks following concerted internal efforts, with the size of the Lower GI PTL – one of our most challenged tumour sites – falling by 50% over the last 3 months. The number of patients waiting over 62 days is now below target in November, although reducing it further in Q4 will become increasingly challenging given the likely impact of the next wave of Covid-19.
- Cancer recovery meetings have been re-focussed to address the ongoing challenges around 62 day performance in Lower GI and Prostate cancer, ensuring adequate time is given to supporting these two specialties to deliver.
- 62-day performance was well below the national standard again despite improving on the prior month, with 13 breaches in the month (of which 5.5 were in Urological cancers and 3.5 in Lower GI). The reintroduction of the straight to test pathway from October should support a reduction in the length of pathways in Lower GI. It has already delivered some radical improvements in the Faster Diagnosis Standard for Lower GI, with an improvement from under 35% to over 40% in October, and a further (un-validated) improvement to over 50% in November and very early data for December at over 60%.

QUALITY SUMMARY

Mortality

- No further Dr Foster reports have been received since the previous update in October. Therefore, as per the previous position, the HSMR is currently within the 'above expected' category. However, when all Covid-19 activity is excluded from the HSMR, the figure falls to 98.5, well below the target we set for March 2021 data, and within the 'as expected' category. This significant difference in index score demonstrates the impact that Covid-19 is having on our mortality indicator, and given the unprecedented nature of such a pandemic, it is helpful to consider multiple mortality indicators at this time, whilst the mortality models continue to be adapted. The in-month HSMR for May 2021 was 93.5, statistically within the 'as expected' band.
- Crude deaths in-month were slightly above previous months, with 33 Covid-19 related deaths compared to 20 in October 2021.

Patient Safety

- There were 3 incidents deemed to be severe or above in November, and these have all been investigated at Harm Free Care and Serious Incident (SI) panels as appropriate. There was an increase in the total number of patient harms reported, but with 95% of these considered to cause either low harm or no harm.
- The Trust failed to meet the national Venous Thromboembolism (VTE) assessment target for the first month since February 2021, with work taking place to understand the reason for the drop in the number of VTE assessments completed within the non-achieving specialties.
- Complaints per 10,000 contacts increased again in month, although this proportionate increase was a result of 5 additional complaints in November. However, Friends and Family Test (FFT) results continued to be positive, with all scores well above the national target.
- Care Hours per Patient Day continued to be below the benchmark, although registered and unregistered fill rates were higher than October. However, unregistered fill rates are now significantly lower than Q1 this year due to an increase in vacancies over the last 6 months. The recruitment position continues to improve but with the expectation of significant staff absence through sickness and isolation over the next few months as well as increasing patient demand, the Trust is anticipating a further deterioration in the CHpPD position during January.

Maternity

- Maternity performance was very strong this month, with the % of emergency Caesarean sections below target for the first time in 6 months. There were improvements in 1:1 care in labour and a significant increase in the breastfeeding initiation rate in month.
- CNST Update – Year 4 safety actions were launched in August 2021. These were reported via CGC in November. Areas of challenge have been identified. Carbon monoxide screening is a challenge for the region and work is ongoing with NHE/I to mitigate this.
- Ockenden – An initial report has been received from the national team regarding our submission, and an action plan is in the process of being developed by maternity services as a response to this preliminary feedback.
- Serious Incidents – There were no SIs reported in October or November.
- Maternity and Neonatal safety Champions - Meetings continue with Lynn Hagger (Non Executive Safety Champion) and Helen Dobson (Interim Chief Nurse).

WORKFORCE SUMMARY

Recruitment and Retention

- The Trust welcomed over 56 WTE in November 2021, with Community Services seeing the highest number of new starters in the month. These Trust figures included 12 new Nursing & Midwifery colleagues and 7 newly-qualified Nurses.
- Total Trust turnover rate was just over 10% which is a 2 percentage point increase on November 2020. Turnover is particularly high within Pharmacy and Therapies. However, the Nursing and Midwifery turnover rate remained the same as the previous month at just under 10%, with the number of nursing vacancies falling further in-month (although note that this includes a number of candidates going through the external recruitment process and awaiting PIN numbers).
- Of the 41 leavers in November, 9 colleagues left for reasons relating to work-life balance.
- There were promotions for over 22 WTE in-month, with more than 10 WTE relating to band 6 clinical staff. This will support our efforts to 'grow our own' and retain and develop our most talented colleagues with the greatest potential.

Sickness

- The monthly sickness rate increased slightly to 6.8%, well above the 4% target. This trend was driven by an increase in short-term sickness, including for reasons of anxiety and stress as well as gastrointestinal problems and cough/cold symptoms. Sickness absence was high across all divisions, although UECC saw the highest in-month figure of 8.5%, followed by Surgery at 8.2%.
- 12-month rolling sickness rate is just under 6% compared to a figure under 4.5% a year ago. Covid-19 sickness accounts for approximately a fifth of the current sickness absence, so excluding Covid-19 sickness, the Trust is still experiencing sickness rates well above pre-pandemic levels.

Appraisals and Mandatory Training

- Overall appraisal compliance rate is now at 82% which is a 3% increase on prior year and the previous month. All divisions are below the Trust target of 90% excluding Surgery, who achieved a figure of 93% at the end of November. Divisions continue to focus on ensuring that colleagues are released to conduct their appraisals, and that the relevant information is recorded onto the system.
- Core Mandatory and Statutory Training (MaST) is above the Trust target at 88%, although this is a slight deterioration on the previous month's performance. All Divisions with the exception of UECC and Medicine are

above the Trust target for both core and job-specific MaST combined together. However, compliance amongst Medical and Dental staff has fallen to below 80%.
- Mental Health Act training (39%), Hand Hygiene (69%) and Information Governance (80%) remain key focus areas for improvement.

FINANCE SUMMARY

Income & Expenditure (I&E)

- The Trust month 8 financial report shows an improvement in I&E performance in the month and year to date against the plan, with a still positive forecast variance for the year-end against the recently agreed H2 2021/22 financial plan. The control total is what the Trust's performance is measured against with NHSE/I, having adjusted for depreciation on donated assets. This positive variance equates to a £630k in-month surplus to plan, and a £1,030 surplus to plan year-to-date.
- Cost Improvement Programme performance showed over-delivery in-month (just under £1m) and year-to-date (just over £800k), based on the risk-adjusted schemes identified. If all of the risk can be eliminated, the forecast variance improves to an over-delivery of £378k against plan (+8%). However, a significant amount of this in year delivery is non-recurrent in nature, which will lead to ongoing cost containment challenges in 2022/23, especially given the financial pressures anticipated next year.
- Pay under-spent in month by £115k, with a substantial under-spend on substantive staff (£666k) being less-than-fully offset by increased expenditure on temporary bank and agency staff costs.
- The Trust is currently forecasting a surplus to plan of just over £500k for the financial year 2021/22. Within this forecast is an assumption that pay costs will overspend significantly, with a forecast improvement in recruitment to substantive staff, but also an increased reliance on agency staff within medical and nursing staff groups.

Capital Expenditure

- Financial results for the first eight months of the 2021/22 financial year show expenditure of just over £4.5m year to date, representing an under-spend of approximately £2.8m year to date against plan. However, the forecast out-turn position shows a recovery of this compared to plan, with an under-spend of just over £1m by year-end. An under-spend of approximately £1m is required as the Trust's contribution to an SYB ICS potential over-commitment.
- There are a number of large and significant capital schemes planned for M9-12 which will lead to an increase in the run-rate. These include the purchase and installation of a new MRI scanner, ward refurbishment to allow for increased and more flexible elective bed capacity and End User

Device Refresh implementation.

Cash Flow

- The Trust's underlying residual cash position is still strong when compared to the same position last year, with a closing cash balance of over £30m at the end of November.
- However, the large capital schemes still to be delivered will drive up commitments in the latter months of the year, with a forecast closing cash balance of £14.4m as at the end of March 2022.

Board of Directors Meeting
07 January 2022

The Rotherham NHS Foundation Trust

Agenda item	P16/21
Report	**Reset and Recovery Operational Report**
Executive Lead	George Briggs, Chief Operating Officer
Link with the BAF	B1 and B2: Risk scores have remained static from the previous quarter based on the Trust receiving increased pressure from admissions and activity showing the operational activity is off course with national standards.
How does this paper support Trust Values	Ambitious: Ensuring the Trust is delivering high quality services Caring: Ensuring patients are seen within the appropriate time frames Together: Working collaboratively with partners to achieve standards
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary	This report is presented for information that the Trust is undertaking the recovery actions where possible amidst delivering activity and emergency care during the ongoing phases of the pandemic and resulting challenging circumstances: • Updates the Board on the recovery actions underway. • Provides an update on the Rotherham NHS Foundations Trust's (TRFT`s) response to the recovery from the effects of the Covid-19 pandemic including the latest advice on the Omicron variant. • Describes the activity and actions the Trust has taken to deal with the pandemic, up to the month of November 2021.
Due Diligence (include the process the paper has gone to prior to presentation at FPC Meeting)	This report is taken from the daily dashboard, the monthly IPR and the regional updates, and the notes from the monthly recovery meetings
Board powers to make this decision	The Board has delegated authority to FPC to review and feedback to the Board any assurance issues, and breaches in SO, SFIs, scheme of delegation etc. The Board has asked for a monthly update on the performance of operational areas of the Trust
Who, what and when (what action is required, who is the lead and when should it be completed?)	A monthly report is provided to the Finance and Performance Committee and to the Board of Directors and any actions required are the responsibility of the Chief Operating Officer with support from colleagues.
Recommendations	It is recommended that the Board note the report.
Appendices	1. Place response to next phase of the pandemic

1.0 Introduction

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

1.2 Recovery had been on plan since the high numbers of positive Covid-19 inpatients started to settle from March 21 although this has since deteriorated over September to November 2021. The phase 2 plans have been submitted to the CCG and ICS with final iterations on the week of 15th November 21.

1.3 The elective wards and surgical wards have been open and ring-fenced for elective patients, during the first half of this year. At times we have cancelled elective activity and utilised Keppel ward for non-electives. We have reinstated the elective ward mid-November and are maintaining a reduced elective program.

1.4 Covid numbers of inpatients has flexed daily varying from 70 in June to 60-70 in November 21. We have seen a gradual reduction to mid-twenties during the last 2 weeks of November.

1.5 Critical care have been under increasing pressure with numbers regularly going above funded beds TRFT has reported Critcon 1 (the network norm is level 0) consistently over the last 3 months. The number of available ICU beds has affected our elective capacity due to numbers of Covid and level 3 patients and staffing levels.

2.0 Recovery

2.1 The national and regional teams have implemented a recovery program, the CEO`s across the North East and Yorkshire were invited to a recovery forum led by Sir James Mackey “the North and East Yorkshire Recovery Taskforce”.

2.2 The key challenges and opportunities as identified by the regional team are detailed below:-

- Without additional action, the overall waiting list size will continue to increase, as will the number of 52 and 104 week long waiters.
- The scale of the recovery challenge in each provider is different, with some providers experiencing much greater mismatch in capacity and demand than others.
- A significant part of the elective recovery challenge (including long waiters) is not about inpatient capacity, but about non-admitted pathways. The biggest volumes by specialty are in orthopaedics; ENT, ophthalmology and “other.”
- The data also identifies further potential opportunities to accelerate elective recovery

TRFT has been working on our internal recovery as below:-

- Benchmark IPC practice as a Trust and as a region to make sure it is applied safely & consistently.
  - Review IPC / testing guidance for patients attending appointments.
- Opportunities to reduce DNA rates.
  - Utilising net call and patient initiated follow up.
- Increase day case activity
- Increase outpatient procedures.
- **Waiting List Management -** Longest Waits; Validation; RTT performance – an organisational focus on very long waits,
- Revisiting waiting list validation and clinical prioritisation of the list.

- **Collaboration on Fast Track High Volume Pathways for Non Admitted & Admitted** – SOP in place and weekly mutual aid meetings.

Priorities		**TRFT Actions**
Time to treat		
	Benchmarking IPC practices	SYB group to review guidelines TRFT involved
	Review IPC testing guidance	SYB group to review guidelines TRFT involved
	Reduce DNA rates	Re-implemented Netcall reminders broken down by specialties
	Increase day case and outpatient procedures	Initially we reduced day case to increase T&O activity we are now increasing activity.
Waiting list management		
	RTT monitoring	Recovery meeting weekly and fortnightly weekly updates
	Focus on long waits 52 weeks	No patients at 104 weeks rapidly reducing 52 weeks
	Validation	Weekly and fortnightly updates
	Clinical prioritisation	J Garner leads ICS TRFT position has improved
Collaboration		
	Sharing T&O and Ophthalmology PTL`s	ICS approach to share long waits opportunities for TRFT to support the ICS and earn additional income

2.3 Referral to Treatment November data

Referral to Treatment performance had improved between January to July hitting 84.7% against the 92% standard. Since then we have seen a gradual levelling off of performance with November being 81.9% (Oct 83.2%)

Total incomplete PTL size **20489** (20478 October 21)
44 x 52 breaches for incompletes (47 in October 21)

The specialty detail below shows delivery in only 2 specialties.

Specialty	*<18*	*>= 18*	*Total*	*%*
Cardiology	985	173	1158	85.1%
Dermatology	1407	34	1441	97.6%
Ear, Nose & Throat	1686	844	2530	66.6%
Gastroenterology	718	231	949	75.7%
General Medicine	220	33	253	87.0%
General Surgery	1594	315	1909	83.5%
Geriatric Medicine	169	15	184	91.8%
Gynaecology	1722	462	2184	78.8%
Ophthalmology	2029	202	2231	90.9%
Oral Surgery	10	2	12	83.3%
Rheumatology	549	240	789	69.6%
Thoracic Medicine	899	182	1018	83.2%
Trauma &Orthopaedics	1782	463	2245	79.4%
Urology	983	130	1113	88.3%
X01 - Clinical Haematology	212	21	233	91.0%
X01 - OMFS	1213	325	1538	78. 9%
X01 - Paediatric	525	12	537	97.8%
X01 - Paediatric Cardiology	70	12	82	85.4%
X01 - Rehabilitation Medicine	14	6	20	70.0%
Total 16787		3702	20489	81.9%

The Trust has previously utilised the independent sector in H1 now that H2 funding has become available we are struggling getting capacity from the IS in South Yorkshire.

Over the previous 2 months we have gradually reduced our elective capacity reducing our ring-fenced elective ward capacity to support Covid and complex medical patients, the elective orthopaedic ward has come back on line in November. We are on plan to reduce the number of patients waiting more than 52 weeks at the end of March 2022 to zero.

The waiting list had grown to approximately 20,500 patients as of the end of November, compared to the 17,000 patients waiting at the end of April. There has been a noticeable increase in referral volumes since March 2021, OP activity is now close to 2019/20

volumes, which means this continued growth in the waiting list is linked to capacity. Demand and capacity plans have been submitted by all divisions, and overall activity plans submitted week of 15th November 21.

Within the waiting list are a number of very long-waiting patients, with divisional teams continuing to focus on bringing these patients in for treatment despite the ongoing capacity challenges. We aim to maintain zero 104 week waits and reduce our long waits

The recovery trajectories are monitored on a weekly and monthly basis, at the divisional Recovery Meetings. Operational teams continue to focus on ensuring clinically prioritised patients are treated within the appropriate timescales, and that long waiting patients are given treatment dates as soon as possible.

Within the outpatient areas we have found a number of anomalies regarding clinic letters being sent to GP`s. The Text reminder system failed and we found a small number of letters hadn't been sent to patients, on review a number of issues re uncertainty of letters was discovered Initially a number of urology letters were believed to have been sent to a non-functioning printer which we believed was causing them to not be posted to GP`s. on review we have found the following issues in the specialties below:-

Sleep
Physiotherapy
0-19 services in UECC
Urology

- In sleep we had 456 appointment letters of which 98 did not attend we are not sure if the patients received these letters but because the other 358 attended we believe the letters were sent as a double check we are doing a harm review on the 98 patients to confirm and to make sure no untoward incident occurred.
- The UECC 0-19 only 4 letters were not sent but duplicates have been sent
- Urology (the initial issue) all letters were sent electronically due to a backup within the server which the team did not realise initially existed.
- Physio all letters were sent electronically.

A report has been set up in the data warehouse to check for any emails that are undelivered. The team are also sending test emails to any GP practice that they believe the email address may be incorrect / wrong.

Synertec are confirming we can close the unused prism printer to prevent further issues of confusion. A small task and finish group has been set up to oversee the final harm reviews and the report checking.

2.4 Cancer Recovery Performance

- 2 week waits numbers are on plan at 93.8% on track to be sustained against a 93% target.
- 2ww breast is now improving with Q3 on target.

Referral volumes are now above the previous year's numbers, services have to manage more patients with restricted capacity, as well as patient engagement challenges and infection prevention and control measures.

Existing performance improvement forums, including fortnightly Cancer Recovery meetings with operational teams and the monthly joint CCG and Trust Cancer Strategy & Improvement Committee are providing focus on the recovery plans.

Cancer Waiting Times Weekly Update 01/12/21 Upload deadline for Q3 2021/22 - 3rd Feb 2022

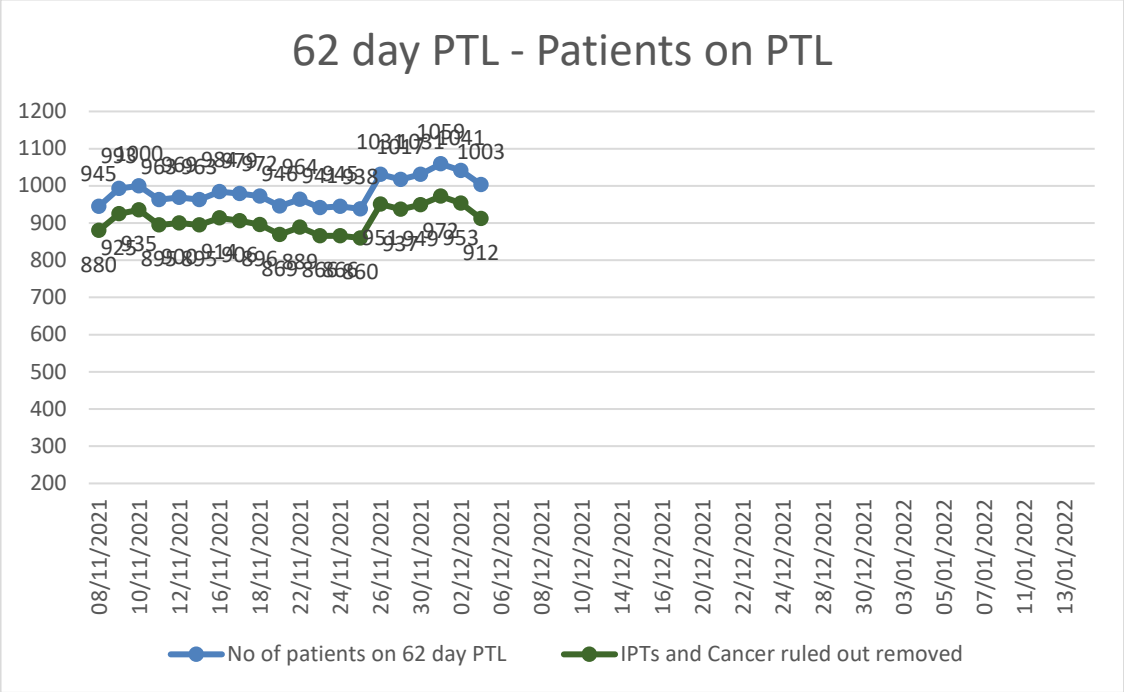
Revision reports - June 2022

Q3 2021/22 SUMMARY	Expected achievement (%) - includes treated and confirmed cancers with a planned treatment date. This report is based on the latest data available in RFT systems and is for preview purposes only. Officially reported performance figures are provided in the monthly CWT report, Specialty SLM reports, Divisional Dashboards, and								
Target	OCT 2021 Validated		NOV 2021 Validating		DEC 2021 Unvalidated		Q3 2021/22 to date		Operational standard (%)
	Data capture 100% complete (estimate)		Data capture 40% complete (estimate)		Data capture 0% complete (estimate)				
	Before reallocations	After reallocations	Before reallocations	After reallocations	Before reallocations	After reallocations	Before reallocations	After reallocations	
2ww	94.2		93.8		92.1		93.8		93
2ww Breast Symptoms	94.7		90.5		95		93		93
62 Day from GP	75.7	75.2	62.8	62.8	77.4	77.4	69.3	69	85
62 Day Consultant Upgrade	82.4	85.7	79.1	79.1	100	100	82.3	84.2	TBC
62 Day from Screening	100	100	100	100	100	100	100	100	90
31 Day First Treatment	96.9		90.3				94		96
31 Day Subs Treatment for Chemotherapy	100		100				100		98
31 Day Subs Treatment for Surgery	90.9		100				91.7		94
Faster Diagnosis Standard - 28 days	73		75.1		96.3		74.3		TBC

The faster diagnosis standard has an indicative target of 75%, which as can be seen we are above for the November and December data although this un-validated Q3 is circa 74.3%.

Cancer 62-day focus

The Trust is achieving 70% in Q3 (indicative) which shows a deterioration in performance since Q1. Linked to high referrals sickness and absence in key pathways, the key areas of failure are Head and neck GI and Urological pathways with Lung being small single numbers.



The numbers of patients on the PTL saw a hike over a number of days in late November the highest number for a while.

2.5 DM01 Performance

DM01 diagnostic performance had been a marked challenge throughout the pandemic. But showing sustained positive improvements.

- The formal performance is 11.11% (17.38% October (24.1% August 19.1% September) against a pre pandemic performance of under 1% this is an improving position.

- 434 breaches (September 930 breaches)

Diagnostics (DM01) - Patients Still Waiting at Month End
November 2021

Category	Investigation	<6 weeks	≥ 6 weeks	Performance (% breaches)	Total WL
Imaging	Magnetic Resonance Imaging	417	210	33.49%	627
	Computed Tomography	328	93	22.09%	421
	Non-obstetric ultrasound	1027	0	0.00%	1027
	Barium Enema	0	0		0
	DEXA Scan	113	0	0.00%	113
Physiological Measurement	Audiology - Audiology Assessments	382	1	0.26%	383
	Cardiology - echocardiography	337	26	7.16%	363
	Cardiology - electrophysiology	0	0		0
	Neurophysiology - peripheral neurophysiology	0	0		0
	Respiratory physiology - sleep studies	265	104	28.18%	369
	Urodynamics - pressures & flows	12	0	0.00%	12
Endoscopy	Colonoscopy	156	0	0.00%	156
	Flexi sigmoidoscopy	78	0	0.00%	78
	Cystoscopy	79	0	0.00%	79
	Gastroscopy	277	0	0.00%	277
	Total	3471	434	11.11%	3905

Key areas of compromised performance are

- Magnetic Resonance Imaging MRI deterioration additional Mobile days have not been available from the company which means we will not recover until March 22
- Respiratory Physiology on track to achieve in January 22
- Audiology assessments improved month on month and have hit the standard at the end of November 21

The biggest area of concern is MRI with plans having to be reviewed, we should have had seventeen additional mobile days per month, and unfortunately, we have not seen the additional days so far due to national demand. Capital funding for a second MRI scanner has been included in the capital plans, which will support the sustainability of this service in the longer-term, especially given the breakdowns which continue to occur on the existing scanner.

Alongside this, our sleep study service saw a rapid growth in the waiting list and the backlog during Covid, due to the IPC guidance around Aerosol Generating Procedures (AGPs). Capacity has been increased recently and new referral guidelines have been agreed with primary care which come into effect in January 2022, hence we will see even more improvement from February.

3.0 Emergency Performance

3.1 The care of our elective and emergency patients is balanced between demand capacity and available resources we are reviewing emergency performance on a daily basis with performance remaining complex. Attendances have varied across SYB and we are now seeing high numbers of Yorkshire ambulance dispositions with 20% increases in category 1 (complex patients). Admissions have been increasing across SYB with Mondays proving very difficult. The pattern has also changed with lots of walk-in and minors patients attending in the afternoon this has manifested in very high numbers of patients in the UECC on numerous occasions over 100 in the evening. These numbers of patients are overwhelming the UECC staff, and causing concern and an inability to manage patients in a timely way. This is a national issue and not specific to TRFT although the long waits in UECC are some of the longest nationally.

3.2 Linked to the above, a shortage of middle grades and inexperienced junior doctors has meant initial assessment times have deteriorated. Times to see a clinician are variable and have deteriorated, whilst overall time in the department has deteriorated. Ambulance handover have deteriorated across South Yorkshire.

3.3 TRFT has develop a capacity wheel which shows key pressure points and levels of escalation whilst the triggers are still being developed the wheel is proving very accurate at highlighting escalation and pressure points.

3.4 There has been an increase in the number of long stay patients which is an indication of reduced capacity in non-acute settings to support patients to return to their usual place of residence. This then contributing to a restriction in flow through the emergency pathway. We were reporting up to 60 plus long length of stay patients over 21 days with half of these awaiting social service support from packages of care to red community beds (this time in 2019 it was 35)

	Rolling	Time to Initial Assessment (Mins)	Time to be seen by a Clinician (Mins)	Mean Total Wait (Mins)	12hrs in Department
Standard		**15**	**60**	**200**	**0**
Pre-Field Test (6wks)		**15**	**93**	**189**	**3 (per day)**
Thu	**18/11/2021**	16	164	293	11
Fri	**19/11/2021**	26	171	309	20
Sat	**20/11/2021**	29	188	354	28
Sun	**21/11/2021**	26	158	322	27
Mon	**22/11/2021**	22	161	292	15
Tue	**23/11/2021**	18	123	282	16
Wed	**24/11/2021**	21	146	296	17
	Rolling 7 Days	**23**	**159**	**307**	**134 (19 per day)**
Year to Date (21/22)		**23**	**157**	**296**	**12 (per day)**
May 21		**18**	**131**	**246**	**2 (per day)**

3.5 As above, the deterioration across all indicators since May 2021 is more marked in long 12 hour waits in UECC. Averaging now 12 patients per day at 12 or more hours in the department.

4.0 Conclusion and winter update

4.1 The recovery of performance was fairly rapid initially during the first half of the year with an accelerated performance in June – July. The developments in the last month shows a reduction in RTT. Linked to no acute elective capacity on the hospital site.

4.2 Trauma and Orthopaedics have now recommenced elective activity.

4.3 Although our referral to treatment time performance is 37th out of 171 trusts and over 52 week waiters are now down considerably. This remains at considerable risk due to emergency demand and the forecasted next phase of Covid Omicron variant.

4.4 Whilst we had planned to retain our ring-fenced orthopaedic ward over winter, non-elective pressures at the start of winter made it impossible to maintain the ward, we have recently reopened it to elective patients and are attempting to maintain that stance over the next 3 months. We have also enacted the additional second phase of winter beds by utilising beds on B10 (decant facility) again ahead of plan.

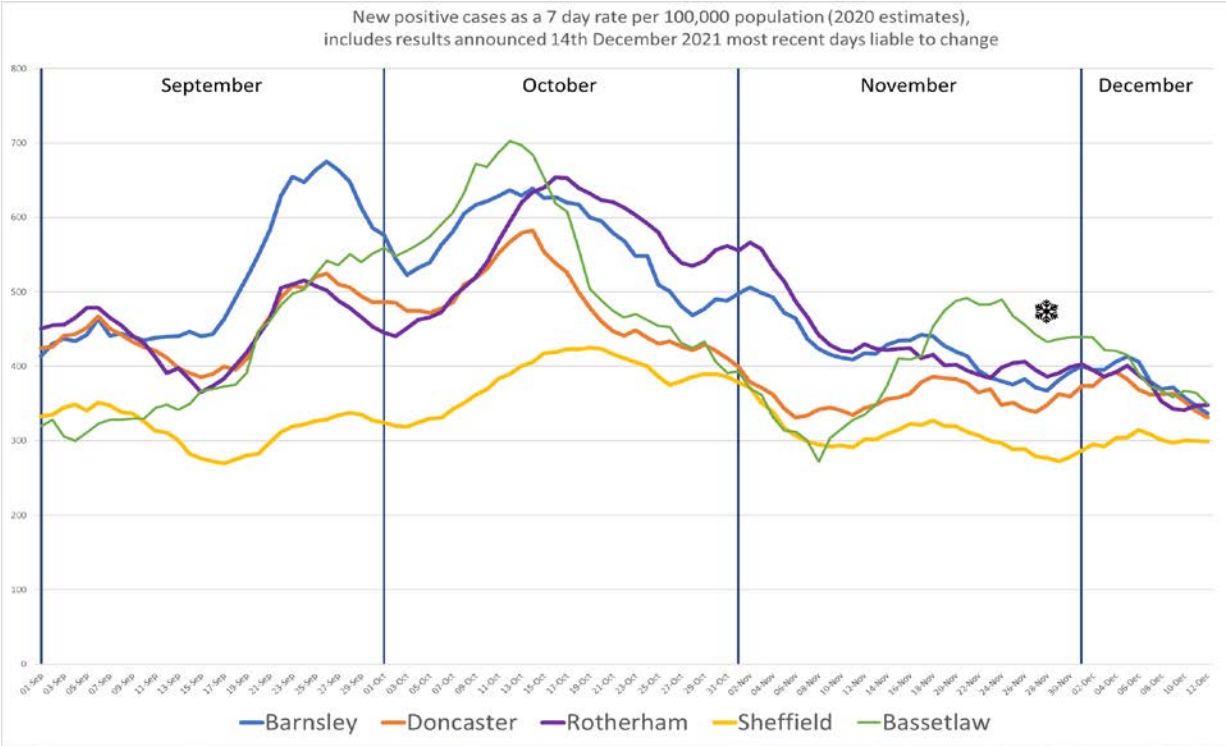
4.5 DMO1 performance has shown a remarkable improvement thanks to the CSS team and particularly cardiac echo, MRI and respiratory improvements.

4.6 Emergency performance has deteriorated markedly and has necessitated command and control with some improvements in flow. Ambulance dispositions and UECC attends are moving to a later period in the day putting pressure on the departments evening resources and creating long waits overnight. We are now looking at additional private sector community beds, to help reduce the complex patients with no right to reside, partnership working across the place is vital to get TRFT through the next few months.

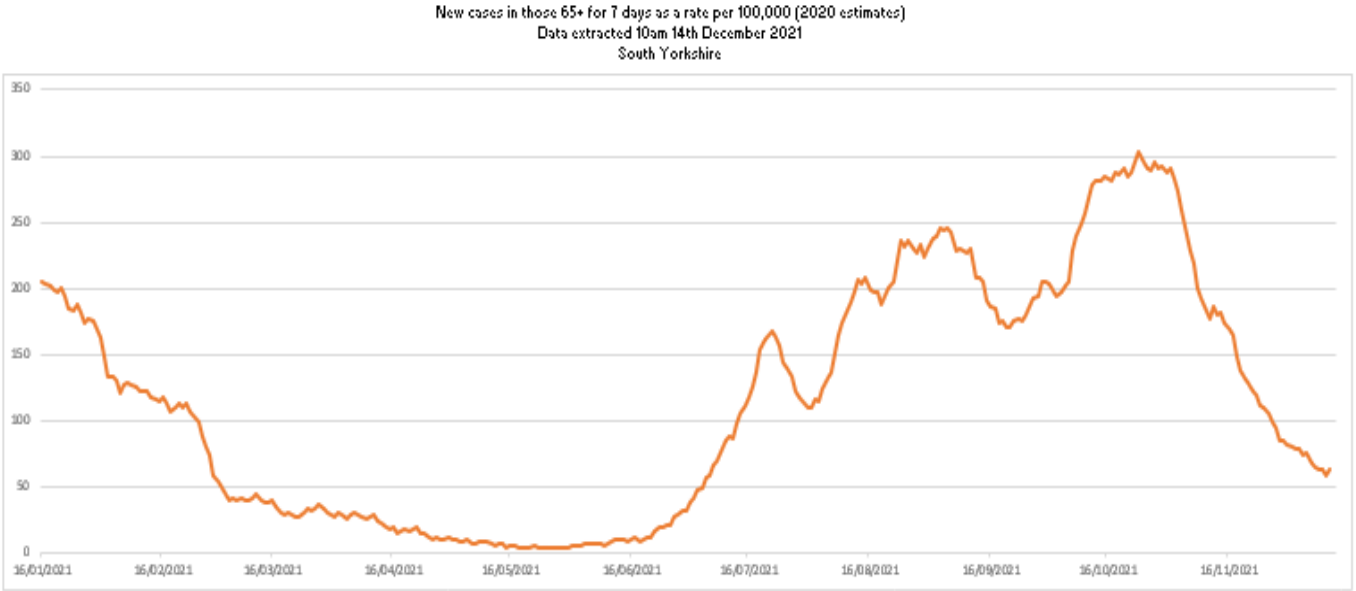
4.7 This performance continues to show an organisation and a department under increased demand and stress with flow across the organisation compromised at key times of the week.

4.8 We are now well into planning the next phase of the pandemic and are preparing the teams for a difficult period if the predicted Omicron variant continues to increase, staffing sickness and absence are expected to be a limiting factor to any increase in capacity.

4.9 As can be seen Covid cases across SYB have shown a gradual reduction through November early December.

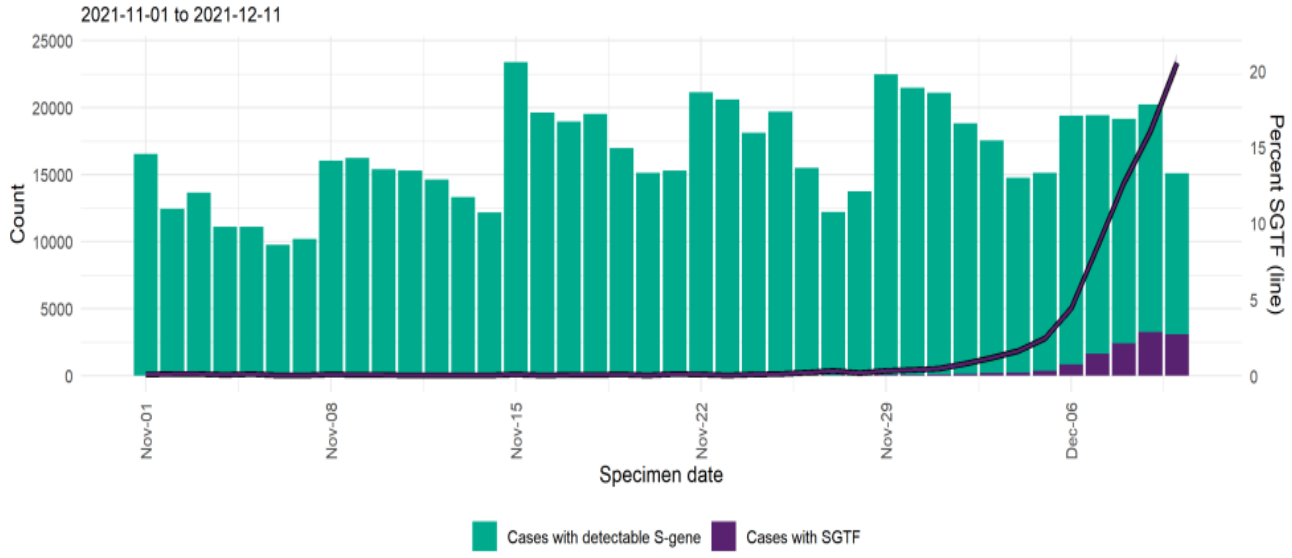


4.10 Patients with a new case of Covid over the age of 65 have also started to reduce considerably.



4.11

Number COVID19 cases with S gene +ve/SGTF and percentage SGTF by day, among those tested in TaqPath Labs
(95% confidence intervals indicated by gray shading). Data updated on 2021-12-12



A detectable S gene is a proxy for Delta since April 2021. SGTF was a surveillance proxy for VOC-20DEC-01 however has largely consisted of Delta since August 2021.
Local trends in these data may be affected by decisions to direct the processing of samples via a TaqPath laboratory.
Only tests carried out with the TaqPath PCR assay and with confirmed SGTF or S gene results included, from Newcastle, Alderley Park, Milton Keynes and Glasgow Lighthouse Labs.
SGTF refers to non-detectable S gene and <=30 CT values for N and ORF1ab genes. Detectable S-gene refers to <=30 CT values for S, N, and ORF1ab genes.
Produced by Outbreak Surveillance Team, UKHSA.

4.12

Breakdown of England daily cases by region.

Region	Confirmed Omicron Cases	Change from Previous Report	SGTF cases*	Change from previous report
East Midlands	453	+157	583	+139
East of England	503	+159	1655	+591
London	1935	+685	4363	+2139
North East	100	+22	52	+14
North West	149	+28	1702	+558
South East	1002	+390	1473	+404
South West	231	+68	229	+61
West Midlands	64	+17	590	+256
Yorkshire and Humber	30	+7	465	+139
Unknown	**20**	**+1**	27	+17
Total	**4487**	**+1534**	**11139**	**+4318**

4.13 Omicron has shown a remarkable ability to grow and as can be seen is increasing daily hence our planning and concern.

4.14 NHSE have issued a requirement for a place update on our place plans for the next phase see appendix 1.

4.15 As a trust we have pre-emptively moved to a command and control footing with daily operational meeting and three times a week strategic gold meetings, planning for staffing shortages and additional capacity specifically in Critical Care.

G Briggs
Chief Operating Officer
December 2021

Preparing the NHS for the potential impact of the Omicron variant and other winter pressures - Rotherham Place

		Lead	Position statement	Actions
Ensure the ramp-up of Covid 19 vaccination programme	General public	Jacqui Tuffnell (CCG)	Capacity now in place for over 30000 appointments per week – 7 days 8-8, this will provide sufficient appointment capacity for all boosters and also those who have not had 1st or 2nd appointments. Excellent support from military and the fire service have also now offered support into vaccination sites.	
	Staff	Steve Ned (TRFT)	Vaccinations will continue on site at TRFT for staff requiring initial vaccinations and boosters.	Maintain sufficient capacity for remaining staff to be vaccinated.
	12-15 year olds	Victoria Takel (TRFT)	Currently in negotiations with CCG about funding increased resource to roll out vaccination of 12-15 year olds to reduce impact on other services. Clinics running over weekend prior to Christmas. Second dose ramp up 12 weeks after first dose so beginning of January is earliest this would be required.	Plan for service provision in schools and Greenoaks for remaining 12-15 year olds. Second dose and those children that have turned 12 recently.
	Housebound patients	Penny Fisher (TRFT)	Not currently in place	Review requirements to enable vaccination of housebound patients who are not able to access walk in services.
	Care home	Jacqui Tuffnell (CCG)	All care homes have been visited for booster jabs. Staff take up appears to be low and staff are being encouraged to attend one of the local vaccination sites.	Encourage staff to take up the booster
Maximise availability of Covid 19 treatments for high risk patients	Acute IV treatments	Sally Kilgariff/Jez Reynard	IV treatments are delivered to patients admitted with Covid or who develop Covid during their inpatient stay. There isn't currently a service for community patients with co-morbidities who require pre-emptive IV treatment. Patients are already receiving this treatment where clinically indicated however the unit will enable the patient to be discharged back to home quickly after treatment or for an oral medication to be quickly dispensed.	Plans are being put in place (led by the ICS) for acute based Covid medicine delivery units with an aim to have this in place in Rotherham from week commencing 20 December. Physical space and staff identified from the 20th
	Community oral treatments	TRFT /Jacqui Tuffnell (CCG)	Oral treatment not yet licenced for use. Once it is it will be dispensed from TRFT as the process is led from the acute	TRFT to have arrangements in place for oral treatment linked to ongoing community contract and transport contract confident we can deliver once required.
ettings, scharge	Discharge before Christmas - 7 day support	Sally Kilgariff/Katia Allchurch (TRFT) Jayne Metcalfe (RMBC)	Discharge co-ordinator support to wards in place substantively. IDT staffing in place over additional bank holidays, focus this week on clearing the board to ensure any discharges referred w/c 20.12.21 can be actioned prior to Christmas.	Seek additional support over bank holidays for ward based co-ordinator support. Confirm arrangements for OOH support on Christmas, boxing and new years day for any pathway 1-3 discharges that need to be supported. Confirm agreement with care homes around screening and accepting of referrals over bank holidays.

Maximise capacity across acute and community s enabling the maximum number of people to be dis safely	Daily system meeting	Sally Kilgariff (TRFT)Claire Smit	Daily calls are in at exec level between Christmas and New Year and Bank Holiday (3rd Jan). Operational Place calls with partners are in before Christmas and in between Christmas and New Year. all OOH rotas to be shared across organisations to support escalation	completed
	Eliminate pathway zero discharge delays	Katia Allchurch (TRFT)	Processes in place to avoid delays including discharge co-ordinators on all wards. Use of personal budgets are considered and hotels (for non social care needs i.e. housing/homeless will be considered). Housing are linked in with the Integrated Discharge Team and there is a shared process on who to contact (including an OOH on call for emergencies only) to expedite decisions to discharge. Housing/Community Urgent Response/CHC/Reablement colleagues linked into the MDTs in Trust to support flow.	To continue focus on supporting timely and efficient discharges. Establish criteria/nurse led discharge processes. Ensure discharge registrar is in place over next few weeks. IDT cover 7 days a week
			Focus on LOS (21 and 14 days) this includes weekly MDTs, Surge Plan actions enacted which focus on increasing capacity and improving processes to support flow.	Additional capacity is being commissioned from Home Care that will respond as an urgent service to reduce the demand/wait for provision, this is likely to be in place after Christmas in Jan 22
	Making full use of non-acute beds	Claire Smith (CCG)	Full use of Hospice capacity is being explored, capacity dashboard includes information on availability of beds and community support daily. Additional funding has been provided via CCG to increase hours in Hospice at Home to meet increasing demand over winter/surge.	Ensure visibility of all non -acute beds including forward view of capacity
	Virtual ward	Penny Fisher (TRFT)	Virtual Wards are in place for the Respiratory pathway	It is recommended that we explore as a Place the ability to widen provision to Frailty. The letter indicates that where evidence of outcomes and new provision is provided, they will support funding into 22/23. This needs to be explored further.
ective care	Ambulance response	Lesley Hammond (TRFT)	Daily review of all delays and cause of such. Utilise when staff allows RAT area out of hours to cohort and off load ambulances	Daily update pan trust. Daily escalation if required to CCG NHSE Plan to open RAT at difficult times weekends and evenings.
	Community crisis response	Claire Smith (CCG) Penny Fisher (TRFT)	Additional resource has been commissioned through Aging Well funding via the CCG and there is a work programme underway to support the Urgent Response 2 hr standard being achieved including ensuring the service has been profiled appropriately on the DOS. Whilst this is on track, there are concerns regarding the capacity of the service due to issues with recruitment/sickness in the team. Our Telecare service is linked in with YAS and a process/pathway is being developed for the DOS. The AT lead for Place is running sessions pre Christmas to promote use of technology in reducing need for care and improving flow from acute/supporting admission avoidance. Additional OT capacity has been resourced through winter monies to support review of Home Care packages.	Ongoing actions within the Rotherham Place Plan for Urgent and Emergency Transformation
	DOS	Claire Smith (CCG)	Service profiled on the DOS are being reviewed, work with Integrated Urgent Emergency Care NHSE is commenced to look at Rotherham's A-TED score and how this can be improved. Work streams have commenced to examine pathway redesign/development such as falls/frailty and Care Homes ANP service.	As above

Support patient safety in urgent care and manage el	Mental health learning disability and autism	Kate Tufnell (CCG) Michelle Vitc	Crisis services, home treatment and adult mental health hospital liaison will continue to able to be accessible over the Christmas Bank holidays. Currently we are seeing an improved position on Patient flow processes and DTOCs improved from the pre-pandemic position so in a stronger position. Business continuity plans have been reviewed to enable staff to move across service areas according to need/demand. At this stage RDaSH is not anticipating stepping down any of the services. Vulnerable groups – teams are continuing to work with these groups and will maintain regular contact with them.	Directory of Services is being refreshed to include information on Rotherham mental health support services (over and above crisis support) to help signpost patients to available services. Scenario planning work underway to explore: oBed flow of beds if patients C-19+ oPhysical health beds – not applicable to Rotherham oStaffing profiles and potential hots spots oSupport to other partners in the system
	Critical care	Ben Vasey (TRFT)	Surge capacity identified up to 21 beds with a split between red and green. We are meeting with critical care team to go through the previous surge plans and see if need adapting. Surge plan written and checking if ok for this situation. More planned trust approach to nurse staffing in critical care and trigger points is get to certain number of beds that will initiated activity being reduced to support critical care. Assurance around oxygen levels - see below.	Shadow rotas being developed Communications out for volunteers to support additional beds all non ward based clinical staff being rostered to support.
	Elective care	Ben Vasey/Victoria Takel (TRFT)	Continued review of long waiters and clinical priority on waiting list. Even when elective activity ios reduced that is taken into account. Plans to maintain elective orthopaedic ward. Endoscopy work to continue. Mutual aid meetings continue at COO level. Biggest challenge we envisage is around our clinically urgent P1-P2 and cancer who require HDU post op. Porces in place to book electives into critical care to give forward view of demand/capacity and GPICs nursing levels.	Communications to all patients explaining position, daily review of plans Silver meeting to agree activity plans linked to capacity
	Independent sector	Ben Vasey/Victoria Takel (TRFT)	No plans currently to utilise IS capacity.	Initial conversation to be started with teams around the use of Kinvara
	Primary Care	Jacqui Tuffnell (CCG)	Consideration has been given to what can be stepped down locally to free up resources and communicated to GPs. Extended access, winter additional capacity schemes and the winter access fund will all be supporting general practice to sustain activity this winter. Additional telephony support is also being recruited to ensure patients calls are handled as quickly as feasible to improve public perception in relation to access.	Ongoing
	Cancer	Kevin Wilkinson (TRFT) Jacqui Tuffnell (CCG)	All diagnostics are in place to support patients with suspected cancer. SYB work collectively to support patients surgery as a system and everything possible is done to ensure P1 and P2 surgery goes ahead. Checklists have been reviewed to ensure patient pathways are optimised. Unfortunately IS within SYB is not able to take cancer however IS is being utilised to release capacity to ensure cancer can be delivered. Communication and safety netting is embedded into processes within TRFT. Our regular communications support the national messaging to come forward if there are any symptoms.	Ongoing
eir	Support for staff to stay well	Paul Ferrie (TRFT)	Work ongoing to support staff wellbeing, links to Mental Health and Wellbeing offers across Place	Look at provision of rest areas, hot food out of hours and other ways of supporting staff to stay well when they are at work. Support staff to take leave when they are able to.

Support staff and maximise their availability	Mental health and wellbeing		Support and advice for staff is available 24 hours a day 7 days a week either by phone or online.	Maintain this service
	Workforce planning, flexibility and training		Review of staff skills and roles already undertaken to enable swift redeployment of staff to critical areas as demand dictates. Staff identified that can work in alternative areas and training and skills will be updated to enable this. Services that can be stood down identified and plans for how the released staff can be utilised will be reviewed in line with the emerging situation. Carry over of annual leave policy reviewed to support staff to carry over leave if they are unable to take it before March.	Task and finish group to be set up review staffing requirements and options. Review options for redeploying office based/back office staff to frontline services i.e. supporting wards at meal times and with communication with families of patients
	Recruitment	Paul Ferrie (TRFT)	Recruitment to support response to Omicron and resulting pressures will be prioritised and fast tracked appropriately.	
	Volunteers	Mavis Francis (TRFT)	RMBC has a volunteer hub and there is a community hub in place that can be access by Rotherham residents supporting health and wellbeing and giving information and advice	Review ask of volunteers i.e. supporting patient communications with family and friends.
Ensure surge plans and processes are ready to be implemented	Incident co-ordination	G Briggs (TRFT)	There is Gold command at Place level, Organisational Gold and Silver meetings (daily when required), all actions at level 3 and 4 across system are being enacted, daily escalation calls in place including 2x weekly operational Place calls and weekly executive escalation calls, TRFT command and control and control centre operationalised	Monitor and ensure appropriate incident co-ordination is in place depending on the escalation levels across Place.
	Surge plans	Claire Smith CCG+C8	Surge/Winter Plan has been signed off by the A&E delivery Board in October 2021, there is an action plan in place monitored through the Board, with risks and key mitigation highlighted at monthly meetings or through the weekly executive escalation meetings. The plan is consistently reviewed with additional actions taking place based on appraisal of success of schemes/emerging trends/demand/areas of escalation or perceived additional blockages. The plan is managed by the Joint Head of Adult Commissioning in the CCG as lead across Place for winter/surge planning.	Ongoing review of surge plan and actions
	Supplies	M King (TRFT)	daily updates from Supplies team add to daily dashboard via Incident control team flag shortages of stock to NHSE and ICS	Daily dashboard re stock available Update by item by previous demand
	Oxygen	Chris Tobin (TRFT)	The bulk Oxygen tank levels are monitored 24/7 by BOC on telemetry, when the level reaches 50% delivery is triggered. The biggest restriction is flow our system is governed to a maximum of 3000 litres per minute. We have monitoring and a series of alarms that trigger alerts should flow reach the thresholds. To note during the last wave we did not reach the peak flow.	Review oxygen requirements during previous waves and ensure that current supply arrangements meet that demand.
	Infection prevention and control	Helen Dobson/Anne Kerrane (TRFT)	Working to current UK Infection prevention and control guidance.	Ensure that IPC practices are responsive to a potentially changing situation and communicate any changes clearly to all areas. Explore links with Barnsley about business continuity plans if IPC staffing is compromised. Review guidance on use of Thor v Bioquell.
er ns				


Othe
actio

Board of Directors' Meeting
07 January 2022

The Rotherham NHS Foundation Trust

Agenda Item	P17/22
Report	**Finance Report**
Executive Lead	Steve Hackett, Director of Finance
Link with the BAF	B9 and B10: This report provides assurance regarding the financial results for April to November 2021 of the financial year 2021/22 against the Trust's approved financial plan for its income and expenditure account and capital programme, together with an update on cash management. A forecast out-turn position is provided up to the end of March 2022 on all of these areas.
How does this paper support Trust Values	This report supports the Trust's core values – (A)mbitious, (C)aring and (T)ogether by specifically focussing on two strategic themes: (a) Governance: Trusted, open governance: • Have an effective performance framework to help deliver outstanding results; • Be outstanding on the Care Quality Commission "well-led" framework across the Trust; • Have high quality data to provide robust information and support key decision making; • Ensure all teams have regular reviews and updates around key issues and opportunities to learn. (b) Finances: Strong financial foundations • Manage within approved budgets at all times; • Improve our efficiency and productivity and invest in our estates and facilities; • Use our money and resources wisely – only spend what we can afford.
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Rationale for presentation in confidential section	This report is presented to the Confidential Board of Directors' meeting because it is commercial in confidence, in that some of the details contained herein are not deemed appropriate to share with a wider public audience.
Executive Summary (including reason for the report,	This detailed report provides the Board of Directors with an update on:

background, key issues and risks)	• Section 1 – Financial Summary in month and year to date – April to November 2021: o A summary of the key performance metrics linked to income and expenditure, capital expenditure and cash management. • Section 2 – Income & Expenditure Account in month, year to date and forecast out-turn: o Financial results for the first eight months of the 2021/22 financial year. - A surplus to plan of £630K in month and £1,030K surplus to plan year to date; - A similar surplus to a deficit (external) control total in month and £1,029K surplus year to date. This external control total performance is calculated after adjusting for depreciation on donated assets - £37K in month and £298K year to date, which does not form part of NHS funding. o A forecast out-turn position for the financial year showing an under-spend against plan of £512K (£513K against the external control total). • Section 3 – Capital Expenditure 2021/22 o Financial results for the first eight months of the 2021/22 financial year show expenditure of £1,105K in month and £4,517K year to date representing an under-spend of £119K in month and £2,817K year to date respectively against plan. o A forecast out-turn position for the full financial year is showing an expectation of delivering total expenditure of £13,581K leading to an under-spend of £1,077K. An under-spend of c. £1,000K is required as the Trust's contribution to an SYB ICS potential over-commitment of £12,400K. • Section 4 – Cash Flow 2021/22 o A cash flow statement for the first eight months of the 2021/22 financial year showing a decrease in cash of £7131K to a closing balance of £30,197K as at 30th November 2021. o An indication of the cash balance as at 31st March 2022 – a further maximum probable decrease in cash of £15,834K to £14,363K.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	This report to the Board of Directors has been prepared directly from information contained in the Trust's ledgers and is consistent with information reported externally to NHSE/I. o The overall financial positions for I&E (both actual and forecast out-turns) have been reviewed collectively by and agreed with the senior Finance Team together with the Director of Finance.

	o The capital expenditure positions (both actual and forecast out-turns) have been discussed and reviewed by the Capital Planning & Monitoring Group, chaired by the Director of Finance. o A more comprehensive and detailed report of the financial results in month, year to date and forecast out-turn has been presented to Finance & Performance Committee. o A summarised position of the information contained in this report has also been presented to the Executive Team.
Board powers to make this decision	Within Section 4.5 of Standing Financial Instructions – Budgetary Control and Reporting – paragraph 4.5.1 states that *"The Director of Finance will devise and maintain systems of budgetary control. These will include:* *(a) Financial reports to the Board, in a form approved by Finance & Performance Committee on behalf of the Board."*
Who, What and When (What action is required, who is the lead and when should it be completed?)	No action to be taken given the overall satisfactory position being reported year to date and forecast out-turn positions in line with or better than plans.
Recommendations	It is recommended that the Board of Directors note the content of the report.
Appendices	1. Income & Expenditure Account Analysis for Month 8 2021/22 (November 2021) 2. Income & Expenditure Account Analysis Forecast Out-Turn Position for the Financial Year 2021/22 3. Capital Expenditure for the Eight Months Ending 30th November 2021 4. Capital Expenditure Forecast Out-Turn Position for the Financial Year 2021/22 5. Cash Flow Statement for the Eight Months Ending 30th November 2021

1. Key Financial Headlines

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

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

Key Headlines	Month P £000s	Month A £000s	Month V £000s	YTD P £000s	YTD A £000s	YTD V £000s	Forecast V £000s	Prior Month FV £00s
I&E Performance (Actual)	(78)	552	630	(381)	649	1,030	512	108
I&E Performance (Control Total)	(41)	589	630	(83)	946	1,029	513	109
Capital Expenditure	1,224	1,105	119	7,334	4,517	2,817	1,077	1,000
Cash Balance	0	1,242	1,242	1,357	30,197	28,840	14,363	13,006

1.2 There is improvement in I&E performance in month and year to date against the plan with still a positive forecast variance for the year-end The control total is what the Trust's performance is measured against with NHSE/I, having adjusted for depreciation on donated assets.

1.3 Capital expenditure is behind plan at present, both in month and year to date. A significant amount of expenditure still has to be incurred in the final four months of the financial year - £9,064K or 67% of the overall annual programme if the Trust is to deliver its planned year-end under-spend of £1,077K.

1.4 The cash position year to date is still very strong and is forecast to remain as such during the remainder of the year, despite a planned reducing cash balance throughout the remaining months.

2. Income & Expenditure Account

2.1 Financial Performance for the Eight Months Ending 30th November 2021

2.1.1 Appendix 1 shows the in-month and year to date position subjectively (by type of income/expenditure). The overall position at Month 8 is an in-month surplus to budget of £630K and a year to date surplus to budget of £1,030K.

2.1.2 Clinical income is very much in line with plan in month, as you would expect given that contracts with NHS commissioners have only recently been reset and agreed as part of setting the H2 2021/22 plan. Over-performance year to date is mainly driven by the funding for national pay awards that was accrued at the end of September 2021 and not previously budgeted for, which has now been paid by commissioners during October 2021.

2.1.3 Other operating income is above plan in month, with the major variance being on staff recharges (+£148K), which will be a direct offset to pay expenditure. Year to date is a mixture of over and under performance. Research & development (+£88K), education & training (+£221K), staff recharges (+£363K) and income from asset sales (+£56K) are all over-performing against budgets, which is being offset by under-performance on non-pay recharges (-£154K) and clinical & non-clinical services provided (-£107K).

2.1.4 Pay is under-spending in month by £115K, with a substantial under-spend on substantive staff (£666K) being less than fully offset by increased expenditure on temporary bank and agency staff costs. This is similar to the year to date position, which is being skewed by the over-commitment on reserves during September 2021 to fund previously unbudgeted national pay awards.

2.1.5 Non pay costs are under-spending against budget in month by £157K which is being primarily driven by clinical supplies and services (£134K, including drugs) and improvements in CIP delivery (+£460K) being offset by over-spends on premises (-£157K) and establishment expenses (-£94K). Year to date performance is showing an over-spend of £983K of which £605K relates to clinical supplies and services (mainly excluded drugs) and £559K relating to premises linked to increased energy and utilities costs.

2.1.6 Non operating costs are under-spending in month and year to date, primarily relating to depreciation charges due to continued slippage on the Trust's capital programme, a position that is replicated in the year to date performance.

2.2 Financial Performance Forecast Out-Turn Position for the Financial Year 2021/22

2.2.1 Appendix 2 shows the forecast out-turn position subjectively (by type of income/expenditure). The Trust is currently forecasting a surplus to plan of £512K for the financial year 2021/22, which still represents a prudent position when considering the values remaining in reserves and contingency.

2.2.2 Clinical income is showing an improvement in performance for Months 9 to 12 due to increased recovery of costs for excluded drugs. The Trust has set itself a zero budget for excluded drugs income in H2 2021/22 due to the variability of income receivable from commissioners (particularly NHSI) during H1 2021/22.

2.2.3 Other operating income is being bolstered by anticipated receipts for research & development and education & training (£394K), increased income from staff recharges (£549K) and further income from agreements with mainly other NHS providers (£169K). There will be some offsetting adjustments to this increased income within both pay and non-pay forecasts.

2.2.4 Pay costs are expected to over-spend significantly during the remaining four months of the financial year. In addition to the additional costs referred to above, there is a significant forecast improvement in recruitment to substantive staff, whilst also indicating an increased reliance upon agency staff within both medical and nursing staff groups to reduce still further the gaps in establishment and rosters.

2.2.5 Non pay costs are also forecast to increase significantly. This represents further increased premises expenditure above levels previously experienced and a consequence of CIP transactions already delivered up to Month 8. With the finalisation of the Carbon & Energy Fund capital scheme having been completed in month, there is an expectation of reduced energy consumption, which is not yet factored into these forecast figures.

2.2.6 Non operating costs assume depreciation charges in line with plan for the remainder of the financial year but a forecast reduction in PDC dividends payable further improving the forecast variance as at 31st March 2022. This is due to the significantly higher than planned cash balances currently being experienced.

3. Capital Programme

3.1 Capital Expenditure for the Eight Months Ending 30th November 2021

3.1.1 In month the Trust incurred costs of £1,105K against a budget of £1,224K, which is an under-spend position of £119K. Year to date, the capital programme is still significantly under-spending by £2,817K. Details are shown in Appendix 3.

3.1.2 **Estates Strategy** – Spend against ward and theatre refurbishments is taking place in advance of when it was initially expected to commence. The Carbon & Energy Fund scheme has now reached practical completion in month.

3.1.3 **Estates Maintenance** – Year to date expenditure is lower than anticipated; this was initially due to delays in schemes starting, which are now being progressed.

3.1.4 **Information Technology** - Expenditure to date against the Switchboard scheme has been low as a result of equipment being ordered and received during last financial year, which was included in the initial current year capital programme. Some of this under-spend has been used to help deliver the full MRI Scanner scheme within medical equipment in year. Expenditure against End User Device Refresh (replacement PCs, etc.) has been lower than originally planned for due to higher than expected stock levels currently being held by the Trust.

3.1.5 **Medical and Other Equipment** is significantly under-spending year to date (£916K) due to delays in business cases being produced as well as determining exact equipment specifications.

3.1.6 The contingency has a budget of £983K year to date, which purely represents a phasing issue with the plan linked to external monitoring requirements with NHSE/I.

3.2 Capital Expenditure Forecast Out-Turn Position for the Financial Year 2021/22

3.2.1 A forecast out-turn position for the full financial year has been produced and is detailed in Appendix 4. This shows expenditure in line with budget of £14,658K subject to the paragraphs below.

3.2.2 As a result of the flood and subsequent fire at Doncaster Royal Infirmary, the SYB ICS has been told that it is required to meet the cost of the repairs from within its overall capital allocation across the system. At present, it is expected that the Trust will be required to under-spend its capital envelope in the region of c. £1,000K, which is all being planned for in the figures reported.

3.2.3 Longer lead times for **Information Technology** equipment have been identified as a potential risk since last month. As such, planned expenditure against End User Device Refresh will be brought forward, which has been updated in the month 8 forecast to ensure that equipment is delivered before the end of the financial year.

3.2.4 Procurement has recently been advised that lead times for some pieces of **Medical & Other Equipment** is now approximately 16 weeks, which could impact on the Trust's ability to use its full year budget if this is not proactively managed by Divisions.

3.2.5 The late notification of PDC funding awards, with further amounts still expected, poses a serious risk to planning and delivering expenditure before the end of the financial year. Any under-spend above that currently being forecast representing a real terms decrease in the Trust's spending power as a result of the way national NHS capital controls are

applied. Any increased under-spend will effectively represent a pre-commitment against available capital resources in 2022/23.

4. Cash Management

4.1 A cash flow statement for the first eight months of the financial year is included in Appendix 5 and shows a significant closing cash balance as at 30th November 2021 of £30,197K.

4.2 Net overall reductions in working capital have effectively reduced the overall cash balance in the first eight months by only £713K, which is still much higher than was originally forecast. However, the cash balance will continue to reduce as financial provisions are released:

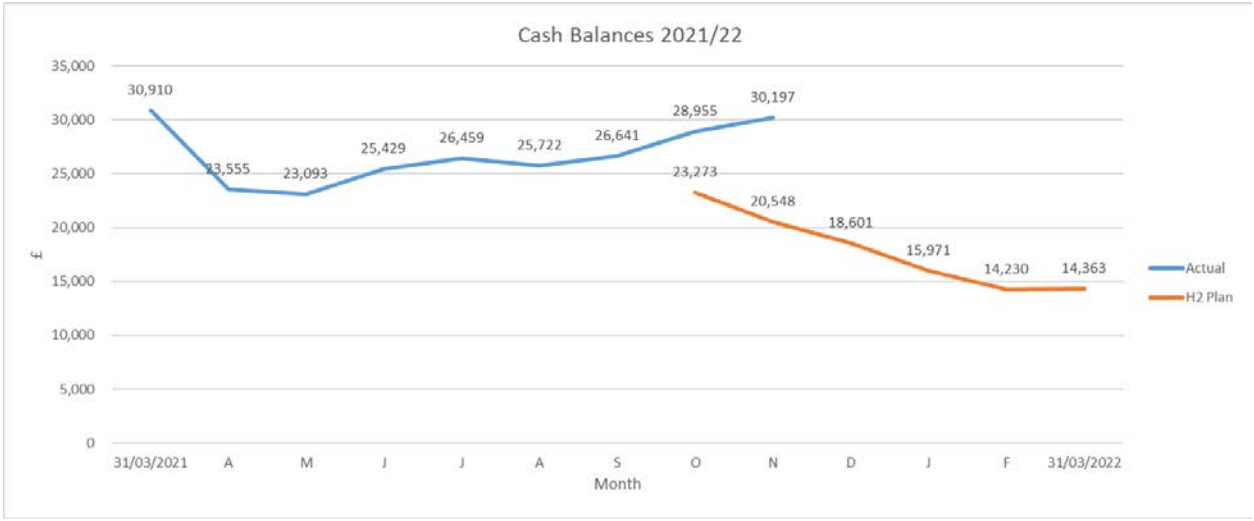
(a) Settlement of creditors, accruals and estimates from 2020/21;

(b) Utilisation of deferred income balances that have arisen in year; and

(c) Release of reserves provided for during H1 2021/22.

4.3 Additionally, capital expenditure will significantly increase in the final four months of the year, with a further £9,064K still to be committed and delivered.

4.4 The Trust's underlying residual cash position is still strong, when compared to the same position last year. However, due to the various uncertainties that have arisen since the plan was produced for H2 2021/22, it is highly probable that there could be significant changes (both positive and negative) that could impact upon the closing cash position, which at this stage are very difficult to forecast. However, the cash position is not expected to be any lower than that produced for the plan as shown in the graph below.



Steve Hackett
Director of Finance
16th December 2021

Appendix 1

Income & Expenditure Account Analysis for Month 8 2021/22 (November 2021)

Summary Income and Expenditure Position	AP	Month			YTD			21/22
		P	A	V	P	A	V	Monthly Trend / Variance
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	
Clinical Income	298,913	24,311	24,394	83	199,226	201,559	2,333	
Other Operating Income	21,182	1,980	2,156	176	14,423	14,845	422	
Pay	(220,174)	(18,521)	(18,405)	115	(146,411)	(147,740)	(1,329)	
Non Pay	(86,031)	(6,606)	(6,449)	157	(58,007)	(58,990)	(983)	
Non Operating Costs	(14,587)	(1,242)	(1,144)	98	(9,611)	(9,025)	586	
RETAINED SURPLUS / (DEFICIT)	(697)	(78)	552	630	(381)	649	1,030	

Appendix 2

Income & Expenditure Account Analysis Forecast Out-Turn for the Financial Year 2021/22

Summary Income and Expenditure Position	AP £000s	21/22 FO £000s	21/22 FV £000s	M1-M6 AV £000s	M7-M08 AV £000s	M09-M12 FV £000s	21/22 Total FV £000s	21/22 Monthly Trend / Variance
Clinical Income	298,913	301,745	2,832	2,280	53	498	2,832	
Other Operating Income	21,182	22,682	1,500	183	239	1,078	1,500	
Pay	(220,174)	(223,271)	(3,097)	(1,622)	292	(1,768)	(3,097)	
Non Pay	(86,031)	(87,548)	(1,518)	(966)	(16)	(535)	(1,518)	
Non Operating Costs	(14,587)	(13,792)	795	374	212	209	795	
RETAINED SURPLUS / (DEFICIT)	(697)	(184)	512	250	780	(518)	512	

Appendix 3

Capital Expenditure for the Eight Months Ending 30th November 2021

Scheme Categories	AP	Month 8			YTD		
		P	A	V	P	A	V
	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Carbon Energy Fund	661	0	581	(581)	661	581	80
Estates Strategy	3,600	400	161	239	1,300	1,784	(484)
Estates Maintenance	2,656	353	236	117	1,662	1,362	300
Information Technology	2,037	353	53	300	1,267	563	704
Medical & Other Equipment	5,704	0	100	(100)	1,461	545	916
Contingency	0	118	(26)	144	983	(317)	1,300
Surplus/(Deficit)	**14,658**	**1,224**	**1,105**	**119**	**7,334**	**4,517**	**2,817**

Appendix 4

Capital Expenditure Forecast Out-Turn Position for the Financial Year 2021/22

Scheme Categories	AP £000s	A M1 - M8 £000s	F M9 £000s	F M10 £000s	F M11 £000s	F M12 £000s	FOT A £000s	FOT V £000s
Carbon Energy Fund	661	581	0	0	0	0	581	80
Estates Strategy	3,600	1,784	171	245	294	378	2,872	728
Estates Maintenance	2,656	1,362	226	375	369	373	2,705	(49)
Information Technology	2,037	563	269	412	481	312	2,037	0
Medical & Other Equipment	5,704	545	272	428	1,627	2,832	5,704	0
Contingency	0	(317)	0	0	0	0	(317)	317
Surplus/(Deficit)	**14,658**	**4,517**	**938**	**1,460**	**2,771**	**3,895**	**13,581**	**1,077**

Appendix 5

Cash Flow Statement for the Eight Months Ending 30th November 2021

	30th November 2021 £000s
Cash flows from operating activities	
Operating surplus/(deficit)	3,495
Depreciation and amortisation	6,177
(Increase)/decrease in receivables	(986)
(Increase)/decrease in inventories	490
Increase/(decrease) in trade and other payables	(1,627)
Increase/(decrease) in other liabilities	3,161
Increase/(decrease) in provisions	56
Net cash generated from / (used in) operations	**10,766**
Cash flows from investing activities	
Interest received	0
Purchase of intangible assets	0
Purchase of property, plant and equipment and investment property	(8,121)
Net cash generated from/(used in) investing activities	**(8,121)**
Cash flows from financing activities	
Public Dividend Capital received	0
Loans from Department of Health and Social Care - repaid	(1,000)
Capital element of finance lease rental payments	(323)
Interest paid	(279)
Interest element of finance lease	(138)
PDC dividend paid	(1,618)
Net cash generated from/(used in) financing activities	**(3,358)**
Increase/(decrease) in cash and cash equivalents	**(713)**
Cash and cash equivalents at start of year	**30,910**
Cash and cash equivalents at end of period	**30,197**

Board of Directors' Meeting
07 January 2022

The Rotherham NHS Foundation Trust

<table>
<tr><td>Agenda item</td><td>P18/22</td></tr>
<tr><td>Report</td><td>Ockenden Monthly Report</td></tr>
<tr><td>Executive Lead</td><td>Helen Dobson, Interim Chief Nurse</td></tr>
<tr><td>Link with the BAF</td><td>B1 and B9</td></tr>
<tr><td>How does this paper support Trust Values</td><td>High Standards for the services we deliver, aim to be outstanding, delivering excellent and safe healthcare</td></tr>
<tr><td>Purpose</td><td>For decision ☐ For assurance ☒ For information ☐</td></tr>
<tr><td>Executive Summary (including reason for the report, background, key issues and risks)</td><td>The Feedback from The Ockenden Phase 2 audit (Table 1) was presented to Board in December 2021 and to date the Trust is awaiting the final sign off from the Regional team of all provider reports. The action plan will be developed as soon as this is received.
<table>
<tr><td>IEA1</td><td>Enhanced Safety</td><td>81%</td></tr>
<tr><td>IEA2</td><td>Listening to Women and families</td><td>82%</td></tr>
<tr><td>IEA3</td><td>Staff training and working together</td><td>78%</td></tr>
<tr><td>IEA 4</td><td>Managing complex pregnancy</td><td>36%</td></tr>
<tr><td>IEA 5</td><td>Risk assessment throughout pregnancy</td><td>100%</td></tr>
<tr><td>IEA 6</td><td>Monitoring Fetal Wellbeing</td><td>61%</td></tr>
<tr><td>IEA 7</td><td>Informed Consent</td><td>64%</td></tr>
<tr><td>Section 2</td><td>Workforce</td><td>80%</td></tr>
</table>
Table 1

The Ongoing assurance will be monitored through the Regional Perinatal Safety and Quality Oversight Group and Maternity services will report Quarter 3 data to the Trust board next month.
It is anticipated in 2022 that the Perinatal Safety quality assurance visits will be commenced by the Regional Teams with the engagement of the Chief and Deputy Midwifery Officer for England.

The Service continues to report monthly on the Divisional IPR and commentary for the Perinatal Safety dashboard data. Please see Summary below for November 2021:</td></tr>
</table>

Obstetric cover gaps (November)	0	
Maternity unit closures (November)	0	System pressures experienced within the month
Utilisation of on call midwife to staff labour ward	0	
1-1 care in labour (November)	100%	
Continuity team midwife present for continuity birth	93%	
Supernumerary labour ward co-ordinator (November)	88%	
Staff absence	21%	
Shifts unfilled	17%	
Number of stillbirths (November)	0	
Stillbirth rate per 1000 births Rolling 12 months	3.62	

- Whilst in the month of November we have seen an increase of the labour ward co-ordinator not being supernumerary (n 8 red flags). After analysis, on no occasions were the co-ordinators caring for labouring women who required 1 to 1 care in labour. Three of the reds flags were within the normal working week and the remaining red flags were in out of hours' time frames. In the periods of high acuity in normal working hours, managers and specialists were asked to support. On two occasions, staffing was below plan with 5 midwives on shift. This was due to late sickness. On all other occasions, staffing was noted to be at plan or above but acuity peaked for between 4 and 8 hours.
- Newly referred claims to NHS Resolution - the service have received their clinical claims scorecard and plan to work through this to interrogate the data and triangulate with complaints and incidents.
- CNST - Year 4 safety actions launched in August 2021, these have been reported via Clinical Governance Committee in November. Areas of challenge have been identified. The recording of the Carbon Monoxide screening is a challenge for the Region and work is ongoing with NHSE/I to mitigate this. There are also some concerns with the extraction of the maternity data to meet the required Maternity Services Data Set (MSDS). We are currently working with the information systems teams to support this. We were informed in late December that collection of this data is being paused for 3 months with immediate effect and this will be reviewed again in February 2022.

Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	This paper has been completed by the Head of Midwifery and will be shared through Maternity and Divisional Governance. The paper is shared with the Executive Maternity Safety Champion.

Board powers to make this decision	The Board is required to have oversight on the Maternity Service's compliance with Ockenden and this paper provides assurance of the current progress.
Who, What and When (what action is required, who is the lead and when should it be completed?)	Helen Dobson, Interim Chief Nurse, is the Board lead and will provide a monthly update to Board on the compliance with the Ockenden IEAS
Recommendations	It is recommended that the Board is assured by the progress and compliance to date.
Appendices	None

Board of Directors' Meeting
07 January 2021

The Rotherham NHS Foundation Trust

Agenda item	P19/22
Report	**Default Midwifery Continuity of Carer (MCoC)**
Executive Lead	Helen Dobson, Interim Chief Nurse
Link with the BAF	B1 and B9
How does this paper support Trust Values	High Standards for the services we deliver, aim to be outstanding, delivering excellent and safe healthcare
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	**Background:** Midwifery Continuity of Carer has been proven to deliver safer and more personalised maternity care. The attached plan to achieve this is based on the nationally agreed template. Building on the recommendations of Better Births and the commitments of the NHS Long Term Plan, the ambition for the NHS in England is for Continuity of Carer to be the default model of care for maternity services, and available to all pregnant women in England. **Where safe staffing allows,** and the building blocks are in place. This should be achieved by March 2023 – with rollout prioritised to those most likely to experience poorer outcomes first**.** https://www.england.nhs.uk/Delivering-midwifery-continuity-of-carer-at-full-scale As a first step, Local Maternity and Neonatal Systems agree a local plan that includes putting in place the 'building blocks' for sustainable models of Continuity of Carer by March 2022; Please refer to the detailed board paper for the full plan using the template and guidance recommended by NHS England for CNST safety action 9. The local plan is required to be discussed with the Maternity and Neonatal safety champions and there is also a requirement for Trust Board level oversight by 31st March 2022 to achieve compliance with CNST safety action 9. In Summary: **<u>The Plan</u>** The Rotherham NHS Foundation Trust aims to extend MCoC model to the eligible 1940 out of 3100 women who book their pregnancy with TRFT. The national target being to enable this provision by March 2023.

	TRFT are aiming to develop our offer over 3 phases. These phases include: **Phase 1**: Current planning November 2021 – March 2022 – Review the current service. (TRFT have x3 MCoC teams with a point prevalence of offering continuity to between 38-45% of women in the Rotherham region). Involve all key stakeholders and service users in innovation and improvement strategies; plan the model of care, recruitment, Board approval. March 2022 – June 2022 – Create a further 2 teams (Team 4 and Team 5). One team to be geographically based in the centre of Rotherham; one team to be based in the acute setting – aimed at providing care to those who are at highest obstetric risk(This will be configured using the existing establishment). **Phase 2:** June 2022 – October 2022 – Review the service, re-configure if required, recruitment, stakeholder and service user input and feedback. Plan a further two teams (Team 6 & 7) October 2022 – January 2023 – Create Team 6 &7 **Phase 3:** January – March 2023 – Review the service, recruitment, stakeholder and service user input and feedback. Plan Team 8 and plan the traditional community midwifery service. May - July 2023 – Team 8 to be created. The traditional community midwifery team to continue the provision of care to the women who book in TRFT but chose to birth elsewhere. Community midwives will continue to work on-calls to ensure a robust escalation process remains in place for delivery suite. This plan will be dependent on the funding being secured for the increase in the midwifery establishment which is outlined below. The second driver to influence the achievement of the ambition by March 2023 is the successful recruitment of the midwives to meet the requirements to achieve the workforce transformation required to support MCoC. This may be a challenge in the current workforce climate. The refreshed staffing requirements to make MCoC the default model for all eligible women using the NHS E/I continuity of Carer workforce model: https://www.maternityandmidwifery.co.uk/continuity-of-carer-workplace-toolkit. This has been recommended by the Regional Chief Midwife for Yorkshire and the North East during the Continuity of Carer assurance visit in August 2021. Overall, the tool recommends that between 7- 8 teams are required to provide MCoC. To achieve this workforce transformation a further 15.66 WTE midwives are required this is based on 7 teams. Currently there are no vacancies in the funded establishment due to the over recruitment which the Family Health Division has supported for ongoing maternity leave and attrition

	due to retirement and leavers. The Division therefore proposes that we request to be funded for an additional 15.66 WTE in 2022/23 at a cost of around £750 K. This will be presented as a business case to The Executive Team in January 2022. The recruitment for these midwives would be planned to include the newly qualified Midwifery intakes for 2022 with Rotherham supporting 10 year 3 student due to qualify in 2022 and 11 year 3 students in 2023. The plan for preceptee and pastoral support for newly qualified midwives at TRFT would fit this model as the current evidence suggests that newly qualified midwives feel more confident and achieve their competencies quicker working in MCoC models of care. **Issues and Risks** In the current National Maternity workforce climate we need to acknowledge that the recruitment of 15.66 WTE midwives will be a challenge as this is additional to any midwifery vacancies attributed to attrition and retirement. The service would not be able to fully implement and operationalise the plan for the proposed 7 teams until the establishment achieved full recruitment to an establishment of 127.09 WTE midwives from the current actual establishment of 111.43 WTE Midwives ensuring that safe staffing and 1:1 care been safely maintained. If the business case is not supported for this plan the Trust would ultimately be unable to commence the workforce transformation building block requirement to achieve the NHS E National ambition for MCoC to be the default model of care for maternity services; available to all eligible pregnant women in Rotherham by March 2023.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	This paper has been presented through Maternity and Neonatal Safety Champions and Maternity and Divisional Governance. Once approved by board it will be presented at the Local Maternity and Neonatal system Board meeting.
Board powers to make this decision	The Trust Board is required to have oversight of the MCoC plan
Who, What and When (what action is required, who is the lead and when should it be completed?)	Helen Dobson, Interim Chief Nurse, is the Executive and Lynn Hagger is the Non-Executive Maternity and Neonatal Safety Champions, they will update board on the plan and the business case to fund the MCoC plan.
Recommendations	It is recommended that the Board has the necessary oversight of the MCoC plan to inform the decisions on the Maternity workforce business case proposal planned for January 2022.
Appendices	None

Purpose of Report: For Board adoption and subsequent monitoring of a plan to achieve Midwifery Continuity of carer as the default model of care.

Maternity Board Paper			
Agenda item:		**Enclosure Number:**	
Date:	December 2021		
Title:	**Plan to Board for Default Midwifery Continuity of Carer (MCoC)**		
Author /Sponsoring Director/Presenter	Sarah Petty, Head of Midwifery Lucy Whitehead, Interim Matron for Community Midwifery Services Trudy Hutson, Lead Midwife for Continuity of Care		

Purpose of Report	Tick all that apply ✓		
To provide assurance		For discussion and debate	
For information only		For approval	√
To highlight an emerging risk or issue		For monitoring	

Summary of Report: *(Include key points and additional information as necessary regarding purpose of report- amend for your situation)*

This paper outlines:

- Background
- Current position including
  - Activity
  - Imports and exports
  - Current staffing
- Staffing deployment plan with time scales and recruitment plan ensuring building blocks are in place
- Framework of activities that will ensure readiness to implement and sustain MCoC
- Time frame and monitoring process.

Recommendation:

- Accept the contents of this report
- Support maternity service in delivery of transformed model of care.
- National guidance requires quarterly monitoring of this plan – agree for return of plan to board on a quarterly basis for review
- Provides XY or Z for staffing/equipment or estate requirements
-

Background:

Midwifery Continuity of Carer has been proven to deliver safer and more personalised maternity care. Building on the recommendations of Better Births and the commitments of the NHS Long Term Plan, the ambition for the NHS in England is for Continuity of Carer to be the default model of care for maternity services, and available to all pregnant women in England. Where safe staffing allows, and the building blocks (see appendix/ A for assurance framework) are in place this should be achieved by March 2023 – with rollout prioritised to those most likely to experience poorer outcomes first**.**

What does it mean to offer Midwifery Continuity of Carer as the 'default model of care'?

In line with *Better Births* and the *NHS Long Term Plan*, all women should be offered the opportunity to receive the benefits of Continuity of Carer across antenatal, intrapartum, and postnatal care. However, not all women will be in a position to receive continuity of carer through choosing to receive some of their care from another maternity service. In a small number of cases, women will be offered a transfer of care to a specialist service for maternal / fetal medicine reasons.

Providing Continuity of Carer by default therefore means:

1. Offering all women Midwifery Continuity of Carer as early as possible in pregnancy.
2. Putting in place clinical capacity to provide Continuity of Carer to all those receiving antenatal, intrapartum and postnatal care at the provider.

Maternity services and LMS (or LMNS) are asked to prepare a plan to reach a position where midwifery Continuity of Carer is the default position model of care available to all women.

As a first step, Local Maternity Systems (or and neonatal systems) agree a local plan that includes putting in place the 'building blocks' for sustainable models of Continuity of Carer by March 2022; so that Continuity of Carer is the default model of care offered to all women. This plan will include:

- The **number of women** that can be expected to receive continuity of carer, when offered as the default model of care
- **When** this will be achieved, with a redeployment plan into MCoC teams to meet this level of provision, that is phased alongside the fulfilment of safe staffing levels
- **How** continuity of carer teams are established in compliance with national principles and standards, to ensure high levels of relational continuity
- How **rollout will be prioritised** to those most likely to experience poor outcomes, including the development of enhanced models of continuity of carer
- **How care will be monitored locally**, and providers ensure accurate and complete reporting on provision of continuity of carer using the Maternity Services Data Set
- **Building blocks** that demonstrate readiness for implementation and sustainability assessment – ensuring all the key building blocks are in place.

Current position:

Current bookings

In 2020, 3100 women in Rotherham had their pregnancies booked by our community midwifery service; and 200 women living in another part of South Yorkshire were booked by our Greenoaks antenatal service as they choose to birth at Rotherham hospital.

In 2020, 650 women had antenatal and postnatal care only from our community midwifery service at Rotherham – as these women chose to go out of area (I.E another hospital) to give birth. The first Maternity Continuity of Care (MCoC) team – Willow - were placed in March 2019 in the South of Rotherham across the Swallownest and Dinnington areas. On average, these areas have 50% of women booking with the Rotherham community midwifery service and choosing to birth at either Bassetlaw or Sheffield. Although the Willow Team have had an impact on the number of women booking and birthing elsewhere, there remains a significant amount of women who chose to do so. Our second MCoC team - Poplar - has successfully reduced the number of women in their geographical choosing to birth elsewhere.

There are a number of reasons why women chose to birth in hospitals other than Rotherham. For many of the women in Rotherham, they simply feel that other units are geographically closer or easier for them to travel to. Some families chose The Jessop wing in Sheffield; as this is the tertiary unit for South Yorkshire and Bassetlaw, and it has historically had a good reputation for being a leading service in Maternity. Other women, who have previously had children, have a preference to birth in the same unit for all of their children, despite where they live. As previously mentioned, there will always be a small number of women who have their care transferred to a tertiary unit for specialist fetal medicine care.

By offering a continuity pathway to women, and educating women and their families about evidence to support that MCoC reduces the likelihood of poor outcomes, it is likely that this will further reduce the number of women who chose to birth elsewhere. Women prefer to see the same midwife throughout their journey, and feel that building a relationship with their midwife is of utmost importance. For this reason, offering a service which promotes such a relationship – and carrying this through the birth process as well as through antenatal and postnatal care – will only promote TRFT Maternity services as a leading provider of maternity care. The number of women requiring care under a specialist fetal medicine unit is likely to remain unchanged.

The number of women who are eligible to receive MCoC will always be affected the points mentioned above and the provision for tertiary referral reasons should remain steady. However, the fact that TRFT is able to provide MCoC should see the overall numbers of women choosing to birth in a different unit reduce with a carefully planned and robust continuity service provision. A ‘Plan, Do, Study, Act’ (PDSA) cycle will be completed at each phase of the roll out to evaluate

this. A PDSA cycle will enable insight into the numbers of women in the core and MCoC teams; and how this may change over time.

Currently, as mentioned above, 200 women chose to birth in Rotherham despite living in another town/city. This number could also reduce slightly as other areas begin to introduce their own continuity teams. However, given that Sheffield, Doncaster and Bassetlaw have paused continuity at present, it is likely that it will take significantly longer for these trusts to roll out their continuity plans. As a result, this number should remain steady for a period of time.

At TRFT, the number of women who are eligible for MCoC is 1940– this means those who live in Rotherham and will be cared for by midwives from our service throughout their pregnancy episode (antenatal, intrapartum and postnatal).

In the last 12 months, we have booked - on average - 33 women from Black, Asian and mixed Ethnicity backgrounds per month. Women of BME ethnicity live throughout Rotherham, however, there are increased numbers of women of BME ethnicities living across the central areas of Rotherham, including Broom, Moorgate, Canklow, Ferham, Holmes, Masbrough, Eastwood, Clifton and East Dene. In November 2021, 31.7% of women with a BME background were booked onto a MCoC pathway. This was an increase from October 2021 – where this rate was 18.3%. The increase is due to a revision of the MCoC service and amendments made to improve maternity outcomes. The next phase of the rollout of MCoC in Rotherham involves a robust plan to set up a 4th MCoC team in the central area of Rotherham to better capture this demographic. Currently, our traditional 'Centre' community midwifery team covers most of the centre of Rotherham; and the MCoC Poplar team covers some of the eastern centre of Rotherham. The next phase of the MCoC roll out is to set the 4th team up in the western central of Rotherham, and for a further team to cover the eastern part of the centre area (see below).

As the ultimate aim is to improve outcomes and experiences for the women and families we provide care for, our Maternity Voice Partnership (MVP) have been invaluable to us on our MCoC journey so far. The Maternity leadership team will continue to engage in regular meetings and will obtain feedback through our MVP, with a specific focus on representation from those communities who can be harder to reach. Networking with the 0-19 team, which specialises in working with families in the Roma community, has already begun to gain feedback and ideas to guide the construction of the MCoC service.

A close partnership is being developed with the Head of Service for Early Help and Family Engagement within RMBC to co-locate midwives into family service hubs; the aim of which is to facilitate and improve the collaborative working of professionals across family services. This will further enable midwives to provide gold-standard continuity of care to women and their families.

During the last 12 months, on average 70 women per month who live at a postcode with a deprivation index below 10 gave birth in Rotherham. The central areas of Rotherham - Canklow, Ferham, Holmes, Masbrough and Eastwood – predominantly have a deprivation index of below

10. Throughout Rotherham there are multiple areas with postcodes with a deprivation index of 10 or below; however, focussing on the most central areas of Rotherham at the beginning of this rollout will contribute towards capturing a large proportion of these families first. However, as the postcodes with a low deprivation index are spread throughout the entirety of the town, the provision of MCoC to all of these families will not be achieved until the rollout is complete.

During November 2021, the percentage of women in Rotherham receiving MCoC who live in a postcode with a deprivation index of 10 or below was 45%. This figure has significantly increased from October 2021, where the percentage was 28%. This was following a review of the service and a reconfiguration of the teams to enable a larger number of these families to be reached as a result. As previously mentioned, until we are able to offer 100% of women MCoC in Rotherham, it will be difficult to see a dramatic rise in this percentage as the postcodes with a lower deprivation index are so spread out.

.

The Plan:

The Rotherham NHS Foundation Trust aims to provide MCoC to 1940 out of 3100 women, with the national target being to enable this provision by March 2023.

This will be dependent on the funding being secured for the increase in the midwifery establishment which is outlined below. The second driver to influence the achievement of the ambition by March 2023 is the successful recruitment of the midwives to meet the requirements to achieve the workforce transformation required to support MCoC.

The remainder of the women receive care from other maternity services and may not change their position due to tertiary referral for fetal medicine reasons, the geographical challenges for women and their previous experiences. Out of these women, 16% are Black, Asian, or Mixed ethnicity and live in a clearly defined geographical area.

MCoC teams will be prioritised for rollout in the areas of the highest Black, Asian and Mixed ethnicity populations and in the postcodes with the lowest deciles as mapped in our Perinatal Equity and Equality Analysis. This ensures that we target women and families who are most likely to experience adverse outcomes first.

Firstly, a review of our 3 current teams will be completed. This will involve engagement groups and meetings with both medical and midwifery teams. The three teams will be re-located into geographical areas with clearly defined postcode boundaries. Willow are currently based in the south, Poplar in the centre; and Maple in the North. The areas covered by the teams will be less spread out; and will be as a result of the fact that 7 teams will eventually be formed –of which are to be geographically based. A traditional Community midwifery team will be maintained along with a hybrid team as outlined below which is configured with the existing establishment.

Maple are likely to continue to cover the Rawmarsh area of Rotherham, but are likely to begin to see women in Swinton also. Willow are likely to stay in the south of the city; and will be covering Swallownest, Aston, Waverly and Treeton areas. Poplar will either move to the west – covering Sunnyside, Wickersley and Maltby; or will moved to the east - which would be the Western centre team. Willow and Maple will continue as they are until other MCoC teams are set up in those areas. Poplar, however, will be amended at the time that the new centre team will be set up – see below.

The ambition is to safely set up and roll out a further 2 MCoC teams in March 2022. The first team will be a geographical team, covering the eastern centre of Rotherham. Networking meetings are underway between the TRFT Estates Team and the RMBC teams to facilitate a hub for this team in RCHC (Rotherham Community Health Centre). Adequate space is being provided to facilitate 2x clinical rooms for community midwives – 5 days per week. There is also suitable office space for the community office administration Team, the Community Midwifery Matron; and 2 of the Community Midwifery Lead Midwives to be based here permanently. Hot desk space, meeting rooms and smaller interview type rooms will be accessible for our midwifery teams there too. Using RCHC as a hub will allow for networking amongst other professional teams based there – such as the 0-19 service; and will allow women to attend for postnatal care as well as antenatal care, thus reducing the need for visits in family homes. This will reduce mileage costs, increase capacity and be responsive to patient feedback. The long-term goal is to utilise this space to its full potential – running infant feeding support sessions, parent education classes and joint service appointments for those who need them.

This team will have a maximum of 8 qualified midwives (as will all of the MCoC teams) based at RCHC; who will work as a team for the provision of gold standard MCoC.

The second team to be set up at that time, will be a hospital-based team. This team will run the same way that a geographical team will run - they will see their women at the same touch points as a community midwife would – but in a hospital-based clinic. This team will be offered to women of the highest obstetric need.

The details of this are not yet finalised as the final decision will be as a result of MVP and staff engagement and ideas combined. However, as a general idea, the criteria could include women who have Type 1 or 2 diabetes, those with a BMI > 40; those with a multiple pregnancy or those whom have experienced a previous stillbirth. Women who have a high-risk pregnancy often have more hospital appointments for extra ultrasound scans and obstetric and anaesthetic input.

The midwives in this team would still be expected to see their women at home at 34 weeks pregnancy for a home assessment, birth plan discussion and discussion about newborn safety – just as community midwives do. They would also be seeing their women at home for their first appointment at home after birth. Following this first appointment, an assessment would be made by the midwife - based on the woman's preference and wellbeing – about whether she would be safe to have the rest of her postnatal care in the clinic at the hospital.

The Matron for Community Midwifery and the Matron for Antenatal Out-Patients are meeting to discuss and plan forward for the details of the location for such a clinic to be facilitated. This team would cover women all over Rotherham who meet their criteria, and would be the only team which is not geographically based.

An external job advert will be live as of the W/C 20th December 2021 for an integrated midwife to aim to fill any current free vacancies. Between this recruitment and the current midwifery establishment, it should be reasonable and safe to set up these 2 teams by 31st March 2022.

The roll out for both teams would see 4 midwives for each team start out – recruiting women into the team, providing early pregnancy care and supporting community and acute midwifery. The further 4 midwives would be released from their positions one day per week to begin to meet their patients and gain experience in their teams. These midwives should then become a substantive part of their teams by 30th June 2022.

The setup of these two teams will mean that half of the centre of Rotherham will be covered by MCoC – contributing to the percentage of women from an area of low deprivation; or from an area with a larger BME population to be on a continuity pathway. In addition, the women with the highest obstetric need will be offered MCoC. These teams, combined with the current teams in place should see a significant improvement in outcomes for mothers and babies in Rotherham.

The ambition will be to set up a further 2 teams in October 2022 – again with 4 midwives starting in each team in October; and a further 4 midwives joining them in January 2023. This will depend on the funded establishment supporting this move to enable the recruitment required.

It will be at this point that Maple Team will be reviewed - in terms of how their team will be re-configured in the North of Rotherham. Maple will likely begin to cover Rawmarsh (as they do currently); with the addition of Swinton, Mexborough and Wath. Although geographically this is a large area, a significant proportion of the women in these areas choose to birth in other units. The new MCoC team created will cover the other side of the North - Greasborough, Wentworth, Thorpe Hesley and Kimberworth.

The second team formed at this time (which will be the 7th MCoC team overall) will be set up in the western centre of Rotherham –as Poplar will likely be migrated towards Sunnyside, Wickersley and Maltby. This re-configuration of teams, and setup of 2 new teams will contribute significantly to covering the largest areas of high deprivation; and areas with a higher population from a BME background.

The final configuration of Rotherham midwifery aims to be completed by 1st May 2023. This will include the final geographical team being set up, Willow team being re-configured to a smaller, more compacted area; and the traditional community midwifery commencing their new ways of working as a team. As like before, the plan would be for 4 midwives to start up the final team – commencing 1st May 2023; and the further and final 4 midwives completing the team by 1st July 2023.

The traditional community midwifery team will provide midwifery antenatal and postnatal care for those women who live at a Rotherham address but birth in a different unit. They will continue to provide community midwifery care – but will be set up in the new hubs to facilitate multi-agency working for the safety and protection of the families in their care. The aim is to reduce the number of home visits in the postnatal period by bringing women into postnatal clinics – this will improve patient satisfaction (as feedback is often that women find it frustrating waiting in all day for a visit), will reduce mileage costs and will increase the capacity for Midwives and Maternity Support Workers to see more women in their working day. Traditional community midwives will

continue to have ‘on-calls’ rostered to support the home birth service, and to support the acute setting when escalation is required.

Safe staffing:

In August 2020, the Division of Family Health commissioned a BR+ re-assessment (last completed in 2017) – this highlighted an opportunity for betterment in reference to the number of midwives and specialist roles. It is recommended that Birthrate plus assessments are undertaken every 3 years (NHS E). Reviewing these recommendations for the Bi Annual Staffing paper in October 2021 they determined that the Trust was currently meeting the staffing requirements for our case mix with our current funded establishment at 123.28 WTE for bands 3-7 with the BR +recommendation at 123.96 WTE. At the time of the Birth rate plus assessment the ambition was to achieve the 51% trajectory of women been in receipt of Continuity of carer therefore to achieve this, further investment would be required for 4.72 WTE.

Birthrate Plus recommends a skill mix of 90% midwives and 10 % band 3/4 support workers, at the time of the assessment this was 88/12. This workforce split now meets the Birthrate plus recommendations with the current establishment demonstrating a skill mix 90.63% Midwives and 9.37% Band 3 /4 support staff.

A Business case was completed and presented to ET in April 2021 with an agreement that the division would submit the bid for the Ockenden Maternity workforce funding. This was submitted in May 2021 to support the midwifery requirements. Unfortunately, this bid was unsuccessful.

The refreshed staffing requirements to make MCoC the default model for all eligible women using the NHS E/I continuity of Carer workforce model : https://www.maternityandmidwifery.co.uk/continuity-of-carer-workplace-toolkit. This has been recommended by the Regional Chief Midwife for Yorkshire and the North East during the Continuity of Carer assurance visit in August 2021.

Overall, the tool recommends for between 7- 8 teams to provide MCoC and the maternity workforce to be redesigned to make the required workforce flip a further 15.66 WTE midwives are required. Currently there are no vacancies in the funded establishment as we are over recruited to support ongoing maternity leave and vacancy. The Division therefore proposes that we request to be funded for an additional…15.66 WTE in 2022/23 at a cost of around £750 K. This will be presented as a business case to The Executive Team in January 2022.

The recruitment for these midwives would be planned to include the newly qualified Midwifery intakes for 2022 with Rotherham supporting 10 year 3 student due to qualify in 2022 and 11 year 3 students in 2023. The plan for preceptor and pastoral support for newly qualified midwives at TRFT would fit this model as the current evidence suggests that newly qualified midwives feel more confident and achieve their competencies quicker working in MCoC models of care.

The service would not be able to fully implement and operationalise the plan for all 8 teams until we were fully recruited to an establishment of 127.09 WTE midwives from the current actual establishment of 111.43 WTE to ensure that safe staffing is maintained and 1:1 care been safely maintained.

The safe staffing escalation policy is line with South Yorkshire and Bassetlaw will require review in 2022 following engagement events and wider discussion with the continuity and labour ward leads and midwives.

We are aiming to develop our offer over 3 phases. These phases include:

Phase 1:
Current planning November 2021 – March 2022 – Review the current service, involve all key stakeholders in innovation and improvement strategies; plan the model of care, recruitment, Board approval.
March 2022 – June 2022 – Create a further 2 teams (Team 4 and Team 5). One team to be geographically based in the centre of Rotherham; one team to be based in the acute setting – aimed at providing care to those who are at highest obstetric risk.

Phase 2:
June 2022 – October 2022 – Review the service, re-configure if required, recruitment, stakeholder and service user input and feedback. Plan a further two teams (Team 6 & 7)
October 2022 – January 2023 – Create Team 6 &7
Phase 3:
January – April 2023 – Review the service, recruitment, stakeholder and service user input and feedback. Plan Team 8, plan the traditional community midwifery service.
May - July 2023 – Team 8 to be created. The traditional community midwifery team to continue the provision of care to the women who book in TRFT but chose to birth elsewhere. Community midwives will continue to work on-calls to ensure a robust escalation process remains in place for delivery suite.

Based on best evidence, our MCoC teams will comprise of mostly mixed risk geographical teams, where the named midwife will follow the woman as necessary and will refer appropriately, where specialist input is required.

1.

i) We have included a team for those women with significant 'risk-factor' and high obstetric need - as we have a high proportion of clinically high-risk women in Rotherham.
ii) We will not have specialist vulnerable women's groups as the evidence suggest that this does not improve outcomes and the women themselves prefer to receive place based (geographical) care. Our vulnerabilities midwifery team are undergoing a re-configuration to re-develop their roles into a supportive midwifery service. This service aims to improve outcomes for the most vulnerable women and families by supporting the midwives in practice, and developing the services, which can be offered. Our vulnerabilities midwives will support with issues surrounding perinatal mental health, teenage pregnancy and families with social care involvement or safeguarding concerns.
iii) We want to manage the flow well by keeping the system as simple as possible – each midwife picking up 3-4 women per month and birthing 3 women per month, in this way we know that every woman will have a midwife at any given time.

2. We have used the NHSE/I toolkit to plan the phased role out. This will demonstrate, Time-frames for roll out, a recruitment plan – (how many midwives and when). The toolkit accounts for staffing ratios, demonstrating planned safe staffing at any given time during this process - providing assurance that appropriate staffing ratios have been considered in this plan.

3. Before commencing phased roll out of MCoC we need to recruit 15.66 to ensure that we can safely staff MCoC and maintain a birth availability model so that we reduce the core labour ward staffing to x1 labour co –ordinator and 2 midwives.

4. We intend to under-take an evaluation at each phase to check that all our systems and processes work as per plan. We also want to observe if there are any emerging patterns such as a reduction in footfall in postnatal ward/triage etc. We want to check there are no unintended consequences. At each phase we will use the PDSA cycle to consider if our plans need amending and make any changes accordingly.

The calculations on the spreadsheet show that we do require extra midwives, this includes what was needed to meet the Birthrate plus requirements.

Communication and engagement plan

The Head of Midwifery and the Interim Matron for the Community Midwifery Service have been leading Innovation and Improvement Groups regularly. These meetings include key stakeholders such as midwives, obstetricians, service managers and the paediatric team. Regular group meetings are planned to continue to engage all stakeholders in providing their input for the development of the service. The Community Matron has been holding 1:1 meetings with midwives in traditional community teams and those already in MCoC teams to discuss plans, and further meetings with staff are organised. Promoting MCoC and recruiting midwives from the acute into teams is already in progress.

Our Trust RCM representative has been present at the engagement meetings and is pro-actively working with the leadership team to support the flip to MCoC for TRFT.

Human Resources and the communications tem have not yet been involved in these sessions, but a meeting is scheduled for this purpose in January 2022.

Communication between the Matron and the procurement team is already underway.

Importantly, our MVP have their voice in the service development with regular meetings planned. A 'walk-around' with the Acute Midwifery Matron and the MVP is planned for our service users to have their say regarding the set-up, the feel and the organisation of the acute department; and their involvement has been crucial when considering the re-modelling of Delivery Suite. This well-established relationship will ensure significant involvement of our service users in the creation of MCoC in Rotherham.

We understand that not all women are represented by our MVP, therefore engagement work is in progress to encourage our service users from areas of a low deprivation index and those with a BME background to become involved in the design of the MCoC service.

Skill mix planning

1. Skill mix will be considered when creating the MCoC teams so that women and babies are safe, and so that midwives feel safe to provide high quality care. A minimum of 5 Band 6 midwives will be in each MCoC team. When considering the home birth service, there will never be an occasion where 2 Band 5 midwives attend a woman labouring at home on their own. A Band 6, 7 or 8 midwife will always be present for a woman having her baby at home.
2. A robust plan will be in place to support Band 5 midwives rotating into MCoC teams. This will include a carefully designed preceptorship package – developed by our Clinical Education Midwives and with the support and guidance of the LMNS. During their time as a Band 5, our midwives will, for the majority of the time, do night shifts on delivery suite rather than 'on-calls'. This is to increase their exposure to labour ward with the aim of consolidating their practice, developing their skills and actively working towards their Band 6 uplift.
3. The staffing on Delivery suite will be altered. The aim is to continue to have one Band 7 labour ward coordinator every day shift; and two every night shift. Our Band 7 coordinators will often cover triage at night if not coordinating delivery suite. There will be an allocated midwife in triage during the day (supported by an allocated Antenatal Day Unit Midwife), and 2 band 5 or band 6 midwives as a 'skeleton' as the core midwives on shift each shift.
   Labour ward co-ordinators will then have 8 teams of midwives to call for their own women when 1:1 labour care is required.
   When called in to delivery suite, the expectation is that our teams will be well supported, relieved for breaks and made to feel part of the team.
4. The Band 5 midwives in the MCoC teams at present report being very well supported whilst undertaking their preceptor programme.
5. We will have four maternity support workers in the community to support the service. Our Maternity Support Workers will be allocated to areas of Rotherham – and will support the areas of greatest need.

6. Our team of labour ward coordinators are invited to the Innovation and Improvement group meetings and the Interim Matron for Community Midwifery Services is attending future meetings had between the labour ward Lead Midwives and the coordinators. Plans are in progress to support a short period of time for or coordinator team to shadow our MCoC midwives for a week each – so increase understanding of the way in which they work. Civility training is being developed for our coordinator team to ensure our Teams will be supported during their working time in the unit.

Training

This is a key building block.

The Maternity Leadership Team will be working closely with our midwives rotating out into MCoC to complete an individually Training Needs Analysis.

Our Professional Midwifery Advocate (PMA) programme in TRFT is undergoing a review and re-development. Further midwives are currently undergoing the PMA course to enable a more resilient support network for our Team. PMAs will be key in supporting the transition to MCoC.

Any training needs which are identified will be actioned appropriately and the PDSA models will be used regularly to ensure that the service provision is safe.

Any midwife who is not rotating into a MCoC team from a community or MCoC role will have a period of time being supernumerary to support their adaption process.

All midwives undergo MAST training once per annum – which includes obstetric emergency training, skills and drills within a community setting as well as an acute setting.
Once Team 4&5 have been developed and rolled out, 'Time-Out' days will be planned and rostered for teams to address contemporary issues in Maternity. These days will have a public health element; include training on birth-rights; supporting women who choose to birth 'outside of guidelines and recommendations'; aromatherapy support and mindfulness. These days will be reviewed and re-constructed to become an annual teambuilding day, as well as a day for learning and development.

Linked Obstetrician

There will be a named Obstetric Consultant Lead for each of the MCoC teams. Women who are under Consultant-Led-Care will continue to see their own named consultant throughout pregnancy – depending on their medical and obstetric history. The Lead Consultant for the teams will be to support with issues in the absence of the named consultant, and to consult for advice for the women who are low-risk or 'Midwifery-Led-Care'
This is loosely referred to in the 'Care of Women in Labour – Continuity of Care' SOP. This guideline gained TRFT Obstetric Governance approval in February 2020. However, due to how MCoC and its ambition have changed, this SOP is currently under review.

Midwifery Pay

No midwife should be financially disadvantaged for working in this way. Each Trust needs to review and manage this in line with NHSE/I toolkit.

Estate and equipment
1) As midwives will no longer be working with a caseload based on the GP surgery a woman is registered with, for the most part, midwives will no longer be working in GP surgeries. Family hubs are being created across Rotherham where community midwives will run their clinics. Other family agencies will also work from these hubs to allow for more streamlined collaborative working. A hub has been identified for 6 out of the 7 divided areas which our teams will be working in. Included in these numbers may be a building with a GP surgery integrated – but these are joint service centres where community midwives are able to welcome all women on their caseloads – no matter which GP the woman is registered with. Plans are in progress to identify a final hub. The geographical area awaiting identification is the area covering Kimberworth, Greasbrough and Wentworth. 2) A close partnership is being formed with the Early help and Family Engagement RMBC Team. 3 hubs have been identified as suitable for estates work to be undertaken almost immediately. Our Head of Midwifery is liaising with our Finance Department and Service Managers to explore options for financial support for the work that need completing to enable these 3 hubs to be suitable and safe. The RMBC team are also providing financial support to contribute to the co-location. 3) It is likely that further financial support from the Trust will be required to support the estates work required for the remaining identified hubs to prepare them for appropriate and safe clinical use. 4) The equipment such as chairs, desks and couches, which are owned by the trust, will be transported into new hubs where possible. However, midwives who are based in GP surgeries at present as highly likely to be using the equipment provided by the practice. Therefore, funding will be required to ensure that there is a suitable patient couch, couch roll, a desk and chair compliant with the TRFT work station assessment guide; and storage (E.G a cupboard or shelving) for each clinical room. *5) As the number of midwives working in the community will be significantly higher than the numbers we have previously seen in TRFT, further equipment will be required.* *As standard, each midwife will require a 4G laptop to facilitate contemporaneous record keeping; a mobile phone with allowance for professional calls, texts and emails; a stethoscope; a manual sphygmomanometer; a fetal sonicaid with batteries; a pinnard stethoscope; a carbon monoxide machine, urinalysis clinistix, disposable tape measures, ultrasound gel; venepuncture equipment; PPE, weighing scales, suitable access to a Transcutaneous Bilirubin meter; a thermometer suitable for neonatal and adult use; an appropriate coat for adverse weather and access to emergency equipment for birth at home.*
Review Process
The progress with the MCoC plan will be monitored through maternity and neonatal safety champions and reported to Trust Board for CNST assurance and the South Yorkshire and Bassetlaw Local Maternity and Neonatal System board.

Board of Directors' Meeting
07 January 2022

The Rotherham NHS Foundation Trust

Agenda item	P20/22
Report	**Mortality and Learning From Deaths Report**
Executive Lead	Dr Callum Gardner, Executive Medical Director
Link with the BAF	B1 – Standards and quality of care not being met B2 – Demand for care exceeds the resources available B7 – Insufficiently robust quality and clinical governance
How does this paper support Trust Values	**Ambitious** – demonstrates that the Trust strives to deliver the highest standards and quality of care possible and to have a Hospital Standardised Mortality Ratio (HSMR)/Summary Hospital Level Mortality Indicator (SHMI) below 100. **Caring** – demonstrates that the Trust strives to give outstanding, compassionate care, including around end of life care. **Together** – demonstrates that the Trust strives to ensure that quality improvement and the learning from deaths is achieved through a multidisciplinary approach.
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	This report provides the Board with the monthly mortality data and an update around changes and quality improvements being made as part of the Trust's learning from deaths. Summary of key points: **HSMR**: After delays due to concerns about the integrity of the data, Dr Foster released the latest HSMR data on the 17th December 2021. The latest HSMR figure for TRFT (Sep 2020 - Aug 2021) is **114.0**. This remains higher than expected. **SHMI: 112.6** for the period August 2020 - July 2021. TRFT have moved just back in to the 'higher than expected' band. **Diagnosis code alerts:** There are currently 4 HSMR diagnosis groups for the Sep 2020 - Aug 2021 12-month period with Relative Risks (RR) that are banded as 'statistically higher than expected': • Acute Bronchitis (RR – 249.7) • Other perinatal Conditions (RR – 231.7) • Liver disease, alcohol-related (RR – 157.9)

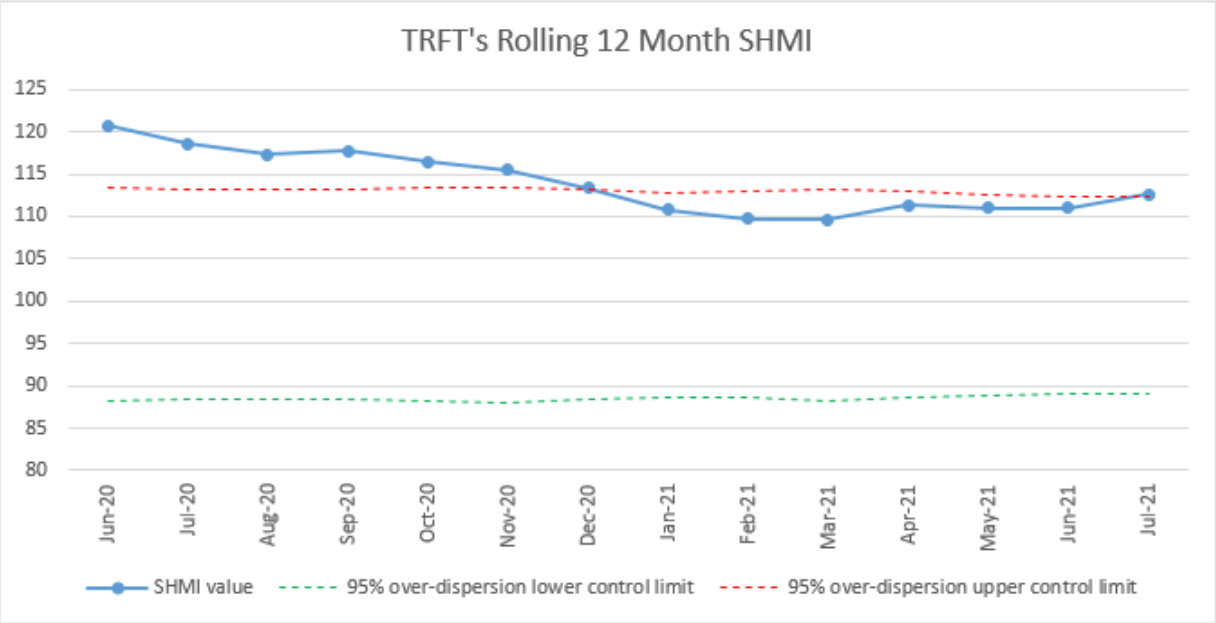
	• Syncope (RR 353.1) The Diagnosis Group 'Acute Bronchitis' remains in Band 1, 'Higher than Expected'.
Due Diligence (include the process the paper has gone through prior to presentation to the meeting)	This data is also presented to the Trust's Clinical Governance Committee, Quality Committee, Safe & Sound Mortality Group, and the Mortality Improvement Group.
Powers to make this decision	N/A
Who, What and When (what action is required, who is the lead and when should it be completed?)	The Trust continues to work extremely hard to understand and quickly improve the HSMR/SHMI and learning from deaths, co-ordinated through the Trust Mortality Improvement Group (MIG), chaired by the Chief Executive Officer, with the Medical Director as the Senior Responsible Officer. This Group is likely to be stood down in the near future, with 'Business as Usual' picked up through the Trust's Safe & Sound Mortality Group, chaired by the Medical Director, with oversight and assurance through the Trust's Clinical Governance Committee and Quality Committee.
Recommendations	It is recommended that the Board notes the mortality position and the significant actions being taken to make improvements.
Appendices	1 Dr Foster Mortality Summary

1.0 Quality of Care

1.1 This section will focus on SHMI data published on the 9th December 2021. The latest 12 month data period is 01/08/2020 – 31/07/2021.

1.2 The Rotherham NHS Foundation Trust (TRFT) has tipped back in to the Band 1, ' higher than expected' band. The chart below tells us that the Trust has been very close to the Upper Control Limit for the last few months. 3 of the 13 Yorkshire and Humber General Trusts are in the 'higher than expected' band.

1.3 Covid patients are excluded from the SHMI, by having a Covid diagnosis code (anywhere in the spell), or it being featured on the Death Certificate. The removal of patients with Covid is less complete in the data that generates the HSMR.



1.4 Yorkshire & Humber Region's General Trusts, SHMI August 2020 – July 2021

PROVIDER_NAME	SHMI_VALUE	SHMI_BANDING
Donc & Bass NHSFT	112.6	1
Hull Uni NHST	114.8	1
Rotherham NHSFT	112.6	1
Airedale NHSFT	98.4	2
Barnsley NHSFT	102.5	2
Bradford NHSFT	103.0	2
Calderdale NHSFT	105.0	2
Harrogate NHSFT	99.3	2
Leeds NHST	111.1	2
Mid Yorks NHST	104.8	2
NLincs & Goole NHSFT	109.0	2
Sheffield NHSFT	99.4	2
York & Scarb NHSFT	93.7	2

2.0 SHMI Coding Indicators

2.1 NHS Digital's SHMI Coding/Data Quality indicate that TRFT is coding a high number of Co-Morbidities per Non-Elective admission. This would tend to improve our mortality indicators, but to be included in the SHMI calculations they need to be listed in the first or second consultant episode; however, this is often not the case.

2.2 TRFT has the highest rates in Yorkshire and Humber for Signs and Symptoms & Invalid codes being recorded in the Primary Diagnosis. This could indicate a problem with data quality or timely diagnosis of patients.

2.3 The Palliative Care metrics indicate our Palliative Care overall coding rate for all spells is relatively low. However, for patients who die at the Trust, the proportion with the palliative care code is average compared with the region, although below national averages.

2.4 A relatively low Palliative Care coding rate could lower TRFT's Expected Rate for HSMR, and a high incidence of Signs and Symptom coding could lower TRFT's Expected Rate for both SHMI and HSMR. TRFT have the highest 'sign and symptom' primary diagnosis in Yorkshire and Humber.

TRFT Rank of 13	1st Highest	1st Highest	2nd Highest	6th Highest	10th Highest
Yorks & Humber Region General Provider Trusts	**% of Spells: Primary Diagnosis is a Sign & Symptom**	**% of Spells: Invalid primary diagnosis code**	**MEAN Secondary Diagnoses per Spell Non Elective**	**% of deaths with either palliative care specialty or diagnosis coding**	**% of spells with either palliative care specialty or diagnosis coding**
Airedale NHSFT	16	*	4.8	19	1.0
Barnsley NHSFT	12.7	0.2	7.5	24	1.6
Bradford NHSFT	11.8	0.3	4.7	30	1.0
Calderdale NHSFT	10	*	6.2	33	1.9
Donc & Bass NHSFT	12.1	0	5.6	45	2.3
ENG	14.3	0.7	6.0	39	1.9
Harrogate NHSFT	15.5	*	5.1	37	1.8
Hull Uni NHST	5.5	0	6.6	32	2.5
Leeds NHST	8	*	6.7	29	1.8
Mid Yorks NHST	9.8	0.7	6.6	34	1.7
NLincs & Goole	14.2	0.1	6.3	25	1.6
Rotherham NHSFT	18.3	4.5	7.3	32	1.4
Sheffield NHSFT	9.9	0	5.8	37	1.9
York & Scarb NHSFT	14.5	0	5.6	25	1.2

3.0 Coding Update

3.1 For both the HSMR and SHMI, allocation to the diagnosis group and calculation of the Co-Morbidity score relies on diagnoses being coded in the 1st & sometimes 2nd Consultant Episode. Any diagnoses coded in further episodes aren't included.

3.2 Measure are in place at TRFT to try to make sure diagnoses are recorded in these episodes, where appropriate.

3.3 TRFT is using a 3M coding analytics product to support this. This product flags diagnoses relevant to the HSMR and SHMI, which could be considered for including in all episodes. Feedback from the Head of Clinical Coding & Data Quality suggests this is having a positive effect on coding practices. However, we may need to undertake further measures to improve coding performance.

3.4 The Head of Clinical Coding & Data Quality is looking at methods to reduce the number of unnecessary Consultant transfers. Reducing the number of Consultant episodes would assist in more spell diagnoses being considered in the Expected Risk calculation.

3.5 Changes have been made in MediTech in order to clearly highlight when a patient has been seen by the specialist palliative care team. The process which looks for Palliative Care Coding now looks at 19 diagnostic positions, rather than 14. This may result in more palliative care codes being picked up, and included in HSMR expected death risk calculations.

4.0 Medicine's 360 Internal Audit Response

4.1 The Deputy Director of Quality Assurance has confirmed that TRFT's Medical Division have uploaded their required information to the 360 Portal and all evidence required submitted. As such, 360 Internal Audit have closed the open actions and a re-audit is planned for Quarter 4.

5.0 Learning from Deaths

5.1 Medical Examiner (ME) Scrutinies (Stage 1) are no longer being captured on MediTech, due to recent guidance from the National ME. The figures for these are therefore not now included on the Mortality Insights Report and are being supplied manually on a spread sheet. Since MediTech has not been used, the automatic notification of ME recommendations to divisions for SJRs ceased. In order to ensure these recommendations for SJRs are known to the divisions, the ME team are now informing the Business Intelligence team, who then will add to the PowerBI system that creates the Mortality Insights Report, for divisions to pick up.

5.2 Work between the ME office, the Mortality & Learning from Deaths Manager and Health Informatics colleagues is being undertaken to repopulate the Mortality Insights Report, with ME Scrutiny figures.

Month of Discharge	Adult IP Deaths	ME Scrutiny (Recorded on MediTech)	% ME Scrunity	ME SJR Recommendations	SJR Completions (ME Rec)	Outstanding SJRs (ME Rec)	SJR Completions (other)
Jan-21	154	129	83.8%	6	1	5	10
Feb-21	104	88	84.6%	1	0	1	12
Mar-21	95	76	80.0%	6	3	3	7
Apr-21	69	57	82.6%	10	4	6	3
May-21	71	62	87.3%	12	4	8	5
Jun-21	66	44	66.7%	11	6	5	2
Jul-21	71	28	39.4%	8	3	5	5
Aug-21	91	7	7.7%	3	1	2	9
Sep-21	89	7	7.9%	4	3	1	6
Oct-21	83	12	14.5%	5	0	5	6
Nov-21	109	0	0.0%	0	0	0	2

6.0 SJRs Learning In the Divisions

6.1 Deaths are being reviewed and discussed in Divisional Mortality Sub Group meetings. However, they are not in the SJR format and are therefore not feeding into the learning from deaths data collection, and this is impeding our ability to maintain an overview and identify themes. As such, learning from these local reviews can't be aggregated or used in any thematic or trend analysis. This is therefore being picked up with the respective Divisional Directors.

7.0 So What?

7.1 Dr Foster has identified inconsistencies with their HSMR data, and have cast doubt on published HSMR figure for the last few months. Our SHMI data tells us that TRFT is in the 'Higher Than Expected' band.

7.2 The lack of mortality data does not stop the various work streams that aim to reduce mortality and improve our understanding of the Trust's Mortality figures.

7.3 Work on Coding continues, to promote thorough and timely diagnosis and Palliative care recording, and these need to appear in the 1st or 2nd Episodes in the patient's Spell to enable the clinical coders to appropriately code the diagnoses.

7.4 The Learning from Deaths Programme, including the SJR Review process, is being reviewed by the new in post Mortality & Learning from Deaths Manager. It is to the intention to embed the SJR process within the Divisions and establish SJRs as the method for case note reviews of deaths. The Trust's Mortality Policy is also being reviewed to ensure that it aligns with national best practice.

7.5 TRFT needs to have well completed SJRs completed consistently to the required standard, in a format that can be analysed for trends and Thematic Analysis (structured analysis of Free Text) performed.

7.6 The Deputy Director of Quality Assurance is working on a training package for SJR reviewers, which should begin in the 1st half of 2022. This will improve the quality and consistency of SJRs, and the number and range of staff that can complete.

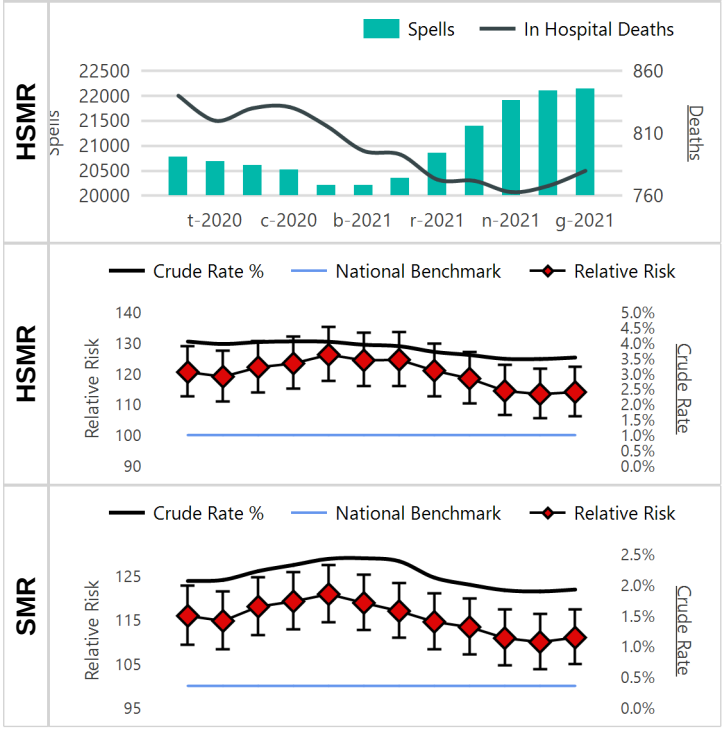
8.0 Conclusion

8.1 A significant amount of work and effort continues to be focussed on improving mortality and the Trust's Learning from Deaths.

8.2 Mortality and the Learning from Deaths will continue to remain one of the Trust's top improvement priorities into next year.

John Taylor
Mortality & Learning from Deaths Manager
December 2021

Rolling 12 month trends



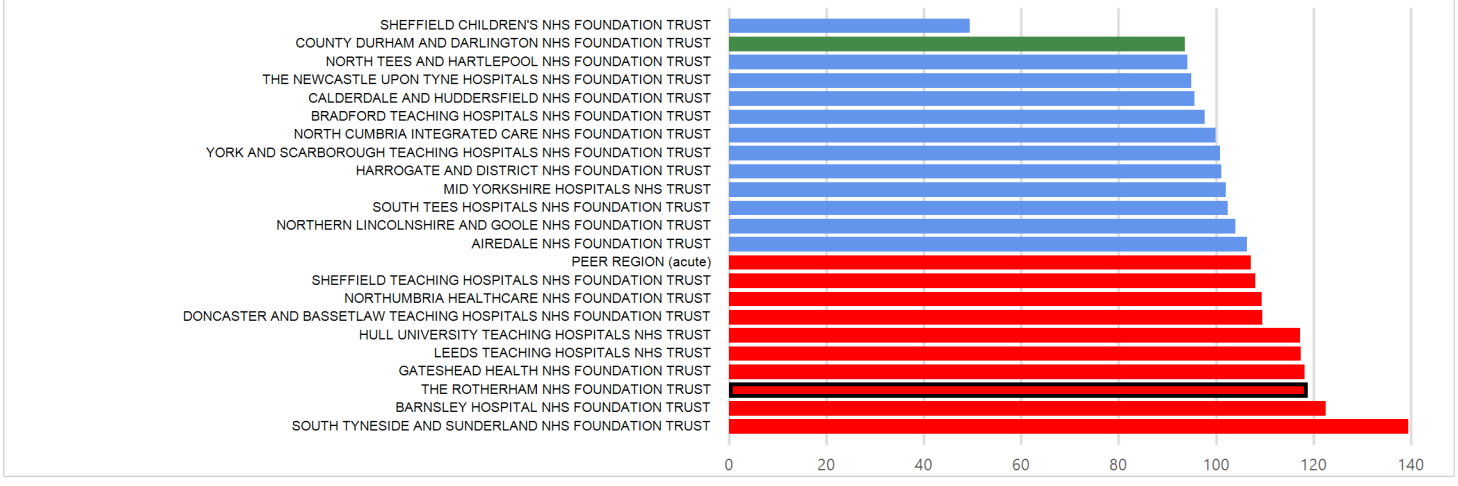
Diagnosis Groups

Relative Risk Alerts (Top 10)	CUSUM	Obs	Exp	RR	LCI	Trend
Acute bronchitis	3	26	9.3	278.1	181.6	
Syncope	0	7	1.9	359.7	144.1	
Other perinatal conditions	1	11	4.3	257.4	128.3	
Liver disease, alcohol-related	1	29	16.4	177.1	118.6	
Other connective tissue disease	1	14	7.1	197.9	108.1	
Nervous system congenital anomalies	1	3	0.6	519.2	104.3	
Poisoning by other medications and drugs	0	3	0.6	510.4	102.6	
Pneumonia	0	163	137.0	119.0	101.4	
CUSUM 99% Threshold (Top 6)	CUSUM	Obs	Exp	RR	LCI	Trend
Acute bronchitis	3	26	9.3	278.1	181.6	
Other perinatal conditions	1	11	4.3	257.4	128.3	
Liver disease, alcohol-related	1	29	16.4	177.1	118.6	
Other connective tissue disease	1	14	7.1	197.9	108.1	
Biliary tract disease	1	13	7.1	182.2	96.9	
Other upper respiratory disease	1	5	1.7	286.1	92.2	
CUSUM 99.9% Threshold (Top 6)	CUSUM	Obs	Exp	RR	LCI	Trend
Acute bronchitis	2	26	9.3	278.1	181.6	
Other connective tissue disease	1	14	7.1	197.9	108.1	
Congestive heart failure, nonhypertensive	1	50	39.9	125.2	92.9	
Patient Safety Indicators		Obs	Exp	RR	LCI	Trend

Mortality Influencers

Performance	Site	Trust	Peer	National
HSMR		114.0	106.7	100.4
SMR		111.0	105.3	100.7
Non-elective (HSMR)		112.5	106.0	100.0
Weekday, emergency (HSMR)		108.6	104.7	98.4
Weekend, emergency (HSMR)		120.9	110.6	104.9
Saturday, emergency (HSMR)		118.4	109.5	104.3
Sunday, emergency (HSMR)		123.4	111.8	105.3
Coding/Casemix	Site	Trust	Peer	National
% Non-elective deaths with palliative care (HSMR)		30.9%	34.3%	38.1%
% Non-elective spells with palliative care (HSMR)		3.6%	4.6%	5.0%
% Spells in Symptoms & Signs chapter		10.9%	5.5%	6.8%
% Non-elective spells with Charlson comorbidity score = 0 (HSMR)		41.6%	39.0%	40.8%
% Non-elective spells with Charlson comorbidity score = 20+ (HSMR)		16.5%	15.9%	15.7%
% Non-elective spells in Risk Band (0-10%) (HSMR)		86.2%	84.3%	84.2%

HSMR Peer Comparison



**** Data suppressed in accordance with HSCIC HES Analysis Guide 2014

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

HSMR
The Hospital Standardised Mortality Ratio is the ratio of observed deaths to expected deaths for a basket of 56 diagnosis groups, which represent approximately 80% of in hospital deaths. It is a subset of all and represents about 35% of admitted patient activity.

CHARLSON COMORBIDITIES
Charlson comorbidities for the spell are derived from the secondary diagnoses codes in the episode of care with the spell-dominant primary diagnosis. Each of these comorbidities has an associated weight according to its relative impact of mortality. These weights are summed to give a comorbidity score for the spell. DIAGNOSIS GROUPS
· Significantly high relative risk- the top 8 when ranked by the lower 95% confidence interval.
· CUSUM alert (less than 1% false alarm rate) but a normal relative risk- the top 6 when ranked by the lower 95% confidence interval

CUSUM
A cumulative sum statistical process control chart plots patients' actual outcomes against their expected outcomes sequentially over time. The chart has upper and lower thresholds and breaching this threshold triggers an alert. If patients repeatedly have negative or unexpected outcomes, the chart will continue to rise until an alert is triggered. The line is then reset to half the starting position and plotting of patients continues. The CQC monitor CUSUM's at a 99.9% threshold to determine outliers.

PALLIATIVE CARE CODING RATE
For each financial year we calculate the proportion of a trust's HSMR superspells excluding day cases which are coded as having palliative care, this is the observed value shown. The expected value is the proportion nationally for the equivalent mix of diagnosis and admission type. The trust's index value is calculated as observed/expected x 100

SYMPTOMS AND SIGNS
Proportion of spells where the primary diagnosis in diagnosis-dominant episode is coded to the symptoms and signs chapter against the total number of spells within the 'all diagnosis' basket.

MORTALITY INFLUENCES – CODING/CASEMIX
% of Non-elective deaths with palliative care (HSMR) – The % of non-elective palliative deaths against the total number of non-elective deaths within the HSMR basket.
% Non-elective spells with palliative care (HSMR) – The % non-elective palliative spells against the total number of non-elective spells within the HSMR basket.
% Spells in Symptoms and Signs chapter (all diagnoses) – The % of spells coded to the Symptoms and Signs chapter against the total numbe of spells within the 'All Diagnosis' basket.
% Non-elective spells with Charlson comorbidity score = 0 (HSMR) – The % of spells coded with a Charlson comorbidity score = 0 within the HSMR basket.
% Non-elective spells with Charlson comorbidity score = 20+ (HSMR) – The % of spells with a Charlson cormorbidity score of 20 and above within the HSMR basket.
% Non-elective spells in Risk Band (0-10%) – The % of spells with a risk band between 0 and 10%.

Board of Directors' Meeting
07 January 2022

The Rotherham NHS Foundation Trust

Agenda item	P21/22
Report	**Health Inequalities Task and Finish Group**
Executive Lead	Mr Michael Wright, Deputy Chief Executive
Link with the BAF	B1,B2,B3
How does this paper support Trust Values	Ambitious: Taking steps to address the inequalities in outcomes in care is an ambitious goal. Caring: This work will ensure that we are providing services that deliver optimum and equitable health outcomes for our patients. Together: Colleagues at the Trust work together with the aim of developing actions to address health inequalities.
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary	The NHS in England is committed to addressing health inequalities and has identified priority actions that build on the measures to implement the NHS Long Term Plan. This has been re-confirmed with the recent publication of the Operational Planning Guidance for 2022/23. Health Inequalities is a core priority for the Trust, especially given our demographics as a place, and as such, a Task & Finish group, chaired by Jo Bibby, one of our Non-Executive Directors, has been established to drive this work forward. This paper updates the Board of Directors on the recent actions taken to develop the Health Inequalities Task & Finish Group, with a brief summary of progress so far and a series of next steps identified.
Due Diligence	This paper reports directly to the Board of Directors.
Board powers to make this decision	No decision is required.
Who, What and When	No action is required
Recommendations	It is recommended that the Board note the contents of the report.
Appendices	None

1.0 Background

1.1 Health is influenced by a broad range of factors. Wider determinants of health include socioeconomic factors, environmental conditions and the social and community networks we have access to. The Marmot review, published in 2010, raised the profile of wider determinants of health by emphasising the strong and persistent link between social inequalities and disparities in health outcomes. However, health inequalities are not inevitable, they are preventable. They are socially determined by circumstances largely beyond an individual's control (such as global economic forces, political priorities and decisions, distribution of power and income). Evidence indicates that these wider determinants have a greater influence on health than the healthcare we receive.

1.2 The NHS in England is committed to addressing health inequalities and has identified priority actions that build on the measures to implement the NHS Long Term Plan. In addition, the NHS 2022/23 operational planning guidance outlines requirements of providers and systems to address inequalities, and along with the publication of the Core20plus5 approach, there is now a wealth of pragmatic support and relevant tools to support this work. People in Rotherham experience poorer health and wellbeing than people in many parts of the country, so the need for action is significant in our place. Below are a few core facts which demonstrate some of these challenges for our place:

- 3 in 4 adults in Rotherham are classified as overweight or obese, compared to 3 in 5 in England
- Rotherham workers earn 15% less than all workers in Great Britain per hour on average
- Gross Disposable Household Income is 22% lower in Rotherham than the England average
- Rotherham is amongst the 14% most deprived local authority areas in England
- More than 11% of the working age population were either unemployed or long-term sick in 2019/20 (compared to 8% for England)

1.3 These inequalities in health are long-lasting, persistent, and driven by social, economic and environmental inequalities. Addressing the unjust differences in health between our communities has always been important, however, as the disproportionate impact of the COVID-19 pandemic, and its roots in the social and economic structure of our society becomes increasingly clear, The Rotherham NHS Foundation Trust (TRFT) and Rotherham place partners must respond.

1.4 Even though the drivers of inequalities are rooted in the social, economic and environmental determinants, equity also needs to be addressed within the health and care system. There are inequitable differences in access, provision, and quality of health care that we can influence. Some of the most marginalised people in our communities have poorer access to health services, and a poorer experience of services, even though they may have more complex needs and require more care. Accordingly, without addressing inequitable access and quality, health care services could widen inequalities rather than help to reduce them.

1.5 For individual patients, it is important that all staff at TRFT understand health inequalities and the huge potential for unmet need within the health and care system. This understanding should influence investigation and management of clinical presentations to ensure need is met. For example, people from more deprived areas are not only more likely to get cancer, they’re more likely to be diagnosed at a late stage for certain cancer types, and face barriers when accessing cancer or screening

services. Consideration of a patient's social history and the inequalities they face has the potential to maximise individual health outcomes.

1.6 The Health Inequalities Task and Finish Group ("the Group") was established as a task and finish group of the Board of Directors (the Board) of TRFT to identify and prioritise key actions in order to reduce inequalities in outcomes from care at TRFT.

The key themes that the group has considered includes:

- *Access.* Improving fair and equitable access to our services and specifically to reflect the impact of the COVID-19 pandemic
- *Person-centred care*. Providing care that is adapted to the circumstances that people are living in and enables them to follow through on the care plans we offer;
- *Prevention.* Building in more preventive activities early on through multiple pathways and seeing care contacts as the Trust's opportunity to promote prevention messages and act on need.
- *Service Users.* Recognising that health inequalities exist within our service users, consider how the Trust can promote better health and wellbeing among the service users, including the benefits to their families and wider community.;
- *Partnership and collaboration*. Ensuring the Trust is actively contributing to and cooperating with the inequalities reduction work of our partners; and
- *Anchor Institution.* In the Trust's role as an 'Anchor' institution, understanding where the opportunities are for the Trust to influence other partners and decision makers to improve the circumstances for healthy and good lives for people in Rotherham;
- *Staff.* Working with our colleagues to encourage more role modelling of positive health behaviours, and supporting our staff to access the support they need to do this.

2.0 Task and Finish Group – initial meetings

2.1 The initial meetings have explored the various initiatives that the Trust is currently working on and the current data available to assist with the identification of health inequalities where TRFT can take action to reduce inequality.

2.2 In the inaugural meeting, the Health Informatics team presented their initial findings from some high-level data analysis around our waiting list profile. This profile demonstrates an evolving level of analysis and understanding around our patients waiting for inpatient care, which requires further work and comparison to the overall population in order to accurately assess the areas with potential inequality. A 'deep dive' review of the data has been diarised for the end of January with key Executive Team members, in order to critically review the latest information available to us. In particular, this will seek to unpick apparent differences in access at specialty level. Further data gathering is planned regarding elective care to understand where any variation in access might be occurring, by analysing Did Not Attend (DNA) rates, as well as cancellation levels where possible.

2.3 From an emergency attendances perspective, it is worth noting that those deemed to be within the 'most deprived' decile according to the Indices of Multiple Deprivation account for a greater percentage of those accessing TRFT non-elective services. It is evident that of the patients accessing care via a non-elective route, just over a fifth (22.4%, 3007) were deemed to be from the most deprived area, according to their IMD Decile. This needs to be balanced with additional insights into the wider needs of the local population and the volume per IMD category within our community. The data demonstrated that pneumonia, congestive heart failure and chronic obstructive pulmonary disease are conditions which drive the requirement for non-elective care and

are worthy of further exploration around the pathways and services on offer to our patients managing these conditions.

2.4 Behavioural information with regards to smoking and alcohol usage is included within the data reviewed, although a cautious approach to drawing meaningful conclusions from this data was required since there is a high proportion of patients whereby this information has not been identified. This may relate to the way in which the data is being sourced. This is being picked up as an action as part of The Group's work.

2.5 The Director of Public Health for Rotherham shared a paper covering the work delivered within the East Midlands region. The report provided practical support to provider and commissioning organisations to support the required shift towards prevention focused health and care system.

2.6 More recently, the Trust's Engagement and Inclusion Lead presented the work in progress in support of reducing health inequalities across the following areas:

- Urgent and Emergency Care
- Orthopaedics
- 0-19 Health Visitors
- Tuberculosis Team
- Integrated Sexual Health Service
- Electronic Health Record
- Help with Travel Costs
- Endoscopy
- Oncology
- Trust Website development

3.0 Actions to take forward

3.1 The Group are clear that health inequalities are caused by complex interactions between many different factors, and therefore will not be solved by a single organisation's action plan. It is therefore particularly important that our work is connected to the ongoing efforts at Place, and that we seek to work with partners to influence this critical agenda. However, it is important that we start somewhere with the factors we can influence internally.

3.2 There are a number of national resources which have been published by NHSE/I recently, which will support The Group in this work, and ensure the focus can be on delivery rather than starting from scratch and designing a unique approach. The Yorkshire and Humber Academic Health Science Network (AHSN) is currently producing a set of evidence-based, high-impact actions around health inequalities based on research with health and care systems across the country, focussed on five clinical areas: cancer, cardiovascular disease, respiratory, mental health and maternity. There are numerous other resources available to support local engagement and buy-in to this work, and ensure that we develop the grassroots movement amongst staff to embed a focus on health inequalities within our everyday work.

3.3 We have developed an initial high-level action plan to describe the priority actions that will be further developed and shaped by some of our analytical work over the next few weeks. Workstream leads have been identified against each of the core themes, and the plan currently has owners with dates for completion to be assigned in January. It draws on the thematic areas outlined above, and ensures that we will use a

methodological approach to drive our areas of focus, by understanding our baseline position, identifying the gaps in service delivery or access, establishing solutions to these issues and agreeing success criteria to measure delivery against. In order to ensure this work has the desired impact, identifying measurable goals and adopting a continuous improvement approach will be critical.

3.4 The goal of the task and finish group is to identify a set of priority actions to be taken forward and monitored through the core processes within the Trust. In addition, it will make recommendations on steps to ensure staff awareness and engagement and mechanisms needed to embed the consideration of impact on inequalities into routine decision making. Once the work of the Task and Finish group has been embedded into business as usual processes, The Group will still convene on a regular basis (with a commitment to do so at least annually) to review the progress being made and assess whether any further input is needed to ensure continued delivery.

3.5 The Group is conscious of much of the excellent work already underway in the Trust, which we need to build on and incorporate into our work. For example, the Trust is one of four trusts nationally to have recently been awarded funding from NHS England to develop an alcohol and mental health outreach team for those people who need it most across Rotherham. The new Community Outreach and Support Team (COAST) is expected to be formed in January and will be led by the Trust's Lead Alcohol Transformation Nurse. The new programme is aimed at those in the community who need some extra support. This follows on from the hugely successful work of the Alcohol Care Team to date, which has been recognised regionally as a model of best practice.

3.6 In addition, the QUIT programme is now fully implemented within the Trust, with a new Healthy Hospitals Programme Manager due to begin in post in late January. Referrals to the service continue to increase, and the team are working with Children's Services, Outpatients, and UECC to roll-out QUIT within these areas as phase 2 of the programme. In particular this will ensure that the service is offered to patients who are attending the hospital for outpatient appointments but not being admitted for care, which will significantly increase the potential impact that the service can have. In addition, the Trust has agreed to fund smoking cessation treatment for TRFT staff and the Pharmacy team have identified an area to run a 'pop-in' clinic in, which will also support our wider health and wellbeing programme for colleagues.

3.7 As well as a series of medium-term actions within the action plan, there are a number of 'quick wins' which The Group plan to implement, to ensure momentum and speed of delivery.

4.0 Capacity

4.1 The Director of Strategy, Planning and Performance was asked to take on the project leadership role initial, under the Deputy Chief Executive's leadership. In addition, a Project Manager has been identified to support the programme of work.

4.2 Following the first three Task & Finish Groups, it was agreed that the Deputy Chief Executive will chair a monthly operational group with all the workstream leads, in order to ensure that our collective actions are joined up and that we have the opportunity to learn from each other's progress. The workstream leads include colleagues representing Health Informatics, Access and Inclusion, PMO, Human Resources and Communications. This will also support speed of delivery, and ensure appropriate Executive Team focus is given to this priority programme of work.

4.3 Given current demands on internal colleagues' time, the Director of Health Informatics has commissioned a package of work to be delivered by an external organisation to support the analytical exploration of the data reviewed so far, and to develop data-driven products that will support this work in the long-term. This will be funded by some of the Global Digital Exemplar funding which The Rotherham NHS Foundation Trust was successful in gaining. It will ensure we develop the insight needed to reduce and ultimately eradicate the health inequalities in existence in Rotherham place, and support Primary Care Networks, Trust teams and Public Health practitioners to gain greater insight into the population. The work has been planned as a fast-paced exercise which should be complete by the end of Q4, at which point we will have a suite of tools to utilise to support decision-making and prioritisation of actions relating to health inequalities. The intention is that this work will make the case for the agreed plan to recruit a small team of people to form the Rotherham Office of Data Analytics in the longer-term, which will give the place a more permanent analytical resource available to support this programme.

5.0 Next steps

5.1 The Task and Finish Group has been operational since September, but work will ramp up in Q4 now we have a Project Manager in place and a clear action plan to work to. An immediate next step is to establish the monthly operational delivery group and to focus on the four to five quick wins in the short term. These will provide the necessary momentum to the Group, as well as the wider organisation. Enhancements to services which are already underway will be supported through The Group (for example the expansion of the QUIT programme to non-inpatient services, and the implementation of the new Community Outreach and Support Team), and new developments to services will be driven forward through the Group's leadership.

5.2 Similarly, the 'deep dive' of our data at the end of January will give us a platform to re-confirm our areas of focus, and ensure that the action plan we have set will deliver the greatest impact for our population. The Group will continue to engage through existing staff groups and communication forums to ensure this work is understood and supported by Trust staff, giving all colleagues an opportunity to come forward with ideas for how they can develop their services to better address health inequalities through a direct online communication platform.

5.3 Finally, the Deputy Chief Executive will continue to play a lead role in the relevant discussions at Place, in order to ensure our plans are aligned to and complement the work of our partners.

Michael Wright
Deputy Chief Executive
January 2022

Board of Directors' Meeting
07 January 2022

The Rotherham NHS Foundation Trust

Agenda item	P22/22
Report	**National CQC Patient Experience Surveys Undertaken in 2020 and reported in 2021**
Executive Lead	Helen Dobson, Chief Nurse
Link with the BAF	B1 Standards and quality of care do not deliver the required patient safety, clinical effectiveness and patient experience that meets regulatory standards B3 Should the Trust fail to actively engage with, or listen to the experience of service users, there is a risk that the organisation will not learn or improve the quality of care (experience, quality and outcomes) for those who use our services
How does this paper support Trust Values	Caring – we embrace the importance of giving the highest possible quality of care for our patients
Purpose	**For decision** ☐ **For assurance** ☐ **For information** ☒
Executive Summary (including reason for the report, background, key issues and risks)	During 2020, the Trust participated in 3 of the 4 national CQC Patient Experience Surveys for acute Trusts. These surveys were specifically measuring experiences within Urgent and Emergency Care, the Inpatient pathway and Children and Young People's Services. Each of these surveys produced results that were worse than expected. This report highlights the broad outcomes of the respective surveys, the Trust's position nationally when benchmarked with other acute service providers and the action planning and monitoring process that has been undertaken. Each action plan has been compiled, to address the areas of concern found and to strengthen the Trust's performance for all future patients. It should be noted, that the time frames for each of the surveys are detailed in figure 1. This does mean that final survey outcome results for the annual Inpatient Survey, were only published shortly before the subsequent annual survey was due to take place. Therefore, the Inpatients of November 2021 are already being surveyed on their experience, whilst the work to address the 2020 results will necessarily be ongoing. This report is to inform the Board of the respective CQC survey findings and the actions that are underway and led by the relevant clinical Divisions. The Trust is striving to offer the assurance of a demonstrable improvement over the next year. Patient feedback is a significant indicator of the effectiveness of care and therefore a full and committed focus on addressing these findings, has the potential to improve patient and public confidence in the Trust's service provision.

Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	This paper in an alternative format, has been delivered to the Trust's Quality Committee in November 2021. The highlights of the respective surveys have been delivered to the Clinical Governance Committee, as each has been published. This content has also been an integral part of the monthly reporting process for the Trust's Patient Experience Group (PEG). The PEG has received detailed presentations on every set of results as soon as they became available and is now monitoring quarterly, the action plan delivery and conclusions.
Board powers to make this decision	No decision required
Who, What and When (what action is required, who is the lead and when should it be completed?)	The Divisional leadership teams for UECC, Integrated Medicine, Surgery including specialities, and the Children and Young People's Services each have their own action plans and these are monitored by their respective Governance Committees. The Patient Experience Group offers support to the Divisional teams and undertakes quarterly monitoring and progress chasing, to ensure that work time frames are delivered as expected. The Board Lead for Patient Experience is the Interim Chief Nurse. The overall expected timescale to deliver all of the survey responses and complete the planned actions, is to be achieved by July 2022.
Recommendations	It is recommended that: the Board considers the information provided and the process that is underway to deliver the needed service delivery changes that the CQC Patient Experience Surveys have highlighted
Appendices	None

1.0 Introduction

1.1 During 2020, the Trust participated in 3 of the 4 national CQC Patient Experience Surveys for acute Trusts. These surveys were specifically measuring experiences within Urgent and Emergency Care, the Inpatient pathway and Children and Young People's Services. Each of these surveys produced results that were worse than expected.

1.2 The Inpatient and Maternity surveys are usually conducted annually and the UECC, Children and Young People's Surveys are biennial. Some of these dates have been altered due to the pandemic and a revised timetable was published. It is expected that the surveys will continue on this revised trajectory throughout 2022/23, and the potential cohorts for current and future surveys appear in the table below.

CQC National Survey Timetable for 2020 - 2022

Survey	Date the patient uses the service	Date of data collection	Date of privileged draft report for Trusts	Date of validated CQC report publication	Sample date for next patient cohort
Urgent and Emergency Care (Biennial)	September 2020	October 2020 to March 2021	End April 2021	September 2021	September 2022
Adult Inpatients (Annual)	November 2020	January to May 2021	End June 2021	October 2021	November 2021 **NB** next cohort of Inpatients already being surveyed
Children and Young People (Biennial)	December 2020 – Feb 2021 (extended due to lower activity levels)	February to May 2021	August 2021	November 2021	December 2022
Maternity Care (Annual)	Late Jan & Feb 2021 to obtain cohort size	April to August 2021	September 2021	**January 2022**	February 2022

(Figure1)

2.0 National Findings from the CQC Urgent and Emergency Care Survey 2020

2.1 This national biennial survey looked at the experiences of people using the Trust's UECC service. Nationally, the 2020 urgent and emergency care survey received feedback from 41,206 people who attended a type 1 service in September 2020. Despite the pandemic, most people surveyed in 2020, continued to be positive about many important aspects of their urgent and emergency care, with patients reporting being treated with respect and dignity, having confidence and trust in the staff and rating their overall experience positively.

2.2 Survey findings were less positive for pain management, emotional support, the availability of staff when needing attention and the reported lack of information provided during the discharge process.

3.0 Local Results from the Rotherham CQC Urgent and Emergency Care Survey

3.1 From a possible cohort of 1250, 435 patients participated which was a notable increase from the Trust's last survey undertaken in 2018. Therefore 35% of the Trust's invited UECC patients participated, compared to poorer uptake amongst other Trusts. Nationally responses were received from 41,206 people who attended a Type 1 department in England (a UECC), giving a response rate of 30.5% overall. The majority of TRFT respondent patients attended the UECC service between 06.00 – 18.00hrs.

3.2 The question bank used in 2020 held 44 questions and this differed to the prior 2018 survey questions, therefore some direct comparisons to the Trust's past performance are not possible or valid. This is most noticeable in three sections: *Patients' Experiences of Waiting Times* (due the changes in the UECC targets since the last survey); in the *Hospital Environment and Facilities* questions, where the infection control measures in place to manage Covid-19 have been added. There are new *Information* provision questions; on transport home and patient care and support provision after leaving the UECC.

3.3 The Trust received scores, which were in line with other similar Trusts across 31 areas. The Trust did not perform 'better' than other Trusts in any areas.

This Trust was an *outlier* with several areas scoring worse than peer's performance in:

- Waiting times after arrival
- Waiting too long to be seen by a clinical member of staff
- Waiting too long to be examined
- Getting help from staff whilst waiting to be assessed
- Discussing anxieties and fears with clinical staff
- Receiving information on own condition
- Getting help when needed during time in UECC
- Having pain needs met
- Being treated with respect and dignity
- Assisted with transport needs on discharge
- Patent feeling that they had a good overall experience

3.4 The Division of UECC has worked with the Deputy Director of Quality Assurance to identify the required actions to address each of these areas and to plan the expected achievement of measurable progress by summer 2022. The action planning undertaken, was done as part of wider service improvement work across the department. This has included addressing issues also raised from the recent CQC assessment visit. In this way the leadership and clinical teams have one plan to focus upon, with congruent goals to support collective team endeavor and achievement.

4.0 National Findings from the CQC National Adult Inpatient Survey 2020

4.1 Due to the pandemic, this annual survey was offered 4 months later than planned to Trust patients who had stayed one night or more in hospital. There were also changes to the questions, reflecting the mid-pandemic different case mix and the notable reductions in elective work in November of last year.

4.2 All acute Trusts are required to participate, which resulted in 137 eligible English NHS Trusts, receiving 73,015 patient responses overall and nationally, this was a response rate of 46%. This Trust secured a 43% response rate, up from 42% the previous year. The survey both locally and nationally saw increased responses in younger age groups, possibly linked to the mixed survey methods offered, including a digital option to encourage participation. However 81% of respondents were over 50 years, with 52% over 66. Notably 81% of Trust patients also reported a long-term health condition, which may suggest that they have had multiple experiences of Trust care in the past. An increased response was received for Asian ethnic groups, in comparison to the Trust's previous inpatient surveys. There were no other remarkable demographic details reported.

4.3 On a national level, patient experiences of Inpatient care, were noted to be more positive than the 2019 survey and overall experience differences between patients with Covid-19 and non-Covid-19 were small, suggesting that care provision was consistent. Most people said they were treated with respect and dignity, had confidence and trust in the doctors and nurses that treated them and observed high levels of cleanliness.

4.4 Nationally the Inpatient findings were less positive for aspects of care related to support, including meeting emotional needs, clear information provision and effective planning for hospital discharge.

4.5 Eight trusts were categorised as 'worse than expected', and two as 'much worse than expected', resulting in a total of 10 English Trusts in the lowest bands. Trusts identified as achieving 'worse than expected' results i.e. in the group of eight, included The Rotherham NHS Foundation Trust.

5.0 Local Results for the Adult Inpatient Survey

5.1 The Trust received no scores that were 'better' than peer Trusts. 24 scores were in the 'same' performance band as other Trusts.

5.2 There were 2 scores that were much worse than other Trusts.

- Patient perceptions of having enough nursing staff on duty
- Being able to get help from staff when needed

5.3 There were 10 scores which were worse than 'most Trusts'.

- Prevented from sleeping by noise at night
- Being able to take own medications
- Getting understandable answers from doctors when asking questions
- Confidence and trust in doctors treating them
- Doctors including the patient in conversations about their care
- Receiving conflicting advice (from any staff)
- Being involved in treatment decisions
- Taking patient's home situation in to account when planning discharge
- Getting information on take home medications
- Rating overall hospital experience highly out of a possible score of 10

5.4 There were 9 scores for this Trust, which were somewhat worse than 'most Trusts'.

- The time waiting for a ward bed
- An explanation of any ward moves

- Cleanliness of room or ward
- Able to talk to staff about worries and fears
- Privacy to discuss condition with staff
- Staff did everything could to control pain
- Having enough notice about leaving hospital
- Written information about self-care after discharge
- Knowing what happens next after discharge

6.0 National Findings from the Children and Young People's Survey 2020

6.1 The eligibility period for the Children and Young People's Survey was extended by 2 months, to attract a larger cohort of potential participants due to altered case mix and reduced admissions at the end of 2020.

6.2 Questions were also reviewed to ensure their relevance in the current health climate and 2 questions were added: Were you able to be with your child as much as you needed to be? *and* When you spoke to hospital staff, did they listen to what you had to say?

6.3 Five further questions were not comparable to the prior survey in 2018, so results are given as a fresh position for the Trust. These questions are on staff knowledge of child's needs, explanations of procedures, having understandable answers to questions, the use of distraction and play to assist with a procedure, and an explanation on the outcome of a procedure.

7.0 Local Results of the Trust's Children and Young People's Survey

7.1 124 Rotherham patients or their carers responded to this survey.
The response rate for the Trust was 21.79% which is a low response rate

7.2 This Trust's results were better or much better than most Trusts for 0 questions.

7.3 This Trust's results were somewhat better than most Trusts for 2 questions.

- Were the people looking after your child friendly
- Was your child well looked after by hospital staff

7.4 This Trust's results were about the same as other Trusts for 54 questions.

7.5 This Trust's results were much worse than most Trusts for 0 questions.

7.6 This Trust's results were worse than most Trusts for 4 questions.

- Could understand what staff said
- Staff involved parents in decisions
- Older children reported pain needs not met
- Staff explained how procedure had gone

7.7 This Trust's results were somewhat worse than most Trusts for 2 questions.

- Staff gave confliction advice
- Had enough information to make decisions for own child

7.8 Of note is that the Trust was an outlier for 6 questions, within the section on the experiences of ages children and young people aged 8 -15, resulting in the Trust being named as an adverse outlier by the Care Quality Commission.

8.0 Responses to Survey Findings

8.1 The Patient Experience Group (PEG) has reviewed each set of results in detail, as soon as the reports became available. The PEG committee reported the key findings though the Clinical Governance Committee and more detailed reporting has been provided for the Quality Committee.

8.2 Following several forums and discussions led by the former Chief Nurse and Deputies, Divisional teams have identified their priorities and determined their local action planning. These action plans are monitored through Divisional Governance processes.

8.3 Each survey action plan is subject to a quarterly monitoring review at PEG; with guidance, support and encouragement offered to the Divisional survey leads and clinical teams to enable them to progress their work to the expected conclusion.

8.4 Progress is reported within the Patient Experience Report to Clinical Governance Committee and Quality Committee, including oversight of detailed action plans.

9.0 Conclusion

9.1 Although the results of these surveys are worse than expected, it should be noted that these surveys were completed on patients receiving care between September 2020 and February 2021. This represented a period of significant challenge within our region linked to the pandemic. It should also be acknowledged that a significant amount of work has been undertaken in the year since the time of these surveys to improve quality and patient experience.

9.2 The quarterly monitoring process is being used to ensure that actions are completed within agreed timescales and that identified improvements become embedded. Other methods of receiving feedback from service users continue to be collated and triangulated against national survey findings through the Patient Experience Group.

Board of Directors' Meeting
07 January 2022

The Rotherham NHS Foundation Trust

Agenda item	P23/21
Report	**Health and Safety Annual Management Report 2020/21**
Executive Lead	George Briggs, Chief Operating Officer
Link with the BAF	B1 - Standards
How does this paper support Trust Values	This paper supports the Trust's ambition to continually improve the safe environment for our employees, patients and visitors.
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	The annual report updates the Board of Directors of the Rotherham NHS Foundation Trust (TRFT) on Health & Safety (H&S) performance across the Trust sites. The report ensures that the Board is informed of its H&S performance in order that it can be assured that it continues to comply with corporate policy/standards, legal and best practice requirements. The report identifies both proactive and reactive measures that must be monitored and reviewed to ensure that effective health and safety management is maintained across the Trust. The report has been prepared using data from the Datix reporting system covering all areas of health and safety reporting. The annual health and safety report forms part of the corporate assurance process for the Board of Directors. In addition, the report also fulfils the following requirements: • Complies with the Health and Safety Executive (HSE) requirements for Boards to receive an annual health and safety report. • Provides evidence for the CQC assessment process. Health, Safety, Fire, Security, Sharps, Ionising Radiation, Ergonomics and carriage of dangerous goods are all non-clinical topics that are covered in this report, as these are areas that fit into the remit of the Health and Safety Committee. This report details what the past year (April 2020 to March 2021) has brought with regard to non-clinical risks and incidents.

Due Diligence (include the process the paper has gone through prior to presentation to the meeting)	This report has been developed with the support of topic experts across the Trust and is in the process of being approved by the Health and Safety Committee. The report has been considered by the Quality Committee (24/11/2021).
Powers to make this decision	N/A
Who, What and When (what action is required, who is the lead and when should it be completed?)	This report is provided for assurance.
Recommendations	It is recommended that the Board of Directors note the progress made during 2020-2021.
Appendices	Annual Health and Safety Report 2020- 21

Annual Health and Safety Management Report 2020/21

Joint report covering Fire Risk Management, Sharps Safety, Moving and Handling, Estates and Facilities, Ionising Radiation and Security

Report compiled by:

Mark Jackson	Head of Health and Safety and Compliance (Estates)
Graham Royle	Health and Safety Advisor

Supporting information provided by:

Lisa Hickling	Professional Lead/Senior PRS Medical Imaging
Duncan White	Consultant Physicist Clinical Radiology, Medical Physics and Medical Photography/Illustration
Ann Kerrane	Assistant Director for Infection Prevention and Control
Darren Mitchell	Fire Safety Advisor
Anthony Bennett	Trust Security Manager Security Manager
June Cadman	Waste Management & Environmental Services Officer
Lesley Westwood	Moving and Handling Lead

Contents

Figures

1. INTRODUCTION

This annual report updates the Board of Directors of the Rotherham NHS Foundation Trust (TRFT) on Health & Safety (H&S) performance across the Trust sites. The report ensures that the Board is informed of its H&S performance in order that it can be assured that it continues to comply with corporate policy/standards, legal and best practice requirements.

The report identifies both proactive and reactive measures that must be monitored and reviewed to ensure that effective health and safety management is maintained across the Trust.

As in previous reports, it has been prepared using data from the Datix reporting system covering all areas of health and safety reporting. The annual health and safety report forms part of the corporate assurance process for the Board of Directors.

In addition, the report also fulfils the following requirements:

- Complies with the Health and Safety Executive (HSE) requirements for Boards to receive an annual health and safety report.
- Provides evidence for the CQC assessment process.

Health, Safety, Fire, Security, Sharps, Ionising Radiation, Ergonomics and carriage of dangerous goods are all non-clinical topics that are covered in this report, as these are areas that fit into the remit of the Health and Safety Committee. This report details what the past year (April 2020 to March 2021) has brought with regard to non-clinical risks and incidents.

1.1 2021 RoSPA Occupational Health & Safety Awards

The Trust has been awarded an eighth consecutive RoSPA Gold Award for Occupational Health and Safety by the external Awards Adjudication Panel, this is the top tier of the achievement category award system. It is a tremendous achievement that the Trust has gained this award for the eighth-year running and demonstrates the organisation has continued commitment to managing health and safety.

1.2 Executive Summary

No enforcement action for health and safety non-compliance has been brought against the Trust within the period of this report; there has been no health and safety related fatalities during this reporting period.

Incidents requiring reporting under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) have remained low with three reports made to the Health and Safety Executive; this is a decrease of seven reports made compared to the same period last year.

The implementation of the third year of the 2018–21 Health and Safety Strategy has taken place. Responses from internal departmental self-questionnaires show no identified trends and indicate generally good management process for health and safety risks.

Management arrangements for radiation safety within the Trust have not changed significantly since the last inspection. Local Rules are in place for all areas.

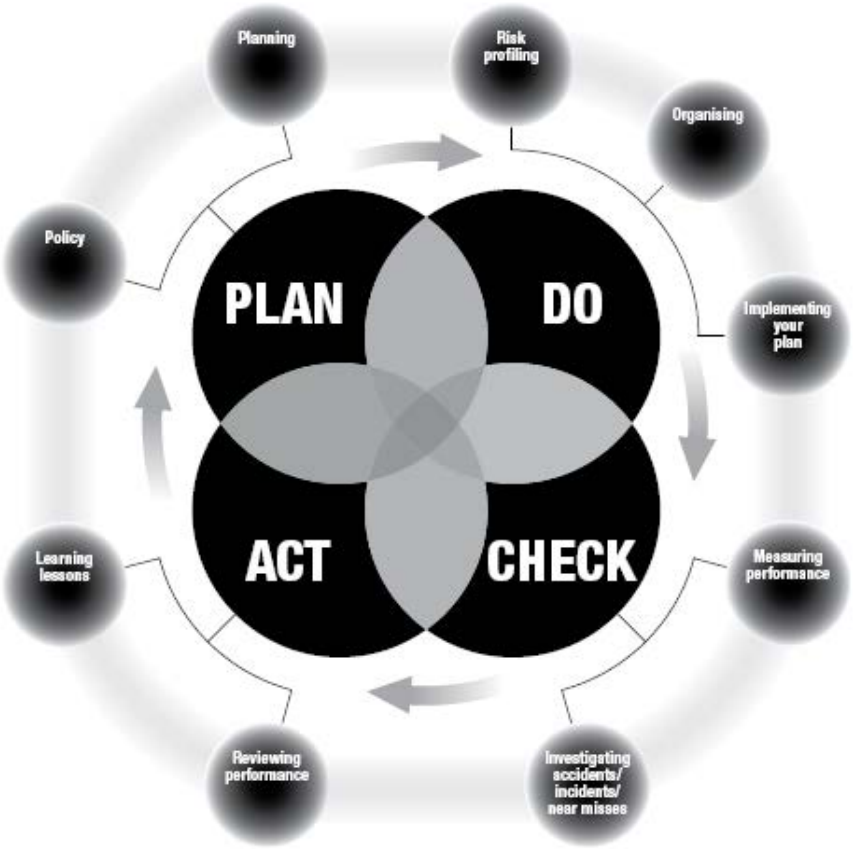
Mandatory training attendances for fire has decreased this period; this decrease is due to the temporary suspension of face-to-face training during the Covid-19 pandemic.

Conflict resolution training is slightly lower than the previous year's figure of 93.16%, which again is due to the temporary suspension of face-to-face training during the Covid-19 pandemic. The Trust still remains above the national average of staff trained which is currently at 91.23% compliance.

There has been one fire within the main hospital site for the reporting period, and none in the community, this is one less amount than the last reporting period. The fire was in the staff accommodation (Swale Court) where a fire occurred in an electric shower unit. The fire was extinguished promptly, with the staff at all adjacent locations carrying out the fire procedures as required. The number of unwanted calls during the year was 44, a decrease of 13 for the same period last year.

2. HEALTH AND SAFETY MANAGEMENT FRAMEWORK

The health and safety management framework, which the Trust operates, reflects the HSE guidance managing for Health and Safety (HSG65). The principles of this guidance are shown below and the framework for this report reflects this approach to the management of health and safety.



2.1 Trust Health and Safety Committee

The Trust Health & Safety Committee physically met on three occasions within the reporting year, this is less than normal so additional virtual meetings were set up for policy agreements and sharing of information. The committee considers reports from staff safety representatives, issues from across the Trust and matters of co-operation and co-ordination between the Trust and other stakeholders.

Risk assessments and incident trends are standing agenda items as well as issues of concern such as musculoskeletal disorders, needle stick injury rates, slips, trip and falls and violence against staff.

The Head of Health and Safety and Compliance (Estates), as the Lead for health and safety in the Trust, chaired the meetings, the meetings were attended by senior managers, and staffside representatives.

3. INTERNAL H&S AUDIT REPORT

3.1 Self-Assessment Questionnaires

It was identified in the Trust approved 2018-21 health and safety strategy that 15 self-assessments would be circulated during this period. All 15 departments/wards have returned their completed questionnaire, which is a 100% return rate. Scrutiny of the returns reveals that there are no significant areas of concern and no trends identified.

3.2 Inspections/Audits

There have been 15 health and safety inspections at satellite premises where services are provided by the Trust, and/or staff are based, actions have been carried out in order to rectify minor shortfalls.

3.3 Incident Audits

Health and Safety incidents reported via Datix are reviewed to ensure that the information including incident grades are consistent throughout the organisation and that all incidents are reported in the agreed Trust format.

4. INCIDENT REPORTING

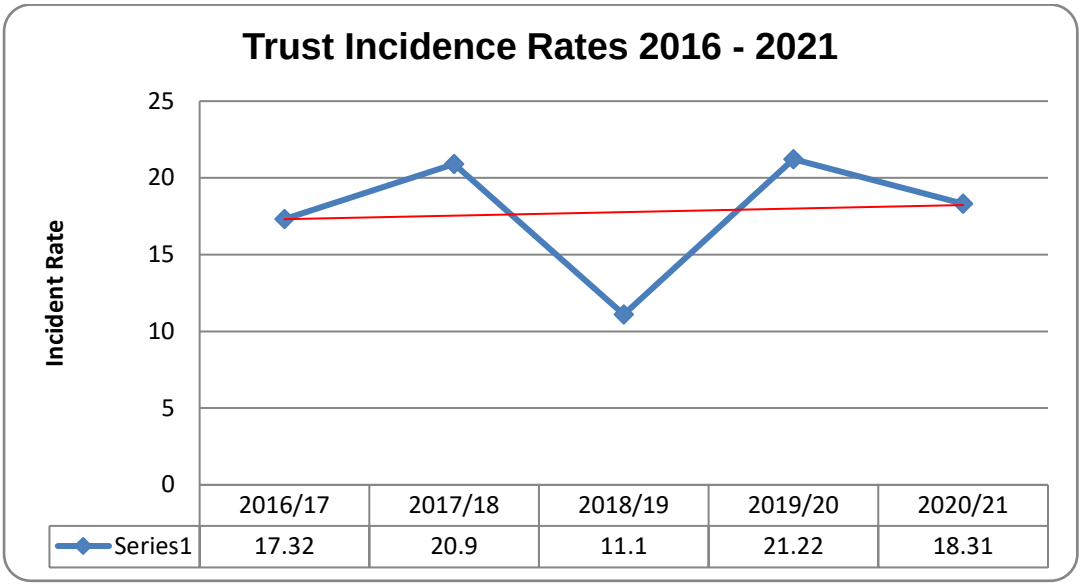
4.1 Incidence Rate

The Incidence Rate for employees has been calculated by using the total number of reported incidents in the period divided by the number of employees multiplied by 100. There have been 869 employee H&S related incidents reported for the 2020/21 period. Substantive workforce figure for 2020/21 financial year is 4744 staff in both clinical and non-clinical roles.

Based on the data collated in this report, the Trust's H&S incidence rate for 2020/21 is therefore 18.31 compared to 21.22 in 2019/20, 11.1 in 2018/19 and 20.9 in 2017/18.

The trend can be seen in Figure 1 below.

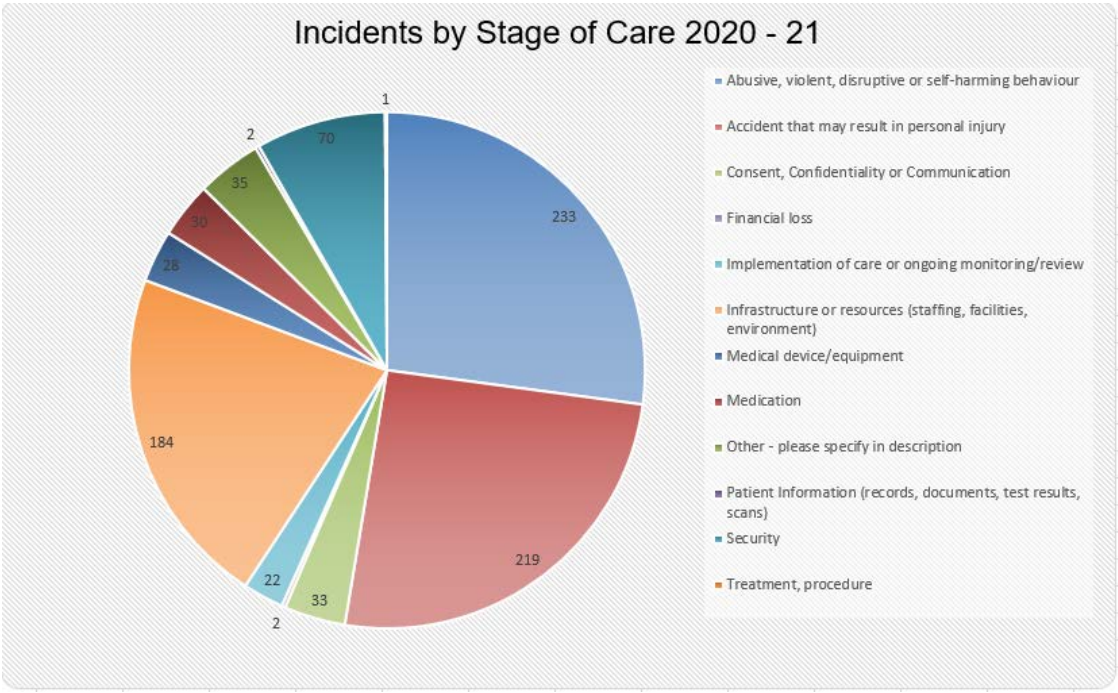
Figure 1



NB: The incidence rate mentioned above is for employees and contractors as this is how the incidents are recorded in Datix.

On average there are 72 health and safety Datix recorded incidents reported each month, these include employee, public and fire/security incidents. The incidents refer to injury, loss or near miss incidents and deal with all incidents outside the clinical risk reporting process. Figure 2 below shows the number of incidents broken down by stage of care.

Figure 2

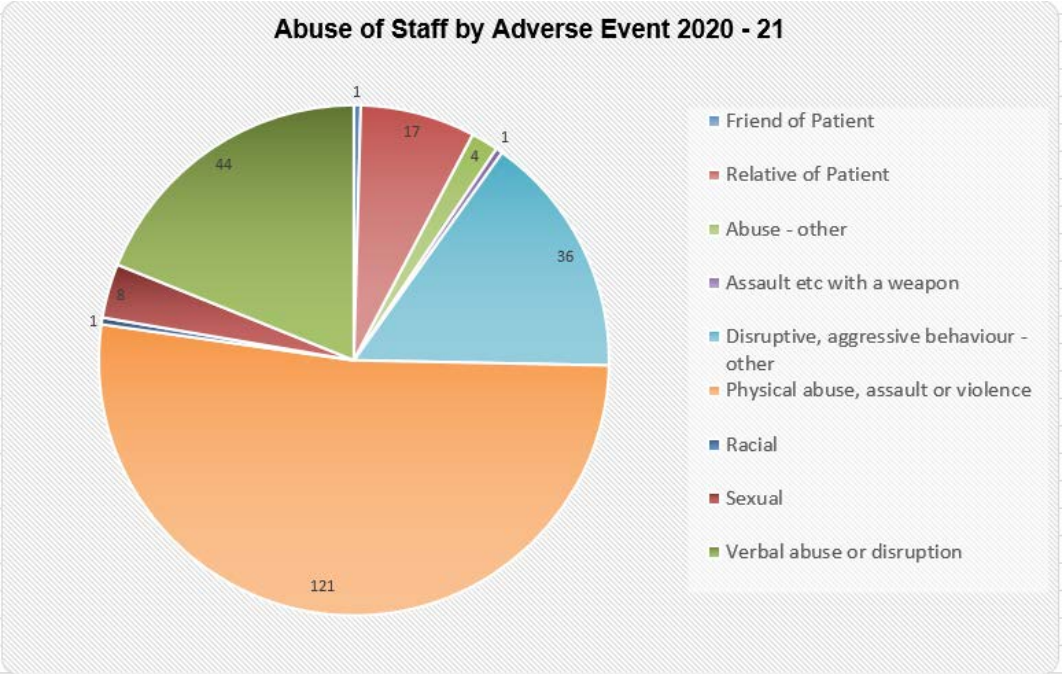


The main two areas of concern in this period are Abusive Behaviour towards employees, 233 incidents and Accidents that could result in personal injury, 219 incidents. The Infrastructure incidents (184) although high it has not identified a trend.

4.2 Abuse against employees

Figure 3 below shows the number of abuse incidents against staff by patients/relatives or visitors that have been reported in the period 2020/21.

Figure 3

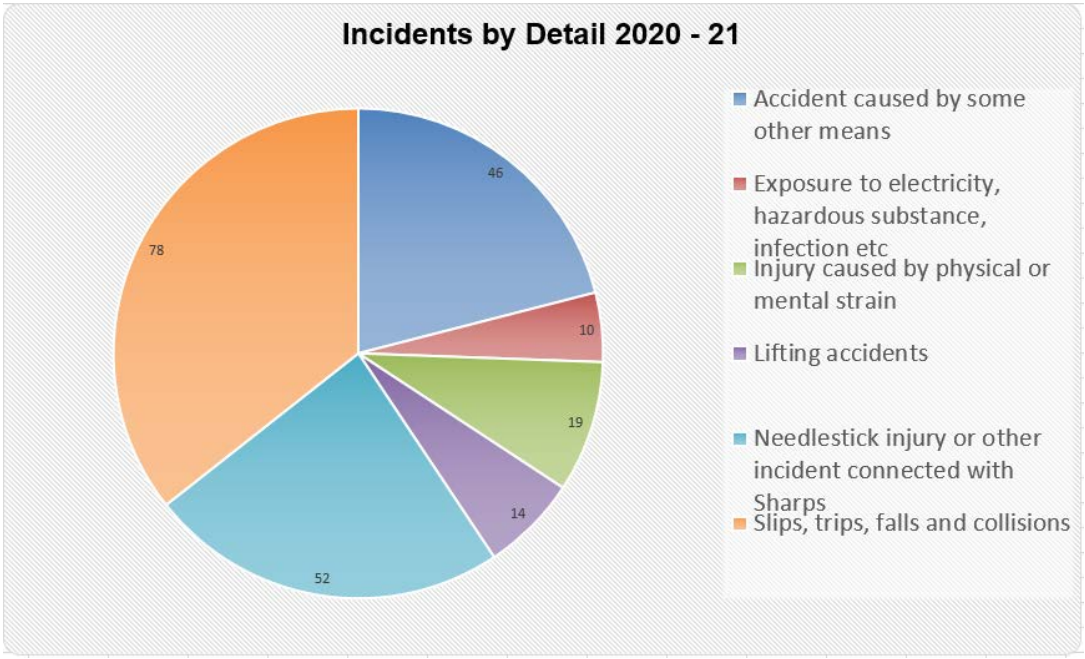


Physical abuse or verbal aggression towards Trust staff form the majority of these incidents.

4.3 Accidents that may result in Personal Injury

Figure 4 below shows the number of incidents that have been reported in the 2020/21 period by incident detail for the category of Accidents that may result in personal injury.

Figure 4

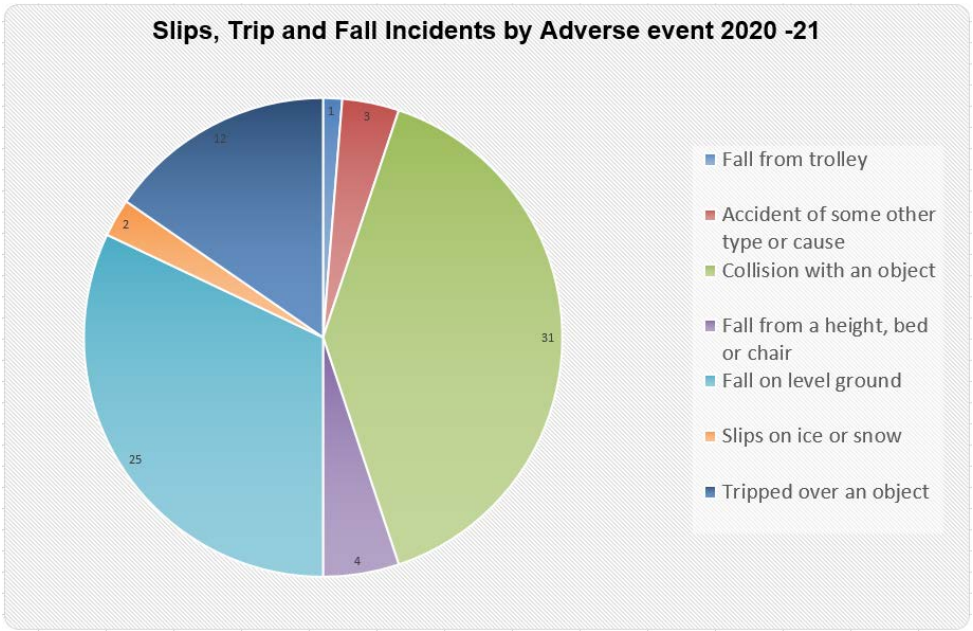


This breakdown identifies that the highest number of incidents are in the Slips, Trips and Falls and Needlestick categories.

4.4 Slip, Trips and Fall Incidents

Figure 5 shows the number of staff and visitor incidents that have been reported in the 2020/21 period for Slips Trips and Falls.

Figure 5



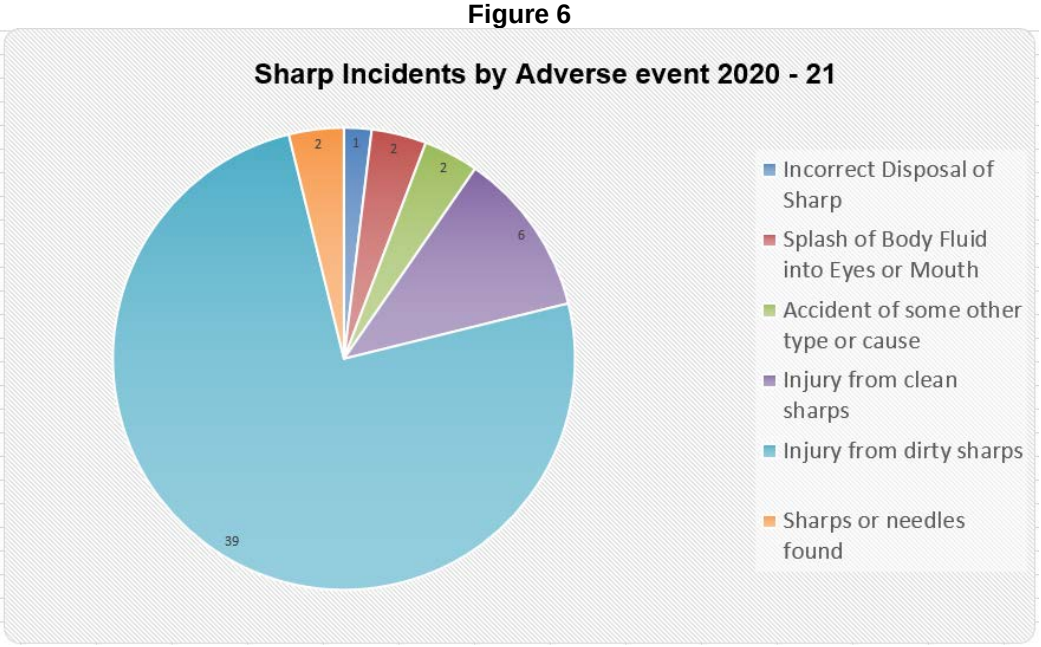
31 of the incidents are due to a 'collision with an object' these incidents are where employees have walked into an object such as a trolley, however due to the setup of Datix these fall under the category of falls.

25 of the incidents are due to falls on level ground however; there is no identified trend or single location of concern for these incidents. A general/generic risk assessment of slips/trips was reviewed and revised in August 2020.

4.5 Sharp Incidents

Figure 6 below shows that the highest number of sharps incidents involves dirty sharps. These incidents are monitored by the Health and Safety Committee. There is no national benchmark with which to compare the Trust's incident rate.

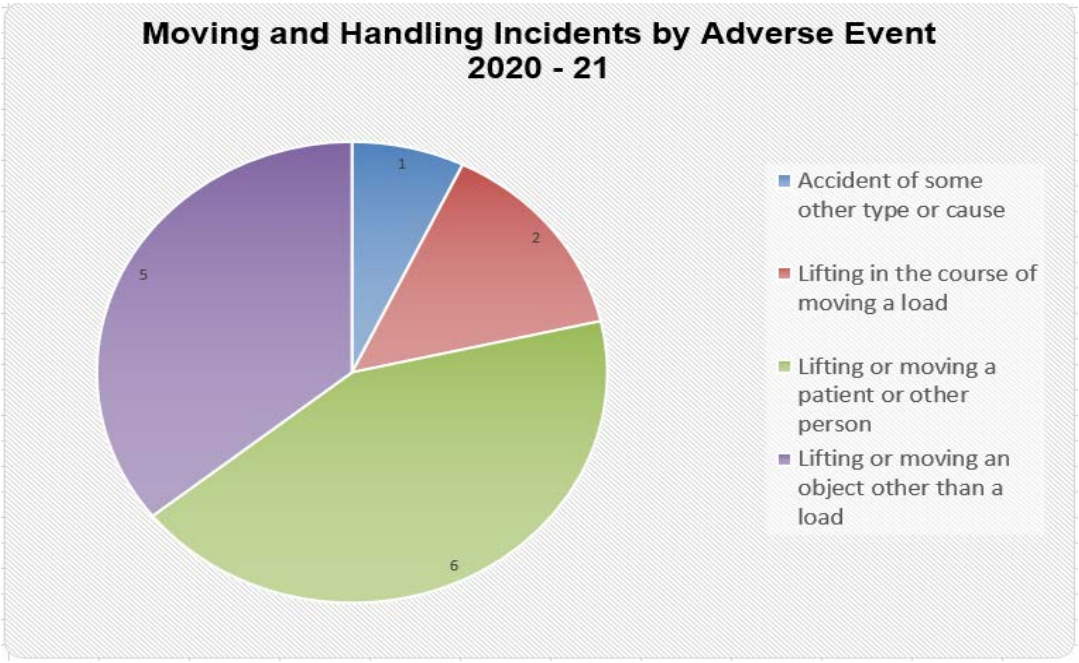
Figure 6



4.6 Moving and Handling

There have been a total of 14 moving and handling incidents recorded during this period (see Figure 7) this is an increase of 2 incidents from the same period last year.

Figure 7



All Datix recorded incidents are fully investigated in accordance with the Policy for the Reporting, Investigation, Management and Analysis of Incidents. The outcome of the incidents and investigations assist in identifying any trends that can help in the development of training packages, The Health and Safety Strategy and annual work programme so lessons can be learnt and shared Trust wide. The Trust also uses the analysis as evidence for external sources and awards such as the RoSPA award.

4.7 Radiation Safety Incidents 2020/21

In general, the Radiology Department continues to put a great deal of effort into the management of radiation protection under both the IRMER and IRR legislation.

There have been 16 radiation incidents reported in the Trust this year of which one incident required reporting to the CQC under the IR (ME)R 2017 Regulations.

The one instance where over/unnecessary exposure of a patient as defined in Significant Accidental and Unintended Exposures (SAUE) reported to CQC.

4.8 Staff Monitoring of Medical Imaging and Physics

150 TRFT staff working in the Radiology, Cardiology and Medical Physics Departments have been provided with approximately 704 personal dosimeters during 2020 calendar year (January to December). by an Approved Dosimetry laboratory.

One member of Medical Imaging staff was registered as a classified worker. All but one staff member, staff received an annual whole-body effective dose foreseeably below 6mSv (the dose at which staff must be classified, which is also three-tenths of the annual dose limit).

mSv= Millis everts TLD=Thermoluminescent dosimeter	X-Ray Dept RRPPS 4030	Medical Physics RRPPS 4031	Breast Imaging RRPPS 4032	Cardiology Dept RRPPS 4033	Total
Total staff supplied/2-mth	91	13	10	37	150
TLD >0.2 mSv/2-mth	3	1	0	0	4
Max. dose per year mSv	1.7	0.2	0	0	1.9
Number of staff > 1mSv/yr	1	0	0	0	1
Number of films lost/spoilt	10	0	3	6	19/704(2.7%)

One member of radiology staff RRPPS 4030 received more than 1mSv (the dose limit for 'Members of the Public'). This staff member (classified during 2018) has a recorded cumulative whole-body dose of 1.7mSv. This is split across the year as follows: Jan/Feb 0.6mSv, Mar/Apr 0.8mSv, May-Aug 0.0mSv, Sept/Oct 0.3mSv, Nov/Dec 0.0mSv. The same staff member also had extremity doses monitored during the entire period with cumulative doses recorded of 22.6mSv to the left hand and 16.5mSv to the right hand (Classification level >150mSv). Classification will remain in place until the end of 2021, at which point the pro rata cumulative dose for 2021 will be reviewed and used to determine whether classification need to be continued. This had been extended from end of 2020 as was documented in the 19/20 report due to Covid-19 and the reduction of patients using the service over this time.

Eye dose measurements were monitored for this staff member with an annual dose of 3.4mSv recorded after a correction factor of x0.5 was applied.

Within Cardiology department 4033 two staff members underwent eye dose monitoring over the Jan/Feb period. Only one staff member had a dose applied for this period 0.1mSv (Averaged from previous doses as TLD unreturned/assumed lost). This indicates that routine monitoring is not presently necessary to demonstrate compliance with the Eye dose limit.

The cardiology nurses who staff the stress sessions for myocardial perfusion scans, have been included in the routine personal dose monitoring from September 2010. Continuing previous experience none had measurable doses last year.

The TLD lost/spoiled figure is 2.7% which is slightly lower than the figure of 3.3% from 2019. Staff are reminded of their legal responsibility to look after and return their badges in a timely manner.

Finger dosemeters supplied by the Sheffield Extremity Dosimetry Service for **Nuclear Medicine 4031** gave annual doses for six staff involved as follows (12.05 mSv average per extremity and <5% of dose limit for 12 monthly users with a maximum for a given individual of 25.5 mSv).

	BD	CL	CD	JM	KP	PR
Right Hand	6.1	4.2	11.8	12.5	11.4	17.2
Left Hand	10	4.6	25.5	12.8	15.9	12.6

The HSE have now stated that any member of staff who systematically fails to wear, use and return their monitoring badges is committing an offence under Section 7 of the Health and Safety at Work act 1974. It was re-iterated at TRFT annual Radiation committee held May 2021 that employees must comply with instructions for their monitoring.

5. LITIGATION

In the reporting year of 2020/21 there have been 4 litigation claims made under the NHS Litigation Authority Risk Pooling Scheme, which is a decrease from the previous year when 8 claims were brought against the Trust. Our Employer and Public Liability claims profile remains modest year on year with 20 claims brought over the past 3 financial years. The claims brought are following health and safety incidents that occurred within the Trust, with the claims recorded on the Datix system.

There has been no identified trend in the litigation/incident claims during this reporting period.

6. STRESS MANAGEMENT STANDARDS

Work related stress is now in the 2020/21 work plan for the HSE. The Trust uses the annual staff survey results as an indicator to identify areas of concern and to assist in the development of the Trust wide risk assessment.

It is important to remember that the survey is not an assessment of stress; it is purely an indicator of causative factors. A Trust wide general/generic assessment of work related stress was undertaken in August 2012. This assessment is reviewed each year following the staff survey results. The assessment is currently under review following the results of the annual staff survey becoming available.

7. RIDDOR REPORTS TO THE HSE

Under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) the Health & Safety Executive (HSE) require all employers to notify them when there is a specified accident or incident resulting in a fatality, major injury, disease or notifiable dangerous occurrence (whether or not anyone is injured).

It is a requirement for Managers on behalf of the Trust to inform the Head of Health and Safety or Health and Safety Advisor of such incidents or

occurrences so that the Trust complies with this legal requirement as identified in the Trust policy
All three reported incidents occurred within Acute. All of RIDDOR events continue to involve over 7-day absence from work for employees. The table at figure 8 below shows a breakdown for the period of RIDDOR reportable incidents across patient, staff and visitors. Since the changes in the regulations (2013). There have been no patient reports made to the Health and Safety Executive in this period.

Summary of Trust RIDDOR Reportable Incidents

Figure 8

	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	Total
PATIENT	0	0	0	0	0	0	0	0	0	0	0	0	0
STAFF	0	0	0	1	0	0	1	1	0	0	0	0	3
VISITOR	0	0	0	0	0	0	0	0	0	0	0	0	0

The Trust will continue to identify key risk areas for incidents that lead to RIDDOR reporting.

8. TRAINING

8.1 Risk Assessment and Risk Management Training

During 2020/21 154 staff received their Risk Management training, significant increase of 115 on last reporting year.

8.2 Conflict Resolution Training (CRT) 2020/21

All MAST training concerning Conflict Resolution is still part of the staff Trust Induction programme, along with a further additional CRT refresher training every 3 years. There is an option for non-patient facing staff to carry out CRT by way of e-learning, however, non – Patient facing staff must carry out a face-to-face session on their following CRT refresher training. This year's figures, as show below in figure 9, are slightly lower than the previous year's figure of 93.16%, due to the temporary suspension of face-to-face training during the Covid-19 pandemic. he Trust still remains above the national average of staff trained which is currently at 91.31% compliance.

Figure 9

Overall Compliance as at 31/03/21

	165|LOCAL|Conflict Resolution|
165 The Rotherham NHS Foundation Trust	91.31%

Compliance by Division as at 31/03/21

Division	165|LOCAL|Conflict Resolution|
165 Clinical Support Services L3	95.23%
165 Community Services L3	90.28%
165 Corporate Operations L3	86.24%
165 Corporate Services L3	91.35%
165 Emergency Care L3	89.29%
165 Family Health L3	92.91%

165 Medicine L3	89.16%
165 Surgery L3	91.35%

8.3 Estates and Facilities Training 2020/21

Face-to-Face training within the Estates & Facilities has been reduced due the Covid-19 pandemic; however the following training was carried out within Estates and Facilities Directorate:

- Health and Safety Advisor trained in ROSPA Occupational Driver assessment.
- 31 Staff assessed on Occupational Driver's assessment awareness course.
- 27 Facilities staff re-trained in safe use of tow trucks (tugs).
- Estate Project Officer trained in HNC Construction and Civil Engineering.
- 8 Estates and Facilities staff trained in the safe use of the forklift truck (counter balance).

The following training has been identified for 2021/22:

- Asbestos Awareness.
- British Abrasive Federation Accredited British Abrasive Federation Accredited - Abrasive wheels.
- Confined Space Competent Person.
- Fire (Qmark) door installation.
- Forklift truck (counter-balance).
- Forklift truck Instructor.
- High Voltage Authorised Person.
- Industrial lift/crane hoist.
- IPAF standards for mobile elevated equipment.
- Legionella awareness.
- Low Voltage Authorised Person.
- Medical Gas Authorised Person
- Mobile-towered scaffold (PASMA).
- Occupational Drivers Assessment.
- Pathway tractor and trailer.
- Stepladder & Leaning Ladder.
- Ventilation Authorised Person.

8.4 Fire Safety Training

At the time of writing this report there are 5368 employees From the figures shown there are 12.75% of the workforce who are currently out of date for their Fire Safety Training which means that there are 87.75% of the workforce who are in date for their Fire Safety Training. Fire Safety Training sessions are being offered face-to-face, via teams or e learning.

9 MOVING AND HANDLING

9.1 Training

- **Induction**:
  All staff receive a booklet on Day 1 which covers moving and handling, at the end of this booklet, there is a test your knowledge quiz. The quiz section is separated and learning & development forward them onto the moving and handling team.

  Day 2 practical training had been suspended due to social distance guidance for Covid-19. Planned to resume April 2021

- **Full patient Handling.**
  Thirty-seven employees have received full patient handler training. This has dramatically reduced from the previous year due to the cancellation of all face-to-face training due to Covid-19.

  Twenty-nine employees received load handling training.

  Forty-eight employees received specific departmental specific training.

- **Key Trainers**
  Key trainer update sessions had been suspended during the Covid-19 pandemic. There are 19 key trainers across the Trust that wish to continue to deliver moving and handling across the Trust, this training will be resume during April 2021.

9.2 Equipment Purchased

- **Mortuary**
  The purchase of a flo-jack system by the mortuary department assisted with the moving & handling into the bottom area of the refrigerator.

- **Review of Slide Sheets**
  A large quantity of single use slide sheets have been purchased throughout 2020 due to increased infection control measures for Covid-19.

- **Hoist Slings**
  An options appraisal is taking place if to transfer to a single patient use sling as this is a safer system for the patients.

- **Hover Mat & jack (flat lift)**
  An additional two flo- jack systems has been purchased for use across the Trust.

10 SHARPS

Sharps Safety forms part of the Health and Safety Committee agenda.

Sharps incidents reported via Datix are on automatic alert to the Lead Nurse/Assistant Director for IPC and the the Head of Health and Safety and Compliance (Estates) who review all incidents reported on a monthly basis to review and share the information with the Health and Safety Committee.

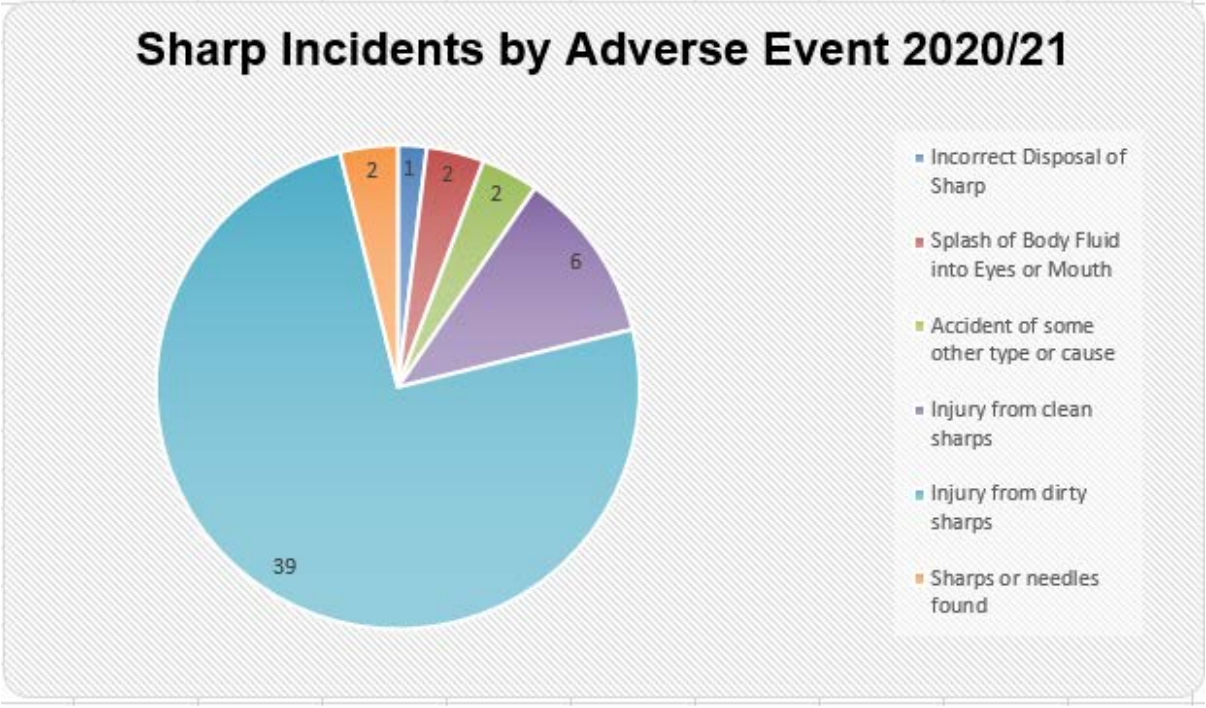
All incidents are investigated locally in accordance with Trust policy. Reports that are related to disposal or incorrect disposal are forwarded to the Waste Officer for investigation.

10.1 Incident Reports

There were 52 reported employee sharps related incidents between 1st April 2020 and 31st March 2021 (see Figure 10) this is a decrease from the previous reporting period of 107 incidents.

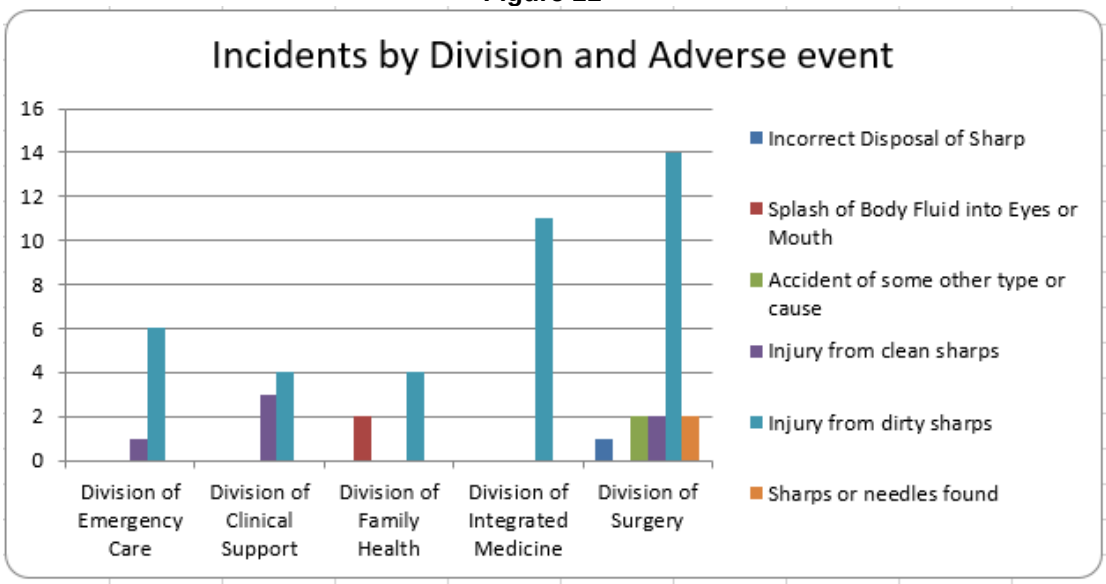
There was no identified trend from the information on Datix to suggest any single procedure or item of equipment has a higher risk than others.

Figure 10



These incidents have been broken down to CSU in Figure 11.

Figure 11



10.2 Safety Products

The regulations for preventing sharp injuries in the hospital (Health and Safety (Sharp Instruments in Healthcare) Regulations 2013) came into force on 11th May 2013.

Work has continued during 2020/21 to identifiy any new safety devices that have become available that would support the regulations.

Sharpsmart waste disposal continues to be used on the main hospital site. Standardised disposable sharps bins are used at all other Trust sites ensuring compliance with the carriage of dangerous goods (ADR 2019).

Where the waste contract is managed by non Trust owned areas the choice of bin remains with the area however this has not been raised as a risk by any staff groups who work in these various sites.

10.3 Risk Management:

The Group continues to review new legislation to reduce risks to staff, patients or the public. Risk assessments are carried out as necessary to improve safety and to manage cost effectively.

11 FIRE SAFETY

It is a statutory requirement for all public bodies to take the necessary precautions to ensure that their premises are safe, suitable and sufficient in regard to fire management. Failure to provide adequate fire management can lead to public prosecution, including imprisonment or fines for the Trust's Responsible Person/s, enforcement orders from the fire authority and an increased risk of fire.

The Rotherham NHS Foundation Trust has a statutory responsibility to ensure that all of the premises owned and/or operated by it comply with current fire safety legislation. The Trust has to ensure that suitable and sufficient arrangements are in place for the management of fire safety and for the implementation of any necessary improvements relating to increased fire safety measures as required under the Regulatory Reform (Fire Safety) Order 2005 (RRO).

Health Technical Memorandum (HTM) 05-01 Managing Healthcare Fire Safety (2013) DH, describes that an Annual Report should be undertaken and presented to the Trust Board.

The Chief Executive Officer is responsible for ensuring that, through appropriate delegation of responsibility within the organisation, current fire legislation is met and that, where appropriate, Fire code guidance is implemented in all premises owned or occupied by the Rotherham NHS Foundation Trust.

This section has been developed in accordance with HTM 05-01: Managing Healthcare Fire Safety.

The following summary gives brief details of this Trust's development towards compliance with the mandatory requirements for the NHS in England (considered as best practice for NHS Foundation Trusts).

REQUIREMENT	PROGRESS	R	A	G
Clearly defined fire policy.	Compliant			✔
Board Level Director accountable to the Chief Executive for fire safety.	Compliant			✔
Fire Safety Manager to take the lead on all fire safety activities.	Compliant			✔

Have an effective fire safety management strategy which enables:

REQUIREMENT	PROGRESS	R	A	G
Preparation and upkeep of the organisation's fire safety policy.	Fire Safety Committee - responsible for the monitoring and review of fire policy and protocols. Fire Policy last reviewed in December 2018			✔
Adequate means for quickly detecting and raising the alarm in case of fire.	Estates - Compliant			✔
Means for ensuring emergency evacuation procedures are suitable and sufficient for all areas, without reliance on external services.	Fire Safety Dept. - Compliant			✔
Staff to receive fire safety training appropriate to the level of risk and duties they may be required to perform.	MaST training ensures all staff have access to correct fire safety training required for their place of work. Additional training sessions for fire wardens and evacuation aids provided to improve resilience in community premises.			✔
Fire Risk Assessments are carried out and reviewed.	Department Managers and Fire Safety Dept. - Compliant			✔
Fire Drills are carried out in all Departments and Ward.	Department Managers and Fire Safety Dept. - Compliant			✔
Reporting of fires and unwanted fire signals.	Fire Safety Dept. - Compliant			✔
Partnership initiatives with other bodies and agencies involved in the provision of fire safety.	Compliant			✔

11.1 Fire Safety Procedures

All employees are aware of the importance of good communication and a good relationship has been established between them and the Fire Safety Advisor. Any concerns or problems have been freely communicated and dealt with by all concerned.

All requirements under the Regulatory Reform (Fire Safety) Order 2005 (RRO) are being met; this includes full fire risk assessments for all wards and

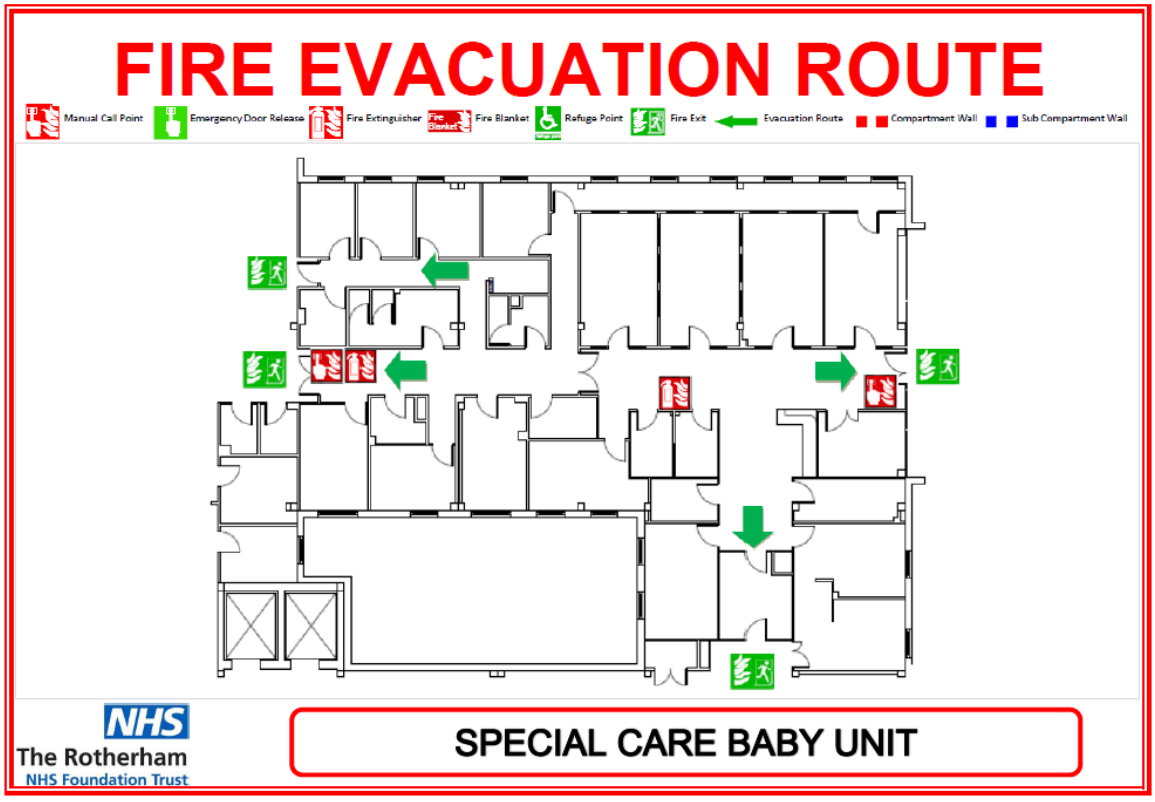
departments. The maintenance of the fire alarm system, emergency lighting and fire-fighting equipment are also being met.

11.2 Trust Fire Risk Assessments and Strategy

Fire risk management is an integral part of the risk management process and, as such, remains a priority for the Fire Safety Advisor.

Department of Health Document 'Managing healthcare fire safety' (HTM 05-01) requires that a Fire Risk Assessment Programme be put in place. This programme is in place with full reference to the Firecode Health Technical Memorandums (HTM) and the RRO. All wards and departments have a full fire risk assessment and an annual audit process is now in place. The Fire Safety Advisor continues to use HTM 05-03 Part K risk assessment as this type of assessment continues to be the best practice for healthcare premises.

During the Covid-19 period the Fire Safety Advisor has been puttig together a program introducing Fire Safety Evacuation Plans and having these prominantly displayed on each Ward & Department entrance. These will be issued during 2021/22. A template can be seen in below



11.3 Issues raised and improvements made 2020/21

After Hospital restructuring a significant amount of work was put in place relocating and refurbishing Wards. All work was completed ensuring the Trust Fire Strategy was not compromised.

The major work for this year included:

- New discharge lounge on D level in place of patient library and IT training rooms.
- Command Centre on D level.

- Full refurbishment of C level Outpatients (Old Ophthalmology).
- Full refurbishment of Ward B6 creating new 4 bay two 3 bed enclosed isolation bays, donning and doffing room, waste room.
- Installation of new ceiling mounted pool hoist at Park Rehab
- Installation of service lift within breathing space
- New Greenoaks refurbishment
- Endoscopy Decontamination unit
- UECC Resus
- UECC main Entrance
- RCHC ground floor left side refurbishment

Trust staff continue to operate from a variety of shared premises in the Rotherham, Barnsley and Doncaster regions, which are managed either by single ownerships or within Joint Service Centres. To ensure compliance with Regulatory Reform (Fire Safety) Order 2005 an up to date copy of the fire risk assessment is kept in liaison with the relative landlords. Fire Risk Assessments have been carried out by the Fire Safety Advisor in a number of locations that are owned by NHS Property Services. All of these properties have Trust staff located in them.

Both the fire alarm system and the fire extinguishers are an important part of fire safety within the Trust and have been maintained and tested by the Trust's approved contractors during the reporting period. A new tender process was undertaken for all fire safety components, ensuring all testing and servicing is being carried out to correct specification and ensuring the Trust is compliant with all legislation and guidance.

11.4 Planned Major Improvements for 2021/22

The major development for the coming year will be:

- New IPS/UPS installation for theatres
- New security hub in concourse
- Refurbishment of purple butterfly rooms Scarborough sweet.
- Ward B11 refurbishment
- Installation of fire doors
- Refurbishment of SCBU
- Fire stopping improvements site wide.
- Refurbishment of Old Greenoaks

11.5 Fires and Unwanted Fire Signals

Any fire is serious within the Trust environment and no matter how small can have big impact on the organisation as a whole. The Trust had one fire that took place within the hospital site for the period.

Details of the fire are as follows:

- Fire in Staff Accommodation (Swale Court). The fire occurred in an electric shower unit.

The above fire was extinguished promptly with the staff at all adjacent locations carrying out the fire procedures as required. Due to the fast response of staff to the fire no patients were put at risk at any time and full evacuations were not needed. All instances were recorded and investigated on the DATIX system.

The total number of unwanted false calls during the year was 44 (see Figure 12**)** a decrease of 13 over the same period last year. As a large organisation the Trust is still committed to reducing the amount of unwanted calls and all staff must ensure that they keep calls to a minimum.

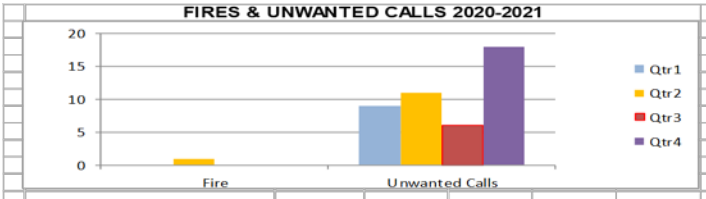
Of these 44 false alarm a considerable number, 18, have had no definite cause. The Trust is putting together a program to have all detector heads that are coming to end of their life span replaced

Due to the size of the alarm system the faults that occur cannot be prevented but are still monitored by the Fire Safety Advisor and the Estates Department. The hospital has its own Fire Response Team that reacts to all fire calls and South Yorkshire Fire & Rescue Service are only called if there is a confirmed fire or exceptional reason; the Fire Service were not called for any of the false alarms, all were dealt with promptly by the Fire Response Team and staff

After recent liaison meetings with South Yorkshire Fire & Rescue Service, they have once again congratulated the Trust in the attitude towards unwanted calls and in the way that the Trust deals with them.

Figure 12

FIRES & UNWANTED CALLS 2020-2021



Type	Qtr1	Qtr2	Qtr3	Qtr4	Total
Fire	0	1	0	0	1
Unwanted Calls	9	11	6	18	44

FIRE CAUSES

CAUSES	Qtr1	Qtr2	Qtr3	Qtr4	Total
Arson	0	0	0	0	0
Electrical (Mains)	0	0	0	0	0
Electrical (Cooking)	0	0	0	0	0
Smoking Related	0	0	0	0	0
Equipment Failure	0	1	0	0	0
Totals	**0**	**1**	**0**	**0**	**1**

UNWANTED CALL CAUSES

CAUSES	Qtr1	Qtr2	Qtr3	Qtr4	Total
Unknown	5	5	2	6	18
Good Intent	0	0	0	1	1
Dust/Water	0	0	0	0	0
Cooking	0	1	0	0	1
Smoking	0	0	0	0	0
Steam	2	0	2	2	6
Aerosol	0	1	0	0	1
Cover Removal	0	0	0	0	0
Contractors	0	1	1	4	6
Toaster	0	0	0	0	0
Faulty Electrical Equipment	1	0	0	1	2
Broken Manual Call Point	1	2	0	4	7
System Fault	0	1	1	0	2
Totals	**9**	**11**	**6**	**18**	**44**

INCIDENT OUTCOMES

	Qtr1	Qtr2	Qtr3	Qtr4	Total
No Injury	0	0	0	0	0
Injury	0	0	0	0	0
Fatality	0	0	0	0	0
Disruption to Services	9	12	6	18	45
Damage	0	0	0	0	0
Totals	**9**	**12**	**6**	**18**	**45**

OTHER INCIDENTS

12 SECURITY

12.1 Security Improvements 2020/2021

This year, the Trust has continued with the improvements of security within the Hospital, and wider Community locations. The below table identifies areas of improvements to the Security systems & areas that needed enhancing to assist with Covid-19 restrictions.

DATE	ITEM	LOCATION
02.04.2020	Net 2 door access system	Dr Mess A level
09.04.2020	Net 2 door access system	THEATRES
09.04.2020	Access control	Ward B4/B5
17.04.2020	CCTV camera	Main car park
20.04.2020	Net2 door access	Keppel front & rear entrance
23.04.2020	CCTV system Avigilon	Woodside Reception
24.04.2020	Net 2 door access system	Ward B6
24.04.2020	CCTV camera	Mortuary garage
11.05.2020	Intruder alarm	I.T building
12.05.2020	X2 PTZ camera's	Baker St car park
14.05.2020	x6 CCTV cameras	I.T building
12.06.2020	X2 cam & panic button	ASU
Aug-20	X2 cam & door access	Greenoaks
Aug-20	Barrier	Greenoaks
Nov-20	Net 2 door access system	Sitwell
Nov-20	Panic alarm (mobile)	UECC
Nov-20	Panic alarm	Patient experience
Dec-20	Access control	Lift No. 2
Jan-21	Access control	Opthalmology C level
Jan-21	CCTV camera	UECC staff room corrdior
Jan-21	Access control	vaccination centre
Jan-21	Access control	UECC new main door
Jan-21	Access control	CCU
Feb-21	CCTV camera	Vaccination centre located on roof above cw

12.2 Security Personnel

The Trust has continued to contract Outsourced Client Solutions (OCS) to meet the physical security and CCTV monitoring requirements of the Main Hospital, Woodside and Park Rehabilitation sites. They conduct twice daily, 'Safe and Well' checks for 'Lone Working' Trust Staff who are in various locations within the Community.

This year the Security team supported the Trust through the Covid-19 pandemic by carrying out the following additional roles:

- Staffing both the main Hospital entrance & UECC entrance, in line with Covid-19 restrictions
- Collection & transfer of Covid-19 swabs from the Woodside building to Pathology
- Patient bed transfer (lockdowns)

The Security team also monitors (out of hours) alarm activations such as:

- Pharmacy fridge alarms

- Mortuary fridge alarms
- Winter temperature alarms
- Park Rehabilitation intruder alarm
- Woodside intruder alarm

All OCS staff are holders of the required Security Industry Authority (SIA) licences; this is a legal requirement in England and Wales for all individuals working in Security and Public Space Surveillance CCTV.

The security staff attended refresher training in the following subjects this period:

- Conflict Resolution Training (CRT)
- Clinical Holding (Restraint)
- Hand Hygiene

12.3 <u>The Criminal Justice and Immigration Act 2008</u>

The NHS continued to deal with low-level anti-social behaviour through Sections 119–120 of the Criminal Justice and Immigration Act (CJIA); this is used when attendees are causing a nuisance or disturbance on NHS hospital premises and refusing to leave - and a power for authorised NHS staff to remove a person suspected of committing this offence.

The offence and power of removal apply only to NHS hospital premises. Physical removal must be the last resort and not a substitute for established verbal conflict resolution techniques to persuade a disruptive individual to leave voluntarily. The Trust currently has 2 Authorised Officers.

There was 121 reported incidents of Physical assault which are recorded on Datix a further 112 reports of Non- Physical assaults were reported:

There were also 53 reported incidents of “proven, alleged or suspected thefts” recorded through Datix.

- **<u>AMU</u>**

  A patient, who allegedly saw a staff member taking money from her bag, made an allegation for theft for the value of £145. SYP was contacted and subsequently attended & arrested the suspected staff nurse.

All staff are given crime prevention advice and, after each incident, an e-mail is sent to all e-mail users reminding them not to leave property on view. In some cases, a security safety & awareness training course has also been provided to several departments.

12.4 <u>Security Serious Incidents</u>

- **<u>Grounds</u>**

  A Mental Health Patient that attended to the UECC, via ambulance on 22.11.2020 absconded from the UECC and was then subsequently located on the roof of the new Green oaks building. The area was put into a partial locked down by Security, and further support was required from the Fire Service & South Yorkshire Police. Fortunately, on this occasion the Patient was safely removed from the roof.

Recommendations have since been made by the Trust Local Security Management Specialist (LSMS), to the Estates Management to help prevent any future un-authorised access to the roof area of the Green oaks building.

- **Ward A5**

  On the 25.02.2021, a recently recalled Prisoner from Marsh Gate Prison was an in-patient on Ward A5, in company of x2 Prison officers. Unfortunately, whilst the prisoner was an in-patient, he was not placed in handcuffs. The prisoner was able to enter the Ward A5 shower room alone where he then subsequently broke the window locks and climbed out of the top floor window, on to the window ledge, and made threats to jump.

  All relevant staff/crisis team & authorities were notified and requested to attend.

  Fortunately, staff were physically able to hold onto the Patient & persuaded him to get down after several hours, then subsequently medically discharged back to prison. A request to carry out a further investigate to this incident has since been made to Marsh Gate Prison.

13 RADIATION

13.1 External Assurance Reports

13.1.1 Medical Imaging Radiation Protection and Assurance Report 2020-21

The key message from the annual Radiation Protection Report in compliance with Reg 14 from the Trust's Radiation Protection Advisor (RPA) remains that the standards of evidence for compliance required far more comprehensive governance and assurance systems to be implemented. Senior Trust Management are expected to have direct oversight and engagement with assurance processes (across all Directorates/Care Groups who use ionising and non-ionising radiation (Lasers and Ultraviolet Light, plus users of Artificial Optical sources and Electromagnetic Fields to which legislation also applies) not just Radiology Departments) that deliver this evidence to the Trust. Audit is particularly critical to demonstrate effective implementation of controls.

This annual Radiation Protection and assurance report by the Professional Lead /Senior Radiation Protection Supervisor (RPS) based on the RPA annual report covers aspects of radiation protection from April 2020-March 2021. The report also contains the annual Nuclear Medicine, lasers, ultraviolet and MRI safety reports.

In general, the Department continues to put a great deal of effort into the management of radiation protection under both the Ionising Radiation (Medical exposure) Regulations (IR(ME)R) 2017 and Ionising Radiation Regulations (IRR)17 legislation.

There have been 16 radiation incidents reported in the Trust this year of which one incident reported in the Trust during 2020 required reporting to the CQC under the IR(ME)R 2017 Regulations.

One staff member is classified until the end of December 2020.

13.1.2 Incidents Requiring Notification to CQC or HSE 2020-21

There has been one incident reported in the Trust during 2020, which required reporting to the CQC under the IR (ME) R 2017 Regulations. Where exposure of staff or an over/unnecessary exposure of a patient, as defined in Significant Accidental and Unintended Exposures (SAUE) CQC Guidance for employers and duty holders June 2019, has been suspected, it is necessary to notify the CQC.

Where the CQC believe an incident may involve IRR17, they will report it to the HSE directly.

The following incidents have been reported locally during the year 2020-2021 financial year for TRFT radiology and Community dental:

Date of incident reported	Patient Dose	Reportable		
	mSv	HSE	CQC	Brief Explanation
24-Feb-21	0.0001	No	No	A member of staff was inadvertently exposed to radiation on 24th February 2021 while making an injection into the catheter on the left arm without donning a lead apron. The member of staff was standing at around 1 metre from the tube.
19-Feb-21	0.003	No	No	A member of the endoscopy staff inadvertently failed to wear their lead apron and was therefore exposed to a higher than intended radiation dose. The staff member realised after 1 minute of exposure at around 1 metre from the patient and alerted the radiographer who ceased exposing and noted the accumulated DAP to that point. The procedure continued after the apron was donned.
29-Jan-21	1.2	No	No	A Patient received a CT Head examination due to Referrer error. The referral from UECC was not required for this patient and as such this represents an accidental exposure.
18-Jan-21	1.3	No	No	A patient recently received a CT Head examination, intended for another patient, due to Referrer error. It is understood that the Referrer has already spoken to the patient's family regarding the error but that the patient involved has sadly passed away on the 15th January. The correct patient has since also received the intended imaging

12-Jan-21	0.001	No	No	A paediatric patient recently attended the department for an examination of the left elbow on 12/01/2021. Due in part to the patient's mother insisting that the patient had injured their right elbow, the incorrect (right) elbow was examined. It was realised that the mother had been confused reading the site of injury and the correct (left) elbow was then examined. Consequently the patient received an unnecessary dose of radiation from the unnecessary examinations.
30-Nov-20	0.001	No	No	A patient recently attended the department for an examination of the left knee as per the request. Unfortunately, the radiographer performed the initial AP projection on the incorrect side (right). The patient therefore received a small unnecessary exposure. The error was noted immediately and the correct left knee exam was then performed.
30-Nov-20	0.04	No	No	A patient recently attended the department for an examination of the left shoulder as per the request. Unfortunately, the student radiographer performed the exam on the incorrect side (right). The patient therefore received a small unnecessary exposure. The error was noted immediately and the correct left shoulder exam was then performed.
26-Oct-20	0.011	No	No	A patient recently attended the department for an examination of their pelvis as per the request. However the Operator, due to a failure to perform the correct 3 point ID check, imaged this patient for a shoulder instead of the intended image of a Pelvis. The patient therefore received an unnecessary dose of radiation. The patient later returned to the department, was correctly identified and a pelvis examination successfully performed

08-Oct-20	0.4	No	No	A patient recently attended the department for an examination of their Pelvis. The Operator undertook the relevant identity checks and asked if the patient had undergone any recent x-rays to which the patient responded that they had not. Unfortunately however, this was not correct and the request was a duplicate which had been cancelled on the Meditech system. However, this does not automatically update the RIS request and the procedure is for the Referrer to contact Radiology to confirm the cancellation. This did not happen and the Operator did not check the RIS for previous images. The exam was therefore performed unnecessarily.
08-Oct-20	0.006	No	No	A patient recently attended the department for an examination of their thumb as per the request. However the Operator, due to a failure to 'Pause and Check', performed the exam using incorrect exposure factors which caused an image that was not diagnostically suitable and therefore rejected. Unfortunately, the mistake was not recognised and a repeat was performed using the same incorrect factors. At this point, a senior radiographer was called, the error was noted and the thumb exam correctly performed. Due to the incorrect exposures, the patient received an unnecessary dose of radiation
16-Sep-20	0.0002	No	No	A patient recently attended the department for an examination of the foot for a suspected 5th metatarsal fracture as per the request. However the Operator, due to a failure to 'Pause and Check', performed an ankle AP exposure instead which was not diagnostically suitable and therefore rejected. The patient therefore received an unnecessary dose of radiation. It is

				believed that the correct foot exposure was then performed.
11-Aug-20	0.003	No	No	A patient recently attended the department for an examination of the right shoulder as per the request. However, after performing the initial examination, a fracture of the clavicle was noted and a decision to perform an extra view was taken. Unfortunately, this extra coned down clavicle view was performed on the incorrect side (left). The patient therefore received a small unnecessary exposure. The error was noted immediately and the correct clavicle view was then performed.
23-Jul-20	0.029	No	No	A patient recently attended the department for a post operation OPT and PA mandible examination on 07/07/2020. The Operators performed the examinations successfully. However it was highlighted by reporting staff that this was a duplicate request, indicating that the second Referrer had not checked for previous images. Additionally, the Operators involved did not themselves check for previous images. Consequently the patient received an unnecessary dose of radiation.
05-Jun-20	0.01	No	No	Two members of staff were accidentally exposed at your department on the 28/4/2020. On arrival in X-ray the nursing staff booked in at reception but the room was not ready to greet them as the staff were unaware that the ward staff had set off already. The radiographers hastily donned PPE and prepared the room while the patient was inside. Due to them being confirmed Covid positive they were unable to wait in the waiting room as they would usually do. Patient ID was checked and introductions and explanations of the examination were completed. The examination began but

				following 3 images, the radiographers realised the nursing staff did not have a lead apron on which had not been spotted due to them wearing full PPE. The examination was halted, lead aprons given to the staff members and explanation of the implications of not having lead protection explained to them both.
12-May-20	0.02	No	No	A wrong patient was given a Chest X-ray exposure accidentally on the 1/5/2020. Patients were similar in age and the nurse directed to the incorrect patient. This appears to be failure to correctly follow the procedure for patient identification. Once the error was realised, the correct patient was been x-rayed.
07-Apr-20	25.7	No	Yes	A patient was recently referred for a CT Head examination. However, due to barriers put in place due to the difficult situation of Covid-19, the patient was wrongly scanned in chest, abdomen & pelvis. Patient was confused and responded to wrong name, when date of birth was checked it was shouted through the glass screen to the operator to whom it sounded correct through mask and screen. Process has already been changed so that checklist is positioned in front of glass screen so rad in room can read and check directly and give thumbs up to the operator. This is all due to infection control measures and change in work flow

No other incidents have been reported locally. This represents a low level of incidents taking place. The feedback from the Trusts Radiation Protection Advisor states that the Trust should assure itself that this represents a good and effective reporting culture, to ensure compliance with CQC reporting requirements. The recording of near misses would provide suitable evidence.

Certain trends can be seen from the above which are:

1. Human errors:
    a) Referrer The most common type of error is still when the wrong patient receives an exposure, with 50% of all diagnostic imaging errors resulting from referrers failing to refer the right patient or operators failing to actively identify their patients. Risk on the register for cancellations via Meditech .
    b) Operators failing to identify the correct site and doing multichecks throughout the procedure
    c) Non radiology staff not following local rules and wearing correct PPE

Learning outcomes to be worked on:

1. A more detailed investigation of the circumstances for repeated types of error
2. A review of working practices including more effective communication, prevent working without proper instruction or attention, presentation at induction, ensuring SOPs are read and followed and this is documented, working group for improvement of electronic systems still ongoing .
3. Multipoint checks made at all stages of the procedures e.g. Stop, pause and check, electronic alert on DR systems before exposure have now been added.

13.1.3 Radiation Protection Assessment for New Installation

Plans were reviewed for a number of areas, including areas identified in response to Covid-19 demands on service, which in many cases required site visits to assess locations' suitability. These included:

Fracture Clinic
Paediatric Resus
Resus Overspill
Rm 1 Mammography

An urgent radiation protection review was also performed for a mobile CT scanner cabin which was to be hosted at the TRFT site.

Site visits were undertaken as required and protection assessments in compliance with IRR17 Regulations 8, 9 and 10 have been sent to the appropriate radiology manager, architects and /or estates departments**.**

13.1.4 Routine Quality Assurance

Fluoroscopy, radiographic units and CT units are checked annually. Mobile radiographic and dental units are checked biennially.

At TRFT there are 40 X-ray units in situ including 3 viewing monitor workstations and 4 CR readers. 44 visits were made for QA purposes at TRFT from 1st April 2020 to 31st March 2021.

A number of QA surveys were postponed in 2020 due to the COVID-19 pandemic and were re scheduled when it was safe and practicable to do so.

It is understood that, where relevant, any minor issues have been dealt with by the RPS concerned in collaboration with the manufacturers.

13.1.5 Acceptance Testing

There were 3 Critical Inspections and 7 Commissioning visits performed between 1st April 2020 and 31st March 2021.

13.1.6 Breast Screening

The responsibility for organisation of QA rests with the Screening Quality Assurance Service (North). Following national guidelines, checks on all mammography and Ultrasound units are made at 6-monthly intervals. Primary reporting monitors and specimen cabinets are tested annually. In general, the equipment was found to be reliable with dose and other QA aspects meeting the published national standards.

Within Breast Screening quality control checks are performed on the mammography machines by radiographers in accordance with the NHSBSP recommendations. Routine testing of Stereotactic accuracy is now a requirement.

13.1.7 Ultrasound QA comments

Breast Screening Ultrasound QA is now reported to the NIR Protection Committee.

13.1.8 Departmental Quality Assurance comments

The department has a substantial quality control programme with the Quality Assurance (QA) Programme for the Diagnostic Imaging Systems manual specifying the tests to be performed. QA results are routinely discussed at the bimonthly radiation protection meetings.

13.2 <u>Patient Dosimetry</u>

13.2.1 Dose Area Product Meters

DAP meters are fitted in all rooms and used in the recording of routine patient doses. The RPA provides calibration values for DAP meters in the QA reports, which are used when comparing DRLs between rooms.

13.2.2 Patient Dose Estimates

There were 16 patient dose estimates required, no other dose assessments were required.

13.2.3 Foetal Dose Assessments

No foetal dose assessments were required since the last report.

13.2.4 Research

No research ethics approvals were requested in 2020-21.

13.2.5 Radiation Protection guidance and advice 20-21

The following are updated actions that have been taken or will be taken at TRFT following advice/guidance given by the local RPA following HSE visits to other UK hospitals and the issues and subsequent reports raised from these visits to other sites.

13.3 IRR17

13.3.1 Risk Assessments

Revised Risk Assessment profomas have been provided by the RPA with additional supporting information to enable comprehensive assessment by the local RPA. All rooms within the trust that undertake radiation procedures have had risk assessments completed in 2020. These are signed off by the senior RPS and RPA and can be found within the IRR risk assessment folder in the Professional leads office.

Guidance on Reasonably Foreseeable Incidents has been provided to support compliance with Risk Assessment review which will be added to all the risk room assessments by end of June 2021.

13.3.2 Contingency Plans

Contingency plans are covered on annual IRMER assessments as a discussion however an update by the RPA are that these need rehearsals (rather than discussion) on a regular basis, with records kept of who participated. Due to Covid 19 no rehearsal of these have taken place and a plan has been put into place that this will be a rolling programme of frequent rehearsals which is documented.

13.3.3 Local Rules

Local Rules are up to date and in place for Medical Imaging and Nuclear Medicine. Updates from HSE have stated that the local rules needs to include what tasks Personal Protective Equipment (PPE) is needed to be worn for, where and when dosimeters need to be worn, actions taken if dosimeter is inadvertently exposed. This work to update the local rules is planned for the end of June 2021.

The local rules are due for review in 2023 however due to guidance on Reasonably Foreseeable incidents being constantly revised and updated then the local rules and risk assessments may need frequently updating as this revised guidance is brought to our attention by the RPA.

13.3.4 Radiation Protection Supervisors

Radiation Protection Supervisors: to ensure there is contact with Radiation Protection supervisors within all working hours that controlled areas are operational, the contact names of the RPS are on the local rules which are on each room walls.

13.3.5 Estates/Facilities staff working in controlled areas

The IRR guidance is that nationally all employees engaged in work with ionising radiations or likely to be affected by it should have Information, Instruction and Training Includes cleaning and ancillary staff, Refresher training must be offered including clinicians.

TRFT staff including ancillary and cleaning staff that work with or are affected by ionising radiation have documented record of training at induction or instructions/information that has been given to them and carried out.

Refresher training for Radiologists or clinicians using the fluoroscan is also documented.

Compliance with IRR17 is a condition of registration and consent. Registrations and consents may be revoked if this condition is not met.

It is clear that the HSE has (and always had) the authority to instruct Trusts to cease all work with ionising radiation if compliance is not satisfactory.

13.4 IR(ME)R17

IR(ME)R requires providers to establish a procedure to identify individuals as duty holders who are entitled to act as referrer, practitioner or operator within a specified scope of practice.

An up-to-date detailed record of all relevant training undertaken by all practitioners and operators including radiographers radiologists (using interventional radiology equipment), cardiologists (using cardiology equipment) and surgeons using a mini C-arm in theatre is required by IRMER. Within Medical Imaging detailed documental evidence for all these multidisciplinary staff can be located electronically on the Radiology I drive.

Ensuring Non-Medical Referrers (NMRs) are suitably trained and have specific Scope of Practice agreed is critical to managing a shortfall in the medical workforce. Unfortunately our electronic referral systems does not allow individuals scope of referral to be limited which has raised the risk of NMRs potentially requesting outside of their scope of practice. This has been highlighted recently with a large number of non-referrers being out of date for renewal and that there are potentially non clinical or inappropriately trained staff who could be requesting outside their scope. A review has been undertaken and this will be regularly audited and reported to the Radiation Protection Committee and Trusts of any future issues.

There is a central log of non-medical referrers held electronically within medical imaging and this is updated when and as necessary to ensure all staff know of any new referrers.

There is a risk on the TRFT register re cancellation of orders which again can be seen as a trend within the incident log above. This is an electronic failure and referrer error and work is still ongoing with multidisciplinary teams to address this and for this to be a part of the doctor's induction.

IRMER states that Providers are required to regularly review diagnostic reference levels (DRLs) and make them available to operators.

Medical Imaging have ensured all adult and paediatric DRLs have been completed based on national reference levels. These are all pinned up within the working radiology rooms.

Monitoring and managing equipment that falls below normal standards of performance i.e. ageing equipment or unreliability is done via TRFTs risk register. This is regularly updated and reviewed for risk scores and a Business case submitted to the trust board for replacement as and when necessary. Medical Physics experts also are involved then in reviewing the frequency and effectiveness of the routine checks and give their advice on the quality.

All Policies are kept up to date and within review date and on the trusts hub for staff to access.

13.4.1 Points to be noted from this annual radiation protection report 2020-21

- The Trust will need to ensure that all policies, procedures, risk assessments and local rules are revised to reflect the requirements of IRR17 and IR(ME)R17.
- The Trust needs to continue to ensure that all staff who act as Referrers, Practitioners and Operators, maintain their competencies through various training routes. Radiology should keep evidence of all staff training including cardiology and theatres within the department.
- The Trust needs to ensure IR(ME)R procedures to appoint and train non-radiological staff as Practitioners and Operators are followed and identify where in Trust management the responsibility for this will be placed. This may be particularly relevant for Cardiology and some surgeons in Theatres.
- Compliance with IRR17 Reg 16, 'Cooperation between Employers' requires that the Hospital identify where staff employed from outside the hospital are receiving radiation monitoring badges, that the supplier of these is aware that the staff concerned may receive exposure from activities other than those in their employment. See Appendix 1. Appendix 2 should also be used where the Trust is using loan imaging equipment.
- Radiation doses to staff are well within acceptable levels so that the statutory requirements of the Ionising Radiations Regulations 2017 are being met within the radiology department.
- Advice from the Department of Health IR(ME)R Inspectorate recommends that the Trust communicate its IR(ME)R policy to all GPs and other referrers external to the Trust on an annual basis, to ensure that any revisions to practice are communicated and that any new staff into the area receive appropriate information. iRefer is one route by which this may be achieved and this or a suitable alternative is being looked into by the ICS. Areas such as interventional and cardiology need to be included.
- The Department reviews and maintains its regulatory policies and procedures to a high standard. It needs to ensure that these are communicated to staff and that they represent actual practice within the department. The annual staff IR(ME)R assessment provides such assurance and ongoing audit continued.
- Target 'Diagnostic Reference Levels' should be reviewed for all equipment and procedures listed in the 2016 National DRL Guidance. Patient doses so far received have been audited against these values. DRLs may need reviewing after each occasion a major software upgrade is undertaken.
- Recognise that the standard for evidencing compliance under IRR17 (and IR(ME)R17) has increased significantly and that, if inspected, (and despite a great deal of work having been done to implement the new legislation) there is a much higher risk of the Clinic receiving a Notification of Contravention or an Improvement Notice from the HSE.

- Identify where in the organisation responsibility should rest for arranging agreements with all suppliers who enter Employer's Controlled Areas (i.e. Estates contractors, service engineers, etc.) do so in compliance with IRR17 Reg16 Cooperation between employers.

13.5 Nuclear Medicine Department Radiation Protection Report 20/21

13.5.1 General

The department has Registration under IRR17 for:

- Working with artificial radionuclides and naturally occurring radionuclides which are processed for their radioactive, fissile or fertile properties.
- Consent under IRR17 for:
  - The deliberate administration of radioactive substances to people or animals for medical or veterinary diagnosis, treatment or research
  - The deliberate addition of radioactive substances in the production or manufacture of consumer products or other products, including medicinal products
  - Discharging significant amounts of radioactive material into the environment

1. Currently there is one ARSAC holder (Rachel Walker) for the Trust. She has a licence issued on 11/01/2019. Under the new system, the site also requires a licence, which was issued on 19/03/2019. Both licences are valid for 5 years.
2. Risk assessments for all activities relating to nuclear medicine are in place and most have been reviewed recently and updated in line with IRR17.
3. The Trust has appointed corporate RPA and RWA services through Sheffield Teaching Hospitals Radiation Protection Services.
4. The Trust has an MPE for nuclear medicine, the Consultant Physicist in Medical Physics. The MPE has registered as required under IR(ME)R 2017.
5. The department has two Radiation Protection Supervisors. These individuals have had their letters of appointment formally updated to reflect IRR17.
6. IR(ME)R 17 has placed additional requirements on the Trust as follows:
   - Requirement for information on benefits/risks attached to a radiation exposure to be provided to the individual wherever practicable, before the exposure takes place.
   - Communication requirements following "significant" unintended exposure with referrer, practitioner and patient
   - Establishment of dose constraint for comforters and carers.

Policies and procedures are in place to address these requirements.

13.5.2 Facilities and Equipment

1. There have been no changes to the Trust's fixed facilities, major items of equipment, type of work carried out, since the last report. One qualified member of staff has retired and one apprentice taken on.

2. The facility for the mobile PET/CT service operated by Alliance Medical to come on site is still in place, however they have not visited the site since the last report, preferring to scan patients at the fixed facility in Sheffield.

13.5.3 Contingency Plans

There was no requirement to invoke any of the department's contingency plans as defined in the Local Rules.

The next contingency-plan rehearsal is planned to take place as part of staff training in July.

This should be done as a requirement of IRR17.

13.5.4 Radioactive Materials, Waste, Transport

The receipt and accounting for radioactive isotopes received documentation are up to date.

The control, accounting and disposal records of waste appear to be up to date.

The procedure for routine monitoring of contamination and check of closed sources, at the end of the day, 100% of scheduled checks and 97% of environmental contamination checks were carried out which is an improvement on previous years.

The Trust also holds an authorisation certificate from the EA to accumulate and Dispose of radioactive waste. Detailed records of disposals are maintained, and the annual statutory return was submitted in February. The Trust has worked within the limits of the certificate of authorisation during 2020/21.

The Trust had a virtual inspection by the South Yorkshire Police on 17/03/2021. No significant issues were identified. Following the inspection the Trust provided the Counter Terrorism Security Adviser (CTSA) with a 'Site Security Plan – Radioactive Sources', compiled in collaboration between the Consultant Physicist and Trust Security Manager.

The Trust only engages in very limited radioactive transport operations.

These were reviewed by the Trust's appointed DGSA during an annual audit which found generally good compliance and security.

13.5.5 Radon

In 2018 radon monitors were sourced from PHE and placed in Trust and Community locations identified by the Health and Safety Adviser. None of the levels in any areas are of concern, with a maximum annual average estimate of 83 Bq m^{-3} (from a Community site in Barnsley) compared with the action level of 300 Bq m^{-3}.

13.5.6 PET/CT Service

The mobile PET/CT service operated by Alliance Medical, has not visited the site since the last report, however the following procedures remain in place.

Alliance Medical hold a registration and authorisation under RSA93 for mobile PET/CT work, to which our site has been added. Aqueous radioactive waste from the service is discharged to sewer on our site under Alliance Medical's Registration for "Mobile Radioactive Sources".

The Rotherham NHSFT receives solid waste from Alliance. This is placed in a secure location by Alliance staff, and is removed by Medical Physics staff after a minimum of three days, monitored, labelled, documented and consigned to the hospital's clinical waste stream.

13.5.7 Incidents

There were no radiation incidents.

13.5.8 Research

There are no current research project involving radioisotopes.

13.5.9 Procedural Audits

The following procedural audits took place in May 2021:

- Administered activity vs. DRL
- Request justification / LMP & Breast feeding checks

Results for both of these audits were satisfactory. They were fed back to staff at staff meetings and reported at the annual Radiation Safety Committee meeting.

13.5.10 Quality Assurance

A quality assurance programme is in place for the equipment within the department, this includes the gamma cameras, SPECT/CT, autogamma counter, isotope calibrators and contamination meters.

The annual calibration exercise for the isotope calibrators against NPL secondary standard, was undertaken during 2020, with satisfactory results and is due to be repeated now.

The CT component of the SPECT/CT system was tested by Sheffield Medical Physics during September 2020, with satisfactory results.

Items were identified that needed action in the annual QA report of relevance to radiation and included:

- Both gamma cameras and a radionuclide calibrator are well over 10 years old and should be replaced.
- We need to arrange the annual QA of the radionuclide calibrators against the NPL national standard asap.
- The departmental inspection by the appointed RPAs is planned for June 2021.

13.6 Laser/UV/US Protection Report 2020-2021

Advice from the British Medical Laser association regarding use of laser services during COVID was passed on to all LPS's on the 27th of January 2021.

13.6.1 Dermatology

As a result of Covid the LPA audit was conducted via MS Teams with Tara Lees .

The laser service was suspended in 2020, due to Covid, and the LPA requested that both lasers be serviced by the company prior to clinical use.

The LPA has reviewed the Local Rules and Risk Assessment for the two lasers and they are both are up to date.

The LPS has sent through pictures of the safety eyewear and also confirmed that the eyewear is in good physical condition**.**

13.6.2 Ophthalmology

The Ophthalmology department has moved to a new location, the Rotherham Community Health Centre, in October 2020. Both lasers were relocated to RCHC and placed in Room G69.

The LPA performed an audit of the facility on 26th October 2020. If either laser is in use the whole room is designated as a Laser Controlled Area.

Local Rules and Risk Assessment documents (October 2020) are up to date.

The protective eyewear for each laser was clearly marked. One set of eyewear (Ellex laser) was scratched and removed from service.

13.6.3 Theatres

The LPA audit report was sent on the 11th of March 2020. All aspects of laser safety were good. A few suggestions were made for improving the Local Rules and Risk Assessments to provide more information regarding the laser beam details and regulatory compliance documents. An audit for 2021 is now being arranged

It was noted that the number of pieces of protective eyewear had reduced.

All other aspects of the audit were satisfactory.

A laser safety awareness lecture, delivered by the LPA, has been arranged for the 19th of May for theatre staff.

13.6.4 Phototherapy

Due to Covid the last audit was conducted on the 24th of March 2020All aspects of safety and dosimetry were satisfactory.

13.6.5 Mammography ultrasound

Two Ultrasound scanners in the mammography department have regular quality assurance checks in accordance with NHSBSP guideline and PHE governance.

Monthly User QA was performed regularly from April 2020 to March 20201with data available for every month and reports issued every month – a 100% completion for User QA.

13.7 MRI Safety Report 2020-2021

This safety report covers Non-ionising (Magnetic Resonance Imaging) Radiation Protection services provided to Rotherham Hospital between 1st April 2020 and 15th April 2021.

Full scanner performance testing and fringe field confirmation measurements was performed on 23/07/2020. On this occasion all QA test results were within tolerance. The fractional uniformity in the x-direction for gradient echo sequences noted in last year's report remained slightly low but still just within tolerance.

Due to the COVID situation a 'self-assessment' safety audit was performed on 22/4/2020.

This identified one item unlabelled which was immediately resolved.

Patient specific safety advice has been provided on 11 occasions for the following

Implants: Oesophageal stent, PDA closure, NG tube, embolization coils, penile implant, aortic stent and pacemakers.

14 ESTATES AND FACILITIES

14.1 Compliance and Risks

The high rated risk assessments have been reviewed and completed for the directorate and added to the Datix Risk Register.

The maintenance of a safe workplace, access/egress, safe systems of work, safe storage and transportation of materials, supervision, training and maintaining records are all being met.

The Directorate has continued to update its Control of Contractors and Permit to Work Systems, which are issued to all staff and contractors. A contractor's induction programme is undertaken on a twice-weekly basis ensuring full on-site awareness of health, safety and welfare precautions and procedures. A total of 76 companies and 293 individuals have attended in this reporting period, which is having a positive impact on the reduction of accidents, near misses and untoward incidents to the Trust.

The Estates and Facilities risk assessments and safe working systems have been reviewed with departmental managers being kept up to date on a monthly basis of all risk score of 12 and above. The Estates & Facilities Department has listed presently two new risk assessments with a 12 risk score, which is one more than last year. The risk assessments are

1. Absence of an isolated power Supply (IPS) within all Theatres.
2. Loss of Electricity to Equipment in All Theatres.

15 EXTERNAL HSE VISITS

There were one internal routine visit carried out by the HSE (Health and Safety Executive) within the Path Labs during this reporting period. From their visit they were no significant findings or recommendations.

16 POLICIES, SOPS & OTHER DOCUMENTS

The Health and Safety Policy and related policies are reviewed in light of any changes to health and safety legislation and other requirements e.g. revised Health Technical Memorandums (HTM). Policies are being ratified by the Risk and Ratification group and the appropriate updates made. The new policies will be available on the Hub and linked from the Estates, Facilities and H&S websites with the older policies being archived.

16.1 Estates and Facilities Policies reviewed and ratified during 2020/21:

Document Title	Ratified
Environmental Management Policy	29/05/20
CS, PAVA & Taser Policy	29/05/20
Health & Safety at Work (Annual Review)	06/10/20
Pest Control Policy	23/10/20
Policy for Undertaking RIDDOR Notifications	20/11/20
Safe Operation of Ventilation Systems	20/11/20
Water Safety Policy	20/11/20
Moving and Handling Policy	19/03/21
Trust Lease Care Scheme Policy	19/03/21

16.2 Policies currently under review:

Document Title	Review Due
Violence Prevention and Reduction Policy	31/05/21
Mobile Communication Equipment Policy	30/06/21
Cleaning Policy	31/08/21
Control of Substances Hazardous to Health Policy	31/08/21
Handling, Supply & Storage of Linen	30/09/21
Security Policy	24/05/21
Car Parking Policy	24/05/21
Managing Occupational Road Risk Policy	24/05/21

16.3 Other Estates and Facilities Documents reviewed and ratified during 2020/21:

Document Title	Ratified
Security Management Strategy (Workplan)	08/05/20
Concordant for the Care of Prisoners Admitted to the Rotherham NHS Foundation Trust	01/06/20
Fire Safety Strategy	04/12/20

16.4 Other Documents currently under review:

Document Title	Review Due
Security Management Strategy (Workplan)	08/05/21
Concordant for the Care of Prisoners Admitted to the Rotherham NHS Foundation Trust	01/06/21
UECC Lockdown Plan	02/06/21
Bomb Threat Plan	02/06/21
Trust Lockdown Plan	02/06/21
Waste Management Policy	31/07/21
Key Management Policy	29/09/21

16.5 Estates and Facilities Standard Operating Procedures (SOPs) reviewed and ratified during 2020/21:

Document Title	Ratified
Drainage Pipework Access SOP	30/04/20
Safe Use of Power Tools SOP	18/05/20
Safe Use of the Master SmartMover SM60/SM100	27/07/20
Basic Battery Maintenance SOP	31/07/20
Administration of TRFT Car parking Facilities	01/08/20
Estates & Facilities Annual leave Procedures	29/09/20
Electric Tow Truck Training	01/10/20
Transport, Assembly and Dismantling of Bariatric Patient Hoists	11/10/20
Safe Use of Grinding Machines	16/11/20
Sealey Parts Cleaning Tank	16/11/20
Procedure for Working on or near Neutral Conductors	16/11/20
Accessing, for Repair, Machines/equipment with Potential to Cause Infection	20/11/20
Site Winter Maintenance Snow/Ice Removal Plan	25/11/20
Supply & Maintenance of Ultraviolet (UV) Tubes	30/11/20
Safe Use of Kubota Tractor	30/11/20
Karcher High Pressure Washer	30/11/20
Delivery & Handling of Pool Associated Chemicals	07/12/20
Water Safety Policy & Water Safety Plan EPD	08/12/20
Hand Digging/Excavation off Roads & Pathways	11/12/20
Road Transport Security Plan	05/03/21
Reporting of Accidents / Infringements for the Carriage of Dangerous Goods	10/03/21

16.6 SOPs currently under Review:

Document Title	Review Due
Procedure for Testing Generators and UPS Systems	19/04/21
Tritech Drink Tower SOP	23/04/21
Deceased Babies and Specimen Transfer to and from Sheffield Children's Hospital for Paediatric Post-Mortem SOP	03/05/21

17 RISK REGISTER

The continuous review and implementation of the Datix web risk register has seen a decrease in the number of risks recorded as live, this is in accordance with the Trust approved Risk Management Strategy. The total number of health and safety risk assessments on Datix now stands at approximately 381, which is down from 409 in the last report. The system is an integral part of producing corporate risk registers for a number of committees throughout the organisation.

18 CARRIAGE OF DANGEROUS GOODS

The Trust underwent an external audit during November 2020 for compliance against the carriage of dangerous goods (ADR 2019). Due to the current COVID 19 pandemic, the auditor was only able to visit departments in the acute settings checking for compliance. No community settings were visited during this audit, it is anticipated these visits will be carried out as soon as COVID 19 restrictions are no longer required. An action plan was produced identifying 11 recommendations of which 8 actions are in the process of completion or have been completed and three are still in progress some awaiting external input. The external report is available for review if required.

19 AREAS FOR FUTURE DEVELOPMENT

Priorities for 2021/22

- Implementation and monitoring of Year 1 of the 2021/24 Health and Safety Strategy.
- Implementation of First Aid Trainer/Assessor.
- Continue the delivery of the health and safety training programme for COSHH and Risk Assessment through 2021/22 including provision of support to staff.
- Continue to develop and embed risk registers across the Trust through the support of the risk assessors to ensure resources and funds are prioritised.
- On-going work to review moving and handling training, and potentially introduction of new moving and handling link workers in all areas including none clinical areas.
- Continue to ensure the Trust is working to achieve the Board approved Security Management Work Plan for 2021/22.
- Continued review of Policies and SOPs for 2021/22 as necessary.

20 SUMMARY

20.1 Health and Safety

The development and implementation of the first year of the H&S Strategy for 2021/24 has assisted in identifiying the Trust's position with regard to the management of H&S risks.

The progress being made is very good as identified by the gaining of the RoSPA Gold Award for the eighth year running. To gain the award the Trust's management systems and outcomes have been scrutinised by an external body.

The implimentation of the approved H&S strategy for 2021/24 and subsequent implementation will assist in ensuring the continuation of good and steady improvement.

20.2 Security

The introduction of the Violence Reduction standards in April 2021 will provide TRFT with a measure as to where we are as an orgainsiation. Work has already commenced on the introduction of new training and a Strategy to reduce incidnets of vilolence and aggression.

All staff will need to maintain their own responsibilities with regards to all security measures in and around their workplace, this will assist with a more positive attitude that will prevent and reduce the small number of incidents relating to opportunist crime that are committed around the Trust.

20.3 Fire

This last year has been a particular challenging period due the ongoing issue with COVID-19. Although the Trusts assurance to fire safety has remained. The Trust should be proud of the end of year results

There was no increase of fires within the Hospital from last year's figures, with one small incident, that was controlled by members of staff. Staff carried out the Trust Fire Procedures with no problems and the fire response team carried out their duties in an exemplary manner.

It can be seen that staff are adhering to the Fire Policy and training with a reduction in number of false alarms falling from 57 to 44.

A large investment is taking place with a lot of refurbishments already taken place and other moves in pipeline for the forthcoming year

Unfortunately, it is well understood that fire can strike at any time so the Trust needs to be prepared for a fire at any time of the day or night. The Trust Fire Response Team attended every incident within the Trust always ensuring that every incident is dealt with effectively. Staff have ensured over the last year that the organisation is a safe place to work and must now keep this excellent attitude towards fire safety and continue to keep fire at bay.

20.4 Sharp Safety

The focus for 2020/21 is on ensuring continued compliance with the UK legislation with continuously scanning for new technological advances for new of improved safety devices.

A controlled review of disposed sharps by SharpSmart will look to provide assurance that safety devices are being activated prior to disposal and that no non-safety devices are in use when there is a safe alternative available.

20.5 Recommendation

The Board of Directors are asked to receive the Annual Health and Safety Management Report for 2020/21 for their information.

N.B: Please note that all data used to populate the Annual Health and Safety Management Report for the period of 2020/21 was extracted from the datix risk management datebase during September/October 2021.

Board of Directors' Meeting
07 January 2022

The Rotherham NHS Foundation Trust

Agenda item	P24/22
Report	**Board Assurance Framework: Quarter 3**
Executive Lead	Angela Wendzicha, Director of Corporate Affairs
Link with the BAF	The paper links with the entire Board Assurance Framework
How does this paper support Trust Values	The Board Assurance Framework is a key element that provides evidence of good governance and therefore supports all three core values, Ambitious, Caring and Together.
Purpose	**For decision** ☒ **For assurance** ☐ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	The Board Assurance Committees discussed the Quarter 3 position in relation to the Board Assurance Framework and their respective BAF risks during the meetings scheduled in December 2021 as follows: **People Committee:** Discussed and approved the position in relation to BAF Risk 4 and BAF Risk 5. **Finance and Performance Committee:** Discussed and approved the position in relation to BAF Risk 2, BAF Risk 8 and BAF Risk 9. **Quality Committee:** Discussed and approved the position in relation to BAF Risk 1, BAF Risk 2, BAF Risk 3 and BAF Risk 6. The Audit Committee met on 30 December 2021 to discuss the position at Quarter 3 and was assured in relation to the process and assessment of the risks as appropriate. The Audit Committee subsequently agreed to recommend that the Board approve the Quarter 3 position in relation to the Board Assurance Framework.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	The Board Assurance Framework position for Quarter 3 has been discussed at the relevant Board Committees prior to further scrutiny at an extra Audit Committee held on 30 December 2021.
Board powers to make this decision	In accordance with the approved Matters Reserved to the Board, Internal Controls- the Board is required to ensure the maintenance of a sound system of internal control and risk management, including "*Approval of the Board Assurance Framework".*
Who, What and When (what action is required, who is the lead and when should it be completed?)	The Director of Corporate Affairs will work with Executive colleagues in order to develop the revised Board Assurance Framework that will align with the new approve 5 Year Strategy in preparation for April 2022. This will include a full review of the Trust's Risk Appetite Statement.

Recommendations	The Board is requested to discuss and approve the position in relation to the Board Assurance Framework for Quarter 3.
Appendices	Board Assurance Framework

1. Introduction

1.1 The Board Assurance Framework has been discussed at the Board Assurance Committees during December 2021. The following report provides the Trust Board with the updated position in relation to the Board Assurance Framework for Quarter 3 as discussed at the Audit Committee on 30 December 2021.

2. Quarter 3 Outcome

2.1.1 **The People Committee** discussed the following Board Assurance Risks at the meeting convened on Friday 17 December 2021:

2.1.2 **BAF Risk 4**: Lack of effective staff engagement will impact on staff experience resulting in poor staff survey results which impact on the organisation's ability to deliver the Trust's plan.

The People Committee noted that two additional levels of control had been added during Quarter 3 as follows:

C13: The Behavioural Framework has been launched during Quarter 3 and
C14: Completion of the tendering process for the new Occupational Health Service has been completed with a view to the new service commencing from April 2022.

Additional commentary in relation to Assurance 2 has been included relating to the response rate for the 2021 Staff Survey, namely our response rate is 59.6% which reflects an increase of 7.4%; the Trust is currently 8.5% above the national average.

The gap relating to capacity to support the Health and Wellbeing Initiative (G5) has been transferred to an assurance as the additional resource has been approved and is in place.

The People Committee discussed the risks in detail, deliberating in relation to whether the Trust's well-being offer could potentially reduce the score for this risk. The People Committee concluded that that risk score should remain the same at **12** (L=3xC=4). In addition, the People Committee discussed the target score for BAF Risk 4 and agreed to increase the target score to **12** (L3xC4).

2.1.3 **BAF Risk 5:** Inability to recruit and retain staff within the organisation leading to impaired ability to deliver the Trust plan and increased temporary staffing costs.

The People Committee discussed the risk and following consideration concluded the risk score should remain the same at **12** (L=3xC=4) as there have been no additional controls or assurances identified. The People Committee concluded the target score was appropriate.

2.1.4 **The Finance and Performance Committee** discussed the following Board Assurance Risks at the meeting convened on Wednesday 22 December 2021:

2.1.5 **BAF Risk 2:** Demand for care exceeds the resources available, leading to failure to achieve recognised healthcare standards and to recover performance to the required levels within agreed timeframes.

The Finance and Performance Committee agreed at the November meeting to include BAF Risk 2 in the BAF Risks aligned to the Finance and Performance Committee. The rationale for this was due to the overarching purpose of the Committee is to oversee both financial and operational matters; BAF Risk 2 relates to the link between demand for care and the availability of resources in addition to the ability to recover performance.

Following review for Q3, the proposed risk score remains the same at **16** (L4xC4). The Finance and Performance Committee discussed the movement of a previous level of assurance around 'right to reside' (A3) from a level of assurance to a gap in control.

2.1.6 **BAF Risk 8**: The financial plan is not delivered.

The Finance and Performance Committee discussed the risk in detail confirming that the financial plan for H1 had been delivered and that due to agreement on the balance position for H2, the risk score is correct at **3** (L=1xC=3). The Committee noted that since the review in Q2, three gaps in controls had been closed (G3, G4 and G7) resulting in a managed risk position within the target risk score and agreed risk appetite.

2.1.7 **BAF Risk 9:** The lack of capital investment may affect the delivery of some services.

The Finance and Performance Committee discussed the risk score of **4** (L=1xC=4) agreeing this has remained unchanged since the score was reduced during Q2 and remains a managed risk within the target risk and agreed risk appetite.

2.1.8 **The Quality Committee** discussed the following Board Assurance Risks at the meeting convened on Wednesday 22 December 2021:

2.1.9 **BAF Risk 1:** Standards and quality of care do not deliver the required patient safety, clinical effectiveness and patient experience that meet regulatory requirements.

The Quality Committee agreed that to retain a risk score of **20** (L=4xC=5) given that the CQC Warning Notices remain in place. The Committee noted that the control relating to the Serious Incident Process had been moved from a control (C6) to a gap in control due to the ongoing work to strengthen this process. An additional control relating to the Medical Directors involvement in medicine safety was noted as an addition during Q3.

2.1.10 **BAF Risk 2:** Demand for care exceeds the resources available, leading to failure to achieve recognised healthcare standards and to recover performance to the required levels within agreed timeframes.

The Quality Committee agreed to retain a risk score of **16** (L=4xC=4) as demand for services have increased with increasing waits in UECC. It is expected that the new

Covid variant will result in further adjustments being made to the risk score. As in the Finance and Performance Committee, the Quality Committee noted the assurance level A3 moved to a gap in control due to the increasing deteriorating position around right to reside.

2.1.11 **BAF Risk 3:** Should the Trust fail to actively engage with, or listen to the experience of service users, there is a risk that the organisation will not learn or improve the quality of care (experience, quality and outcomes) for those who use our services.

The Quality Committee agreed to retain a risk score of **16** (L=4xC=4) due to no changes in gaps or controls for BAF Risk 3.

2.1.12 **BAF Risk 6:** Insufficiently robust Trust-wide quality and clinical governance arrangements impede the delivery of a number of Trust plans/objectives.

The Quality Committee agreed to retain a risk score of **20** (L=4xC=5) due to the ongoing work around the quality governance agenda.

3. Risks for Discussion by the Board

The following BAF Risks are allocated to the Board of Directors for discussion and agreeing the risk scores:

BAF Risk 10: There is a risk that the Trust has insufficient governance in place with partners in the South Yorkshire and Bassetlaw ICS which will impact on the Trust's ability to contribute effectively to the partnerships in Place, Provider Collaborative.

The risk score is currently at **8** (L=2xC=4).

BAF Risk 11: Joint working with key partners is developing steadily and relationships are in formative periods. Unless these relationships continue to develop, there is a risk to continuity and poor service configuration across the Rotherham Place.

The risk score is currently at **8** (L=2xC=4).

4. The Audit Committee

The Audit Committee met on 30 December 2021 with Internal Audit present in order to discuss the Quarter 3 position. Discussion ensued in relation to the ongoing dialogue and assessment of the Board Assurance Risks in addition to the plan going forward to further strengthen the process. The

5. Next Steps

The Director of Corporate Affairs will continue to work in conjunction with Executive colleagues to further strengthen the process around the Board Assurance Framework and aligning the risk register to the Board Assurance Risks.

In addition, work will commence during January 2022 to develop the revised Board Assurance Framework to align with the new 5 Year Strategy. In addition, Internal Audit will commence a review into Risk Management the outcome of which will be included in the planned work going forward to strengthen the overarching risk management processes.

6. Recommendations

The Board is requested to discuss the outcomes following review of the Board Assurance Framework for Quarter 3 and approve the current position. In addition, the Board is asked to note the review of Risk Management by the Trust Internal Audit function and the proposed development of a revised Board Assurance Framework to align with the new 5 Year Strategy for discussion at the Strategic Board in February 2022.

Angela Wendzicha
Director of Corporate Affairs
31 December 2021

Strategic Objective	BAF ID	Risk Identity	Operational Plan Cross Reference	Risk Register Cross Reference	Risk Owner	Committee Owner	Date Last Reviewed by Committee	Initial Risk Score (at 01 April 2021)			Q1 Risk Score			Q2 Risk Score			Q3 Risk Score			2021/22 Target Risk Score		
								L	C		L	C		L	C		L	C		L	C	
PATIENTS: Excellence in healthcare Which means…	**B1**	**Standards and quality of care do not deliver the required patient safety, clinical effectiveness and patient experience that meet regulatory requirements**	**Focus on the fundamentals of care** - Embed agreed standards of care and support teams to deliver and embed quality improvement - Implement effective learning from deaths practices and deliver improved mortality rate	4174, 5169, 5442, 5761, 5950, 6119, 6296, 6386	**CN / MD**	**All to QC -** BAF Risk2 also to F&P	**28-Apr-21**	4	5	20	4	5	20	4	5	20	4	5	20	**3**	**5**	**15**
PATIENTS: Excellence in healthcare Which means… - Deliver high quality care to our patients every day - Put patients at the centre of what we do - Continuously improve the quality of care and services we provide - Develop and implement new models of care for the future	**B2**	**Demand for care exceeds the resources available, leading to failure to achieve recognised healthcare standards and to recover performance to the required levels within agreed timeframes**	**Deliver elective recovery for patients:** - Plan the long term recovery of elective care and deliver 2021/22 recovery plan - Implement programme of ensuring operational excellence in elective care	5715, 5779, 6127, 4514, 6119, 6198, 6199, 6213, 6215, 6226, 6417	**COO**			4	4	16	4	4	16	4	4	16	4	4	16	**3**	**4**	**12**
	B3	**Should the Trust fail to actively engage with, or listen to the experience of service users, there is a risk that the organisation will not learn or improve the quality of care (experience, quality and outcomes) for those who use our services**	**Focus on the fundamentals of care** - Embed agreed standards of care and support teams to deliver and embed quality improvement - Implement effective learning from deaths practices and deliver improved mortality rate	No risks	**CN / MD**		**28-Apr-21**	4	4	16	4	4	16	4	4	16	4	4	16	**3**	**4**	**12**

Strategic Objective	BAF ID	Risk Identity	Operational Plan Cross Reference	Risk Register Cross Reference	Risk Owner	Committee Owner	Date Last Reviewed by Committee	Initial Risk Score (at 01 April 2021)			Q1 Risk Score			Q2 Risk Score			Q3 Risk Score			2021/22 Target Risk Score		
								L	C		L	C		L	C		L	C		L	C	
COLLEAGUES: Engaged, accountable colleagues Which means… - Recruit, retain and develop a high performing, effective and motivated workforce - Be a learning organisation with a culture of continuous improvement - Engage with colleagues and communicate effectively - Develop strong leadership at all levels of the organisation	**B4**	**Lack of effective staff engagement will impact on staff experience resulting in poor staff survey results which impact on the organisation's ability to deliver the Trust's plan**	**Safely exit the COVID-19 pandemic:** deliver full programme of Health & Wellbeing initiatives for staff **Empower and enable staff to deliver:** - design and launch organisational development programme for divisional teams	No risks	**DoW**	**PC**	**30-Apr-21**	3	4	12	3	4	12	3	4	12	3	4	12	**3**	**4**	**12**
	B5	**Inability to recruit and retain staff within the organisation leading to impaired ability to deliver the Trust plan and increased temporary staffing costs**	**Safely exit the COVID-19 pandemic:** identify new practices from COVID--19 to embed in the long term and implement new ways of working **Empower and enable staff to deliver:** - Build a culture so that the trust is seen as an employer of choice, appointing to key clinical leadership vacancies	4959, 5442, 4514, 5715, 6417				3	4	12	3	4	12	3	4	12	3	4	12	**3**	**4**	**12**

Strategic Objective	BAF ID	Risk Identity	Operational Plan Cross Reference	Risk Register Cross Reference	Risk Owner	Committee Owner	Date Last Reviewed by Committee	Initial Risk Score (at 01 April 2021)			Q1 Risk Score			Q2 Risk Score			Q3 Risk Score			2021/22 Target Risk Score		
								L	C		L	C		L	C		L	C		L	C	
GOVERNANCE: Trusted, open governance Which means… - Have an effective performance framework to help deliver outstanding results - Be outstanding on the CQC 'well-led' framework across the Trust - Have high quality data to provide robust information and support decision making - Ensure all teams have regular reviews and updates around key issues and opportunities to learn	**B6**	**Insufficiently robust Trust-wide quality and clinical governance arrangements impede the delivery of a number of Trust plans / objectives**	**Focus on the fundamentals of care** - Embed agreed standards of care and support teams to deliver and embed quality improvement - Implement effective learning from deaths practices and deliver improved mortality rate	4174, 5169	**CN / MD**	**QC**	**28-Apr-21**	4	4	16	4	5	20	4	5	20	4	5	20	**3**	**5**	**15**
	B7	**There is a risk that robust financial governance arrangements are not embedded across the Trust which could impact on the achievement of Trust plans / objectives, and subsequent removal of the financial planning undertakings and breach of the provider licence**	**Drive the organisation forwards:** - Deliver on our financial commitments and ensure removal of breach of licence	No risks	**DCE / DoF**	**Audit**	**N/A**	N/A			3	4	12	3	4	12	**2**	**4**	**8**	**3**	**4**	**12**

Strategic Objective	BAF ID	Risk Identity	Operational Plan Cross Reference	Risk Register Cross Reference	Risk Owner	Committee Owner	Date Last Reviewed by Committee	Initial Risk Score (at 01 April 2021)			Q1 Risk Score			Q2 Risk Score			Q3 Risk Score			2021/22 Target Risk Score		
								L	C		L	C		L	C		L	C		L	C	
FINANCES: Strong financial foundations Deliver strong financial foundations through: - Improving liquidity whilst ensuring appropriate investment in estates and assets - Managing within the approved budget and reduce the underlying deficit - Improving financial performance through service transformation and co improvement.	**B8**	**The financial plan is not delivered**	**Drive the organisation forwards:** - Deliver on our financial commitments and ensure removal of breach of licence	5779	**DoF**	**F&PC**	**28-Apr-21**	1	3	3	1	3	3	1	3	3	**1**	**3**	**3**	**3**	**3**	**9**
	B9	**The lack of capital investment may affect the delivery of some services**		6198				2	5	10	2	4	8	1	4	4	**1**	**4**	**4**	**2**	**4**	**8**

Strategic Objective	BAF ID	Risk Identity	Operational Plan Cross Reference	Risk Register Cross Reference	Risk Owner	Committee Owner	Date Last Reviewed by Committee	Initial Risk Score (at 01 April 2021)			Q1 Risk Score			Q2 Risk Score			Q3 Risk Score			2021/22 Target Risk Score		
								L	C		L	C		L	C		L	C		L	C	
PARTNERS: Securing the future together Which means… - Work with our partners to provide sustainable health and care services for the population of Rotherham - Be open to new ideas and innovations and adopt these wherever we can - Collaborate with partners across South Yorkshire & Bassetlaw on key services to improve service resilience and sustainability	**B10**	~~Misaligned governance and decision-making may arise from divergent Trust and ICS interests and objectives~~ **There is a risk that the Trust has insufficient governance in place with partners in the South Yorkshire and Bassetlaw ICS which will impact on the Trust's ability to contribute effectively to the partnerships in place, provider collaboratives, and digital and data to drive systems**	**Drive the organisation forwards:** - Publish a new five year strategy and support partners with re-organisation	No risks	**DCE**	**BoD**	**N/A**	N/A			2	4	8	2	4	8	**2**	**4**	**8**	**2**	**4**	**8**
	B11	~~Ineffective relationships with key partners may lead to a lack of integrated working and poor service configuration across the Rotherham Place~~ **Joint working with key partners is developing steadily and relationships are in formative periods. Unless these relationships continue to develop there is a risk to continuity and poor service configuration across the Rotherham Place**		6226, 6386	**COO**	**BoD**		N/A			2	4	8	2	4	8	**2**	**4**	**8**	**1**	**4**	**4**

DCE	Deputy Chief Executive
CN	Chief Nurse
MD	Medical Director
DoW	Director of Workforce
DoF	Interim Director of Finance
COO	Chief Operating Officer
Co Sec	Company Secretary
BoD	Board of Directors
QC	Quality Committee
Audit	Audit Committee
F&PC	Finance & Performance Committee
PC	People Committee

Risk Matrix:

	Likelihood				
Consequence	Rare (1)	Unlikely (2)	Possible (3)	Likely (4)	Almost certain (5)
Catastrophic (5)	5	10	15	20	25
Major (4)	4	8	12	16	20
Moderate (3)	3	6	9	12	15
Minor (2)	2	4	6	8	10
Negligible (1)	1	2	3	4	5

PATIENTS: Excellence in healthcare

BAF Item B1: Standards and quality of care do not deliver the required patient safety, clinical effectiveness and patient experience that meet regulatory requirements *Risk Owner: ~~Interim~~ Chief Nurse & Medical Director* *Board Committee: Quality Committee* *Date the risk last reviewed: 28-Apr-21*	**Link to 2021/22 Operational Plan** **Focus on the fundamentals of care** **- Embed agreed standards of care and support teams to deliver and embed quality improvement** **- Implement effective learning from deaths practices and deliver improved mortality rate**	**Link to Operational Risks (scoring 15+):** **4174:** Clinicians do not always recognise the deteriorating patient **5169:** Significantly raised HSMR and SHMI meaning higher mortality rates than expected **5442:** Inability to fill high number of registered nurse vacancies leading to potentially a reduction in patient experience and safety **5761**: UECC patient safety due to overcrowding **5950:** Lack of consistent triage through a single overnight service (streaming undertaken during COVID-19 and impact on having split clinical areas in UECC) **6119:** Management of the department during COVID-19 (UECC) **6296:** Overcrowding in the UECC waiting room relating to concerns with COVID **6386:** CAMHs inpatients on Children's Ward and Children's Assessment Unit (CAU)

STRATEGIC OBJECTIVE:
PATIENTS: Excellence in healthcare
Which means…
- Deliver high quality care to our patients every day
- Put patients at the centre of what we do
- Continuously improve the quality of care and services we provide
- Develop and implement new models of care for the future

Executive Summary - Quarterly Update:
Q1: Not appropriate to reduce current risk score whilst CQC warning notice still in place and report from most recent CQC inspections awaited.

Q2: Not considered appropriate to reduce risk score whilst CQC inspection report is still awaited and whilst CQC warning notices are in effect. **Q3 Update: CQC report recieved and warning notices remain in place therefore score remains the same.**

LIKELIHOOD X CONSEQUENCE = RISK SCORE

INITIAL RISK SCORE (pre-mitigation) as at 01 April 2021	Q1 RISK SCORE	Q2 RISK SCORE	Q3 RISK SCORE	Q4 RISK SCORE	MOVEMENT	TARGET RISK SCORE to be achieved by 31/09/2021
4 x 5 = 20 L (likely) x C (catastrophic)	**4 x 5 = 20 L (likely) x C (catastrophic)**	**4 x 5 = 20 L (likely) x C (catastrophic)**	**4 x 5 = 20 L (likely) x C (catastrophic)**		➔	3 x 5 = 15 L (possible) x C (catastrophic)

Risk Appetite:
TRFT has a **VERY LOW** risk appetite for risk that may compromise the delivery of outcomes for our service users (score of 1 - 5)
TRFT has a **LOW** risk appetite for risks that may affect the experience of our service users (score of 6 -10)
TRFT has a **VERY LOW** risk appetite for risks that may compromise safety (1-5)
TRFT has a **VERY LOW** risk appetite for Compliance / Regulatory risk which may compromise the Trust's compliance with its statutory duties and regulatory requirements (1-5)

Current Risk Appetite (based on current risk score):
High (16 - 25)

Target Risk Appetite (based on target risk score):
In line with / below appetite of MODERATE (12 - 15)

CONTROLS and MITIGATION:
(i.e. what are we currently doing about this risk?)

What are the key controls that are in place to mitigate this risk?

Ref	CONTROL
C1	Achievement and embedding of Quality Priorities
C2	Regular monitoring of quality indicators and instigation and implementation of remedial action by Quality Committee, Clinical Governance Committee and sub-groups, Risk Management Committee and sub-group
C3	Oversight of implementation of 'must do' and 'should do' actions and responsiveness to warning notices by Divisional, pathway and Trust-wide CQC Action Plan Steering Groups including escalation of issues and implementation of remedial action. Regulatory compliance against section 29A and section 31 warning notices in place.
C4	Reintroduction of Trust's professional standards entitled *'Who goes where'* at the beginning of June 2021 to ensure that patients go to the most appropriate specialty and that flow is optimised within the organisation
C5	Review of risk assessments by Risk Management Committee and sub-group and Divisions on a monthly basis complemented by quarterly review of risk scoring 15+ by Board Assurance Committees. All new risks scoring 15+ reviewed on a weekly basis at Executive Team Meeting.

ASSURANCE OR EVIDENCE ACTUALLY RECEIVED
(i.e. how do we know that we are making an impact in managing the risk?)

Ref	ASSURANCE / EVIDENCE (positive or negative)	SOURCE OF ASSURANCE / EVIDENCE			DATE LAST ASSURANCE PROVIDED
		1. Internal (operational)	2. Internal: (oversight)	3. External	
A1	Monthly reporting of HSMR and SHMI at CGC, QC and Trust Board and via monthly IPR at Perf Meetings (monthly, negative: SHMI 109 and Trust is no longer an outlier; HSMR at 125; Jan-21 data). Q3 Update: Delay in receiving data from Dr Foster, last data received in May 2021.			✓	**Quality Committee and Clinical Governance Committee Jan-21**
A2	Monthly contact between Chief Nurse and CQC to provide assurance relating to implementation of 'must do' and 'should do' actions arising from inspections as well as any other quality concerns. Regulatory compliance against section 29A and section 31 warning notices in place. (monthly, positive)			✓	**Sep-21**
A3	Incident management and escalation enacted by senior leaders in accordance with acuity of situation across the Trust (e.g. Gold, silver or bronze meetings as required) (regular, mixed assurance)	✓			**Jun-21**
A4	Assurances in relation to mortality A) 2 Medical Examiners (ME) in post, ME officers now fully recruited. Clinical coding staff member based in ME office (ongoing, positive) B) Monthly Safe & Sound mortality group meeting in place with Divisional representation including Health Informatics and Divisional mortality sub-groups being aligned to Terms of Reference. All Divisional mortality sub-groups are in place including in Medicine and Surgery Divisions (monthly, mixed assurance) C) Monthly mortality Task & Finish Group chaired by Chief Executive with parallel insight mortality group reporting into Task & Finish group (started Dec-20). Overarching mortality improvement action plan in place and reported to Clinical Governance Committee, Quality Committee and Board monthly (monthly, mixed assurance) **Q3 Gap due to long term sickness in the ME service**	✓			**Jun-21**
A5	Reports on Quality Priorities 2020/21 Monthly updates to Clinical Governance Committee and Quality Committee (monthly, Mixed assurance)		✓		**Jun-21**

GAPS IN CONTROL (C) or ASSURANCE (A)
gap in control = exist where adequate controls are not in place, or where collectively they are not sufficiently evident
gap in assurance = exist where there is a failure to gain evidence that the controls are effective

Ref	GAP	MITIGATING ACTIONS TO BE TAKEN TO CLOSE THE GAP	RESPONSIBLE EXECUTIVE DIRECTOR	DEADLINE BY WHICH THE GAP WILL BE CLOSED
G1	Standards of Care & Quality Improvement (Mandate 2A) **(C&A)**	1. Establish a Quality Strategy Working Group 2. Identify the Quality Improvement Methodology (Toolkit)to be utilised across the Trust and its method of support and implementation - *revised timescale TBC as need to ensure refreshed Quality Strategy links to Trust strategy. Q2 Update: Methodology still being worked on. Will complete in Q3* 3. Identify and agree the standards of care required and measurement for improvement - *revised timescale Q3 as need to ensure refreshed Quality Strategy links to Trust strategy* 4. Refine Quality Strategy and present for Board sign off 5. Relaunch the Safe and Sound Quality Strategy *Q2 Update: delayed by 2 months* 6. Refresh of the Safe and Sound Quality Scorecard using the metrics identified in the strategy 7. Launch the KPIs data collection of perfect ward - completed 8. Develop Quality Improvement Methodology (Toolkit)and launch it 9. Embed Quality Improvement and encourage continuous improvement as BAU Q3: Quality Governance Structure under review.	Chief Nurse	**1. 31-May-21 -** completed **2. ~~30-Jun-21~~ -** revised timescale to Q3 **3. ~~30-Jun-21~~ -** revised timescale to Q3 **4. ~~9-Jul-21~~** Q3 **5. ~~31-Jul-21~~** Q3 **6. ~~31-Jul-21~~** Q3 **7. 31-Jul-21 - completed** **8. 30-Sep-21** **9. 31-Mar-22**
G2	Learning from Deaths (Mandate 2B) **(A)**	1. Completion of investigation and initial actions into Palliative Care processes and coding 2. Completion of actions identified by Internal Audit review of Governance 3. Transfer of work from MIG and MAG into Business-as-Usual governance and ways of working 4. Appointment to Associate Medical Director Mortality and Learning from Deaths and Mortality Manager posts 5. Implement Community Acquired Pneumonia (CAP) policy 6. Completion and learning from Improvement Academy work in the Urgent and Emergency Care Centre (UECC)	Medical Director	**Q2 Q3 Q3 Q2 Q1 Q4**
G3	Ensuring all actions from SI and red incident investigations are completed and sustained **(A)**	**Q4 Update:** Currently 24 red incident investigations and 4 SI investigations are overdue. In order to close gap would need to have overdue red incidents under 10 and overdue SIs under 5. **Q1 Update**: as at end May-21 5 overdue SIs and 21 overdue red incidents **Q2 Update:** as at Aug-21 QC report zero overdue SIs, 3 overdue incidenrs (all HSIB investigations) and 14 overdue red incidents therefore gap remains.	Deputy Chief Nurse	**Q4**
G4	CQC issued section 29A warning notice on 11 February 2021 **(C&A)**	Preliminary response sent to CQC on 11-Dec-10, feedback awaited. Work has commenced on the required action plan. Submission date 19 Feb 2021 **Q1 Update:** Only a small number of actions are still open and all are due for completion in Q2 2021/22 **Q2 Update:** 1 action is outstanding, due to complete in Q3	Chief Nurse	**Q2** Q3
G5	Lack of Trust-wide consistent and robust quality governance arrangements **(C&A)**	**Q4 Update:** Sufficient assurance in place regarding Divisional governance meetings. Less assurance available regarding CSU meetings so a member of Chief Nurse / Medical Director team will start attending CSU level meetings. Assurance should be in place by end Q1 2021/22. Medical Director now chairing Clinical Effectiveness Group with enhanced focus on NICE compliance plus revised ToR to include policy compliance moving forward. **Q1 Update:** 360 Assurance Strategic Quality Assurance review (Jun-21) gave 'Significant Assurance' rating and made 4 medium recommendations (see BAF item B6 G16 for action plan). There has been a sustained improvement in policy compliance and NICE compliance. There needs to be evidence of discussion and dissemination of learning from deaths and SJRs happening at Divisional and CSU level before this gap can be closed. **Q2 Update:** gap remains. Learning from Deaths Manager recruitment is underway.	Medical Director & Chief Nurse	**Q2 2021/22**

CONTROLS and MITIGATION:
(i.e. what are we currently doing about this risk?)

What are the key controls that are in place to mitigate this risk?

Ref	CONTROL
C6	Robust Serious Incident process in place in accordance with the Incident and Serious Incident Management Policy
C7	Coordinated approach to monitoring and learning from morbidity and mortality in accordance with agreed processes
C8	Annual Clinical Audit Plan completion monitored via quarterly reports to Clinical Governance Committee and via monthly Clinical Effectiveness and Research Group
C9	Monthly Safe & Sound mortality group continues to meet; Deteriorating patient and sepsis group and clinical leads Safe & Sound Internal Professional Standards meeting are also continuing to meet. Other Safe & Sound workstreams are being reviewed as part of the refresh of the Quality Strategy and identification of quality improvement methodology (links to G1)
C10	Organisational Learning Action Forum (OLAF) introduced in late September 2020 to ensure that learning from claims, complaints, incidents and inquests can be used to positively impact on quality of care to close the loop with the clinical audit process to provide assurance.
C11	Existing Mental Health strategy in place to ensure best practice care is provided
C12	
C13	

ASSURANCE OR EVIDENCE ACTUALLY RECEIVED
(i.e. how do we know that we are making an impact in managing the risk?)

Ref	ASSURANCE / EVIDENCE (positive or negative)	SOURCE OF ASSURANCE / EVIDENCE			DATE LAST ASSURANCE PROVIDED
		1. Internal (operational)	2. Internal: (oversight)	3. External	
A6	CQC Insight for Acute NHS Trusts reports (periodic, mixed assurance)			✓	**Aug-21**
A7	360 Assurance 'Learning from deaths review - stage 1 mortality reviews' report (Sept 20) gave 'limited assurance' rating and made 4 medium actions (ad hoc, negative) See BAF item B6 G14 for action plan 360 Assurance Learning from Deaths Governance review Apr-21 gave 'limited assurance rating and made 2 high and 9 medium recommendations (ad hoc, negative) See BAF item B6 G13 for action plan			✓	**Sep-21** **Apr-21**
A8	CQC have reduced the frequency of quality assurance meetings				
A9	CQC section 31 warning notice;(See G14 for action plan) CQC issued section 29A warning notice on 11 February 2021; Section 29A improvement action plan in place (see G4 for action plan) CQC Children's Safeguarding action plan. All actions now completed and Deputy Chief Nurse for Safeguarding is undertaking a review to ensure that all actions are sustained. (ad hoc, positive)			✓	**Feb-21** **Jun-21**
A10	NHS England qualitative risk profile (QRP) assessment undertaken in conjunction with RCCG: submission of a self-assessment of risk score and evidence. Follow on meeting concluded no need to escalate to single item quality surveillance group or risk summit (ad hoc, positive outcome) NHSE/I attending monthly RCCG Contract Quality Meetings			✓	**Sep-21**
A11	Executive Directors' weekly walkarounds (weekly, positive) Chief Nurse and Medical Director clinics (twice monthly, positive)	✓			**Jun-21**
A12	Senior Nurse and AHP 'Back to the floor' monthly sessions to be reinstated in July and August 2021 (monthly, mixed assurance)	✓			**Q2 2021/22**
A13	NHS E/I external review of medicines management (ad hic, mixed assurance)			✓	**Q2 2021/22**
A14	Deprivation of Liberty Safeguards (DoLS) performance is included in Safeguarding quarterly report to Quality Committee and also reviewed at Startegic Safeguarding Group (quarterly, mixed assurance)		✓		**Aug-21**
A15	Serious Incident reports to Clinical Governance Commmittee and Quality Committee (Monthly, mixed assurance)				

GAPS IN CONTROL (C) or ASSURANCE (A)

gap in control = exist where adequate controls are not in place, or where collectively they are not sufficiently evident
gap in assurance = exist where there is a failure to gain evidence that the controls are effective

Ref	GAP	MITIGATING ACTIONS TO BE TAKEN TO CLOSE THE GAP	RESPONSIBLE EXECUTIVE DIRECTOR	DEADLINE BY WHICH THE GAP WILL BE CLOSED
G6	Gap in assurance and control relating to: - medication safety / medicines management at Divisional and Pharmacy level **(C&A)** - delayed administration of critical medications and controlled drugs **(C&A)**	Medication Safety Group with be chaired by Medical Director in Q2 Rotherham Medicines Optimisation Group (RMOG) to be chaired by Deputy Medical Director during Q2 Working to arrange NHS E/I external review of medicines management to take place in Q2 Ongoing challenge of getting the SCRIPT training module onto the ESR system working with Learning & Development department and Chief Pharmacist. **Q2 Update:** External review has not yet taken place. SCRIPT is not on ESRas yet. ***Medical Safety Officer role with direct link to Medical Director.***	Medical Director	**Q2**
G7	Out of hours resilience and capacity to respond to deteriorating or acutely ill patients **(C)**	**Q4 Update:** Medical Director has liaised with Director of Workforce to ensure consultation process is in train. Current mitigation by NHS Professionals to strengthen current workforce pending substantive recruitment in line with business case. NEWS2: revisions made to fluid balance monitoring and AKI policy. NEWS2 and urine output continues to be a standing agenda item for Deteriorating Patient and Sepsis Group. **Q1 Update:** Acute Response Team (ART) business case has been approved and staff consultation in progress. The fact that NEWS 2 does not incorporate urine output is a national issue and remains a gap which is being progressed via the Deteriorating patient and sepsis group. **Q2 Update:** staff consultation will start in Sep-21. Quality Improvement Matron working on deteriorating patient work stream. Escalation proforma in Meditech and now live and fully compliant. Also working with Portsmouth Foundation Trust and with support from NHSE/I around mangement of deteriorating patients.	Medical Director	**Q1 2021/22 - advertise** **Q2 2021/22 - staff in post** **Q1 2021/22 - NEWS2** **Q4 2021/22**
G8	Assurance re: compliance with NICE guidance and /or policies is lacking **(C&A)**	**Q4 Update:** Medical Director now chairing Clinical Effectiveness Group with enhanced focus on NICE compliance plus revised ToR to include policy compliance moving forward. Clinical Effectiveness and Research Group being split into Clinical Effectiveness Group and separate Research and Innovation Group. Draft ToR being revised. **Q1 Update:** Deputy Medical Director of Professional Standards is now chairing the Clinical Effectiveness Group. The Clinical Effectiveness and Research Group has not yet been split as the business case was unsuccessful at its first submission. NICE non-compliance is now at its lowest level in several years. The targets that have been set are to have no NICE guidance over 6 months overdue by end Jun-21; between 3 and 5 months overdue by end Jul-21 and over 3 months overdue by end Aug-21. **Q2 Update:** Policy compliance is now at 94% complaince in relation to overdue policies. New process in Document Ratification Group whereby all policies due for review in 6 months and 3 months' time will be communicated to Divisions.	Medical Director	**Q2**
G9	Safe & Sound work streams not yet having breadth of representation and limitation of bandwidth to complete all required actions **(C)**	**Q3 Update:** Deteriorating patient and sepsis group; Mortality Group and Medicine Management group continuing to meet and are well attended. Other workstreams have been reviewed and proposals created which require sign off by Interim Chief Executive. **Q4 Update:** as for Q3 **Q1 Update:** Deteriorating patient and sepsis group continues to meet and is well attended. Addition of internal Safe & Sound Internal Professional Standards meeting on a monthly basis. Reviewing current ToR and chairmanship of Medicines Safety Group and Rotherham Medicines Optimisation Group. Other Safe & Sound workstreams are being reviewed as part of the refresh of the Quality Strategy and identification of quality improvement methodology.	Medical Director & Chief Nurse	~~**Q2**~~ ~~**Q3**~~ ~~**Q4**~~ **Q2 and ongoing**
G10	Impact of COVID-19 on the Trust's capacity (staffing and / or conflicting prioritisation) to maintain focus on quality and ability to adhere to national standards if resources are overwhelmed **(C)**	**Q1 Update:** During Q1 COVID-19 numbers and impact had improved however local, regional and national levels started to increase at end of Q1 again with consequent impact on capacity and staffing. Mitigations for staff absence include use of PPE and lateral flow tests etc. **Q2 Update:** recognition that this is going to be a long term issue. There has been some improvement in line with relaxation of national guidance following successful vaccination and self-isolation however it remains a significant concern.	Medical Director & Chief Nurse	**Update at Q2 2021/22**
G11	Lack of assurance that estate is conducive to prevention of cross infection of COVID-19 **(A)**	**Q1 Update:** discharge lounge complete, Resus complete, in the main work detailed in Q4 update that needed to be done has been done with only minor snagging issues remaining. However new issues emerged during Q1 e.g. overcrowding in UECC waiting room (looking to implement screens) and a large number of side rooms do not have en-suite facilities. The issue of en suite facilities is being picked up as part of view of Trust's estate strategy refresh which is in train (due to complete Nov-21) and which will tie into the Trust's revised strategy to be approved in Sep-21. **Q2 Update:** discussions have commenced about what long term estate facilities are required to manage future COVID-19 situations. This may include a designated Infection Control ward and potential reduction the number of beds in all bays down to 4. Work on ward B6 to increase capacity to care for critically ill patients by creating additional intensive care facilities now complete.	Chief Nurse	~~**Q2 and Q3 2021/22**~~ **Q4 2021/22**
G12	Change in regulation meaning that Deprivation of Liberty Safeguards (DoLS) will be replaced with Liberty & Protection Safeguards **(C&A)**	Trust is working on Liberty & Protection Safeguards (LPS) standards and implementation in line with national mandate. Have also commisioned 360 Assurance to undertake a benchmarking and external assurance review.	Chief Nurse (Deputy Chief Nurse)	**National deadline was Apr-22 . Is now likely to be Sep 22**
G13	Implementation of Patient Safety Incident Response Framework (PSIRF) which is a new national process to oversee patient safety incidents **(C&A)**	Trust has already started and a project mandate is in place in order to achieve the key milestones set nationally. Mandate to be presented to Executive Team Meeting. Meeting taken place with HM Coroner and Trust now has 3 Patient Safety Specialists in post.	Chief Nurse (Deputy Chief Nurse)	**National launch delayed until Mar-22**
G14	Section 31 warning notice action plan **(A)**			
G15	**Stage 1 mortaltiy review impacted by ability to put on meditech**			
G16	**Serious Incident Process moved from a control to a gap.**	**The current SI policy is in date but under review. Current review of how action plans are embedded.**	**Chief Nurse**	
G17	**Streamlining of Committee structure**	**Process commenced. Consulted with Executives and Board in December for further development Jan, Feb and comencement from April 2022.**	**Director of Corporate Affairs**	

PATIENTS: Excellence in healthcare

BAF Item B2: Demand for care exceeds the resources available, leading to failure to achieve recognised healthcare standards and to recover performance to the required levels within agreed timeframes

Risk Owner: Chief Operating Officer
Board Committee: Quality Committee & Finance & Performance from Q2
Date the risk last reviewed: 28-Apr-21

Link to 2021/22 Operational Plan	Link to Operational Risks (scoring 15+):
Deliver elective recovery for patients: **- Plan the long term recovery of elective care and deliver 2021/22 recovery plan** **- Implement programme of ensuring operational excellence in elective care**	**4514:** The Division's ability to deliver the full range of gastroenterology services by substantive Consultant workforce challenges **5715:** Ability to treat deteriorating patients in a timely manner due to lack of capacity within the Hospital at Night team **5779:** Opening additional capacity on AMU above the funded 44 bed base **6119:** Management of the department during COVID-19 (UECC) **6127:** Inability to deliver planned and emergency services due to national pandemic **6198:** Loss of the MRI service due to age-related failure of the MRI scanner **6199:** Increased respiratory workload due to COVID-19 (Breathing Space) **6213:** COVID-19 - threat to Business as Usual **6215:** COVID-19 - procurement of clinical equipment **6226:** COVID-19 - organisational recovery **6417:** The Division of Medicine's ability to deliver the full range of inpatient (Nursing) Diabetes Specialist Care

STRATEGIC OBJECTIVE
PATIENTS: Excellence in healthcare
Which means…
- Deliver high quality care to our patients every day
- Put patients at the centre of what we do
- Continuously improve the quality of care and services we provide
- Develop and implement new models of care for the future

Executive Summary - Quarterly Update:
Q4: There has been a significant improvement in nursing staff recruitment and improvements in patient flow hence the proposed reduction in risk score to 4x4=16

Q1: A degree of good progress has been achieved during the quarter. Good progress has been achieved in elective care recovery and in patient flow. However challenges were experienced in non-elective demand during Q1. The Command Centre and Discharge Lounge were opened in April and May 2021 respectively. This has contributed to the Trust improving RTT to the fifth best in the country supporting elective recovery and patient flow. However demand for emergency care has increased to 15 - 20% above pre pandemic levels. Quality Committee on 28-Jul-21 noted that this BAF risk was overseen by Quality Committee as opposed to Finance & Performance Committee since it focussed on quality levels due to COVID-19 impact. Q2 review - score remains the same at 16 but likely to increase in Q3 due to capacity issues.

LIKELIHOOD X CONSEQUENCE = RISK SCORE

INITIAL RISK SCORE (pre-mitigation) as at 01 April 2021	Q1 RISK SCORE	Q2 RISK SCORE	Q3 RISK SCORE	Q4 RISK SCORE	MOVEMENT	TARGET RISK SCORE to be achieved by 31/09/2021
4 x 4 = 16 L (likely) x C (major)	4 x 4 = 16 L (likely) x C (major)	4 x 4 = 16 L (likely) x C (major)	4 x 4 = 16 L (likely) x C (major)		➔	3 x 4 = 12 L (possible) x C (major)

Risk Appetite:
TRFT has a LOW risk appetite for Compliance / Regulatory risk which may compromise the Trust's compliance with its statutory duties and regulatory requirements (6-10)

Current Risk Appetite (based on current risk score):
High (16 - 25)

Target Risk Appetite (based on target risk score):
In line with MODERATE (12 - 15)

CONTROLS and MITIGATION:
(i.e. what are we currently doing about this risk?)

What are the key controls that are in place to mitigate this risk?

Ref	CONTROL
C1	Daily monitoring of: mean time of patients in UECC; initial time to be seen; time to be seen by a clinician and all patients waiting 12hrs+ . During Q1 began recording patients who had been waiting for 4 hours since their decision to admit.
C2	A&E Delivery Group. This is a monthly meeting responsible for developing winter plans, implementing Place-wide policies and programmes and reviewing Place-wide risks and mitigations. Involves Deputy Chief Operating Officer, Head of UECC, Head of Nursing for UECC as well as Rotherham CCG representatives and RMBC Deputy Heads. During Dec-20, Jan-21 and Feb-21 moved to weekly meetings due to winter plan

ASSURANCE OR EVIDENCE ACTUALLY RECEIVED
(i.e. how do we know that we are making an impact in managing the risk?)

Ref	ASSURANCE / EVIDENCE (positive or negative)	SOURCE OF ASSURANCE / EVIDENCE: 1. Internal (operational)	2. Internal: (oversight)	3. External	DATE LAST ASSURANCE PROVIDED
A1	Still part of national program on emergency care standards reporting weekly and daily (Q3: moving to consultation) - **The National Team have confirmed this remains on hold. - this will now move to a gap in control**	✓			~~Nov 21~~ July 2022
A2	Continued marked improvement in initial assessment, time to see clinician and mean waiting time in A&E, now well below national standard and maintained since February 2020. Q2 Update Increase in attendance to UECC with increase in acuity and ambulance dispositions; marked deterioration in mean time in dept, time to initial assessment and time to be seen by doctor - this is likely to remain the same in Q3.	✓			~~Nov 21~~ January 2022

GAPS IN CONTROL (C) or ASSURANCE (A)

gap in control = exist where adequate controls are not in place, or where collectively they are not sufficiently evident
gap in assurance = exist where there is a failure to gain evidence that the controls are effective

Ref	GAP	MITIGATING ACTIONS TO BE TAKEN TO CLOSE THE GAP	RESPONSIBLE EXECUTIVE DIRECTOR	DEADLINE BY WHICH THE GAP WILL BE CLOSED
G1	Plan the long-term recovery of Elective Care / Operational Excellence (Mandate 3) **(C&A)**	1. Convert existing red theatre into green theatre and utilise additional capacity ***Q1 Update:*** *Complete, operational from May-21.* 2. Complete waiting list analysis based on deprivation and BAME cohort and identify any issues to be addressed Q2 completed 3. Complete outpatient productivity project (with support from external provider) and develop plan from outputs Q2 completed 4. Deliver planned H1 activity on monthly basis Q2 Achieved 5. Implement MS Teams Ox.wr single IT solution across all appropriate sub-specialties Using MTeams or telephone now for consultations. 6. Implement waiting list analysis by WL and BAME cohort in standard internal reporting. Completed and shared with ICS and CCG. 7. Rollout PIFU pathway to a further two specialties On track 8. Increase use of advice and guidance across 3 key specialties 9. Define relevant processes, procedures and responsibilities for elective care operational management across the Trust 10. Implement full RTT training package, and ensure appropriate policy and procedure documents are in place across the Trust (SOPs etc)	Chief Operating Officer	**Jun-21 - complete** **Jul-21** **Sep-21** **Sep-21** **Sep-21** **Oct-21** **Oct-21** **Mar-22** **Mar-22** **Mar-22**
G2	Insufficient acute inpatient beds leading to delays in accessing beds **(C)**	Trust has recently participated in a review undertaken by ECIST utilising the ECIST bed modelling tool. The review shows an ongoing gap of 60+ beds. Business case to be developed for development of a short stay unit, frailty ward and same day emergency care service. **Q2 Update:** Business case has been written and is linked to the new transformation programme which began in September 2020 until January 2021 and has 7 work streams: • UECC processes • Ward processes • SDEC, AMU and short stay • Minor injuries • Frailty • Speciality medical wards • ASU. Business case is for confirmation and challenge during Q3. **Q3 Update:** paused due to COVID-19 **Q4 Update:** restarted the work re: short stay AMU and SDEC and frailty unit. Number of meetings held and opened a short stay ward. Piloting the frailty unit in May-21. **Q1 Update -** Paper regarding reconfiguration of medicine ward bed base submitted to Transformation Meeting and work continues to refine further. Short AMU operational and working well. Q2 update: Business case completed part funded for 2020/21 - will require updated business case for March 2022.	Chief Operating Officer	**Q2 Q4** **Transformation Programme: Jan-21 March 2022**

CONTROLS and MITIGATION: (i.e. what are we currently doing about this risk?)	
What are the key controls that are in place to mitigate this risk?	
Ref	**CONTROL**
C3	Weekly PTL meetings for 18-week target
C4	Divisional performance meetings chaired by the Deputy Chief Executive or Chief Operating Officer on a monthly basis and corporate directorate performance meetings on a quarterly basis. Meetings use a set agenda and updated Integrated Performance Report and focus on all activity and quality indicators. They are used to work through anything that is off track and identify key risks, actions and mitigations.
C5	Cancer Recovery Group Meetings (weekly) track progress with the PTL and feed into the COVID-19 recovery programme. Clinical representatives responsible for reviewing long-waiting individual patients to minimise risk to each patient
C6	Monthly COVID-19 Recovery Programme Meeting introduced in May 2020 and chaired by Chief Operating Officer. Consists of cancer recovery, waiting list and capacity recovery, PPE management process, outpatient recovery programme and operational management. Spilt into work streams and each has a recovery meeting in place with an identified lead (e.g. Chief Nurse for PPE, Chief Operating Officer for outpatient activity and Director of Strategy, Planning & Performance for waiting list and cancer). Q3: moved into business as usual and meetings now three times a week linked to Gold Command from Oct-20. **Q4:** Appointed Recovery Director who also attends this meeting which is chaired by the Chief Operating Officer
C7	Gold, Silver and Bronze Command meetings as required by site pressures
C8	Daily record of length of stay obtained.
C9	
C10	
C11	
C12	
C13	
C14	

ASSURANCE OR EVIDENCE ACTUALLY RECEIVED (i.e. how do we know that we are making an impact in managing the risk?)					
Ref	**ASSURANCE / EVIDENCE (positive or negative)**	**SOURCE OF ASSURANCE / EVIDENCE**			**DATE LAST ASSURANCE PROVIDED**
		1. Internal (operational)	2. Internal: (oversight)	3. External	
A3	National drive on 'right to reside' (whether a patient should be in a hospital bed or not). New requirement to record daily and weekly began in April 2020. Significant reduction in Delayed Transfers of Care and whole programme of inpatient acute and inpatient community bed reviews. Patients who are medically fit for discharge are number in the 20s rather than between 60 -80 (30s at mid-Sep-20; 39 as at 31-Dec-20; mid-20s as at end Mar-21). Q2 update deterioration to mid 40's and expected to deteriorate further.	✓			~~Nov 21~~ January 2022
A4	<61 and <91 cumulative ambulance handover delay targets met in May and June 2020. Targets met in Oct-20 and Nov-20. Deteriorated in Dec-20 due to COVID-19 **Q4 Update:** Trust is best performing Trust in South Yorkshire against these indicators. Since Dec-20 targets have been met and feedback from YAS very positive. Letter from NHSE actions across each ICS to reduce handover delays. Q3 update: Position documentated on a daily basis.	✓			Q4
A5	Rotherham Reset Week ran from Wednesday to Wednesday from 03-Feb-21 and was very positive creating a reduction in long waits for patients in A&E, an increase in discharges and flow across the organisation and improvement in morale across key areas. Learning from the Reset Week has been reviewed and now there is a programme of Mini Reset Weeks in place throughout 2021/22 (e.g. focus on golden patient 05-Apr-21). Additional reset week planned for November. Reset week completed.		✓		Nov-21
A6	New Frailty Consultant in post.	✓			Nov-21
A7					
A8					
A9					
A10					
A11					
A12					
A13					

Sources of assurance: 1. Internal: Management, operational day to day departmental reporting; 2. Internal: Oversight functions & review by committees; 3. Independent, external review

N.B. the assurances detailed in italics are planned assurances which have not yet been received. Once received each entry will be updated to state whether the assurance was positive or negative.

GAPS IN CONTROL (C) or ASSURANCE (A) gap in control = exist where adequate controls are not in place, or where collectively they are not sufficiently evident gap in assurance = exist where there is a failure to gain evidence that the controls are effective				
Ref	**GAP**	**MITIGATING ACTIONS TO BE TAKEN TO CLOSE THE GAP**	**RESPONSIBLE EXECUTIVE DIRECTOR**	**DEADLINE BY WHICH THE GAP WILL BE CLOSED**
G3	Lack of capacity in same day emergency service **(C)**	Double the capacity of same day emergency care in AMU. This is a 2 year project led by Head of Nursing for Surgical Division. ECIST supporting the Trust in this project. Project overseen by Deputy Chief Executive **Q2 Update:** linked to the new transformation programme which began in September 2020 until January 2021 as business case mentioned in G2 includes capacity for SDEC. **Q3 Update:** have increased capacity in SDEC. Business cases are completed and will be reviewed in Jan-21 based feedback received ETM in Dec-20. **Q4 Update:** SDEC business case has been reviewed and will be rewritten to take into account comments from ETM and colleagues. **Q1 Update:** Medical input into SDEC continues to be progressed in order to increase streaming of patients via the service. 1 consultant appointed 2 still required.	Deputy Chief Executive / Chief Operating Officer	~~Jan-22~~ ~~Apr-21~~ ~~Q1 2021/22~~ Sept 2022
G4	Vacancies in key posts (e.g. General Medical Consultants **(C)**	Number of vacancies has reduced since 2019/20. Develop joint posts with Barnsley NHS FT and Doncaster & Bassetlaw NHS FT. Recruitment to key posts led by TRFT Medical Director, and exploring other workforce solutions. **Q2 Update:** ongoing, still pursuing joint posts with Barnsley as well as TRFT posts **Q3 Update:** deteriorated due to both vacancies and sickness absence. During Q3 vacancies continued to increase in key areas. **Q4 Update:** minimal changes since Q3. Now have a joint Gastro lead with Barnsley FT in place (2 days a week on site). Q2 update joint lead resigned now have 1 year interim Gastro lead in place.	Chief Operating Officer and Medical Director	~~Jul-20~~ ~~Apr-21~~ ~~Q2 2021/22~~ April 2022
G5	Best Practice Discharge Processes (Mandate 5A) **(C)**	1. Command centre build delivered - ***Q1 Update*** *- Complete operational from April 2021* 2. Discharge lounge open - ***Q1 Update*** *- Complete operational from 31 May 2021* 3. Agree best practice for ward led discharge processes - ***Q1 Update*** - Task and Finish Group established. Deputy Chief Operating Officer Executive Lead. Q2 update best practice agreed and presented to CQC completed Q3 completed 4. Commenced Ward Programme of Improvement - ***Q1 Update*** *- Remit of T & G Group, see above. Trust wide plan developed on a ward by ward basis to provide intensive support. At Q1 workshops have been held with the Medicine Division x 2 and independently the Acute Medical Unit (AMU) and Surgical Division. A QI process has been adopted involving Heads of Nursing and key members of the MDTs to undertake process mapping including TTO medication.* Q2 update paused due to covid and reinstatement dependant upon pandemic. 5. Centralised discharge support agreed Q2 - completed and agreed and recruiting. 6. Escalation management tool tested Q2 - In place 7. IDT review completed - Q2 - completed 8. Centralised discharge support structure in place 9. Commence auditing ward processes and practice. Q2 update - commenced. 10. Go live for escalation management 11. Go live for ward requests via tele tracking Q2 update - now in pilot Nov 21. 12. Embed reporting arrangements to replace DTOC –in line with national guidance once received (date TBC) 13. Evaluate impact of all changes	Chief Operating Officer	**Apr-21 - complete** **Jun-21 - complete** **Jun-21** **Jun-21** **Jul-21** **Jul-21** **Aug-21** **Sep-21** **Oct-21** **Sep-21** **Oct-21** **TBC** **Mar-22**
G6	Nurse staffing on medical wards **(C)**	International recruitment: the Trust made a commitment to recruit 40 international nurses using NHS Professionals' international arm as part of an ICS wide-initiative. COVID-19 delayed the plan however the first 7 nurses arrived in the UK on July 2020 and the second cohort of 11 nurses will arrive on 29 October 2020. All of these nurses have been recruited from India. **Q2 Update:** first 7 nurses are in post and part of the teams. Deputy Chief Nurse is planning further recruitment. Gap remains as 50 nurses are required to close the current gap in control. **Q3 Update:** ongoing, gaps are similar however next phase of international recruitment for nurses has been agreed. **Q4 Update:** agreement to continue with international nurse recruitment plans to recruit a further 50 nurses during 2021/22. Another 10 nurses arriving in next few weeks. Plan is to have only minimal vacancies by end of 2021/22. Q2 update new starters commencing by end September and on a phased approach up to April 2022.	Chief Nurse	~~Jul-20~~ **Sep-21** April 2022
G7	Consultant cover in AMU currently provided by agency Consultants **(C)**	See actions for G4. **Q3 Update:** have lost agency Consultants **Q4 Update:** still being covered by agency as and when available. **Q1 Update:** 3 Substantive Consultants appointed to AMU and one long term locum. Q2 update - 2 substantive recruited with 1 to recruit.	Chief Operating Officer and Medical Director	~~Jul-20~~ ~~Apr-21~~ **Update in Q1 2021/22** Sept 2022
G8	Due to COVID-19 pandemic the Trust has seen a large increase in its waiting list and the ability to undertake routine elective work has been reduced. Had to reduce capacity across inpatient and outpatient services **(C)**	Recovery action plan in place and following national guidance. Envisage compliance with new national guidance relating to waiting lists by September 2021. **Q2 Update:** Phase 3 letter received in Q2, plan to be compliant after April 2021, on track for September 2021. **Q3 Update:** phase 3 letter actions put on hold due to wave 2 of COVID-19 pandemic - Expect further adjustments due to omnicon variant. **Q4 Update:** recovery programme agreed and shared with ICS. National trajectories advised, plan to achieve trajectory by Q3 2021/22. **Q1 Update:** An update to mitigations due in Q1 regarding elective care are included in G1.1. Currently it is not advised to absorb or recommend closure of the gap and await Q2 update. Q2 update- H1 recovery plan completed and met above expectations. H2 recovery plan data submitted in November 2021.	Chief Operating Officer	**Sep-21** **Q3 2021/22**
G9	Admission Avoidance (Mandate 5B) **(C)**	1. Run pilot for frailty pathway from ED (will go live 24 May for 4 weeks). 2. Agree next steps following review of pilot –including medical input to the combined assessment of frail patients in SDEC. Q2 Pilot reamins ongoing 3. Agree frailty pathway model and embed in working practice	Chief Operating Officer	**Jul-21** **Oct-21** **Jan-22**
G10				
G11				
G12				
G13				

PATIENTS: Excellence in healthcare

BAF Item B3: Should the Trust fail to actively engage with, or listen to the experience of service users, there is a risk that the organisation will not learn or improve the quality of care (experience, quality and outcomes) for those who use our services *Risk Owner: Interim Chief Nurse / Medical Director* *Board Committee: Quality Committee* *Date the risk last reviewed: 28-Apr-21*	**Link to 2021/22 Operational Plan** **Focus on the fundamentals of care** **- Embed agreed standards of care and support teams to deliver and embed quality improvement** **- Implement effective learning from deaths practices and deliver improved mortality rate**	**Link to Operational Risks (scoring 15+):** **No risks**

STRATEGIC OBJECTIVE
PATIENTS: Excellence in healthcare
Which means…
- Deliver high quality care to our patients every day
- Put patients at the centre of what we do
- Continuously improve the quality of care and services we provide
- Develop and implement new models of care for the future

Executive Summary - Quarterly Update:
Q1: Until arrangements for visiting are back to normal and there has been a reduction in the number of concerns and complaints linked to visiting it is not considered appropriate to reduce the risk score. In addition new gap identified during Q1 relating to staff shortages leading to reduced opportunity to communicate with clinical teams.

Q2: The Trust managed to reintroduce some visiting in Q2. The visiting hotline was very successful. Insufficient reduction in complaints and concerns sufficient to reduce risk score in Q2.

LIKELIHOOD X CONSEQUENCE = RISK SCORE

INITIAL RISK SCORE (pre-mitigation) as at 01 April 2021	Q1 RISK SCORE	Q2 RISK SCORE	Q3 RISK SCORE	Q4 RISK SCORE	MOVEMENT	TARGET RISK SCORE to be achieved by 31/09/2021
4 x 4 = 16 L (likely) x C (major)	**4 x 4 = 16 L (likely) x C (major)**	**4 x 4 = 16 L (likely) x C (major)**	**4 x 4 = 16 L (likely) x C (major)**		➔	3 x 4 = 12 L (possible) x C (major)

Risk Appetite:
TRFT has a **VERY LOW** risk appetite for risk that may compromise the delivery of outcomes for our service users (score of 1 - 5)
TRFT has a **LOW** risk appetite for risks that may affect the experience of our service users (score of 6 -10)
TRFT has a **VERY LOW** risk appetite for risks that may compromise safety (1-5)

Current Risk Appetite (based on current risk score):
High (16 - 25)

Target Risk Appetite (based on target risk score):
In line with / below appetite of MODERATE (12 - 15)

CONTROLS and MITIGATION:
(i.e. what are we currently doing about this risk?)

What are the key controls that are in place to mitigate this risk?

Ref	CONTROL
C1	Implementation of actions based on the outcomes of the national patient surveys (annual Inpatient, Maternity and UECC surveys and bi-annual C&YPS survey).
C2	External benchmarking to ensure the Trust is employing best practice to responded to the outcomes of patient surveys, some of which may be facilitated by Picker
C3	All patient survey action plans monitored quarterly at Patient Experience Group and within the Divisions to ensure completion of actions. Also monitored to completion by Clinical Governance Committee via register for Action Plans.
C4	Responding to national guidance to ensure visiting and communication with families is optimised as far as it is safe to do so.
C5	Organisational Learning Action Forum (OLAF) to ensure that learning from claims, complaints, incidents and inquests can be used to positively impact on quality of care to close the loop with the clinical audit process to provide assurance.
C6	Driving the implementation of the Engagement and Inclusion strategy to ensure that the voices of service users are heard and acted upon in a meaningful way.
C7	Ongoing compliance with the Complaints Strategy to ensure that learning from complaints is embedded and action from in a meaningful way
C8	
C9	

ASSURANCE OR EVIDENCE ACTUALLY RECEIVED
(i.e. how do we know that we are making an impact in managing the risk?)

Ref	ASSURANCE / EVIDENCE (positive or negative)	SOURCE OF ASSURANCE / EVIDENCE			DATE LAST ASSURANCE PROVIDED
		1. Internal (operational)	2. Internal: (oversight)	3. External	
A1	Findings of national patient surveys (annual or bi-annual, mixed assurance) Surveys have been delayed during COVID-19 so the Trust has not received other results this year although the surveys have now started to collect data. Publication dates as follows: UECC: Sep-21 C&YPS (bi-annual): Nov-21 Maternity: Jan-22 Inpatients: Nov-21			✓	UECC: **Oct-19** C&YPS: **Nov-19** (bi-annual) Maternity: **Jan-20** Inpatients: **Jul-20**
A2	Friends & Family Test reinstated with a new process which places greater emphasis on qualitative responses rather than response rates. Monitored via monthly report reviewed at Friends & Family Test Group and Patient Experience Group and is summarised quarterly within Patient Experience report for Clinical Governance Committee and Quality Committee (monthly, mixed assurance)	✓	✓		**Sep-21**
A3	Quality Boards in all ward areas including 'You said, We did' section based on Friends & Family Test or patient survey feedback The perfect ward audits are ensuring that up to date Friends & Family Test feedback is displayed on Quality Boards in all clinical areas (monthly, positive). Quarterly reports on Perfect Ward to Clinical Governance Comittee and Quality Committee (quarterly, positive)	✓			**Sep-21**
A4	Compliance with timeliness of responses to complaints monitored monthly via reports to Clinical Governance Committee and Quality Committee (monthly, positive) Quality of the complaints responses and robustness of action plans is reported quarterly to Clinical Governance Committee and Quality Committee (quarterly, mixed) Annual Complaints Report to Board of Directors and included in the Trust's Quality Account (annual, positive)	✓	✓		**Sep-21** **Sep-21** **Jun-21**
A5	Engagement and inclusion update included in quarterly Patient Experience report for Clinical Governance Committee and Quality Committee (quarterly, positive)	✓	✓		**Aug-21**
A6	Regular Perfect Ward audits relating to patient experience began in Q11 (monthly, mixed assurance)	✓			**Sep-21**
A7	360 Assurance audit of complaints management (Jul-21) save 'significant assurance' rating for complainst handling and 'limited assurance' for learning from complaints (ad hoc, mixed) (See G2 for action plan)			✓	**Jul-21**
A8	Ongoing work of Engagement and Inclusion Lead with hard to reach communities. Evidenced through quarterly Patient Expereince Report report for Clinical Governance Committee and Quality Committee (quarterly, positive)		✓		**Aug-21**
A9					

GAPS IN CONTROL (C) or ASSURANCE (A)

gap in control = exist where adequate controls are not in place, or where collectively they are not sufficiently evident
gap in assurance = exist where there is a failure to gain evidence that the controls are effective

Ref	GAP	MITIGATING ACTIONS TO BE TAKEN TO CLOSE THE GAP	RESPONSIBLE EXECUTIVE DIRECTOR	DEADLINE BY WHICH THE GAP WILL BE CLOSED
G1	TRFT is the only Trust in ICS to not run Friends & Family Test via text message leading to a lack of choice for patients about how to respond **(A)**	**Q1 Update:** now a choice of ways for people to complete test including electronically via a QR code. To discuss at Executive Team Meeting and determine whether there is an appetite to launch text messaging.	Chief Nurse (Head of Patient Experience)	**Update in Q2**
G2	360 Assurance audit of complaints management (Jul-21) save 'significant assurance' rating for complaint handling and 'limited assurance' for learning from complaints **(C)**	Audit made 3 medium and 1 low recommendations: 1.1 and 1.2 (Medium) Deadline: 31-Mar-22 2.0 (Low) Deadline: 31-Mar-22 3.0 (Medium) Deadline: 31-Mar-22	Chief Nurse (Deputy Chief Nurse)	**Q4 2021/22**
G3	Public having access to up to date information via the Trust's website **(A)**	Review of electronic info on website provided by the trust is required. **Q1 Update:** situation improved ahead of CQC well led inspection in Jun-21, further work is still required.	Interim Director of Communications	~~**Q1 2021/22**~~ **Q3 2021/22**
G4	COVID-19 restrictions have negatively impacted on the communication between ward staff and patient's families leading to concerns being raised with complaints team **(C)**	**Q1 Update:** Development of a visiting' hot line' allowing one visitor per patient to visit at an agreed time for 50mins to maintain safety and enable cleaning between visitors. Pre-bookable slots are managed through a centralised admin / volunteer team. Special circumstances enabling enhanced visiting are still in operation e.g. for patients at end of life of paediatric patients as per the SOP. **Q2 Update:** In line with national guidance The Trust has relaxed some visiting rules, SOP in place to support arrangements. Closure of visiting hotline and although restrictions remain in place they are now managed locally at ward level. Gap remains as the Trust goes into winter as may need to impose vsiiting restrictions again..	Chief Nurse (Deputy Chief Nurse)	**Q1 for SOP -** complete **Gap will remain until all visiting restrictions are removed**
G5	Staff shortages leading to reduced opportunity for relatives to communicate with clinical teams **(C&A)**	Work to support the teams with extra resources (non-clinical) to look to a method to enable communication to increase **Q2 Update:** Relaxation on visiting has improved the situation but will need to be monitored for one more quarter before the gap can be considered closed. Concerns data acts as a barometer for whether or not communication is improving.	Chief Nurse and Medical Director	**Q3**
G6	How to safely reintroduce volunteer workforce back into the Trust **(A)**	Additional members of staff to support volunteer coordinator to enable one to one conversations with all existing volunteers to identify safe roles they would be comfortable returning to and beginning to look to actively recruit new volunteers. One to one conversations will be complete in early Q3. Looking to increase volunteer presence on site by end of Q3 providing it is safe to do so.	Chief Nurse	**Q3**
G7				
G8				
G9				

CONTROLS and MITIGATION: (i.e. what are we currently doing about this risk?)	
What are the key controls that are in place to mitigate this risk?	
Ref	**CONTROL**
C10	
C11	
C12	
C13	

ASSURANCE OR EVIDENCE ACTUALLY RECEIVED (i.e. how do we know that we are making an impact in managing the risk?)					
Ref	**ASSURANCE / EVIDENCE (positive or negative)**	**SOURCE OF ASSURANCE / EVIDENCE**			**DATE LAST ASSURANCE PROVIDED**
		1. Internal (operational)	2. Internal: (oversight)	3. External	
A10					
A11					
A12					
A13					

Sources of assurance: 1. Internal: Management, operational day to day departmental reporting; 2. Internal: Oversight functions & review by committees; 3. Independent, external review

N.B. the assurances detailed in italics are planned assurances which have not yet been received. Once received each entry will be updated to state whether the assurance was positive or negative.

GAPS IN CONTROL (C) or ASSURANCE (A) gap in control = exist where adequate controls are not in place, or where collectively they are not sufficiently evident gap in assurance = exist where there is a failure to gain evidence that the controls are effective				
Ref	**GAP**	**MITIGATING ACTIONS TO BE TAKEN TO CLOSE THE GAP**	**RESPONSIBLE EXECUTIVE DIRECTOR**	**DEADLINE BY WHICH THE GAP WILL BE CLOSED**
G10				
G11				
G12				
G13				

COLLEGUES: Engaged, accountable colleagues

BAF Item B4: Lack of effective staff engagement will impact on staff experience resulting in poor staff survey results which impact on the organisation's ability to deliver the Trust's plan *Risk Owner: Director of Workforce* *Board Committee: People Committee* *Date the risk last reviewed: 30-Apr-21*	**Link to 2021/22 Operational Plan** **Safely exit the COVID-19 pandemic: deliver full programme of Health & Wellbeing initiatives for staff** **Empower and enable staff to deliver:** **- design and launch organisational development programme for divisional teams**	**Link to Operational Risks (scoring 15+):** **No risks**

STRATEGIC OBJECTIVE:
COLLEAGUES: Engaged, accountable colleagues
Which means…
- Recruit, retain and develop a high performing, effective and motivated workforce
- Be a learning organisation with a culture of continuous improvement
- Engage with colleagues and communicate effectively
- Develop strong leadership at all levels of the organisation

Executive Summary - Quarterly Update:
Q4: 2020 staff survey results have revealed that the Trust scored an average of 6.9 for staff engagement and comparator Trusts scored 7.0. In addition TRFT was 5th most improved trust in the country; of the 10 themes measured 9 have improved from previous year hence proposed reduction in score to 3(L) x 5(C) = 12

Q1 Update: Positive progress made during Q1 in relation to opening of staff gardens, Executive Director walkarounds across both hospital and community locations and NHS Big Tea Party. Challenges encountered in relation to capacity to undertake further staff engagement work due to requirement for Health & Wellbeing team to support COVID-19 and 'flu vaccination programme between September and December 2021. Q2 Update: Despite anticipated challenges, TRFT has delivered a sucessful flu and Covid booster vaccination programme.

LIKELIHOOD X CONSEQUENCE = RISK SCORE

INITIAL RISK SCORE (pre-mitigation) as at 01 April 2021	Q1 RISK SCORE	Q2 RISK SCORE	Q3 RISK SCORE	Q4 RISK SCORE	MOVEMENT	TARGET RISK SCORE to be achieved by 31/09/2021
3 x 4 = 12 L (possible) x C (major)	3 x 4 = 12 L (possible) x C (major)	**3 x 4 = 12 L (possible) x C (major)**	**3 x 4 = 12 L (possible) x C (major)**		➔	**3 x 4 = 8 L (possible) x C (major)**

Risk Appetite:
TRFT has a **MODERATE** risk appetite for actions and decisions taken in relation to workforce (12 - 15)

Current Risk Appetite (based on current risk score):
Moderate (12 - 15)

Target Risk Appetite (based on target risk score):
In line with appetite of LOW (6 - 10)

CONTROLS and MITIGATION:
(i.e. what are we currently doing about this risk?)

What are the key controls that are in place to mitigate this risk?

Ref	CONTROL
C1	Trust has organised staff inclusion networks (BAME, LGBTQI, Disability) and work continues to develop these networks and increase staff engagement from those with protected characteristics
C2	Risk assessment process for COVID-19 aimed specifically at supporting staff who were shielding and those staff who may be suffering from Long COVID
C3	Equality, Diversity & Inclusion Steering Group designed to address issues of equality at a corporate and policy level from an Equality, Diversity & Inclusion perspective
C4	Established regular meetings with Trade Union colleagues in order to ensure Trade Unions are informed, engaged and updated regarding changes within the organisation
C5	Revised national approach to staff survey including additional quarterly local staff surveys and a revised annual national staff survey
C6	Divisional attendance at People Committee to provide assurance around staff engagement activities
C7	Proactive well-being programme publicised through the Trust via 'Your People Pack' on intranet
C8	Reviewed Personal Development Review (PDR) process and documentation to facilitate better appraisal conversations including conversations about health and wellbeing
C9	Continued implementation of People Strategy approved by Board of Directors in June 2020 of which staff engagement is a key factor
C10	People Committee seeks assurance that staff engagement is sufficiently effective, resulting in improved staff survey results
C11	Continued implementation of local staff survey action plans by Divisions monitored through Divisional performance meetings from March 2021 onward
C12	Proud award process including the event and monthly excellence awards
C13	**Trust has launched the Behavioural Framework in Q3.**
C14	**The tender process for Occupational Health Service has completed with a view to the new service from April 2022.**
C15	**Additional resources approved to deliver the Health and Wellbeing Initiative and is now in place.**

ASSURANCE OR EVIDENCE ACTUALLY RECEIVED
(i.e. how do we know that we are making an impact in managing the risk?)

Ref	ASSURANCE / EVIDENCE (positive or negative)	SOURCE OF ASSURANCE / EVIDENCE			DATE LAST ASSURANCE PROVIDED
		1. Internal (operational)	2. Internal: (oversight)	3. External	
A1	People Strategy approved by Board of Directors of which staff engagement is a key factor (positive)		✓		**Jun-20**
A2	National Staff Survey 2020: - Response rate of 52.2% compared to average national response rate of 47.3%. Improved rate compared to last year and is evidence of increased engagement in staff survey - 3rd most improved trust in the country; of the 10 themes measured 9 have improved from previous year (positive, annual) **2021 response rates 59.6% which is an increase of 7.4%. We are 8.5% above the national average**			✓	**Nov-20 Mar-21**
A3	Individual meetings have taken place between Board members and members of staff as part of reciprocal mentoring scheme Also commenced meetings with Leadership Academy to take forward reciprocal mentioning scheme (positive, ad hoc)			✓	**May-21**
A4	Current completion rate of PDR is 70% against target of 90% New window for appraisals commenced Apr-21 to Aug-21 (negative, monthly)		✓		**May-21**
A5	During pandemic managed to stage Proud Awards and Recognition of Learning Event virtually which led to positive engagement with staff in terms of viewing on YouTube (positive, annual)		✓		**Nov-20**
A6	NHS Tea Party held on 5 July 2021 to support engagement with Trust staff (both hospital and community).		✓		**Jul-21**
A7	Charitable funding utilised to develop hospital garden including outdoor gym facility and to create a woodland walk for staff		✓		**Q1 2021/22**
A8	Established programme of Executive Director weekly walkarounds (hospital and community) which are reported back through Executive Team Meeting		✓		**Q1 2021/22**
A9	Delivered Flu and Covid booster vaccinaion programme within TRFT the best performing within the North East and Yorkshire for Flu vaccinations.		✓	✓	**Q2 2021/22**
A10					
A11					
A12					
A13					

Sources of assurance: 1. Internal: Management, operational day to day departmental reporting; 2. Internal: Oversight functions & review by committees; 3. Independent, external review

N.B. the assurances detailed in italics are planned assurances which have not yet been received. Once received each entry will be updated to state whether the assurance was positive or negative.

GAPS IN CONTROL (C) or ASSURANCE (A)
gap in control = exist where adequate controls are not in place, or where collectively they are not sufficiently evident
gap in assurance = exist where there is a failure to gain evidence that the controls are effective

Ref	GAP	MITIGATING ACTIONS TO BE TAKEN TO CLOSE THE GAP	RESPONSIBLE EXECUTIVE DIRECTOR	DEADLINE BY WHICH THE GAP WILL BE CLOSED
G1	**BAF deep dive at People Committee in April said that we needed to detail what actions have actually made the difference in terms of staff engagement. Steve to speak to Lynn about what additional assurance is needed. Need to prove we do know what has made the difference.**	**To be confirmed**		
G2				
G3	Heath & Wellbeing (Mandate 1A) **(C&A)**	1. Individual health & well-being conversations to take place: 1a. employee / manager training available- completed 1b. HWB conversations to be completed/recorded as part of the appraisal during the first half of the year 2. Stakeholder group established for review of Our People Pack- completed 2a. new version available for colleagues to access 3. Occupational health & wellbeing support available to all staff including rapid access to psychological and specialist support- completed 4. E-Roster governance meeting established 5. Encourage maximum uptake for Covid(and flu) vaccinations / booster jabs inline with national guidance	Director of Workforce	**Apr-21 Aug-21 Jun-21 Sep-21 May-21 May-21 Mar-22**
G4	Organisational Development Programme (Mandate 4A) **(C&A)**	1. Appoint an external company to deliver the Divisional Leadership Team (DLT) Programme 2. Outline a scope of works / statement of requirements for the DLT Programme. 3. Completion of DLT OD programme 4. Post programme diagnostic	Director of Workforce	**31-May-21 31-May-21 30-Nov-21 28-Feb-22**
G5	~~Capacity to support Health and Wellbeing initiatives caused by team having to support COVID-19 booster and annual flu vaccination programme between Sep-21 and Dec-21 **(C&A)**.~~	~~Identify additional resources to support Health and Wellbeing programme~~	Director of Workforce	~~Q2 2021/22~~ **Moved to assurance**
G6				
G7				
G8				
G9				
G10				
G11				
G12				
G13				

COLLEAGUES: Engaged, accountable colleagues

BAF Item B5: Inability to recruit and retain staff within the organisation leading to impaired ability to deliver the Trust plan and increased temporary staffing costs *Risk Owner: Director of Workforce* *Board Committee: People Committee* *Date the risk last reviewed: 30-Apr-21*	**Link to 2021/22 Operational Plan**	**Link to Operational Risks (scoring 15+):**
	Safely exit the COVID-19 pandemic: identify new practices from COVID-19 to embed in the long term and implement new ways of working **Empower and enable staff to deliver:** **- Build a culture so that the trust is seen as an employer of choice, appointing to key clinical leadership vacancies**	**4514:** The Division's ability to deliver the full range of gastroenterology services by substantive Consultant workforce challenges **4959:** The Divisions (Acute CSU) ability to ensure that there are adequate numbers of suitably qualified, competent and experienced nurses **5442:** Inability to fill high number of registered nurse vacancies leading to potentially a reduction in patient experience and safety **5715:** Ability to treat deteriorating patients in a timely manner due to lack of capacity within the Hospital at Night team **6417:** The Division of Medicine's ability to deliver the full range of inpatient (Nursing) Diabetes Specialist Care

STRATEGIC OBJECTIVE:
COLLEAGUES: Engaged, accountable colleagues
Which means…
- Recruit, retain and develop a high performing, effective and motivated workforce
- Be a learning organisation with a culture of continuous improvement
- Engage with colleagues and communicate effectively
- Develop strong leadership at all levels of the organisation

Executive Summary - Quarterly Update:
Q4: There has been no deterioration in the position during Q4 although there have also been no significant gaps closed hence recommend no change in risk score for Q4.

Q1 Update: The Trust has the lowest level of nursing and midwifery vacancies it has had for a long time. However, more needs to be embedded before a reduction in risk score is proposed.

LIKELIHOOD X CONSEQUENCE = RISK SCORE

INITIAL RISK SCORE (pre-mitigation) as at 01 April 2021	Q1 RISK SCORE	Q2 RISK SCORE	Q3 RISK SCORE	Q4 RISK SCORE	MOVEMENT	TARGET RISK SCORE to be achieved by 31/09/2021
3 x 4 = 12 L (possible) x C (major)	**3 x 4 = 12** **L (possible) x** **C (major)**	**3 x 4 = 12** **L (possible) x** **C (major)**	**3 x 4 = 12** **L (possible) x** **C (major)**		➔	3 x 4 = 12 L (possible) x C (major)

Risk Appetite:
TRFT has a **MODERATE** risk appetite for actions and decisions taken in relation to workforce (12 - 15)

Current Risk Appetite (based on current risk score):
Moderate (12 - 15)

Target Risk Appetite (based on target risk score):
In line with MODERATE (12 - 15)

CONTROLS and MITIGATION:
(i.e. what are we currently doing about this risk?)

What are the key controls that are in place to mitigate this risk?

Ref	CONTROL
C1	Operational Workforce Group reviews with Divisions key operational workforce metrics to understand performance and areas of assurance. People Committee seeks assurance that staff recruitment and retention is effective and supports a decrease in temporary staffing costs
C2	Implementation of People Strategy approved at Board of Directors in June 2020
C3	Medical workforce job plans to ensure that the Trust has sufficient capacity of medical workforce to meet service demand.
C4	Medical agency sign off process to ensure that the Trust tries to minimise additional temporary staff costs by having a rigorous process of control
C5	Vacancy control process established: Panel of Executive Directors reviews and scrutinises vacancies when they occur in order to control workforce costs on a weekly basis.
C6	Ongoing recruitment campaigns including participation in South Yorkshire & Bassetlaw international nurse recruitment programme

ASSURANCE OR EVIDENCE ACTUALLY RECEIVED
(i.e. how do we know that we are making an impact in managing the risk?)

Ref	ASSURANCE / EVIDENCE (positive or negative)	SOURCE OF ASSURANCE / EVIDENCE: 1. Internal (operational)	2. Internal: (oversight)	3. External	DATE LAST ASSURANCE PROVIDED
A1	People Strategy approved by Board of Directors which includes focus on recruitment and retention (positive) People Committee endorsed Talent Management Framework for the Trust at the Oct-20 meeting (positive, ad hoc)		✓		**Jun-20** **Oct-20**
A2	A number of simultaneous strategies to increase recruitment for registered nurses have been successful during 2020/21 and have all achieved the desired outcomes. This includes: newly qualified recruitment, return to practice and international recruitment and links to G3 (positive)	✓			**Feb-21**
A3	Increased number of nurse staffing placements to accommodate increased take up of nurse training (positive)	✓			**Jun-21**
A4	360 Assurance Integrity of e-rostering gave a 'limited assurance' rating and made 3 high and 3 medium recommendations (negative) All actions completed as at Q2 2020/21 *360 Assurance e-rostering audit planned for Q3/4 2021/22*			✓	**Oct-20** ***Q3/4 2021/22***
A5	*360 Assurance Consultant job planning internal audit planned for ~~Q3/Q4 2020/21~~ Q4 2021/22*			✓	**Q4 2021/22**
A6	People Committee undertook a 'deep dive' on Medical workforce job plans in Q4		✓		**Q4 2020/21**

GAPS IN CONTROL (C) or ASSURANCE (A)
gap in control = exist where adequate controls are not in place, or where collectively they are not sufficiently evident
gap in assurance = exist where there is a failure to gain evidence that the controls are effective

Ref	GAP	MITIGATING ACTIONS TO BE TAKEN TO CLOSE THE GAP	RESPONSIBLE EXECUTIVE DIRECTOR	DEADLINE BY WHICH THE GAP WILL BE CLOSED
G1	Employer of Choice (Mandate 4B) High Level milestones….not included in report to Board in June 2021	**To be confirmed**	Director of Workforce	TBC
G2	Lack of coverage for relevant Medical & Dental staff groups in relation to electronic rostering **(C)**	The Trust has secured regional funding to implement rostering for medical and dental staff	Director of Workforce	**Jul-21** **Q4 2021/22**
G3	~~Trust's inability to recruit to vacancies across the organisation **(C)**.~~ Significant staffing gaps still exist in some specific areas **(C)**	Registered nurse vacancy rate has reduced form 11% to 5% over last 12 months hence gap in control has been reworded. With recruited registered nurse staff currently in the pipeline it is anticipated that the overall gap will be eradicated by end Q3 2021/22. Sideways transfer policy is being utilised to smooth out discrepancies between areas such as supporting community nursing. In line with NHS E/I target Health Care Support worker has reduced from 37 WTE in Oct-20 to an over recruited position in Apr-21. **Q2 Update:** as for Q1 except that the vacancy rate for the substantive funded beds is now down to 3.25% , the lowest it has ever been. The sideways transfer plan for Community has had positive results. All other plans continue on track.	Chief Nurse and Chief Nurses of SY&B ICS	**Q3 2021/22**
G4	Medical Workforce job Plans **(C)**	Job Planning for 2021/22: A 'light touch' to job planning has been adopted throughout the period of COVID; however, job plans have been reviewed and updated as and when required, particularly where there are pay affecting changes. The Medical Director has sent out communication to the Divisional Directors (DDs) (including General Managers) on 17-Jun-21 asking that they liaise with the respective Clinical Leads in order to ensure that they are progressing job plans through and that DDs are also signing off those job plans that are awaiting 3rd Managerial Sign off. The percentage figures for Q1 reflect the job planning status for 2020/21: Total number of the Consultants in post as of 8 July 2021 = 166 / Total number of SAS Grades in post as of 8 July 2021 = 59 12% of Consultant job plans are now signed off on the e-Job Plan System / 65% of Consultant Job Plans are awaiting Consultant or managerial sign off / 23% of Consultant job plans have not been submitted for sign off and are still at the Discussion stage 5% of SAS doctor job plans are signed off / 49% are awaiting manager approval / 46% of job plans have not been submitted for sign off and are still at the Discussion stage. The Medical Director has hastened Divisional Directors to ensure job planning is completed by 31 July 2021. The Medical Workforce Manager (Quality and Standards) continues to support the Divisions with the job planning process	Medical Director	**31-Jul-21**
G5	Identify new practices to embed (Mandate 1B) **(C)**	1. Publish two 'Learning from Covid-19' Team Completion Packs for use across the organisation 2. Begin engagement with services around Service Sustainability Reviews 3. Complete second round of Service Sustainability Reviews 4. Consolidate key actions from Service Sustainability Reviews and ensure these are built into plans for the following year	Director of Strategy, Planning and Performance	**Sep-21** **Oct-21** **Dec-21** **Mar-22**
G6				

CONTROLS and MITIGATION: (i.e. what are we currently doing about this risk?)	
What are the key controls that are in place to mitigate this risk?	
Ref	**CONTROL**
C7	NHS Professionals in place to ensure value for money supply of temporary staff
C8	Interface for interaction between NHS Professionals and e-roster
C9	E-roster Implementation Group established in Q1 to oversee appropriate implementation of e-roster system across the Trust
C10	
C11	
C12	
C13	

ASSURANCE OR EVIDENCE ACTUALLY RECEIVED (i.e. how do we know that we are making an impact in managing the risk?)					
Ref	**ASSURANCE / EVIDENCE (positive or negative)**	**SOURCE OF ASSURANCE / EVIDENCE**			**DATE LAST ASSURANCE PROVIDED**
		1. Internal (operational)	2. Internal: (oversight)	3. External	
A7	In 2020/21 Trust began a career development programme for disabled staff in partnership with Disability Rights UK, funded by the £10K the Trust has been awarded from the WDES Innovation fund (ad hoc, positive)		✓		**Q1 - Q4 2021/22**
A8	Reciprocal mentorship participation in Leadership Academy program in (ad hoc, positive)			✓	**Jun-21**
A9	Monthly workforce report scrutinised by Operational Workforce Group, Executive Team Meeting and People Committee to obtain assurance on recruitment and retention metrics	✓	✓		**Jun-21**
A10					
A11					
A12					
A13					

Sources of assurance: 1. Internal: Management, operational day to day departmental reporting; 2. Internal: Oversight functions & review by committees; 3. Independent, external review

N.B. the assurances detailed in italics are planned assurances which have not yet been received. Once received each entry will be updated to state whether the assurance was positive or negative.

GAPS IN CONTROL (C) or ASSURANCE (A) gap in control = exist where adequate controls are not in place, or where collectively they are not sufficiently evident gap in assurance = exist where there is a failure to gain evidence that the controls are effective				
Ref	**GAP**	**MITIGATING ACTIONS TO BE TAKEN TO CLOSE THE GAP**	**RESPONSIBLE EXECUTIVE DIRECTOR**	**DEADLINE BY WHICH THE GAP WILL BE CLOSED**
G7				
G8				
G9				
G10				
G11				
G12				
G13				

GOVERNANCE: trusted, open governance

BAF Item B6: Insufficiently robust Trust-wide quality and clinical governance arrangements impede the delivery of a number of Trust plans / objectives

Risk Owner: Interim Chief Nurse & Medical Director
Board Committee: Quality Committee
Date the risk last reviewed: 28-Apr-21

Link to 2021/22 Operational Plan

Focus on the fundamentals of care
- Embed agreed standards of care and support teams to deliver and embed quality improvement
- Implement effective learning from deaths practices and deliver improved mortality rate

Link to Operational Risks (scoring 15+):

4174: Clinicians do not always recognise the deteriorating patient
5169: Significantly raised HSMR and SHMI meaning higher mortality rates than expected

STRATEGIC OBJECTIVE:
GOVERNANCE: Trusted, open governance
Which means…
- Have an effective performance framework to help deliver outstanding results
- Be outstanding on the CQC 'well-led' framework across the Trust
- Have high quality data to provide robust information and support decision making
- Ensure all teams have regular reviews and updates around key issues and opportunities to learn

Executive Summary - Quarterly Update:
Q4: Consider the current risk score cannot be reduced given current level of CQC scrutiny and qualitative risk profile (QRP) undertaken during Q4.

Q1: Not appropriate to reduce current risk score whilst CQC warning notice still in place and report from most recent CQC inspections awaited.

Q2: Not considered appropriate to reduce risk score whilst CQC warning notices are in place. Q3: Position remained the same

LIKELIHOOD X CONSEQUENCE = RISK SCORE

INITIAL RISK SCORE (pre-mitigation) as at 01 April 2021	Q1 RISK SCORE	Q2 RISK SCORE	Q3 RISK SCORE	Q4 RISK SCORE	MOVEMENT	TARGET RISK SCORE to be achieved by 31/09/2021
4 x 4 = 16 L (likely) x C (major)	4 x 5 = 20 L (likely) x C (major)	**3 x 5 = 20 L (likely) x C (major)**	**3 x 5 = 20 L (likely) x C (major)**		➔	3 x 5 = 15 L (possible) x C (catastrophic)

Risk Appetite:
TRFT has a **VERY LOW** risk appetite for risk that may compromise the delivery of outcomes for our service users (score of 1 - 5)
TRFT has a **LOW** risk appetite for risks that may affect the experience of our service users (score of 6 -10)
TRFT has a **VERY LOW** risk appetite for risks that may compromise safety (1-5)
TRFT has a **VERY LOW** risk appetite for Compliance / Regulatory risk which may compromise the Trust's compliance with its statutory duties and regulatory requirements (1-5)

Current Risk Appetite (based on current risk score):
High (16 - 25)

Target Risk Appetite (based on target risk score):
In line with / below appetite of MODERATE (12 - 15)

CONTROLS and MITIGATION:
(i.e. what are we currently doing about this risk?)

What are the key controls that are in place to mitigate this risk?

Ref	CONTROL
C1	Reporting on results of external reviews (e.g. Cancer Peer Review, JAG accreditation, GIRFT) to Clinical Governance Committee on a monthly basis with appropriate challenge and escalation as necessary. Remedial action plans monitored to conclusion by Clinical Governance Committee.
C2	The refreshing and embedding of Quality Strategy (previously known as Safe & Sound framework). Being refreshed to incorporate more emphasis on quality improvement
C3	Implementing and embedding Safeguarding Strategy including appropriate governance
C4	Robust Serious Incident process in place in accordance with the Incident and Serious Incident Management Policy
C5	Implementation of the Risk Management Strategy and ongoing education programme

ASSURANCE OR EVIDENCE ACTUALLY RECEIVED
(i.e. how do we know that we are making an impact in managing the risk?)

Ref	ASSURANCE / EVIDENCE (positive or negative)	SOURCE OF ASSURANCE / EVIDENCE: 1. Internal (operational)	2. Internal: (oversight)	3. External	DATE LAST ASSURANCE PROVIDED
A1	Monthly reporting of HSMR and SHMI at CGC, QC and Trust Board and via monthly IPR at Perf Meetings (negative: SHMI 109 and Trust is no longer an outlier; HSMR at 125; Jan-21 data).			✓	**Quality Committee and Clinical Governance Committee Jan-21**
A2	Monthly contact between Chief Nurse and CQC to provide assurance relating to implementation of 'must do' and 'should do' actions arising from inspections as well as any other quality concerns. Regulatory compliance against section 29A and section 31 warning notices in place. (monthly, positive)			✓	**Sep-21**
A3	CQC Children's Safeguarding action plan. Q1 2021/22: All actions now completed and Deputy Chief Nurse for Safeguarding is undertaking a review to ensure that all actions are sustained (ad hoc, positive)			✓	**Jun-21**
A4	360 Assurance 'Learning from deaths review - stage 1 mortality reviews' report (Sept 20) gave 'limited assurance' rating and made 4 medium actions (negative) See G14 for action plan 360 Assurance Learning from Deaths Governance review Apr-21 gave 'limited assurance rating and made 2 high and 9 medium recommendations (ad hoc, negative) See G13 for action plan *360 Assurance Learning from deaths governance review scheduled for Q3 2021/22*			✓	**Sep-20** **Apr-21**
A5	360 Assurance Policy management framework internal audit (Sept 20) gave 'limited assurance' rating and made 4 medium and 2 low recommendations (negative). **Q1 2021/22:** all recommendations have now been implemented.			✓	**Sep-20**

GAPS IN CONTROL (C) or ASSURANCE (A)
gap in control = exist where adequate controls are not in place, or where collectively they are not sufficiently evident
gap in assurance = exist where there is a failure to gain evidence that the controls are effective

Ref	GAP	MITIGATING ACTIONS TO BE TAKEN TO CLOSE THE GAP	RESPONSIBLE EXECUTIVE DIRECTOR	DEADLINE BY WHICH THE GAP WILL BE CLOSED
G1	Standards of Care & Quality Improvement (Mandate 2A) **(C&A)**	1. Establish a Quality Strategy Working Group 2. Identify the Quality Improvement Methodology (Toolkit)to be utilised across the Trust and its method of support and implementation - *revised timescale TBC as need to ensure refreshed Quality Strategy links to Trust strategy.* *Q2 Update: Methodology still being worked on. Will complete in Q3* 3. Identify and agree the standards of care required and measurement for improvement - *revised timescale Q3 as need to ensure refreshed Quality Strategy links to Trust strategy* 4. Refine Quality Strategy and present for Board sign off 5. Relaunch the Safe and Sound Quality Strategy *Q2 Update: delayed by 2 months* 6. Refresh of the Safe and Sound Quality Scorecard using the metrics identified in the strategy 7. Launch the KPIs data collection of perfect ward - completed 8. Develop Quality Improvement Methodology (Toolkit)and launch it 9. Embed Quality Improvement and encourage continuous improvement as BAU	Chief Nurse	**1. 31-May-21** - completed **2. ~~30-Jun-21~~** - revised timescale to Q3 **3. ~~30-Jun-21~~** - revised timescale to Q3 **4. ~~9-Jul-21~~ Q3** **5. ~~31-Jul-21~~ Q3** **6. ~~31-Jul-21~~ Q3** **7. 31-Jul-21 - completed** **8. 30-Sep-21** **9. 31-Mar-22**
G2	Learning from Deaths (Mandate 2B) **(A)**	1. Completion of investigation and initial actions into Palliative Care processes and coding 2. Completion of actions identified by Internal Audit review of Governance 3. Transfer of work from monthly Mortality Improvement Group and Mortality Analytical Group into Business-as-Usual governance and ways of working 4. Appointment to Associate Medical Director Mortality and Learning from Deaths and Mortality Manager posts 5. Implement Community Acquired Pneumonia (CAP) policy 6. Completion and learning from Improvement Academy work in the Urgent and Emergency Care Centre (UECC)	Medical Director	**Q2** **Q3** **Q3** **Q2** **Q1** **Q4**
G3	Gaps remain in Medical Director and Chief Nurse structures ©	**Q4 Update:** Chief Nurse team: temporary additional posts to support CQC process. Gap remains for Chief Nurse teams. Medical Director team: Medical Director structure has been strengthened by appointment and commencement of first Deputy Medical Director in Apr-21 whose focus includes professional standards. Second Deputy Medical Director and Business Manager have been appointed (start dates TBC). New Associate Medical Director for learning from deaths was not appointed therefore going back out to recruit for this post. **Q1 Update:** Medical Director team: Deputy Medical Director for Quality and Business Manager have been recruited but are not yet in post. Business Manager starts in Aug-21 and Deputy Medical Director for Quality in mid-Sep-21. Unsuccessful in recruiting to Associate Medical Director for Learning From Deaths role, currently under Deputy Medical Director for Professional Standards. Clinical Lead for Mortality and Learning From Deaths to be advertised and open to all colleagues at band 8A and above to apply. No gaps in Chief Nurse structure.	Chief Nurse & Medical Director	MD:**Q2 2021/22** CN: **Q2** for advert, **Q3 / Q4** before in post
G4	CQC issued section 29A warning notice on 11 February 2021 **(C&A)**	Preliminary response sent to CQC on 11-Dec-10, feedback awaited. Work has commenced on the required action plan. Submission date 19 Feb 2021 **Q1 Update:** Only a small number of actions are still open and all are due for completion in Q2 2021/22 **Q2 Update:** 1 action is outstanding, due to complete in Q3	Chief Nurse	**Q2** **Q3**
G5	Gap in assurance and control relating to: - medication safety / medicines management at Divisional and Pharmacy level **(C&A)** - delayed administration of critical medications and controlled drugs **(C&A)**	Medication Safety Group with be chaired by Medical Director in Q2 Rotherham Medicines Optimisation Group (RMOG) to be chaired by Deputy Medical Director during Q2 Working to arrange NHS E/I external review of medicines management to take place in Q2 Ongoing challenge of getting the SCRIPT training module onto the ESR system working with Learning & Development department and Chief Pharmacist. **Q2 Update:** External review has not yet taken place. SCRIPT is not on ESRas yet. ***Medical Safety Officer role with direct link to Medical Director***	Medical Director	**Q2**

CONTROLS and MITIGATION: (i.e. what are we currently doing about this risk?)	
What are the key controls that are in place to mitigate this risk?	
Ref	**CONTROL**
C6	Monthly Safe & Sound mortality group continues to meet; Deteriorating patient and sepsis group and clinical leads Safe & Sound Internal Professional Standards meeting are also continuing to meet. Other Safe & Sound workstreams are being reviewed as part of the refresh of the Quality Strategy and identification of quality improvement methodology (links to G1)
C7	Regular monitoring of quality indicators and instigation and implementation of remedial action by Quality Committee, Clinical Governance Committee and sub-groups, Risk Management Committee and sub-group
C8	Annual Clinical Audit Plan completion monitored via quarterly reports to Clinical Governance Committee and via monthly Clinical Effectiveness and Research Group
C9	Executive Team Meeting (ETM) covers quality governance and operational performance with wider stakeholder input than previous ETM. All new risks scoring 15+ reviewed on a weekly basis at Executive Team Meeting. Action plans arising from CQC inspections receive scrutiny confirmation and challenge at ETM.
C10	Most deaths reviewed by Medical Examiner within 1 month and standing mortality section as part of Clinical Governance Committee Separate Safe & Sound mortality group meeting (monthly). Mortality will remain a standing agenda item on Clinical Governance Committee agenda until HSMR / SHMI below 100
C11	Effective quality governance structure at Divisional level with regular spot checks undertaken by members of Chief Nurse / Medical Director team
C12	Organisational Learning Action Forum (OLAF) introduced in late September 2020 to ensure that learning from claims, complaints, incidents and inquests can be used to positively impact on quality of care to close the loop with the clinical audit process to provide assurance.
C13	Medical Director chairing Clinical Effectiveness Group during Q3 & Q4 Deputy Medical Director assumed chairmanship in Q1
C14	Existing Mental Health strategy in place to ensure best practice care is provided
C15	
C16	
C17	
C18	
C19	

ASSURANCE OR EVIDENCE ACTUALLY RECEIVED (i.e. how do we know that we are making an impact in managing the risk?)					
Ref	**ASSURANCE / EVIDENCE (positive or negative)**	**SOURCE OF ASSURANCE / EVIDENCE**			**DATE LAST ASSURANCE PROVIDED**
		1. Internal (operational)	2. Internal: (oversight)	3. External	
A6	360 Assurance CSU-level risk management internal audit (Jan-21) gave 'significant assurance' rating. All recommendations completed in Q4 2020/21			✓	**Jan-21**
A7	360 Assurance Strategic Quality Assurance review (Jun-21) gave 'Significant Assurance' rating and made 4 medium recommendations (ad hoc, positive)			✓	**Jun-21**
A8	360 Assurance CQC Action Plan – advisory work June 2021 reported 19 findings with associated actions (ad hoc, mixed assurance). Findings added to Trust's CQC action plan.			✓	**Jun-21**
A9	CQC section 31 warning notice (ad hoc, negative)(See G15 for action plan) CQC issued section 29A warning notice on 11 February 2021 (negative, ad hoc) Section 29A improvement action plan in place (see G4 for action plan)			✓	**Feb-21**
A10	Safeguarding Strategic Board (quarterly) and Safeguarding Operational meeting review assurances provided across safeguarding and instiitage remedial actions where required. Monthly, quorate and meeting (monthly, mixed)	✓	✓		**Q1**
A11	NHS England qualitative risk profile (QRP) assessment undertaken in conjunction with RCCG: submission of a self-assessment of risk score and evidence. Follow on meeting concluded no need to escalate to single item quality surveillance group or risk summit (ad hoc, positive outcome) NHSE/I attending monthly RCCG Contract Quality Meetings			✓	**Sep-21**
A12	Weekly Harm Free Care meetings chaired by Medical Director or Chief Nurse review prpvision of safe care on a weekly basis and determine remeidal action to be take where required (weekly, positive) Weekly Serious Incident Panel chaired by Medical Director or Chief Nurse to ensure robust reveiw of SI and progerss with investigations (weekly, positive)	✓			**Jun-21**
A13	360 Assurance Learning from Incidents review (Sep-21) gave 'signficant assurance' for evidence of learning from incidents and 'limited assurance' for Organisational Learning Action Tracker (ad hoc, mixed) (See G12 for action plan)			✓	**Sep-21**
A14	*360 Assurance Liberty Protection Safeguards: Implementation of the Mental Capacity (Amendment) Act 2019 (client wide review) scheduled for Q1-4 2021/22* *360 Assurance Governance & Risk Management review scheduled for Q2/Q3 2021/22*			✓	**Q1 - Q4 2021/22**

Sources of assurance: 1. Internal: Management, operational day to day departmental reporting; 2. Internal: Oversight functions & review by committees; 3. Independent, external review

N.B. the assurances detailed in italics are planned assurances which have not yet been received. Once received each entry will be updated to state whether the assurance was positive or negative.

GAPS IN CONTROL (C) or ASSURANCE (A) gap in control = exist where adequate controls are not in place, or where collectively they are not sufficiently evident gap in assurance = exist where there is a failure to gain evidence that the controls are effective				
Ref	**GAP**	**MITIGATING ACTIONS TO BE TAKEN TO CLOSE THE GAP**	**RESPONSIBLE EXECUTIVE DIRECTOR**	**DEADLINE BY WHICH THE GAP WILL BE CLOSED**
G6	Lack of standardised SJR and morbidity meetings in Integrated Medicine Division **(C&A)**	**Q4 Update:** Safe & Sound Mortality subgroups now in place in Medicine Division. Anticipate that this gap can be closed when the Trust can evidence it is doing 100% of SJR within two months. **Q1 Update:** Safe & Sound Mortality subgroups in place Medicine and Surgery and meeting monthly. Need increased evidence that outputs form SJRs are being routinely discussed at these meetings. Gap can be closed when there is evidence of 100% completion of SJRs within 2 months and evidence of dissemination of learning from these reviews.	Medical Director (Divisional Director for Integrated Medicine)	**Q2**
G7	Lack of Trust-wide consistent and robust quality governance arrangements **(C&A)**	**Q4 Update:** Sufficient assurance in place regarding Divisional governance meetings. Less assurance available regarding CSU meetings so a member of Chief Nurse / Medical Director team will start attending CSU level meetings. Assurance should be in place by end Q1 2021/22. Medical Director now chairing Clinical Effectiveness Group with enhanced focus on NICE compliance plus revised ToR to include policy compliance moving forward. **Q1 Update:** 360 Assurance Strategic Quality Assurance review (Jun-21) gave 'Significant Assurance' rating and made 4 medium recommmendations (see BAF item B6 G16 for action plan). There has been a sustained improvement in policy compliance and NICE compliance. There needs to be evidence of discussion and dissemination of learning from deaths and SJRs happening at Divisional and CSU level before this gap can be closed **Q2 Update:** gap remains. Learning from Deaths Manager recruitment is underway. Q3 Learning from Deaths manager now in post move to an assurance level.	Medical Director & Chief Nurse	**Q2 2021/22**
G8	Assurance re: compliance with NICE guidance and /or policies is lacking **(C&A)**	**Q4 Update:** Medical Director now chairing Clinical Effectiveness Group with enhanced focus on NICE compliance plus revised ToR to include policy compliance moving forward. Clinical Effectiveness and Research Group being split into Clinical Effectiveness Group and separate Research and Innovation Group. Draft ToR being revised. **Q1 Update:** Deputy Medical Director of Professional Standards is now chairing the Clinical Effectiveness Group. The Clinical Effectiveness and Research Group has not yet been split as the business case was unsuccessful at its first submission. NICE non-compliance is now at its lowest level in several years. The targets that have been set are to have no NICE guidance over 6 months overdue by end Jun-21; between 3 and 5 months overdue by end Jul-21 and over 3 months overdue by end Aug-21. **Q2 Update:** Policy compliance is now at 94% complaince in relation to overdue policies. New process in Document Ratification Group whereby all policies due for review in 6 months and 3 months' time will be communicated to Divisions.	Medical Director	**Q2**
G9	Safe & Sound work streams not yet having breadth of representation and limitation of bandwidth to complete all required actions **(C)**	**Q3 Update:** Deteriorating patient and sepsis group; Mortality Group and Medicine Management group continuing to meet and are well attended. Other workstreams have been reviewed and proposals created which require sign off by Interim Chief Executive. **Q4 Update:** as for Q3 **Q1 Update:** Deteriorating patient and sepsis group continues to meet and is well attended. Addition of internal Safe & Sound Internal Professional Standards meeting on a monthly basis. Reviewing current ToR and chairmanship of Medicines Safety Group and Rotherham Medicines Optimisation Group. Other Safe & Sound workstreams are being reviewed as part of the refresh of the Quality Strategy and identification of quality improvement methodology.	Medical Director & Chief Nurse	~~**Q2**~~ ~~**Q3**~~ ~~**Q4**~~ **Q2 and ongoing**
G10	Chief Nurse and Medical Director Clinics not having the desired impact **(C&A)**	**Q3 Update:** Looking to have a session similar to Team Brief once a month. during Q4. Medical Director liaising with Interim Director of Communications to increase awareness and convert to virtual clinics in late Q3 and Q4. **Q4 Update**: Restarting virtually in Q1 **Q1 Update:** Clinics are running virtually, ongoing communications required to increase attendance and effectiveness.	Medical Director & Chief Nurse	~~**Sep-20**~~ ~~**Q3**~~ ~~**Q4**~~ **Q1 2021/22**
G11	Ensuring all actions from SI and red incident investigations are completed and sustained **(A)**	**Q4 Update:** Currently 24 red incident investigations and 4 SI investigations are overdue. In order to close gap would need to have overdue red incidents under 10 and overdue SIs under 5. **Q1 Update**: as at end May-21 5 overdue SIs and 21 overdue red incidents **Q2 Update:** as at Aug-21 QC report zero overdue SIs, 3 overdue incidenrs (all HSIB investigations) and 14 overdue red incidents therefore gap remains.	Medical Director & Chief Nurse	**Q4**
G12	360 Assurance Learning from Incidents review (Sep-21) gave 'signficant assurance' for evidence of learning from incidents and 'limited assurance' for Organisational Learning Action Tracker **(C)**	Review made 2 High, 2 Medium and 2 Low recommendations: 1.1 (High) deadline 31-Dec-21 1.2 (High) deadline 31-Mar-22 2.0 (Low) deadline 30-Sep-21 (Check with 360, not on portal) 3.0 (Low) deadline 31-Oct-21 4.0 (Medium) deadline 31-Mar-21 5.0 (Medium) deadline 31-Mar-21	Chief Nurse & Division of Surgery	**Q4 2021/22**
G13	360 Assurance Learning from Deaths Governance review Apr-21 gave 'limited assurance rating and made 2 high and 9 medium recommendations **(A&C)**	1.1 and 1.2 (Medium) deadline 30-Sept-21 2.1 (Medium) deadline 30- Sep-21 completed and 2.2 (Medium) deadline 30-Oct-21 completed 3.1 and 3.2 (High) deadline 30-Jun-21 both in progress revsied deadline of 30-Nov-21 4.1 (Medium) deadline 30-Sep-21 outstanding 4.2 (Medium) deadline 30-Sep-21 completed 5.1 (Medium) deadline 30-Sep-21 and 5.2 (Medium) deadline 30-Jun-21 revsied deadline 39-Nov-21 6.1 (Medium) deadline 30-Sep-21 outstanding check with Callum	Medical Director	**Q2 2021/22**
G14	360 Assurance 'Learning from deaths review - stage 1 mortality reviews' report (Sept 20) gave 'limited assurance' rating and made 4 medium actions **(C)**	Action plan in place. **Q3 Update:** as at 31-Dec-20 all four recommendations are outstanding. **Q4 Update:** 3 recommendations have been completed with the remaining recommendation being in progress with a deadline of 31-Jul-21 **Q1 Update:** as for Q4. **Q2 Update:** all recomendations now implemented	Medical Director	**Gap closed**
G15	Section 31 warning notice action plan **(A)**			
G16	360 Assurance Strategic Quality Assurance review (Jun-21) gave 'Significant Assurance' rating and made 4 medium recommendations **(C&A)**	1.1 and 1.2 Medium deadline 30-Sep-21 Chief Nurse both completed 2.1 and 2.2 Medium deadline 30-Sep-21 Company Secretary	Chief Nurse (Deputy Chief Nurse) Company Secretary	**Sep-21**
G17	Insufficient current resource in Clinical Effectiveness team to manage national and local audits, NICE, CQUINS and TARN **(C&A)**	Business case in progress to increase establishment. First pass of business case was not approved, therefore business case being revised	Medical Director	**Update in Q2**
G18	Gap in control due to increase in mental health demand post-COVID for all ages but especially in relation to Children and Adolescent Mental Health Services (CAMHS) **(C)**	Establishing a Mental Health Steering Group and refreshing the Trust's existing Mental Health strategy. First meeting of Steering Group scheduled for Jul-21, refresh of strategy due for completion in Q3	Chief Nurse	**Steering Group: Jul-21** **Refreshed strategy: Q3**

GOVERNANCE: trusted, open governance

BAF Item B7: There is a risk that robust financial governance arrangements are not embedded across the Trust which could impact on the achievement of Trust plans / objectives, and subsequent removal of the financial planning undertakings and breach of the provider licence *Risk Owner: Deputy Chief Executive / Director of Finance* *Board Committee: Audit Committee* *Date the risk last reviewed: 30-Apr-21*	**Link to 2021/22 Operational Plan** Drive the organisation forwards: - Deliver on our financial commitments and ensure removal of breach of licence	**Link to Operational Risks (scoring 15+):** No risks

STRATEGIC OBJECTIVE:
GOVERNANCE: Trusted, open governance
Which means…
- Have an effective performance framework to help deliver outstanding results
- Be outstanding on the CQC 'well-led' framework across the Trust
- Have high quality data to provide robust information and support decision making
- Ensure all teams have regular reviews and updates around key issues and opportunities to learn

Executive Summary - Quarterly Update:
Q1: Financial governance processes are now well embedded. Further work required across corporate areas and harmonisation of financial reporting to Divisional performance meetings. All improvements materially completed in Q1 and the organisation is receiving clarity in terms of the messages relating to financial governance.

Q2: On 13 August 2021, formal confirmation was received from NHS England / Improvement, North East and Yorkshire Regional Provider Support Group (RSG), that the Trust was no longer in breach of its provider licence.

LIKELIHOOD X CONSEQUENCE = RISK SCORE

INITIAL RISK SCORE (pre-mitigation) as at 01 April 2021	Q1 RISK SCORE	Q2 RISK SCORE	Q3 RISK SCORE	Q4 RISK SCORE	MOVEMENT	TARGET RISK SCORE to be achieved by 31/09/2021
N/A	**3 x 4 = 12 L (possible) x C (major)**	**3 x 4 = 12 L (possible) x C (major)**	**2x4=8**		↓	3 x 4 = 12 L (possible) x C (major)

Risk Appetite:
TRFT has a **VERY LOW** risk appetite for Compliance/Regulatory risk which may compromise the Trust's compliance with its statutory duties and regulatory requirements (1-5)
TRFT has a **LOW** risk appetite for actions and decisions taken in relation to Information Governance / IT. (6-10)
TRFT has a **LOW** Risk appetite for financial/VFM which may grow the size of the organisation whilst ensuring we minimise the possibility of financial loss and comply with statutory requirements. (6 - 10).

Current Risk Appetite (based on current risk score):
Moderate (12 - 15)

Target Risk Appetite (based on target risk score):
In line with MODERATE (12 - 15)

CONTROLS and MITIGATION:
(i.e. what are we currently doing about this risk?)

What are the key controls that are in place to mitigate this risk?

Ref	CONTROL
C1	Financial control and scrutiny of financial performance through the hierarchical structure from Divisions through to Board of Directors (monthly / bimonthly meetings)
C2	Suite of Board documentation in place (SFIs, SO's, Standards of Business Conduct, Constitution, Matters Reserved). SFIs are being updated in relation to Executive Management Team (see G3)
C3	Outstanding recommendations from internal audits reviewed at every Audit Committee meeting and Executive Directors invited to attend as necessary. From Nov-20 also reviewed at ETM on a bi-monthly basis.
C4	Overview and scrutiny of Trust's financial performance by the ICS and NHSE/I regional finance team
C5	Contract Performance Meeting ensures adherence to contracts and financial goals (N.B. These meetings were stood down during the pandemic but recommenced from September 2020 and have been held monthly since. The agenda has been changed slightly to focus on waiting list recovery as opposed to the traditional activity / income volume variances).
C6	CIP Efficiency Board (monthly) holding Divisions to account for development and delivery the Cost Improvement Plan and subsequent delivery of financial benefit

ASSURANCE OR EVIDENCE ACTUALLY RECEIVED
(i.e. how do we know that we are making an impact in managing the risk?)

Ref	ASSURANCE / EVIDENCE (positive or negative)	SOURCE OF ASSURANCE / EVIDENCE			DATE LAST ASSURANCE PROVIDED
		1. Internal (operational)	2. Internal: (oversight)	3. External	
A1	360 Assurance Integrity of General Ledger and Financial Reporting audit April 2021 gave indicative opinion of 'significant assurance' rating (annual, positive)			✓	**Apr-21**
A2	Final Head of Internal Audit Opinion detailed that The Trust has implemented a total of 96% of all internal audit actions due in-year and gave a 'moderate assurance' opinion overall (annual, positive)			✓	**Jun-21**
A3	2020/21 External Auditors' ISA 260 issued unqualified opinion, without modification, on the financial statements (annual, positive)			✓	**11-Jun-21**
A4	360 Assurance Payroll internal audit July 2020 gave 'significant assurance' rating (ad hoc, positive)			✓	**Jul-20**
A5	360 Assurance Advisory review re: leases (Oct 20) - no assurance rating assigned (ad hoc, mixed assurance)			✓	**Oct-20**
A6	Carbon Energy Fund external review (negative, ad hoc) Financial governance external review (negative, ad hoc) See G2 for action plan..			✓	**Jul-21**

GAPS IN CONTROL (C) or ASSURANCE (A)

gap in control = exist where adequate controls are not in place, or where collectively they are not sufficiently evident
gap in assurance = exist where there is a failure to gain evidence that the controls are effective

Ref	GAP	MITIGATING ACTIONS TO BE TAKEN TO CLOSE THE GAP	RESPONSIBLE EXECUTIVE DIRECTOR	DEADLINE BY WHICH THE GAP WILL BE CLOSED
G1	Removal of breach of licence / Five Year Strategy (Mandate 6) (C&A)	1. Delivery the financial plan for 2020/21 (post audit). Break even position on plan at Q1 and forecast to achieve at month 6 of 21/22 2. Break even position achieved at month 6 (H1), Capital Plan delivered at end of month 6 (H1), Financial Governance Plan implemented 3. Breach of licence removed - achieved	Director of Finance	**Jun-21** - achieved and Q1 on plan **Oct-21** **Mar-22** - achieved
G2	Carbon Energy Fund and Financial Governance external reviews led to recommendations for actions to be taken **(C)**	One combined action plan has been robustly developed with actions led by members of the Board of Directors. A significant number of actions are already complete or in progress, with the vast majority scheduled to be implemented before the end of March 2021. **Q4 Update:** Acton plan has been substantially completed as at Q4. **Q1 Update:** materially completed all actions with completion dates in Q1	Board of Directors	**Jun-21** - materially completed all actions scheduled for completion **Sep-21** - for completion of all actions
G3	Standing Financial Instructions to be reviewed to ensure that Executive Team Meeting has appropriate delegated authority via lead officers **(C)**	SFIs to be updated. **Q2 Update:** SFIs will be updated by end March 2021 **Q4 Update:** SFIs will be updated by end June 2021 **Q1 Update:** Agreed with Finance & Performance Committee and Audit Committee that a summary document of the proposed changes to SFI's will be made available at the Committees along with a proposal to Business Case approvals. The final suite of documents will go to Oct-21 Audit Committee Q2 Update: At Sep-21 Board of Directors' meeting approval was given to the proposed wording changes to the AFIs and the prposed changes to the 'Authorisation Limits For In Year Changes To Budgets'. Revised SFIs to be presented for approval to Nov-21 Board meeting. Q3 update - approved therefoer move to an assurance	Interim Deputy Director of Finance (Deputy Director of Finance) and Company Secretary	~~**Q2 Q4 Q1 2021/22 Q3 2021/22**~~
G4				
G5				
G6				

CONTROLS and MITIGATION: (i.e. what are we currently doing about this risk?)	
What are the key controls that are in place to mitigate this risk?	
Ref	**CONTROL**
C7	Implementation of Internal Audit, External Audit and Counter Fraud report recommendations
C8	
C9	
C10	
C11	
C12	
C13	

ASSURANCE OR EVIDENCE ACTUALLY RECEIVED (i.e. how do we know that we are making an impact in managing the risk?)					
Ref	**ASSURANCE / EVIDENCE (positive or negative)**	**SOURCE OF ASSURANCE / EVIDENCE**			**DATE LAST ASSURANCE PROVIDED**
		1. Internal (operational)	2. Internal: (oversight)	3. External	
A7	Financial governance improvement plan progress reported to Confidential Board of Directors' meetings on a monthly basis (monthly, positive)		✓		**Jul-21**
A8	Correspondence from Director of Operational Finance at NHS E/I noted the Trust had demonstrated a positive improvement in financial governance and delivery which had improved the level assurance for NHSE/I and SY&B ICS leading to the decision by NHSE/I that the monthly finance review meetings would cease with immediate effect (ad hoc, positive)			✓	**May-21**
A9	Undertakings and license condition: The progress made on the Governance Improvement Plan has been recognised by NHSE/I. As a result, there has been an indication that the lifting of the undertakings will be considered. This would need to be approved at a regional level. Further feedback on this and the outcome will be received in the near future. Additionally, consideration on the lifting of the legacy licence conditions will also be considered, although this must be undertaken at a national rather than regional level (ad hoc, positive)			✓	**Q1 2021/22**
A10	Formal confirmation received from NHS England / Improvement, North East and Yorkshire Regional Provider Support Group (RSG), that the Trust was no longer in breach of its provider licence (ad hoc, positive)			✓	**13-Aug-21**
A11					
A12	*Finance & Performance Committee Annual Report to Board of Directors for 2020/21*				
A13					
A14					

Sources of assurance: 1. Internal: Management, operational day to day departmental reporting; 2. Internal: Oversight functions & review by committees; 3. Independent, external review

N.B. the assurances detailed in italics are planned assurances which have not yet been received. Once received each entry will be updated to state whether the assurance was positive or negative.

GAPS IN CONTROL (C) or ASSURANCE (A) gap in control = exist where adequate controls are not in place, or where collectively they are not sufficiently evident gap in assurance = exist where there is a failure to gain evidence that the controls are effective				
Ref	**GAP**	**MITIGATING ACTIONS TO BE TAKEN TO CLOSE THE GAP**	**RESPONSIBLE EXECUTIVE DIRECTOR**	**DEADLINE BY WHICH THE GAP WILL BE CLOSED**
G7				
G8				
G9				
G10				
G11				
G12				
G13				

FINANCE: Strong financial foundations

BAF Item B8: The financial plan is not delivered *Risk Owner: Director of Finance* *Board Committee: Finance & Performance Committee* *Date the risk last reviewed: October 2021*	**Link to 2021/22 Operational Plan** **Drive the organisation forwards:** **- Deliver on our financial commitments and ensure removal of breach of licence**	**Link to Operational Risks (scoring 15+):** **5779:** Opening additional capacity on AMU above the funded 44 bed base

STRATEGIC OBJECTIVE:
Deliver strong financial foundations through:
- Improving liquidity whilst ensuring appropriate investment in estates and assets
- Managing within the approved budget and reduce the underlying deficit
- Improving financial performance through service transformation and cost improvement.

Source: Five Year Strategy 2017 - 2022

Executive Summary - Quarterly Update:
Q4 Update: Financial plan will be delivered by end of Q4 2020/21 hence proposal to reduce risk score for Q4 to 1(L) x 3(C) = 3. The only risk that remains is the potential for adjustments which arise from completion of the external audit.

Q1 Update: Trust is reasonably confident it will be able to deliver the first half plan for 2021/22. Half 2 financial regime currently unknown. Challenges expected from second half financial regime may be mitigated by non recurrent support. Q2 update H1 plan achieved.
Q3 Update: Three gaps in controls have been closed (G3, G4 and G7) therefore following overall review of the risk score the recommendation is that this BAF risk 8 is now a mananged risk.

LIKELIHOOD X CONSEQUENCE = RISK SCORE

INITIAL RISK SCORE (pre-mitigation) as at 01 April 2021	Q1 RISK SCORE	Q2 RISK SCORE	Q3 RISK SCORE	Q4 RISK SCORE	MOVEMENT	TARGET RISK SCORE to be achieved by 31/09/2021
1 x 3 = 3 L (Rare) x C (moderate)	1 x 3 = 3 L (Rare) x C (moderate)	1 x 3 = 3 L (Rare) x C (moderate)	**1 x 3 = 3** **L (Rare) x C** **(moderate)**		➔	2 x 3 = 6 L (possible) x C (moderate)

Risk Appetite:
TRFT has a **LOW** Risk appetite for financial/VFM which may grow the size of the organisation whilst ensuring we minimise the possibility of financial loss and comply with statutory requirements (6 - 10).

Current Risk Appetite (based on current risk score):
Very Low (1 - 5)

Target Risk Appetite (based on target risk score):
In line with appetite of LOW (6 - 10)

CONTROLS and MITIGATION:
(i.e. what are we currently doing about this risk?)

What are the key controls that are in place to mitigate this risk?

Ref	CONTROL
C1	Key committees in place which receive reports and subsequently monitor implementation of action plans: - Executive team meeting receives monthly financial performance data and project mandate updates reviewing progress (monthly) - Divisional performance management meetings chaired by Deputy Chief Executive receives latest performance data by Division (monthly) - Finance Oversight Meetings for Divisions - Finance and Performance Committee scrutinises financial performance and progress with project mandates in addition revised forecast positions (monthly) - Workforce control groups review progress against trajectory (weekly) - Capital planning and monitoring group scrutinises progress against capital plan (monthly) (See B9 for further detail) - Cash review meeting scrutinises cash flow forecast (monthly) - ETM receives monthly update on financial position
C2	Project mandate are in place for Removal of Breach of Licence and Five Year Strategy (see G1) Mandate has been signed off and monthly progress will be reported against the mandate.
C3	Business cases scrutinised by FPC with recommendation made to Board of Directors (N.B. all business cases are scrutinised first by ETM then by F&PC and finally by Board of Directors where they are above £250K in value plus in exceptional and urgent circumstances e.g. early stages of a pandemic, ETM approval can be up to £1M)
C4	Plan submitted to NHSE/I and ICS with transparent assumptions owned by all budget holders. This will be closely monitored and overseen at meetings detailed in C1.
C5	Monitoring of individual budgetary control positions against budget holder accountabilities
C6	Maximisation of income opportunities with Commissioners where appropriate given current planning guidance
C7	Dedicated finance and PMO support to the Divisions and Corporate Directorates
C8	Monthly Rotherham CCG Contract Performance Meetings (N.B. These meetings were stood down during the pandemic but recommenced from September 2020 and have been held monthly since. The agenda has been changed slightly to focus on waiting list recovery as opposed to the traditional activity / income volume variances).
C9	Overview and scrutiny of Trust's financial performance by the ICS and NHSE/I regional finance team

ASSURANCE OR EVIDENCE ACTUALLY RECEIVED
(i.e. how do we know that we are making an impact in managing the risk?)

Ref	ASSURANCE / EVIDENCE (positive or negative)	SOURCE OF ASSURANCE / EVIDENCE			DATE LAST ASSURANCE PROVIDED
		1. Internal (operational)	2. Internal: (oversight)	3. External	
A1	2020/21 External Auditors' ISA 260 issued unqualified opinion, without any adjusted or unadjusted misstatements, on the financial statements			✓	**11-Jun-21**
A2	360 Assurance Payroll internal audit July 2020 gave 'significant assurance' rating (positive) All actions completed as at Q1 2021/22 360 Assurance Integrity of e-rostering (Oct-20) gave a 'limited assurance' rating and made 3 high and 3 medium recommendations (negative) All actions completed as at Q4 2020/21			✓	**Jul-20** **Oct-20**
A3	Q1 favourable to plan at Jun-21 and forecasting for H1 to be favourable to plan.	✓			**Jun-21**
A4	Integrated financial performance report (monthly) (positive / negative)		✓		**Mar-21**
A5	Detailed forecast (quarterly) (positive assurance)		✓		**Jun-21**
A6	Divisional performance management log of issues and actions (monthly) (positive / negative)	✓			**Jun-21**
A7	Monthly financial escalation meetings with NHS E/I regional team stood down from May-21 because Trust's financial performance is to plan and future forecasts have been achieved (positive)			✓	**May-21**
A8	360 Assurance Integrity of the general ledger and financial reporting review April 2021 gave 'significant assurance' rating and made 1 medium and 3 low recommendations (annual, positive) 360 Assurance Procurement review (May 2021) gave 'significant assurance' rating and made 2 medium and 2 low recommendations (ad hoc, positive)			✓	**Apr-21** **May-21**
A9					

GAPS IN CONTROL (C) or ASSURANCE (A)

gap in control = exist where adequate controls are not in place, or where collectively they are not sufficiently evident
gap in assurance = exist where there is a failure to gain evidence that the controls are effective

Ref	GAP	MITIGATING ACTIONS TO BE TAKEN TO CLOSE THE GAP	RESPONSIBLE EXECUTIVE DIRECTOR	DEADLINE BY WHICH THE GAP WILL BE CLOSED
G1	Removal of breach of licence / Five Year Strategy (C&A)	1. Delivery the financial plan for 2020/21 (post audit). Break even position on plan at Q1 and forecast to achieve at month 6 of 21/22 2. Break even position achieved at month 6 (H1), Capital Plan delivered at end of month 6 (H1), Financial Governance Plan implemented 3. Breach of licence removed	Director of Finance	**Jun-21** - achieved and Q1 on plan **Oct-21** **Mar-22**
G2	Insufficient workforce to deliver the Operational Plan and therefore being overly reliant on agency **(C)**	See Employer of Choice Mandate detailed at G5 on BAF item B5	Executive Team	**Q4**
G3	360 Assurance Integrity of the general ledger and financial reporting review April 2021 gave 'significant assurance' rating and made 1 medium and 3 low recommendations **(C)**	1.0 (Low) completed 2.0 (Medium) deadline Sep-21 3.0 (Low) deadline Jun-21 - completed 4.0 (Low) deadline Jun-21 - completed	Director of Finance	**Gap closed Q3.**
G4	Unknown financial regime from 1 October 2021 (C&A)	NHS E/I to publish financial regime for Half 2.	NHS E/I	**Gap closed Q3.**
G5	360 Assurance Payroll internal audit July 2020 gave 'significant assurance' rating and made 2 medium and 7 low recommendations **(C)**	Action plan in place. **Q2 Update**: 6 recommendations have been implemented, 3 recommendations outstanding. **Q3 Update:** 2 medium and 5 low recommendations implemented. 2 low recommendations in progress with due dates of 31-Mar-21 and 31-Oct-20 **Q4 Update:** 1 low recommendation outstanding with due date of 31-May-21 **Q1 Update:** All recommendations have now been implemented	Director of Workforce	**Gap closed**
G6	Lack of assurance relating to budget setting and budgetary control processes across the organisation using forecasting methodology and links to recovery plans **(C&A)**	More robust process used for budget development for Half 1 2021/22. Specific budget sign off requests from all Divisions and corporate directorates. Zero based budgets to be developed for 2022/23 budgeting process linked to activity requirements and underpinning capacity.	Director of Finance	**Q4**
G7	360 Assurance Procurement review (May 2021) gave 'significant assurance' rating and made 2 medium and 2 low recommendations **(C)**	1 (Low) deadline 31-Jul-21 2.1 and 2.2 (Medium) deadline 31-Jul-21 3 (Low) implemented	Director of Finance	**Gap closed Q3.**
G8				
G9				

CONTROLS and MITIGATION: (i.e. what are we currently doing about this risk?)	
What are the key controls that are in place to mitigate this risk?	
Ref	**CONTROL**
C10	Implementation of Internal Audit, External Audit and Counter Fraud report recommendations
C11	CIP Efficiency Board (monthly) holding Divisions to account for development and delivery the Cost Improvement Plan and subsequent delivery of financial benefit
C12	3 workforce meetings (medical agency, substantive vacancy control and NHS Professionals agency and bank) all chaired by DCEO with Director of Finance and / or Deputy Director of Workforce also attending have oversight of staffing levels within the Trust to control pay cost
C13	Director of Finance now participates in the development and review of the monthly financial results and preparation of forecast outturn to the year end

ASSURANCE OR EVIDENCE ACTUALLY RECEIVED (i.e. how do we know that we are making an impact in managing the risk?)					
Ref	**ASSURANCE / EVIDENCE (positive or negative)**	**SOURCE OF ASSURANCE / EVIDENCE**			**DATE LAST ASSURANCE PROVIDED**
		1. Internal (operational)	2. Internal: (oversight)	3. External	
A10					
A11	*Internal Audits relating to finance controls in 2020/21: Integrity of general ledger and financial reporting scheduled for Q3 2021/22 Key Financial Systems scheduled for Q3 2021/22 Estates Procurement scheduled for Q2 2021/22*			✓	***Q2 and Q3 2021/22***
A12	*360 Assurance Review of Performance Management scheduled for Q2 2021/22*			✓	***Q2 2021/22***
A13	*Post investment reviews (positive / negative)*		✓		

Sources of assurance: 1. Internal: Management, operational day to day departmental reporting; 2. Internal: Oversight functions & review by committees; 3. Independent, external review

N.B. the assurances detailed in italics are planned assurances which have not yet been received. Once received each entry will be updated to state whether the assurance was positive or negative.

GAPS IN CONTROL (C) or ASSURANCE (A) gap in control = exist where adequate controls are not in place, or where collectively they are not sufficiently evident gap in assurance = exist where there is a failure to gain evidence that the controls are effective				
Ref	**GAP**	**MITIGATING ACTIONS TO BE TAKEN TO CLOSE THE GAP**	**RESPONSIBLE EXECUTIVE DIRECTOR**	**DEADLINE BY WHICH THE GAP WILL BE CLOSED**
G10				
G11				
G12				
G13				

FINANCE: Strong financial foundations

BAF Item B9: The lack of capital investment may affect the delivery of some services *Risk Owner: Director of Finance* *Board Committee: Finance & Performance Committee* *Date the risk last reviewed: October 2021*	**Link to 2021/22 Operational Plan** **Drive the organisation forwards:** **- Deliver on our financial commitments and ensure removal of breach of licence**	**Link to Operational Risks (scoring 15+):** **6198:** Loss of the MRI service due to age-related failure of the MRI scanner

STRATEGIC OBJECTIVE:
Deliver strong financial foundations through:
- Improving liquidity whilst ensuring appropriate investment in estates and assets
- Managing within the approved budget and reduce the underlying deficit
- Improving financial performance through service transformation and cost improvement.

Source: Five Year Strategy 2017 - 2022

Executive Summary - Quarterly Update:
Q4: It is now considered unlikely that the Trust will experience an event that leads to the death of a patient or staff member due to a lack of capital investment hence proposal to reduce Q4 risk score to 2(L) x 5(C) = 10

Q1 Update: Capital plan has been recently set and includes a £500k contingency as well as the ability to vire expenditure from other schemes that may be seen as lower priority should a major risk arise. Hence proposed Q1 risk score of 2(L) x 4(C) = 8. Following Deep Dive review at Finance & Performance Committee on 28-Jul-21 it was agreed to add reference to the fact that during Q1 the Trust had reacted to a high risk issue and had reallocated the capital plan accordingly which it was envisaged would be formally approved in Q2. D&BHFT have experienced an emergency issue which has resulted in a 12.4m capital requirement in addiiton to their normal capital spend. All partners across the STB ICS will be required to underspend their capital limits to match additional expenditure. TRFT is estimated to be impacted by £1m whcih does not adversely impact on patient care hence maintenance of the risk score. Discussion at November F&P Committee reduce the score to 4. **Q3 update: The risk score is below the target score and within the risk appetite and therefore a managed risk.**

LIKELIHOOD X CONSEQUENCE = RISK SCORE

INITIAL RISK SCORE (pre-mitigation) as at 01 April 2021	Q1 RISK SCORE	Q2 RISK SCORE	Q3 RISK SCORE	Q4 RISK SCORE	MOVEMENT	TARGET RISK SCORE to be achieved by 31/09/2021
2 x 5 = 10 L (unlikely),x C (catastrophic)	2 x 4 = 8 L (unlikely) x C (major)	1 x 4 =4 L (unlikely) x C (major)	1 x 4 =4 L (unlikely) x C (major)		➔	2 x 4 = 8 L (possible) x C (major)

Risk Appetite:
TRFT has a **LOW** Risk appetite for financial / VFM which may grow the size of the organisation whilst ensuring we minimise the possibility of financial loss and comply with statutory requirements. (6 - 10).

Current Risk Appetite (based on current risk score):
Low (6 - 10)

Target Risk Appetite (based on target risk score):
In line with appetite of **LOW** (6 - 10)

CONTROLS and MITIGATION:
(i.e. what are we currently doing about this risk?)

What are the key controls that are in place to mitigate this risk?

Ref	CONTROL
C1	Establishment of appropriate capital plan which is funded either through depreciation, cash balance in organisation or loans / PDC from Department of Health & Social Care
C2	Strategic review of lease options and clarity on treatment as revenue or finance leases that count against capital delegated limits
C3	Capital Monitoring Group in place to monitor capital expenditure and propose either corrective actions or new schemes to spend capital. Fit for purpose membership and delegated powers. Feeds into the hierarchy of Finance & Performance Committee and Board of Directors meetings. This is the key control for IT capital investment with all updates on progress with the capital plan containing these themes: Estates, Digital and Medical Equipment

ASSURANCE OR EVIDENCE ACTUALLY RECEIVED
(i.e. how do we know that we are making an impact in managing the risk?)

Ref	ASSURANCE / EVIDENCE (positive or negative)	SOURCE OF ASSURANCE / EVIDENCE			DATE LAST ASSURANCE PROVIDED
		1. Internal (operational)	2. Internal: (oversight)	3. External	
A1	Clarity that Trust has no surplus land, building or assets for disposal and declaration to this effect made to NHS Improvement annually. Link to action detailed in G2. Trust is required to make a surplus land declaration to NHS Surplus Land Collection on a quarterly basis	✓			**Q1 2021/22** **Jul-21 for quarterly declaration**
A2	Capital programme delivered to plan at Q1 (positive)	✓			**Jun-21**
A3	Six facet survey undertaken during Q2 2020/21 by external company (NIFES) which will enable the Trust to articulate an accurate response to annual ERIC to NHS Improvement in 2021/22 and to develop Estates Strategy (positive, ad hoc)			✓	**Sep-20**

GAPS IN CONTROL (C) or ASSURANCE (A)

gap in control = exist where adequate controls are not in place, or where collectively they are not sufficiently evident
gap in assurance = exist where there is a failure to gain evidence that the controls are effective

Ref	GAP	MITIGATING ACTIONS TO BE TAKEN TO CLOSE THE GAP	RESPONSIBLE EXECUTIVE DIRECTOR	DEADLINE BY WHICH THE GAP WILL BE CLOSED
G1	Gap in assurance from measured term contract arising from out of scope use. Independent review undertaken by DKP in scoping value for money of MTC **(A)**	Trust has reasserted the maximum single tender order value as £200K in accordance with SFIs. Trust is looking to redefine the measured term contract and retender this via the north of England procurement framework collaborative. **Q4 Update:** Action plan is to redesign the MTC framework and to retender the MTC. Looking to appoint quantity surveyor to help write specification. Expressions of interest to be issued during Q4 2020/21 with a view to MTC tender specification being generated and tendered in Q2 2021/22 via NHS SBS framework. Maximum single tender order values of £200k asserted in Q3. **Q1 Update:** continuing to reassert maximum value of £200K. MTC will be re-tendered in Q3 this year. **Q2 Update:** Will be re-tendered in Q4. **Q3 update:** Paper to Finance and Performance Committee in October 2021 supporting re-procurement with 8 month extension to existing contract.	Chief Operating Officer (Director of Estates & Facilities)	**Retender ~~Q2~~ ~~Q3~~ Q4 21/22**
G2	The Trust does not have a suite of schemes already developed ready to use for short-notice announcements of capital funding **(C)**	**Estates & Facilities:** Work planned to develop such schemes. Would require expenditure in order to appoint a design team to establish preferred options and a defendable cost. Approval for such development costs to be sought for schemes that are highly likely to be progressed. **Q4 Update:** Envisage will have a suite of prospective business cases by ~~Q2~~ Q4 2021/22. **Q2 Update:** these business cases will be informed by the revised Estates Strategy which is under development and is scheduled for completion by end of Nov-21 **Digital:** Creation of well prepared and approved business cases ready to use at short notice. **Q3 update the Trust is in a stronger position and has a targeted investment scheme in place.**	Chief Operating Officer (Director of Estates & Facilities) Deputy Chief Executive (Director of Health Informatics)	**~~Q2~~ Q4 2021/22**
G3	The time taken from a successful business case to procurement can result in changes in cost base (A)	If there a significant difference in costs the business case is taken back through the approval process via the Capital Monitoring Group then Finance & Performance Committee and Board of Directors (if required) to seek approval for actual costs. Other mitigations include: - contingency allowances included within business cases - improvement in cost estimates - engagement with Procurement as soon as possible - use of national frameworks where applicable - creation of the highest quality of specification possible to reduce risk of unexpected issues arising when contact awarded to suppliers Action to be taken: look to reduction in friction between approval of business case and procurement. Measure will be the number of times digital business cases have to be taken back to CMG and FPC.	Deputy Chief Executive (Director of Health Informatics)	**Q4 2021/22**

CONTROLS and MITIGATION: (i.e. what are we currently doing about this risk?)	
What are the key controls that are in place to mitigate this risk?	
Ref	CONTROL
C4	Standing Financial Instructions which clearly detail the scheme of delegation

ASSURANCE OR EVIDENCE ACTUALLY RECEIVED (i.e. how do we know that we are making an impact in managing the risk?)					
Ref	ASSURANCE / EVIDENCE (positive or negative)	SOURCE OF ASSURANCE / EVIDENCE			DATE LAST ASSURANCE PROVIDED
		1. Internal (operational)	2. Internal: (oversight)	3. External	
A4	Measured term contract independent review undertaken by DKP (negative assurance) See G1 for action plan			✓	Sep-20

GAPS IN CONTROL (C) or ASSURANCE (A) gap in control = exist where adequate controls are not in place, or where collectively they are not sufficiently evident gap in assurance = exist where there is a failure to gain evidence that the controls are effective				
Ref	GAP	MITIGATING ACTIONS TO BE TAKEN TO CLOSE THE GAP	RESPONSIBLE EXECUTIVE DIRECTOR	DEADLINE BY WHICH THE GAP WILL BE CLOSED
G4	Inability to implement agreed and approved digital capital work due to reasons outside of control e.g. COVID-19 or operational pressures causing suppliers to not bill the Trust within anticipated timeframes **(C)**	Creation of accruals by Finance team. Monitored through Capital Monitoring Group and Finance & Performance Committee. Work underway to try to achieve zero accruals which will be assessed year end.	Deputy Chief Executive (Director of Health Informatics)	Q4 2021/22

CONTROLS and MITIGATION: (i.e. what are we currently doing about this risk?)	
What are the key controls that are in place to mitigate this risk?	
Ref	**CONTROL**
C5	Revised business case process captures all necessary capital projects ensuring proper approvals
C6	The organisation's yearly business planning cycle means that digital developments requiring capital expenditure are forecast and funding is allocated dependent on prioritisation
C7	
C8	
C9	
C10	
C11	
C12	
C13	

ASSURANCE OR EVIDENCE ACTUALLY RECEIVED (i.e. how do we know that we are making an impact in managing the risk?)					
Ref	**ASSURANCE / EVIDENCE (positive or negative)**	**SOURCE OF ASSURANCE / EVIDENCE**			**DATE LAST ASSURANCE PROVIDED**
		1. Internal (operational)	2. Internal: (oversight)	3. External	
A5	Digital Transformation Committee receive digital programme updates which include capital expenditure. The Committee seeks assurance as to whether the digital capital programme is on track and achieving its objectives (positive, monthly)	✓			**Sep-21**
A6	ICS Digital Transformation Strategy 2021-2024 provides a level of assurance that the Trust is spending digital capital on the right things to maximise interoperability and achievement of the paper-free agenda, as well as a stable digital infrastructure (5 yearly, positive)			✓	Endorsed by Board of Directors Sep-21
A7					
A8					
A9					
A10					
A11					
A12					
A13					

GAPS IN CONTROL (C) or ASSURANCE (A) gap in control = exist where adequate controls are not in place, or where collectively they are not sufficiently evident gap in assurance = exist where there is a failure to gain evidence that the controls are effective				
Ref	**GAP**	**MITIGATING ACTIONS TO BE TAKEN TO CLOSE THE GAP**	**RESPONSIBLE EXECUTIVE DIRECTOR**	**DEADLINE BY WHICH THE GAP WILL BE CLOSED**
G5				
G6				
G7				
G8				
G9				
G10				
G11				
G12				
G13				

Sources of assurance: 1. Internal: Management, operational day to day departmental reporting; 2. Internal: Oversight functions & review by committees; 3. Independent, external review

N.B. the assurances detailed in italics are planned assurances which have not yet been received. Once received each entry will be updated to state whether the assurance was positive or negative.

PARTNERS: Securing the future together

BAF Item B10: There is a risk that the Trust has insufficient governance in place with partners in the South Yorkshire and Bassetlaw ICS which will impact on the Trust's ability to contribute effectively to the partnerships in place, provider collaboratives, and digital and data to drive systems *Risk Owner: Deputy Chief Executive* *Board Committee: Board of Directors* *Date the risk last reviewed: 02-Feb-21*	**Link to 2021/22 Operational Plan** **Drive the organisation forwards:** **- Publish a new five year strategy and support partners with re-organisation**	**Link to Operational Risks (scoring 15+):** **No risks**

STRATEGIC OBJECTIVE:
PARTNERS: Securing the future together
Which means…
- Work with our partners to provide sustainable health and care services for the population of Rotherham
- Be open to new ideas and innovations and adopt these wherever we can
- Collaborate with partners across South Yorkshire & Bassetlaw on key services to improve service resilience and sustainability

Executive Summary - Quarterly Update:

Q1: Trust has strong representation across the various system-related groups and the position has been maintained during Q1.

LIKELIHOOD X CONSEQUENCE = RISK SCORE

INITIAL RISK SCORE (pre-mitigation) as at 01 April 2021	Q1 RISK SCORE	Q2 RISK SCORE	Q3 RISK SCORE	Q4 RISK SCORE	MOVEMENT	TARGET RISK SCORE to be achieved by 31/09/2021
N/A	**2 x 4 = 8 L (unlikely) x C (major)**	**1 x 4 = 8 L (unlikely) x C (major)**	**1 x 4 = 8 L (unlikely) x C (major)**		N/A	2 x 4 = 8 L (unlikely) x C (major)

Risk Appetite:
TRFT has a **MODERATE** risk appetite for partnerships which may support and benefit the people we serve (12 - 15)

Current Risk Appetite (based on current risk score):
Moderate (12 - 15) / Low (6-10) / Very Low (1-5)

Target Risk Appetite (based on target risk score):
In line with / below appetite of / LOW (6 - 10)

CONTROLS and MITIGATION:
(i.e. what are we currently doing about this risk?)

What are the key controls that are in place to mitigate this risk?

Ref	CONTROL
C1	Clear governance structures are in place to support decision making for the ICS (although COVID-19 remains a key focus)
C2	TRFT Committee (in Common) in place
C3	Regular attendance at ICS governance fora e.g. Health Executive Group (HEG)
C4	Change proposals are circulated to all providers prior to adoption
C5	The Trust is taking a lead role in a number of ICS-wide developments (e.g. hosted network)
C6	Collaboration across ICS in relation to response to COVID-19
C7	
C8	
C9	
C10	
C11	
C12	
C13	

ASSURANCE OR EVIDENCE ACTUALLY RECEIVED
(i.e. how do we know that we are making an impact in managing the risk?)

Ref	ASSURANCE / EVIDENCE (positive or negative)	SOURCE OF ASSURANCE / EVIDENCE			DATE LAST ASSURANCE PROVIDED
		1. Internal (operational)	2. Internal: (oversight)	3. External	
A1	Monthly ICS update provided to Board of Directors by Interim Chief Executive as appendix to Chief Executive's report including ICS Health Executive Group and sub-group reporting to Board of Directors (monthly, positive)	✓			**Jun-21**
A2	Updates relating to the ICS is a standing agenda item on the Executive Team Meeting agenda (monthly, positive)	✓			**Jun-21**
A3	Deputy Chief Executive also provides monthly update on ICS to the public Board of Directors meetings (monthly, positive)		✓		**Jun-21**
A4	Trust is part of SYB ICS Acute Federation in which the Interim Chief Executive is heavily involved thereby giving the Trust the opportunity to influence the development of the way forward for the ICS (monthly, positive)		✓		**Jun-21**
A5					
A6	*360 Assurance 'System and joint Working' review scheduled fro Q1-Q4 2021/22*			✓	Q1 - Q4 2021/22
A7					
A8					
A9					
A10					
A11					
A12					
A13					

Sources of assurance: 1. Internal: Management, operational day to day departmental reporting; 2. Internal: Oversight functions & review by committees; 3. Independent, external review

N.B. the assurances detailed in italics are planned assurances which have not yet been received. Once received each entry will be updated to state whether the assurance was positive or negative.

GAPS IN CONTROL (C) or ASSURANCE (A)

gap in control = exist where adequate controls are not in place, or where collectively they are not sufficiently evident
gap in assurance = exist where there is a failure to gain evidence that the controls are effective

Ref	GAP	MITIGATING ACTIONS TO BE TAKEN TO CLOSE THE GAP	RESPONSIBLE EXECUTIVE DIRECTOR	DEADLINE BY WHICH THE GAP WILL BE CLOSED
G1	Collaborative governance arrangements across SYB ICS still do not have a statutory / regulatory framework in place (and remain subject to legal challenge) and are not legally binding **(C&A)**	NHSE/I published the Integrated Care System (ICS) Design Framework on 16 June 2021 which sets out the operating model for ICS from April 2022 onwards. Once the Health and Care Bill has been enacted, ICS will be placed on a statutory footing. The Design Framework document sets out how ICS should develop and prepare for their new statutory status between June 2021 and March 2022. In SYB the ICS Development Steering Group is focussing on the work of the provider collaboratives and the main transition commitments for 2021.	Interim Chief Executive and Deputy Chief Executive	**Mar-22**
G2				
G3				
G4				
G5				
G6				
G7				
G8				
G9				
G10				
G11				
G12				
G13				

PARTNERS: Securing the future together

BAF Item B11: Joint working with key partners is developing steadily and relationships are in formative periods. Unless these relationships continue to develop there is a risk to continuity and poor service configuration across the Rotherham Place *Risk Owner: Chief Operating Officer* *Board Committee: Board of Directors* *Date the risk last reviewed: 2-Feb-21*	**Link to 2021/22 Operational Plan** **Drive the organisation forwards:** **- Publish a new five year strategy and support partners with re-organisation**	**Link to Operational Risks (scoring 15+):** **6226:** COVID-19 - organisational recovery **6386:** CAMHs inpatients on Children's Ward and Children's Assessment Unit (CAU)

STRATEGIC OBJECTIVE
PARTNERS: Securing the future together
Which means…
- Work with our partners to provide sustainable health and care services for the population of Rotherham
- Be open to new ideas and innovations and adopt these wherever we can
- Collaborate with partners across South Yorkshire & Bassetlaw on key services to improve service resilience and sustainability

Executive Summary - Quarterly Update:
Q1: still on track to develop integrated performance plans and services and most of the controls in place have restarted post COVID-19. Q2 score remains the same but likely to decrease in Q3/4 due to increasing partnership working.

LIKELIHOOD X CONSEQUENCE = RISK SCORE

INITIAL RISK SCORE (pre-mitigation) as at 01 April 2021	Q1 RISK SCORE	Q2 RISK SCORE	Q3 RISK SCORE	Q4 RISK SCORE	MOVEMENT	TARGET RISK SCORE to be achieved by 31/09/2021
N/A	2 x 4 = 8 L (unlikely) x C (major)	1 x 4 = 8 L (unlikely) x C (major)	1 x 4 = 8 L (unlikely) x C (major)		N/A	1 x 4 = 8 L (rare) x C (major)

Risk Appetite:
TRFT has a **MODERATE** risk appetite for partnerships which may support and benefit the people we serve (12 - 15)

Current Risk Appetite (based on current risk score):
Moderate (12 - 15)

Target Risk Appetite (based on target risk score):
In line with / below appetite of LOW (6 - 10)

CONTROLS and MITIGATION:
(i.e. what are we currently doing about this risk?)

What are the key controls that are in place to mitigate this risk?

Ref	CONTROL
C1	Trust engages at a senior level with Rotherham Place e.g. Deputy Chief Executive sits on Integrated Care and Reablement Project. This enables the sharing of developments and agreeing across the Place how any developments are taken forward.
C2	Clear governance structures are in place to support decision making for the Place
C3	Delivery Oversight Group (DOG) is a new control added in Q1 2020/21. The purpose of the DOG is to ensure that Directors at the Trust and Rotherham CCG agree the initiatives to be focussed upon by each organisation and to avoid project workstreams being initiated without the relevant Director input / support and governance being in place. The Deputy Chief Executive, Chief Operating Officer and Interim Director of Finance represent the Trust at the DOG.
C4	Operational Partnership Board (weekly) chaired by TRFT's Deputy COO and Deputy Director of Commissioning from RMBC and CCG. This Board operationally manages issues of concern e.g. operationally writes the winter plan for the Rotherham Place. Also feeds into A&E Delivery Board.
C5	Rotherham Place COVID-19 Bronze response meeting led by Rotherham CCG to align and prioritise actions (met weekly for most of Q1 then twice weekly at end of Q1)
C6	Restarted monthly Contract Monitoring Group with Rotherham CCG in Dec-20 reviewing performance against the whole contract
C7	A&E Oversight Board chaired by Interim Chief Executive. This is the oversight board for whole of SY&B ICS and ensures that Place discussions and debate are aligned to S&YB ICS.
C8	
C9	
C10	
C11	
C12	
C13	

ASSURANCE OR EVIDENCE ACTUALLY RECEIVED
(i.e. how do we know that we are making an impact in managing the risk?)

Ref	ASSURANCE / EVIDENCE (positive or negative)	SOURCE OF ASSURANCE / EVIDENCE			DATE LAST ASSURANCE PROVIDED
		1. Internal (operational)	2. Internal: (oversight)	3. External	
A1	Rotherham Integrated Health & Social Care Plan 2020 to 2022 (positive) Updated fro 2021/22		✓		**Jun-21**
A2	Place Executive Meeting oversees Place performance and is attended by Deputy Chief Executive (weekly, mixed assurance)			✓	**Jun-21**
A3	A&E Delivery Board. Place-led meeting chaired by Rotherham CCG Chief Officer with representation from RMBC, TRFT, GP Federation, Yorkshire Ambulance Service and voluntary groups. Receives reports on performance (monthly, mixed assurance)			✓	**Jul-21**
A4	Deputy Chief Executive also provides monthly update on Place and ICS to the public Board of Directors meetings (monthly, positive)		✓		**Jun-21**
A5	Refreshed Rotherham Integrated Care Partnership Agreement received at Board of Directors in Sep-21		✓		**Sep-21**
A6	Rotherham Integrated Care Development Plan received at Board of Directors in Sep-21		✓		**Sep-21**
A7					
A8					
A9					
A10					
A11					
A12					
A13					

Sources of assurance: 1. Internal: Management, operational day to day departmental reporting; 2. Internal: Oversight functions & review by committees; 3. Independent, external review

N.B. the assurances detailed in italics are planned assurances which have not yet been received. Once received each entry will be updated to state whether the assurance was positive or negative.

GAPS IN CONTROL (C) or ASSURANCE (A)

gap in control = exist where adequate controls are not in place, or where collectively they are not sufficiently evident
gap in assurance = exist where there is a failure to gain evidence that the controls are effective

Ref	GAP	MITIGATING ACTIONS TO BE TAKEN TO CLOSE THE GAP	RESPONSIBLE EXECUTIVE DIRECTOR	DEADLINE BY WHICH THE GAP WILL BE CLOSED
G1	All activity delivered is appropriately reimbursed **(C)**	Accurately capture all activity undertaken and ensure it feeds into contract discussion **Q2 Update:** COVID -19 fixed national contact for months 1 - 6. Months 7 - 12 guidance now released. **Q3 Update:** now on block national contract therefore progress cannot be made against this gap at present. **Q1 Update**: block contract continuing for H1. Further detail will be available in Q2 relating to H2	Deputy Chief Executive	Q4 2020/21 - paused due to current block contract arrangements **Q2 2021/22**
G2	Trust does not have a substantive Executive Team in place **(C&A)**	Interim Chief Executive, Deputy Chief Executive and Interim Director of Finance. New appointments to Executive Team will require time to embed. **Q3 Update**: substantive Deputy Chief Executive in post and substantive Director of Finance appointed. **Q4 Update**: as for Q3 **Q1 Update:** Substantive Director of Finance in post.	Chairman and Interim Chief Executive	~~**Q2 Q4 2020/21**~~ **Q2 2021/22**
G3	Five Year Strategy (Mandate 6) **(C&A)**	2. Publication of a Trust Strategy following robust engagement.	Director of Strategy, Planning and Performance	**Sep-21**
G4				
G5				
G6				
G7				
G8				
G9				
G10				
G11				
G12				
G13				

Board of Directors' Meeting
07 January 2022

The Rotherham NHS Foundation Trust

Agenda item	P25/22
Report	**Enhancing Board Oversight: A New Approach to Non-Executive Director Champion Roles**
Executive Lead	Angela Wendzicha, Director of Corporate Affairs
Link with the BAF	The report is linked across all Board Assurance Risks.
How does this paper support Trust Values	The report supports all Trust values.
Purpose	**For decision** ☒ **For assurance** ☐ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	In December 2021, NHS England/Improvement published guidance on a new recommended approach for Non-Executive Director champion roles. The following report provides a summary of the recommendations in addition to recommendations for the Trust in implementing the guidance.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	Due to the nature of the report, this paper has not been presented at any other committee.
Board powers to make this decision	The Board has the power as directed under the approved Matters Reserved for the Board.
Who, What and When (what action is required, who is the lead and when should it be completed?)	Following approval at Board, the Director of Corporate Affairs will lead on the required amendments to the relevant Terms of Reference in addition to supporting the Non-Executive Directors in the champion roles.
Recommendations	The Board is asked to approve the recommendations contained within the report.
Appendices	None

1. Introduction

1.1 New guidance was published by NHS England and Improvement in December 2021 relating to a new approach to Non-Executive Director champion roles.[1]

1.2 The Non-Executive Director champion roles have increased over the years largely in response to high profile failings in care and or leadership that have resulted in the need to establish designated Non-Executive champions for specific issues in order to drive change.

1.3 It has been recognised that the increasing number of these champion roles have become challenging for some organisations to effectively discharge their responsibilities in addition to the variable position around availability of relevant role descriptions.

2. Current Non-Executive Champion Roles

The following table illustrates the current Non-Executive Director champion roles.

Role	Non-Executive Director Champion
Maternity Board Safety Champion	Lynn Hagger
Wellbeing Guardian	Lynn Hagger
Freedom to Speak Up	Lynn Hagger
Doctors Disciplinary	Vacant
Hip, fracture, falls and dementia	Mike Smith
Learning from Deaths	Rumit Shah
Safety and Risk	Rumit Shah
Palliative Care and End of Life	Mike Smith
Health and Safety	Martin Havenhand
Children and Young People	Lynn Hagger
Resuscitation	Rumit Shah
Cybersecurity	Vacant
Emergency Preparedness	Mike Smith
Safeguarding	Heather Craven
Counter Fraud	Kamran Malik
Procurement	Nicola Bancroft
Security Management- violence and aggression	Mike Smith

3. Recommendations

3.1 The NHS England/Improvement document sets out the Non-Executive champion roles recommended for retention with the remaining roles being aligned and overseen through the appropriate Board Committees.

[1] NHS England/Improvement: (December 2021) Enhancing Board Oversight: A New Approach to Non-Executive Director Champion Roles

3.2 The following champion roles are recommended for retention with the proposed Non-Executive Director:

3.2.1 Maternity Board Safety Champion – Lynn Hagger
3.2.2 Wellbeing Guardian - Jo Bibby
3.2.3 Freedom to Speak Up - Kamran Malik
3.2.4 Doctors Disciplinary - Nicola Bancroft
3.2.5 Security Management - Mike Smith

3.3 In accordance with the guidance document, it is recommended that the following champion roles transition to the new approach of being overseen via the appropriate Board Assurance Committees through the annual work plan as follows:

3.3.1 **Quality Committee**

- Hip Fractures, Falls and Dementia
- Palliative and End of Life Care
- Resuscitation
- Learning from Deaths
- Health and Safety
- Safeguarding
- Safety and Risk
- Lead for Children and Young People

3.3.2 **Audit Committee**

- Counter Fraud
- Emergency Preparedness

3.3.3 **Finance and Performance Committee**

- Procurement
- Cyber Security

3.3.4 **People Committee**

- Security Management – violence and aggression

3.4 To some extent the Board Assurance Committees already receive existing reports on the majority of the above. Subject to approval by the Board of the revised approach, the changes will be incorporated into the review of the existing Terms of Reference in addition to further supporting the remaining Non-Executive champion roles with supportive training material and relevant role description.

4. Recommendations

4.1 The Board is requested to approve the revised approach to strengthen the alignment of those transitioned roles to the Board Assurance Committees in addition to the approach for supporting the retained champion roles.

Angela Wendzicha
Director of Corporate Affairs
December 2021