The Rotherham NHS Foundation Trust

Board of Directors
Public AGENDA

Date: **Friday 08 July 2022**
Time: **0900hrs – 1130hrs**
Venue: **Boardroom Level D**

Time	Item no.			Page	Required Actions	Lead
		Procedural Items				
0900	*P93/22*	*Chairman's welcome and apologies for absence*	*Verbal*	*-*	*For information*	*Martin Havenhand, Chairman*
	P94/22	*Quoracy Check*	*Verbal*	*-*	*For assurance*	*Martin Havenhand, Chairman*
	P95/22	*Declaration of conflicts of interest*	*Verbal*	*-*	*For assurance*	*Martin Havenhand, Chairman*
	P96/22	*Minutes of the previous meeting held on 06 May 2022*	*Enc.*	*4*	*For decision*	*Martin Havenhand, Chairman*
	P97/22	*Matters arising from the previous minutes (not covered elsewhere on the agenda)*	*Verbal*	*-*	*For assurance*	*Martin Havenhand, Chairman*
	P98/22	*Action Log*	*Enc.*	*18*	*For assurance*	*Martin Havenhand, Chairman*
		Overview and Context				
0910	*P99/22*	*Report from the Chairman*	*Enc.*	*19*	*For information*	*Martin Havenhand, Chairman*
0915	*P100/22*	*Report from the Chief Executive*	*Enc.*	*23*	*For information*	*Dr Richard Jenkins, Interim Chief Executive*
		Culture				
0920	*P101/22*	*Annual Responsible Officer Report*	*Enc.*	*40*	*For decision*	*Dr Callum Gardner, Executive Medical Director*
0925	*P102/22*	*Mortality and Learning From Deaths Annual Report – 2021/22*	*Enc.*	*49*	*For assurance*	*Dr Callum Gardner, Executive Medical Director*
		Strategy				
0930	*P103/22*	*National, Integrated Care Board and Integrated Care Partnership Report*	*Enc.*	*87*	*For information*	*Michael Wright, Deputy Chief Executive*
0935	*P104/22*	*Operational Objectives 2022/23 Review*	*Enc.*	*91*	*For assurance*	*Michael Wright, Deputy Chief Executive*
		Assurance				

0940	*P105/22*	*Board Committees Chairs Assurance Log:* *i. Finance and Performance Committee* *ii. Quality Committee* *iii. People Committee*	*Enc.*	*115* *118* *120*	*For assurance*	*Committee Chairs and Lead Executives*
0950	*P106/22*	*Care Quality Commission Assurance Report*	*Enc.*	*124*	*For assurance*	*Helen Dobson, Chief Nurse*
0955	*P107/22*	*Monthly Integrated Performance Report*	*Enc.*	*129*	*For assurance*	*Michael Wright, Deputy Chief Executive*
1000	*P108/22*	*Reset and Recovery Operational Report*	*Enc.*	*149*	*For assurance*	*Sally Kilgariff, Chief Operating Officer*
1005	*P109/22*	*Finance Report*	*Enc.*	*157*	*For assurance*	*Steven Hackett, Director of Finance*
1010	*P110/22*	*Learning from COVID-19*	*Enc.*	*163*	*For information*	*Louise Tuckett, Director of Strategy, Planning & Performance*
1015	*P111/22*	*Quality Improvement Plan*	*Enc.*	*173*	*For assurance*	*Helen Dobson, Chief Nurse*
1020	*P112/22*	*Maternity Safety including Ockenden monthly report'*	*Enc.*	*179*	*For assurance*	*Helen Dobson, Chief Nurse*
1025	***BREAK***					
1035	*P113/22*	*Quarterly Medical Workforce Report*	*Enc.*	*182*	*For assurance*	*Dr Callum Gardner, Executive Medical Director*
1040	*P114/22*	*Data Security and Protection Toolkit*	*Enc.*	*187*	*For assurance*	*Michael Wright, SIRO*
1045	*P115/22*	Senior Information Risk Owner (SIRO) Annual Information Governance Report	*Enc.*	*191*	*For assurance*	*Michael Wright, SIRO*
1050	*P116/22*	*Health Inequalities Task & Finish Group Update Report*	*Enc.*	*199*	*For assurance*	*Michael Wright, Deputy Chief Executive*
		Regulatory Compliance Risk and Assurance				
1055	*P117/22*	*Board Assurance Framework*	*Enc.*	*213*	*For decision & assurance*	*Angela Wendzicha, Director of Corporate Affairs*
		Board Governance				
1100	*P118/22*	*Corporate Governance Report*	*Enc.*	*222*	*For information*	*Angela Wendzicha, Director of Corporate Affairs*
1105	*P119/22*	*Board Assurance Committees*	*Enc.*	*226*	*For decision*	*Martin Havenhand, Chairman &* *Angela Wendzicha, Director of Corporate Affairs*
1110	*P120/22*	*Senior Independent Director and Vice Chair Roles*	*Enc.*	*239*	*For decision*	*Martin Havenhand, Chairman*
1115	*P121/22*	*Escalation from Council of Governors*	*Verbal.*	*-*	*For information*	*Martin Havenhand, Chairman*

		Closing matters				
1120	*P122/22*	*Any other business*	*-*	*-*	*For noting*	*Martin Havenhand, Chairman*
	P123/22	*Date of next meeting:* *09 September 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, 06 MAY 2022

Present:
Mr M Havenhand, Chairman
Miss N Bancroft, Non-Executive Director
Dr J Bibby, Non-Executive Director
Mr G Briggs, Chief Operating Officer
Mrs H Craven, Non-Executive Director
Mrs H Dobson, 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 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 P72/22 & P73/22 only)
Mr I Hinitt, Director of Estates and Facilities
Mrs S Kilgariff, Director of Operations / Deputy Chief Operating Officer
Dr G Lynch, Guardian of Safe Working (minute P71/22 only)
Mrs S Petty, Head of Midwifery (minute P86/22 only)
Mr J Rawlinson, Director of Health Informatics
Ms K Richardson, Community Outreach Worker (minute P68/22 only)
Mr M Smith, Healthy Hospital Programme Manager (minute P68/22 only)
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 K Malik, Non-Executive Director

PROCEDURAL ITEMS

P62/22 CHAIRMAN'S WELCOME AND APOLOGIES FOR ABSENCE

Mr Havenhand welcomed all present with apologies for absence noted.

Mrs Dobson was welcomed to her first meeting since her substantive appointment as Chief Nurse.

P63/22 QUORACY CHECK

The meeting was confirmed to be quorate.

P64/22 **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.

P65/22 **MINUTES OF THE PREVIOUS MEETING**

The minutes of the previous meeting held on 04 March 2022 were agreed as a correct record.

P66/22 **MATTERS ARISING FROM THE PREVIOUS MEETING**

There were no matters arising from the previous meetings that were not either covered by the action log or agenda items.

P67/22 **ACTION LOG**

The Board of Directors reviewed the action log and agreed log number 44 (from 2021 relating to the alignment of the risks from the Five Year Strategy to the Board Assurance Framework) would be closed.

The three remaining open actions would be reported to the July 2022 meeting.

OVERVIEW AND CONTEXT

P68/22 **STAFF STORY**

The Board of Directors welcomed to the meeting Mr Smith, Healthy Hospital Programme Manager and Ms Richardson, Community Outreach Worker, to discuss the Healthy Hospital Programme which included supporting colleagues to quit smoking.

Mr Smith explained that the quit smoking initiative, which was a 12 week support programme, was available to all staff. Ms Richardson had been the first member of staff to complete the programme. Whilst uptake so far had been slow, further communications were planned to promote the service.

Ms Richardson, informed the Board that she had attempted to stop smoking in the past without any success. However, she had found that the Healthy Hospital Programme had offered her one to one support on a weekly basis, without this she did not believe she would have been able to maintain momentum. She would highly recommend the service to colleagues, as now having stopped smoking had enabled her to undertake other healthy activities she had previously not been able to pursue.

The Board of Directors thanked colleagues for their attendance at the meeting.

P69/22 **REPORT FROM THE CHAIRMAN**

The Board of Directors received and noted the Chairman's Report.

P70/22 **REPORT FROM THE INTERIM CHIEF EXECUTIVE**

The Board of Directors received and noted the report from the Interim Chief Executive which highlighted the challenges with operational flow and recovery.

CULTURE

P71/22 **GUARDIAN FOR SAFE WORKING – ANNUAL REPORT**

The Board of Directors welcomed to the meeting Dr Lynch, Guardian for Safe Working, to present his annual Guardian of Safe Working Report.

In taking the report as read, Dr Lynch highlighted that the annual data reflected the challenges faced by the junior doctors and trainees during 2021/22. This was particularly noticeable in the Division of Medicine due to the requirement to move colleagues around the organisation to address the gaps in clinical areas during the pandemic. A number of actions had and were being taken to mitigate the position across all areas and were detailed within the report.

The Board of Directors thanked Dr Lynch for his continued support to the Junior Doctors, and noted the Guardian for Safe Working Annual Report.

P72/22 **FREEDOM TO SPEAK UP POLICY**

The Board of Directors welcomed to the meeting Mr Bennett, Lead Freedom to Speak up Guardian to support discussion on the next two agenda items.

The Board of Directors received the Freedom to Speak Up; Raising Concerns (Whistleblowing) Policy.

Mrs Dobson explained that pending publication of the new national policy template by the National Guardians Office (NGO), the Trust had reviewed its current policy to ensure that it remained in date. However, once the national policy was released the Trust's own policy would be again reviewed and brought in line with the national standard.

There had been minor revisions to the policy, which had been considered by a number of groups and committees as part of its consultation and approval process. This had included the People Committee and Audit Committee.

The Board noted the aspiration remained to be a high performing trust in this area, supporting staff to speak out and take action for any sub-standard services.

The Board of Directors approved the Freedom to Speak Up; Raising Concerns (Whistleblowing) Policy.

P73/22 **FREEDOM TO SPEAK UP GUARDIAN – ANNUAL REPORT**

The Board of Directors received the Annual Report (2021/22) from the Lead Freedom to Speak Up Guardian.

Mr Bennett took the opportunity to highlight a number of matters, including:

- 45 concerns had been raised in year, which was an increase from the 34 raised in 2020/21. This demonstrated that colleagues, particularly those from a clinical background, were more confident in raising concerns;
- Colleagues from a BAME background were reporting concerns, demonstrating the targeted work undertaken in year;
- Consistent themes had been attitudes and behaviour;
- More concerns had been raised relating to patient safety, reflecting organisational challenges;
- The NGO had published new e-learning packages with an organisational Mandatory and Statutory Training compliance rate of 97.23%.

Dr Shah in cross referencing the position with the national staff survey noted that Trust staff had indicated that they were confident in raising concerns, but were less confident that the organisation would address concerns raised and questioned how this could be rectified. Mr Bennett explained that although this was a new question in the staff survey, feedback on the action taken as a result of any concern raised would be key. In addition development of a Freedom to Speak Up communication strategy would facilitate sharing case studies with the wider organisation demonstrating that the Trust acted upon concerns.

The Board of Directors noted the Lead Freedom to Speak Up Guardian Annual report and supported development of a Freedom to Speak Up communication strategy.

P74/22 **COMPLAINTS ANNUAL REPORT**

The Board of Directors received the 2021/22 Complaints Annual Report presented by the Chief Nurse.

Mrs Dobson indicated that it was an annual requirement to produce an annual summary of complaints received and made available on the Trust's website.

Key to be brought to the Boards attention was the increase in complaints which in the main were associated with the pandemic, such as visitor restrictions and delays to treatment. Steps had been taken to improve communication with family members and it was anticipated that some practices would continue as the organisation returned to business as usual.

In response to a question from Dr Bibby regarding the time invested by Trust staff in complaints handling, Mrs Dobson indicated that each Division had a governance lead who played a pivotal role alongside the matrons when complaints were first received. The feasibility of central management was being explored; however the ideal scenario would be speedier resolution to concerns raised thereby reducing formal complaints.

Dr Jenkins concluded that the pandemic had seen an increase in complaints, which was being replicated at other organisations. Whilst complaints should reduce as the Trust resumed normal activities, some of the key areas of complaints should be incorporated into organisational plans and priorities to improve the patient experience.

The Board of Directors approved the Complaints Annual Report 2021/22.

P75/22 **GENDER PAY GAP REPORT**

The Board of Directors received the Gender Pay Gap Report which detailed the position as at 31 March 2021.

It was noted that the report had been considered by the Executive Team and People Committee prior to the required publication on the Trust's website.

Detailed within the report was a range of metrics, including the mean and median gap for pay and bonus pay, and potential reasons for the gaps. These included the number of male medical and dental colleagues compared to females and this group actively accessing clinical excellence awards.

Both the Executive Team and People Committee had supported proposed actions to address the pay gaps. These included the review of person specifications, job re-grading, job evaluation, pay progression, recruitment processes and ensuring flexible working opportunities. Progress against these actions would be monitored by the People Committee.

Dr Jenkins commented that gender pay gap was an important area for the Trust. Whilst the information provided within the report met the requirements for publication, further analysis and breakdown would be provided to the Executive Team and People Committee to support their understanding and identify further actions to be taken.

The Board of Directors noted the Gender Pay Gap Report for the period up to 31 March 2021.

STRATEGY

P76/22 **NATIONAL, INTEGRATED CARE SYSTEM AND INTEGRATED CARE PARTNERSHIP REPORT**

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

Mr Wright specifically highlighted the collaborative work with Thomas Rotherham College as a means to highlight career opportunities within health and social.

P77/22 **OPERATIONAL OBJECTIVES 2021/22 REVIEW**

The Board of Directors received the month twelve position against the Operational Objectives 2021/22 presented by the Deputy Chief Executive.

As at month twelve, two of the ten programmes were rated blue (completed/closed) one rated green (on plan), six rated amber (behind plan) and one rated red (significantly behind plan).

Mr Wright indicated that the report provided a comprehensive overview of the year end position. In quarter four, as had been the case throughout the year, progress had had been adversely impacted by the pandemic.

All Board Assurance Committees had rigorously monitored progress throughout the year, with only those programmes rated green having full assurance from their associated Committees on delivery.

The Board commented that in establishing objectives, the focus should be one of delivery of the outcomes, rather than process, as there may be occasions when objectives were delivered but not necessarily as a result of actions originally specified at the start of the year.

The Board of Directors noted the outturn position for the Operational Objectives 2021/22.

P78/22 **OPERATIONAL PLAN 2022/23**

The Board of Directors received the report introduced by the Interim Chief Executive detailing the mandates which would support delivery of the five key priorities of the 2022/23 Operational Plan.

The priorities had been developed following discussions across the Trust, including the Board of Directors, with the mandates having been considered by each of the Board Assurance Committees.

Mrs Tuckett, who had led the work on the development of the Operational Plan, outlined the key areas of the objectives aligned to the P-R-O-U-D[1] strategic ambitions. With it noted that the Rotherham (R) objective would be monitored by the Finance and Performance Committee rather than the Quality Committee.

Following detailed consideration of the mandates by the Quality Committee, a number of changes had been made to the Patient (P) mandates to ensure there was increased emphasis on patients and that the measurements / key performance indicators were relevant to support this priority.

With regards to the Our Partners (O) it was commented by Mrs Kilgariff that it would be beneficial that the activities in this area complimented the improvement work already in progress with our partner organisations.

[1] Patients – Rotherham – Our Partners – Us - Delivery

It was noted that the Finance and Performance Committee had discussed the feasibility of ring fencing resources to support delivery of the priorities, recognising the conflicting demands on colleagues to also deliver on other matters. Mr Wright confirmed that some of the priorities were 'must do' and therefore would be appropriately resourced. However, those of a transformational nature may require additional investment which would necessitate business cases to be developed.

With regards to the Us (U) priority, Mr Ned confirmed in response to a question from Dr Bibby, that the list of key areas presented in relation to workplace wellbeing was not exhaustive, with other activities also planned.

The Board of Directors approved the Operational Plan 2022/23, in addition to the five priorities and mandates to support delivery. A one page document would be now be developed and shared with the organisation to outline the priorities for 2022/23.

P79/22 **TARGET OPERATING MODEL SOUTH YORKSHIRE AND BASSETLAW – PATHOLOGY PARTNERSHIP AGREEMENT**

The Board of Directors received the South Yorkshire and Bassetlaw Pathology Partnership Agreement presented by the Deputy Chief Executive.

Mr Wright reminded the Board that in 2018, Trusts across South Yorkshire and Bassetlaw had signed a memorandum of understanding to create a single pathology service. The aim being to reconfigure pathology services that would ensure the local region had an innovative and sustainable pathology service, capable of adapting to the changing needs of clinicians and patients.

The Partnership Agreement set out a number of areas including arrangements for the pathology network, how Trusts would contribute resources, and collaboration to optimise benefits and efficiencies.

The Pathology Agreement would be the legal underpinning of the agreed Partnership between the Trusts.

It was confirmed that once the partnership agreement had been approved by all five Boards, the full Business Case would be progressed. This would be the document which would detail such matters as asset transfer, TUPE (transfer of undertakings regulation), and financial matters. Once known, the latter would be incorporated into the Trust's future financial plans.

The Board of Directors approved the Partnership Agreement, supporting establishment of the South Yorkshire and Bassetlaw Pathology Network, subject to approval by the respective Boards of all five Acute Trust member organisations.

ASSURANCE

P80/22 BOARD COMMITTEES CHAIRS ASSURANCE LOGS

The Board of Directors received and noted the Chairs logs from the following Board Assurance Committees:

i. Finance and Performance Committee (23/03/2022 & 27/04/2022 meetings)

Miss Bancroft highlighted the end of year position and commended colleagues across the organisation for its delivery.

Financial governance processes had been further strengthened, with Chair assurance logs from sub committees now being received by the Committee.

Similar to other Board Assurance Committees, Divisional presentations continued, affording the chance to understand the opportunities and risks being addressed by the Division. All Committee Chairs stated that they valued attendance by the Divisions, with Mrs Kilgariff adding that the Divisions in turn welcomed being able to contribute to the debate.

It was noted that there was a correction to the April Chairs log with the integrated financial performance section to state *'There has been an over spend in pay costs against an underspend in non-pay costs'.*

ii. Quality Committee (30/03/2022 & 27/04/2022 meetings)

Dr Shah specifically highlighted, and acknowledged, the positive and improving mortality position with the Trust being within the expected bandings. The ongoing challenge would be to maintain the position and ensure learning from deaths was undertaken.

Progress also continued in addressing the recommendations from the Care Quality Commission and seeking removal of sanctions by demonstrating improvement.

Focus had been given by the Committee to the year-end 2021/22 Operational Plan objectives and provision of comments in relation to the 2022/23 Operational Plan.

In noting the Committee's limited assurance in respect of compliance with mandatory Safeguarding Training and that it had requested further information as to the actions being taken to address the matter, the Board requested that it be updated periodically on the positon by the Chief Nurse.

ACTION – Chief Nurse

iii. People Committee (18/03/2022 & 22/04/2022 meetings)

Ms Hagger highlighted the continued positive and insightful Divisional attendance, with two recent presentations from corporate areas – Estates/Facilities and Finance.

The Committee welcomed the work being undertaken with regard to strengthening risk management processes and the Board Assurance Framework.

iv. Audit Committee (29/04/2022 meeting)

Mr Smith, as vice Chair of the Committee, highlighted the reviews undertaken by the Internal Auditor and specifically the two limited assurance revisit reports (Learning from Deaths – Governance and Strategic Risk Management).

The Committee in receiving an update on strategic risk management at each meeting, did not have a similar oversight of learning from deaths, this was within the remit of the Quality Committee. As such the Committee would be seeking assurance from the Quality Committee that the internal audit recommendations were being implemented.

The interim Head of Internal Audit Opinion had been received with a significant assurance opinion, demonstrating improvement in the Trust's overall performance to ensure a sound framework of governance, risk management and control.

P81/22 **CARE QUALITY COMMISSION ASSURANCE REPORT**

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

Mrs Dobson indicated that the report detailed the activities undertaken in March including confirm and challenge sessions, and an unannounced inspection by the CQC to the Urgent and Emergency Care Centre (UECC). Appended to the report was the Trust's response to the CQC feedback letter following the unannounced visit, which demonstrated that whilst acknowledging areas for improvement, the Trust had challenged some of the findings, providing further evidence to clarify the position.

Generally, good progress was being seen in addressing CQC actions, with focus now being given to address the remaining red and amber rated actions. The emphasis being to complete and embed the actions, then revisit and test adherence. It would be for each Division to present evidence to the CQC Delivery Group, and Divisional colleagues present, that actions had been completed and robustly tested. It was confirmed that the areas documented within the report whose rating had been downgraded since the unannounced visit to UECC had been as a consequence of not fully closing the loop.

It was noted that the CQC had yet to complete the process of considering the Trust's application to have the UECC Section 31 Condition removed, it was understood that final approval by the Deputy Chief Inspector was still required.

It was noted that a number of actions in UECC had been aligned to the Acute Care Transformation (ACT) Programme. To ensure that the Board remained sighted on this programme Dr Jenkins suggested that as a report had been provided to the March Board meeting, progress should be reported through the Finance and Performance Committee.

ACTION – Chief Operating Officer

The Board of Directors noted the report.

P82/22 **MONTHLY INTEGRATED PERFORMANCE REPORT**

The Board of Directors received and noted the Integrated Performance Report (IPR) which highlighted the challenges being seen by the Trust.

To ensure consistency of reporting mortality data to the Board and the Board Assurance Committees, Mrs Tuckett would discuss the matter with Dr Gardner. **ACTION – Director of Strategy, Planning and Performance**

Mr Rawlinson also confirmed with regard to the kite mark, as a number of areas had been rated red or amber, that process continued and the reason for the rating in some areas was due to final sign off being required.

P83/22 **RESET AND RECOVERY OPERATIONAL REPORT (INCLUDING COVID-19 UPDATE)**

The Board of Directors received the Reset and Recovery Operational Report, which included an update on COVID-19, presented by the Chief Operating Officer.

Mr Briggs provided an overview of the report, indicating that the number of COVID positive patients continued to reduce, resulting in an improved patient flow.

Progress continued in the development of the elective hubs in Sheffield and Doncaster and Bassetlaw with both anticipated to ease pressures across South Yorkshire through provision of additional inpatient/outpatient/operating theatre capacity. In addition, diagnostic hubs continued to be progressed.

Mrs Craven highlighted that compared to other organisations, the Trust did not have a Clinical Decision Unit which could prove beneficial in supporting patient flow. Mr Briggs indicated that the option to reintroduce such a unit could be explored alongside a Same Day Emergency Care unit.

The Outpatient Transformation programme had commenced and would be an extensive piece of work. Progress reports would be provided to both the Finance and Performance Committee and Quality Committee. A summary report was also being submitted to the Council of Governors to provide an update against a discussion held at a previous meeting.

The Board of Directors noted the report, acknowledging its appreciation to Trust staff in their commitment to maintain services for patients as demonstrated by the report.

P84/22 **FINANCE REPORT**

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

Mr Hackett highlighted the following key financial matters as at the year-end:

- In March 2022 there had been an income and expenditure deficit to plan of £276k. Cumulatively, the position had been a £1,158k surplus to plan;
- The deficit to the (external) control total in month had been £290k and £1,727k surplus year to date;
- Capital expenditure had significantly over-spent in month, with the last quarter seeing additional capital commitments against both internal and external resources. However, the year–end outturn had been an underspend of £693k;
- The cash position has reduced by £2,138k in month, with the year-end position being £33,303k.

The Board of Directors noted the month twelve / year end Finance Report, placing on record its appreciation to the organisation for its finance due diligence.

P85/22 **SAFE NURSE STAFFING – SIX MONTH REVIEW MARCH 2022**

The Board of Directors received the report confirming that the six month nurse and midwife staffing review had been completed.

Reviews had been undertaken across the Divisions of Medicine, Surgery, Family Health and the Urgent and Emergency Care Centre. Mrs Dobson concluded that based upon the findings of the review, current staffing levels were appropriate and were being planned in accordance with establishments. Additional requirements had been identified within the Division of Surgery, with a business case being developed for further investment.

The Board of Directors noted the report detailing the review of nurse and midwife staffing levels.

The outcome of the review would be required to be made available to the public via the Trust website.

P86/22 **OCKENDEN MONTHLY REPORT**

The Board of Directors welcomed the Head of Midwifery to the meeting to support discussion on this item.

The Board of Directors received the monthly report which provided oversight and assurance on the Maternity Service's compliance with the Ockenden Independent Review into maternity services.

The Board was informed that following publication of the final Ockenden Independent review findings in March 2022, an additional fifteen Immediate

and Essential Actions (IEAs) had been recommended for implementation. These new requirements had been shared with all relevant teams, with the Trust's self-assessment of the position appended to the report.

The regional assurance visit to the Trust was planned for the 25 May 2022, with feedback to be included in a future report.

It was noted that following publication of the final Ockenden Report, the Trust had issued a public comment to the Rotherham population in order to provide assurance as to the Trust's position.

The Board of Directors noted the comprehensive Ockenden Monthly Report and were assured on the continued positive progress and plans in place to ensure compliance with the recommendations.

P87/22 **MORTALITY AND LEARNING FROM DEATHS REPORT**

The Board of Directors received the Mortality and Learning from Deaths Report presented by the Executive Medical Director.

Dr Gardner took the opportunity to share the recently released December mortality data, stating that the Hospital Standardised Mortality Ratios (HSMR) rolling position now stood at 102.6, which when excluding COVID stood at 96.9. The Summary Hospital-Level Mortality Indicator (SHMI) stood at 100, excluding COVID standing at 94.2.

Although both indicators highlighted a significantly improving position, Dr Jenkins offered a note of caution on the data, due to community deaths being below historical baselines assumed to be a result of increased death rates during the early stages of the pandemic. This could be impacting on the Trust's mortality data.

However, due to the improvements being seen, Dr Jenkins confirmed that the Mortality Improvement Task and Finish Group having achieved all its objectives had been stood down.

The Board of Directors noted the Mortality and Learning from Deaths Report. It was agreed that due to the progress made in this area the reporting frequency would move from monthly to quarterly.

P88/22 **DIGITAL STRATEGY AND DATA QUALITY REPORT**

The Board of Directors received the Digital Strategy and Data Quality Report presented by the Director of Health Informatics which comprehensively showcased activities since the last report to the Board.

Mr Rawlinson highlighted that the digital aspirant programme had concluded at the end of the 2021/22 financial year, with the Trust having seen investment in a number of areas, with recently the Patient Letters going live and other systems being in their final phase of implementation.

The technology infrastructure had been upgraded in a number of areas including shared records, with the Wi-Fi switch over planned for June. It was pleasing to see when visiting clinical areas that colleagues were proactively interacting with the technology available to them. This was supported by Mrs Kilgariff who commented that external organisations were visiting the Trust to view the systems in place.

NHS England had launched 2022 as the Year of the digital profession, with Mr Rawlinson confirming that the majority of staff within Health Informatics were a member of a professional body and were encouraged to continue their learning.

The Trust would shortly be developing a new Digital Strategy required for 2023 and beyond, with a session to be held on 13 May facilitated by NHS Providers, to start the discussions. The proposed new Digital Strategy should be complete for consideration and approval by the Board in November 2022.

The Board of Directors noted the Digital Strategy and Data Quality Report, and acknowledged the achievement of Mr Rawlinson and colleagues as outlined within the report.

REGULATORY COMPLIANCE RISK AND ASSURANCE

P89/22 BOARD ASSURANCE FRAMEWORK

The Board of Directors received the report detailing the proposed 2022/23 Board Assurance Framework (BAF) presented by the Director of Corporate Affairs.

Ms Wendzicha highlighted that following discussion by the Board and a small focus group of Board members, the proposed draft strategic risks, aligned to the Five Year Strategy and the five ambitions of P-R-O-U-D, were as detailed within the report.

Once approved by the Board the next phase would be, in liaison with the relevant Executive Director leads, to commence the detailed work to develop the full BAF including the risk scoring.

The Board of Directors approved the draft 2022/23 Board Assurance Framework.

BOARD GOVERNANCE

P90/22 GOVERNANCE REPORT

The Board of Directors received and noted for information the Governance Report from the Director of Corporate Affairs

CLOSING MATTERS

P91/22 ANY OTHER BUSINESS

There were no items of any other business.

P92/22 **DATE OF NEXT MEETING**

The next meeting of the Board of Directors would be held on Friday, 08 July 2022, commencing at 9am.

Before closing the meeting, the Chairman indicated that this would be the last meeting for Mr Briggs, Chief Operating Officer, who would be retiring later in the month. On behalf of the Board, Mr Havenhand thanked Mr Briggs for his leadership, contributions to the Board meetings and the support provided to colleagues, particularly during the challenging last two years. The Board wished him every success in any future ventures.

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						
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	~~01/04/2022~~ ~~08/07/22~~ 09/09/22	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
		2022						
6	04-Mar-22	Operational Objectives	P44/22	Board should have further oversight of the position with regards to the positive changes made through COVID 19 would be either maintained, developed or embedded, .	DoSPP	Jul-22	It is proposed that a paper is brought to the next Public Board Meeting (in July 2022) which outlines these changes so the Board are sighted as appropriate. Internal discussions at a more detailed and operational level will continue in the meantime. Agenda item P110/22	Recommend to close
7	04-Mar-22	Care Quality Commission Report	P48/22	Requirement to consider the proposed new CQC operating framework, which would be a risk based approach.	CN	Jul-22	Brief overview included in CQC paper. Further verbal information received at CQC engagement meeting on 30th June. Formal written guidance not yet received. Agenda item P106/22	Recommend to close
8	06-May-22	Quality Committee Chairs Log	P80/22	Board to remain updated via chairs log of position re mandatory safeguarding training	CN		There was no QC this month. For June 22: Adult Safeguarding training compliance - 90-100% across Levels 1-4. Children's Safeguarding compliance 85-100% across Levels 1-4.	Recommend to close
9	06-May-22	Care Quality Commission Report	P81/22	Regular updates on Acute Care Transformation Programme to be provided to Finance and Performance Committee	COO		Added to FPC work plan for September 2022	Recommend to close
10	06-May-22	IPR	P82/22	To discuss with Dr Gardner a way forward for consistent reporting of mortality data across all Committees.	DoSPP		Mortality data to remain consistent with Quality Committee figure, with the latest month's figure to be provided verbally at Board due to release dates.	Recommend to close

Board of Directors' Meeting
08 July 2022

The Rotherham NHS Foundation Trust

Agenda item	P99/22
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 a brief update on a number of issues since our May 2022 Board meeting: • Strategic Board Meeting 10 June 2022 • South Yorkshire and Bassetlaw Acute Federation • Reciprocal Mentoring Programme • Rotherham Together Partnership (showcase event) 13th June • Non-Executive Director reports
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 06 May 2022.

2.0 Strategic Board Meeting 10 June 2022

2.1 The Board of Directors addressed three issues, firstly an externally facilitated session from NHS England / Improvement on the topic of 'Leadership for Quality Improvement', secondly the 'Development of the Digital Board', which was a follow up discussion to a workshop led by NHS Providers held on 13 May. Finally, the Future working arrangements between the Trust and the Integrated Care Board and Rotherham Place'.

3.0 South Yorkshire and Bassetlaw Acute Federation

3.1 The South Yorkshire and Bassetlaw Acute Federation (SYBAF) has produced its Annual Report for 2021/22 and it has been posted on our website.

3.2 The Acute Federation Board has been working with the NHS England and Improvement 'Provider Development Team' to prepare for the new Integrated Care Boards being established on 1st July under the Health and Social Care Act 2022. Board members of all five acute trusts in South Yorkshire and Bassetlaw met virtually on 16th May to discuss the Acute Federations Purpose Statement, objectives and priorities for the next two years.

4.0 Reciprocal Mentoring Programme

4.1 Our Reciprocal Mentoring Programme which matches board directors with colleagues working in the organisation from our equality and diversity network has been operating for eight months. The objective is to develop a better understanding of the challenges our colleagues face working in the Trust and helping colleagues better understand how board governance works.

5.0 Rotherham Together Partnership Showcase Event – 13 June

5.1 Rotherham Borough Council organised this showcase event at the New York Stadium which included how partners had collectively responded to the Covid-19 pandemic and how well the partnership had been in attracting additional funding into the area.

6.0 Lead Non-Executive Director (Michael Smith)

6.1 Michael Smith, as NED lead for the Urgent and Emergency Care (UECC) Division, had met with the recently appointed General Manager of UECC, Lesley Hammond. They discussed progress with Care Quality Commission actions following the March inspection and staff wellbeing.

7.0 Lead Non-Executive Director (Nicola Bancroft)

7.1 Nicola Bancroft attended, on behalf of the Chairman, the South Yorkshire ICS Development Workshop Number 4 on System Governance on 14 June 2022. The workshop was led by Gavin Boyle, Chief Executive Designate of the South Yorkshire Integrated Care Board.

7.2 The main purpose of the workshop was to develop the thinking around system governance and share initial conversations on the System Leadership Executive and the People and Culture Delivery Group.

7.3 Specifically the following areas were covered:

- System Leadership Executive: draft purpose, role, membership, chairing, decision making, frequency of meetings, ways of working, relationships and accountabilities
- Progress updates on quality, urgent and emergency care and finance
- People and culture: context, guidance and emerging thinking for the System People and Culture agenda.

8.0 Lead Non-Executive Director (Lynn Hagger)

8.1 On 20 May 2022 Lynn chaired the Organ Donation Committee where it was noted that there were no missed donations and that the Committee has donated £1000 to the Transplant Games in common with other committees in the region. It is hoped that there will be a presence at the Rotherham Show this year now we have the funds to pay for a stall.

8.2 Lynn attended the NHS Confederation/NHSE/I Conference in Liverpool on 15 and 16 June 2022. Of particular note were the following sessions:

8.3 Inclusive recovery: tackling health inequalities when bringing down the elective backlog

Huddersfield and Calderdale NHS FT provided some excellent examples of how they use data to identify those experiencing health inequalities such as BAME frequent attenders at A and E who wait seven weeks longer for P2 procedures. They have developed a tool to drill down into long waits with clinicians and patients are brought forward where possible. They also focus on digital inclusion, BAME maternal outcomes, patients with a learning disability, BAME paediatric readmissions and DNAs by ethnicity producing a plan on a page to cover all the actions. In their view, unless health inequalities are considered with respect to elective recovery the gaps will continue to widen.

The Yorkshire and Humber VCSE highlighted how clinical and social risk should be taken into account when dealing with elective waiting lists. As part of the Waiting Well initiative they considered that their early involvement and funding for co-production was essential.

8.4 Realising the NHS People Promise: improving employee experience, retention, and nurturing talent

This session highlighted a range of tools available: Scope for Growth Tool (a career conversations framework), a retention self-assessment tool and a team measures/team engagement diagnostic tool. With the exception of the latter, the Trust is already using these. The use of a monthly Pulse survey was advocated.

8.5 The Fuller Stocktake: how can primary care work best with partners across newly formed integrated care systems to meet the health needs of people in their local areas?

The Fuller Report advocates the alignment of secondary care medical staff with neighbourhood teams amongst other things but also underlined from the floor was the need to support primary care with back-office function where appropriate and provide the same opportunities for leadership development as enjoyed by the acute setting. There was a strong message that when engaging with the community it was not advisable to focus on community leaders who are not necessarily representative. It was proposed that all boards should have this report on an agenda because there should be system wide support for its recommendations.

9.0 Lead Non-Executive Director (NED) (Heather Craven)

9.1 On 20th May Heather attended the inauguration of Councillor Tajamal Khan as the Mayor of Rotherham on behalf of the Rotherham Hospital and Community Charity. The Mayor announced that the Trust was one of the three charities he would be supporting during his year in office.

9.2 On 6 June Heather attended the hospital Jubilee Party in the Well-being garden hosted by the Charity and joined colleagues and volunteers in distributing cakes to staff on the wards who had been unable to attend.

9.3 As the NED lead for the Community Division Heather met with the Community Division to discuss the plans for the current year and attended a number of safeguarding meetings.

Martin Havenhand
Chairman
June 2022

Board of Directors' Meeting
08 July 2022

The Rotherham NHS Foundation Trust

Agenda item	P100/22
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. NHS South Yorkshire Integrated Care Board (SY ICB) Executive Portfolios 2. Update from Gavin Boyle, Chief Executive (Designate) SY ICB

1.0 Covid-19

1.1 **Activity:** There was a decline in Covid-19 activity through May and the first half of June but the Trust, along with other local organisations, is now seeing a steady rise in inpatient Covid-19 levels. This is believed to be driven by the more highly transmissible BA5 variant of Omicron which may also be able to evade prior immunity to some extent. It's not possible at this stage to predict the size of this new wave but it will provide a challenge to our ongoing recovery efforts.

1.2 In line with national guidance, a number of changes to current restrictions practice have been made including the wearing of face masks, which will no longer be mandatory except in Covid-19 positive areas, UECC and Sexual Health Services, due to the current UK outbreak of the monkey pox virus (when within a meter of a patient). Cleaning routines will revert back to pre-pandemic requirements and there will be no formal social distancing requirements, routine testing at day 3 and day 6 for asymptomatic patients and a phased approach to face to face meetings going forward.

1.3 **Recovery**: The work to recover the accumulated long waiting times has slowed in recent months, due in part to the intense site pressures from the latest Covid-19 wave and resulting bed pressures, as well as increased sickness amongst our own staff. We have continued to experience medical workforce shortages in particular areas, including in Anaesthetics, which has exacerbated the demand and capacity challenge we are facing. The growth in our overall waiting list has stabilised in recent months, remaining at just over 22,000 patients at the end of May, although this is just over a 30% increase compared to April 2021. The number of 26+ week waiters has increased 1.5-fold since the start of November, from approximately 1,200 patients to over 3,100 patients in the latest weekly data. Within these figures, there are a handful of significant pressure points, with 4 specialties accounting for over half of the long waiters (Trauma & Orthopaedics, OMFS, Gynaecology and Gastroenterology). Following some recent investment in additional external capacity in ENT and Rheumatology, waiting times in these two areas have fallen, and the position is now more positive, albeit it is fragile given the anticipated ongoing workforce challenges in these specialties. The Trust is working across the system to see how we can resolve the remaining challenged areas and exploring all options available to us, including use of the independent sector where appropriate. We are also taking opportunities to introduce new ways of working in order to better manage the demand and to maximise our capacity, particularly within outpatient settings, given the national programme of work which has been set out. Whilst all Trusts are facing similar elective care challenges, Rotherham was in the top fifteen acute or combined Trusts in the country for overall Referral to Treatment (RTT) performance in April (latest national data).

1.4 **Urgent and Emergency Care Activity (UECC):** The Trust has seen sustained levels of demand through our Urgent and Emergency Care Centre (UECC), both in terms of overall attendances as well as ambulance conveyances. At times the increased demands on urgent care has put additional pressure on our elective capacity. Operational plans were put in place to support the urgent care demand over the extended bank holiday for the Jubilee celebrations, in line with the plans that were implemented over the Easter period.

Work continues internally, as part of the Acute Care Transformation (ACT) programme, to improve flow through the hospital by improving our urgent care pathways. Work also continues with partners to deliver improvements in urgent care, including Yorkshire Ambulance Service to reduce ambulance handovers and social care to improve community bed capacity. The number of complex long stay patients remaining in

hospital is gradually improving, which alongside reduced numbers of patients in hospital with Covid-19 is starting to improve our overall bed capacity and patient flow.

1.5 **CEO Acute Emergency Performance Meetings:** A new weekly meeting, chaired by myself is being established to commence on 5th July 2022 and will focus on rapid change to improve performance in the Urgent and Emergency Care department. The meeting will involve a number of senior colleagues across the Divisions and will look to identify changes required and challenges to be overcome on a weekly basis. This is intended to complement the ACT work.

2.0 Integrated Care System (ICS), Acute Federation and Rotherham Place Development

2.1 The SYB ICB has continued to develop in advance of the formal commencement date of 1st July 2022. The Chief Executive (Designate) has recently confirmed the full ICB Executive team and portfolios, which can be seen at appendix one. The process for ICB provider board roles is ongoing and expected to be completed soon. Appendix two is the Chief Executive (Designate) update for June 2022.

2.2 Members of the Board, together with Board colleagues from all other organisations in South Yorkshire attended the first Acute Federation led strategic development session, as part of an on-going development programme, to discuss how we will work together going forwards. The session was both enjoyable and effective in exploring both short term opportunities and longer term strategic deliverables.

2.3 Representatives from the Trust have attended a number of Place meetings including the Health and Well-Being Board, the Health Select Commission and the Place Board.

3.0 Care Quality Commission Update

3.1 Following a factual accuracy check, the CQC published its final inspection report on 10th June following their inspection in March 2022. The Trust was able to demonstrate areas of improvement and the action plan continues to be monitored. Further detail on the work associated with the CQC can be found in the Chief Nurse's report.

3.2 I am pleased to report that the Trust has received a notice of decision from the CQC to remove conditions of our registration as a service provider in respect of a regulated activity: Treatment of disease, disorder or injury. The CQC have completed their assessment of the application to remove the conditions of registration and have now removed the condition for the regulated activity. This is great news and testament to the work undertaken by colleagues to drive improvements, to the safety and quality of care for our patients.

4.0 Staffing

4.1 I have received notification that the Medical Director will be leaving the Trust to take up a Medical Director role in Peterborough in the autumn. The recruitment process to replace Dr Gardner has commenced. I would like to take this opportunity to thank Dr Gardner for his contributions to the Trust over the past four years and to wish him every success in his new role.

4.2 I can also confirm that Mrs Angela Wood, who is currently on secondment from the role of Chief Nurse has been successful in securing another post outside the region and therefore will formally leave the Trust for pastures new on 31st July 2022. Again, I would like to take this opportunity to wish her very success in her new role.

4.3 Preparations for the 2022 Trust Proud Awards ceremony, taking place at Magna on 15th July 2022, are now being finalised. It promises to be a fantastic night of celebration and I hope to see as many of you there as possible.

4.4 The Trust held its first Estates and Facilities day on 15th June 2022, in the well-being garden. The event was well attended and showcased the fantastic work undertaken by staff in this area. A lot of planning took place and the feedback received was really positive.

5.0 Quality, Service Improvement and Redesign (QSIR)

5.1 The Trust has commenced on a training programme, consisting of five full day sessions, during June and July and facilitated by Helen Ledger, North System Improvement Lead from NHS England/Improvement. We have approximately 20 colleagues signed up to attend on the first cohort of training, with the aim to provide a second cohort in September. The programme will focus on service improvement and will teach attendees to develop quality and efficiency improvement capability within the organisation, based on tried and tested tools and approaches. Attendees have been asked to consider an improvement aim/project to work through on the days.

Dr Richard Jenkins
Interim Chief Executive
July 2022

South Yorkshire & Bassetlaw Integrated Care System
722 Prince of Wales Road
Sheffield
S9 4EU
Programme Office: 0114 3051905

30 May 2022

Letter sent by email:
South Yorkshire Health and Care System Partners

Dear Colleagues,

NHS South Yorkshire Integrated Care Board – Executive Portfolios

Once again can I thank you for your continued support and commitment in the run up to the 1 July and the legal establishment of NHS South Yorkshire. This is a really exciting time as the Health and Care Act, 2022, gives us a once in a lifetime opportunity together to improve the health and wellbeing of everyone in South Yorkshire. As part of our final preparations, I wanted to share with you a summary of ICB executive portfolios from 1 July. I hope this is helpful and facilitates conversations as the new designate ICB executives start to take up their new areas of accountability and responsibility. I have attached a document separately for ease.

I previously updated you on the schedule of NHS South Yorkshire Board meetings which will take place on the first Wednesday of the month. Please be aware that there is a legal requirement to hold the first meeting of NHS South Yorkshire on Friday 1 July 2022, following disestablishment of CCGs at midnight on 30 June 2022. Following the 1 July our next meeting will take place on Wednesday 3 August. Further details will be published on the public ICS Website in advance of Board meetings and until the ICB website goes live on 1 July 2022.

If you have any questions, please do not hesitate to get in touch.

Yours sincerely,

Gavin Boyle
Chief Executive (Designate)
NHS South Yorkshire Integrated Care Board

South Yorkshire and Bassetlaw
Integrated Care System

NHS South Yorkshire Integrated Care Board
Executive Portfolios

ICB Executive Portfolios

Chief Executive Officer - Gavin Boyle

- Design & deliver a 5 year system plan
- Secure the provision of comprehensive and integrated health services for South Yorkshire
- Allocate & manage NHS budgets across the system
- Performance and oversight arrangements
- Support innovation to improve services.
- Ensure the ICB is Well-led.
- Chair of the System Leadership Executive
- Lead on Anchor Institution and major stakeholder relationships e.g. LAs, Universities, SYCMA and others

Executive Place Director – Barnsley - Wendy Lowder

- Develop strong partnerships in Place particularly with the Local Authority, VCSE and others.
- Establish effective local governance and operating arrangements to ensure that the ICB's aims are delivered at Place.
- Leading the development and delivery of integrated health and care services at Place.
- Delegated arrangements (functions and commissioning of services) which could have a range of between £300 - £700m plus
- Providing Place leadership and ICB performance (accountability)
- Place based plans and governance development
- **Mental Health, Learning Disability & Autism**
- **ICB Executive link to MHLDA Alliance**

Executive Place Director- Doncaster - Anthony Fitzgerald

- Develop strong partnerships in Place particularly with the Local Authority, VCSE and others.
- Establish effective local governance and operating arrangements to ensure that the ICB's aims are delivered at Place.
- Leading the development and delivery of integrated health and care services at Place.
- Delegated arrangements (functions and commissioning of services) which could have a range of between £300 - £700m plus
- Providing Place leadership and ICB performance (accountability)
- Place based plans and governance development
- **Wider Primary Care (GP, Dental, Optometry and Pharmacy),** Prescribing, Medicines Management and Vaccination
- **ICB Executive link to Primary** Care Alliance.

Executive Place Director – Rotherham and Deputy Chief Executive - Chris Edwards

- Develop strong partnerships in Place particularly with the Local Authority, VCSE and others.
- Establish effective local governance and operating arrangements to ensure that the ICB's aims are delivered at Place.
- Leading the development and delivery of integrated health and care services at Place.
- Delegated arrangements (functions and commissioning of services) which could have a range of between £300 - £700m plus
- Providing Place leadership and ICB performance (accountability)
- Place based plans and governance development
- **Acute Hospital Services**
- **ICB Executive link to Acute Federation.**

Executive Place Director – Sheffield - Emma Latimer

- Develop strong partnerships in Place particularly with the Local Authority, VCSE and others.
- Establish effective local governance and operating arrangements to ensure that the ICB's aims are delivered at Place.
- Leading the development and delivery of integrated health and care services at Place.
- Delegated arrangements (functions and commissioning of services) which could have a range of between £300 - £700m plus
- Providing Place leadership and ICB performance (accountability)
- Place based plans and governance development
- Cancer
- **ICB Executive Link to Cancer Alliance and Specialised Commissioning.**

All Executives:

Partnership building
Strategy development and delivery including participation in the Integrated Care Partnership
Commissioning
Organizational culture & values
Role modelling our agreed behaviours
Providing support to the assurance committees of the ICB in your area of corporate responsibility.
To be a member of the unitary board of the ICB

ICB Executive Portfolios

Chief Finance Officer
- Lee Outhwaite

- Development and delivery of system financial Plan aligned to the delivery of the ICBs aims.
- Responsible for the internal and external Audit arrangements.
- Financial leadership and financial performance of the ICB
- Contracting and Commissioning oversight
- Estate's strategy, procurement, capital planning
- long-term financial strategy of the ICB
- Chair the System Deliver Group for Finance, Capital & Estates

Chief People Officer
- Christine Joy

- Integrated people strategy for the ICB underpinned by a one workforce ethos
- Fostering an organizational culture based on our co-created values.
- Workforce transformation, Strategy and planning
- Learning & Education
- Delivery of a high-quality, values-based People Services function
- Equality, Diversity and Inclusion
- Organizational Development
    - System OD
    - Board development
    - ICB leadership development
- Chair the System Delivery Group for People and Culture

Executive Director of Strategy and Partnerships
- Will Cleary-Gray

- 5-year system plan development
- NHS ICB Governance
- Lead for developing external partnerships and public engagement. Supporting all ICB executives to ensure partnerships are active and aligned to the delivery of the strategy
- Digital and data
- Governance and corporate
- Communications, and involvement (accountability)
- Chair the Environmental Sustainability System Delivery Group
- Co-Chair the Digital, Research & Innovation System Delivery Group
- Coordinate our wider partnership engagement and our contribution as an Anchor Institution to the wider development of SY.
- ICB Accountable Emergency Officer and lead on EPRR
- Co Chair of the LRF and LHRP
- **Children & Young People**
- ICB Executive Link to CYP Alliance.
- **VCSE and ICB Executive** link to VCSE Alliance.

Chief Medical Officer
- Dr David Crichton

- Clinical & Professional Leadership with a focus on Medical workforce.
- Facilitate collective responsibility for improving whole pathways
- Innovation and service transformation
- Chair the System Delivery Group for Population Health, Health Inequalities and Inclusion
- Public Health lead.
- Co-Chair System Delivery Group for Digital, Research & Innovation Group
- Co Chair the System Delivery Group for Quality
- ICB lead Executive Lead for UEC

Clinical Strategy
Quality
Clinical risk management processes
Clinical input/challenge to decision making at all levels

Chief Nursing Officer
- Cathy Winfield

- Clinical and Professional Leadership with a focus on Nursing, Midwifery, AHPs and others
- Safeguarding
- Infection Prevention & Control
- ICB Executive lead on maternity safety and service delivery and link to LNMS.
- Continuing Health Care
- Co-Chair the System Delivery Group for Quality

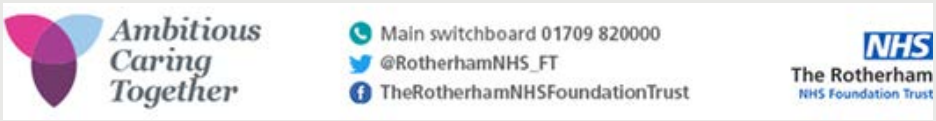
All Executives:

Partnership building
Strategy development and delivery including participation in the Integrated Care Partnership
Commissioning
Organizational culture & values
Role modelling our agreed behaviours
Providing support to the assurance committees of the ICB in your area of corporate responsibility.
To be a member of the unitary board of the ICB

South Yorkshire and Bassetlaw
Integrated Care System

From: JOHNSTONE, Sharree (THE ROTHERHAM NHS FOUNDATION TRUST)
To: JOHNSTONE, Sharree (THE ROTHERHAM NHS FOUNDATION TRUST)
Subject: For Board: W: 10/06/22: Update from Gavin Boyle, Chief Executive Designate of South Yorkshire Integrated Care Board
Date: 10 June 2022 10:07:02
Attachments: image001.png

Sharree Johnstone
Executive Assistant to the Chief Executive
Ext: 4001 **Direct line:** 01709 424001
Email: sharree.johnstone@nhs.net



From: SYB ICS Communications <hello@healthandcaretogethersyb.co.uk>
Sent: 10 June 2022 09:25
To: JENKINS, Richard (BARNSLEY HOSPITAL NHS FOUNDATION TRUST) <richard.jenkins4@nhs.net>
Subject: 10/06/22: Update from Gavin Boyle, Chief Executive Designate of South Yorkshire Integrated Care Board

View in browser

Update from Gavin Boyle, Chief Executive Designate of South Yorkshire Integrated Care Board

This update goes to the wider partners in health and care in South Yorkshire and Bassetlaw (SYB) to keep everyone informed. To join our distribution list please email: *helloworkingtogether@nhs.net*

Friday 10 June 2022

Dear Richard

Today's bulletin includes an update on the progress we are making towards becoming NHS South Yorkshire (Integrated Care Board) on July 1st 2022, details about a campaign to help partners understand the new systems, an update on Monkeypox, the Fuller Stocktake review, and our usual partners' updates.

I hope you find this a useful update and if you do have any feedback about what would make it more useful, or anything about which you would like to hear more, please email helloworkingtogether@nhs.net

South Yorkshire Integrated Care Board (ICB) Development

We are now very close to our first official Board meeting, which will take place on Friday 1 July to allow legal responsibility to officially transfer from the CCGs. As the new ICB website will also go live on 1 July, papers for the ICB meeting will be available on the South Yorkshire ICS website a week before the meeting here . We have now agreed that other than the first meeting, NHS South Yorkshire Board meetings will take place on the first Wednesday of the month, so after the 1 July our next meeting will take place on Wednesday 3 August.

Further to my last update, we continue to recruit to our Board and have recently extended the deadline for the nomination and selection process for our Partner Member – Primary Care, due to the complexities of the process for recruiting this member, it will now close to nominations on the 16th June.

We have now met as a shadow-Board for the first time and are confident that all the work that has taken place over the last few months, and continues to take place, overseen by the Transition Executive Group puts us in a great position for officially commencing our work as our new organisation on 1st July.

Covid Response, Vaccinations update

Nationally, the Joint Committee on Vaccination and Immunicaiton (JCVI) has issued interim advice on COVID-19 booster doses this autumn for more vulnerable adults, frontline social care staff and health workers https://www.gov.uk/government/publications/jcvi-interim-statement-on-covid-19-autumn-2022-vaccination-programme

Whilst the advice is that this should be considered as interim we will shortly commence the operational planning for the autumn for our system based on the assumption that this will become official guidance.

Working Together for Better Health and Care National Campaign launched

A national 'Working together for better health and care' campaign that aims to introduce Integrated Care Systems to health and care staff is now live. The campaign aims to provide ICS staff and people working in partner organisations with an introductory knowledge of ICSs, as Integrated Care Boards prepare to become statutory organisations on 1 July 2022 as part of the Health and Care Act 2022.

The key messages of the campaign are as follows:

What is integrated care?
Integrated care is about giving people the support they need, joined up across local councils, the NHS, and other partners including social care providers, voluntary and community enterprise sector and charities.

Integrated care involves partnerships of organisations that come together to plan and deliver joined up health and care services to improve the lives of people in their area, improving population health and reducing inequalities.

What are Integrated Care Systems?
Integrated Care Systems are partnerships of organisations that come together to plan and deliver joined up health and care services to improve the lives of people in their area. They

will be responsible for how health and care is planned, paid for and delivered.

The Health and Care Act 2022 will establish 42 ICSs across England on a statutory basis. Each Integrated Care System will have two statutory elements, an Integrated Care Partnership (ICP) and Integrated Care Board (ICB):

an Integrated Care Partnership (ICP) - a statutory committee jointly formed between the NHS Integrated Care Board and all upper-tier local authorities that fall within the ICS area. The ICP will bring together a broad alliance of partners concerned with improving the care, health and wellbeing of the population, with membership determined locally. The ICP is responsible for producing an integrated care strategy on how to meet the health and wellbeing needs of the population in the ICS area.
an Integrated Care Board (ICB) - a statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in the ICS area. When ICBs are legally established, Clinical Commissioning Groups (CCGs) will be abolished.

ICSs have four key purposes:

improving outcomes in population health and healthcare;
tackling inequalities in outcomes, experience and access;
enhancing productivity and value for money;
supporting broader social and economic development.

Campaign materials include social media posts that will be going out on our channels in the coming weeks, information for partners and their staff – including videos such as 'What ICSs mean for NHS workers' with (our own) Prof Des Breen; 'What ICSs mean for social care staff' with Raina Summerson; 'What ICSs mean for children and young people' with Javed Khan and 'What ICSs mean for patients' with Dr James Thomas. There is also an easy read document and a ppt presentation in the campaign pack.

If you would like any of the 'Working Together for Better Health and Care' campaign materials to share with your colleagues and partners please contact alice.pennock1@nhs.net

National partner organisations have also released a number of resources to help explain the changes, including NHS Confederation who have developed slide decks with animated videos to explain ICS' to the public, NEDs and elected members and council officials: https://www.nhsconfed.org/networks-countries/integrated-care-systems-network/integrated-care-communications-toolkit

The Kings Fund have also produced a helpful explainer video: https://www.youtube.com/watch?v=blapgFKXv0I

Monkeypox Update

The UK Health Security Agency (UKHSA) has advised that cases of monkeypox have increased recently, but the risk to the UK population remains low. UKHSA has confirmed that community transmission is occurring in the UK with multiple generations of spread. Illness appears to be generally mild, consistent with other information about the West African clade.

A letter has been sent to NHS organisations outlining the response.

Additional information for patients is available on nhs.uk

Next steps for integrating primary care: Fuller stocktake report

This week, the final report of the stocktake undertaken by Dr Claire Fuller, looking at what is working well, why it's working well and how we can accelerate the implementation of integrated primary care (incorporating the current 4 pillars of general practice, community pharmacy, dentistry and optometry) across systems has been published. We are working through the findings of the report and looking at where we can learn from the findings.

Thank you

Gavin

COVID-19 data dashboard

The latest Sitrep data for the Yorkshire and Humber region and our five places can be viewed online:

https://coronavirus.data.gov.uk/details/cases

Partners' news

South Yorkshire and regional

Weekly blog, written by the South Yorkshire PCC, Dr Alan Billings: PCC PCC Blog 103 - South Yorkshire Police and Crime Commissioner (southyorkshire-pcc.gov.uk)

PCC PCC Blog 104 - South Yorkshire Police and Crime Commissioner (southyorkshire-pcc.gov.uk)

C1657 - Next steps on Infection Prevention and Control (IPC) Guidance Letter.

Please find the next steps on IPC letter here.

Digital Health Partnership Award - closing date 24 June 2022

The Digital Health Partnership Award is focused on leveraging the value that partnership working can bring in delivering and accelerating digital health technology projects within the NHS. We know that delivering digital health solutions to support patients and improve

outcomes is a focus of many NHS organisations across the country, however the management, resourcing and delivery of these projects can often prove challenging.

The Award supports the deployment of digital health technologies (DHT's) across the spectrum of development, from initial feasibility with a plan to build a product through to innovation scaling within clinical pathways to the point that they could be blueprinted for rollout across the NHS. The types of technologies supported vary from web platforms and patient facing apps, to cutting edge solutions for wearables and extended reality (XR).

More information can be found here.

Lived Experience Open Session

The Lived Experience team are holding an Open Session from 1pm – 2pm on Wednesday 22nd June for people who would like to know more about the opportunities available to them through the Peer Leadership Development Programme. The Peer Leadership Development Programme is a personal development programme that supports people to become 'Peer Leaders', equipping participants with the tools to effect change in the health and social care systems, as well as to support themselves through their own long-term health condition, disability or caring role.

Please contact england.pldp@nhs.net for details of how to join the Open Session on Wednesday 22nd June.

Statement from Bluebell Wood Children's Hospice

This is to inform you that due to staffing issues, Bluebell Wood Children's Hospice are temporarily suspending delivery of our clinical activity. This may impact a number of your patients who receive respite care or have planned to receive end of life from the hospice.

For the duration that our clinical services are suspended, we will not be able to offer any clinical palliative care guidance or support to your teams. However, if a child who is registered with Bluebell Wood Children's Hospice presents at one of your clinical services, and you need up-to-date information we will be able to share this information with you.

To request this information, please call 01909 508104. This service will be available 24 hours a day, 7 days a week, until we resume clinical activity. Please note that any information shared will be sent only to a valid nhs.net email address.

We are in the process of clarifying with CQC which elements of our non-clinical family support services we will be able to continue to offer to families during this time.

If your teams would ordinarily make a referral to the hospice, please let them know that we are unable to take new referrals at present.

We would be grateful if you could cascade this to your teams to make them aware. For any further information, please contact Emma Doughty, Head of Family Support or Judith Bentley, Head of Care at Bluebell Wood Children's Hospice on 01909 517 369.

Senior Prevention Programme Manager - Job Vacancy

The South Yorkshire Integrated Care System is seeking an experienced and committed

Senior Prevention Programme Manager to work at a System level across the whole of South Yorkshire. You will support the new Integrated Care Board and Integrated Care Partnership to improve the health and wellbeing of the citizens of South Yorkshire and to decrease inequalities in health. For more information click here.

Barnsley

Cancer Research UK's 'Cancer Awareness Roadshow' will be coming to Barnsley on Tuesday 14 and Wednesday 15 June, in the Glassworks Square.

The team will be offering advice and sharing information to help increase cancer awareness.

Doncaster

Doncaster People Focused Group receives The Queens Award for Voluntary Service

Doncaster's People Focused Group (PFG) is celebrating the announcement that they have been awarded The Queens Award for Voluntary Service in recognition for their continued work and dedication to support the needs of local citizens across Doncaster. Read more here...

Rotherham

Rotherham Council has trialled the UK's forst carbon negative asphalt as part of its road to resurfacing programme

The Council, alongside Rotherham based company SteelPhalt, trialled the pioneering new asphalt, made partly of trees, on a stretch of Broom Lane, just outside the town centre. Read more here...

Sheffield

How the role of GP receptionist has evolved to improve patient experience

The role of GP receptionist has changed in recent years, they play a key part in helping patients get the right care, by the right healthcare professional at the right time.

Now known as care navigators or care coordinators, receptionists have a much wider role than just answering phones and making appointments. Read more here...

Health and care updates from NHS E/I

Updates up to and including 10th June 2022

Workforce Quarterly Update

Latest figures show that over 18,000 FTE additional staff have been recruited to PCNs as part of expanded community multidisciplinary teams since March 2019 and we are on track to achieving the government target of 26,000 FTE additional staff by March 2024.

Embedding these new roles into general practice teams means that people have greater access to a range of professionals to meet their needs within their practice. Our latest case study explores how West Leeds PCN have used the Additional Roles Reimbursement Scheme to introduce new roles into their PCN, pooling capacity, experience, knowledge and skills to deliver care to their patients.

Eligibility Criteria for Non-Emergency Patient Transport Published

Updated eligibility criteria for NEPTS has been published following a review into the services in August 2021 and a subsequent public consultation.

The national NEPTS implementation will now support the system in adopting the criteria.

NHS Big Tea party set to raise funds for NHS staff, patients and volunteers

On Tuesday 5 July the NHS will mark 74 years of service – a milestone which presents opportunities to showcase how the organisation has innovated and adapted to meet the changing needs of each successive generation.

As part of the celebrations, NHS Charities Together is asking trusts and charities to take part in the NHS Big Tea. This is the perfect chance for staff, patients and communities to come together for a moment of thanks after a challenging couple of years.

NHS Charities Together hopes to make this year's event the biggest NHS Big Tea to date, with a fundraising target of over £775,000. The NHS could not have achieved all it has in the past year without the skill and dedication of our people, so grab your teapot, pop the kettle on and let's get brewing!

To sign up to host a NHS Big Tea event and receive a fundraising support pack please visit www.nhscharitiestogether.co.uk

Regional Greener NHS Virtual Event

All staff across the NEY region are welcome to join us in celebration of the Green Plan achievements of trusts and Integrated Care Systems in the North East and Yorkshire, the support for NHS-wide ambition to become the world's first healthcare system to reach net zero carbon emissions, and a look ahead to a greener and healthier region.

Register for the event here.

If you would not like to receive further emails from us please click here to unsubscribe.

Board of Directors' Meeting
08 July 2022

The Rotherham NHS Foundation Trust

Agenda item	P101/22
Report	**Responsible Officer's Annual Report & Statement of Compliance**
Executive Lead	Dr Callum Gardner, Medical Director & Responsible Officer
Link with the BAF	**P1:** There is a risk that we will not embed quality care within the 5 year plan because of lack of resource, capacity and capability leading to poor clinical outcomes and patient experience for our patients.
How does this paper support Trust Values	Demonstrates that medical staff are supported and engaged by the Trust to ensure that they have opportunity to reflect on clinical practice.
Purpose	**For decision** ☒ **For assurance** ☐ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	The Responsible Officer's Annual Report to Board is a statutory requirement, and includes a Statement of Compliance to be signed and returned to NHS England. Whilst no national date has yet been set for this return, it is assumed that it will be the end of September again. In the last 12 months, support and governance arrangements around the Responsible Officer's (RO) statutory responsibilities have continued to be strengthened. Overall engagement with Appraisal is 94%. The number of trained Appraisers is 24 for 260 Doctors.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	Not applicable - presented to the Board on an annual basis, but no other Committee.
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 Medical Director/RO continues to aim to have 100% of all Appraisals completed within their due date (except for those for whom there is an accepted reason).
Recommendations	It is recommended that the Board note the continued improvements made over the last 12 months. It is recommended that the Board approves the report and the Statement of Compliance.
Appendices	Appendix 1: Designated Body Annual Board Report 2022

Designated Body Annual Board Report 2022
Section 1 – General:

The Board of The Rotherham NHS Foundation Trust can confirm that:

1. The Annual Organisational Audit (AOA) for this year has been suspended due to COVID-19.

Date of AOA submission: N/A – please note that, whilst submission of the AOA has not been required for the last 2 years, the Trust still submitted this in October 2020 and were one of only a few Trusts to have done so. It is still suspended.

Action from last year: Continue good engagement across all sectors (until March 2022) and focus on supportive, reflective appraisals.

Comments: Overall engagement further improved from 92% to 94%, despite the pandemic.

Action for next year: Continue to maintain the high level of activity and to aim for 100% completion rate for all appraisals within expected date, *unless* there is an accepted reason by the RO and AMD Appraisal, Revalidation & Mentorship.

2. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: The Trust's Deputy Medical Director – Professional Standards undertook RO and Case Manager training in Financial Year 21/22. The Trust's AMD Appraisal, Revalidation & Mentorship also undertook RO training in Financial Year 21/22, in order to strengthen their awareness and to increase the Trust's resilience.

Comments: Dr Gardner attended refresher RO training in September 2020.

Action for next year: Confirm interim RO arrangements with departure of current Medical Director/RO, pending appointment of substantive Medical Director/RO replacement.

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes

Action from last year: There has been a significant investment in training to support the RO's responsibilities*, which should improve capacity and quality, as well as the appointment of a new Business Manager to the Medical Director, who is helping ensure adherence to the national Quality Standards.*

Whilst the RO also appointed a new Deputy Medical Director – Professional Standards, part of who's role is to support the RO/Medical Director in undertaking his RO duties, they have since left for promotion at another acute Trust in the region. Recruitment into this vacancy has been temporarily paused until a new substantive Medical Director/RO is in post*.*

In the last 12 months, whilst training was funded for Appraisal, Case Manager and RO training, plus funding made available to support individual interventions as required, the RO continues to have no overall non-pay budget to undertake the duties of this role.

eAppraisal was successfully rolled out in January 2022.

Action for next year: Clarification of resources available within MD/RO budget and creation of a nominal non-pay budget to support the RO functions.

4. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: Nil required.

Comments: This is maintained and updated regularly, but could be further strengthened by the appraisal and revalidation office routinely receiving the 'new starters and leavers' list.

Action for next year: The appraisal and revalidation office to routinely receive the 'new starters and leavers' list from Medical & Dental Workforce.

5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: The Trust continued to use the national version of MHPS to support local investigations.

Comments: MHPS policy and review of 'Good Medical Practice' currently being revised nationally by GMC.

Action for next year: Continue Trust-wide roll out of Trust medical mentorship programme for all new Consultant and SAS Doctor starters. Await launch on new national MHPS guidance and revised 'Good Medical Practice' by GMC, then review policies and procedures accordingly.

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

Action from last year: Successful implementation of eAppraisal IT system.

Comments: No external or peer review has been undertaken in the last 12 months due to national pandemic and introduction of new appraisal.

Action for next year: Complete external review and implement recommended changes.

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: Continue to improve engagement of short-term contract holders.

Comments: All new Doctors to the Trust have a priming appraisal with the Medical Appraisal & Revalidation Manager, as approved by NHS England, as part of our drive to improve the engagement of short-term contract holders. Monthly notification of new starters with some background information has been provided and needs to continue to be provided.

Action for next year: Continue this process.

Section 2 – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year: Start transition to an electronic appraisal system (eAllocate).

Comments: Transition to electronic appraisal system completed following training of all appraisers and appraisal team.

Action for next year: Appoint Deputy Appraisal Lead. Ensure minimum 3-yearly MSF (peer and patient). Introduce a new pre-appraisal checklist.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: Continue to support Doctors and send reminders where needed, with escalation up through the Associate Medical Director – Appraisal, Revalidation & Mentorship, then to the MD/RO, as required.

Comments: Managed between AMD Appraisals and Medical Director. The resurgence of COVID-19 has caused some challenges.

Action for next year: Continue support for appraisee and appraiser. The implementation of Allocate appraisal system provides a dashboard which is regularly used to remind colleagues of appraisal dates.

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: Policy has been rewritten due to implementation of Allocate appraisal system.

Comments: Policy has been updated and is being reviewed before being sent for ratification.

Action for next year: Ensure policy up to date and fully implemented.

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: Interview and appoint to vacancies (planned for 13/7/21), including opening up opportunity to non-medical Appraisers (several currently interested).

Comments: 8 newly appointed over last FY, now all trained. There are currently 24 (as there have been some retirements) Appraisers versus a target of 26. One of the appraisers is non-medical.

Action for next year: Continue to appoint Appraisers and appoint a Deputy Appraisal Lead.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent).

Action from last year: Continue to use forum meetings for discussion and benchmarking of practice. Comments: Collated feedback is generally good; individual Doctors receive their own feedback annually. Appraisers have an annual review meeting with the Medical Appraisal Lead. Medical Appraisal & Revalidation Manager and Medical Appraisal Lead have attended all Medical Appraisal meetings in 2021 and 2022, and disseminated the information to all Appraisers. 3 internal updates done. External training organised for September 2022. Action for next year: Continue to provide 4 appraiser forums a year and ensure attendance at these. Appraiser reviews once a year.

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: Actions from NHS review completed. RO's Advisory group reviews activity quarterly. This group includes Non-Executive Director (NED) and lay representation (Lead Governor). Comments: The RO's Advisory Group continues to provide a range of expertise to support and challenge the processes in place. Action for next year: Continue quarterly Board reporting.

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: 100% compliance. Comments: Action for next year: Continue with above.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: All deferral recommendations are discussed and agreed with the relevant Doctor prior to being made. Comments: Action for next year: Continue as above.

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: Improved information from complaints and SI's to inform appraisal. Comments: All Doctors now routinely informed about complaints and SI's they were involved in, which can be cross-checked against statements made during appraisal if required. Monthly data is now provided. Action for next year: Continue to explore how to improve routine flow of information about clinical performance and the ease of access to information, including around medico-legal claims data. Explore examples and systems in place in other Trusts.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: Flows of information to the RO have improved. Comments: New appointments to DMD and MD's Business Manager roles should further support this. Action for next year: Continue to strengthen the process for, and tracking of, responding to concerns about a Doctor's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: New policy agreed; has been used to support a colleague. Comments: Feedback from all concerned would be useful about the effectiveness of the new policy. Due to small numbers, the information and feedback is limited at the moment. Action for next year: Seek and respond to feedback.

3. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[2].

Action from last year: RO's group continues to meet and supports this function. Comments: Quarterly RO's Advisory Group meetings where any such concerns are discussed. This complements regular detailed discussion with GMC Employment Liaison Advisor (ELA) and the quarterly RO's reports to the Board. Data collection should now be possible with the agreement to establish a case tracking system, supported by the MD's new Business Manager and the Head of Medical & Dental Workforce. In addition, for any concerns involving the potential to lead to a restriction in practice or exclusion, a Maintaining High Professional Standards (MHPS) process and/or a GMC referral, the RO

[4]This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

always seeks support and advice from the independent Practitioner Performance Advice Service (PPAS), to ensure transparency and adherence to due process.

Action for next year: Still very small number who have been involved, limiting the opportunity for feedback.

4. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[3].

Action from last year: Yes, via email and facilitated by GMC ELA where required.

Comments: Variable responses, mainly when dealing with Locum Agencies.

Action for next year: Continue to support information sharing in a timely manner. Ensure that an Medical Practice Information Transfer (MPIT) Form is sent for all leavers and requested for all new medical starters (non-Deanery).

5. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: Establish RO's Advisory Group to monitor this activity.

Comments: Diverse (gender and race) RO's Advisory Group continues to meet quarterly, chaired by the RO. This complements regular detailed discussions with GMC ELA. In addition, for any concerns involving the potential to lead to a restriction in practice or exclusion, a Maintaining High Professional Standards (MHPS) process and/or a GMC referral, the RO always seeks support and advice from the independent Practitioner Performance Advice Service (PPAS), to ensure transparency and adherence to due process.

Numbers too small currently to comment. Aware of national data around this issue. Doctors with short term contracts seem to have caused the most concerns.

Action for next year: Review of cases to be presented at RO's Advisory Group.

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: Monthly data now provided to RO about new starters.

Comments: Monthly updates not routinely being received; picked up with Medical & Dental Workforce.

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Action for next year: Reinstate monthly reporting and seek further clarification around the processes for locums via NHSP. Spot checks of robustness of pre-employment checks, including adequacy of references, to be undertaken by Medical & Dental Workforce.

Section 6 – Summary of comments, and overall conclusion

The GMC deferred a cohort of Doctors due to revalidate between 16th March 2020 and 15th March 2021, due to the pandemic. However, we continued to recommend those suitable for Revalidation, as per GMC guidance. Furthermore, we did not stop the appraisal service and felt it needed to continue to support Doctors, and indeed some Doctors wishing to complete their appraisal approached us; where possible, these were undertaken. We have achieved 94%, which is one of the highest in the region and nationally.

Processes for responding to concerns have improved and progress has been made in resolving a number of historical concerns, with all historical MHPS investigations now closed. Two colleagues are still receiving Enhanced Support, in line with the revised guidance.

In seeking to support colleagues, the flow of information could still be improved. Over the last 12 months, we have agreed processes to share information about complaints and SI's, but easier access to routine data would be beneficial. This continues to need refining.

The RO's Advisory Group should invite other expertise as required to support the RO as the new roles within the Trust develop.

Overall conclusion:

Overall engagement continues to be good and reflects the enthusiasm of the current group of Appraisers. This is also seen in the feedback from Appraisers over the last 12 months. Appraisals have continued to be offered using remote technology where appropriate.

Still scope for improvement in access to information to support appraisal, but overall there has been a welcome and significant investment in time and training for activities which support the RO's role and which will benefit the Trust going forward.

Section 7 – Statement of Compliance:

The Board of The Rotherham NHS Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: The Rotherham NHS Foundation Trust

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _ _

Board of Directors' Meeting
08 July 2022

The Rotherham NHS Foundation Trust

Agenda item	P102/22
Report	**Mortality and Learning From Deaths Annual Report – 2021/22**
Executive Lead	Dr Callum Gardner, Executive Medical Director
Link with the BAF	**U4:** There is a risk that we do not develop and maintain a positive culture because of insufficient resources and the lack of compassionate leadership leading to an inability to recruit, retain and motivate staff. **D5:** There is a risk that we will not deliver safe and excellent performance because of insufficient resource (financial and human resource) leading to an increase in our patient waiting list backlog and potential for patient deterioration and inability to deliver our Operational Plan. **D6:** There is a risk that we will not be able to deliver our services because we have not delivered on our Financial Plans for 2022-23 in line with national and system requirements leading to financial instability and the need to seek additional support to deliver our services.
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) both 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)	**HSMR –** The Rotherham NHS Foundation Trust's (TRFT) latest rolling 12-month HSMR value is 98.3. TRFT remain in the 'As Expected' band. **SHMI –** TRFT's latest rolling 12-month SHMI value is 107.5. TRFT remain in the Band 2 'As Expected' band. **Learning From Deaths - 2021/22** TRFT has seen sustained declines in the HSMR and SHMI. Both are in the 'As Expected' band. The Trust has continued to use Mortality indicator data to identify potential areas of poor care for investigation and

	also its coding data to benchmark the Trust's performance against other Trusts. The Trust is aware of its shortcoming in its Learning from Deaths programme. The Trust is being assisted by 360 Assurance with regard to the governance of the programme. The Trust also joined NHS England & Improvement's Better Tomorrow: Learning from Deaths, Learning for Lives programme, which focuses on the completion of good quality Structured Judgement Reviews, and how they can be used to learn and drive improvement. Both improvement projects have action plans which were agreed in 2021/22. These are currently being implemented and will be finalised in 2022/23.
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 Safe & Sound Mortality Group, Mortality Improvement Group and the Quality Committee.
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 hard to establish a robust Learning from Deaths process where both good and poor practice is identified. The purpose is to identify problems in care which might have contributed to the death, and to learn in order to prevent recurrence. Reviews and investigations are only useful for learning purposes if their findings are shared and acted upon. Learning from Deaths is co-ordinated and run through the Trust's Safe & Sound Mortality Group, chaired by the Executive Medical Director, with oversight and assurance through the Trust's new Clinical Effectiveness Committee and Quality Committee. The Trust aims to understand its Mortality Indicators and to use them to assist the Learning from Deaths process, in order to indicate areas where TRFT may have problems in care and needs to investigate.
Recommendations	It is recommended that the Board notes the mortality position and the significant actions being taken to make sustained improvements in the Learning from Deaths programme.
Appendices	1. Dr Foster Mortality Report

1.0 MORTALITY INDICATORS

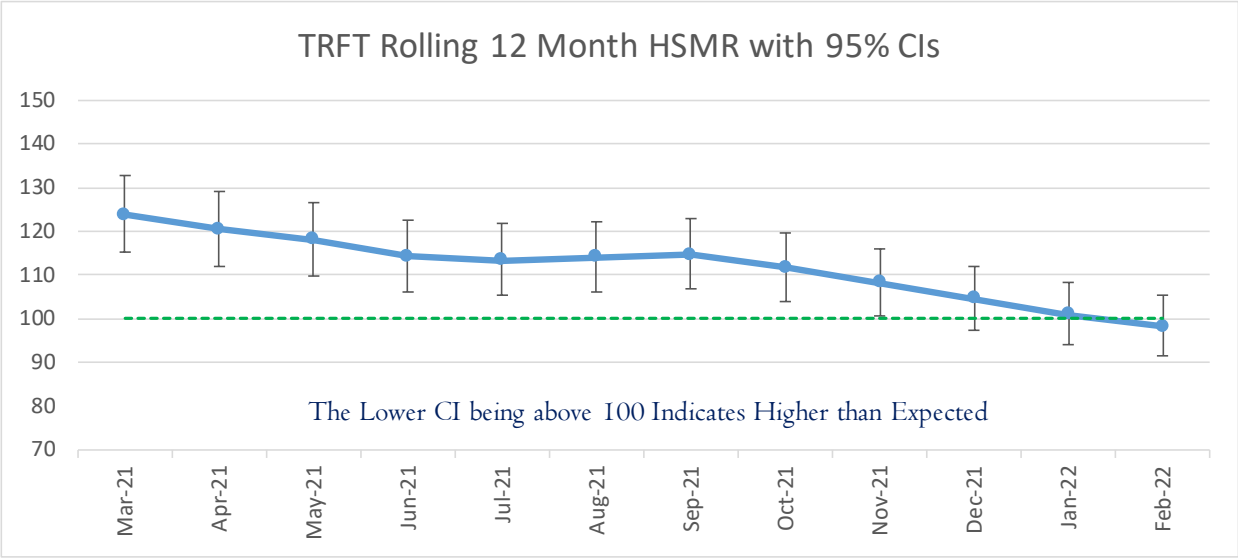
1.1 Hospital Standardised Mortality Ratios (HSMR), produced by Dr Foster

Latest Month Available for The Rotherham NHS Foundation Trust (TRFT): February 2022

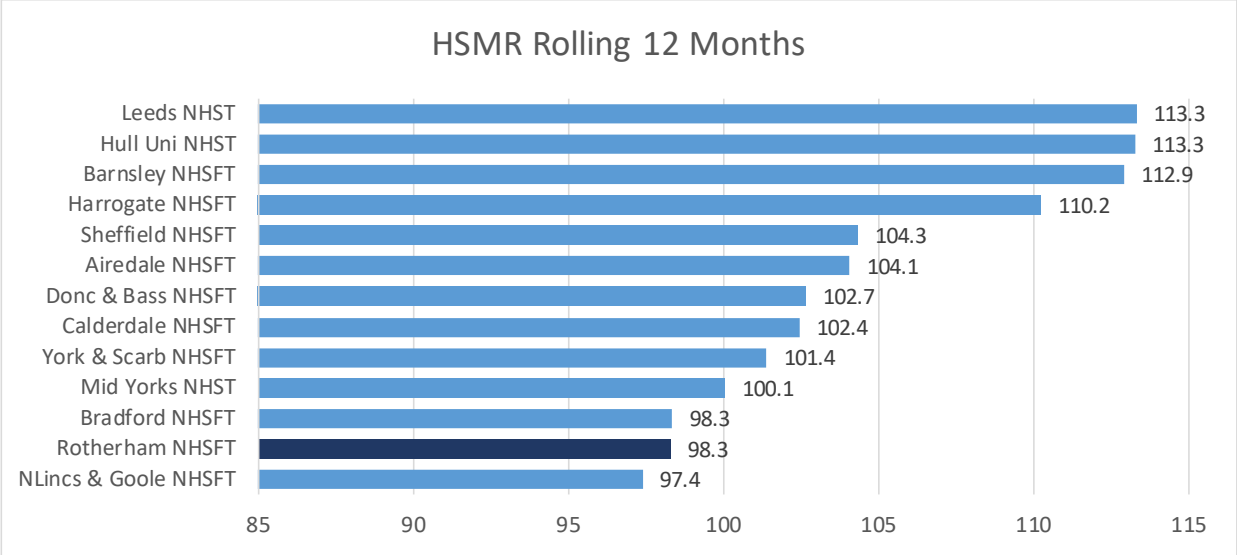
TRFT's latest rolling 12-month HSMR value is 98.3, which is the lowest it has been for 4 years. TRFT are in the 'As Expected' band.

1.2 HSMR Rolling 12-Month Trend

This chart shows that TRFT's rolling 12-month HSMR has followed a sustained downward trend during 2021/22.



1.3 Yorkshire & Humber Regions General Trusts, HSMR Mar 2021 – Feb 2022



1.4 Summary Hospital-Level Mortality Indicator (SHMI), produced by NHS Digital

Latest Month Available for TRFT: January 2022

TRFT's latest rolling 12-month SHMI value is 107.5. TRFT remains in the 'As Expected' band.

The main difference between the SHMI and the HSMR is that the SHMI also includes deaths that occurred within 30 days of a hospital discharge.

2.0 RECORDING OF CORRECT DIAGNOSES AND PROCEDURES AND ITS CODING

Clinical coding is the process whereby information from the hospital case notes for each patient are expressed as codes; this includes the operation/treatment, diagnosis, complications and co-morbidities.

To ensure that the number of 'Expected Deaths' calculated in the HSMR and SHMI accurately reflects TRFT's inpatient case mix, the following clinical recording/coding factors are important:

- Recording of a definitive diagnosis in the 1st or 2nd Episode of care, where possible
- Capture of all relevant Co-Morbidities
- Capture of Palliative Care (HSMR Only)

2.1 SHMI Coding Indicators (Feb 2021 - Jan 2022)

NHS Digital's SHMI Coding/Data Quality indicate that TRFT has a good depth of coding, indicated by a high number of Co-Morbidities per Non-Elective admission. 2nd highest in the region.

However, TRFT also has the highest rates of signs and symptoms and invalid codes recorded in the Primary Diagnosis. This could indicate a problem with data quality or timely diagnosis of patients. Our 12-month rate is affected by spikes in this metric during March and April 2021, when there were staffing shortages in Clinical Coding.

The Palliative Care metrics indicate that TRFT's Palliative Care coding rate for all spells is average for the region, and below the national average. For deaths, TRFT is the 2nd highest in the region and just above the national average.

Coding affects the expected rate for both SHMI and HSMR.

TRFT Rank of 13	1st Highest	1st Highest	2nd Highest	6th Highest	2nd Highest
Yorks & Humber Region Non Spec Provider Trusts	**% of Spells: Primary Diagnosis is a Sign & Symptom**	**% of Spells: Invalid primary diagnosis code**	**MEAN Secondary Diagnoses per Spell Non Elective**	**% of Spells with palliative care(spec or Diag)**	**% of deaths with palliative care(spec or Diag)**
Rotherham NHSFT	18.5	5.0	7.3	1.7	40
Airedale NHSFT	16.3	0.0	5.0	1.1	22
NLincs & Goole NHSFT	15.0	0.1	5.8	1.5	22
Harrogate NHSFT	15.0	0.1	4.8	1.9	37

York & Scarb NHSFT	13.6	0.1	5.4	1.4	28
Barnsley NHSFT	13.0	0.2	7.7	1.4	23
Bradford NHSFT	12.7	0.5	4.4	1.1	31
Donc & Bass NHSFT	11.2	0.1	5.3	2.3	44
Calderdale NHSFT	9.8	*	5.9	1.7	32
Mid Yorks NHST	9.7	0.6	6.3	1.6	33
Sheffield NHSFT	9.3	0.0	5.5	2.1	39
Leeds NHST	7.6	*	6.4	2.0	32
Hull Uni NHST	5.0	0.0	6.3	2.6	34
England	14.2	0.9	5.8	2.0	39

3.0 CLINICAL CODING UPDATE

3.1 Learning From Deaths Related Work – 2021/22

The Clinical Coding Team continue to have an important contribution to the Learning from Deaths Programme and the Safe & Sound Mortality Group.

3.2 Clinical Coding Performance

Mortality indicators calculate a risk score for each inpatient admission, which forms a major part of the Mortality indicator Score. Having an accurate risk score is dependant of having good quality and accurate clinical coding.

The Clinical Coding department has maintained the highest level of accuracy (Standards Exceeded) at external DSPT audit for the fifth consecutive year, with further improvements in primary diagnosis and primary procedure percentages.

RESULTS

TABLE 2 – OVERALL RESULTS – CODER AND NON-CODER ERRORS

Area audited	Number of FCEs	Primary Diagnosis accuracy	Secondary diagnosis Accuracy	Primary Procedure Accuracy	Secondary Procedure Accuracy
Overall	**200**	**98.50%**	**97.94%**	**100%**	**99.54%**

200 FCEs were audited – the accuracy percentages were as noted above.

These figures correspond to Standards Exceeded in the Data Security and Protection Toolkit requirements.

The auditor noted exceptional depth of coding in all areas and good attention to detail, with many audited cases having a high number of relevant comorbidities captured. There were some areas of potential improvement identified which are being worked on by the Team.

3.3 Investigation of Mortality Indicator Alerts

The Team complete in-depth Clinician Coding Reports for deaths, which contribute to a Diagnosis Group Alert.

These reviews can determine how many of these deaths could or should have been allocated to another Diagnosis Group, which attract a higher risk score. The reviews can determine the cause of this:

- The lack of a correct recording of the diagnosis in the Medical Records
- The diagnosis wasn't available in the 1st two Consultant episodes of the admission (only the first two episodes count for the risk score)
- Omission from a Clinical Coder

3.4 Additional Contributions

Reducing Multi Short Duration Consultant Episodes (CEs) in AMU

The Team have been involved in a Working Group looking at ways to reduce the amount of short stay Consultant episodes in the Acute Medical Unit. The Team has worked with clinicians in AMU to gain a better understanding of the high prevalence of short duration CEs in the early part of the admission.

A resolution must be clinically driven and subsequent actions must be based around the change being legitimate clinically, and a new process has been agreed through the Safe & Sound Mortality Group.

Identifying Deaths Requiring an SJR

There are national criteria for deaths that require an SJR. In addition, trusts can determine their own groups. TRFT requires SJRs for all Trauma, Asthma, Autism and Learning Difficulties Deaths.

Clinical Coding have been assisting the Learning from Deaths and Mortality Manager and Health Informatics to identify these deaths via ICD10 Diagnosis Codes. These deaths are expected to be identified in the Mortality Insights Report by the end of July 2022.

4.0 LEARNING FROM DEATHS IMPROVEMENT PROGRAMMES

TRFT is involved in two Learning from Deaths Improvement Programmes, which complement each other. The review with 360 Assurance focuses on reporting and governance for the Learning from Deaths programme. The outcome is to maximise the transparency and competence of the governance process.

The 2nd review programme with NHS England/Improvement also focuses on the operational side. The key feature of this programme is to move TRFT to their SJR+, cloud-based System. This system has an enhanced SJR form, and an analytical reporting tool. The anticipated outcome from this audit is better quality and complete SJRs from which learning can be extracted and disseminated.

4.1 Update 360 re Audit Update

The 360 full Learning from Deaths governance re-audit report was presented to the Trust in March. An agreed action plan is in place and being worked on. Action point target dates range from April 2022 to March 2023, and are now being tracked monthly at the Safe & Sound Mortality Group Meetings.

4.2 Update NHSE/I Learning from Deaths Improvement Programme

The Learning from Deaths Improvement project with NHSE/I is well underway. The main aim is to improve the standard of Structured Judgement Reviews and the analysis/learning gained from them. The project outline was presented to the Safe & Sound Mortality Group Meeting in May, and to a number of Executive Directors, with firm support and approval being achieved.

5.0 STRUCTURED JUDGEMENT REVIEW (SJR) REPORT

SJRs All Adult Inpatient Deaths

Month of Discharge	No of Adult Inpatient Deaths	SJR Requested	SJRs Completed	SJRs Outstanding	Overall Care Score < 3	Avoidability Score < 4
Apr-21	69	20	16	4	2	0
May-21	71	22	19	3	0	0
Jun-21	66	14	12	2	2	1
Jul-21	71	19	16	3	0	0
Aug-21	91	25	17	8	0	0
Sep-21	89	26	17	9	0	0
Oct-21	83	34	16	18	1	0
Nov-21	108	23	13	10	1	0
Dec-21	96	20	16	4	0	0
Jan-22	100	31	19	12	0	0
Feb-22	80	15	6	9	0	0
Mar-22	81	13	5	8	0	0
2021/22	1005	262	172	90	6	1

Care Score	1 - Very Poor	2 - Poor	3 - Adequate	4 - Good	5 - Excellent

Avoidability Score	1 - Definitely avoidable	2 - Strong evidence	3 - Probably (more than 50:50)	4 - Possibly (less than 50:50)	5 - Slight evidence	6 - Definitely not avoidable

Timeliness of SJR Completions

Financial Quarter	SJR Requested	SJRs Completed	% Completed	Completed Within 60 Days of Death	% Completed Within 60 Days of Death
2021/22 Q1	56	47	83.9%	13	23.2%
2021/22 Q2	70	50	71.4%	19	27.1%
2021/22 Q3	77	45	58.4%	30	39.0%
2021/22 Q4	59	30	50.8%	17	28.8%
2021/22	262	172	65.6%	79	30.2%

5.2 Learning from Deaths - Learning Disabilities and Leder Reviews

The LeDer Programme is a Commissioner-led review of deaths for patients with Learning Difficulties, regardless of the place of death. Provider Trusts are frequency asked to assist with a LeDer review when they have been involved in care provision for that patient. From 1 April 2022, this also includes Autism deaths.

In hospital, deaths for patients with Learning Difficulties are a group for which SJRs are recommended. From 1 April 2022, this also includes Autism deaths.

SJRs for Learning Disability deaths are identified and marked as priority for the Divisions to complete.

A new process has been established between the Matron in Learning Difficulties and Autism and the LFD & Mortality Manager. This process will identify where there is a completed SJR that could assist/enhance a LeDer review or where a LeDer request suggests an SJR would be beneficial for Trust learning, if the patient died in the community within 30 days of a TRFT discharge.

LeDer Requests and SJR for Adults with a Learning Disability

Month of Discharge	SJR Requests	SJRs Completed	SJRs Outstanding	Overall Care Score < 3	Avoidability Score < 4	LeDer Requests
Apr-21	0	0	0	0	0	0
May-21	0	0	0	0	0	0
Jun-21	2	2	0	0	0	2
Jul-21	1	1	0	0	0	1
Aug-21	4	2	2	0	0	1
Sep-21	0	0	0	0	0	0
Oct-21	0	0	0	0	0	1
Nov-21	2	0	2	0	0	3
Dec-21	3	3	0	0	0	2
Jan-22	5	3	2	0	0	6
Feb-22	2	1	1	0	0	3
Mar-22	2	1	1	0	0	1
FYTD Total	21	13	8	0	0	20

6.0 SJRs LEARNING IN THE TRUST AND DIVISIONS

Deaths are being reviewed and discussed in Divisional Safe & Sound Mortality Sub-Group meetings. However, they are not in the SJR format and therefore are not feeding into the Learning from Deaths data collection. This is impeding TRFT's ability to maintain an overview and identify themes.

Learning from these local reviews can't be aggregated and used in any thematic or trend analysis.

TRFT's SJRs are being completed with very little free text judgement statements, which are crucial to enable learning from SJRs. This is in part due to the SJR form design which limits free text entry and due to a training issue. This should be solved once the Trust adopts the new SJR+ process.

6.1 SJR Scores & Themes In 2021/2022

Summary

71% of SJRs had an Overall Care Score of Good or Excellent. 6 SJRs had an Overall Care Score of poor. These 6 are following the Trust's process for SJRs with an Overall Care Score less than 3; this includes a review and discussion at the Divisional Safe and Sound Mortality Group, followed by the Trust-wide Safe and Sound Mortality Group, and an escalation to the Serious Incident panel if required.

1 death in 2021/22 was judged to have likely been avoidable. This has or is following the Trust's process for SJRs with an Overall Care Score less than 3; this includes a review and discussion at the Divisional Safe and Sound Mortality Group, followed by the Trust-wide Safe and Sound Mortality Group, and an escalation to the Trust's Serious Incident panel.

17 SJRs identified Problems in Health Care. This number is likely to be artificially low due to the current brevity of SJR completion at TRFT. It is believed that the introduction of SJR+ (and supportive SJR training) in the second half of 2022 will result in an increased number of problems being identified and encourage more narrative detailing the problem. This increase will enhance the learning available to TRFT from its SJRs.

SJR Scores 2021/22

Overall Care Score	SJRs
1 - Very Poor	0
2 - Poor	6
3 - Adequate	21
4 - Good	68
5 - Excellent	54
Not Recorded	23
2021/22 Total	172

Avoidability	SJRs
1 - Definitely avoidable	0
2 - Strong evidence of avoidability	0
3 - Probably avoidable (more than 50:50)	1
4 - Possibly avoidable (less than 50:50)	8
5 - Slight evidence of avoidability	21
6 - Definitely not avoidable	120
Not Recorded	22
2021/22 Total	172

Problems in Healthcare	SJRs
No	128
Yes	17
Not Recorded	28
2021/22 Total	172

Problems In Healthcare Breakdown	Problems
1 Assessment Investigation Or Diagnosis	8
2 Medication IV Fluids Electrolytes Oxygen	9
3 Treatment And Management Plan	6
4 Infection Control	1
5 Operation Invasive Procedure	1
6 Clinical Monitoring	7
7 Resus Following Cardiac Respiratory Arrest	1
8 Other	6
2021/22 Total	39

Initial Phase Care Score	SJRs
1 - Very Poor	0
2 - Poor	2
3 - Adequate	21
4 - Good	76
5 - Excellent	56
Not Recorded	17
2021/22 Total	172

On Going Care, Care Score	SJRs
1 - Very Poor	0
2 - Poor	8
3 - Adequate	19
4 - Good	75
5 - Excellent	52
Not Recorded	18
2021/22 Total	172

Care During A Procedure Care Score	SJRs
1 - Very Poor	0
2 - Poor	1
3 - Adequate	10
4 - Good	40
5 - Excellent	34
Not Recorded	87
2021/22 Total	172

Perioperative Care Score	SJRs
1 - Very Poor	0
2 - Poor	2
3 - Adequate	6
4 - Good	25
5 - Excellent	24
Not Recorded	115
2021/22 Total	172

End Of Life Care Score	SJRs
1 - Very Poor	0
2 - Poor	2
3 - Adequate	15
4 - Good	57
5 - Excellent	71
Not Recorded	27
2021/22 Total	172

Thematic Analysis of SJR Narrative/Comments

A crucial aspect of SJRs are the free-text comments, which detail good or bad care. Whilst most SJRs completed in 2021/22 don't contain this information, we have been able to analyse the comments we do have. The table below details the Categories these fall into.

2021/22 TRFT Free Text Poor Care Comment by Category

Problem Category	Number
Delay /Omission/Choice Medication or Treatment	18
Delay/Omission/Interpretation - Tests/Results/Monitoring	18
Delay /Omission - Escalation	8
Delay/Omission Assessment/Opinion/Review	8
Location of Care/Bed Availability/Inappropriate Moves	6
Do Not Attempt CPR	5
End of Life / Palliative Care	5
Medical History	1
Communication	1

Good Care

SJRs are a useful tool to identify both good and poor care. Most SJRs highlighting examples of poor care include many more instances of good care within them.

7.0 CONCLUSION

A significant amount of work and effort continues to be focused on improving mortality and the Trust's Learning from Deaths programme.

Mortality and the Learning from Deaths will continue to remain one of the Trust's top Quality Improvement priorities next financial year.

Some required short-term fixes have and are being put in place to deal with immediate issues such as Learning Difficulty Deaths not being reviewed. Changes to enhance TRFT's Learning from Deaths Programme will come from the Trust's implementation of the recommended actions from our 2 reviews programmes.

To date, SJRs have been used at TRFT to investigate and identify areas of good and bad care for individual cases. In 2022/23, the aim of TRFT is to ensure good quality, qualitative reviews, in order to enhance the learning from SJRs by using thematic analysis to identify trend and themes.

John Taylor
Learning From Deaths and Mortality Manager
June 2022

Trust	THE ROTHERHAM NHS FOUNDATION TRUST
Report Date	Monday, 6 June 2022
Senior Consultant	Robert Douce
Area	Consultancy
Contact Details	Robert.douce@health.telstra.com
Data Period	Feb 2021 - Jan 2022

TABLE OF CONTENTS	
REPORT OUTLINE	
REPORT HEADLINES	
SUMMARY	
HOSPITAL STANDARDISED MORTALITY RATIO OVERVIEW	
STANDARDISED MORTALITY RATIO OVERVIEW	
HSMR WEEKDAY/WEEKEND ANALYSIS	
TRENDS IN CODING	
CUSUM ALERTS	
PATIENT SAFETY INDICATORS	
MONTHLY SHMI	
APPENDICES	
REFERENCES	

REPORT OUTLINE

Background

The report provides an overview of mortality using the Hospital Standardised Mortality Ratio and the Standardised Mortality Ratio. The report presents intelligence with potential recommendations for further investigation. This report should be used as an adjunct to supplement other pieces of work completed within the Trust and not used in isolation.

Methods

Using routinely collected hospital administrative data derived from Hospital Episode Statistics (HES) and analysing in the Healthcare Intelligence Portal tool, this report examines in-hospital mortality, for all inpatient admissions for the 12 month time period Feb 2021 - Jan 2022.

Risk adjustment is derived from risk models based on the last 10 years of national HES data up to and including November 2021(unless otherwise stated). This is the most recent benchmark period available. Statistical significance is determined using 95% confidence intervals unless otherwise stated.

SHMI data for the time period January 2021 to December 2021 was obtained from NHS Digital's Indicator Portal. SHMI is updated and rebased monthly.

REPORT HEADLINES

Data Period: Feb 2021 - Jan 2022

Metric	Result

HSMR	• HSMR = 100.1 and banded as statistically 'within expected'.
	  o Excluding spells with secondary COVID-19 codes the Trusts HSMR for the period was 95.5 and banded as statistically 'within expected'.
	  ▪ For the last available 12 months patients with secondary Covid-19 within the HSMR basket represented 2.0% of admissions (452 super-spells, 79 deaths) at the Trust.
	• The latest months HSMR value (Jan-22) = 99.1 and banded as statistically 'within expected'.
	• Non-elective HSMR = 98.7 and banded as statistically 'within expected'.
	• Crude mortality (all diagnosis) was 3.4% over the 12 month period compared to 3.2% regional average (acute, non-specialist) and 3.2% national average (acute, non-specialist).
	• For the 12 month period there were 2 HSMR diagnosis groups with a relative risk banded as statistically 'higher than expected':
	  o Other upper respiratory disease
	  o Syncope

HSMR position vs. peers	• The Trust is 1 of 12 within the regional peer group with an HSMR banded as statistically 'within expected' over the 12 month period. • If the regional HSMR values are ranked (lowest to highest) the Trusts HSMR is 7th of 21 acute, non-specialist NHS providers.

SMR outlying groups	• For the 12 month period there were 3 diagnosis groups with a relative risk banded as statistically 'higher than expected':
	  o Other upper respiratory disease
	  o Syncope
	  o Diabetes mellitus with complications *New Alert (11 observed outcomes)

All Diagnosis SMR	• SMR (all diagnosis) = 96.7 and banded as statistically 'within expected'. o Excluding spells with both primary and secondary COVID-19 codes the Trusts SMR for the period was 92.8 and banded as statistically 'lower than expected'.

	▪ For the last available 12 months patients with either primary or secondary Covid-19 represented 3.0% of admissions (1,951 super-spells, 247 deaths) at the Trust. • The latest month (Jan-22) SMR = 88.5 banded as statistically 'within expected'. • Crude mortality (all diagnosis) was 1.7% over the 12 month period compared to 1.6% regional average (acute, non-specialist) and 1.6% national average. • The Trust is 1 of 12 within the regional peer group with an SMR banded as statistically 'within expected' over the 12 month period. • If the 12 month SMR values for the regions acute, non-specialist Trusts are ranked (lowest to highest) The Rotherham NHD FT ranks 4th of 21 Trusts.
CUSUM breaches	• Over the 12 month period there were 9 CUSUM alerts (using 99% detection threshold criteria) in the following diagnosis groups: o Nonspecific chest pain *New Alert in Jan-22 o Acute bronchitis o Other upper respiratory disease o Biliary tract disease o Liver disease, alcohol-related o Nervous system congenital anomalies o Other perinatal conditions o Other psychoses o Anxiety, somatoform, dissociative, and personality disorders
SHMI position	Time period: January 2021 to December 2021. • SHMI for The Rotherham NHS FT = 107.32 banded as statistically 'within expected' using the 95% control limits (adjusted for over dispersion) published by NHS digital. • During the 12 month period there were 815 in-hospital deaths and 455 out of hospital deaths (within 30 days of discharge) recorded within the SHMI. • The Trust is one of 10 within the NHS England North (Yorkshire and Humber) region with a SHMI banded in the statistically 'within expected' range. • Of the SHMI diagnosis groups banded by NHS digital (using 95% control limits adjusted for over dispersion) there was a single outlying group: o Fluid and electrolyte disorders (30 observed deaths, 15 predicted by the modelling).

Key points

- HSMR = 100.1 and banded as statistically 'within expected'.
  - Excluding spells with secondary COVID-19 codes the Trusts HSMR for the period was 95.5 and banded as statistically 'within expected'.
    - For the last available 12 months patients with secondary Covid-19 within the HSMR basket represented 2.0% of admissions (452 super-spells, 79 deaths) at the Trust.

Diagnoses - HSMR | Mortality (in-hospital) | Feb-21 to Jan-22 | COVID-19 Y/N

Analyse by: COVID-19 Y/N Measure: Relative risk Show: All

COVID-19 Y/N	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	22,900	100.0%	22,944	785	3.4%	784.4	3.4%	0.6	100.1	93.2	107.3
Yes	452	2.0%	456	79	17.5%	44.9	9.9%	34.1	176.1	139.4	219.5
No	22,448	98.0%	22,488	706	3.1%	739.5	3.3%	-33.5	95.5	88.6	102.8

- The latest months HSMR value (Jan-22) = 99.1 and banded as statistically 'within expected'.
- Non-elective HSMR = 98.7 and banded as statistically 'within expected'.
- Crude mortality (all diagnosis) was 3.4% over the 12 month period compared to 3.2% regional average (acute, non-specialist) and 3.2% national average (acute, non-specialist).
- For the 12 month period there were 2 HSMR diagnosis groups with a relative risk banded as statistically 'higher than expected':
  - Other upper respiratory disease
  - Syncope

Diagnoses - HSMR | Mortality (in-hospital) | Feb-21 to Jan-22 | Diagnosis group

Diagnosis group: Other upper respiratory disease, Syncope

Analyse by: Diagnosis group Measure: Relative risk Show: All

Diagnosis group	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	760	100.0%	762	11	1.4%	3.2	0.4%	7.8	339.1	169.0	606.8
Other upper respiratory disease	471	62.0%	473	6	1.3%	1.8	0.4%	4.2	335.2	122.4	729.7
Syncope	289	38.0%	289	5	1.7%	1.5	0.5%	3.5	343.8	110.8	802.4

- The Trust is 1 of 12 within the regional peer group with an HSMR banded as statistically 'within expected' over the 12 month period. If the regional HSMR values are ranked (lowest to highest) the Trusts HSMR is 7th of 21 acute, non-specialist NHS Trusts.

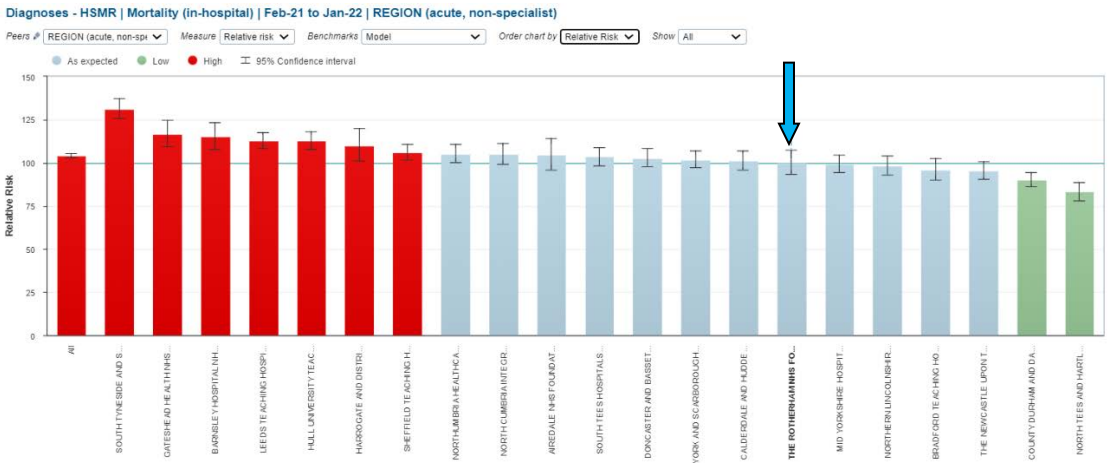


Figure 1 – HSMR Monthly Trend

Diagnoses - HSMR | Mortality (in-hospital) | Feb-21 to Jan-22 | Trend (month)

Analyse by: Trend (month) Measure: Relative risk Show: All

Trend (month)	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	22,900	100.0%	22,944	785	3.4%	784.4	3.4%	0.6	100.1	93.2	107.3
Feb-21	1,735	7.6%	1,737	66	3.8%	58.5	3.4%	7.5	112.9	87.3	143.6
Mar-21	1,825	8.0%	1,827	74	4.1%	64.2	3.5%	9.8	115.3	90.5	144.8
Apr-21	1,527	6.7%	1,529	47	3.1%	45.8	3.0%	1.2	102.5	75.3	136.3
May-21	1,908	8.3%	1,910	60	3.1%	62.7	3.3%	-2.7	95.7	73.0	123.2
Jun-21	2,117	9.2%	2,119	59	2.8%	63.6	3.0%	-4.6	92.8	70.6	119.7
Jul-21	2,048	8.9%	2,051	62	3.0%	62.5	3.1%	-0.5	99.1	76.0	127.1
Aug-21	1,894	8.3%	1,898	61	3.2%	57.3	3.0%	3.7	106.5	81.4	136.8
Sep-21	2,022	8.8%	2,029	59	2.9%	55.3	2.7%	3.7	106.7	81.2	137.6
Oct-21	2,030	8.9%	2,038	60	3.0%	71.0	3.5%	-11.0	84.5	64.5	108.8
Nov-21	1,996	8.7%	1,998	81	4.1%	77.3	3.9%	3.7	104.9	83.3	130.3
Dec-21	2,016	8.8%	2,020	80	4.0%	89.5	4.4%	-9.5	89.4	70.9	111.3
Jan-22	1,782	7.8%	1,788	76	4.3%	76.7	4.3%	-0.7	99.1	78.1	124.0

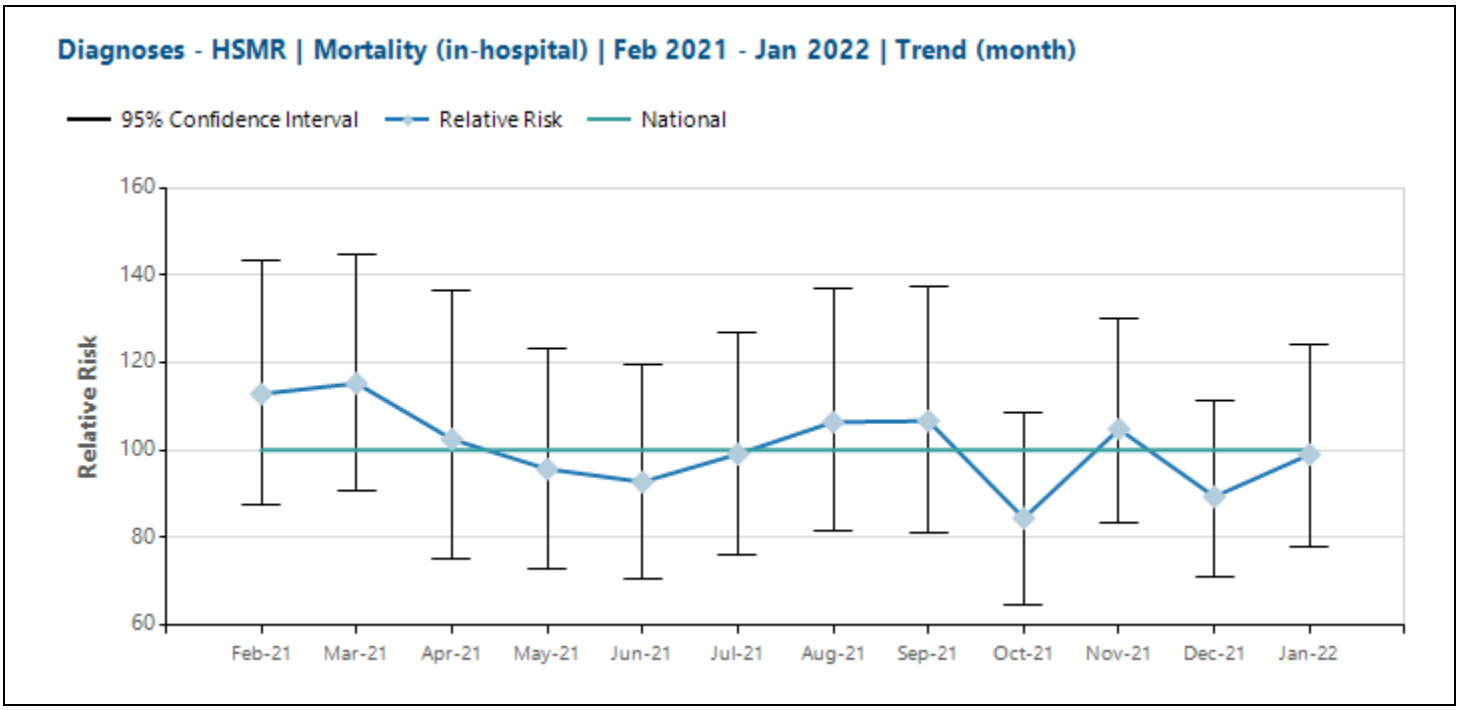
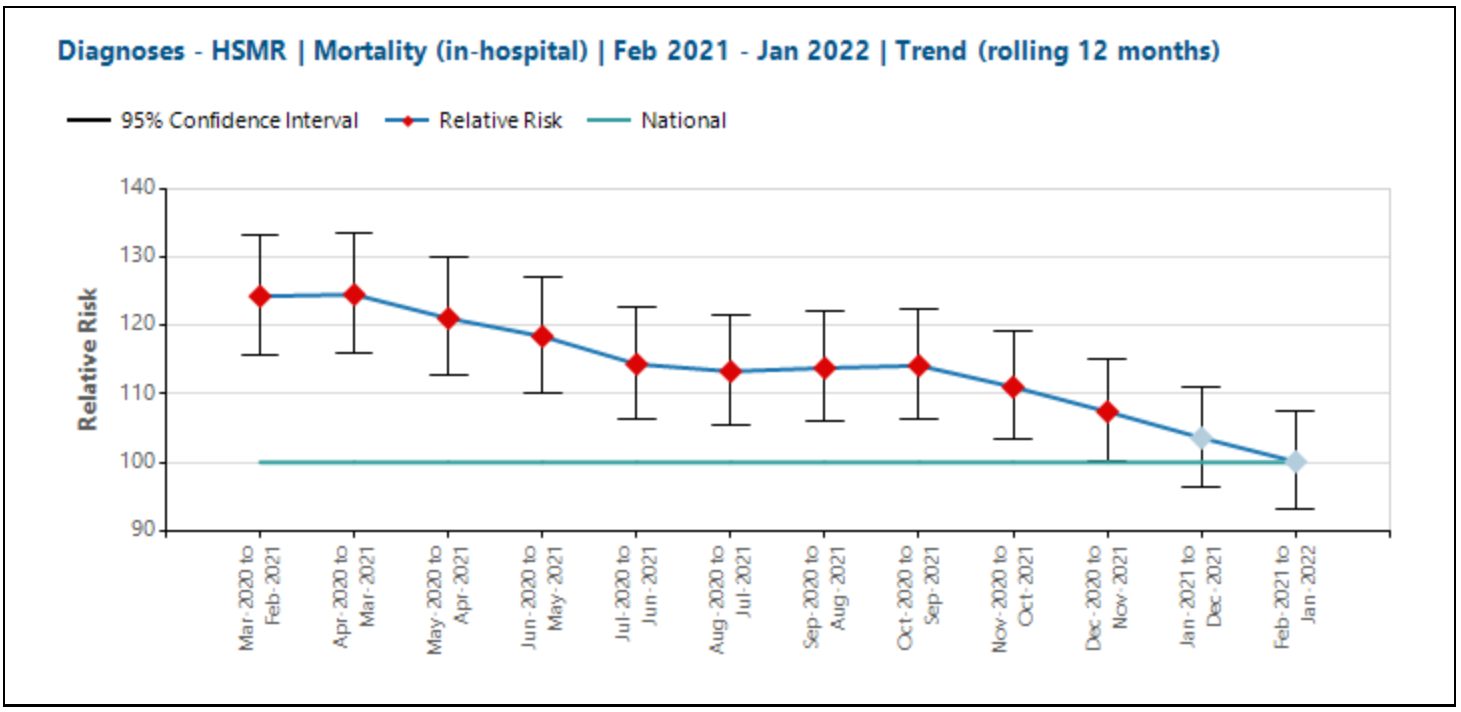


Figure 2 – HSMR 12 Month Rolling Trend



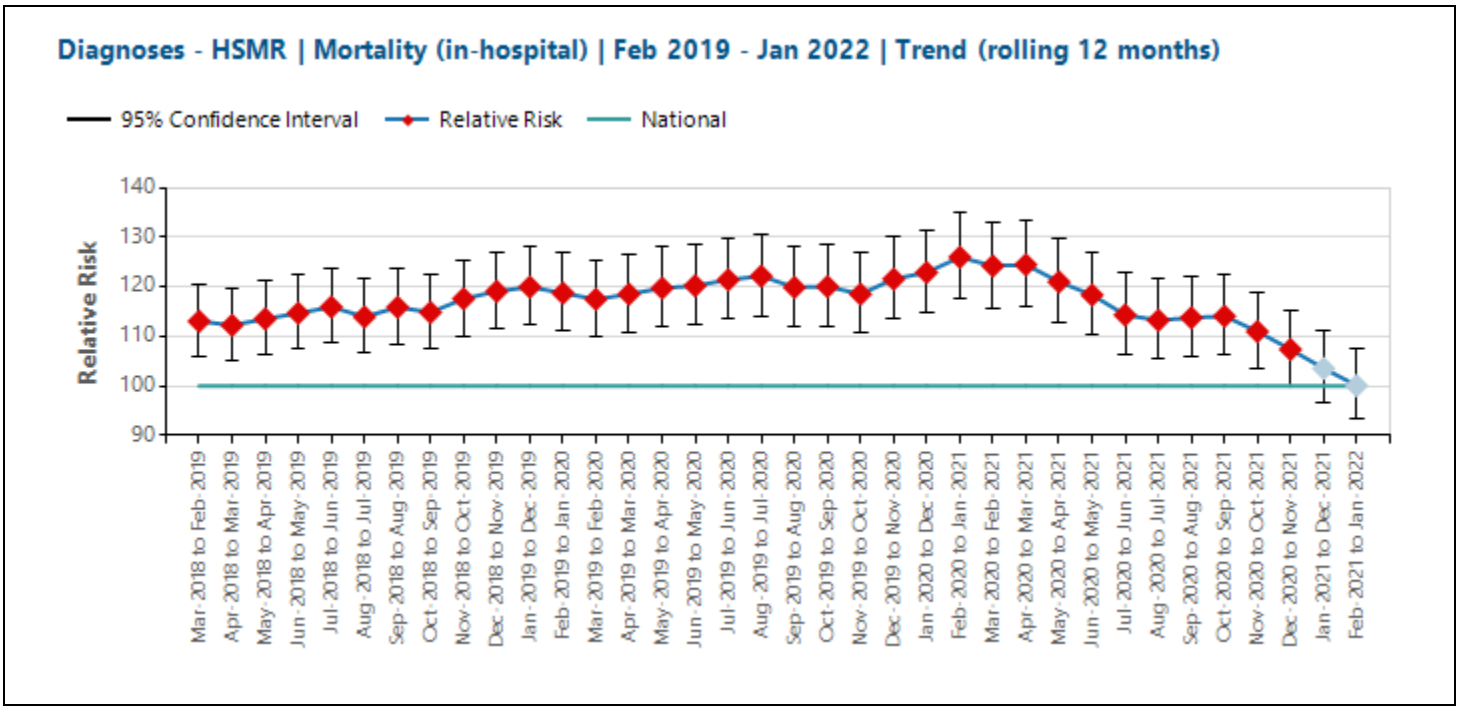


Figure 2.1 – HSMR vs HSMR (Exc. Covid-19) trend (rolling 12 months)

- The HSMR metric doesn't include any patients with a primary diagnosis of Covid-19 (ICD-10 U07) instead these patients are housed in the 'viral infections' diagnosis group that forms part of your SMR (all diagnosis).
- It is however important to note that patients with a Covid-19 code in a secondary position will be included in the HSMR basket.
    - Excluding spells with secondary COVID-19 codes the Trusts HSMR for the period was 95.5 and banded as statistically 'within expected'.
        - For the last available 12 months patients with secondary Covid-19 within the HSMR basket represented 2.0% of admissions (452 super-spells, 79 deaths) at the Trust.
- The following chart shows the rolling 12 month HSMR (excluding Covid-19) to highlight the impact of these patients on the HSMR metric.

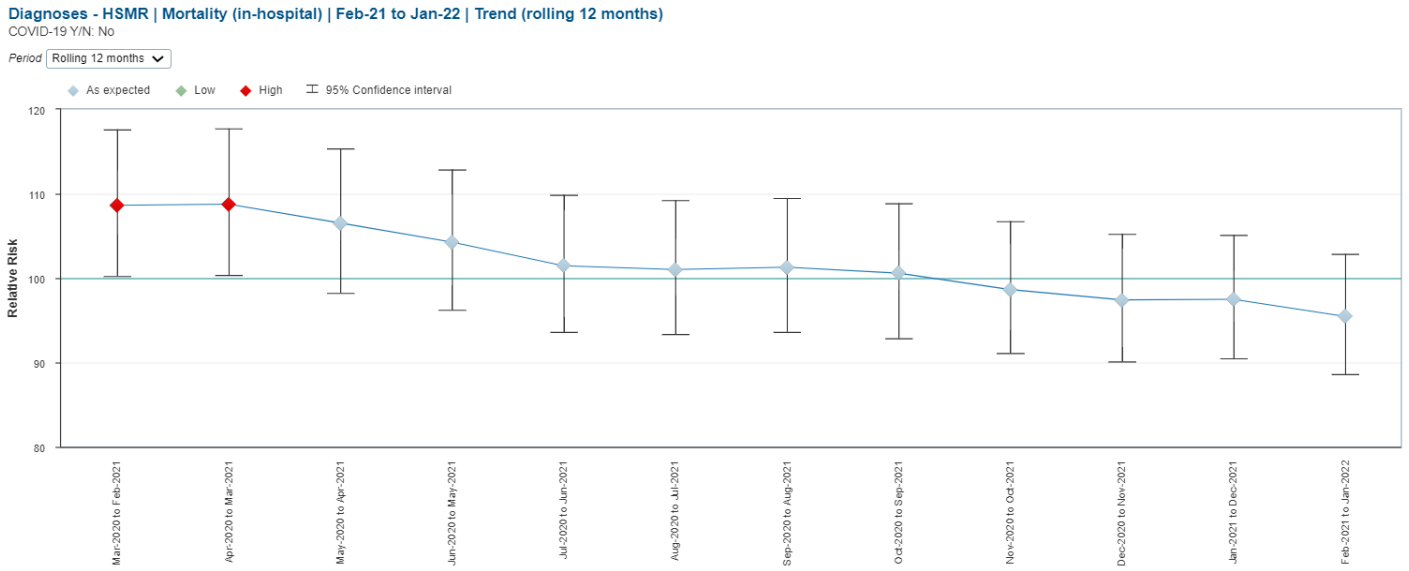
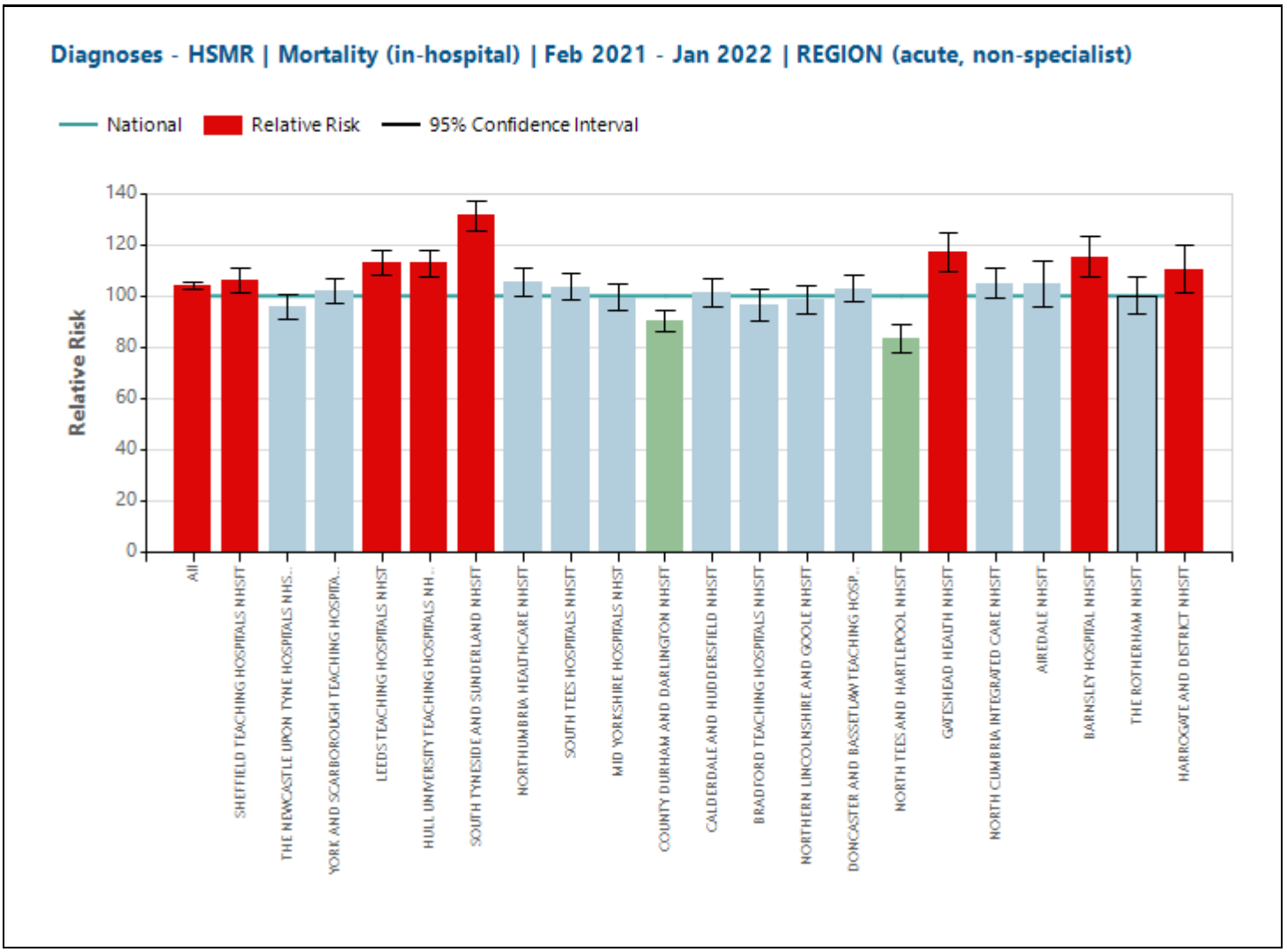


Figure 3 – HSMR 12 Month Peer Comparison



REGION (acute, non-specialist)	Code	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All		876,755	100.0 %	887,620	28,325	3.2 %	27,204.4	3.1 %	1,120.6	104.1	102.9	105.3
SHEFFIELD TEACHING HOSPITALS NHSFT	RHQ	84,580	9.6 %	85,925	1,975	2.3 %	1,862.8	2.2 %	112.2	106.0	101.4	110.8
THE NEWCASTLE UPON TYNE HOSPITALS NHSFT	RTD	70,795	8.1 %	72,840	1,420	2.0 %	1,486.2	2.1 %	-66.2	95.5	90.6	100.6
YORK AND SCARBOROUGH TEACHING HOSPITALS NHSFT	RCB	56,535	6.4 %	57,115	1,710	3.0 %	1,677.7	3.0 %	32.3	101.9	97.2	106.9
LEEDS TEACHING HOSPITALS NHST	RR8	54,045	6.2 %	55,395	2,340	4.3 %	2,075.2	3.8 %	264.8	112.8	108.2	117.4
HULL UNIVERSITY TEACHING HOSPITALS NHST	RWA	52,105	5.9 %	52,805	1,845	3.5 %	1,637.9	3.1 %	207.1	112.6	107.6	117.9
SOUTH TYNESIDE AND SUNDERLAND NHSFT	R0B	51,330	5.9 %	51,680	2,015	3.9 %	1,534.5	3.0 %	480.5	131.3	125.6	137.2
NORTHUMBRIA HEALTHCARE NHSFT	RTF	48,925	5.6 %	49,270	1,525	3.1 %	1,450.4	3.0 %	74.6	105.1	99.9	110.6
SOUTH TEES HOSPITALS NHSFT	RTR	47,485	5.4 %	48,740	1,470	3.1 %	1,420.2	3.0 %	49.8	103.5	98.3	108.9
MID YORKSHIRE HOSPITALS NHST	RXF	44,245	5.0 %	44,680	1,535	3.5 %	1,546.5	3.5 %	-11.5	99.3	94.3	104.4
COUNTY DURHAM AND DARLINGTON NHSFT	RXP	43,405	5.0 %	43,560	1,790	4.1 %	1,987.7	4.6 %	-197.7	90.1	85.9	94.3
CALDERDALE AND HUDDERSFIELD NHSFT	RWY	42,030	4.8 %	42,345	1,325	3.1 %	1,308.5	3.1 %	16.5	101.3	95.9	106.9
BRADFORD TEACHING HOSPITALS NHSFT	RAE	35,645	4.1 %	36,020	900	2.5 %	935.5	2.6 %	-35.5	96.2	90.0	102.7
NORTHERN LINCOLNSHIRE AND GOOLE NHSFT	RJL	34,975	4.0 %	35,085	1,225	3.5 %	1,246.9	3.6 %	-21.9	98.2	92.8	103.9
DONCASTER AND BASSETLAW TEACHING HOSPITALS NHSFT	RP5	33,415	3.8 %	33,640	1,455	4.4 %	1,416.4	4.2 %	38.6	102.7	97.5	108.1
NORTH TEES AND HARTLEPOOL NHSFT	RVW	32,795	3.7 %	32,870	970	3.0 %	1,164.8	3.6 %	-194.8	83.3	78.1	88.7

GATESHEAD HEALTH NHSFT	RR7	25,910	3.0 %	26,145	890	3.4 %	762.4	2.9 %	127.6	**116.7**	109.2	124.7
NORTH CUMBRIA INTEGRATED CARE NHSFT	RNN	25,525	2.9 %	25,595	1,215	4.8 %	1,157.4	4.5 %	57.6	105.0	99.2	111.1
AIREDALE NHSFT	RCF	24,860	2.8 %	25,135	525	2.1 %	502.3	2.0 %	22.7	104.5	95.8	113.8
BARNSLEY HOSPITAL NHSFT	RFF	23,800	2.7 %	24,110	865	3.6 %	750.6	3.1 %	114.4	**115.2**	107.7	123.2
THE ROTHERHAM NHSFT	RFR	22,900	2.6 %	22,944	785	3.4 %	784.4	3.4 %	0.6	100.1	93.2	107.3
HARROGATE AND DISTRICT NHSFT	RCD	21,450	2.4 %	21,720	545	2.5 %	495.5	2.3 %	49.5	**110.0**	100.9	119.6

STANDARDISED MORTALITY RATIO OVERVIEW

Key points

- SMR (all diagnosis) = 96.7 and banded as statistically 'within expected'.
  - Excluding spells with both primary and secondary COVID-19 codes the Trusts SMR for the period was 92.8 and banded as statistically 'lower than expected'.
    - For the last available 12 months patients with either primary or secondary Covid-19 represented 3.0% of admissions (1,951 super-spells, 247 deaths) at the Trust.

Diagnoses | Mortality (in-hospital) | Feb-21 to Jan-22 | COVID-19 Y/N

Analyse by: COVID-19 Y/N Measure: Relative risk Show: All

COVID-19 Y/N	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	66,069	100.0%	66,206	1,103	1.7%	1140.7	1.7%	-37.7	96.7	91.1	102.6
No	64,118	97.0%	64,242	856	1.3%	922.4	1.4%	-66.4	92.8	86.7	99.2
Yes	1,951	3.0%	1,964	247	12.7%	218.2	11.2%	28.8	113.2	99.5	128.2

- The latest month (Jan-22) SMR = 88.5 banded as statistically 'within expected'.
- Crude mortality (all diagnosis) was 1.7% over the 12 month period compared to 1.6% regional average (acute, non-specialist) and 1.6% national average.
- For the 12 month period there were 3 diagnosis groups with a relative risk banded as statistically 'higher than expected':
  - Other upper respiratory disease
  - Syncope
  - Diabetes mellitus with complications *New Alert (11 observed outcomes)
- The Trust is 1 of 13 within the regional peer group with an SMR banded as statistically 'within expected' over the 12 month period.
- If the 12 month SMR values for the regions acute, non-specialist Trusts are ranked (lowest to highest) The Rotherham NHD FT ranks 4th of 21 Trusts.

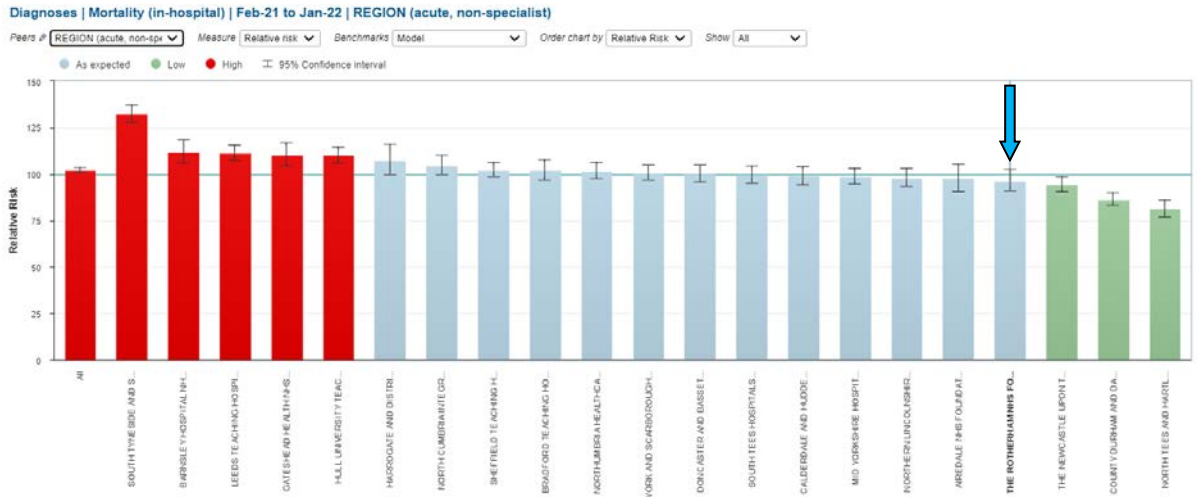


Figure 4 – SMR Monthly Trend

Diagnoses | Mortality (in-hospital) | Feb-21 to Jan-22 | Trend (month)

Analyse by: Trend (month) Measure: Relative risk Show: All

Trend (month)	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	66,069	100.0%	66,206	1,103	1.7%	1140.7	1.7%	-37.7	96.7	91.1	102.6
Feb-21	4,910	7.4%	4,917	109	2.2%	105.3	2.1%	3.7	103.5	85.0	124.9
Mar-21	5,572	8.4%	5,585	100	1.8%	100.3	1.8%	-0.3	99.7	81.1	121.2
Apr-21	5,298	8.0%	5,312	72	1.4%	71.0	1.3%	1.0	101.4	79.3	127.7
May-21	5,466	8.3%	5,475	75	1.4%	76.7	1.4%	-1.7	97.8	77.0	122.6
Jun-21	5,880	8.9%	5,889	72	1.2%	77.3	1.3%	-5.3	93.2	72.9	117.4
Jul-21	5,730	8.7%	5,740	74	1.3%	79.1	1.4%	-5.1	93.6	73.5	117.5
Aug-21	5,558	8.4%	5,568	95	1.7%	88.1	1.6%	6.9	107.8	87.2	131.8
Sep-21	5,962	9.0%	5,975	98	1.6%	88.5	1.5%	9.5	110.8	89.9	135.0
Oct-21	5,704	8.6%	5,725	88	1.5%	104.8	1.8%	-16.8	84.0	67.3	103.5
Nov-21	5,591	8.5%	5,601	116	2.1%	114.4	2.0%	1.6	101.4	83.8	121.6
Dec-21	5,363	8.1%	5,373	102	1.9%	120.0	2.2%	-18.0	85.0	69.3	103.2
Jan-22	5,035	7.6%	5,046	102	2.0%	115.3	2.3%	-13.3	88.5	72.2	107.4

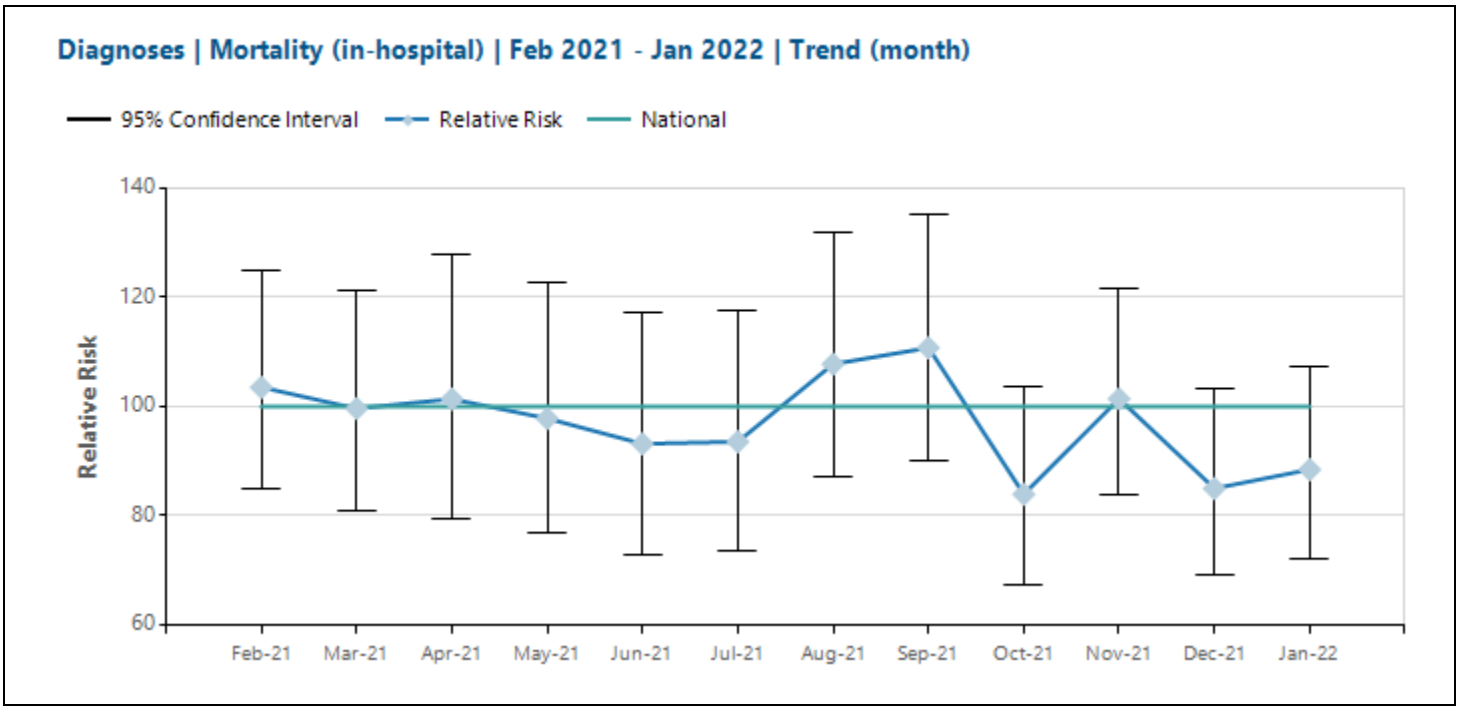
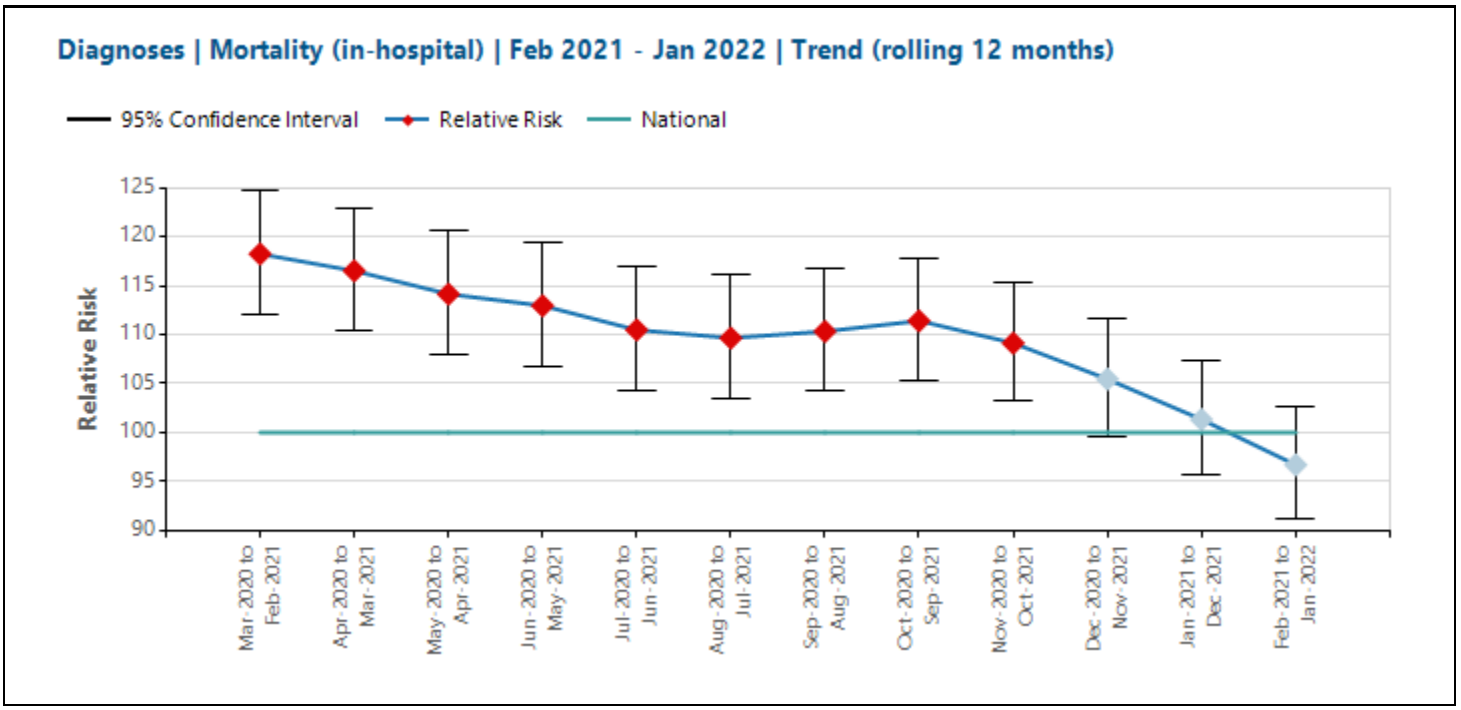

Diagnoses | Mortality (in-hospital) | Feb 2021 - Jan 2022 | Trend (month)
95% Confidence Interval
Relative Risk
National
Relative Risk
140
120
100
80
60
Feb-21
Mar-21
Apr-21
May-21
Jun-21
Jul-21
Aug-21
Sep-21
Oct-21
Nov-21
Dec-21
Jan-22

Figure 5 – SMR All Diagnoses Rolling Trend



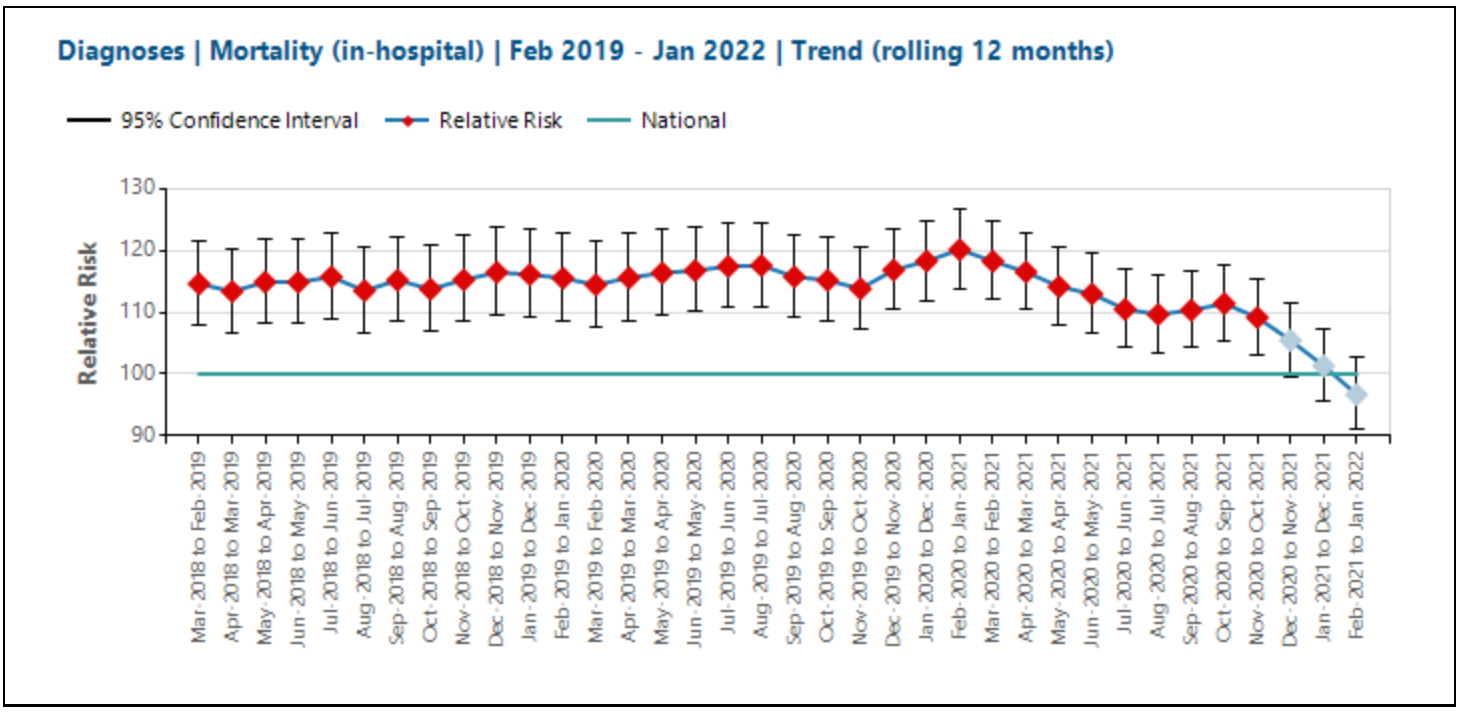
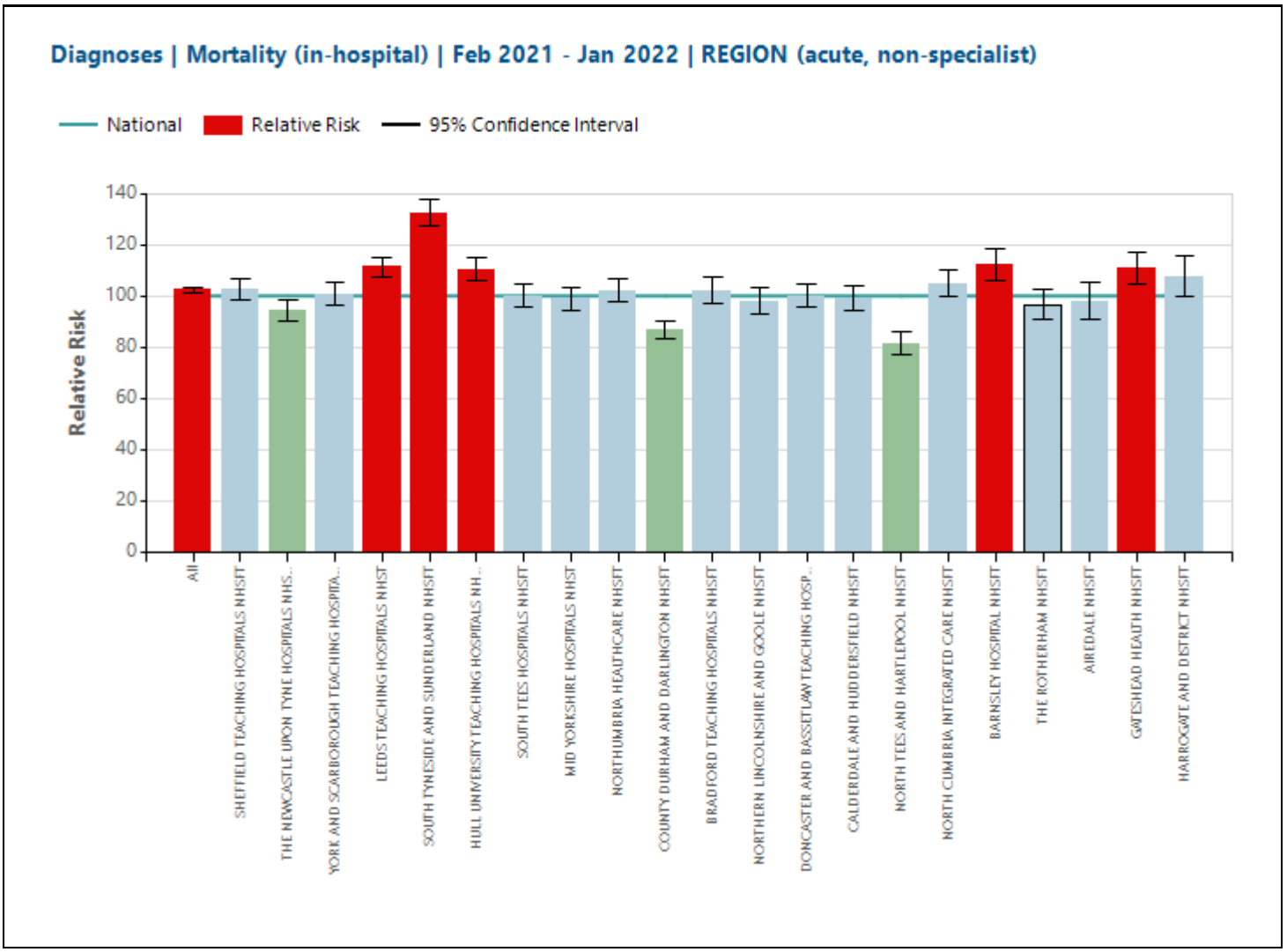


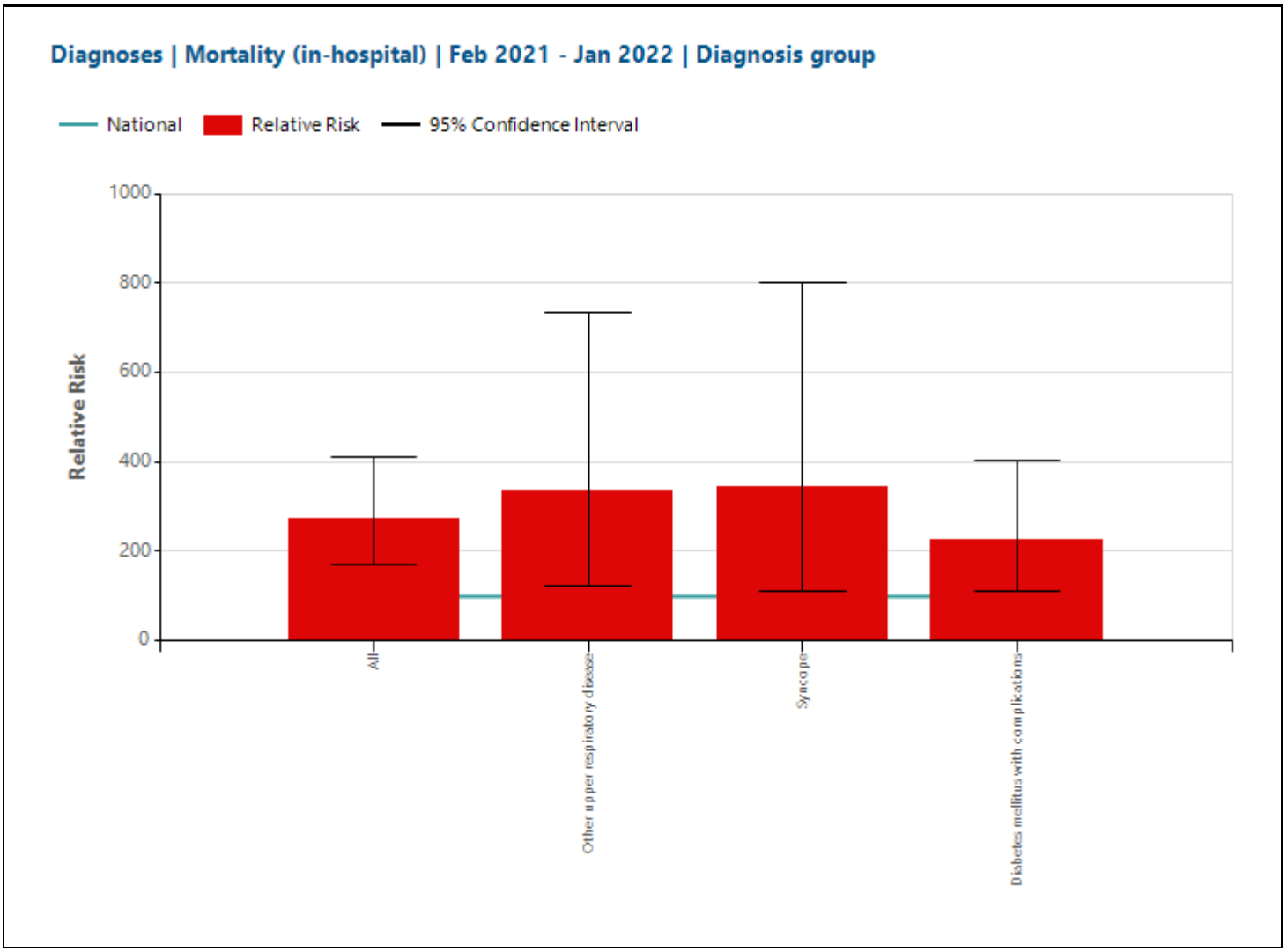
Figure 6 – SMR 12 Month Peer Comparison



REGION (acute, non-specialist)	Code	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All		2,425,830	100.0 %	2,449,195	37,725	1.6 %	36,876.4	1.5 %	848.6	**102.3**	101.3	103.3
SHEFFIELD TEACHING HOSPITALS NHSFT	RHQ	222,295	9.2 %	224,825	2,650	1.2 %	2,588.2	1.2 %	61.8	102.4	98.5	106.4
THE NEWCASTLE UPON TYNE HOSPITALS NHSFT	RTD	208,385	8.6 %	212,960	1,930	0.9 %	2,044.8	1.0 %	-114.8	**94.4**	90.2	98.7
YORK AND SCARBOROUGH TEACHING HOSPITALS NHSFT	RCB	155,900	6.4 %	157,260	2,185	1.4 %	2,168.6	1.4 %	16.4	100.8	96.6	105.1
LEEDS TEACHING HOSPITALS NHST	RR8	153,040	6.3 %	155,930	3,105	2.0 %	2,789.9	1.8 %	315.1	**111.3**	107.4	115.3
SOUTH TYNESIDE AND SUNDERLAND NHSFT	R0B	140,530	5.8 %	141,465	2,815	2.0 %	2,125.1	1.5 %	689.9	**132.5**	127.6	137.5
HULL UNIVERSITY TEACHING HOSPITALS NHST	RWA	136,450	5.6 %	138,060	2,395	1.8 %	2,171.7	1.6 %	223.3	**110.3**	105.9	114.8
SOUTH TEES HOSPITALS NHSFT	RTR	133,115	5.5 %	135,295	1,900	1.4 %	1,903.3	1.4 %	-3.3	99.8	95.4	104.4
MID YORKSHIRE HOSPITALS NHST	RXF	132,215	5.5 %	133,535	2,105	1.6 %	2,130.5	1.6 %	-25.5	98.8	94.6	103.1
NORTHUMBRIA HEALTHCARE NHSFT	RTF	131,105	5.4 %	131,835	2,045	1.6 %	2,006.3	1.5 %	38.7	101.9	97.6	106.4
COUNTY DURHAM AND DARLINGTON NHSFT	RXP	115,710	4.8 %	116,160	2,355	2.0 %	2,721.9	2.4 %	-366.9	**86.5**	83.1	90.1
BRADFORD TEACHING HOSPITALS NHSFT	RAE	114,475	4.7 %	115,545	1,360	1.2 %	1,331.3	1.2 %	28.7	102.2	96.8	107.7
NORTHERN LINCOLNSHIRE AND GOOLE NHSFT	RJL	108,725	4.5 %	109,020	1,570	1.4 %	1,602.3	1.5 %	-32.3	98.0	93.2	103.0
DONCASTER AND BASSETLAW TEACHING HOSPITALS NHSFT	RP5	108,420	4.5 %	108,840	1,870	1.7 %	1,868.4	1.7 %	1.6	100.1	95.6	104.7
CALDERDALE AND HUDDERSFIELD NHSFT	RWY	105,320	4.3 %	105,895	1,735	1.6 %	1,750.0	1.7 %	-15.0	99.1	94.5	103.9
NORTH TEES AND HARTLEPOOL NHSFT	RVW	83,030	3.4 %	83,250	1,240	1.5 %	1,522.3	1.8 %	-282.3	**81.5**	77.0	86.1

NORTH CUMBRIA INTEGRATED CARE NHSFT	RNN	71,310	2.9 %	71,515	1,585	2.2 %	1,513.7	2.1 %	71.3	104.7	99.6	110.0
BARNSLEY HOSPITAL NHSFT	RFF	67,690	2.8 %	68,275	1,240	1.8 %	1,106.4	1.6 %	133.6	**112.1**	105.9	118.5
THE ROTHERHAM NHSFT	RFR	66,069	2.7 %	66,206	1,103	1.7 %	1,140.7	1.7 %	-37.7	96.7	91.1	102.6
AIREDALE NHSFT	RCF	60,305	2.5 %	60,710	675	1.1 %	690.3	1.1 %	-15.3	97.8	90.6	105.4
GATESHEAD HEALTH NHSFT	RR7	59,590	2.5 %	60,030	1,160	1.9 %	1,048.8	1.8 %	111.2	**110.6**	104.3	117.2
HARROGATE AND DISTRICT NHSFT	RCD	52,155	2.2 %	52,585	700	1.3 %	650.7	1.2 %	49.3	107.6	99.8	115.9

Figure 7 – SMR Statistically Significant Diagnosis Groups



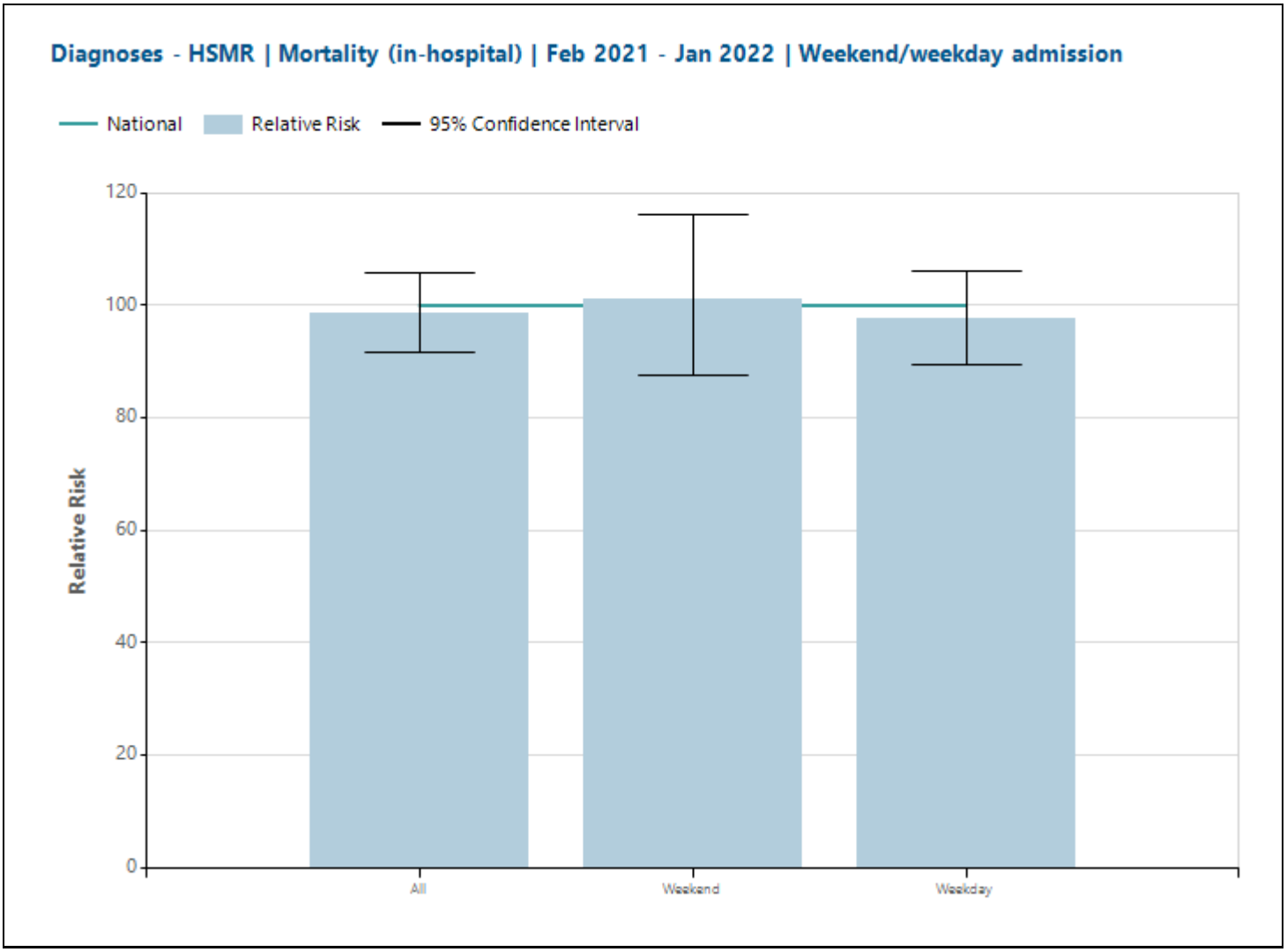
Diagnosis group	Code	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All		959	100.0 %	963	22	2.3 %	8.1	0.8 %	13.9	**271.2**	169.9	410.6
Other upper respiratory disease	134	470	49.0 %	473	6	1.3 %	1.8	0.4 %	4.2	**337.4**	123.2	734.4
Syncope	245	288	30.0 %	289	5	1.7 %	1.5	0.5 %	3.5	**344.2**	110.9	803.2
Diabetes mellitus with complications	50	201	21.0 %	201	11	5.5 %	4.9	2.4 %	6.1	**225.3**	112.3	403.2

HSMR WEEKEND/WEEKDAY ANALYSIS

Key points

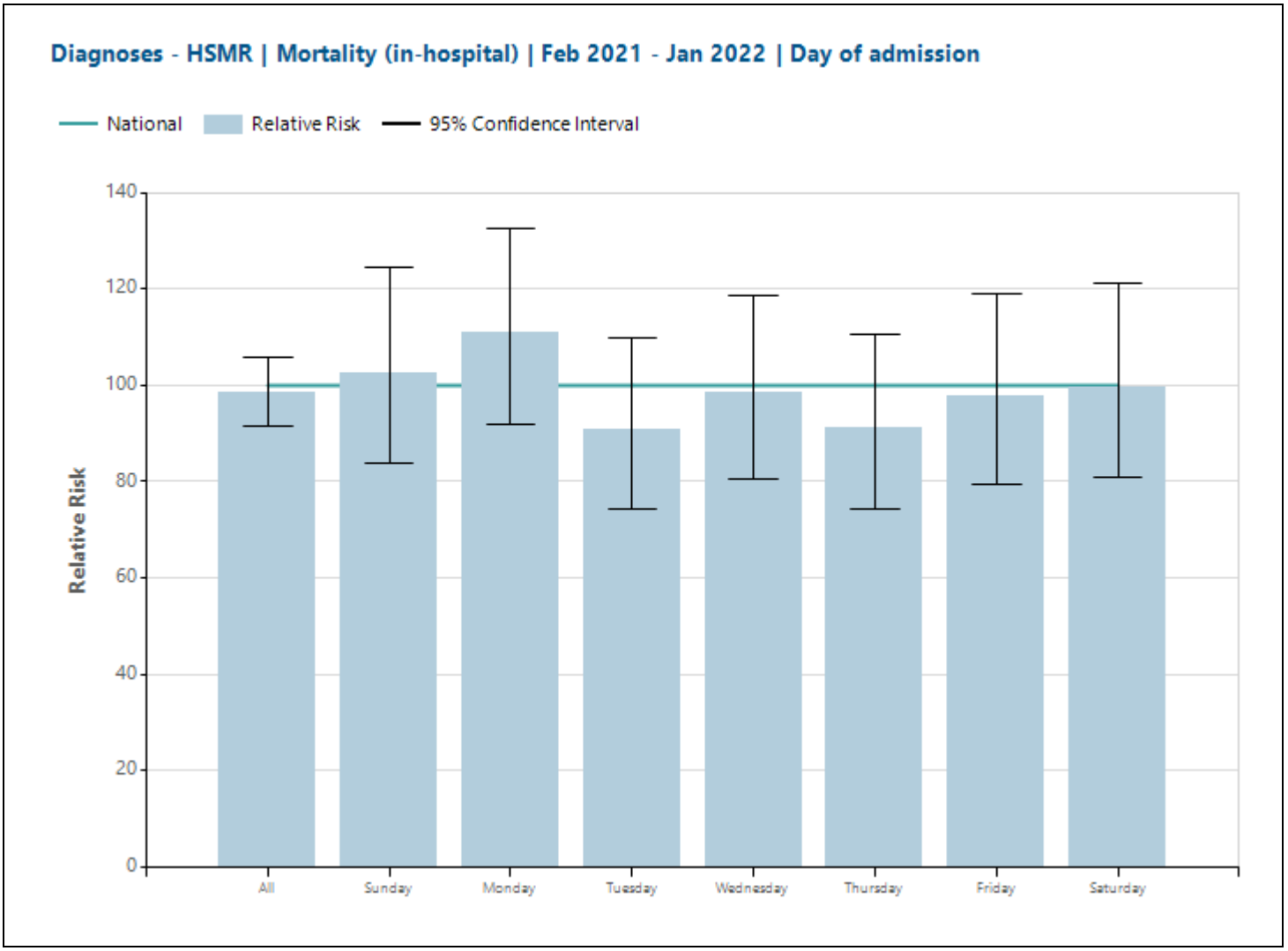
- For the 12 month period Weekend (emergency) HSMR = 101.1 banded as statistically 'within expected'.
- For the 12 month period Weekday (emergency) HSMR = 97.6 banded as statistically 'within expected'.

Figure 8 – HSMR Weekend/Weekday Admissions Emergency only



Weekend/weekday admission	Code	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All		13,956	100.0 %	13,969	737	5.3 %	748.0	5.4 %	-11.0	98.5	91.5	105.9
Weekend	1	3,289	23.6 %	3,290	203	6.2 %	200.8	6.1 %	2.2	101.1	87.7	116.0
Weekday	2	10,667	76.4 %	10,679	534	5.0 %	547.2	5.1 %	-13.2	97.6	89.5	106.2

Figure 9 – HSMR Day of admission - Emergency only



Day of admission	Code	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All		13,956	100.0 %	13,969	737	5.3 %	748.0	5.4 %	-11.0	98.5	91.5	105.9
Sunday	1	1,564	11.2 %	1,565	103	6.6 %	100.4	6.4 %	2.6	102.6	83.7	124.4
Monday	2	2,135	15.3 %	2,137	119	5.6 %	107.4	5.0 %	11.6	110.8	91.7	132.5
Tuesday	3	2,150	15.4 %	2,151	106	4.9 %	116.7	5.4 %	-10.7	90.8	74.4	109.9
Wednesday	4	2,145	15.4 %	2,148	107	5.0 %	108.9	5.1 %	-1.9	98.3	80.6	118.8
Thursday	5	2,118	15.2 %	2,118	103	4.9 %	112.9	5.3 %	-9.9	91.2	74.4	110.6
Friday	6	2,119	15.2 %	2,125	99	4.7 %	101.3	4.8 %	-2.3	97.8	79.5	119.0
Saturday	7	1,725	12.4 %	1,725	100	5.8 %	100.4	5.8 %	-0.4	99.6	81.0	121.1

Key points

- The proportion of both non-elective spells within the HSMR basket coded as receiving specialist palliative care is above the regional average but slightly below the national averages for this the 12 month period.
- The proportion of non-elective spells with a 0 comorbidity score within the HSMR basket (40.8%) is below the national average (40.6%) is marginally above the regional average (40%) and below the national average (41.4%).
- The proportion of non-elective spells with a 20+ comorbidity score within the HSMR basket (18%) is above the regional average (15.8%) and national average (15.7%).

Figure 10 – Palliative Care Coding Rate Vs National

Trend (financial year)	Non-elective spells	Palliative care	Rate	National Rate	Peer Group Rate
2017/2018	26,357	428	1.62%	1.99%	1.96%
2018/2019	31,232	734	2.35%	2.07%	2.05%
2019/2020	29,165	678	2.32%	2.18%	2.21%
2020/2021	37,334	705	1.89%	2.60%	2.58%
2021/2022	36,835	743	2.02%	2.26%	2.19%

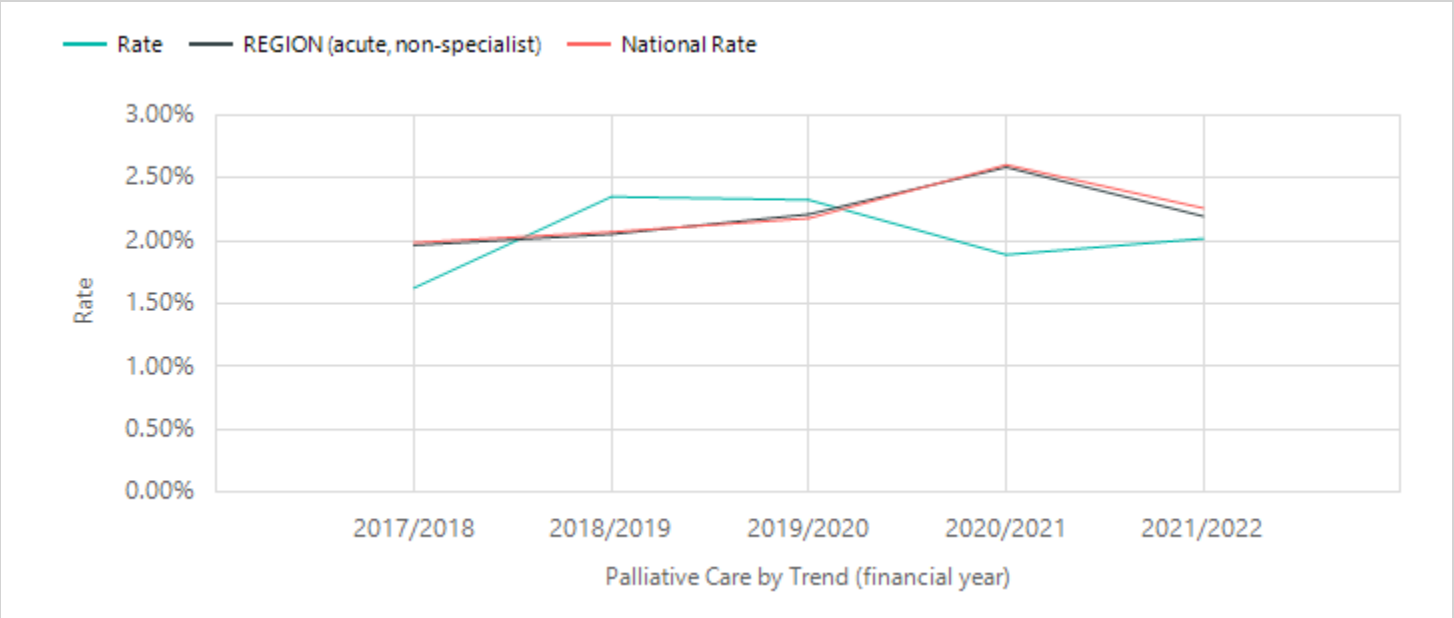


Figure 11 – HSMR and Influencers

Performance	Trust	Peer	National
HSMR	100.1	104.1	97.6
SMR	96.7	102.3	96.6
Non-elective (HSMR)	98.8	103.6	97.2
Weekday, emergency (HSMR)	97.6	102.3	95.5
Weekend, emergency (HSMR)	101.1	108.4	102.0
Saturday, emergency (HSMR)	99.6	107.3	101.7
Sunday, emergency (HSMR)	102.6	109.6	102.2
Coding / Casemix	**Trust**	**Peer**	**National**
% Non-elective deaths with palliative care (HSMR)	38.6%	35.4%	39.2%
% Non-elective spells with palliative care (HSMR)	4.3%	4.5%	4.9%
% Spells in Symptoms & Signs chapter	10.9%	5.5%	6.5%
% Non-elective spells with Charlson comorbidity score = 0 (HSMR)	40.6%	40.0%	41.4%
% Non-elective spells with Charlson comorbidity score = 20+ (HSMR)	18.0%	15.8%	15.7%
% Non-elective spells in Risk Band (0-10%) (HSMR)	85.5%	84.5%	84.4%

Figure 12 – Palliative Care Coding (Palliative Observed Mortality v Superspell Count)

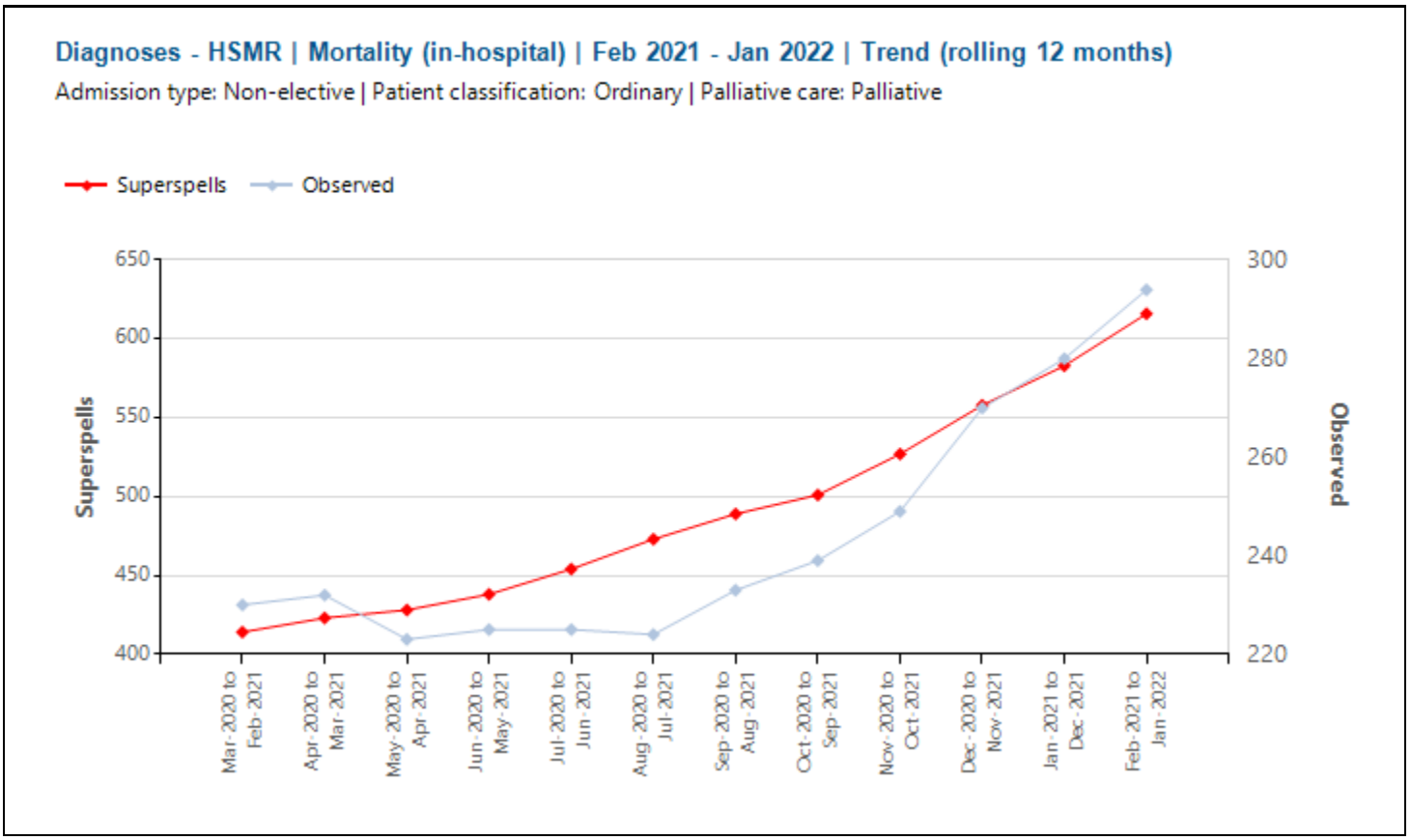


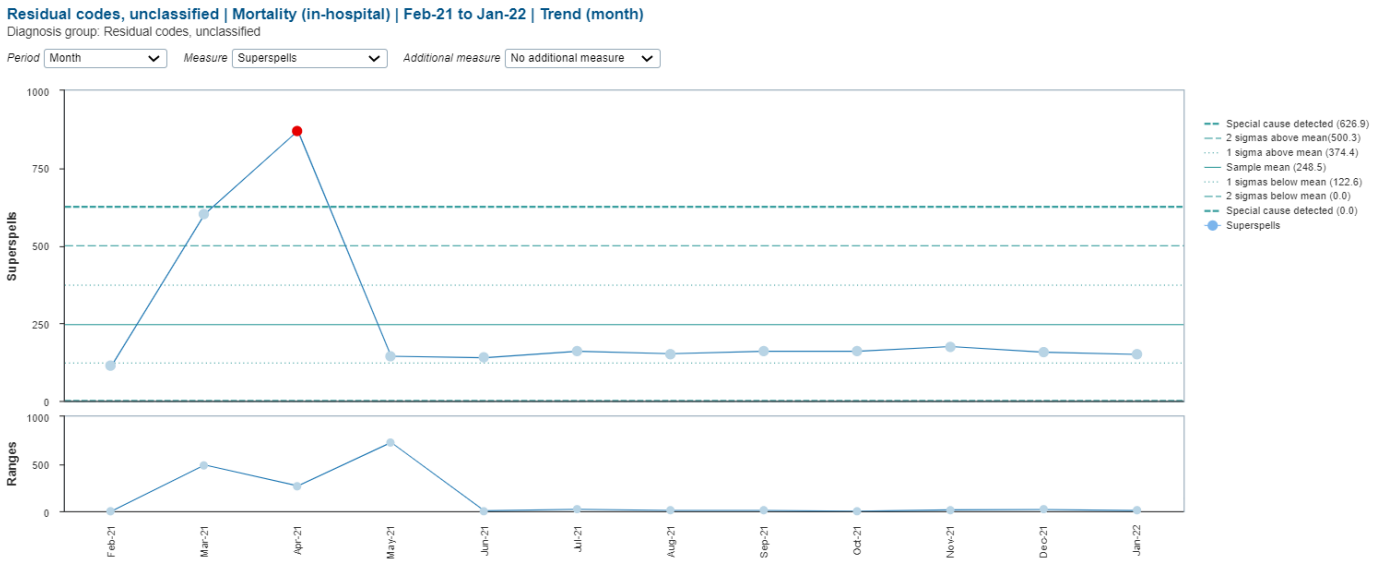
Figure 13 – Charlson Index Co-morbidity Coding Rates Vs National

Vol	Mean number of codes				
21/22	21/22	20/21	*England Mar 21 - Feb 22*		
Mar-Feb	Mar-Feb	Mar-Feb	*P25*	*P50*	*P75*
66,888	**6.2**	6.0	**3.1**	**4.3**	**5.1**

Vol	No codes (%)				
21/22	21/22	20/21	*England Mar 21 - Feb 22*		
Mar-Feb	Mar-Feb	Mar-Feb	*P25*	*P50*	*P75*
66,888	**13.2%**	8.9%	**10.7%**	**14.7%**	**24.2%**

Vol	No comorbidity (%)				
21/22	21/22	20/21	*England Mar 21 - Feb 22*		
Mar-Feb	Mar-Feb	Mar-Feb	*P25*	*P50*	*P75*
66,888	**60.0%**	60.7%	**60.2%**	**65.9%**	**78.2%**

Figure 13.5 – SPC, volume (super-spells) within the 'Residual Codes, unclassified' diagnosis group.

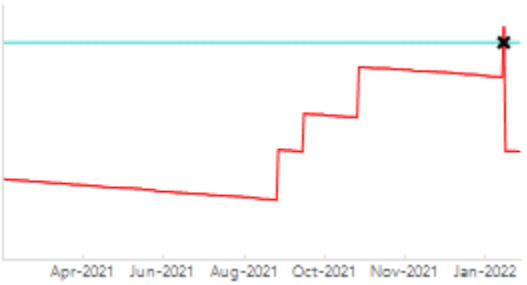
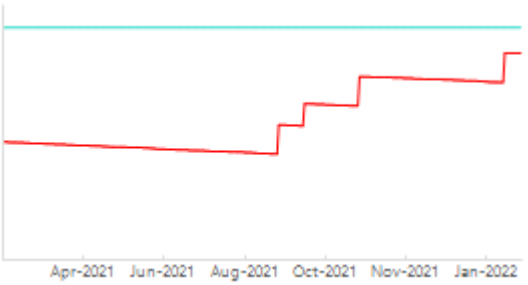
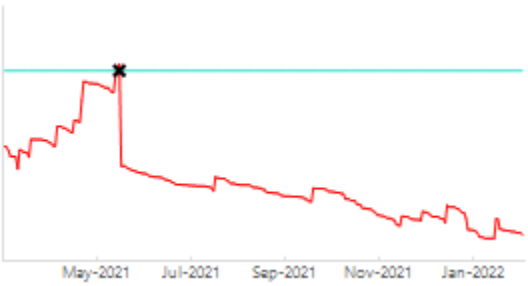
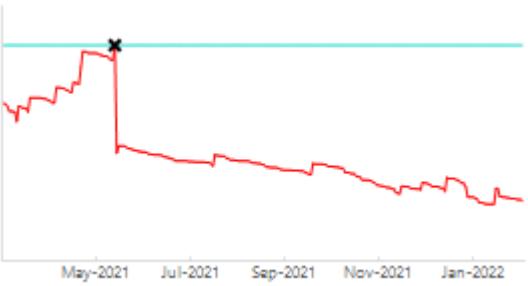
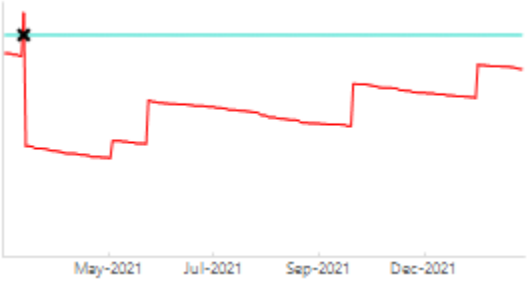
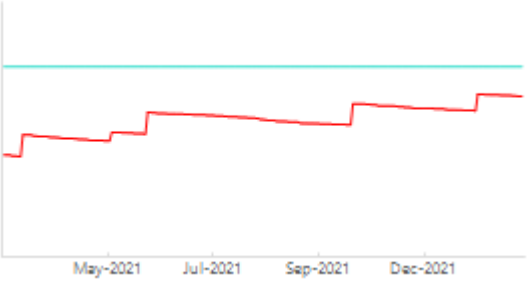
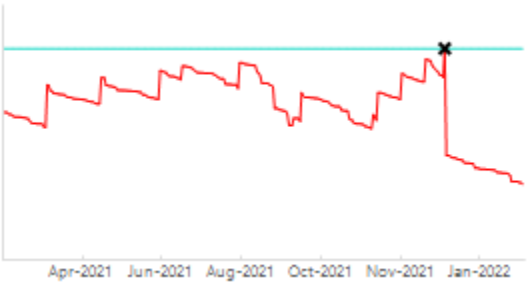
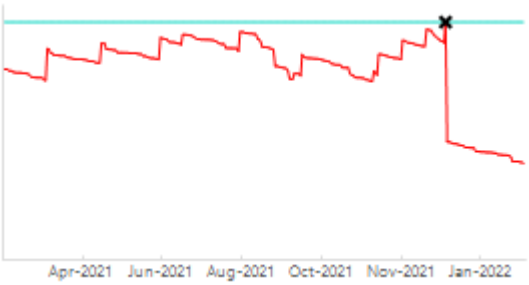


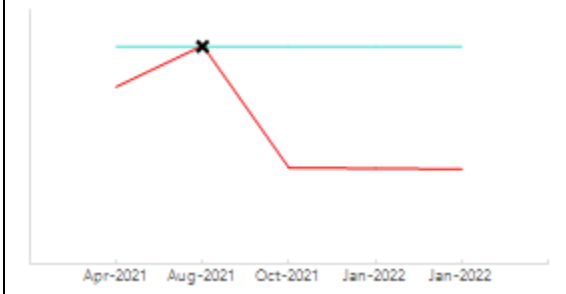
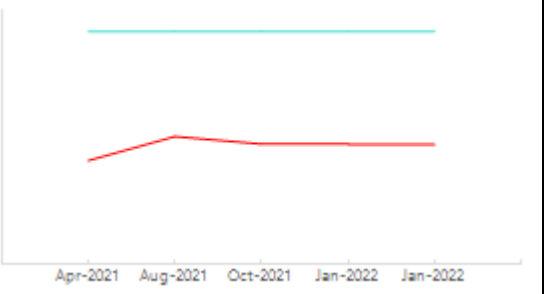
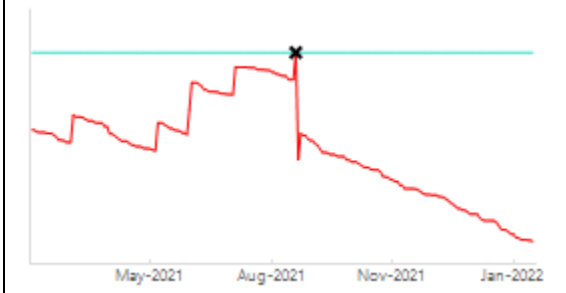
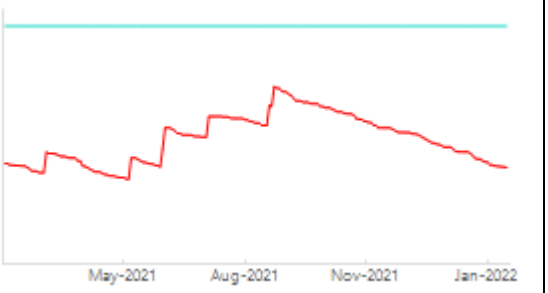
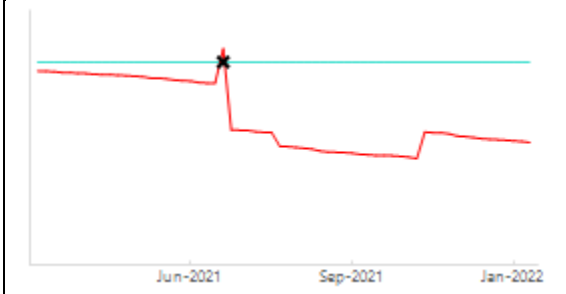
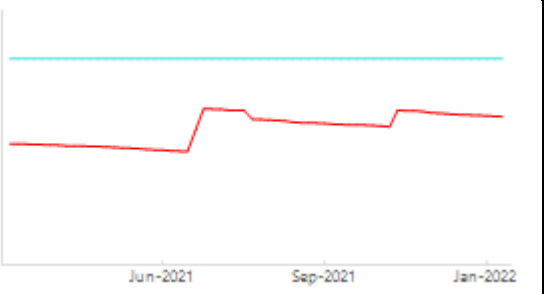
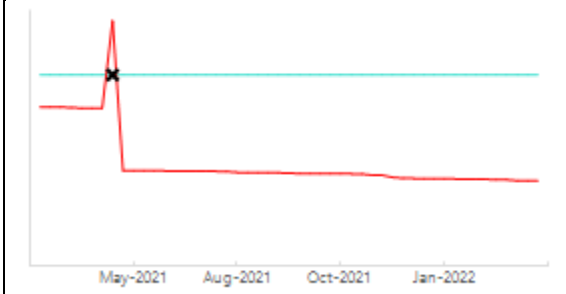
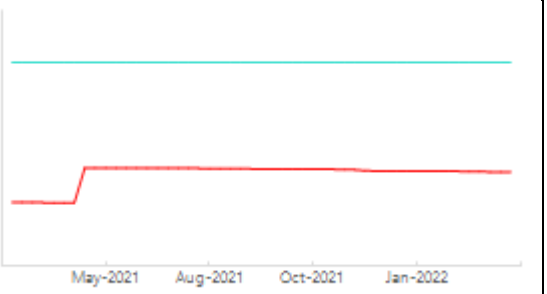
CUSUM ALERTS

Key points

- Over the 12 month period there were 9 CUSUM alerts (using 99% detection threshold criteria) in the following diagnosis groups:
    - Nonspecific chest pain *New Alert in Jan-22
    - Acute bronchitis
    - Other upper respiratory disease
    - Biliary tract disease
    - Liver disease, alcohol-related
    - Nervous system congenital anomalies
    - Other perinatal conditions
    - Other psychoses
    - Anxiety, somatoform, dissociative, and personality disorders

Figure 14 – Relative Risk and CUSUM Alerts (Feb 2021 - Jan 2022)

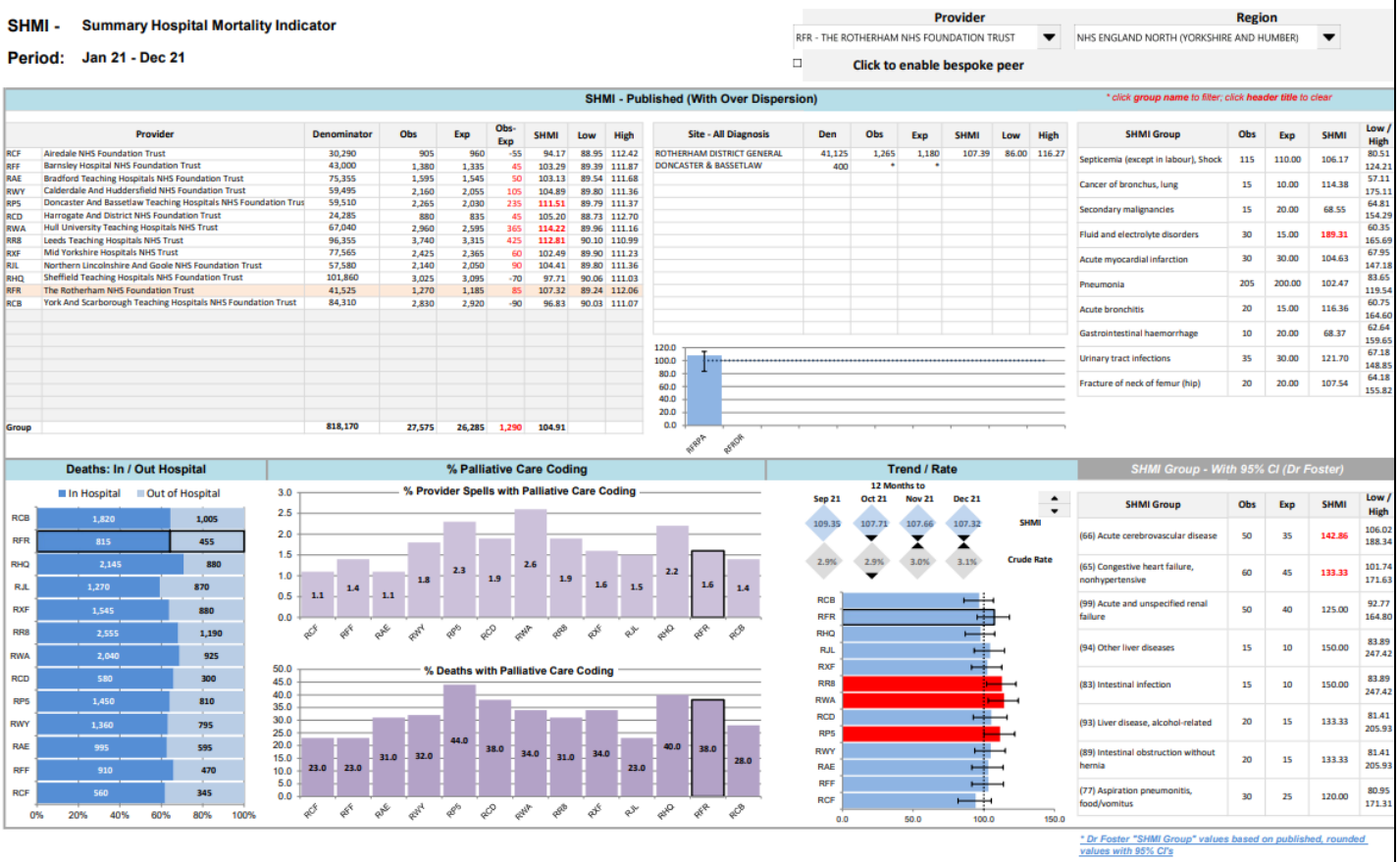
	99% Detection Threshold	99.9% Detection Threshold
Nonspecific chest pain		
Acute bronchitis		
Other upper respiratory disease		
Biliary tract disease		

Liver disease, alcohol-related		
Nervous system congenital anomalies		
Other perinatal conditions		
Other psychoses		
Anxiety, somatoform, dissociative, and personality disorders		

Key points

Time period: January 2021 to December 2021.

- SHMI for The Rotherham NHS FT = 107.32 banded as statistically 'within expected' using the 95% control limits (adjusted for over dispersion) published by NHS digital.
- During the 12 month period there were 815 in-hospital deaths and 455 out of hospital deaths (within 30 days of discharge) recorded within the SHMI.
- The Trust is one of 10 within the NHS England North (Yorkshire and Humber) region with a SHMI banded in the statistically 'within expected' range.
- Of the SHMI diagnosis groups banded by NHS digital (using 95% control limits adjusted for over dispersion) there was a single outlying group:
    - Fluid and electrolyte disorders (30 observed deaths, 15 predicted by the modelling).



Diabetes mellitus with complications diagnosis group

- 201 super-spells over the 12 month period and 11 deaths (4.9 'expected' by the modelling). Relative risk of mortality = 225.9 banded as statistically 'higher than expected'.

Admission type

Diabetes mellitus with complications | Mortality (in-hospital) | Feb-21 to Jan-22 | Admission type

Diagnosis group: Diabetes mellitus with complications

Analyse by Admission type *Measure* Relative risk *Show* All

Admission type	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	201	100.0%	201	11	5.5%	4.9	2.4%	6.1	225.3	112.3	403.2
Non-elective	198	98.5%	198	11	5.6%	4.9	2.5%	6.1	225.9	112.6	404.2
Elective	3	1.5%	3	0	0.0%	0.0	0.4%	-0.0	0.0	0.0	30903.2

Trend (month)

Diabetes mellitus with complications | Mortality (in-hospital) | Feb-21 to Jan-22 | Trend (month)

Diagnosis group: Diabetes mellitus with complications

Analyse by Trend (month) *Measure* Relative risk *Show* All

Trend (month)	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	201	100.0%	201	11	5.5%	4.9	2.4%	6.1	225.3	112.3	403.2
Feb-21	11	5.5%	11	0	0.0%	0.3	2.8%	-0.3	0.0	0.0	1208.7
Mar-21	10	5.0%	10	0	0.0%	0.2	1.5%	-0.2	0.0	0.0	2368.8
Apr-21	12	6.0%	12	1	8.3%	0.8	6.3%	0.2	133.1	1.7	740.8
May-21	19	9.5%	19	0	0.0%	0.3	1.5%	-0.3	0.0	0.0	1324.7
Jun-21	18	9.0%	18	0	0.0%	0.3	1.7%	-0.3	0.0	0.0	1210.5
Jul-21	12	6.0%	12	0	0.0%	0.2	2.0%	-0.2	0.0	0.0	1512.6
Aug-21	16	8.0%	16	1	6.3%	0.2	1.4%	0.8	436.7	5.7	2429.8
Sep-21	23	11.4%	23	4	17.4%	0.7	2.9%	3.3	608.7	163.8	1558.3
Oct-21	21	10.4%	21	2	9.5%	0.8	3.7%	1.2	258.1	29.0	931.8
Nov-21	20	10.0%	20	0	0.0%	0.3	1.3%	-0.3	0.0	0.0	1368.4
Dec-21	24	11.9%	24	1	4.2%	0.7	3.0%	0.3	140.2	1.8	780.0
Jan-22	15	7.5%	15	2	13.3%	0.2	1.4%	1.8	964.7	108.3	3482.9

Specialty of diagnosis

Diabetes mellitus with complications | Mortality (in-hospital) | Feb-21 to Jan-22 | Specialty (of diagnosis)

Diagnosis group: Diabetes mellitus with complications

Analyse by Specialty (of diagnosis) *Measure* Relative risk *Show* All

Specialty (of diagnosis)	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	201	100.0%	201	11	5.5%	4.9	2.4%	6.1	225.3	112.3	403.2
ACUTE INTERNAL MEDICINE	160	79.6%	160	9	5.6%	4.0	2.5%	5.0	227.7	103.9	432.3
GENERAL MEDICINE	19	9.5%	19	0	0.0%	0.4	2.1%	-0.4	0.0	0.0	937.4
PAEDIATRICS	7	3.5%	7	0	0.0%	0.0	0.1%	-0.0	0.0	0.0	91234.6
RESPIRATORY MEDICINE (also known as thorac…	6	3.0%	6	1	16.7%	0.5	7.5%	0.5	221.5	2.9	1232.6
TRAUMA & ORTHOPAEDICS	3	1.5%	3	0	0.0%	0.1	2.2%	-0.1	0.0	0.0	5569.1
GENERAL SURGERY	2	1.0%	2	0	0.0%	0.0	0.1%	-0.0	0.0	0.0	2.11e+5
CARDIOLOGY	1	0.5%	1	0	0.0%	0.0	0.7%	-0.0	0.0	0.0	51714.9
ENDOCRINOLOGY	1	0.5%	1	0	0.0%	0.0	0.3%	-0.0	0.0	0.0	1.46e+5
GERIATRIC MEDICINE	1	0.5%	1	1	100.0%	0.0	0.5%	1.0	18436.2	241.0	1.03e+5
OPHTHALMOLOGY	1	0.5%	1	0	0.0%	0.0	0.0%	-	-	-	-

Primary Diagnosis (ICD-10)

Diabetes mellitus with complications | Mortality (in-hospital) | Feb-21 to Jan-22 | ICD10 (3-char)

Diagnosis group: Diabetes mellitus with complications

Analyse by ICD10 (3-char) *Measure* Relative risk *Show* All

ICD10 (3-char)	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	201	100.0%	201	11	5.5%	4.9	2.4%	6.1	225.3	112.3	403.2
E11 Type 2 diabetes mellitus	105	52.2%	105	7	6.7%	3.8	3.6%	3.2	184.3	73.8	379.8
E10 Type 1 diabetes mellitus	92	45.8%	92	4	4.3%	1.0	1.0%	3.0	414.6	111.5	1061.4
E14 Unspecified diabetes mellitus	3	1.5%	3	0	0.0%	0.0	1.3%	-0.0	0.0	0.0	9309.9
E13 Other specified diabetes mellitus	1	0.5%	1	0	0.0%	0.1	8.0%	-0.1	0.0	0.0	4580.7

Covid-19 (secondary diagnosis)

Diabetes mellitus with complications | Mortality (in-hospital) | Feb-21 to Jan-22 | COVID-19 Y/N

Diagnosis group: Diabetes mellitus with complications

Analyse by: COVID-19 Y/N Measure: Relative risk Show: All

COVID-19 Y/N	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	201	100.0%	201	11	5.5%	4.9	2.4%	6.1	225.3	112.3	403.2
No	183	91.0%	183	5	2.7%	4.1	2.2%	0.9	121.7	39.2	284.0
Yes	18	9.0%	18	6	33.3%	0.8	4.3%	5.2	775.7	283.3	1688.4

Age profile (bands)

Diabetes mellitus with complications | Mortality (in-hospital) | Feb-21 to Jan-22 | Age (broad bands)

Diagnosis group: Diabetes mellitus with complications

Analyse by: Age (broad bands) Measure: Relative risk Show: All

Age (broad bands)	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	201	100.0%	201	11	5.5%	4.9	2.4%	6.1	225.3	112.3	403.2
0-17	9	4.5%	9	0	0.0%	0.0	0.1%	-0.0	0.0	0.0	81161.6
18-29	25	12.4%	25	0	0.0%	0.0	0.1%	-0.0	0.0	0.0	22640.8
30-49	46	22.9%	46	1	2.2%	0.2	0.4%	0.8	519.2	6.8	2888.9
50-64	60	29.9%	60	4	6.7%	1.0	1.7%	3.0	399.9	107.6	1023.9
65-74	24	11.9%	24	2	8.3%	0.6	2.3%	1.4	361.3	40.6	1304.6
75-84	26	12.9%	26	3	11.5%	2.2	8.3%	0.8	138.8	27.9	405.6
85+	11	5.5%	11	1	9.1%	1.0	8.7%	0.0	104.9	1.4	583.6

Comorbidity profile (score)

Diabetes mellitus with complications | Mortality (in-hospital) | Feb-21 to Jan-22 | Comorbidity score

Diagnosis group: Diabetes mellitus with complications

Analyse by: Comorbidity score Measure: Relative risk Show: All

Comorbidity score	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	201	100.0%	201	11	5.5%	4.9	2.4%	6.1	225.3	112.3	403.2
0 (none)	87	43.3%	87	3	3.4%	0.5	0.5%	2.5	663.3	133.3	1938.0
3	2	1.0%	2	0	0.0%	0.0	0.4%	-0.0	0.0	0.0	46419.1
4	22	10.9%	22	1	4.5%	0.2	0.9%	0.8	503.4	6.6	2801.0
5	10	5.0%	10	1	10.0%	0.1	1.1%	0.9	928.8	12.1	5167.7
6-9	22	10.9%	22	1	4.5%	0.4	2.0%	0.6	229.0	3.0	1274.3
10-19	32	15.9%	32	4	12.5%	1.4	4.2%	2.6	295.5	79.5	756.7
20-49	26	12.9%	26	1	3.8%	2.3	8.9%	-1.3	43.0	0.6	239.3

Diagnosis group on discharge

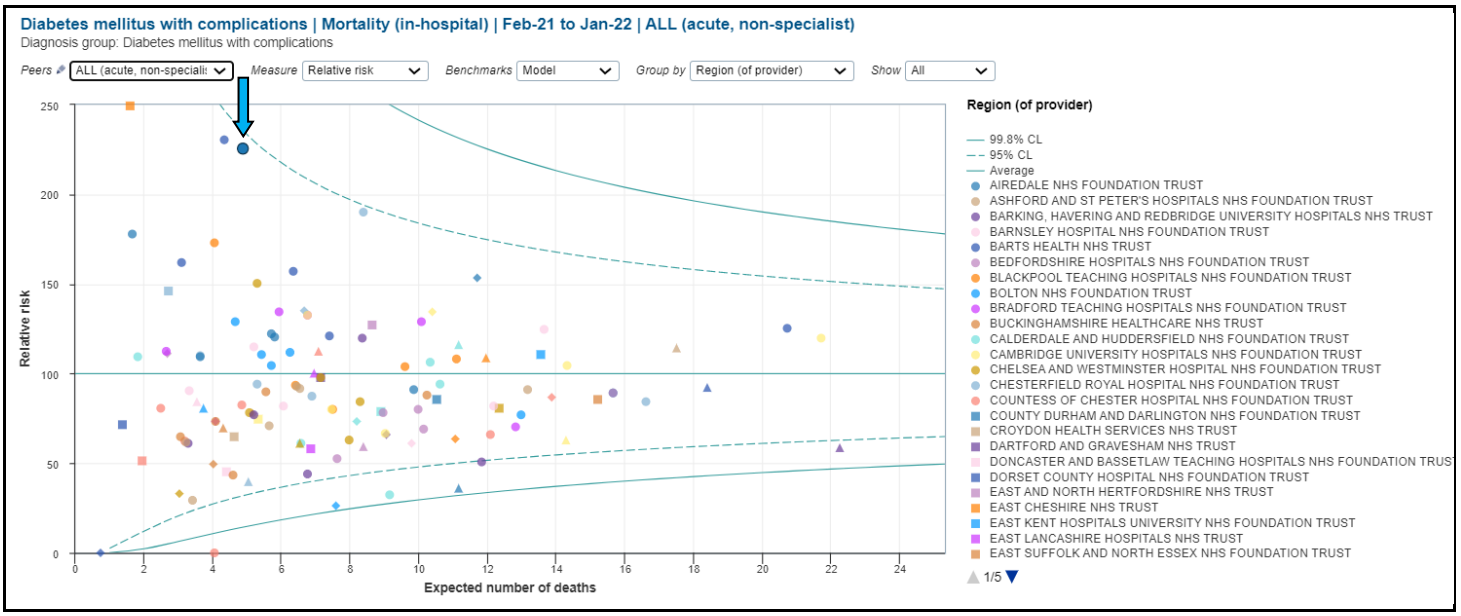
Diabetes mellitus with complications | Mortality (in-hospital) | Feb-21 to Jan-22 | Diagnosis group (discharge)

Diagnosis group: Diabetes mellitus with complications

Analyse by: Diagnosis group (discha Measure: Relative risk Show: All

Diagnosis group (discharge)	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	H
All	201	100.0%	201	11	5.5%	4.9	2.4%	6.1	225.3	112.3	403.2
Diabetes mellitus with complications	179	89.1%	179	8	4.5%	4.5	2.5%	3.5	177.4	76.4	349.6
Gastrointestinal haemorrhage	1	0.5%	1	1	100.0%	0.0	3.1%	1.0	3206.1	41.9	17838.2
Infective arthritis and osteomyelitis	6	3.0%	6	1	16.7%	0.1	1.9%	0.9	874.0	11.4	4862.7
Respiratory failure, insufficiency, arrest (adult)	1	0.5%	1	1	100.0%	0.0	0.2%	1.0	42428.7	554.5	2.36e+5
Acute and unspecified renal failure	1	0.5%	1	0	0.0%	0.0	0.8%	-0.0	0.0	0.0	46479.4
Acute cerebrovascular disease	1	0.5%	1	0	0.0%	0.0	2.1%	-0.0	0.0	0.0	17618.8
Aspiration pneumonitis, food/vomitus	1	0.5%	1	0	0.0%	0.0	2.5%	-0.0	0.0	0.0	14493.2
Biliary tract disease	1	0.5%	1	0	0.0%	0.0	0.6%	-0.0	0.0	0.0	59800.2
Coronary atherosclerosis and other heart disease	1	0.5%	1	0	0.0%	0.0	1.1%	-0.0	0.0	0.0	33133.9
Diabetes mellitus without complication	4	2.0%	4	0	0.0%	0.0	0.5%	-0.0	0.0	0.0	20142.2
Gastritis and duodenitis	1	0.5%	1	0	0.0%	0.0	0.2%	-0.0	0.0	0.0	2.15e+5
Pneumonia	1	0.5%	1	0	0.0%	0.0	0.9%	-0.0	0.0	0.0	40687.1
Septicemia (except in labour)	1	0.5%	1	0	0.0%	0.0	3.7%	-0.0	0.0	0.0	9906.8
Viral infection	2	1.0%	2	0	0.0%	0.1	4.4%	-0.1	0.0	0.0	4186.2

National comparison (funnel plot)


Diabetes mellitus with complications | Mortality (in-hospital) | Feb-21 to Jan-22 | ALL (acute, non-specialist)
Diagnosis group: Diabetes mellitus with complications
Peers
ALL (acute, non-specialis
Measure
Relative risk
Benchmarks
Model
Group by
Region (of provider)
Show
All
Relative risk
Expected number of deaths
Region (of provider)
99.8% CL
95% CL
Average
AIREDALE NHS FOUNDATION TRUST
ASHFORD AND ST PETER'S HOSPITALS NHS FOUNDATION TRUST
BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST
BARNSLEY HOSPITAL NHS FOUNDATION TRUST
BARTS HEALTH NHS TRUST
BEDFORDSHIRE HOSPITALS NHS FOUNDATION TRUST
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST
BOLTON NHS FOUNDATION TRUST
BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST
BUCKINGHAMSHIRE HEALTHCARE NHS TRUST
CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST
CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST
COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST
CROYDON HEALTH SERVICES NHS TRUST
DARTFORD AND GRAVESHAM NHS TRUST
DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST
DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST
EAST AND NORTH HERTFORDSHIRE NHS TRUST
EAST CHESHIRE NHS TRUST
EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST
EAST LANCASHIRE HOSPITALS NHS TRUST
EAST SUFFOLK AND NORTH ESSEX NHS FOUNDATION TRUST
1/5

REFERENCES

SMR

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

HSMR

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

Benchmark

The benchmark used in this analysis is the monthly benchmark available within the Healthcare Intelligence Tool.

CUSUM

A cumulative sum statistical process control chart plots patients' actual outcomes against their expected outcomes sequentially over time. The chart has upper and lower thresholds and breaching this threshold triggers an alert. If patients repeatedly have negative or unexpected outcomes, the chart will continue to rise until an alert is triggered. The line is then reset to half the starting position and plotting of patients continues. The CQC monitor CUSUM's at a 99.9% threshold to determine outliers, whereas the default on the HIP dashboard is set at 99%, to provide trusts with an early warning of potential areas of alert for investigation.

HSMR Comparison

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

Charlson Index of Comorbidities

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

Charlson Upper-Quartile Rate

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

Palliative Care Coding Rate

For each financial year we calculate the proportion of a trust's HSMR superspells excluding day cases which are coded as having palliative care, this is the observed value shown. The expected value is the proportion nationally for the equivalent mix of diagnosis and admission type. The trust's index value is calculated as observed/expected x 100

Board of Directors' Meeting
08 July 2022

The Rotherham NHS Foundation Trust

Agenda item	P103/22
Report	**National, Integrated Care Board and Integrated Care Partnership Update**
Executive Lead	Michael Wright, Deputy Chief Executive
Link with the BAF	R2: There is a risk we will not establish ourselves as leaders in improving the lives of the population we serve because of insufficient influence at PLACE leading to increased ill health and increased health inequalities OP3: There is a risk robust service configuration across the system will not progress and deliver seamless end to end patient care across the system because of a of lack of appetite for developing strong working relationships and mature governance processes leading to poor patient outcomes
How does this paper support Trust Values	Together – the paper demonstrates how the Trust and partners across both Rotherham Place and the wider system work together in providing patient care and also providing mutual support in the continued response to the COVID-19 pandemic and subsequent period of recovery.
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 and developments across the South Yorkshire Integrated Care Board (SY ICB) and the Integrated Care Partnership (ICP - Rotherham Place). Key points to note from the report are: • The NHS Confederation Conference was held in Liverpool in June. Keynote speakers included Amanda Pritchard, Chief Executive of NHS England and Sajid Javid, Secretary of State for Health and Social Care • In his speech, The Secretary of State spoke about 'reform partnerships' as a vehicle for how the best leaders don't stay in the 'walled gardens' of good performing Trusts and helped those in trouble. • Terms of reference for the Rotherham Place Committee of the ICB were received at the Rotherham Place Design Team at the end of June, setting out the role proposed role of the committee. • A Rotherham Place recruitment event took place at New York Stadium which was attended by multiple partners across the borough.

Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	The Executive Team receives a weekly verbal update covering key Place and ICS level activities in addition to specific papers periodically, as and when required.
Board powers to make this decision	N/A
Who, What and When (what action is required, who is the lead and when should it be completed?)	N/A
Recommendations	It is recommended that the Board note the content of this paper
Appendices	

1. Introduction

1.1. This report provides an update on national developments and developments across the South Yorkshire Integrated Care System (SYICS) and Integrated Care Partnership (ICP- Rotherham Place).

2. National Update

2.1. The NHS Confederation Conference was held in Liverpool in June. It was the first time the (usually) annual conference has been held since the start of the pandemic and is usually seen as the primary leadership conference within the NHS. Colleagues from the Trust attended the event. Speakers included Amanda Pritchard, NHS Chief Executive, Sajid Javid and Secretary of State for Health and Social Care alongside multiple other service and private sector speakers.

2.2. In his speech at the Conference Sajid Javid said that underperforming trusts may be forced to join 'reform partnerships' designed to speak the NHS best leaders across the service. He said he was exploring how this could ensure that "leadership doesn't stay in the walled garden of England's best performing trusts but is there to help turn trusts around".

2.3. Chris Hopson was appointed as NHS England's first Chief Strategy Officer, moving from his role as Chief Executive of NHS Providers. In one of his first developments, he has written out to local Chairs and Chief Executives setting out an immediate priority to create a new relationship between NHS England (NHSE) and senior frontline leaders based on the principle of co-creation, with the strategic objective to create a "single, aligned leadership team across the NHSE national, regional leaders, [ICB] chairs and CEOs and Trusts chairs and CEOs"

2.4. The Messenger review into health and social care leadership in England has been published along with a set of seven recommendations. Led by Dame Linda Pollard and Sir Gordon Messenger, the review is a promising start for health and social care leadership reform, In the report, they conclude that "the prospect of greater integration, both within integrated care systems and the recently reconfigured NHS England, provide perhaps the best opportunity in recent history to refocus the NHS's relationship with its leaders and managers in England".

3. South Yorkshire Integrated Care Board (SYICB)

3.1 On the 1st July 2022, the the Health and Care Act 2022 (the Act) initiates one of the biggest reforms to the NHS in nearly a decade. The Act moves the 42 integrated care systems (ICSs) across England into a new form and onto a statutory footing from 1 July. ICSs brought together NHS trusts and foundation trusts, primary care, local authorities, and voluntary sector partners. Their goal was to remove barriers between organisations to deliver better, more joined up care for local communities and ultimately to improve population health. The successor statutory bodies – integrated care boards (ICBs) – will, from 1 July, continue to deliver on that ambition by embedding integration and collaboration across the system. The South Yorkshire ICB has been preparing for the 1st July which includes a public Board meeting on the go live date. During June, the ICB held an engagement workshop with senior leadership colleagues across South Yorkshire. The session covered the future workings and challenges that the system faces.

3.2 Two members of the ICB leadership team, The Medial Director, Dr David Crichton and Chief Nurse, Cathy Winfield both visited the Trust in June and met a number of Trust colleagues as part of their introductory meetings.

4. Rotherham Integrated Care Partnership (ICP)

4.1. A cross organisational Rotherham Place recruitment event was held at New York Stadium on the 23rd June. Led by Leanne Dudhill of the Rotherham Metropolitan Borough Council (RMBC) and Lauren Witton (employed by the Trust on secondment to work across the Rotherham Place) and supported by Human Resource and Organisational Development teams from employers across the Rotherham Place. In total over 180 vacancies were available including nursing roles, domestic posts, therapies, human resources and finance roles. Further detail in relation to the outcomes of the event will be provided at the next Trust Board meeting.

4.2. An IT service review has been taking place across Rotherham Place. Stakeholder interviews have taken place with representatives from the Trust, Rotherham Doncaster and South Humber Healthcare, Voluntary Action Rotherham, Rotherham Hospice, RMBC, the GP Federation, GP practices and Rotherham CCG. The review included applications, interoperability, end user devises, servers, storage, hosting, governance, and security (as well as other areas). The review will feed into the programme of work across place.

4.3 The Health and Wellbeing Board met on the 22nd June. The Annual Report was received that provided an update on activities during 2021/22. The Health and Wellbeing Board intend to hold a review of the impact of Covid-19 and lessons to be learnt from it. Health inequalities will be the main uniting theme. The Health and Wellbeing Board will also need to consider the changes being brought in through the Health and Care Bill, including the impacts at a place-level. In the current year, there will also be a refresh of Health and Wellbeing Strategy.

4.4 The Rotherham Place Design Team met on the 29th June and received the draft Terms of Reference for the Rotherham Place Board. The Terms of Reference are being considered by the NHS South Yorkshire Integrated Care Board (ICB). The key point to note is that the proposal is for the Place Board to sit as the Rotherham ICB Committee ("ICB Place Committee"), which is a committee of the ICB.

4.5 Colleague from the Trust attended the Health Select Commission on the 29th June. The agenda included a joint presentation on cancer screening programmes for Rotherham residents with NHS E and the Trust presenting information.

Michael Wright
Deputy Chief Executive
July 2022

Board of Directors' Meeting
08 July 2022

The Rotherham NHS Foundation Trust

Agenda item	P104/22
Report	**Operational Objectives 2022/23 Review**
Executive Lead	Michael Wright, Deputy Chief Executive
Link with the BAF	All BAF items – P1, R2, OP3, U4, D5 and D6
How does this paper support Trust Values	Ambitious – The paper provides detail of the delivery of the ambitious operational objectives for 2022/23. 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 2022/23 Operational Plan priorities and associated programmes as at Months 1 and 2. During the course of the first two months of implementation, and through discussions with Executives, it has been found necessary to amend the mandates for Priorities 3 and 5 in the following ways:- ***Priority 3 Our Partners: Work together to Succeed for our Communities –*** this priority is aligned to the Rotherham Integrated Health and Social Care plan and as such its key milestones must deliver across a broader range of schemes. The milestones for delivery which were deliberately omitted from the original mandate due to the need to hold further discussions with stakeholders, have now been included to reflect the interrelated nature of the work. The updated version of the mandate is attached at Appendix 2. The associated metrics assigned to this programme require further discussion before the profile can be updated. ***Priority 5 Delivery: Implement sustainable change to deliver high quality, timely and affordable care -*** changes have been made to this mandate due to the need to re-focus the scope described in sub-programme 5.2 in order to progress the work on same day emergency care pathways that will be re-designed to reduce pressure on our emergency services. The updated version of the mandate is attached at Appendix 2. The associated metrics assigned to this programme also require further discussion before the profile can be updated. No changes have been made to the sub-programmes Priority 5.1 relating to elective waiting times and outpatients or Priority 5.3 relating to financial viability and patient level costing.

	At the end of Month 2, ten programmes are individually rag rated green (on track) and three are rag rated amber (not on track). None of the programmes are rag rated red (significantly off track) or blue (closed/completed) and as such there has not been a requirement to seek Executive approval in April or May to change the delivery plan timelines for any of the programmes.
Due Diligence	The content of individual monthly highlight reports has been presented to People Committee and Finance and Performance Committee meetings held in June 2022. Papers were, however, not called for consideration at the Quality Committee scheduled to take place in June as the meeting was officially stood down.
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 2022-23 Programme Highlight Reports (April – May 2022) 2: Updated Mandates – Priority 3 Our Partners - Work Together to Succeed for Our Communities and Priority 5 Delivery - Implement sustainable change to deliver high quality, timely and affordable care

1.0 Introduction

1.1. The Operational Plan for 2022/23 is built around 5 key priorities aligned to the Trust's strategic PROUD framework:-

- **P1 Patients**: Empower our teams to deliver improvements in the care they strive to provide
- **P2 Rotherham**: Ensure equal access to services
- **P3 Our Partners**: Work together to succeed for our communities
- **P4 Us**: Commit to a focus on workplace wellbeing and compassionate Leadership
- **P5 Delivery:** Implement sustainable change to deliver high quality, timely and affordable care

1.2 The priorities are supported by 13 operational programmes that have been set out in formal mandates agreed at the Trust Board meeting held in May 2022.

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 This paper presents a high level update on progress during Months 1 and 2 against the thirteen programmes of work and reports, by exception, any areas of concern with recommendations for continuance into the next planning cycle.

1.5 Amendments have been made to the original mandates produced for Priorities 3 and 5 in order to better align the content to the work being undertaken at place level (P3) and plans to circumvent patients away from the urgent and emergency care centre, as appropriate, through the re-design of same day emergency care pathways (P5). (See Appendix 2 attached for information).

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 rated (Blue, Red, Amber, Green) as to their status at the end of May 2022 as illustrated below:

- Completed/Closed
- On track
- Not on track
- Significantly not on track

2.2 The following tables provide the summary position at Months 1 and 2 on each of the programmes of work with their respective BRAG rating. More detailed highlight reports are attached at Appendix 1.

PRIORITY 1 Patients - Empower our teams to deliver improvements in the care they strive to provide

Programme	Scope	Summary Position	Status
P1.1 Implement a Quality Improvement Methodology in the Organisation	Agree our organisational approach to quality improvement by evaluating and agreeing the Trust model to be used, launch our new Quality Improvement approach across the Trust and begin implementation.	Due to cancellation of the Quality Committee in June, a full update on progress will be provided at the Quality Committee scheduled to take place in August. The report will then cover the period April to July to complete the assurance process. There are no key milestones or metrics planned for delivery in April and May.	**GREEN**
P1.2 Embed effective quality governance processes and practices across our organisation	Reset our quality governance expectations and embed revised, effective practices and processes across our organization, restructuring relevant teams as appropriate.	Due to cancellation of the Quality Committee in June, a full update on progress will be provided at the Quality Committee scheduled to take place in August. The report will then cover the period April to July to complete the assurance process There are no key milestones or metrics planned for delivery in April and May.	**GREEN**
P1.3 Deliver the Trust Quality Priorities	Deliver the 9 Quality Priorities for 2022-23	This sub-programme is out of scope for Operational Plan highlight reporting to Quality Committee therefore status will be provided for assurance purposes only for the remainder of this year.	**GREEN**

PRIORITY 2 Rotherham - Ensure Equal Access to Services

Programme	Scope	Summary Position	Status
P2.1 Ensure equal access to services and reduce health inequalities in Rotherham	Uphold the requirements set out in the NHS national planning guidance 2022-23 and NHS Long Term plan in relation to health inequalities and service provision and take proactive action to improve health equity across Rotherham, building our services to be inclusive and accessible for those that need them and encouraging our colleagues to instill positive health behaviors in themselves and our patients.	Data Deep-Dive work has commenced. Developments are on track for ward based communication stations, including translation, L.D. & impaired hearing materials initiated (including open day event to obtain feedback from clinical/ward colleagues).	**AMBER**
P2.2 Implement year one of our Green Plan	Implement the ambitions set out within our Green Plan and move towards delivering on the NHS net Zero Challenge reducing the environmental impact of the Trust	Nifes Consulting have been appointed to identify specific carbon reduction opportunities in line with NHS Long Term plans. Engagement undertaken with First Energy for prospect of developing “Local Heat Network” in conjunction with RMBC and other Rotherham Place Stakeholders. CEF Scheme Year 1 savings currently being evaluated.	**GREEN**

Programme	Scope	Summary Position	Status
P2.3 Enhance our digital services to support patients and their families across Rotherham	Advance our digital offer to patients and their families, and ensure this supports our communities to better manage their interactions with us	Module purchased to permit implementation of "Patient Hub", which will include Maternity digital offering, Appointment Cancellation and Amendment functionality. Scoping and discussions commenced to obtain Rotherham Health App utilisation metrics.	GREEN

PRIORITY 3 Our Partners - Work Together to Succeed for our Communities

Programme	Scope	Summary Position	Status
P3.1 Deliver the new Urgent Community Response 2 hour standard	Work with partners to develop an affordable 7 day model which supports avoidable admission and timely discharge to the right place providing the right treatment, care and support for individuals.	National milestones have been met to provide a two hour urgent response service operating 8-8, 7 days a week providing cross borough cover and the community services data set is being submitted monthly. Work has commenced to digitally capture data for Community Right-To-Reside mandated reporting.	GREEN
P3.2 Ensure discharge arrangements are highly effective and sustainable through working with partners in Rotherham	Acute and community discharge pathways, Health and care intermediate care pathways, Commissioned community bed base, therapy provision and Care homes where it is the patients normal place of residence	Work has been scoped to develop a sustainable integrated discharge model. Activity is underway to develop the delivery plan. Work has been scoped to improve discharge planning and processes in the acute setting, reducing waste and maximising efficiencies of discharge planning and processing.	GREEN

PRIORITY 4 Us – Commit to a Focus on Workplace Wellbeing and Compassionate Leadership

Programme	Scope	Summary Position	Status
P4.1 Improve our staff facilities and increase the wellbeing support available to our staff	Design wellbeing facilities available across all areas of work that will enable staff to take a break in an environment that supports their general health and wellbeing.	To advance our wellbeing offer around the establishment of a "wellbeing centre" and enhance services currently located in old Greenoaks. A business case brief is to be developed next month for consideration by the Executive Management Team which, if supported, will proceed to obtaining the necessary architect sketches, quantity surveyor requirements as well as dependable costings. A full inventory of hospital and community based rest break facilities will also be undertaken. Subject to approval, new colour schemes will be selected based on colour pallets designed by psychologists that will bring a sense of harmony to the space.NHS Charities funding has been awarded which will allow continuation of the intra-trust sporting league as well as the introduction of art therapy sessions and support from Barnsley's clinical/occupational psychologist.	GREEN
P4.2 Divisional leadership teams will undertake a bespoke leadership development programme	All divisional leadership teams will participate in a programme designed to ensure that they are able to take greater responsibility for the continuous improvement of employee welfare and engagement, communication and performance ownership as well as partnership	On 26th May Professor Michael West (Senior Visiting Fellow) made a compelling presentation to senior leads on the subject of compassionate leadership (attending, understanding, empathising helping). The presentation was well attended and feedback has been excellent. The specification for this year's leadership development programme is, however, delayed awaiting final sign off.	AMBER

Programme	Scope	Summary Position	Status
	development and working better together		

PRIORITY 5 Delivery : Implement Sustainable Change to Deliver High Quality, Timely and Affordable Care

Programme	Scope	Summary Position	Status
P5.1 Shorten elective waiting times for patients, modernise our outpatient services and improve theatre throughput	Restore and improve the efficiency of our theatre pathways, through innovation and improvement including waste reduction where possible and realign our Outpatient (OP) capacity, growing our use of tools such as Advice and Guidance and improve our efficiency	Initial meeting conducted to scope Theatre pathway efficiencies in early April-22, due to significant operational and resource pressures further work and scoping deferred until Q2.Prioritisation of outpatient work stream deliverables conducted to identify timeline of deliverables and identify areas out of scope for the current fiscal year. Outpatient Programme Governance has been amended.	AMBER
P5.2 Increase the use of same day emergency care and shorten waiting times for patients in UECC	Release pressure on Urgent and Emergency Care services and reducing waiting times for our patients in UECC by ensuring care is provided in the right place, at the right time, including establishing a consistent approach to our same day emergency care pathways.	New SDEC business case is complete and will be discussed with the Chief Executive in July, before submission to the Executive Team. Priority pathways have been identified by the ICS, which can now be reviewed alongside SDEC opportunity tool data, and to inform the prioritisation and development of standardised, condition specific pathways. A visit from the National lead for SDEC/Frailty and regional Urgent Care Lead has been planned for July.	GREEN
P5.3 Implement new systems to better understand the costs of our service delivery at patient level	Redesigning our approach to transformational efficiency to deliver financial savings Allow for a better and 'live' understanding of the financial viability of our services through patient level information so that we can gain a clear understanding of those that provide a contribution / benchmark well to the organisation and those that do not.	A number of large scale efficiency schemes are in development with divisional and corporate teams, and are being taken forward through Efficiency Board e.g. e-Roster, stock management, diagnostic testing. Financial savings for efficiency schemes have not been identified/agreed at this stage. Sivicia system to be developed in house to provide PLIC (patient level information costing). Project work structure developed, awaiting approval.	GREEN

3.0 Conclusions

3.1 The Board Assurance Committees play a key role in ensuring effective oversight and delivery of the Operational Plan. However, due to the cancellation of the Quality Committee meeting scheduled to take place in June, a full report on progress and assurance has been postponed until the next bi-monthly update scheduled in August. The next assurance report will therefore cover the period April to June 2022 for the following areas of work:-

- P1.1 Implement a Quality Improvement Methodology in the Organisation
- P1.2 Embed effective quality governance processes and practices across our organisation
- P1.3 Deliver the Trust Quality Priorities

There were no key milestones or metrics planned for delivery in April and May.

In June, the People Committee and Finance and Performance Committee considered reports on progress in all of their associated areas and confirmed the following with recommendations for action as deemed applicable.

5.0 People Committee

5.1 The People Committee held on 24th June considered the highlight reports for the period April – May 2022 (see Appendix 2) in relation to the following areas of work:-

- P4.1 Improve our staff facilities and increase the wellbeing support available to our staff
- P4.2 Divisional Leadership teams will undertake a bespoke leadership development programme

The Committee duly noted the report, and, whilst recognising progress to date decided that, until a Divisional leadership programme was in place the Committee had **limited** assurance.

6.0 Finance and Performance Committee

6.1 The Finance and Performance Committee held on 29th June considered the highlight reports for the period April – May 2022 (see Appendix 2) in relation to the following areas of work:-

- P2.1 Ensure equal access to services and reduce health inequalities in Rotherham
- P2.2 Implement year one of our Green Plan
- P 2.3 Enhance our digital services to support patients and their families across Rotherham
- P 3.1 Deliver the new Urgent Community Response 2 hour standard
- P 3.2 Ensure discharge arrangements are highly effective and sustainable through working with partners in Rotherham
- P 5.1 Shorten elective waiting times for patients, modernise our outpatient services and improve theatre throughput
- P 5.2 Increase the use of same day emergency care and shorten waiting times for patients in UECC

- P5.3 Implement new systems to better understand the costs of our service delivery at patient level

6.2 The Committee duly noted the reports and after a general discussion agreed that a formal process for requesting and recording changes to plan will be required in the future to ensure that the committee remains fully sighted on any potential set backs to plan as well as making sure that outputs, risks and issues and measures of success are being regularly re-assessed and reported.

6.3 The Committee discussed the importance of clinician engagement and the risk that this will present to the timely progression of key milestones and activities if not carefully managed. The Committee were assured that conversations have taken place with clinical leads in relation to the risks identified so far and that there is a consensus within the divisions that they effectively reflect the operational challenges they are currently facing. It was also noted that different work streams are also coming through from NHS England/Improvement (NHSE/I) as well as the Integrated Care System (ICS) which will present their own challenges. Representative working groups are now in place to progress the priority areas and ownership within Divisions is now much improved.

6.4 The Committee also discussed the requirement for a Clinical Lead to progress Priority 5.3 and "champion" this sizeable piece of work which will lead to the implementation of new systems aligned to service sustainability. The Committee agreed that the level of clinician engagement required to progress the new system will be significant and that the role must therefore be factored into the work structure assigned to deliver the programme.

6.5 The Committee were **assured** against what has already been planned for delivery at this point in the year whilst noting the importance of keeping on top of change control in the coming months.

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

Michael Wright
Deputy Chief Executive
July 2022

Operational Objectives 2022 - 23

April – May 2022

Appendix 1: Programme Highlight Reports

Board of Directors Meeting

8th July 2022

OPERATIONAL PLAN 22/23 HIGHLIGHT REPORT: APRIL-MAY 2022

The Rotherham NHS Foundation Trust

Priority:	**P.2 Ensure Equal Access to Services**
Programme:	**P 2.1 Ensure equal access to services and reduce health inequalities in Rotherham** **P 2.2 Implement year one of our Green Plan** **P 2.3 Enhance our digital services to support patients and their families across Rotherham**
Executive Lead:	**Michael Wright, Deputy Chief Executive**
SRO:	**Louise Tuckett, Director of Strategy, Planning and Performance**

RAG STATUS

Programme Overview:	Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society, which lead to inequality of access to services. Health inequalities arise because of the conditions in which we are born, grow, live, work and age.These conditions influence our opportunities for good health, and how we think, feel and act, and this shapes our mental health, physical health and well-being. As such, we must ensure that: we uphold the requirements set out in the NHS national planning guidance 2022-23 and NHS Long Term plan in relation to health inequalities and service provision, we take proactive action to improve health equity across Rotherham, building our services to be inclusive and accessible for those that need them and encouraging our colleagues to instill positive health behaviors in themselves and our patients, we implement the ambitions set out within our Green Plan and move the organisation towards delivering on the NHS net Zero Challenge reducing the environmental impact of the Trust and we advance our digital offer to patients and their families, and ensure this supports our communities to better manage their interactions with us
Summary Position:	**Health Inequalities -** Data Deep-Dive work has commenced with some continuing work required to produce robust analysis to enable identification of Areas and Services to prioritise. Subsequent workstreams Re: Waiting list segmentation etc. dependent on completion of Deep-Dive. Ward based communication stations, including translation, L.D. & impaired hearing materials initiated (including open day event to obtain feedback from clinical/ward colleagues), all developments for implementation are on track. Digital Communication materials to be produced to permit accessibility online for non-ward based colleagues inc. community colleagues **Green Delivery Plan -** currently being actioned by Nifes Consulting (due July 2022), to identify specific carbon reduction opportunities in line with NHS Long Term plans. Engagement undertaken with First Energy for prospect of developing “Local Heat Network” in conjunction with RMBC and other Rotherham Place Stakeholders. CEF Scheme Year 1 savings currently being evaluated. **Rotherham Health App -** Module purchased to permit implementation of “Patient Hub”, which will include Maternity digital offering and Appointment Cancellation and Amendment functionality. Scoping and discussions commenced to obtain Rotherham Health App utilisation metrics.

act

Proud

PROGRAMME

Activities completed in April/May:	• Initial Health Inequalities Data Deep-Dive commenced with initial data and associated reports and analysis currently under review • Initial Communication Station information packs produced • Nifes Consulting appointed to produce Delivery Plan • BSDF Funding £2,300K granted (supported by 500K internal Capital) for Year 1 schemes • Rotherham Health App “Patient Hub” module purchased
Activities planned for June/July:	• Completion of Health Inequalities Data Deep-Dive and Service prioritisation • Publication of Green Delivery Plan (Nifes Consulting) • Validation of CEF Year 1 Financial and Carbon Savings • Identify appropriate metric and source of Rotherham Health App users • Rotherham Health App “Patient Hub” project to be initiated (Health Informatics PMO) to permit delivery of “Maternity Digital Offering” and “Appointment Cancellation and Amendment” functionality required to achieve project milestones
Key changes in April/May	

Risks:	• Health Informatics Resource availability (New) • Availability of accurate up-to-date Deprivation Population data (New) • Meditech Integration with E-Referral Service (New)	**Issues:**	None

OPERATIONAL PLAN 22/23 HIGHLIGHT REPORT: APRIL-MAY 2022

The Rotherham NHS Foundation Trust

Priority:	**P.3 – Our Partners – Work Together to Succeed for Our Communities**
Programme:	**P3.1 Deliver the new Urgent Community Response 2-hour standard** **P3.2 Ensure discharge arrangements are highly effective and sustainable through working with partners in Rotherham**
Executive Lead:	**Michael Wright, Deputy Chief Executive**
SRO:	**Jodie Roberts, Deputy Chief Operating Officer**

RAG STATUS

Programme Overview:

The Rotherham Urgent and Community Transformation programme is part of the Rotherham Integrated Health and Social Care plan which aims to support Primary Care, Mental Health and the Voluntary Sector to develop and deliver more integrated health and care. The current priorities are aligned to the NHS Long Term Plan, Better Care Fund objectives and the Aging Well projects which sit within this. These include the nationally mandated standards to:-

- Deliver the new Urgent Community Response 2-hour standard
- Embed the necessary actions and ways of working from the discharge priorities across Place

Summary Position:

The national milestones have been met to:

- Provide a two hour urgent response service operating 8-8 7 days a week providing cross borough cover
- Submit a monthly community services data set

Work has commenced to digitally capture data for Community Right-To-Reside mandated reporting and work has been scoped to develop a sustainable integrated discharge model. Activity is underway to develop the delivery plan. The IDT “as is” process mapping has been completed and additional work has been scoped to improve discharge planning and processes in the acute setting, reducing waste and maximising efficiencies of discharge planning and processing. Following submission of a paper to Executives, support is now in place to progress the NHS Improvement academy Achieving Reliable Care for Safety (ARCS) Programme.

PROGRAMME

Activities completed in April/May:	**Sustainable Discharge** **Acute/ IDT:** • IDT "Current State" Process Mapping completed • Paper submitted to Executives to secure their support to progress the NHS Improvement Academy ARCS Programme. **Community:** • Recruitment commenced for Community Flow Co-Ordinator • System changes implemented to permit digital Community Sit-rep reporting **Urgent Community Response** • Introduction of clock start/stop protocols, training and submission of report. Data quality improvement activity completed
Activities planned for June/July:	**Sustainable discharge** **Acute/IDT:** IDT Future State Process Mapping, Commence All Acute Discharge Project Pilots **Community:** • Development and embedding of patient flow management and escalation. Progress options paper for shared care record. **Urgent Community Response:** • On going data quality improvement including workshops to develop consistency of clinical definitions.
Key changes in April/May	

Risks:	• Insufficient Clinical Capacity for implementation (New) • Insufficient BI/HI resource to develop required reporting structure (New)	**Issues:**	Forthcoming (known changes to) Urgent Community Response requirements may require agile project management changes. (new)

OPERATIONAL PLAN 22/23 HIGHLIGHT REPORT: APRIL-MAY 2022

The Rotherham NHS Foundation Trust

Priority:	**P.4 US - Commit to a focus on workplace wellbeing and compassionate leadership**
Programme:	**P4.1 Improve our staff facilities and increase the wellbeing support available to our staff** **P4.2 Divisional leadership teams will undertake a bespoke leadership development programme**
Executive Lead:	**Steve Ned, Director of Workforce**
SRO:	**Paul Ferrie, Deputy Director of Human Resources**

RAG STATUS

Programme Overview:

2.1 Workplace Wellbeing - Staff health and wellbeing remains a key area of focus for the Trust as outlined in the People Strategy 2020-2023 Staff Engagement objectives. Wellbeing initiatives implemented last year, particularly building on experience learned through Covid, are set to continue with a view to providing a supportive and holistic approach to staff wellbeing across the trust. Through staff survey results and listening to staff in open discussions about what is important and what effect the workplace has on their overall wellbeing it is apparent that there is a lack of local facilities which would enable staff to take time out from their place of work, not only for refreshment breaks but also to have the option to step into a "calmer" space that will help them re-balance and return to their work location feeling re-energised.
2.2 Compassionate Leadership - The Trust aims for senior leaders within its six divisions to take greater responsibility for the continuous improvement of employee welfare and engagement, communication and performance ownership as well as partnership development and working better together. The investment in a development programme again this year will enable the trust to meet the objectives set out in this mandate and through a formal tender process engage a new provider, building on last year's work provided by Team at the Top.

Summary Position:

Workplace Wellbeing – During the pandemic the trust introduced an extensive range of psychological and physical health and wellbeing initiatives including the establishment of the Wellbeing Garden and the Woodland Walk. The old Greenoaks building has provided a much needed indoor space where other wellbeing initiatives have taken place such as the roll out of COVID and flu vaccinations. This year the prospect is to advance our wellbeing offer around the establishment of a "wellbeing centre" and enhance services currently located in old Greenoaks. A business case brief is therefore to be developed next month for consideration by the Executive Management Team which, if supported, will proceed to obtaining the necessary architect sketches, quantity surveyor requirements as well as dependable costings. A full inventory of hospital and community based rest break facilities will also be undertaken as part of the options appraisal due to the resulting impact on revenue maintenance costs to undertake this work. Subject to approval, new colour schemes will be selected based on colour pallets designed by psychologists that will bring a sense of harmony into the altered space. The trust Staff Engagement team, Learning and Development and HR Business Partners continue to receive feedback from colleagues on general wellbeing and support available during local engagement sessions and through the Pulse survey. NHS Charities funding has been awarded which will allow continuation of the intra-trust sporting league as well as the introduction of art therapy sessions and support from Barnsley's clinical/occupational psychologist.
Compassionate leadership - On 26th May Professor Michael West (Senior Visiting Fellow) made a compelling presentation to senior leads on the subject of compassionate leadership (attending, understanding, empathising, helping). The presentation was well attended and feedback has been excellent. The specification for this year's leadership development programme is, however, delayed awaiting final sign off.

PROGRAMME

Activities completed in April/May:	• NHS Charity funding successful • Ongoing staff engagement sessions/Pulse Survey • Compassionate Leadership Presentation to senior leaders – Professor Michael West • New Leadership Programme specification ready for final sign off
Activities planned for June/July:	• Sign off new Leadership Programme specification • Present a business case brief at EMT outlining proposals for a wellbeing centre and the re-decoration of existing staff rest rooms
Key changes in April/May	• The Milestone due for completion at the end of May – *Leadership Programme Specification signed off* – is off track however a suitable provider has already been identified therefore as soon as the specification is signed off (June/July period) the learning events will be formally confirmed and participants notified. If the specification is not signed off by the end of July, however, a formal change request will need to be made to Executives to agree on a new timeline for completion.

Risks:	• Leadership programme starts later than planned resulting in delayed changes to desired behaviours/compassionate leadership • Preferred option for "wellbeing centre" and changes to staff rest areas is deemed too expensive due to cost improvement pressures	**Issues:**	

OPERATIONAL PLAN 22/23 HIGHLIGHT REPORT: APRIL-MAY 2022

The Rotherham NHS Foundation Trust

Priority:	**P5 Delivery – Implement Sustainable Change to Deliver High Quality, Timely and Affordable Care**
Executive Lead:	**Sally Kilgariff, Chief Operating Officer**
SRO:	**5.1 - Louise Tuckett, Director of Strategy, Planning and Performance; 5.2 - Jodie Roberts, Director of Operations; 5.3 - Mark Bloy, Deputy Director of Finance**

RAG STATUS

Programme Overview:

- **5.1 - Shorten elective waiting times for patients, modernise our outpatient services and improve theatre throughput.** As well as our day-to-day delivery of the recovery programme, we will need to:
  - Restore and improve the efficiency of our theatre pathways, through innovation and improvement including waste reduction where possible
  - Realign our Outpatient (OP) capacity, growing our use of tools such as Advice and Guidance and improve our efficiency
- **5.2 - Release pressure on Urgent and Emergency Care services and reducing waiting times for our patients in UECC** by ensuring care is provided in the right place, at the right time, including establishing a consistent approach to our same day emergency care pathways.
- **5.3 - Implement new systems to better understand the costs of our service delivery at patient level.** We plan to undertake the preliminary work to enable a better, 'live' understanding of the financial viability of our services through patient level information so that we can understand those that provide a contribution and those that do not.

Summary Position:

- **Theatres:** Initial meeting conducted to scope Theatre pathway efficiencies in early April-22, due to significant resource pressures, further work deferred until Q2.
- **Outpatients:** Prioritisation of workstream deliverables conducted to identify timeline of deliverables and identify areas out of scope for the current fiscal year. Outpatient Programme Governance has been amended from formal workstream meetings to individualised specialist liaison approach to permit individual traction on a service by service basis.
- **SDEC:** The final draft of the new SDEC business case is complete and is planned for discussion with the Chief Executive in July, before submission to the Executive Team. ICS SDEC meetings have also commenced and are being led by Kay Stenton, UECC Consultant. Priority pathways have been identified by the ICS, which can now be reviewed alongside SDEC opportunity tool data, and to inform the prioritisation and development of standardised, condition specific pathways. A visit from the National lead for SDEC/Frailty and regional Urgent Care Lead has been planned for July, which will also help inform the development of our pathways and SDEC Standard Operating Procedures.
- **Sustainability:** A number of large scale efficiency schemes are in development with teams, and are being taken forward through Efficiency Board to provide assurance / oversight on delivery. These schemes may be added to as the year develops and further opportunities / ideas are identified. They are currently: 1) E-Roster Best Practice and Implementation, 2) Stock Management, 3) Service Specifications Review, 4) Diagnostic Testing, 5) Pharmacy Invest to Save, 6) Digital Self Check-in. Financial savings have not been identified/agreed at this stage. However, some initial developments/improvements are:
  - 42 day approval of Rosters is now at 80%, compared with around 30% this time last year
  - Pharmacy invest to save business case (c500k saving) presented to Executive Management Team
  - A joint approach with Barnsley around PLIC (Patient Level Information Costing) was considered, but it has been decided that Rotherham will develop this in-house through the Sivica system. A project structure to support this has been developed, with approval through the Director of Finance to be sought.

PROGRAMME 5.1 - Shorten elective waiting times for patients, modernise our outpatient services and improve theatre throughput

Activities completed in April/May:	**Theatres** • Initial Scoping meeting held **Outpatients** • Digital Self-Check-In Launched • Outpatient Locations now allocated utilising Bookwise Room booking web tool • Work commenced to integrate Meditech with E-Referral Service • ENT PIFU Implemented
Activities planned for June/July:	**Theatres** • Restart of Theatres Efficiencies work **Outpatients** • Implementation of 6:4:2 clinic meeting reviews • Clinical Triage Pilot in ENT to commence • 2 further specialties to go live with PIFU (to add to the 3 services already active)
Key changes in April/May	

Risks:	• Lack of Engagement (New) • Lack of required Health Informatics Resource, Significant Operation Pressures (New)	**Issues:**	Accessing suitable data for Outpatients Benchmarking and Metrics to be configured (new) Lack of integration between e-Referral Service, Meditech & SystemOne (new)

PROGRAMME 5.2 - Increase the use of same day emergency care and shorten waiting times for patients in UECC

Activities completed in April/May:	• Finalised draft of new SDEC business case in May • ICS SDEC Meetings commenced • ICS prioritised cardiac, respiratory and gastro SDEC pathways, followed by surgery for re-design across the region • Confirmed SDEC ICS are looking at access to SDEC in hours and OOH • SDEC opportunity tool demonstrated to Medicine and Project Managers • National lead for SDEC/Frailty and regional Urgent Care Lead visit planned for July 4th
Activities planned for June/July:	• Meeting with Chief Executive in July to discuss SDEC Business Case, before submission to Executive Team • Review of priority pathways (?Cardiac, Respiratory and Gastro SDEC), considering data from SDEC opportunity tool and feedback from SDEC meetings • National lead for SDEC/Frailty and regional Urgent Care Lead visit in July • Commence planning for development of SOP for Same Day Emergency Care provision (across all areas)
Key changes in April/May	• Progression of SDEC Business Case to final draft • ICS SDEC meetings commenced and led by Kay Stenton

Risks:	Specialties do not support the pathways/processes that will circumvent UECC (new)	**Issues:**	Lack of shared ownership of acute pathways (new) UECC is treated as default location for all urgent care needs (new)

PROGRAMME 5.3 - Implement new systems to better understand the costs of our service delivery at patient level

Activities completed in April/May:	• Paper delivered to the May Efficiency Board on Large Scale Efficiency Schemes progress • Job Descriptions, to support an outline staffing and project structure to drive and maintain PLIC, have been matched • Pharmacy invest to save business case presented to ETM
Activities planned for June/July:	• Paper to be delivered to the June Efficiency Board (and also to Finance and Performance Committee) on Large Scale Efficiency Schemes progress • Pharmacy invest to save business case to be re-presented to Executive Management Team • Job Descriptions approved by the Director of Finance for PLIC project management • Staffing and project structure to support PLIC approved by the Director of Finance
Key changes in April/May	

Risks:	• Some savings around large scale efficiency schemes may not deliver in 22/23 (New)	**Issues:**	None

Operational Objectives 2022 - 23

April – May 2022

Appendix 2: Revised Mandates (for information)

Priority 3 – Our Partners and Priority 5 - Delivery

Board of Directors Meeting

8th July 2022

22/23 OPERATIONAL PLAN

P3 Our Partners: Work together to succeed for our communities

SCHEME OWNERSHIP	
Executive Lead	Michael Wright, Deputy Chief Executive
SRO	Sally Kilgariff, Deputy COO
Reporting Forum	Finance and Performance Committee and Rotherham Place Governance Framework

The Rotherham NHS Foundation Trust

OUTLINE / OVERVIEW

The Rotherham Urgent and Community Transformation programme is part of the Rotherham Integrated Health and Social Care plan which aims to support people and families to live independently in the community, with prevention and self-management at the heart of delivery. The Trust is working in partnership with the Rotherham Clinical Commissioning Group, the Council, Primary Care, Mental Health and the Voluntary Sector to develop and deliver more integrated health and care. The current priorities are aligned to the NHS Long Term Plan, Better Care Fund objectives and the Aging Well projects which sit within this. These include the nationally mandated standards to

- Deliver the new **Urgent Community Response** 2-hour standard
- Embed the necessary actions and ways of working from the **discharge priorities** across Place

OBJECTIVES / PURPOSE

To work with partners to develop an affordable 7 day model which supports avoidable admission and timely discharge to the right place providing the right treatment, care and support for individuals. The model will provide choice, taking account of patient and carer wishes whilst meeting the needs of system flow.

Urgent Community Response:
Respond within 2 hours of receipt to urgent community referrals at least 70% of the time by December 2022 providing geographical cover across the borough at minimum 8am to 8pm.
Submit a monthly national data set according to the agreed criteria.

Discharge Priorities:
Early discharge planning and allocation of resource to assess/support individuals in their own home wherever possible
Develop and embed clear protocols, accountability, roles, responsibilities and escalation routes based on home first principles
Acute discharge improvement plan – ward level programme of work to include ward discharge processes including length of stay, right to reside and use of discharge lounge

SCOPE

IN SCOPE	OUT OF SCOPE
Acute and community discharge pathways Admission avoidance pathways and activity in relation to UECC, AMU, ASU and SDEC including frailty where this can result in the patient returning home Health and care intermediate care pathways Commissioned community bed base, therapy provision Care homes where it is the patients normal place of residence	UECC transformation programme SDEC development Acute frailty ward following an unavoidable admission

DELIVERY PLAN

TIME	KEY ACTIVITIES	OUTPUTS / DELIVERABLES / KEY MILESTONES
Q1	Map 'as is' integrated discharge team processes Scope 'Achieving reliable care for safety ward' improvement pilot with Change Academy Review flow across the commissioned community bed base Establish 2 hour urgent response standard according to national criteria, developing systems and processes to support clock start/stop requirements	Complete IDT process mapping (milestone) Secure agreement for work with Change Academy to run 2 ward pilot (deliverable) Establish and embed discharge planning with discharge actions captured on meditech, recruit and embed community flow co-ordinator (deliverable) Cross borough urgent response operating 8-8 7 days with submission of first urgent community response data set (milestone)
Q2	Conduct pilots within the acute setting to address barriers to discharge: - 2 wards (A2 and Fitzwilliam working with Improvement Academy on Achieving Reliable Care for Safety (ARCS) project - Criteria led discharge short stay unit - TTOs 'getting it right first time'. Promotion of discharge lounge. Launch of pick up point and targeted comms	Complete pilots (deliverable) Understand delays and create Task and Finish groups to resolve themes and trends (deliverable) Reduction in duplicates (TTOs) (output) Increase in uptake of discharge lounge (output) Complete IDT future state process mapping (milestone) Complete pharmacy and professional standards GIRFT pilots (milestone)
Q3	Analyse and expand acute improvement pilots Streamlined IDT processes & roles and responsibilities defined Develop urgent community response capacity and improve data quality	'To be' mapped, duplication reduced releasing capacity (Milestone) Increased activity, improved data quality, 2 hour threshold met 70% of time (output) Complete ARCS and criteria led discharge processes (milestone) Complete Pharmacy & Professional Standards Roll-Out Trustwide (Subject to Pilot evaluations) Milestone)
Q4	Development of underpinning systems to support IDT and discharge process Cross system performance monitoring	Whole system single version of truth automated capacity and escalation wheel (deliverable) Reduction in manual activity (output)

ANTICIPATED IMPACT

IMPACT	DOMAIN
Potential reduction in avoidable admissions	Quality/operational
Reduction in number of surge beds	Operational/finance
Improvement in national discharge measures	Quality/operational /finance

MEASUREMENT OF SUCCESS

MEASUREMENT / KPIs	TARGET
National 2 hour urgent response standard met Growth trajectory met	70%
Improvement in discharge measures including Long length of stay /right to reside, discharge before 5pm & use of discharge lounge. Community bed base occupancy levels (90%)	Tbc

RISKS	ISSUES
Commissioners are unable to agree a joint risk approach to short term funding resulting in delays to discharge decision making. Mitigation: discussion of proposals are underway Acute and community accountability is not agreed to support the virtual ward. Mitigation: accountability to be agreed and monitored through clinical/project governance Barriers to cross organization/team working cannot be overcome. Mitigation: high level exec lead support / joint design and development work	National funding is reduced to support aging well projects. Mitigation: funding to be clarified by ICS. Virtual ward funding may mitigate impact There is insufficient capacity to support people at home due to recruitment issues and staff sickness. Mitigation: a joint approach to recruitment is being proactively pursued through the Place workforce enabler group

22/23 OPERATIONAL PLAN

P5 Delivery: Implement sustainable change to deliver high quality, timely and affordable care

SCHEME OWNERSHIP	
Executive Lead	George Briggs, Chief Operating Officer
SRO	Sally Kilgariff, Deputy COO; Louise Tuckett, Director of Strategy, Planning and Performance; Mark Bloy, Deputy Director of Finance
Reporting Forum	Finance and Performance Committee

The Rotherham NHS Foundation Trust

OUTLINE / OVERVIEW

Implement a consistent approach to Same Day Emergency Care and take action to relieve the pressure in our UECC:

- Increase the use of Same Day Emergency Case and shorten waiting times for patients in UECC

Drive forward our elective recovery, realigning our outpatient capacity and improving the efficiency of our theatres:

Elective recovery is a key priority for the NHS, but there will be significant challenge in meeting the expectations set out within the NHS planning guidance unless we make fundamental changes to our services and ways of working. As well as our day-to-day delivery of the recovery programme, we will need to:

- Restore and improve the efficiency of our theatre pathways, through innovation and improvement including waste reduction where possible
- Realign our Outpatient (OP) capacity, growing our use of tools such as Advice and Guidance and improve our efficiency

Build the sustainability of the organisation through a refreshed approach to delivering efficiencies and by improving our understanding of sustainability of services. This priority is focused on delivering the financial plan and gaining the tools to make long term change, by:

- **Redesigning our approach to transformational efficiency** – implement a greater focus on a longer term, transformational approach to efficiency to deliver our financial savings
- **Sustainability of services** - Undertake the preliminary work to allow for a better and 'live' understanding of the financial viability of our services through patient level information so that we can gain a clear understanding of those that provide a contribution / benchmark well to the organisation and those that do not.

OBJECTIVES / PURPOSE

- Release pressure on UECC services by ensuring care is provided in the right place, at the right time, including establishing a consistent approach to our same day emergency care services and pathways.
- Develop a transformational, cross-cutting approach to efficiency
- Implement changes to our OP pathways which result in increased efficiency, such as patient-initiated follow-up and full clinical triage of referrals, and increase our capacity in clinics
- Utilise our new data dashboards to increase theatre throughput, ensuring we are working efficiently with our teams and improving satisfaction at work
- Understand the level of financial contribution to the Trust at service level
- Produce 'live' contribution and benchmarking information on a regular basis (ie monthly) through the use of PLICs, SLR and reference costs

SCOPE

IN SCOPE	OUT OF SCOPE
• UECC, Same Day Emergency Care and Assessments Units for Gynaecology and Surgery. • Digital transformation and Estates work. • Patient and public involvement • Outpatients • Theatres – full theatre pathway	• Existing SDEC business case, IV Pilot. • Any community clinical pathways. • Implementation of the decisions based on the 'live' contribution information / benchmarks produced

DELIVERY PLAN		
TIME	**KEY ACTIVITIES**	**OUTPUTS / DELIVERABLES / KEY MILESTONES**
Q1	Finalise draft of new SDEC business case Identify, scope out and agree medium to large scale efficiency schemes	New SDEC business case Medium to large scale schemes signed off (milestone)
Q2	Complete initial theatres deep-dive and agree resulting priorities Agree and sign off SDEC business case Agree SOP for same day emergency care provision (across all areas) to ensure consistency Initiate and commence 3 transformational / medium to large scale schemes	Patient involvement events take place (milestone) SDEC business case signed off SDEC SOP Service specifications reviewed against services provided (milestone)
Q3	Develop assessment unit pathways Discuss initial ' live' report at October CIP Board and agree priorities for next 6 months	Live Contribution Report in place Priorities agreed for better understanding of services (Milestone)
Q4	Implement revised same day emergency care pathways Review of services provided by division against service specifications	AGU, ASU and AMU pathways established (milestone) Efficiency /service priorities for 23/24 agreed (Milestone)

ANTICIPATED IMPACT	
IMPACT	**DOMAIN**
Possible costs associated with SDEC Business cases	Finance
Reduced pressure and more appropriate utilisation of UECC and efficient, high quality same day emergency care.	Operational
Financial / Quality impact of transformational approach to efficiency / waste programme (Positive)	

MEASUREMENT OF SUCCESS	
MEASUREMENT / KPI	**TARGET**
Zero length of stay for patients following re-designed pathways	
Efficiency target delivered in full (by year end)	
22/23 financial plan delivered (year-end)	

RISKS	ISSUES
• Specialties do not buy into the "pull" pathway processes that will circumvent UECC • Capacity of staff to deliver change and improvements • Not having capacity to deliver Trust transformational schemes (corporate and divisional) • Lack of clinical / divisional engagement to make efficiency savings and service change • Agreement on strengthening team / system to be used for PLICs takes longer than plan • Challenge in identifying income at service level given current contracts	• Lack of shared ownership of acute pathways • Support services capacity to work with UECC, eg Health Informatics • Unfilled (hard to fill) vacancies • Not having capacity within the finance & contracting team to deliver 'live ' contribution information / benchmarking

Subject:	Finance and Performance Committee 25 May 2022 and 29 June 2022 Combined CHAIR'S ASSURANCE LOG – PART 1 AGENDA: Public Quorate: Yes	Ref: P105/22(i)	BoD: 08 July 2022

CHAIR'S LOG: Chair's Key Areas for Assurance/Escalation

Committee / Group: Finance and Performance Committee	Date: 25 May 2022 and 29 June 2022	Chair: Nicola Bancroft

Ref		Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
1	**Cyber Security**	The Committee received a report on the Trust's progress on addressing Cyber Security. Key points noted: - Ongoing action plan in place, updated monthly and reviewed at the Information Governance Committee - Independent annual audit as part of the Data Security and Protection Toolkit. Last year the Trust received significant assurance - Current organisational cyber risks are being aligned with the Trust's risk register - Rotherham's approach to testing resilience is regarded as exemplary across the ICB. It is owned across the Trust rather than just IT. It was agreed that the Committee would review progress and assurance three times a year.	Board of Directors	Assured

Ref		Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
2	**Operational Performance**	The Trust is 15th nationally in terms of the Referral to Treatment (RTT) position (as at April 2022), however there has been a deterioration in performance over the last 9 months. Funding has been agreed and allocated to assist with this over the next 2 months. Further discussions on "What Good Looks Like", the required decision making process and any support needed across the Integrated Care Board are taking place with the Executive Team. An update from those discussions is expected at the July Committee.	Board of Directors	Limited Assurance
3	**Financial Performance**	The Integrated Care System set a balanced financial plan with a c£25m unfunded deficit. After 2 months, the Committee noted a Trust deficit of £281k to the external income and expenditure control total. The Cost Improvement Programme was off plan by £626k (78%) on a risk-adjusted basis, albeit some recovery is anticipated in month 3 and month 4. From Month 3 the Committee will review the financial forecast and associated risks and opportunities for the year end to inform financial decisions going forward.	Board of Directors	Limited Assurance
4	**Cost Improvement Programme (CIP)**	The current annual target of c£9.1m is deemed extremely challenging. However, delivery in this area is pivotal to the achievement of the overall Trust Income and Expenditure plan. Alongside divisional and corporate targets, a number of complex/transformational efficiency schemes have been identified and cover the following areas: - eRoster - Stock management	Board of Directors	Limited Assurance

Ref		Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
		- Service specification - Clinical testing - Pharmacy investment to save - Digital self check-in. The potential size of the prize and phasing of delivery is under evaluation. The Committee requested that a prudent view of delivery be fed into the current forecasting process.		

Subject:	Quality Committee 25 May 2022 CHAIR'S ASSURANCE LOG – PART 1 AGENDA: Public Quorate: Yes	Ref: P105/22(ii)	BoD: 08 July 2022

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

Committee / Group: Quality Committee	**Date:** 25 May 2022	**Chair: Rumit Shah**

Ref		Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
1	Body Mapping Audits: Compliance Report	The Committee noted audits relating to body mapping in UECC were being undertaken. The Safeguarding Operational Group commissioned an audit of all paediatric patients attending UECC during May 2022 with the findings being reported to the Safeguarding Committee.	Board of Directors	Assured.
2	Sepsis Task & Finish Group	The Committee recognised that although work had commenced in process mapping management of sepsis, limited assurance received as there was an acknowledgement this work remains in its infancy. The Committee requested sight of the different work streams in place to address management of sepsis to include timescales for completion to be incorporated into the next report.	Board of Directors	Limited Assurance
3	CQC Assurance Report	The Committee welcomed the position that the Trust currently had no Section 31 or Section 29A in place. The Committee noted and discussed the challenges facing UECC with support being provided by the Executive Team.	Board of Directors	Assured
4	Performance Update	The Committee noted significant assurance on a number of the quality performance metrics. It was highlighted that a number of the metrics did not, as yet, have the data quality kite marks attached to them and clarity was sought for the next meeting in terms of timescales for the remaining metrics.	Board of Directors	Assured

Ref		Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
5	Quality Priorities 2022-23	The Committee received, discussed and approved the Quality Priorities for the next financial year subject to minor amendments.	Board of Directors	To note
6	Divisional Presentation: Community	The Committee received a positive presentation from the Senior Management Team from the Community Division who provided an overview of the Division and highlighted the following key points: • Production of a Divisional Strategy • Good compliance against the two hour Urgent Response Target • Good compliance with Mandatory training • Acknowledgement that there needs to be an improvement in the staff survey response. The Committee was assured that the Division has identified key challenges and priorities for the next year and actions are in place to address these.	Board of Directors	Assured

Subject:	**People Committee: 24 June 2022 CHAIR'S ASSURANCE LOG – PART 1 AGENDA** **Quorate: Yes**	Ref:P105/22iii	**BoD: 08/07/2022**

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

Committee / Group: People Committee	**Date:** 22 April 2022	**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 - Family Health	The Committee welcomed the leadership team from the Division of Family Health who provided an overview of the Senior Management Team highlighting the following: • The five services provided by the Division covered a broad range of areas, including community provision; • Total WTE was 649.45, with a pay budget of £30.7m; • Average vacancy rate of approx. 30 WTE, with proactive recruitment; • Demographics - average length of service 9yrs / average age mid-forties / predominately white and female workforce. • Numerous successes including an embedded senior leadership structure, mobilisation to the sexual health service following award of the tender in 2021, and excellent feedback from the Care Quality Commission and the Ockenden assurance visits. There was a programme of listening events, and supportive health and well-being provision; • Key risks were an exhausted workforce, increased pressures associated with the organisational recovery, and compliance with BAPM medical staffing standards on SCBU;	Board of Directors	Assured.

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
		• A sickness absence rate of circa 5%, and MAST compliance of circa 90%; • Staff survey – the Division was above the average in all sections, with engagement with the teams to progress areas of action The Committee noted the positive messages from the Division of Family Health despite ongoing challenges and was assured around the plan to address the risks and issues.		
2	Operational Plan 2022-23	The Committee received the report detailing the two programmes assigned to the People Committee and the position as at the end of quarter one: The programmes are: P4.1 Improve our staff facilities and increase the wellbeing support available to our staff – rated Green P4.2 Divisional leadership teams will undertake a bespoke leadership development programme – rated amber The Committee recognised progress to date, however until a Divisional leadership programme was in place the Committee had limited assurance.	Board of Directors	Limited Assurance
3	Workforce Report	The Committee received and noted the Workforce report highlighting the following: • Sickness absence for May stood at 6.44%, with COVID legacy still being seen. • Appraisal rates stood at 18%; • Core MAST stood at 90%, with Information Governance (IG) Training at 95%;	Board of Directors	Limited Assurance due to the continued sickness absence rates

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
		• Wagestream had been implemented which offered staff the ability to access their wages in the event of urgent and unforeseen expenditure; • The Executive Team has reviewed business mileage rates, and agreed an increase of the lower rate from 25p to 35p per mile for those colleagues undertaking over 3,500 business miles.; • The new NHS Jobs system had been implemented; • The E-rostering system had been revisited by the Internal Auditor, with a draft outcome of a significant assurance rating. • The seven recommendations from The Messenger Review of NHS leadership had been noted The Committee would continue to ensure that where possible the Trust would support colleagues due to the current economic challenges.		
4	Medical and Dental Workforce	The Committee had received three reports relating to the Medical and Dental workforce, namely: • In Depth Medical Workforce Report • Medical and Dental CPD Update • Medical Consultant Recruitment Pack Update Positive progress had been seen in all areas covered by the three reports.	Board of Directors	Assured
5	Risk Register	There were 6 risks rated at 15 or above directly aligned to the People Committee, with action plans in place for 3. The Committee noted that 2 risks rated 15 or above previously aligned to the People Committee had been re-graded to below 15 by the Risk Management Committee, and therefore removed from the Committee's risk register.	Board of Directors	Limited assurance, due to the current format of the report presented.

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee	Recommendation / Assurance/ mandate to receiving body
		The Committee noted that discussions continued with the Divisions to ensure appropriate articulation of the risks and that actions plans were in place. There remained a requirement for some risks to be reviewed, however this was being taken forward as part of the discussions with the Divisions. The Committee had also discussed the format of the report presented and had requested that it be revised.		
6	Board Assurance Framework	The Committee received and discussed the Quarter 1 position for the Board Assurance Risk aligned to the People Committee, namely: *U4: There is a risk that we do not develop and maintain a positive culture because of insufficient resources and the lack of compassionate leadership leading to an inability to recruit, retain and motivate staff.* The report detailed that the risk for quarter one had been scored at 3(L) x 4 (C) = 12, with no recommendation that it be changed for the quarter.	Board of Directors	Assured that appropriate processes were in place regarding the BAF.

Board of Directors' Meeting
08 July 2022

Agenda item	P106/22
Report	**Care Quality Commission (CQC) Assurance Report**
Executive Lead	Helen Dobson, Chief Nurse
Link with the BAF	B1
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: • The Inspection to UECC March 2022 • Assurance update from CQC Delivery group June 2022 • CQC Engagement – return to on-site visits • Quality Assurance Programme • Update on the CQC Operating Model
Due Diligence (include the process the paper has gone through prior to presentation to the meeting)	A summary of this paper has been presented to the Patient Safety Committee
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 2021/22 Inspection process. The Chief Nurse is the Board lead for Regulatory Compliance.
Recommendations	It is recommended that the Board of Directors: • Note the content of the Report • Acknowledge the Quality Assurance Programme
Appendices	None

1. CQC Visit – Urgent and Emergency Care – March 2022

1.1 The Trust received the final CQC Inspection Report on 31 May following the unannounced visit to the Urgent and Emergency Care Centre in March 2022. CQC published the Report on their Website on 10 June.

1.2 CQC issued a Notice of Decision confirming that the Section 31 condition received by UECC in 2018 had been lifted. The condition related to the statutory requirement to provide two Registered Sick Children's Nurses on every shift supported by the continued oversight of a medical practitioner at all times. Although this can still be challenging, due to staffing constraints, CQC recognised there is now a robust process in place to ensure compliance with rotas and that where there is a potential shortfall immediate actions are taken to agree appropriate mitigations.

2. CQC Assurance

2.1 Confirm and Challenge meetings have been held with Children and Young People, Maternity, Urgent and Emergency Care and Medicine throughout June. The Must and Should take Action Plan has been updated accordingly and was presented to the CQC Delivery Group on 14 June.

2.2 CQC confirmed that the Section 29a Warning Notification issued to UECC in August 2021 has now expired with no further urgent sanctions required. The Section 29a Action Plan is being amalgamated with the UECC wider Must/Should take Action Plan and will include the additional eight Must Take and four Should take actions identified within the 2022 CQC Inspection Report. Progress against these actions will continue to be closely monitored via the CQC Delivery Group.

3. CQC Engagement

3.1 CQC colleagues were due to visit the Trust on Thursday 30 June as part of their regular engagement process but this unfortunately had to be converted to a virtual meeting. In addition to the routine business they heard presentations from the Clinical Support Services and Community Divisions which were both well received.

3.2 The CQC Lead Pharmacist was due to meet with pharmacy individuals and review progress against the Medicines Management agenda. This is a follow up visit to the External Review carried out by NHSE/I in 2021. This will now be incorporated into the site visit rearranged for July.

3.3 The Trust welcomes a return to on-site visits as they provide an excellent opportunity to showcase some of the good work being undertaken and build confidence with clinical teams in meeting with CQC outside a formal inspection process. An on-site visit is planned for alternate CQC Engagement meetings, which will allow the organisation to plan an effective visiting programme, giving all clinical areas the chance to be involved over the remainder of the year.

4. Quality Assurance

4.1 A programme of proactive Quality Assurance visits is in place. We are working collaboratively with Barnsley Hospital NHS Foundation Trust where we can both contribute to and learn from each other at clinical service level.

4.2 A three-man team from Rotherham joined BHNFT colleagues on Friday 10 June to visit the Children and Young People service. The team found the experience extremely

rewarding and productive and their contribution was much appreciate by their Barnsley counterparts.

4.3 A return visit is planned for the Surgical Division, including Critical Care on 5 July with a five strong team joining the day from Barnsley. A significant amount of preparation has been put into the day in order to ensure we optimise the full benefit. Colleagues from the Surgical and Medicine Divisions are joining the 'inspection' team as a way of helping them appreciate what to expect from a visit and what evidence they should be looking for to provide the necessary assurance on the delivery of safe, high quality care.

4.4 Planning is underway with the Division of Medicine, with an expected date in the last week of September. BHNFT have confirmed they will support again and are currently sourcing a team.

4.5 The Trust will support BHNFT with a Quality Assurance visit to the Urgent and Emergency Care centre at Barnsley, again at an agreed date in September.

4.6 Early planning discussions are in hand with the Outpatient and Community Services.

4.7 A 360 Internal Assurance Audit has been commissioned to look at the Trust End of Life Care service. End of Life Care is a CQC core service in its own right, despite being applicable Trustwide. It is often quite a challenging experience as it covers a number of generic and highly specialised areas. The 360 Audit outcome will provide an excellent baseline on which to develop our plans going forward.

4.8 All core services identified above are currently completing a self-assessment against their individual Inspection Framework, which will populate the Quality Assurance intelligence gathering and focus the visit agenda on the day.

4.9 The output of each Quality Assurance visit will be presented to the CQC Delivery Group and form an integral part of the Improvement Plans for 2022/23.

5. CQC Strategy

5.1 As reported to the Board of Directors in December 2021, CQC launched *'A new strategy for the changing world of health and social care'* at the end of May 2021

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

5.3 It is expected that regulation will be more relevant to how care is delivered, and more flexible to manage risk and uncertainty

5.4 There will be changes to the operating model and assessment framework from 2022. The following points are included within their overarching strategy:

- 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

5.5 In addition there will be an enhanced monitoring approach with:

- A timeline of interaction with providers, partners and people, led by CQC teams to inform service profiles
- Decisions and prioritisation informed by evidence and insight profiles
- Profiles, which will identify services or quality statements, which may require further information and evidence collection
- A strengthened Provider Portal to encourage continuous information, evidence collection, providing a more granular view
- Site visits to focus on observations of care and speaking to people who use the services
- A proactive approach to ratings - for example - where thresholds are reached (e.g. where ratings are changed or there is a significant change to a scoring) the changes are approved and any necessary changes published outside of a formal inspection
- Ongoing collection of evidence will also influence frequencies of inspection and ratings changes

5.6 Since the launch of the new Strategy we have received no further intelligence as to when this will be implemented or what it will mean for Rotherham.

5.7 The predictions for a possible visit during the 2022/23 cycle included the national profile on Urgent and Emergency Care and Maternity services. We have seen this play out in the recent external visits to both these services.

5.8 The CQC guidance *'How CQC monitors, inspects and regulates NHS Trusts'* details the frequency of inspection in response to ratings. See table 1 below:

Previous overall rating	Maximum interval between inspection
Outstanding	Normally within five years of publishing the last core service inspection report
Good	Normally within three and a half years of publishing the last core service inspection report
Requires improvement	Normally within two years of publishing the last core service inspection report
Inadequate	Normally within one year of publishing the last core service inspection report

Table 1

5.9 Regardless of the guidance above the Trust needs to be mindful that:

- **Acute Services** - Critical Care, Surgery, Outpatient Services and End of Life have not been inspected since 2015/2017 and as such may be prioritised – all are currently rated as 'Good' overall; however the Quality Assurance Review described above is also designed to identify whether there has been any deterioration since this time

- **Community Services –** Community health services for both adults and children and Community End of Life Care are currently rated as 'Requires Improvement'. These services have not been inspected since 2017 so again may well be a focus in the 2022/23 cycle. Again, they are included in the Quality Assurance Programme.

6. Next steps

6.1 At the CQC Delivery Group on 14 June, it was recognised that for the first time in a number of years, the Trust does not have any urgent enforcement action against it. Although we recognise that we are at the beginning of our improvement journey, this is a positive message for our patients and staff.

6.2 As the level of external scrutiny diminishes, coupled with the slow but steady return to what will become the new norm, it is perhaps time for a re-set. We need to move away from a retrospective, reactive approach to one of continuous quality improvement.

6.3 Whilst we must ensure all issues that have been identified through the variety of intelligence sources, are addressed at pace, not least the concerns raised through the CQC Inspection Reports of 2021 and 2022, our improvement work must now be driven by our own vision and strategy.

6.4 By building a programme of continuing quality improvement, supported by a robust Quality Assurance programme and an effective, productive and collaborative working relationship with all stakeholders, we will meet the requirements of our regulators by default but importantly we will meet the expectations of our patients and our staff.

Board of Directors Meeting
08 July 2022

The Rotherham NHS Foundation Trust

Agenda item	P107/22
Report	**Integrated Performance Report – March 2022**
Executive Lead	Michael Wright, Deputy Chief Executive
Link with the BAF	D5, D6, P1, R2
How does this paper support Trust Values	The Integrated Performance Report supports the Trust's *Ambitious* value in ensuring we are constantly striving to deliver stronger performance across all of the core domains.
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	The Integrated Performance Report (IPR) is the monthly summary of Trust performance across the four domains of Operational Delivery, Quality, Finance and Workforce. This month's report relates to May 2022 data wherever it is available. It highlights performance against agreed national, local or benchmarked targets. Statistical Process Control charts are included against key metrics. The Trust has carried out an assessment of inequalities of access to care, which is provided in the separate Health Inequalities paper on the agenda today. Moving forward, this analysis will form part of the IPR itself. There are two core metrics around maternity care which currently reflect the metrics as defined in the Yorkshire and Humber Maternity Dashboard. However, these metrics differ to the national reporting, and as such, from next month, both sets of metrics will be reported within the IPR for completeness and to ensure full transparency around our performance. A full explanation of the differences between the metrics and any performance differences will be provided at that time.
Due Diligence	The Finance and Performance and People Committees have received the relevant elements of the Integrated Performance Report or identical information, with the Executive Directors approving the content for their domain. There was no Quality Committee held in June so for this month alone, the Quality domain has not previously been discussed via a Board Assurance Committee.
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 – May 2022

Board of Directors

Integrated Performance Report - May 2022

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				

Trust Integrated Performance Dashboard - Operations

KPI	Reporting Period	Type of Standard	Target 22/23	Benchmark	Previous Month (3)	Previous Month (2)	Previous Month (1)	Current Month	YTD	Same Month Prev. Yr	Trend	Data Quality
Planned Patient Care												
Waiting List Size	May 2022	L	**25,000**		22,486	22,378	22,244	22,228	22,228	16,965		
Referral to Treatment (RTT) Performance	May 2022	N	**92%**		76.2%	74.8%	73.9%	76.7%	75.3%	84%		
Number of 52+ Weeks	May 2022	L	**125**		59	62	73	79	79	332		
Number of 104+ Weeks	May 2022	N	**0**		0	0	0	0	0	0		
Overdue Follow-Ups	May 2022	L	-		11,622	12,517	13,869	14,062	14,062	9,734		
First to follow-up ratio	May 2022	B	**2.4**		2.53	2.33	2.25	2.23	2.24	3.00		
Day case rate (%)	May 2022	B	**80%**		87.6%	85.0%	87.2%	86.2%	86.7%	80%		
Diagnostic Waiting Times (DM01)	May 2022	N	**1%**		6.1%	5.8%	6.2%	7.3%	6.7%	26%		
Diagnostic Activity Levels	May 2022	L	**9059**		7,688	7,911	6,895	8,357	8,357	7708		
Emergency Performance												
Number of Ambulance Handovers > 60 mins	May 2022	N	**0**		109	270	201	226	427	60		
Ambulance Handover Times % > 60 mins	May 2022	N	**0%**		5.8%	14.8%	10.8%	12.3%	23.0%	3%		
Number of Ambulance Handovers 30-60 mins	May 2022		-		232	261	241	267	508	168		
Ambulance Handover Times % 30-60 mins	May 2022	L	**5%**		12.3%	14.3%	12.9%	14.5%	27.4%	8%		
Average Time to Initial Assesment in ED (Mins)	May 2022	N	**15**		23	26	25	27	26	19		
Proportion of patients spending more than 12 hours in A&E from time of arrival	May 2022	L	**2%**		8.0%	9.7%	9.4%	9.2%	9.3%	1%		
Number of 12 hour trolley waits	May 2022	N	**0**		0	0	0	0	0	0		
Proportion of same day emergency care	May 2022	L	**33%**		42.3%	41.1%	38.4%	41.1%	39.8%	41%		
Cancer Care												
2 Week Wait Cancer Performance	Apr 2022	N	**93%**		91.0%	92.0%	90.5%	88.2%	88.2%	97%		
2 Week Wait Breast Symptoms	Apr 2022	N	**93%**		78.0%	88.9%	90.6%	81.6%	81.6%	95%		
31 day first treatment	Apr 2022	N	**96%**		94.8%	92.9%	94.5%	97.6%	97.6%	93%		
62 Day Performance	Apr 2022	N	**85%**		74.2%	74.5%	77.2%	82.8%	82.8%	72%		
Patients waiting longer than 62 days on the PTL	May 2022	L	**65**		82	65	73	94	94	-		
28 day faster diagnosis standard	Apr 2022	N	**75%**		72.2%	76.5%	75.6%	73.5%	73.5%	66%		
Inpatient Care												
Mean Length of Stay - Elective (excluding Day Cases)	May 2022				2.81	2.64	3.08	2.29	2.65	3.07		
Mean Length of Stay - Non-Elective	May 2022				6.16	5.66	6.47	5.91	6.19	5.00		
Length of Stay > 7 days (Snapshot Numbers)	May 2022	L	**142**		187	217	178	216	216	156		
Length of Stay > 21 days (Snapshot Numbers)	May 2022	L	**42**		56	80	67	80	80	38		
Right to Reside - % not recorded (Internal Performance from May)	May 2022	B	**5%**		4.6%	3.8%	3.2%	4.3%	4.3%	16%		
Discharges before 5pm (inc transfers to Dis Lounge)	May 2022	L	**70%**		54.0%	50.2%	60.9%	56.4%	58.6%	56%		
Outpatient Care												
Did Not Attend Rate (OutPatients)	May 2022	B	**6.2%**		7.6%	9.2%	8.3%	8.3%	8.3%	8%		
% of all Outpatient activity delivered remotely via telephone or video consultation	May 2022	N	**25%**		15.6%	16.5%	15.9%	14.5%	15.1%	17%		
Advice and Guidance - Metric still being worked up												
Number of patient pathways moved or discharged to PIFU, expressed as a proportion of all outpatient activity.	May 2022	N	**5%**		0.3%	0.2%	0.3%	0.5%	0.4%			
Community Care												
MusculoSkeletal Physio <4 weeks	May 2022	L	**80%**		19.9%	21.0%	11.0%	12.7%	11.9%	18%		
% urgent referrals contacted within 2 working days by specialist nurse (Continence)	May 2022	L	**95%**		63.6%	62.7%	48.9%	56.0%	52.8%	70%		
A&E attendances from Care Homes	May 2022	L	**144**		138	142	86	138	138	136		
Admissions from Care Homes	May 2022	L	**74**		60	69	54	90	90	62		
Patients assessed within 5 working days from referral (Diabetes)	May 2022	L	**95%**		83.3%	90.9%	75.0%	88.9%	84.6%	100%		
Urgent 2 Hour Community Response	May 2022	L	**70%**		83.3%	73.2%	89.4%	88.7%	88.7%	0%		

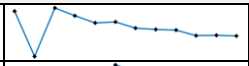
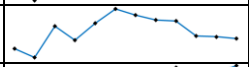
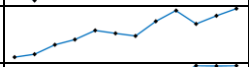
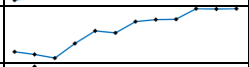
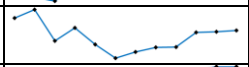
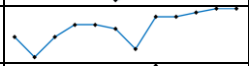
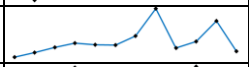
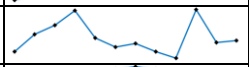
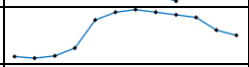
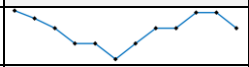
The Rotherham NHS
NHS Foundation Trust

Trust Integrated Performance Dashboard - Quality

	Reporting Period	Type of Standard	Target 22/23	Benchmark	Previous Month (3)	Previous Month (2)	Previous Month (1)	Current Month	YTD	Same Month Prev. Yr	Trend	Data Quality
Mortality												
Mortality index - SHMI	Dec 2021	B	**As Expected**		109.5	107.7	107.7	107.3	--	115.5		
Mortality index - HSMR (Rolling 12 months)	Jan 2022	B	**As Expected**		111.5	107.0	102.6	100.1	--	121.5		
Number of deaths (crude mortality)	May 2022		-		82	83	102	88	190	72		
Infection, Prevention and Control												
Clostridium-difficile Infections	May 2022		-		2	2	4	0	4	1		
Clostridium-difficile Infections (rate)	May 2022		-		17.5	18.0	19.2	18.3	18.3	17.5		
MRSA Infections (Methicillin-resistant Staphylococcus Aureus)	May 2022	L	**0**		0	0	0	0	0	0		
MRSA Infections (Methicillin-resistant Staphylococcus Aureus) (Rate)	May 2022		-		0.70	0.69	0.69	0.68	0.68	0.0		
E.coli blood bactertaemica, hospital acquired	May 2022		-		4	2	3	6	9	3		
CPE Infections, Hospital Provider	May 2022		-		1	0	0	0	0	-		
GRE Infections	May 2022		-		1	0	0	0	0	0		
Patient Safety												
Incidents - severe or above (one month behind)	Apr 2022	L	**0**		7	3	4	2	2	1		
% Potential of Under Reporting of Pt Safety Incidents	May 2022		-		52.54	51.80	52.60	52.77	52.68	47		
Never Events	May 2022	L	**0**		0	0	0	0	0	0		
Number of Patient Harms	May 2022		-		624	604	646	654	1,300	538		
Number of Patient Harms (Moderate and above)	May 2022		-		34	23	20	14	34	19		
Number of Patient Falls	May 2022		-		80	91	91	92	183	99		
Number of Pressure Ulcers (G3 and above)	May 2022		-		0	0	3	1	4	0		
Medication Incidents	May 2022		-		106	107	120	147	267	113		
Readmission Rates (one month behind)	Apr 2022	L	**7.6%**		8.1%	7.3%	7.6%	7.9%	7.9%	8.3%		
Venous Thromboembolism (VTE) Risk Assessment	May 2022	N	**95.0%**		95.4%	96.5%	97.3%	97.3%	97.3%	96.3%		
Number of complaints per 10,000 patient contacts	May 2022	L	**8**		8.08	10.49	11.09	9.38	10.18	9.60		
Proportion of complaints closed within 30 days	May 2022	L	**100.0%**		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
Hip Fracture Best Compliance	May 2022	L	**65.0%**		64.3%	86.7%	59.1%	83.6%	83.6%	73.3%		
F&F Postive Score - Inpatients & Day Cases	May 2022	N	**95.0%**		97.3%	97.0%	96.5%	98.8%	98.0%	97.7%		
F&F Postive Score - Outpatients	May 2022	N	**95.0%**		98.6%	96.9%	96.8%	97.4%	97.1%	97.7%		
F&F Postive Score - Maternity	May 2022	N	**95.0%**		96.9%	98.1%	97.2%	97.9%	97.7%	100.0%		
Care Hours per Patient Day	May 2022	L	**7.3**		6.50	6.20	6.50	6.50	6.50	7.9		
Maternity												
Bookings by 12 Week 6 Days	May 2022	N	**90.0%**		87.4%	93.7%	91.0%	91.2%	91.1%	92.4%		
Breast Feeding Initiation Rate	May 2022	N	**66.0%**		67.9%	63.6%	61.7%	70.8%	66.2%	69.8%		
Stillbirth Rate per 1000 live births (Rolling 12 months)	May 2022	L	**4.66**		3.14	2.35	2.33	2.72	2.72	3.72		
1:1 care in labour	May 2022	L	**75.0%**		98.6%	97.2%	96.4%	97.5%	97.0%	96.6%		
Serious Incidents (Maternity)	Apr 2022	L	**0**		0	0	1	0	0	1		
Moderate and above Incidents (Harm Free)	Apr 2022		-		0	0	0	0	0	0		
Cases Referred to HSIB	May 2022	L	**5**		0	0	0	0	0	1		
Consultants on labour (Hours on Ward)	May 2022		-		62.50	62.50	62.50	62.50	62.50	--		
% women on continuity of care pathway	--											

The Rotherham NHS
NHS Foundation Trust

Trust Integrated Performance Dashboard - Workforce

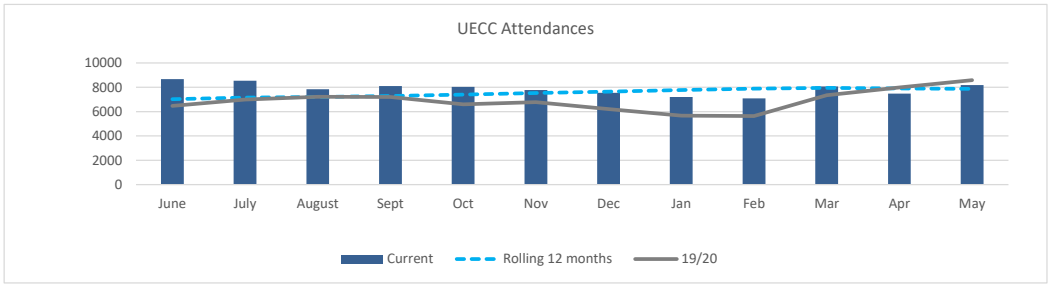
	Reporting Period	Type of Standard	Target 22/23	Benchmark	Previous Month (3)	Previous Month (2)	Previous Month (1)	Current Month	YTD	Same Month Prev. Yr	Trend	Data Quality
Workforce												
Whole Time Equivalent against plan - Total	May 2022	L			-325	-357	-357	-360	-360	-200		
Whole Time Equivalent plan - Nursing	May 2022	L			-37	-53	-54	-56	-56	-67		
Total Headcount	May 2022				4,953	4,925	4,942	4,957	4,957	4851		
Vacancy Rate - TOTAL	May 2022	L			7.32%	8.04%	8.02%	8.05%	8.05%	4.74%		
Vacancy Rate - Nursing	May 2022	L			2.73%	3.96%	4.01%	4.13%	4.13%	5.15%		
Time to Recruit	May 2022	L	**34**		33	34	35	35	35	28		
Sickness Rates (%) - inc COVID related	May 2022	L	**3.95%**		6.63%	7.05%	8.35%	6.44%	7.00%	5.68%		
Turnover	May 2022		**0.63%**		0.68%	1.21%	0.85%	0.87%	0.86%	0.70%		
Appraisals complete (% 12 month rolling)	May 2022	L	**90.00%**		81.00%	80.00%	75.00%	73.00%	73.00%	69.58%		
Appraisals Season Rates (%)	May 2022	L	**90.00%**					18.00%		-		
MAST (% of staff up to date)	May 2022	L	**85.00%**		90.00%	91.00%	91.00%	90.00%	90.00%	90.96%		
% of jobs advertised as flexible	May 2022		-		46.46%	51.43%	58.02%	55.81%	56.92%	-		

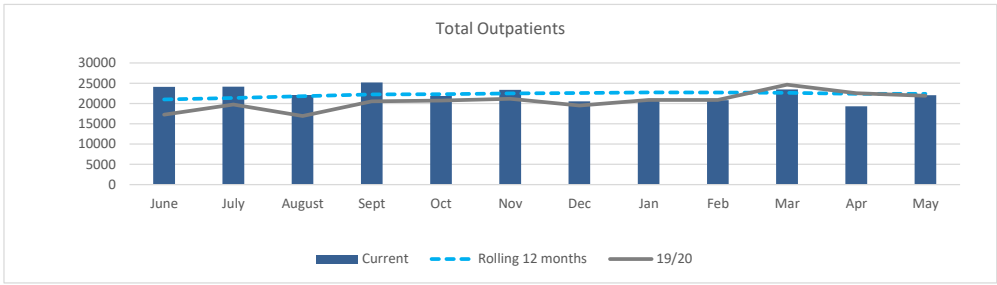
The Rotherham NHS
NHS Foundation Trust

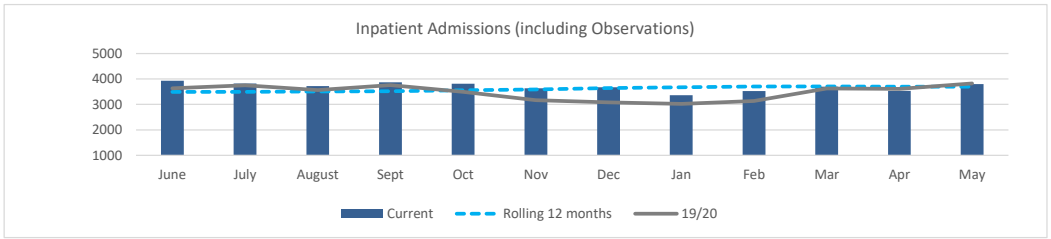
Trust Integrated Performance Dashboard - Finance

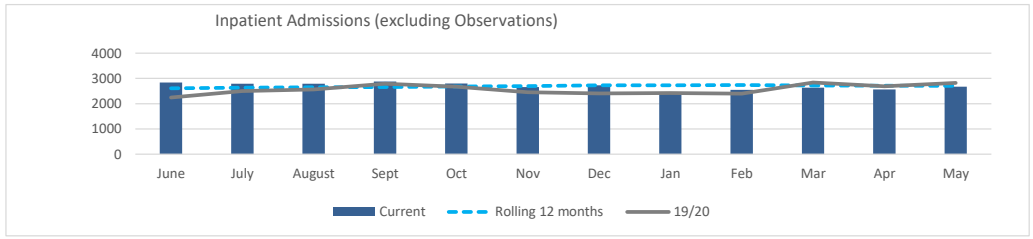
	In Month Plan £000s	In Month Actual £000s	In Month Variance £000s	YTD Plan £000s	YTD Actual £000s	YTD Variance £000s
I&E Performance (Actual)	(971)	(1,107)	(136)	(1,295)	1,564	(269)
I&E Performance (Control Total)	(1,115)	1,257	(142)	2,267	(2,548)	(281)
iciency Programme (CIP) - Risk Adjusted	402	100	(301)	803	148	(626)
Capital Expenditure	376	270	106	435	329	106
Cash Balance	(2,272)	(1,008)	1,264	26,304	21,882	(4,422)

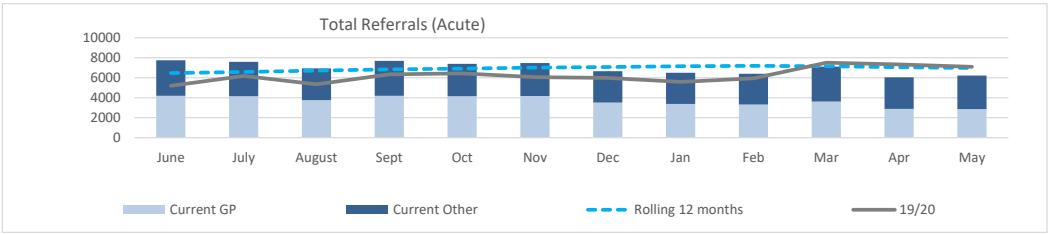
Trust Integrated Performance Dashboard - Activity

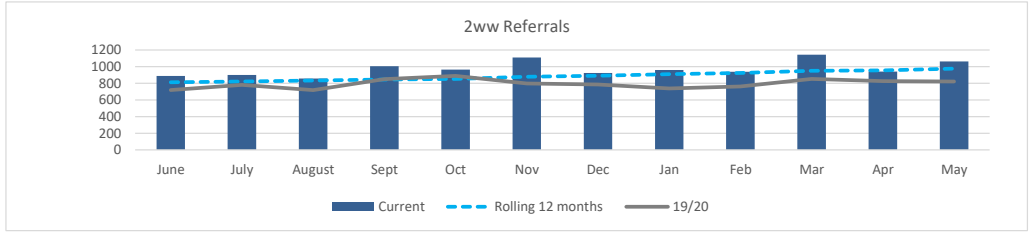












Trust Integrated Performance Dashboard - Activity

ACTIVITY

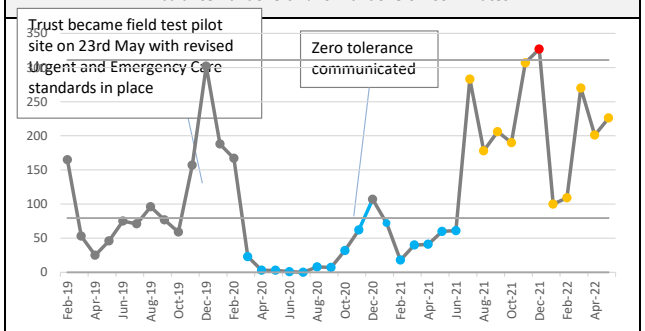
OUTPATIENTS			
	Activity 22/23	Activity 19/20 (WDA)	As % of 2019/20 WDA
May	22,208	23,305	-5%
YTD monthly average	20,738	22,092	-6%

DAYCASES			
	Activity 22/23	Activity 19/20 (WDA)	As % of 2019/20 WDA
May	1,876	1,934	-3%
YTD monthly average	1,716	2,073	-17%

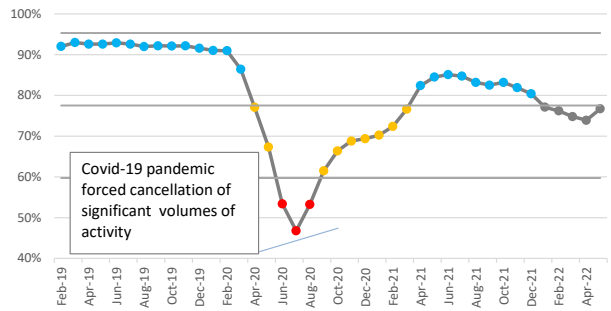
ELECTIVE ACTIVITY			
	Activity 22/23	Activity 19/20 (WDA)	As % of 2019/20 WDA
May	311	349	-11%
YTD monthly average	277	370	-25%

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

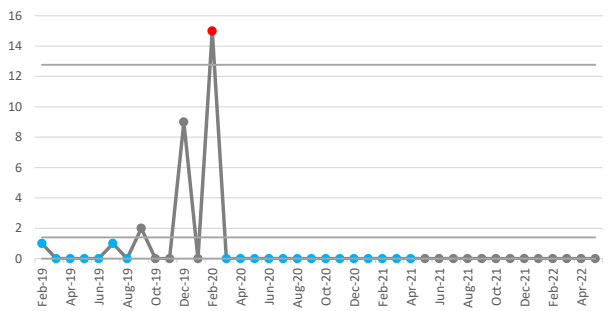
Ambulance Handovers - % of handovers > 60 minutes



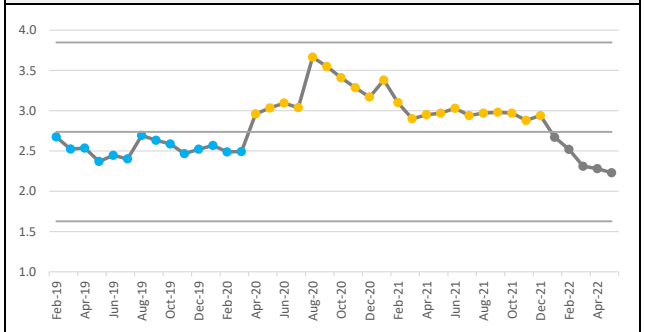
Referral to Treatment - % of patients waiting less than 18 weeks for treatment



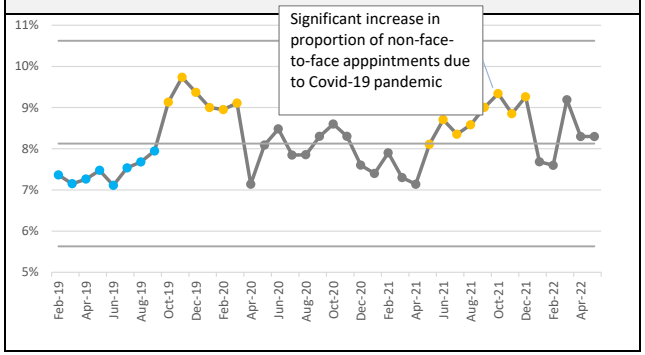
12 hour trolley waits - per month



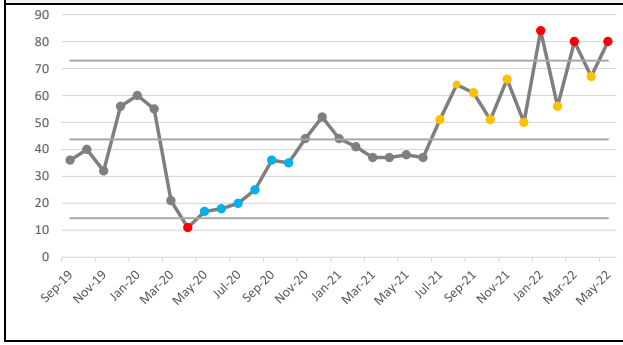
First to Follow-Up Ratio



Did Not Attends (DNAs) % of appointments

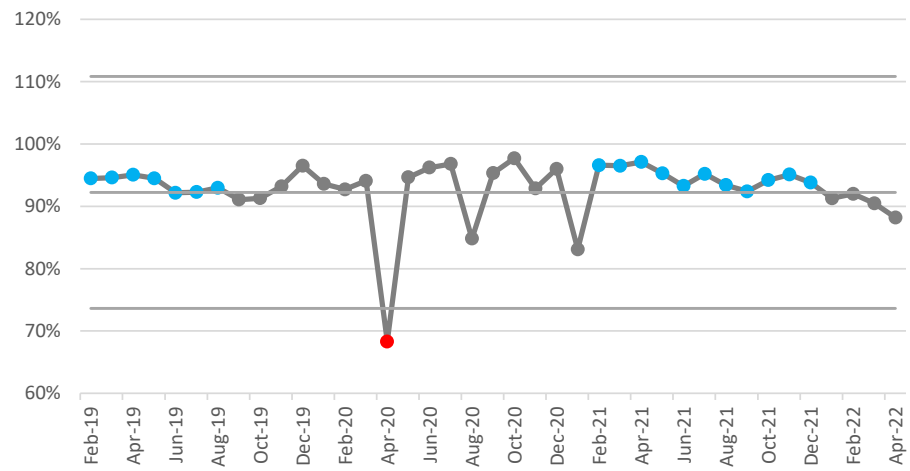


Length of Stay > 21 days (Snapshot Numbers)

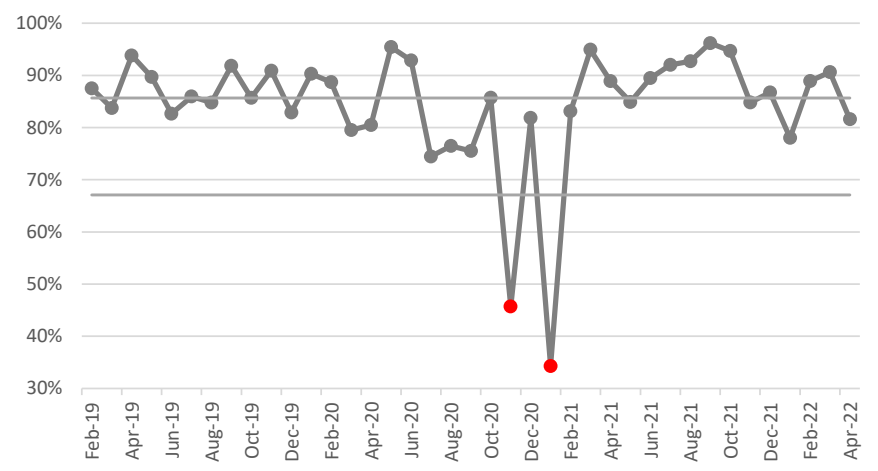


Trust Integrated Performance Dashboard - SPC Charts - Operational Performance (2)

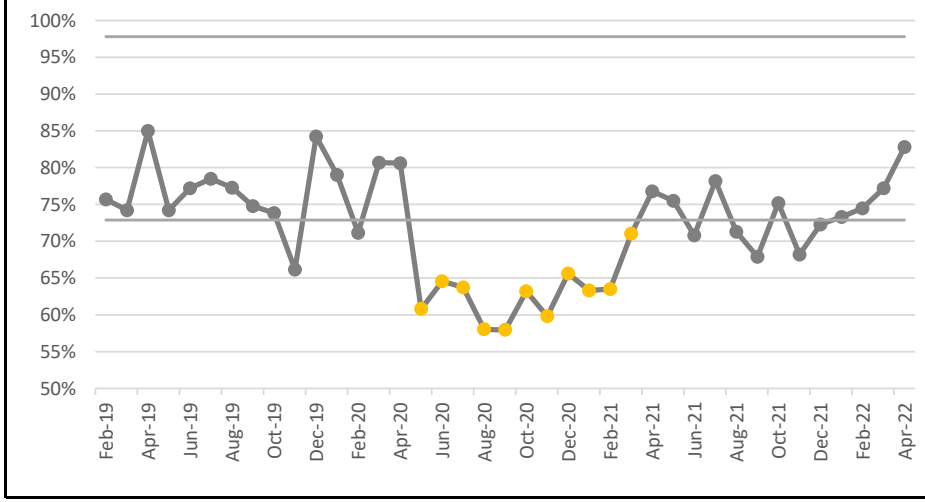
Cancer 2 week wait standard



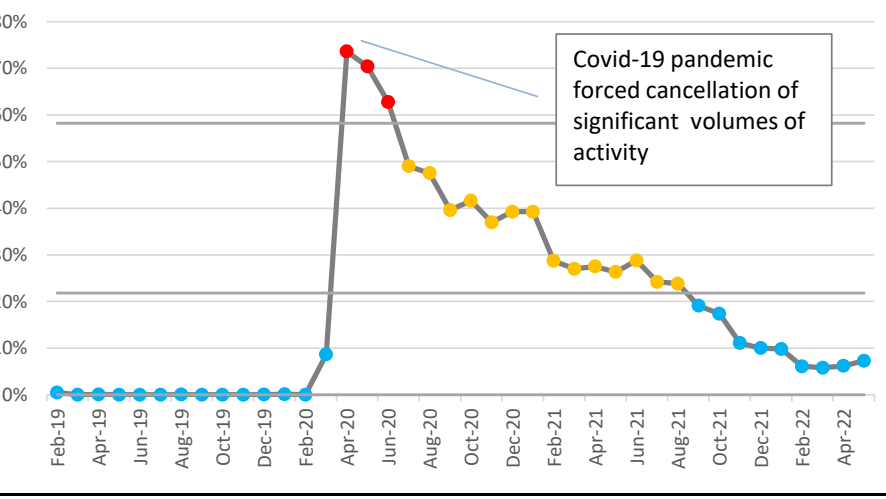
Cancer 2 week wait breast symptoms standard



Cancer 62 day first treatment standard

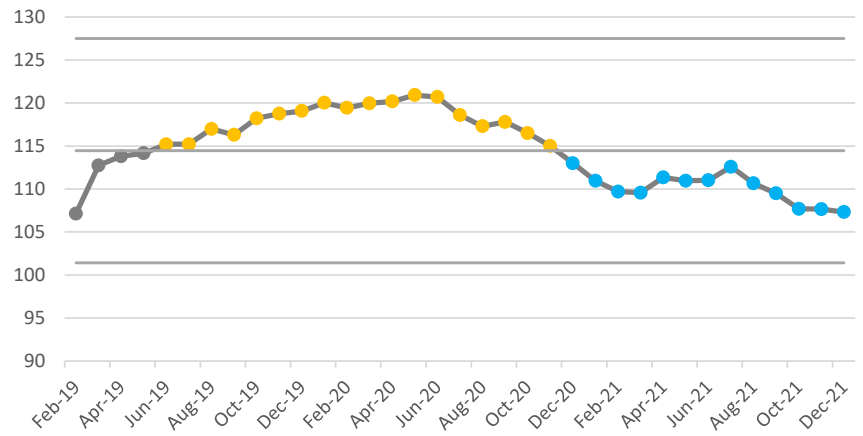


Diagnostics - % of breaches over 6 weeks (DM01)

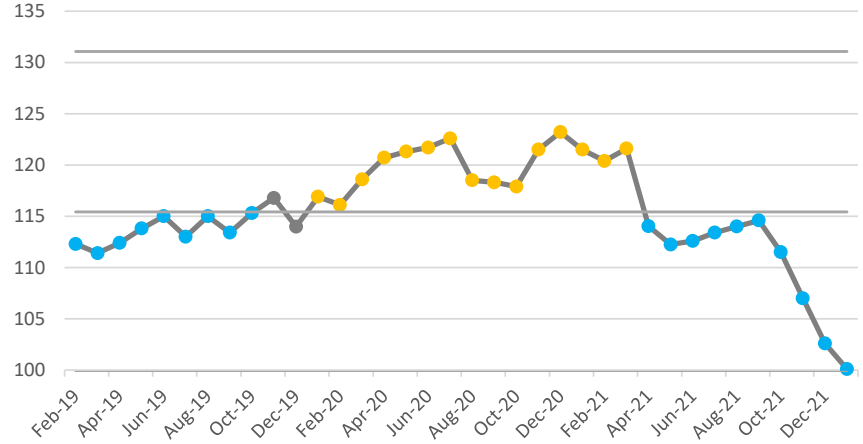


Trust Integrated Performance Dashboard - SPC Charts - Quality (1)

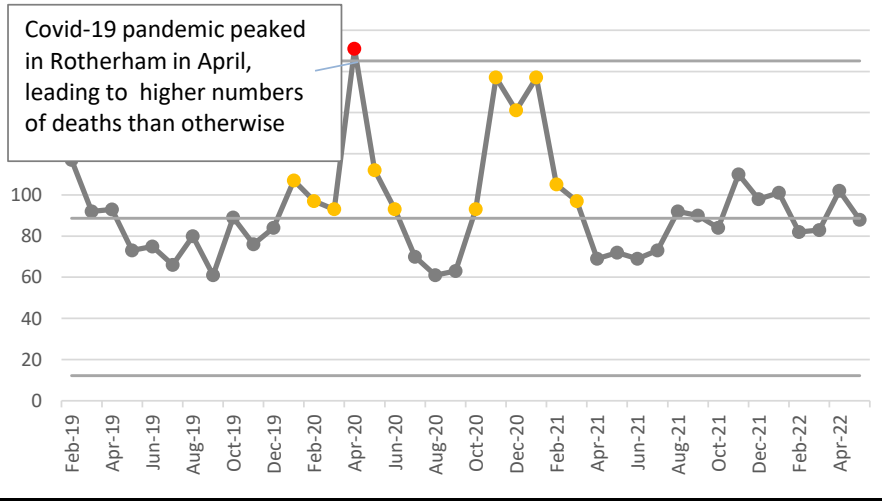
Standardised Hospital Mortality Indicator (SHMI)



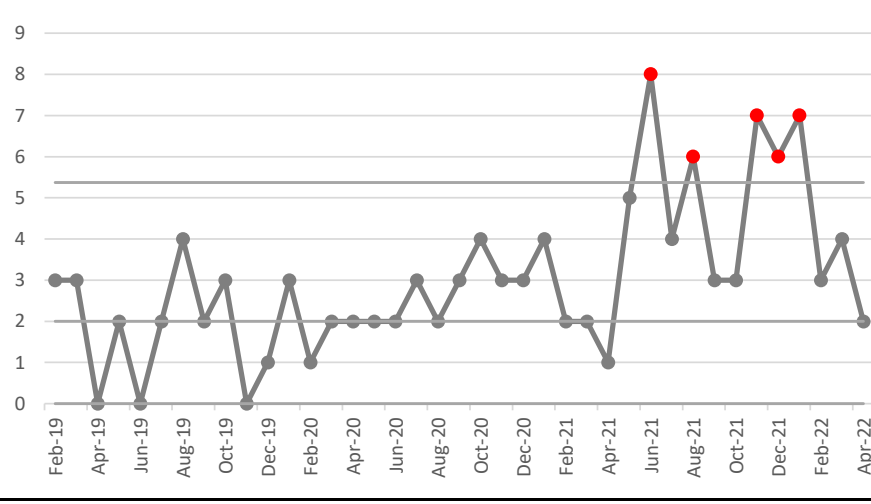
Hospital Standardised Mortality Ratio (HSMR)



Crude Mortality (number of deaths)

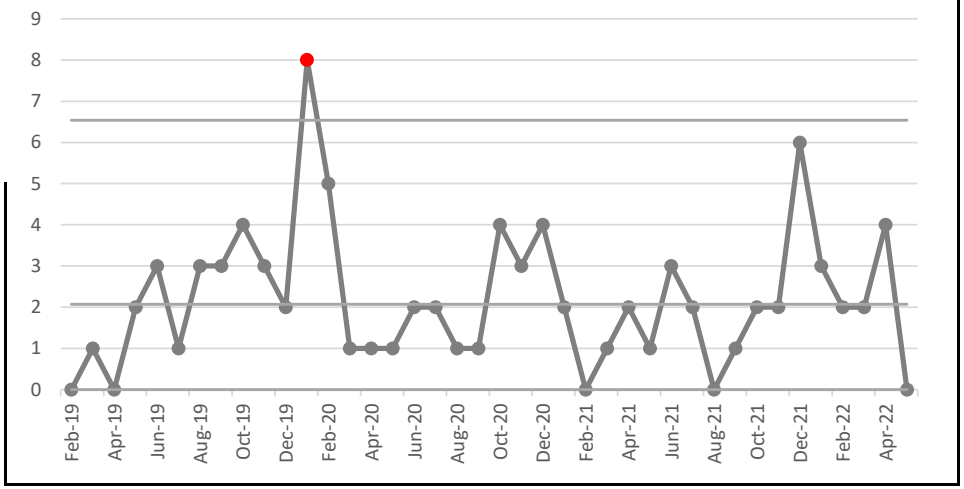


Incidents (severe or above)

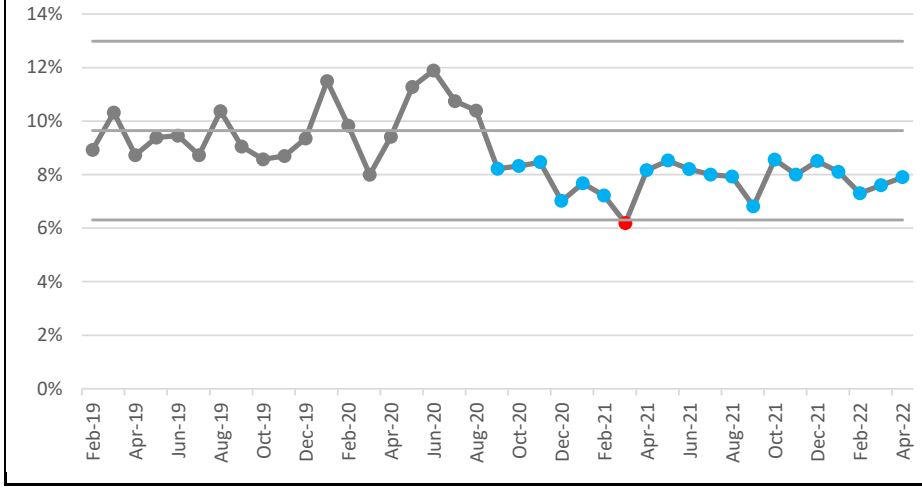


Trust Integrated Performance Dashboard - SPC Charts - Quality (2)

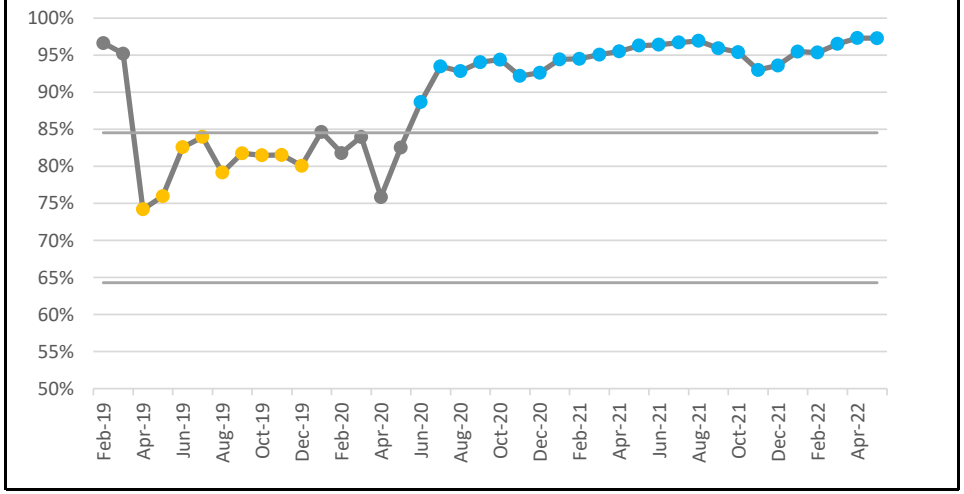
Clostridium difficile infections (number)



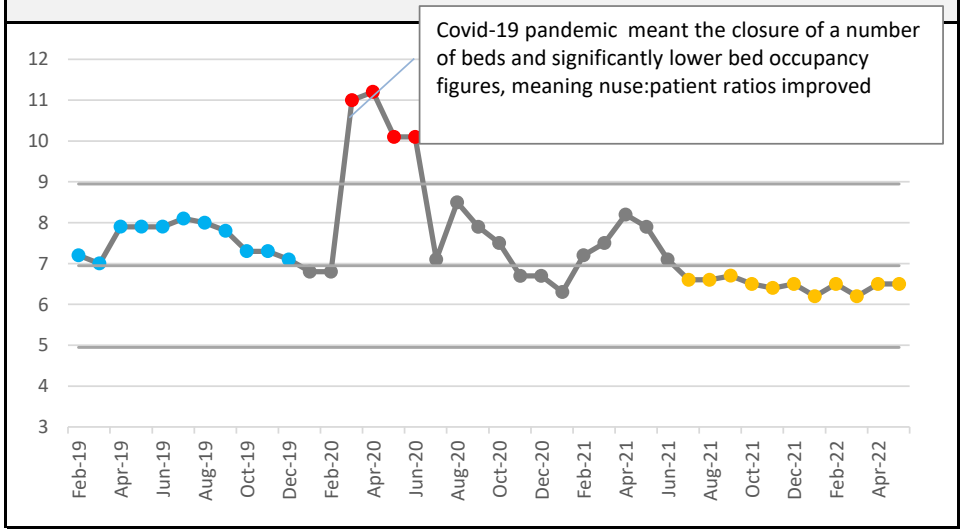
Readmissions (%)



Venous Thrombous Embolism compliance (%)

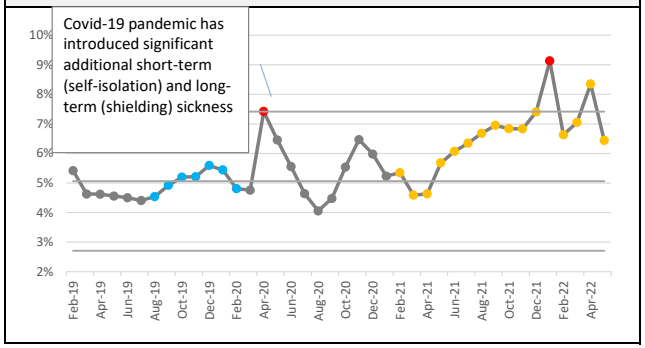


Care Hours per Patient Day

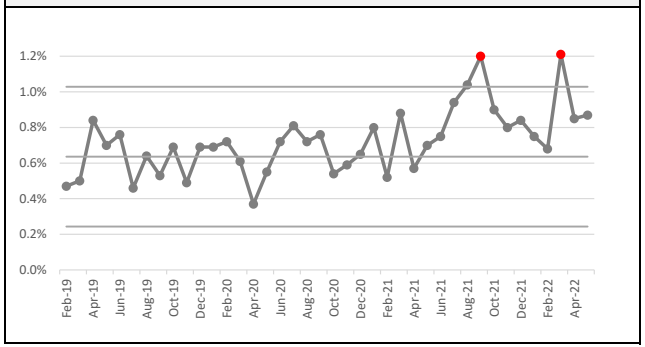


Trust Integrated Performance Dashboard - SPC Charts - Workforce

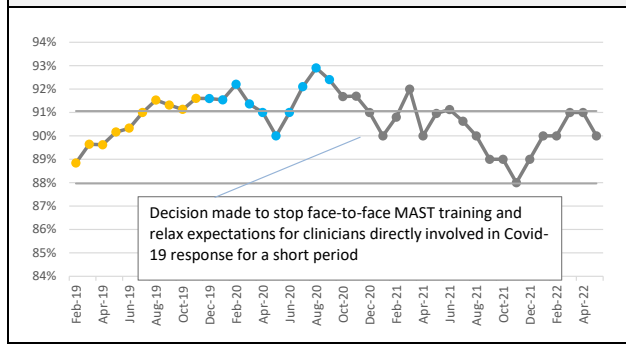
Sickness (%)



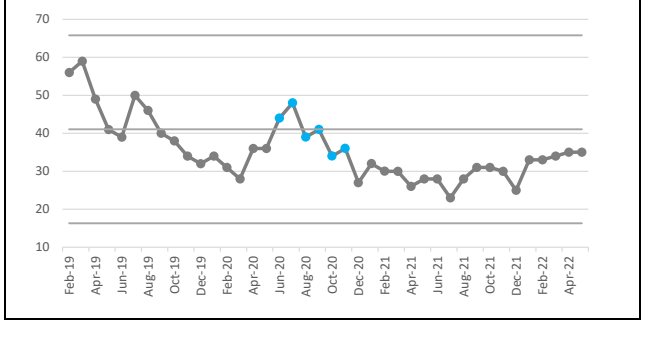
Turnover (%)



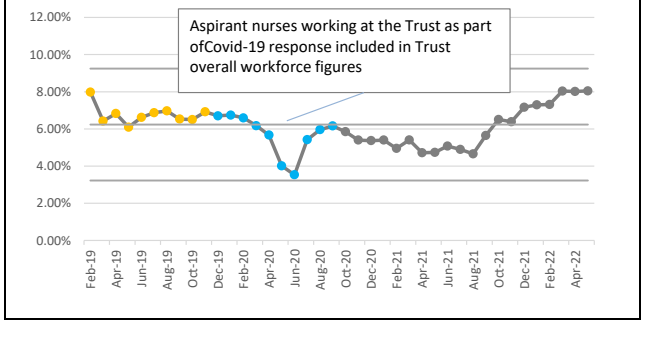
Mandatory and Statutory Training (MAST)



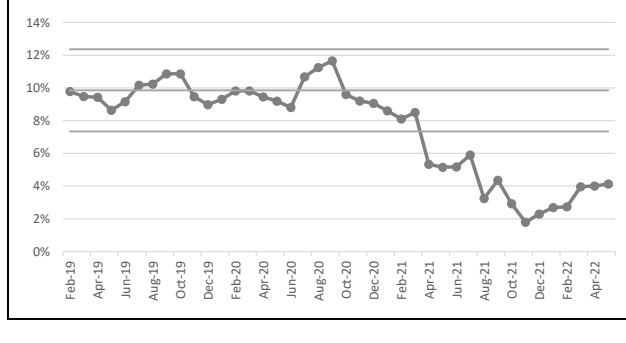
Time to Recruit - days



Vacancy Rate (TOTAL)



Vacancy Rate (Nursing)



Safer Staffing

Trust Wide Scorecard Rolling 12 Months & Year End position 21/22	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Daily staffing -actual trained staff v planned (Days)	89.80%	85.40%	82.55%	84.17%	87.39%	85.51%	86.74%	89.65%	87.75%	87.62%	86.48%	86.33%	84.11%
Daily staffing -actual trained staff v planned (Nights)	87.10%	89.95%	86.37%	83.00%	83.93%	82.94%	86.32%	87.50%	87.06%	86.41%	84.29%	88.00%	85.52%
Daily staffing - actual HCA v planned (Days)	129.70%	108.39%	104.30%	103.18%	100.43%	99.16%	101.90%	94.90%	90.63%	89.55%	89.47%	96.05%	95.88%
Daily staffing - actual HCA v planned (Nights)	113.20%	105.09%	101.02%	101.69%	98.49%	89.90%	95.29%	90.95%	89.28%	89.06%	92.35%	89.51%	91.18%
Care Hours per Patient per Day (CHPPD)	7.9	7.1	6.6	6.6	6.7	6.5	6.4	6.5	6.2	6.5	6.2	6.5	6.5

Integrated Performance Report Commentary

OPERATIONAL PERFORMANCE

Urgent & Emergency Care and Flow

- Site pressures were extremely high in April and May, with the numbers of Covid-19 patients occupying acute beds peaking at the start of April and then gradually falling throughout April and May. UECC Attendances over the reported two-month period were 4% below 2019 levels, with admissions similarly slightly below the levels pre-pandemic for the same period.
- Related to this, the number of super-stranded patients (21 day+ length of stay) remained high during April and May following the increase in March, which relates to the high Covid-19 occupancy in the Trust.
- The increased challenges with flow through the organisation led to another difficult two months regarding ambulance handover delays over 60 minutes, with over 200 'black breaches' in each month. In May, the Trust trialled a cohorting approach over a two week period with Yorkshire Ambulance Service (YAS), with the a report reviewing the results from the pilot due to be received in June. The proportion of patients waiting 12 hours in department was still well above the national targets that have now been set for 2022/23 (2%), with over 9% of patients spending at least 12 hours in the UECC in both months. It is worth noting that on occasion these long-wait challenges were due to the Trust accepting a divert from another neighbouring trust, which subsequently led to demand which could not be easily accommodated.
- These figures demonstrate the intense challenges experienced in the Trust in this month, through the combination of high demand at the front door, the ongoing Covid-19 demand and high levels of staff sickness due to the prevalence of Covid-19 in the community. With the changes in IPC guidance implemented within the Trust in late April, we had expected to see some pressures ease given the reduced need for additional cohorting and therefore reduced ward moves, but in reality, the changes haven't been significant enough to affect these core metrics.

Elective Care

- The size of the waiting list again remained relatively stable, although this still represents growth of over 30% compared to the start of the year. Referrals increased significantly in May however (compared to the previous year and were above 2019/20 levels) which will put further pressure on the waiting list

over the next few months.

- The RTT position has deteriorated significantly over the last 9 months, driven in part by capacity challenges within a few of the larger specialties and the constraints on our elective capacity for a number of weeks due to the reduction in the number of general elective beds. However, we saw an improvement in May due to the insourced activity within ENT and Rheumatology, with these two specialties accounting for 85% of the reduction in long-waiters. More recently, the Trust has had significant sickness levels within the Anaesthetic department, which has led to high numbers of cancelled lists due to a lack of sufficient staff. Inpatient activity has remained well below 2019/20 levels in the first two months of 2022/23 (-25%).
- With the capacity constraints noted above, we have seen an increase in the number of 52+ week waiters, which has more-than-doubled since December 2021. Teams continue to put plans in place to ensure as many as possible of these long-waiting patients are treated as quickly as possible, including utilising the Independent Sector in July to free up capacity at the Trust to deliver more activity wherever possible.

Cancer

- The size of the Cancer Patient Tracking List (PTL) increased during April and May. This has been driven by increases in the Lower GI PTL in particular, with a likely increase in referrals expected due to the recent media attention around bowel cancer symptoms. Similarly, the number of patients waiting over 62 days increased, with a deep dive review being undertaken to ensure patients are being moved through pathways as expected.
- 62-day performance improved significantly in the most recent month, but this is not driven by a sustained change to delivery. We continue to see more patients waiting longer for their treatment due to being unfit, or due to poor engagement in their pathway, as well as high numbers of patients now wanting to wait for their appointments or diagnostics due to holidays in recent weeks.
- The Faster Diagnosis Standard (FDS) was not met in May, driven by challenges in Lower GI, Urology and Skin. The medical workforce in Dermatology has fallen to just one substantive consultant which has led to under-performance in FDS, with a locum due to start in early July.
- 2ww has not been met for fourth consecutive month, with almost 80% of breaches in Lower GI, Skin and Upper GI. The performance in Skin pathways is expected to fall further in June and July as the backlog of patients is cleared. Delays in the triage of Lower GI patients have been rectified following a review of the root cause.

QUALITY SUMMARY

Mortality

- The latest Dr Foster data has now been updated to January 2022 for the HSMR and December 2021 for the SHMI. As per the previous position, the HSMR is currently within the 'as expected' category. However, when all Covid-19 activity is excluded from the HSMR, the figure falls to 95.5, well within the 'as expected' category. The in-month HSMR for January 2022 was 99.1, which is statistically within the 'as expected' band. If the regional HSMR values are ranked (lowest to highest) the Trust' s HSMR is 7th of 21 acute, non-specialist NHS providers.
- For the 12 month period there were 2 HSMR diagnosis groups with a relative risk banded as statistically 'higher than expected':
    - Other upper respiratory disease
    - Syncope
- Crude mortality was 3.4% over the 12-month period, compared to 3.2% regional and national average (acute, non-specialist Trusts).

Patient Safety

- There were 3 incidents deemed to be severe or above in March and 2 in April, and these have all been investigated at Harm Free Care and Serious Incident (SI) panels as appropriate. Staffing levels continued to be affected due to the Covid-19 pandemic, with a reduction in the proportion of trained nursing staff compared to plan, but an improvement in the Healthcare Assistant position. The numbers of falls remained relatively consistent with the prior month despite these movements. There was a reduction in the number of patient harms reported as moderate harm or above in the latest data, with more than 98% of all harms considered to cause either low harm or no harm.
- The Trust re-continued to meet the national Venous Thromboembolism (VTE) assessment target, although for the specialties who are not achieving this performance standard, the Medical Director continues to raise the issue with the relevant Divisional Directors and Clinical Leads.
- Complaints per 10,000 contacts have fallen since the re-introduction of wider visiting which is positive, although continue to be above target. However, the increase in the absolute number of complaints suggests this is not of significant concern at this stage – with an average monthly number of complaints of 22 last year, compared to the two latest months of 27 and 26. In addition, the Friends and Family Test (FFT) results continued to be positive, with all scores well above the national target.

- Care Hours per Patient Day continues to be well below the benchmark, with a deterioration in trained fill rates in the most recent two months. This is expected to improve in the next 3 months with additional recruitment and filling of vacancies, and the Trust has been pleased to see the volumes of student nurses who have selected TRFT as their first or second preference trust when they complete their training.
- Ockenden – An Ockenden visit took place in late May, with initial verbal feedback given being incredibly positive. This is part of the national visits to all acute sites following the publication of the latest report.
- CNST – the scheme has relaunched and the maternity team continue to work on the workstreams. There are challenges around the maternity service dataset and carbon monoxide monitoring which are being addressed.

WORKFORCE SUMMARY

Recruitment and Retention

- The number of new starters for May 2022 increased significantly (75 WTE) compared with previous month (49 WTE), and represents a 40 WTE increase compared with May 2021. Surgery continue to see the highest number of new starters for May 2022, (14 WTE) followed by Community Services, (11 WTE). The Trust welcomed 12 WTE qualified Nursing & Midwifery staff in May 2022, 7 WTE of which were attributed to the Medicine Division.
- Overall vacancies for Nursing & Midwifery and support to Nursing & Midwifery was 111 WTE for the month of May. This is reduced to 62 WTE when taking into consideration the 49 WTE candidates going through the external recruitment process. There are currently 33 WTE newly qualified nurses/midwives who are currently awaiting confirmation of registration which have been included in the above figures.
- 12 month rolling turnover (voluntary leavers only) for the Trust was 11.7%, and represents a 0.2% increase compared to May 2021. The Nursing & Midwifery turnover (12 month rolling rate) for the month of May 2022 was 10.9% and represents an increase of 0.4% compared with previous month.
- Further analysis shows that of the 59 voluntary leavers for May 2022, 16, had the leaving reason of worklife balance, followed by 6 with the reason of relocation.
- Promotions, both permanent and temporary taken place over the month of May 2022 equate to 24 WTE, including 4.5 WTE attributed 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

- Monthly sickness absence rate (inc COVID-19) decreased by 1.9% to 6.4%, which remains above the Trust target by 2.5%. The decrease in the overall Trust sickness rate was driven by short-term sickness (2.1%), a 1.4% decrease compared with previous month. Long-term sickness remains the

most significant challenge, with 68 staff off on long-term sick with anxiety and stress-related illness.

- Sickness absence (inc COVID-19) remains above target in all divisions for the month of May, with the exception of Corporate Services. Medicine remains the highest at 8.6%.
- 12 month rolling sickness absence for May 2022 was 7% and represents a very small decrease compared to previous month. Compared with May 2021, rolling sickness absence has increased by 2%. 12 month rolling sickness absence excluding Covid-19 is 5.5%. All Divisions have seen a decrease in sickness absence for the month of May 2022 with Emergency Care with the highest decrease of 3.51%. This is reflective of the reduced prevalence of Covid-19.

Appraisals and Mandatory Training

- Overall appraisal rolling 12 month compliance rate for the month of May is 73% which is a 3% increase compared to May 2021. The rolling 12 month appraisal rate has decreased by 2% compared to previous month. All Divisions remain below the Trust target of 90%.Trust appraisal season compliance rate as at the end of May 2022 was 18% which is an 8% increase when compared to May 2021. Band 7 and above compliance for May 2022 was 20%.
- Core MaST compliance has decreased by 1% (90%), compared to previous month and is 5% above the Trust target (85%). Hand Hygiene compliance has increased by 4% (77%), compared to previous month but remains below the Trust target. Information Governance compliance has increased by 5% to 95%, which meets the CQUINN target (95%).
- All Divisions are above the Trust target for both core and job specific combined together, which is a fantastic achievement given the staff sickness challenges and ongoing pressures. Patient safety has the lowest compliance rate at 57%. The Estates and Ancillary staff group has the lowest compliance rate overall for both Core and Job Specific combined together with 83%.

FINANCE SUMMARY

The Finance summary commentary is included within the separate Finance Report.

Board of Directors' Meeting
08 July 2022

The Rotherham NHS Foundation Trust

Agenda item	P108/22
Report	**Reset and Recovery Operational Report**
Executive Lead	Sally Kilgariff, 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 to the Board of Directors for information regarding the recovery actions and plans to deliver elective activity and emergency care during the ongoing phases of the pandemic and resulting challenging circumstances: • Updates 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 • Describes the activity and actions the Trust has taken to deal with the pandemic, up to the month of May 2022
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 actions from the recovery meetings
Board powers to make this decision	The Board has delegated authority to the Finance and Performance Committee to review and feedback to the board any assurance issues, and breaches in SO, SFIs, scheme of delegation etc.
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 of Directors note the report.
Appendices	1. Operational update

Appendix 1

1.0 Introduction

1.1 This paper covers key operational indicators, an overview of Covid-19 related issues and the recovery plans as of May 2022.

1.2 Recovery continued during May, will both elective wards being open to elective capacity. The end of the month saw the extended bank holiday period due to the Jubilee celebrations. Operational plans were put in place to support the urgent care demand over the bank holiday, in line with the plans that were implemented over the Easter period.

2.0 Covid-19 position

2.1 Through this period the number of patients in hospital with Covid-19 remained fairly stable, with around 20-30 patients in hospital with Covid-19 throughout the month. The number of patients in critical care with Covid-19 remained at minimal levels, with only 1 or 2 patients requiring intensive support over the course of the month.

2.2 The new national IPC guidance that was implemented late April continued to positively impact on the trusts available bed capacity.

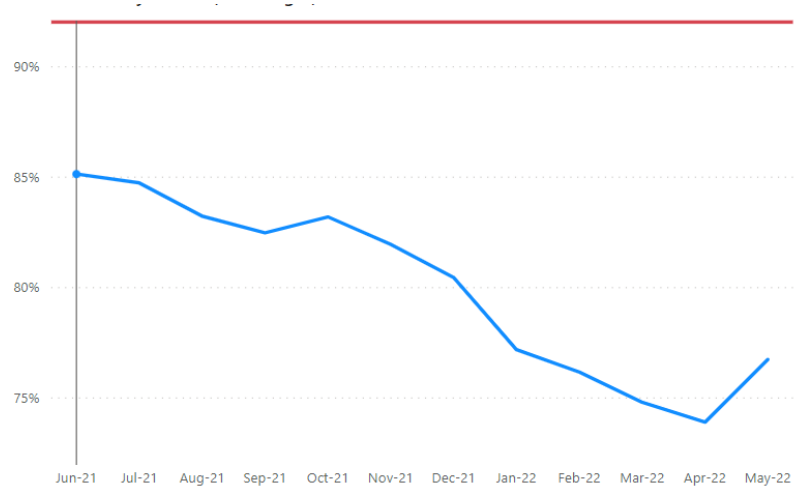
3.0 Latest Performance Update

3.1 Referral to Treatment

3.2 The Trust continues to meet the national requirement to have no patients waiting more than 104 weeks for treatment, ahead of the national target of the end of July 2022.

3.3 The Trust's overall RTT performance improved in the most recent month, largely due to the investment in insourcing within ENT and Rheumatology, with almost 85% of the reduction in 18+ week waiters coming from these two specialties. This is shown below in Figure 1, with the movement by specialty included within Table 1.

3.4 Figure 1: Trust RTT performance, June 2021 – May 2022

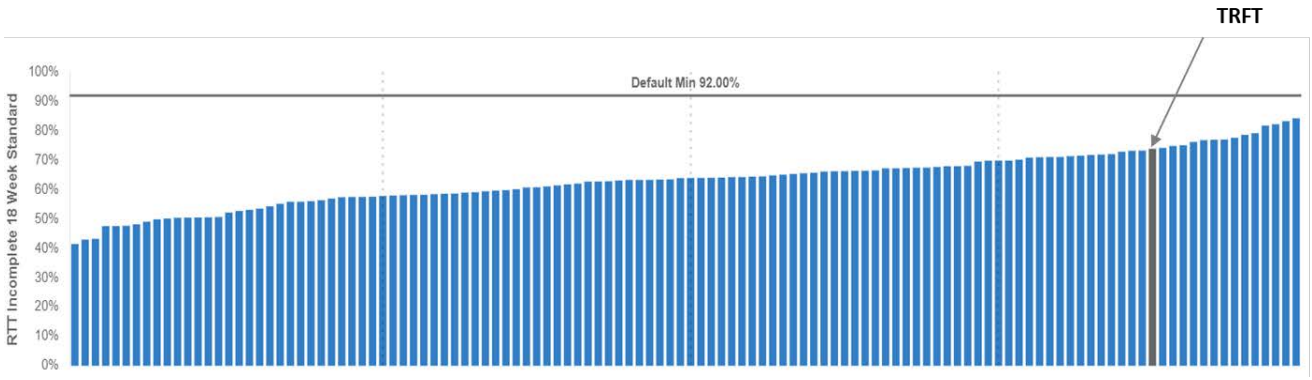


3.5 Table 1: RTT performance by Specialty, April 2022 and May 2022

	Variance in 18+ week waiters, April to May 2022	Variance in RTT incomplete standard performance, April to May 2022
Cardiology	-2	-0.8%
Dermatology	39	-0.3%
Ear, Nose & Throat	-323	12.1%
Gastroenterology	-26	1.7%
General Medicine	24	-4.6%
General Surgery	44	-0.7%
Geriatric Medicine	3	-2.5%
Gynaecology	31	-0.8%
Ophthalmology	-39	2.2%
Oral Surgery	-2	13.3%
Rheumatology	-210	13.8%
Thoracic Medicine	-86	6.3%
Trauma & Orthopaedics	28	2.8%
Urology	-6	1.8%
Clinical Haematology	-4	2.0%
OMFS	-93	4.3%
Paediatrics	-9	2.0%
Paediatric Cardiology	-5	4.3%
Rehabilitation Medicine	0	-7.4%
TOTAL	**-636**	**2.8%**

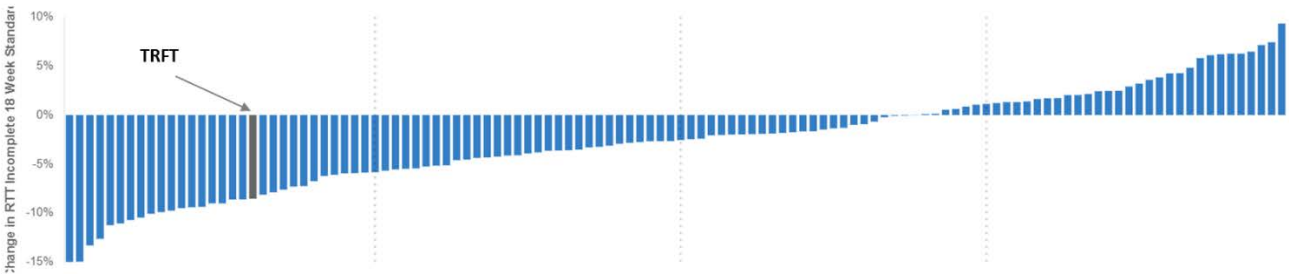
3.6 When compared to other trusts nationally, TRFT continues to benchmark well, ranking 15th out of 120 acute or combined trusts in the latest national data (April 2022) – see Figure 2.

3.7 Figure 2: RTT performance, April 2022, all acute or combined trusts



3.8 Whilst it is positive that performance has improved in the latest month, the position is a significant deterioration on performance several months ago. However, this represents a deterioration from Q3 2021, where the Trust was the most improved in the country over the previous 12 months. The latest data showing the change in our RTT performance over the last 12 months, shows an 8.5 percentage point decline, compared to a median of 2.5 percentage points – see Figure 3.

3.9 **Figure 3: Change in RTT performance, April 2021-April 2022 (latest available national data)**



3.10 This deterioration is due to three factors – firstly, the need to halt additional activity in the latter months of 2021/22 due to the uncertainty around the financial position; secondly, increased challenges around medical workforce capacity in a few key specialties; and finally, the closure of the elective bed capacity for a number of months over the peak Covid periods. Whilst the position has stabilised in recent weeks as some of these issues have been resolved, we are not yet seeing the improvement that we saw when capacity was reopened after the initial Covid-19 closure of capacity during 2020.

4.0 Cancer

4.1 Cancer performance has not met some of the key national constitutional standards since pre-Covid, but in the last few months there has been a noticeable deterioration in our 2ww performance in particular. In the latest data (April 2022), 2ww performance fell to 88.2%, with 106 patients not recorded as receiving a first appointment in two weeks. This was due to significant increases in the breaches in Lower GI (43), Upper GI (25) and Skin (19). Further analysis has uncovered the issue in Lower GI relating to when patients are being graded, which is occurring later than necessary to ensure patients are booked in within two weeks. Mitigations will be put in place to rectify this, which should improve performance from Q2 onwards.

4.2 In Skin, a shortage of cancer-trained clinicians has led to a sudden and significant deterioration in the performance, which is likely to worsen in May and June, before starting to recover in July when a new locum consultant is due to start. The position is being monitored daily, but without additional clinical cover and given the volume of referrals coming in, there is no other immediate solution. To date, requests for mutual aid from other providers have yielded no offers of support. As noted in previous reports, draft new cancer waiting times guidance for 22/23 (which is currently being consulted on across the NHS) suggests that the two week wait standard may be removed when the new guidance is implemented.

4.3 The Trust's performance improved against the 62-day standard, to 83%, which is the best performance since December 2019. However, looking ahead at May's provisional data, there is a significant drop-off in the subsequent month, which suggests the April position was potentially a matter of timing around when breaches occurred rather than a sustained improvement in performance.

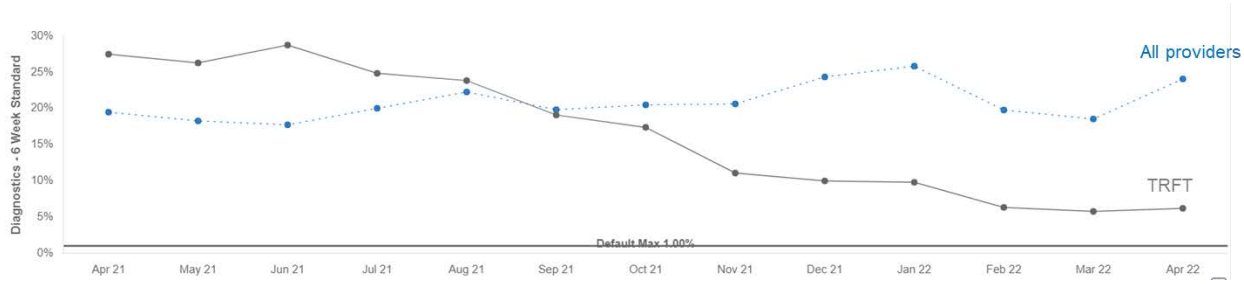
4.4 Fortnightly Cancer Recovery meetings with operational teams and the monthly joint CCG and Trust Cancer Strategy & Improvement Committee are providing focus on the recovery plans. The Trust has recently had confirmation of £350k of non-recurrent monies in 2022/23 from the Cancer Alliance, which will be used to fund a number of cancer-related posts within the organisation to support improved patient care.

4.5 Based on the draft new cancer waiting times standards guidance, the faster diagnosis standard (FDS) is likely to become the NHS's key metric for managing performance at the front-end of caner pathways. The Trust just missed that standard in April, with 73.4% of patients given a definitive diagnosis within the required 28 days. The impact of the 2ww capacity challenge will be seen in the May, June and July FDS performance figures as well, especially given the high numbers of expected breaches in Skin pathways. The mitigations above should help resolve these issues in the medium term so that the Trust can return to delivery of the standard from Q3 onwards.

5.0 Diagnostic Waiting Times

5.1 Diagnostic performance against the DM01 standard has been a marked challenge throughout the pandemic. We have shown positive improvements in our position with the Trust 8th best in the country against the full DM01 standard, following a rapid improvement trajectory over the last year when compared to the national position. However, there have been some significant workforce challenges in Endoscopy and Radiology in recent weeks, which are likely to mean a deterioration in the position when more recent data is published.

5.2 Figure 4: Trend in DM01 performance for TRFT compared to all providers, April 21-April 22



5.4 The performance as at the end of April is 7.3% of patients waiting over 6 weeks, against a pre pandemic performance of under 1%. This was based on just under 450 patients waiting over 6 weeks at the end of the month. Unfortunately, due to significant sickness challenges over the last two months (which are currently ongoing), the Trust has not achieved the DM01 standard, as anticipated. It is hoped that this will be recovered by August, but delivery will be dependent on an improvement in the current staff sickness levels. In addition, DM01 was failed in non-obstetric ultrasound for the first time since April 2021, again, due to unexpected challenges around staff sickness. The position has already significantly improved in May, and it is anticipated that performance will be returned to standard by the end of July.

5.5 Cardiac CT performance has remained static at just under 20%, with short-term additional resource agreed to support recovery. In addition, review of the patient referrals is being undertaken, to identify if any of the diagnostics are no longer required.

5.6 Table 2: Diagnostics DM01 performance, May 2022

Diagnostics (DM01) - Patients Still Waiting at Month End
May 2022

Category	Investigation	<6 weeks	≥ 6 weeks	Performance (% breaches)	Total WL
Imaging	Magnetic Resonance Imaging	482	10	2.03%	492
	Computed Tomography	731	172	19.05%	903
	Non-obstetric ultrasound	1929	151	7.26%	2080
	Barium Enema	0	0		0
	DEXA Scan	199	0	0.00%	199
Physiological Measurement	Audiology - Audiology Assessments	370	27	6.80%	397
	Cardiology - echocardiography	538	13	2.36%	551
	Cardiology - electrophysiology	0	0		0
	Neurophysiology - peripheral neurophysiology	0	0		0
	Respiratory physiology - sleep studies	287	18	5.90%	305
	Urodynamics - pressures & flows	0	3	100.00%	3
Endoscopy	Colonoscopy	407	27	6.22%	434
	Flexi sigmoidoscopy	100	2	1.96%	102
	Cystoscopy	130	4	2.99%	134
	Gastroscopy	373	7	1.84%	380
	Total	5546	434	7.26%	5980

6.0 Recovery Activity

6.1 The Trust continues to undertake as much activity as possible within the current constraints (workforce, financial and bed-base). The key issue continues to be the high levels of Anaesthetic sickness, which has led to more cancellations of theatre lists at short notice. In addition, gaps in theatre staffing have proven challenging to fill through normal bank and agency staff, which has exacerbated the theatre list cancellation issue over the last few weeks. Members of the Executive Team have met with relevant divisional colleagues to discuss options for mitigating the issue, with agreement to utilise short-term agency cover if suitable candidates can be sourced.

7.0 Elective Recovery Group Update

7.1 In late May, a decision was made to delegate authority to the Director of Finance and the Chief Operating Officer to allocate £500k to recovery schemes for investment as soon as possible. It was expected that this would enable additional activities for June and July, and further funding would need to be agreed for after this point. An Elective Recovery Group was established to manage this process, and ensure there was a collaborative forum which was focussed on recovery efforts. The inaugural meeting, chaired by the Chief Operating Officer, took place on 17th June. Key schemes have been agreed including some insourcing, independent sector and additional locum cover.

8.0 Looking Forward

8.1 Alongside managing the very immediate pressures and risks related to elective care delivery, there is a need to generate and deliver a longer-term plan for recovery, in order to reignite the ambition and belief within teams that TRFT can be a standout performer in elective care for our patients.

8.2 Discussions are taking place with the Executive Team and divisions about how we can mitigate the risk of insufficient progress on recovery of patient waiting times through the

year, both in terms of providing further financial certainty over the potential support for the year, and also confirming the organisation's ambition for the year. Both these elements will enable the wider Elective Recovery Group to develop a collective plan for recovery, which is likely to involve specialty-level focus months (often referred to as "sprint events") which will focus on the specific issues for each individual specialty, and take a targeted approach to recovery.

9.0 Emergency Performance

9.1 Demands on urgent care have remained a challenge and we have continued to see high acuity across our emergency pathways. The Trust continued to operate at OPEL level 3 or 4 throughout the month of May.

9.2 Plans were put in place to support urgent care demand through the extended bank holiday period due to the Jubilee celebrations at the end of the month. These provided additional medical cover over this period, to support ongoing review and discharge of patients.

9.3 The overall demands on urgent care continue to be a challenge, with the waiting times in UECC being a particular concern. The total time patients are spending in the department is high, with a high proportion of patients spending more than 12 hours in the department. Delays have been seen due to increased waiting times to see a clinician, as well as due to patients waiting for a bed.

9.4 Table 3: Urgent Care Metrics, May 2022

	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)**
Tue	**24/05/2022**	28	136	324	29
Wed	**25/05/2022**	14	155	317	17
Thu	**26/05/2022**	39	214	362	24
Fri	**27/05/2022**	23	156	270	10
Sat	**28/05/2022**	39	232	410	34
Sun	**29/05/2022**	33	188	351	22
Mon	**30/05/2022**	36	200	391	44
Rolling 7 Days		**30**	**183**	**346**	**180 (Avg 26)**
Year to Date (22/23)		**24**	**163**	**311**	**25 (per day)**

9.5 Yorkshire Ambulance Service have continued to see high demand, particularly on category 1 complex patients. Work to reduce ambulance handover times is ongoing and the Trust continues to perform well comparatively with others in the region. A pilot has been undertaken in conjunction with YAS to support rapid handover of patients at times of increased pressure. The aim was to release crews to be able to respond to outstanding 999 calls. This took place over a period of two weeks at the beginning of May. The evaluation of the pilot is currently being undertaken, but initial results were positive, with the average handover times during the pilot being faster than the comparative period before and after the pilot.

9.6 Length of stay remained a challenge in May, with the Trust having 60-70 patients in hospital over 21 days throughout the course of the month. This is over the national ambition of 12%, but slightly improved on the April position of 70-80 patients. The ongoing pressures in social care remain a challenge, particularly in relation to accessing packages of care to support more complex discharges.

9.7 A 'Community Assurance Week' took place prior to the Jubilee bank holiday period with partners across health and social care. This was run along the principles of 'Rotherham Reset' in order to support oversight of community bed capacity and to ensure timely discharge and flow of patients through the available capacity. This was found to be really beneficial and the working arrangements have remained in place in the weeks following the bank holiday period. The Trust is now starting to see the benefits in terms of available community bed capacity and the number of patients in hospital over 21 days reducing.

10.0 Conclusion

10.1 The Trust continues to achieve the national requirement to have no patients waiting over 104 weeks and whilst RTT performance in May improved, the overall recovery of RTT performance has declined over the last 9 months. Divisional teams are focussing on maximising use of our available capacity at this point, with the additional funding agreed in June likely to support these efforts over the next two months. It will be critical to resolve the ongoing challenges around anaesthetic and theatre staffing if we are to ensure that our patients receive their surgery in a more timely manner, and to reduce the current operational inefficiencies we are dealing with as a result of these gaps.

10.2 Emergency performance remains challenged, with patients waiting longer in our UECC. At times the increased demands on urgent care are putting additional pressure on our elective capacity. Work continues internally as part of the Acute Care Transformation programme, to improve flow through the hospital by improving our urgent care pathways. Work with partners, is also delivering improvements in urgent care, including the handover pilot with YAS and 'Community Assurance Week'.

10.3 The key challenge for the organisation over the coming months remains balancing the cost of additional activity to support further recovery with the challenging financial position, alongside balancing the competing demands of elective and non-elective care.

S Kilgariff
Chief Operating Officer
June 2022

Board of Directors' Meeting
08 July 2022

Agenda item	P109/22
Report	**Finance Report**
Executive Lead	Steve Hackett, Director of Finance
Link with the BAF	D5: There is a risk we will not deliver safe and excellent performance because of insufficient resource (financial and human resource) leading to an increase in our patient waiting list backlog and potential for patient deterioration and inability to deliver our Operational Plan. D6: There is a risk we will not be able to deliver our services because we have not delivered on our Financial Plans for 2022-23 in line with national and system requirements
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** ☐
Executive Summary (including reason for the report, background, key issues and risks)	This detailed report provides the Board of Directors with an update on: • Section 1 – Financial Summary for April to May 2022: o A summary of the key performance metrics linked to income and expenditure (including cost improvement performance), capital expenditure and cash management. • Section 2 – Income & Expenditure Account for April to May 2022:

	o Financial results for the first two months of the financial year 2022/23. - A deficit to plan of £136K in month and £269K year to date; - A deficit to the (external) control total in month of £142K in month and £281K year to date. The control total is what the Trust's performance is measured against with NHSE/I, having normally adjusted for depreciation on donated assets. The figures are significantly different this year due to non-cash income for the take-on of donated finance leases under IFRS 16 (£685K) as at 1st April 2022 and a contribution to capital expenditure (£379K) for the Public Sector Decarbonisation scheme. • Section 3 – Capital Expenditure 2021/22 o Financial results for the first two months of the financial year 2022/23 show expenditure of £329K year to date compared to a budget of £435K: an under-spend of £106K. • Section 4 – Cash Flow Position 2021/22 o A cash flow position for April and May 2022 showing a decrease in cash of £11,422K to a closing balance of £21,882K as at 31st May 2022, which is £4,422K lower than plan.
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 position for I&E has been reviewed collectively by and agreed with the senior Finance Team together with the Director of Finance. o The capital expenditure position has been discussed and reviewed by the Capital Planning & Monitoring Group, chaired by the Director of Finance. o More comprehensive and detailed reports of the financial results have been presented to Finance & Performance Committee and the Executive Team.
Board powers to make this decision	Within Section 4.5 of Standing Financial Instructions – Budgetary Control and Reporting – paragraph 4.5.1 states that *"The Director of Finance will devise and maintain systems of budgetary control. These will include:* *(a) Financial reports to the Board, in a form approved by Finance & Performance Committee on behalf of the Board."*

Who, What and When (What action is required, who is the lead and when should it be completed?)	No action to be taken given the overall satisfactory position being reported year to date.
Recommendations	It is recommended that the Board of Directors note the content of the report.
Appendices	None.

1. Key Financial Headlines

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

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

Key Headlines	Month P £000s	Month A £000s	Month V £000s	YTD P £000s	YTD A £000s	YTD V £000s
I&E Performance (Actual)	(971)	(1,107)	(136)	(1,295)	(1,564)	(269)
I&E Performance (Control Total)	(1,115)	(1,257)	(142)	(2,267)	(2,548)	(281)
Capital Expenditure	376	270	106	435	329	106
Cash Balance	(2,272)	(1,008)	1,264	26,304	21,882	(4,422)

1.2 The Trust has continued to marginally over-spend against its I&E plan for the second month of the new financial year. The control total is what the Trust's performance is measured against with NHSE/I, having normally adjusted for depreciation on donated assets. The figures are significantly different this financial year due to non-cash income for the take-on of donated finance leases under IFRS 16 (£685K) as at 1st April 2022 and a contribution to capital expenditure (£379K) for the Public Sector Decarbonisation scheme.

1.4 Capital expenditure is below plan at present by £106K, based upon a plan that has been profiled in consultation with individual budget holders. However, minimal expenditure has been planned during these first two months of the new financial year.

1.5 The cash position at the end of May 2022 is still very strong despite being £4,422 below plan, due primarily to an increase in outstanding debtors.

2. Income & Expenditure Account for the Two Months Ending 31st May 2022

2.1 The table below shows the in-month and year to date position. The overall position at Month 2 is an in-month deficit to plan of £136K and a year to date deficit to plan of £269K.

Summary Income and Expenditure Position	AP £000s	Month P £000s	Month A £000s	Month V £000s	YTD P £000s	YTD A £000s	YTD V £000s	2022/2023 Monthly Trend / Variance
Clinical Income	301,858	25,199	25,309	110	50,005	50,169	165	
Other Operating Income	23,928	2,189	2,273	83	4,752	4,898	146	
Pay	(225,798)	(19,058)	(19,466)	(408)	(38,111)	(38,659)	(548)	
Non Pay	(81,050)	(7,736)	(7,709)	27	(14,809)	(14,930)	(121)	
Non Operating Costs	(19,217)	(1,566)	(1,514)	51	(3,131)	(3,042)	89	
Retained Surplus/(Deficit)	(278)	(971)	(1,107)	(136)	(1,295)	(1,564)	(269)	

2.2 Clinical Income is ahead of plan in month, with extra income anticipated for additional patient transport, Aging Well Funding and minor eye clinic surgery from Rotherham CCG (£109K). Year to date performance reflects recovery of additional costs for rechargeable medical devices to NHS England (£33K) and over-recovery of income from patient charges (£30K).

2.3 Other Operating Income is ahead of plan in month and year to date with increased income from research, education & training, staff recharges and non-clinical services recharges across various services. Some of these will be a direct offset to additional expenditure incurred.

2.4 Pay costs are over budget in month by £408K with increasing over-spends for medical staff (£97K); nursing & support staff (£121K) and allied health professionals (£60K). Both in month and year to date performance is also being influenced by outstanding undelivered cost improvement targets of £248K and £487K respectively.

2.5 Non Pay costs are under-spending in month. A big contributory factor is clinical supplies and services under-spending by £253K, reflecting below target levels of elective activity in the first two months of the financial year. Year to date performance reflects the outstanding undelivered cost improvement targets of £138K. However, the cumulative underspend on clinical supplies and services (£311K) is therefore, being offset by over-spends on general supplies and services (£137K) and premises (£145K).

2.6 Non Operating Costs reflects slippage on depreciation charges.

2.7 Cost containment and CIP delivery will need to be managed proactively across all services if the Trust is to deliver against its overall plan successfully.

3. Capital Expenditure for the Two Months Ending 31st May 2022

3.1 During May 2022 the Trust incurred capital expenditure of £270K against a budget of £376K representing an under-spend of £106K both in month and year to date, as shown in the table below.

Scheme Categories	AP	Month			YTD		
		P	A	V	P	A	V
£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Estates Strategy	5,882	278	9	269	283	(14)	297
Estates Maintenance	1,720	54	168	(114)	74	196	(122)
Information Technology	1,691	37	43	(6)	65	95	(30)
Medical & Other Equipment	3,362	0	49	(49)	0	50	(50)
Contingency	78	7	0	7	13	1	12
Surplus/(Deficit)	**12,733**	**376**	**270**	**106**	**435**	**329**	**106**

3.2 Any works or goods accrued at year end where invoices have now been received have been matched off in Month 2; where the invoice has not yet been received the accrual has been carried forward and will be released against receipt of the invoice.

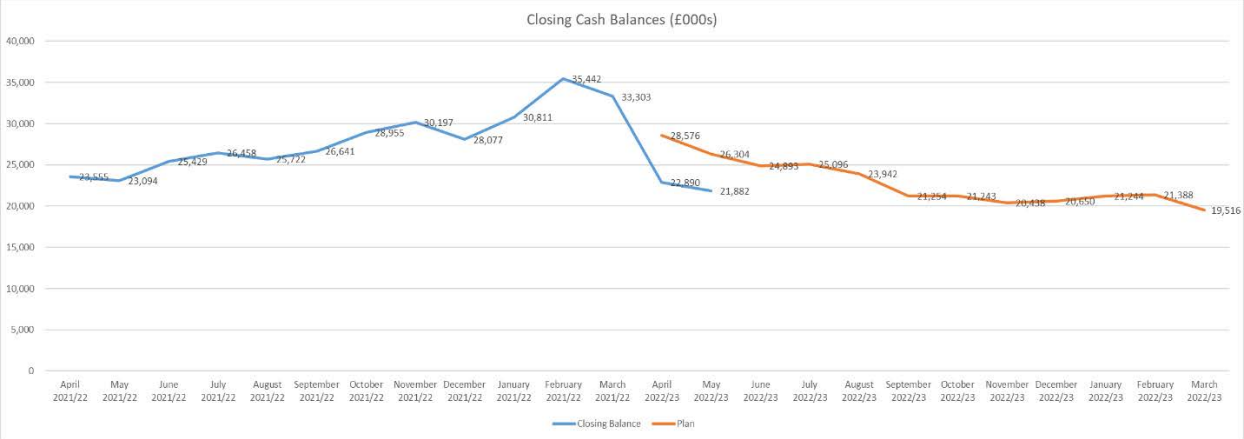
3.3 At the end of the 2021/22 financial year, there were orders for medical equipment totalling £54K where items were not delivered before 1st April 2022 (where no budget provision has been made in 2022/23). However, there are also credits within the capital programme

totalling £74K, relating to accruals that have been released where expenditure was lower than the accrual (£47K) and subsequent VAT adjustments (£27K).

3.4 The Trust has also adopted IFRS 16 for finance leases from 1st April 2022 and as such has brought assets to the value of £16,853K on to its balance sheet. £685K of this amount is funded from donations as the Trust does not formally pay for these assets, with the balance expected to be funded from an increased Capital Departmental Expenditure Limit (CDEL) allocation in due course. These figures have clearly been excluded from these reported figures.

4. Cash Flow Position up to 31st May 2022

4.1 Cash remains buoyant as at 31st May 2022 (£21,882K) although this is £4,442K behind plan. This is primarily due to increased debtors resulting from delays in agreeing contract values with Health Education England and Rotherham MBC.



4.2 Cash balances will need to be closely monitored throughout the year in light of the previously identified risks associated with delivery of the annual financial plan.

Steve Hackett
Director of Finance
22nd June 2022

Board of Directors Meeting
08 July 2022

The Rotherham NHS Foundation Trust

Agenda item	P110/22
Report	**Learning from COVID-19**
Executive Lead	Louise Tuckett, Director of Strategy, Planning & Performance
Link with the BAF	P1, R2, OP3, U4, D5
How does this paper support Trust Values	This paper demonstrates how the Trust is *ambitious* in wanting to learn from the past two years. It focusses on how we can work *together* to ensure we benefit from the experiences of our staff and our patients, in order to improve the care we can offer and maximise the opportunities we now have.
Purpose	**For decision** ☐ **For assurance** ☐ **For information** ☒
Executive Summary (including reason for the report, background, key issues and risks)	Following discussions at the Board Development Day in March 2022, it was agree that a paper setting out how and what we have learnt from the last two years of the pandemic would be presented to the Board in July 2022. This paper summarises the challenges that the NHS has faced during the pandemic and how that has affected the way we have worked as teams and with our colleagues, patients and their families. It explains some of the constraints we have had to manage and the changes we have seen throughout the development of the pandemic. As individuals, teams and indeed the entirety of the NHS, we have learnt some incredibly valuable lessons over the last two years, which will shape the future of the NHS. We have needed to adopt changes at a pace never before seen in the NHS, and it is therefore appropriate that we take time to reflect on what has proven valuable and beneficial, and what challenges we still need to resolve. These learnings are highlighted in here, within three over-arching categories of workforce, operational delivery and patient care.
Due Diligence	This paper has been presented to the Executive Team for information.
Board powers to make this decision	No decision is requested
Who, What and When	No decision is requested. This paper brings together a number of aspects across workforce, clinical ways of working and operational processes.
Recommendations	It is recommended that the Board of Directors note the contents of this report.
Appendices	Learning from COVID-19

Learning from COVID-19

1.0 Introduction

The last two years have been unprecedented in the history of the NHS. The COVID-19 pandemic required a phased, rapid, clinically-led response. The immediate task was to identify how we needed to change our service delivery to ensure we were managing the urgent and critical demands of COVID-19 patients. However, over the subsequent two years the NHS has had to adapt and respond to a multitude of different situations as the pandemic (and the NHS's response) has developed. This has included the arrival of point of care testing for COVID-19, the successful rollout of a national mass vaccination programme, and most recently, the need to relax most infection, prevention and control restrictions in order to enable the NHS to maximise its capacity again. Each of these phases have required different responses at organisational level and within individual services, and Trust colleagues have continually embraced the asks of them to work flexibly and adapt what they are doing in an appropriate manner.

In order to ensure we recognise what we have learnt from the past two years, the paper reminds us of the progression of the pandemic at a high level initially, in order to set the context around our response. It then sets out some of the ways in which we have worked differently in order to respond to the pressures at different points in time and summarises our current thinking on how we intend to move forward in these areas, noting there are still some ongoing challenges which we are yet to resolve.

2.0 Background

2.1 Phase 1 – Immediate Response

As the first wave of COVID-19 spread throughout the country, very clear national direction was given to NHS organisations on how they needed to react. Trusts were encouraged to discharge all patients they could on the basis of an assessment of risk, and occupancy levels in the hospital subsequently fell to levels never seen in recent history. Nationally, the public supported and rallied around the NHS (for example with regular Thursday evening 'Clap for Carers'), and there was an intense pride felt amongst colleagues, with a huge collective effort in response. Colleagues with front-line clinical training who had moved into support roles went back to being clinical; almost all meetings switched immediately to being virtual and many administrative staff switched to working from home as much as they could, whilst still delivering their roles.

2.2 Phase 2 – Managing Wave 1

Following the immediate shutdown of many planned services in order to ensure the safety of patients and staff, the Trust then had to rapidly agree how to develop the physical estate to manage the change in demand. This resulted in a new 20-bedded critical care ward developed within a matter of months, a mobile mortuary brought onto site, and changed use of one of the acute wards as a potential 'red' (or Covid-19) UECC capacity, for patients presenting at the front door with Covid symptoms. The use of PPE became standard for staff, with very regular new guidance (both clinical and non-clinical) published nationally. The Trust established a PPE group to ensure we had adequate PPE and provide oversight of the supply, including identifying appropriate alternatives where stock levels were low. During this time, many colleagues were managing the challenges of reduced or removed childcare and school provision, needing to balance their personal and caring responsibilities with the huge demands being placed on the health service and our Trust.

2.3 Phase 3 – Planning for future waves

For the last two years there have been significant clinical developments in response to the emergence of the Covid-19 virus, most of which have been made more quickly than ever before, due to necessity and a collective global effort. This has included new treatments, the development of multiple different vaccines, and a suite of varying testing methods. As cases subsided after wave one, some of these new elements started to change the landscape around Covid-19, particularly in the case of the testing regime. For the Trust, it soon became apparent that the pandemic would likely last a number of months, and therefore, teams needed to continue to work and plan in a flexible manner, responding to the latest needs of patients and the latest national guidance available. This was a difficult time for many colleagues, as there was so much uncertainty around the future of the pandemic.

2.4 Phase 4 – Subsequent waves and the vaccine

As the NHS prepared for the most challenged winter in its history, a new Covid-19 wave hit the UK, with the government testing programme quickly ramping up at the same time. Attention turned again to managing the peak in non-elective demand, with colleagues' roles in flux as teams responded to the latest patient needs. Availability of a vaccine was on the horizon, with the Trust also having to rapidly prepare for a mass rollout programme amongst our staff, wider health and social care system colleagues, and the broader population. Non-urgent activity was significantly reduced to protect patients and staff, and once again, colleagues continued to work and operate under extreme social restrictions, managing the understandable anxieties of patients and their families, with infection, prevention and control measures in place in every area of our work.

2.5 Phase 5 – Reduced prevalence and ongoing restrictions

During 2021/22, whilst Covid-19 continued to affect our operations, the national focus turned to the ever-growing backlog of elective patients, and the Accelerator Programme was launched nationally. South Yorkshire & Bassetlaw ICS opted to participate, with the Trust developing a plan for focussed on driving through as much elective activity as possible, whilst remaining focussed on the health and wellbeing of our staff. Our elective activity returned to close to 100% for two of the summer months, despite significant isolation criteria for all elective patients and swabbing requirements to test for Covid-19 before any procedures. By Q3 however, given the ambition driven through the Accelerator Programme, the Trust was the most improved Trust in the country for Referral to Treatment performance. During this period, the Trust was still working under significant infection, prevention and control measures, with colleagues having to continue to adapt all aspects of their work to manage this, making delivery of this level of activity an extraordinary achievement.

Due to uncertainty around the financial position at the start of H2, combined with a few stark medical workforce challenges in a few specialties, this level of activity reduced as we were unable to continue with the additional activity we had been delivering. Further waves of Covid-19 affected us again, with staff sickness a significant factor in challenges around managing the non-elective demand as well as focussing on the elective backlog. However, restrictions were gradually lifted nationally, and teams continued to manage the greatest needs of patients, and respond in an agile and flexible manner. Nationally, Trusts were asked to plan for activity to return to above 2019/20 levels, which the Trust had not been close to for over 9 months.

2.6 Phase 6 – Emerging from the pandemic and adapting for the future

For the last couple of months, the vast majority of Covid-19 infection, prevention and control measures and wider restrictions have been revoked, meaning some of the more basic

functions and operations of the Trust – such as hospital visiting and face-to-face meetings – can return to pre-pandemic ways of working. Despite this, the Trust is continuing to manage a radically altered landscape of healthcare needs within our population, particularly regarding our elective work, where patient waits are significantly longer than pre-pandemic, and as such, patients are often much more deconditioned and less ready for surgery. The following section highlights some of the ongoing differences in ways of working, and the lessons we have learnt from the last two years of the pandemic.

3.0 Learning from Covid-19

There are three primary areas of learning from Covid-19. Firstly, how we work with our staff and teams; secondly, how we manage our services and our patients to respond to the very different demand (and capacity) we are seeing; and finally, how we interact differently with our patients to support their care. These three areas are discussed in more detail below, with examples of specific learning provided to emphasise the ways in which the Trust has changed ways of working as a result.

3.1 Workforce

The most significant learning from the last two years - and the area where the changes we've made are likely to be sustained for a long time - relate to how we have asked our colleagues to work differently, and also the ways in which we've supported them to do so. Some of these changes were implemented almost immediately with the start of the first national lockdown, whereas some are more recent changes we have made as we have reflected on the past two years and how we need to ensure we have a flexible, adaptable, committed and healthy workforce for the future.

These changes have come in a variety of forms, including changing how our workforce operates, how we ensure we respond appropriately to what matters to our colleagues, and finally how we can support our colleagues to succeed in their work. Some of the specific changes we have made include:

- **Flexible working** – As national lockdowns were put in place in the first year in particular, colleagues were managing different caring responsibilities as childcare facilities and schools reduced or closed their provision. In response, where appropriate and possible, we have enabled colleagues to work more flexibly, working different hours to deliver the required outputs.

- **Working from Home** – Related to this response and alongside the government advice around staying at home, we encouraged relevant staff to work from home to safeguard their health and that of their colleagues at the peak of the pandemic. Staff were provided with IT equipment to enable them to work remotely, and the majority of meetings were moved to online platforms, such as Microsoft Teams and Zoom.

- **Health and wellbeing** – The pandemic took a toll on all of us, both at work and in our personal lives, as we dealt with the impact of social isolation, fears around our health and in some cases, the deaths or loved ones. Throughout the last two years, the Trust has placed significant emphasis on making decisions that support the health and wellbeing of our colleagues. This has included developing a full suite of health and wellbeing support for staff, including one-to-one psychological support, mindfulness sessions, 'thank you' packages and trauma resilience training. This package of support was developed based on clear evidence around what is important to staff, and what can

help colleagues manage the intense stress and ever-changing challenges we have had to respond to. Following the publication of the NHS Improvement Academy's report, *'Beyond Demoralised',* the Trust also requested their team's support in working with us to understand the specific challenges within one of our teams. This work is underway now, and has been designed to enable us to identify what we can do to remove some of the constraints and barriers to colleagues feeling motivated, energised and excited by their work. It particularly focuses on exploring where we are falling short on providing colleagues' basic needs, so we can respond appropriately.

- **Adaptability –** as the pandemic developed, national guidance around how to manage infection, prevention and control measures was being communicated on a very regular basis. This led to changes in process and ways of working never before experienced by the NHS. Staff adapted to completely new expectations on an almost weekly basis, including in terms of what PPE they needed to use, what restrictions were in place around patient contact, how the clinical risk landscape had changed and the new functions they were expected to perform. This adaptability led to an ability to respond to the needs of patients, and an ability to move forwards in some critical areas which the NHS has historically struggled to make progress on (such as the use of remote consultations).

- **Collaborative working** – as noted above, at the start of the pandemic, the entire country supported the NHS very publicly, with regular expressions of appreciation for healthcare staff. This encouraged a camaraderie amongst all NHS staff, not just those who we normally work closely with. At the same time, and with the full launch of Integrated Care Systems (ICSs, now Integrated Care Boards), national policy was encouraging healthcare organisations towards a more system-based approach to provision of healthcare. This opened up an increased appetite amongst staff for collaborative working and sharing resources, with mutual aid being requested and supported across different trusts within the ICS. At the peaks of the pandemic, our critical care clinicians met daily with other clinical colleagues from across the ICS (through the Critical Care Operational Delivery Network) via Microsoft Teams, giving them an ability to identify opportunities to better utilise the whole system critical care capacity through direct discussions. Data on provider operational positions and delivery was shared transparently on open access NHS platforms nationally, which inspired more informed learning on how other trusts were coping, and a better ability to learn from others.

- **Managing Covid-19 sickness –** given the specialist nature of Covid-19 absence, with nationally-dictated rules and requirements set around when colleagues are able to return to work, sickness relating to Covid-19 has been recorded differently to all other sickness, as per the national guidance. Whilst this has likely been a supportive measure for some staff, it has made fully understanding sickness absence more challenging, especially when compared historically. The Trust had to quickly implement a number of different recording and reporting methods and processes to enable managers to have a clear picture of the true sickness picture and profile, whilst adhering to the necessary guidance. In order to ensure staff were accurately informed about their needs around how to manage any Covid-19 symptoms and sickness, the Trust established a staff Covid-19 Incident Control Rom from very early on in the pandemic, with colleagues

from across the organisation redeployed to this team seven days a week. This team was responsible for collating and auctioning all of the national and regional guidance, as appropriate, as well as submitting the daily and weekly Covid-19 returns to the national team. Later on in the pandemic, we also introduced a Staff Helpline to provide advice to staff on the guidance around isolation and testing. This also gave staff a direct route for booking Covid-19 tests and minimised the challenges of access that were sometimes experienced by members of the public, in order to ensure any delays to staff returning to work were minimised.

- **Utilising colleagues' skills –** As discussed earlier in the report, the very early weeks of the pandemic were driven by a full Emergency Preparedness, Resilience and Response programme, with many colleagues undertaking roles that were not normally their core business. For us as a Trust, this reminded us how the breadth of experience we have amongst our staff is so valuable to their ability to perform to the level they do. However, it also demonstrated a lack of formal record of some of these skills, which in future, it may be useful to call on again.

- **Remote meetings –** It has become second nature to all of us to have meetings via Microsoft Teams now, but the speed at which this change was introduced to the organisation is impressive, and this practice as standard will no doubt continue to many years. It has enabled us to bring together larger groups of colleagues than we would have been able to do even before the pandemic, such as through the monthly 'Team Brief' sessions which are led by our Interim Chief Executive. Equally, it has supported our work to more closely collaborate with our partners, with a meeting of 5 acute trust teams now easily able to take place via Microsoft Teams without the need for an hour of travel time either side for all attendees. This has significantly increased the number of cross-system interactions which we are having, and brought us closer to colleagues from across the wider NHS. Colleagues have recognised how easy this is to establish, and have even utilised different technologies to maximise the effectiveness of these remote interactions (such as the use of 'Slido' for workshop sessions amongst staff).

3.2 Operational

The other key area of focus in response to the pandemic was how to change our ways of operating in order to safely provide our services whilst protecting patients and staff from potential harm from Covid-19. This required a cross-organisational response, which was driven by a Command and Control structure running from the national team through regional and local teams and on to providers. Daily gold, silver and bronze escalation meetings were in place, with the Executive Team attending the gold meetings and the Chief Operating Officer or Deputy Chief Operating Officer leading the silver meetings, with wide representation from divisional leadership teams as well as corporate colleagues such as Health Informatics, Information Technology and Infection, Prevention and Control. This carefully managed Emergency, Preparedness, Resilience and Response approach ensured risks and issues were responded to, and clear actions and mitigations were in place.

More broadly, there were a number of other areas where the Trust was required to change our practices in order to respond to national guidance and to our local situation. A few examples of these are given below, but this is by no means an exhaustive list.

- **Testing staff and patients –** the requirements around testing both staff and patients have changed throughout the pandemic as the availability and accuracy of tests has developed and national reporting has been established. However, in the first year of the pandemic, requirements to test all patients attending the hospital for any elective procedures were implemented, and a mass swabbing programme for staff needed to be established in response to the government testing programme. The Trust's testing site was set up at our Woodside building near to the main acute hospital site, staffed by healthcare support workers seven days a week. TRFT was one of the first trusts in our region to establish this drive-through facility, enabling higher throughput and maximising the safety of the swabbing team. However, this is an area where the guidance and requirements have changed regularly, with the arrival of lateral flow tests significantly altering the landscape and the accessibility of tests for patients and staff, which enabled us to alter our required capacity at our own site.

- **Isolation –** Similarly to testing, patients were asked to isolate before any elective surgery, with the length of time of isolation varying from 3 to 14 days over the last year based on different clinical guidelines. Some patients were unable to adhere to these requirements, often for personal reasons or due to caring responsibilities, and whilst sometimes this was known in advance, there were many times when our teams established patients had been unable to fully isolate, and this often led to last minute cancellations of procedures. Learning from these incidents, certain specialties identified back-up patient lists for particular theatre slots, in order to ensure that in the event of last minute cancellations due to a positive Covid-19 test of lack of adherence to isolation criteria, the theatre list could still be utilised. With a particular mind to ensuring we are reducing health inequalities across our communities, the Trust also implemented different pathways for patients who were unable to isolate, where this was acknowledged in advance of booking the procedure. A 'red' pathway (which assumed a positive Covid-19 patient) was designed for patients who were unable to isolate fully, ensuring our staff and patients were protected from harm.

- **Utilising our estate differently** – during the pandemic, there has been a need to utilise our estate differently to accommodate our patient's needs. Teams have learnt from and adapted to these changes as they have been tested and implemented. There are examples where are keen to continue with these (such as carrying out all cystoscopies through our Posswillow Suite and utilising our Theatre Treatment Suite for minor operations), as well as other changes where teams have reverted back to ways of working prior to Covid-19 (such as increased use of our outpatient department to offer face-to-face appointments).

- **Utilisation of our electronic patient record –** Prior to the pandemic, it was standard practice for full patient notes to be provided for all outpatient appointments, as well as clinicians having access to the Electronic Patient Record (EPR). However, with the arrival of the pandemic, we trialled removing provision of the paper notes for all

outpatient appointments and instead making better use of our EPR, and this has now been successfully implemented across our outpatient department.

- **Development of new pathways** – the constraints on capacity from the infection, prevention and control requirements forced the development of new pathways in order to minimise crowding in busy areas. For example, we established a combined SDEC and assessment area within our Acute Surgical Unit for a period of time during the early waves, in order to minimise crowding in our UECC and encourage delivery of same day care, despite the operational pressures. We also developed a direct paediatric streaming pathway from UECC to Children's ward which has worked well for children and their families. This closer link between the UECC and our Paediatrics team has also been hugely positive for working relationships between teams.

- **Virtual triage** – given the need to utilise our scarce resources for the patients in greatest need, during the pandemic we introduced virtual triage of referrals, in order to enable clinicians to determine the most appropriate clinic for patients. We've now trialled an even more thorough triage methodology by working with an external partner, which has demonstrated how effective this early scrutiny of referrals can be in order to identify if some patients are best directed straight to test (thus avoiding the need for an initial outpatient appointment to make that assessment) or managed in primary care. This work has been so successful that we are planning to embed full clinical triage within most specialties through our Outpatient Transformation Programme.

- **Remote consultations –** The Trust was already leading the way in remote consultations before the pandemic, with our Speech and Language Therapy teams picking up an award for their virtual sessions in 2018. However, the pandemic has accelerated the NHS's rollout of virtual reviews for OOH GP patients, and as a Trust, we have taken huge amounts of learning from the rapid implementation of this way of consulting with patients. For some specialties, it has been hugely effective, and has been well received by patients – reducing travel time and needs (which has many other indirect benefits), reducing the need to take time off work or rearrange caring responsibilities etc. However, now our IPC restrictions have been lifted, many clinicians are preferring more face-to-face interactions with patients (particularly in surgical specialties where a physical examination of a patient is always necessary) and we are therefore utilising the Outpatient Transformation Programme to manage these requirements carefully. We still have constraints on physical space to take into account, and nationally, there is a big drive to increase the proportion of consultations taking place virtually. We are utilising the learning from the last two years to ensure these changes take place in a managed way, and resolving some of the more pragmatic issues with virtual consultations as we do so.

- **Front Door Streaming –** Given the need to assess all patients for signs and symptoms of Covid-19, we established front door streaming within our UECC very early on in the pandemic. This allowed us to take a basic history from the patient and direct them to the most appropriate place in the Trust, to ensure they get the right care. We have had to modify our physical estate to enable this (building an outdoor canopy to protect waiting patients from the weather during winter), and rework our rotas to accommodate the

additional clinical resources required. However, we have continued to utilise this early triage of patients to support the 'right care, right place, first time' approach.

- **Discharge Processes –** the national guidance on discharge protocols and processes was implemented at pace, with staff redeployed to phone patients who were discharged to be followed up at home. This ensured that we freed up bed capacity as quickly as possible for other patients, but again, also minimise the likelihood of hospital-acquired Covid-19 infections for our vulnerable patients.

- **Partnering with Place –** The Trust commissioned a quantity of 'red' beds to ensure patients who had a positive Covid-19 test needing care home support could be effectively discharged and supported in the right place for their needs, and to minimise the risk of cross-infection within the hospital, where side rooms and single cubicles are a very scarce resource. Alongside this, we worked closely with local care homes to ensure robust testing of patients prior to discharge, and provided support into care homes to reduce admissions. A lot of this work was driven and managed through regular calls with partners across Place, to ensure there were appropriate services in place to support patients at home. This included a daily Place Exec-level escalation call, where partners discussed operational challenges and identified joint solutions to these issues, as well as a joint operational and clinical meeting.

3.3 Quality

- **Communication with families** – one of the hardest elements for our staff to manage during the pandemic was the restricted visiting which we had to have in place. This meant families felt out of touch around their loved ones' care, and teams were so busy given the demand pressures that it was often difficult to ensure a member of staff was available to answer the ward phones. This caused understandable frustration for some family members, and was upsetting for teams who enjoy being able to allow visitors in more normal times. In addition, it sometimes meant that some important details around patients' wishes, needs and behaviours (that would often be shared with clinical teams by families at the bedside), were not provided, which affected how personalised our care may have been. The Trust implemented video calling for families using tablets early on in the pandemic (including for parents with babies in our Special Care Baby Unit), and this enabled patients to see their families and ensure they felt connected. In addition, during later peaks, we established a phone line for families to call and request an update from a patient's clinical team, with families then receiving a call back from a senior member of the nursing team a few hours later. This was received hugely positive by families, and also enabled our teams to ensure they were having that two-way conversation with families around the care they were providing. Whilst this offer has now been stood down with the return of visiting, the removal of visiting and communication with families reminded staff of how critical this can be in ensuring our patients receive the best care.

- **Focus on health inequalities –** The Covid-19 pandemic has exposed the health inequalities that exist in our country, and opened our eyes to some of the challenges around accessing care for some of our communities. As a Trust, we have established a

Board Task and Finish Group to agree an action plan for how we reduce the health inequalities that exist in Rotherham, based on a deep dive review of all of the data we hold about which patients are accessing which services. The work has shown significant discrepancies in how patients from more deprived areas are able to access our outpatient services in particular for example, and as such, a programme of work has been defined to ensure we are responding to these issues.

- **Digital patient communications** – Our need to work flexibly and react quickly to different situations has meant we have significantly increased the use of digital communications with our patients. This has been important to ensure patients are aware of any changes to appointments, where we have utilised text messaging reminders to keep patients informed. More recently, we have developed our Patient Hub to enable patients to manage their appointments online, and this is now being rolled out following a successful trial. Given the move to greater digital interactions stemming from the pandemic, we are also now looking at further innovative ways to communicate with patients through tools such as chatbots and two-way messaging.

- **Delivery of medicines to patients** – during the pandemic, we introduced delivery of medicines to some patients in their homes in order to reduce the need for patients to travel to the main hospital site and potentially expose themselves to Covid-19. This has even been in place following virtual consultations, which has supported our most vulnerable patients in particular (and as noted above, reduced travel time and costs, with the subsequent indirect benefits this provides in terms of our wider responsibilities within our Green Plan).

- **E-consent service** – Our Family Health division led the vaccination programme for school pupils towards the end of 2021/22, and in order to simplify processes and increase uptake, the Trust introduced e-consent forms for 12-15 year old vaccinations. This made the process for gaining consent much simpler and more trackable, and eradicated issues over lost paperwork for example. The Trust has recently purchased some software to enable wider e-consent for patients within our elective pathways, which is planned for implementation later in the summer.

4.0 Conclusion

This paper reminds us all of the phenomenal efforts of the NHS and specifically TRFT colleagues during the pandemic. It demonstrates examples of the incredible learning we have taken from the need to respond and adapt quickly, and how we as an organisation have gone about ensuring this learning translates into better care for patients and positive experiences for staff. Whilst the above provides a number of specific examples of changes to processes, ways of working and services offered, more widely, the last two years has opened our eyes to what the NHS can achieve when called upon to deliver for the public through the greatest pandemic in modern history.

Board of Directors' Meeting
08 July 2022

The Rotherham NHS Foundation Trust

Agenda item	P111/22
Report	**Quality Improvement Plan**
Executive Lead	Helen Dobson, Chief Nurse Dr Callum Gardner, Medical Director
Link with the BAF	P1: There is a risk that we will not embed quality care within the 5 year plan because of lack of resource, capacity and capability leading to poor clinical outcomes and patient experience for our patients.
How does this paper support Trust Values	The Trust's values are: Ambitious, Caring and Together. This paper supports all three values, in that it presents the Trust's ambition to drive the quality improvement strand of the 2022-2027 strategy, which will in turn, improve the way we care for our service users and colleagues, and details how we plan to achieve this objective by working together with staff and patients.
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☒
Executive Summary (including reason for the report, background, key issues and risks)	The paper provides an update to the Board of Directors regarding progress being made with the quality improvement objective as detailed in the Trust's strategy for 2022-2027. The paper provides a summary update on: 1. The background to quality improvement at the Trust 2. Embarking on a quality improvement journey, including the high-level outputs of a recent task and finish group and supporting business case 3. Next steps on the quality improvement journey
Due Diligence (include the process the paper has gone through prior to presentation to the meeting)	The Quality Improvement programme, supported by the Interim Director of Quality and Governance Improvement, is overseen by a weekly executive Quality and Governance Improvement Steering Group, which is chaired by the Interim Chief Executive.
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 paper is presented to the Board of Directors for information, and there are no specific actions required at this stage.
Recommendations	It is recommended that the Board of Directors note the contents of the report and provide any feedback to the Medical Director and / or the Chief Nurse.

1. Introduction

1.1 As we move from the emergency phase of delivering care during the Covid 19 pandemic, it is critical that colleagues in our organisation are capable and supported to lead innovative and fast paced service change and improvements through re-starting, re-designing or developing new processes, pathways and services.

1.2 To that end, the executive team has agreed to take a strategic and systematic approach to quality improvement (QI), particularly with a view to achieving key improvement aims described in the Trust's 2022 – 2027 strategy.

2. Background

2.1 There are many approaches for improving quality, and they all vary in terms of their underlying principles, their efficacy, resource implications, and applicability within the healthcare arena.

2.2 Recently, external QI support has been sought from:

- The Improvement Academy (IA) from the Bradford Institute for Health Research (who have been commissioned by the CEO, PMO and the nursing directorate to provide quality improvement support and training for specific projects).
- Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust, who have launched their own approach the Quality Improvement and Innovation (QII) Way, and have shared with us a toolkit and training, which we have been using in the Trust.

2.3 Moving forwards, the organisation requires a systemised, structured and affordable approach to enable and empower colleagues at the frontline and the heart of patient care to make meaningful, measurable and sustainable improvement.

2.4 Several improvement approaches and providers were considered by a dedicated QI task and finish group made up of colleagues from across the divisions and central corporate functions, and a recommendation to adopt the NHSE/I Quality Service Improvement and Redesign (QSIR) approach (as part of a wider QI business case) was approved by the executive team.

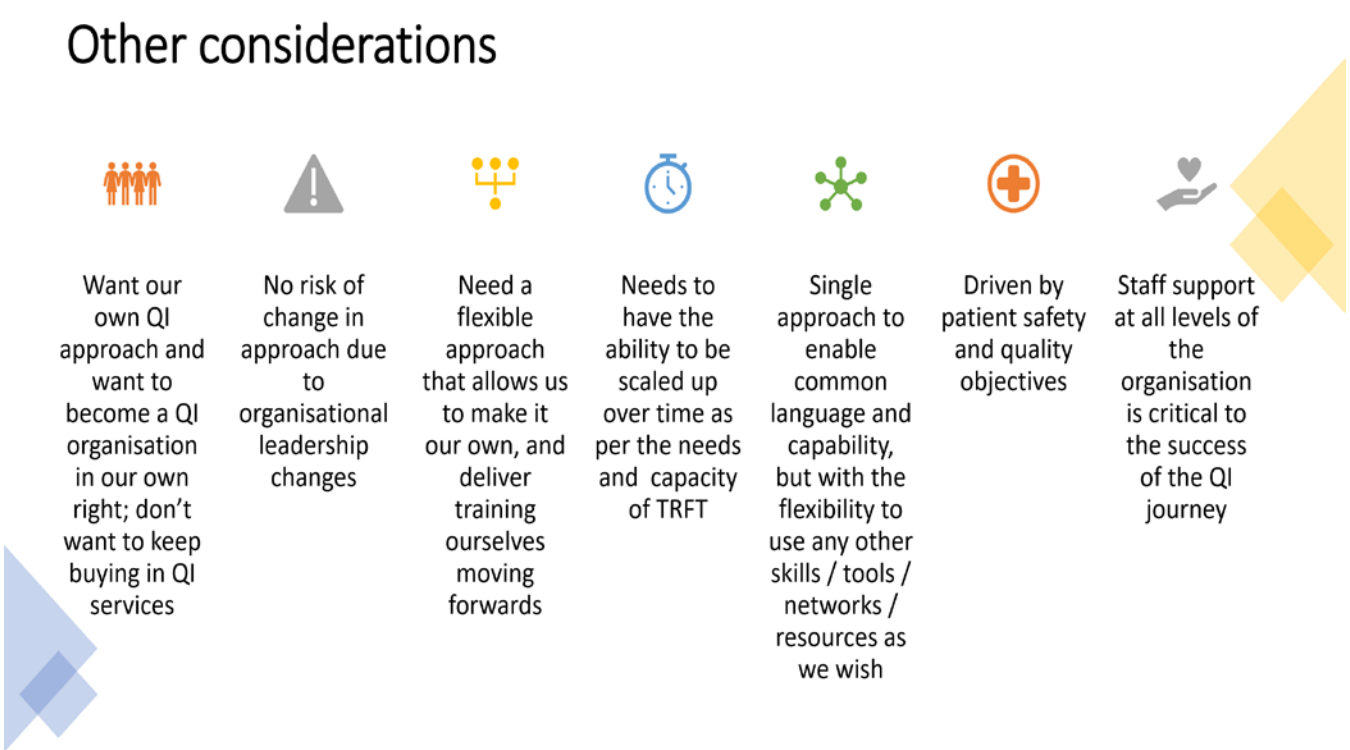
3. Embarking on our QI journey

3.1 A preliminary QI business case, (informed by the outputs of the task and finish group and the executive team's support for QSIR), was presented to, and approved by, the executive team on June 9th 2022. The approval of the business case means that the development of supporting infrastructure for QI (including a QI team with initial funding for a Head of Quality Improvement and an Associate Medical Director for Quality Improvement at 2 PAs per week), associated governance processes, annual QSIR training plan and communications and engagement plan are now all being progressed.

3.2 The timely approval of the business case also enabled a fast-paced roll out of QSIR training to over 20 colleagues across the Trust in June, as well as a dedicated Board session for QI from NHSE/I on 10th June 2022.

3.3 There are several factors which will be key to the success and sustainability of the Trust's QI journey. These were identified by colleagues who attended the task and finish group sessions, and are illustrated below:

Further, colleagues want to ensure that any next steps take into consideration the following:



3.4 The flexible and dynamic approach QSIR offers allows for the considerations described above to be realised, which will further enhance staff commitment to QI.

3.5 It will be important to ensure that staff continue to be actively engaged in the QI journey, to maintain momentum, inform direction of travel, and keep improvement priorities aligned to the needs of our patients, and the front line who care for them. The communications and engagement plans being drafted include plans for a monthly QI network / engagement event to facilitate this. NHSE/I have also offered to provide support for, and attendance at, these events.

4. Next steps

4.1 Successful implementation of QI programmes requires consideration of the following:

- Early Board-level support
- Appropriate funding
- Release of staff for training
- Commissioner support

4.2 Further sessions for the Board and NHSE/I about QI will take place later in the year. These sessions will be used to understand more about the organisation's QI culture and journey, and support for the Board in terms of how to progress and maintain QI.

4.3 As QSIR training comes at no charge, and the costs are mainly around staff release, catering, venue hire and training materials, it is the most affordable solution of all approaches considered by the Trust's QI task and finish group. This makes this approach more sustainable for the longer term.

4.4 The executive team are working together with NHSE/I to identify suitable QSIR training dates throughout the year, to ensure that colleagues can be proactively freed up and booked onto the training. This includes consideration of operational pressures, summer holidays and adequate notice for staff.

4.5 At a system level, it has been agreed that organisations do not need to adopt the same quality improvement approach or methodology, what is important is that there is support for a chosen QI approach that is adopted and applied consistently. Several organisations in the Northern regions have signed up to QSIR, and by the end of July, it is envisaged that nearly 190 NHS organisations across England will have signed up to QSIR.

4.6 **The high level 2-year plan**

A 2-year programme to roll out and embed QSIR in the organisation is proposed in the first instance, and the following are the cornerstones to delivery:

I. **Board engagement and support** - achieved

II. **Agree the engagement of an improvement partner** – achieved - NHSE/I for QSIR

III. Build a central QI team - developing

The primary functions of this team will be:

- Gaining and holding expert knowledge
- Engaging the workforce, service users and carers
- Develop QI resources and determine suitable platforms to share these

- Providing training and coaching to the organisation to build improvement capability from the ground up
- Providing focused support to QI projects in high priority areas
- Reporting on progress
- Lean governance to support delivery, monitor progress and provide assurance of effectiveness

This team will form the organisation's central QI hub which will be placed at the heart of the quality directorate. The aim will be to support this function with microsystems for QI throughout the divisions to drive and deliver local quality improvement. Microsystems will involve the embedding of QSIR trained improvement leads at service and divisional level to build networks of improvers. As the business case for a Head of Quality Improvement and an Associate Medical Director for Quality Improvement have been approved, this can now be expedited.

As the QI training is scaled up (see below), and QI initiatives increase in number, the QI team will require administrative and facilitative support; this will be considered as part of a more detailed look at the quality directorate structure over the coming months.

IV. Scalability – training, staffing and supporting systems - developing

It will be important to take a strategic approach to building improvement infrastructure and capability.

In year 1 (22-23), it is envisaged that up to 50 colleagues can be trained as QSIR practitioners, and the Associate Medical Director for Quality Improvement and the Head of Quality Improvement can be recruited.
In year 2 (23-24), it is envisaged that a further 50 colleagues can be trained as QSIR practitioners, and of the circa 100 colleagues trained, 5 – 10 colleagues can go on to become QSIR faculty teachers, to support the organisation in driving up its improvement capability. In essence, the approach aims to develop a QI faculty for the Trust.

It is also envisaged, that should the improvement training and resultant QI team and improvement programme become embedded at the Trust, IT systems may be required to provide the supporting infrastructure and governance to the QI programme.

Systems such as LifeQI and Improvewell (which require paid user licences to be purchased) have been adopted by several NHS organisations (such as East London NHS Foundation Trust) to drive the delivery of successful QI programmes. This will be further considered in Q4 22-23.

5. Conclusion

5.1 The success of the Trust's QI journey will depend on several factors, including Board appetite, the longer-term commitment both strategically and financially, and the factors described by colleagues in section 3 above. Working with NHSE/I to gauge Board and organisational culture over the coming months will be important in addressing any potential barriers to success. Above all, continued and meaningful engagement, and credibility of the agreed approach (achieved by delivering against our strategic and QI objectives) will

go a long way to ensuring that the hearts and minds of staff are engaged with – and delivering – the Trust's improvement ambitions.

Kaajal Chotai, Interim Director of Quality and Governance Improvement
Helen Dobson, Chief Nurse

July 2022

Board of Directors' Meeting
08 July 2022

The Rotherham NHS Foundation Trust

Agenda item	P112/22
Report	**Maternity Safety including Ockenden Monthly Report**
Executive Lead	Helen Dobson, Chief Nurse
Link with the BAF	P1: There is a risk that we will not embed quality care within the 5 year plan because of lack of resource, capacity and capability leading to poor clinical outcomes and patient experience for our patients.
How does this paper support Trust Values	High Standards for the services we deliver, aim to be outstanding, delivering excellent and safe healthcare
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	TRFT continue to await the formal feedback from The Regional Ockenden Support Visit, which was undertaken on the 25th May 2022. NHSE/I are awaiting the publication of the East Kent report in June 2022 before requesting any further assurance from Trusts on the 15 IEA's in the Final Ockenden Report. As per the Ockenden Letter dated 1st April 2022 from NHS England, TRFT Maternity Services reviewed the position for continuity of carer and maintaining minimum safe staffing requirements on all shifts in the acute service. The position was assessed as: ***Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC, but can meet the safe minimum staffing requirements for existing MCoC provision, should cease further roll out and continue to support at the current level of provision or only provide services to existing women on MCoC pathways and suspend new women being booked into MCoC provision.*** Following engagement with all stakeholders including the Midwives, wider Maternity team, LMNS and the Regional Chief Midwife, TRFT have developed a pilot plan to ensure that there is sustainable labour care cover on labour ward from the Continuity of Carer teams. This has been approved and will commence on the 18th July 2022. **CNST** The Scheme relaunched on the 6th May 2022, Maternity Services continue to meet weekly to work through our tracker to review compliance with all safety actions. The main areas of challenge at the moment include:

Safety Action 2: Maternity Service Datasets: Teams have been working collaboratively to meet the required standard of at least 9 out of the 11 Clinical Quality Improvement Metrics (CQUIMS) for the July data submission and the indicative data received for May 2022 demonstrates that we should achieve this.

Safety Action 8: Multidisciplinary Training, Maternity Services have a local training plan in place to meet the core competency framework. Training compliance has been a challenge due to the ongoing sickness and absence gaps due to maternity leave. The training compliance for May 2022 is 75% reflected below and there is a plan in place to achieve the required standard of 90% in the 18th month period from August 2021 to January 2023.

Maternity Digital:
A paper was presented to the Executive Team Meeting on the 16th June 2022 for noting regarding the LMNS ambition for a Single Maternity information System across all 4 providers in the system. A gap analysis has been conducted of the current Maternity Information Systems used by providers identifying strengths, weaknesses, opportunities and threats. It should be noted that Family Health are providing feedback to the LMNS to request a more detailed gap analysis with appropriate stakeholders, including support from Senior Health Informatics colleagues, as a number of statements included in the tables were viewed to be factually inaccurate by the Trust.

The Service continues to report monthly on the Divisional IPR and commentary for the Perinatal Safety dashboard data. Please see the summary below for May 2022:

Maternity unit closures	0	
Utilisation of on call midwife to staff labour ward	1	Birthrate Plus data
1-1 care in labour	100%	Data from Birthrate Plus acuity tool reflects 100%
Continuity team midwife present for continuity birth	92%	Data from Birthrate Plus acuity tool
Supernumerary labour ward co-ordinator	98.5%	Data from Birthrate Plus acuity tool
Staff absence	11.69%	Midwife only, including Maternity and Sickness
Shifts unfilled	30%	Data from Birthrate Plus acuity tool
Short notice unexpected Midwife absence/ Sickness	13%	Birthrate Plus data
Number of stillbirths	1	Dashboard data
Stillbirth rate per 1000 births Rolling 12 months	2.77	Dashboard data
MDT Training	75%	

<table>
<tr><td></td><td>Obstetric cover gaps: table below illustrates the locum breakdown

<table><tr><th>Grade</th><th>No of Shifts</th><th>Reason</th><th>Internal / External</th></tr><tr><td>ST1/2</td><td>18</td><td>Vacancy</td><td>4 x Internal
14 x External</td></tr><tr><td>ST3/7</td><td>19</td><td>8 x Sickness
7 x Vacancy
1 x Compassionate Leave
3 x Phased Return</td><td>14 x Internal
5 x External</td></tr><tr><td>Consultant</td><td>24</td><td>3 x Sickness
13 x Vacancy
5 x Annual/Study Leave
3 x Additional ANC</td><td>24 x Internal</td></tr></table>
There were no escalations from the Maternity and Neonatal Safety Champions meeting held on 28th June 2022.</td></tr>
<tr><td>Due Diligence
(include the process the paper has gone through prior to presentation at Board of Directors' meeting)</td><td>This paper has been prepared by the Head of Midwifery and will be shared through Maternity and Divisional Governance.

The paper is shared with the Executive Maternity Safety Champion.</td></tr>
<tr><td>Board powers to make this decision</td><td>The Board is required to have oversight on the Maternity Safety work streams</td></tr>
<tr><td>Who, What and When
(what action is required, who is the lead and when should it be completed?)</td><td>Helen Dobson, Chief Nurse, is the Board Executive Lead and The Head of Midwifery attends board monthly to discuss the Maternity Safety agenda.</td></tr>
<tr><td>Recommendations</td><td>It is recommended that the Board is assured by the progress and compliance to date with the Maternity Safety Work streams</td></tr>
</table>

Board of Directors' Meeting
08 July 2022

The Rotherham NHS Foundation Trust

Agenda item	P113/22
Report	**Quarterly Medical Workforce Report**
Executive Lead	Dr Callum Gardner, Medical Director
Link with the BAF	**U4**: There is a risk that we do not develop and maintain a positive culture because of insufficient resources and the lack of compassionate leadership leading to an inability to recruit, retain and motivate staff.
How does this paper support Trust Values	**Ambitious** – to be an employer of choice. **Caring** – to ensure job plans meet the needs of our patients. **Together** – to ensure a MDT approach to patient care
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	To provide the Committee with an update on job planning progress, along with a summary of recent Consultant recruitment.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	N/A
Board powers to make this decision	N/A
Who, What and When (what action is required, who is the lead and when should it be completed?)	No action is required, the report is for information only.
Recommendations	It is recommended that the summary and update are noted.
Appendices	1. Job Planning Summary (as at 16 June 22)

Job Planning

1. The Trust utilises Allocate e-Job Plan software and the tables at Appendix 1 show the current situation on progress of job plans. A major software update has been installed, which, in turn, has improved the e-Job Plan module; support and training will be provided where required.

Consultant Recruitment

2. With the latest data available, a summary of the Consultant establishment is provided below, with a comparison from February 2022:

Consultants – 21 Feb 22	
Consultant Establishment (wte)	183.85
Cons Sub Vacancies (excl. NHS Locums / temp staff)	41.54
Cons Substantive Fill %	77.4%
Cons Vacancies (incl. NHS Locum / Acting Up in post)	24.2
Cons Fill % (incl. NHS Locum / Acting Up in post)	86.8%
Cons Sub Vacancies (incl. NHS Locums / temp staff)	15.24
Cons Total Fill as Percentage	91.7%

Consultants – 20 Jun 22	
Consultant Establishment (wte)	180.85
Cons Sub Vacancies (excl. NHS Locums / temp staff)	36.94
Cons Substantive Fill %	79.6%
Cons Vacancies (incl. NHS Locum / Acting Up in post)	19.6
Cons Fill % (incl. NHS Locum / Acting Up in post)	89.1%
Cons Sub Vacancies (incl. NHS Locums / temp staff)	10.64
Cons Total Fill as Percentage	94.1%

4. Overall, the Trust is in a healthy situation with regard to overall fill rate, with an increase of 2.5% from the previously reported position. In addition, substantive vacancies have reduced by 5 (headcount), with new starters coming into post.

5. The reduction in established posts is due to a review carried out with Divisions to ensure data is accurate, as it is carried out manually, and reflects that of the ledger / budget. A large piece of work has commenced to regularise / update the medical and dental establishment in ESR, which will allow vacancy reporting as per other staff groups.

6. An update on Consultant recruitment for 2022 is provided below (L = Locum):

Specialty	Name	Start Date
Obs & Gynae	Dr Loretta Ogboro-Okor (L)	31 Jan 22
Obs & Gynae	Miss Hannah Mistry	16 Feb 22
Acute Medicine	Dr Victoria Thorley-Dickinson	23 May 22
Diabetes & Endocrinology	Dr Abdul Basit	8 Feb 22
Gastro	Dr Abdel Alswaf (L)	4 Jan 22
HCOP	Dr Sunil Punoose	14 Mar 22
HCOP / Palliative	Dr Joanna Ulley	TBC
Respiratory	Dr Nitish Marathe	7 Feb 22
Anaesthetics	Dr Tharaka Wijerathne	1 Jun 22

Specialty	Name	Start Date
ITU	Dr Susannah Robinson	4 Jan 22
Ophthalmology	Dr Hibba Quhill	7 Mar 22
Rheumatology	Dr Leticia Garcia-Montoya	3 May 22
Urology	Mr Panagiotis Apalidis	16 Feb 22
Emergency Medicine	Dr George Kay	15 Aug 22
Emergency Medicine	Dr Eamon Staunton	1 Sep 22
Emergency Medicine	Dr Akinola Olaniyan	TBC

7. We now have 4 out of 5 Acute Medicine posts filled, the best position we have been in for over 3 years, plus a substantive consultant has commenced in Rheumatology. We remain challenged in Gastro, Histopathology and Microbiology, engaging with contracted agencies to source candidates for those specialties. As usual, gaps at this level are mitigated by long-term agency cover where appropriate and authorised.

Derek Thomas
Head of Medical & Dental Workforce
June 2022

Job Planning – 2022/23

Consultants – data as at 16 June 2022							
Division	Discussion	Awaiting owner sign off	Awaiting 1st manager sign off	Awaiting 2nd manager sign off	Awaiting 3rd manager sign off	Signed off	Total
CSS	12	1		1			14
Family Health	14	5	3	2	2	3	29
Integrated Medicine	14	2	4	4	9	2	35
UECC	7	1	2	2	1		13
Surgery	32	9	8	15	4	9	77
Total	**79**	**18**	**17**	**24**	**16**	**14**	**168**

Consultants – data as at 3 May 2022							
Division	Discussion	Awaiting owner sign off	Awaiting 1st manager sign off	Awaiting 2nd manager sign off	Awaiting 3rd manager sign off	Signed off	Total
CSS	**13**		**1**				**14**
Family Health	**15**	**6**	**5**	**1**	**2**	**1**	**30**
Integrated Medicine	**14**	**2**	**5**	**5**	**9**	**1**	**36**
UECC	**8**	**1**	**1**	**2**	**1**		**13**
Surgery	**39**	**7**	**4**	**14**	**4**	**8**	**76**
Total	**89**	**16**	**16**	**22**	**16**	**10**	**169**

Job Planning – 2022/23

SAS Grades – data as at 16 June 2022							
Division	Discussion	Awaiting owner sign off	Awaiting 1st manager sign off	Awaiting 2nd manager sign off	Awaiting 3rd manager sign off	Signed off	Total
CSS							
Family Health	5	1	1				7
Integrated Medicine	2	2	1	1	5	1	12
UECC	7		1				8
Surgery	11	5	3	11		5	35
Total	**25**	**8**	**6**	**12**	**5**	**6**	**62**

SAS Grades – data as at 3 May 2022							
Division	Discussion	Awaiting owner sign off	Awaiting 1st manager sign off	Awaiting 2nd manager sign off	Awaiting 3rd manager sign off	Signed off	Total
CSS							
Family Health	4			1			5
Integrated Medicine	3	3	1	1	5		13
UECC	8						8
Surgery	15	6	4	3		5	33
Total	**30**	**9**	**5**	**5**	**5**	**5**	**59**

Board of Directors' Meeting
08 July 2022

The Rotherham NHS Foundation Trust

Agenda item	P114/22
Report	**Data Security and Protection Toolkit Report**
Executive Lead	Michael Wright, Deputy Chief Executive
Link with the BAF	
How does this paper support Trust Values	The Trust aims to achieve compliance year on year against the Data Security and Protection Toolkit in order to meet its contractual obligations and this can only be achieved with contributions from all areas (Together) which provides assurance that the Trust is dedicated to protecting the personal information it holds (Caring).
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	This report relates solely to the current position in relation to the submission of the Data Security and Protection Toolkit (DSPT) assessment for 2021/22. This is the fourth year that the Trust has submitted an assessment against the toolkit – a requirement for all NHS organisations. There is an increasing number of assertions relating to Cyber Security and compliance with Cyber Essentials (CE), the Minimum Cyber Security Standard (MCSS), Network and Information Systems (NIS) Regulations 2018 and the Cyber Assessment Framework (CAF), rather than the protection of information by individuals (IG). During the Covid-19 pandemic, NHS Digital took the decision to extend the submission date for the Toolkit to 30 June from 31 March. This remains unchanged and is likely to remain. The Trust has submitted the toolkit assessment ahead of the deadline.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	The IG Committee have been appraised of the position of the Trust with regards to its compliance against the Toolkit throughout 2021/22. The Audit Committee will receive the related Internal Audit Report in due course.
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 notes the current position.
Appendices	Data Security Protection Toolkit Status June 2022. 360 Assurance Audit results June 2022.

Introduction

Data and information is a critical business asset that is fundamental to the continued delivery and operation of health and care services across the UK. The Health and Social Care sector must have confidence in the confidentiality, integrity and availability of their data assets. Any personal data collected, stored and processed by public bodies are also subject to specific legal and regulatory requirements. Data security and data protection related incidents are increasing in frequency and severity; with hacking, ransomware, cyber-fraud and accidental data losses all having been observed across the Health and Social Care sector.

The need to demonstrate an ability to defend against, block and withstand cyber-attacks has been amplified by the introduction of the EU Directive on security of Network and Information Systems (NIS Directive) and the EU General Data Protection Regulation (GDPR). The NIS Directive focuses on Critical National Infrastructure and 'Operators of Essential Services'. The GDPR focuses on the processing of EU residents' personal data. As such, it is essential that Health and Social Care sector organisations take proactive measures to defend themselves from cyber-attacks and evidence their ability to do so in line with regulatory and legal requirements.

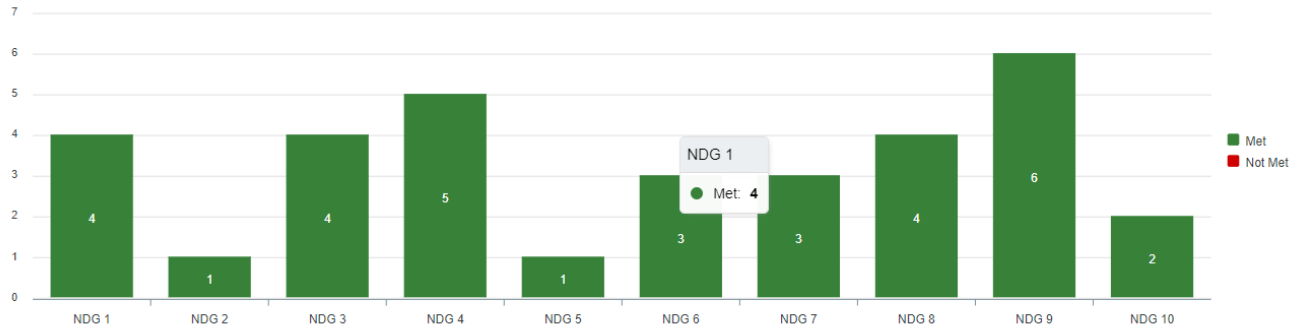
The Data Security and Protection Toolkit (DSPT) is one of several mechanisms in place to support Health and Social Care organisations in their ongoing journey to manage data security and data protection risk. The Toolkit allows organisations to measure their performance against the National Data Guardian's ten data security standards, as well as supporting compliance with legal and regulatory requirements (e.g. the GDPR and NIS Directive) and Department of Health and Social Care policy through completion of an annual DSPT online self-assessment. The DSPT online assessment has to be submitted to NHS Digital by the 30th June each year.

The Trust's Internal Auditors, 360 Assurance have completed a review in respect of the Trust's Data Security and Protection Toolkit (DSPT) self-assessment. They examined the effectiveness of controls in place in accordance with the Public Sector Internal Audit Standards. The Auditors performed their review to provide an objective and unbiased opinion.

Status of the Toolkit

The Toolkit has been submitted ahead of the 30th June submission date, although this is awaiting NHS Digital confirmation of the compliance. Evidence of compliance has been submitted against all 109 mandatory items and 33 non-mandatory items.

This is clearly shown in the accompanying graph, with all areas deemed to have been met.



NDG 1 - Personal confidential data
NDG 2 - Staff responsibilities
NDG 3 - Training
NDG 4 - Managing data access
NDG 5 - Process reviews
NDG 6 - Responding to incidents
NDG 7 - Continuity planning
NDG 8 - Unsupported systems
NDG 9 - IT protection
NDG 10 - Accountable suppliers

Audited Assertions

The following shows the audited Assertions and the overall outcome of the internal audit carried out by 360 Assurance. The full audit report will be received by the Audit Committee in due course.

The Assertions audited relate to the 10 National Data Guardian (NDG) Standards shown in the table below and a selection of assertions were pre-selected for audit by the audit team. Evidence presented, must clearly show compliance against each of the assertions on the Toolkit. The low risk rating in the table below indicates that there were no issues of concern raised by the Auditor and the assertion risk rating points indicate that the Toolkit evidence supplied against the assertion, meets or exceeds the NHS Digital standard for compliance.

Audit Results.

NDG Standard*	No of assertions assessed	Critical	High	Medium	Low	Assertion risk rating points (average)	Overall Classification	Overall Risk Assessment
Personal Confidential Data	1 of 4				1	1	Substantial	Substantial
Staff Responsibilities	1 of 1				1	1	Substantial	
Training	1 of 4				1	1	Substantial	
Managing Data Access	3 of 5				3	1	Substantial	
Process Reviews	1 of 3				1	1	Substantial	
Responding to Incidents	1 of 3				1	1	Substantial	
Continuity Planning	2 of 3				2	1	Substantial	
Unsupported Systems	1 of 4				1	1	Substantial	
IT Protection	1 of 6				1	1	Substantial	
Accountable Suppliers	1 of 5				1	1	Substantial	
Total	13 of 38	0	0	0	13			

Conclusion

Although the Trust is still waiting for the final result of the Toolkit submission from NHS Digital for the year 2021/22, the audit report clearly shows there is confidence in the Trust's compliance with the national standards and the Toolkit, having received a rating of '**Substantial**' for the 2nd year running from the auditors. It is clear however that the emphasis is moving more towards IT and Cyber Security compliance and this emphasis is likely to increase next year (2022/23).

Board of Directors' Meeting
08 July 2022

Agenda item	P115/22
Report	**Senior Information Risk Owner (SIRO) Annual Information Governance Report**
Executive Lead	Michael Wright, Senior Information Risk Owner, Deputy Chief Executive
Link with the BAF	
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	This report documents the Trust's compliance with legislative and regulatory requirements relating to the handling of information, including compliance with the Freedom of Information Act 2000, Data Protection Act 2018 and the General Data Protection Regulations for the period 1 April 2021 – 31 March 2022. The current status of the Trust's annual Data Security and Protection Toolkit (DSPTK) submission is also provided for the period 1 July 2021 – 30 June 2022. Key points to note from the report are: 1. The internal audit review of the DSPTK, which is required annually was carried out against 13 Assertions covering 48 separate items on the Toolkit. 3 items were selected for strengthening but overall the Trust was awarded 'substantial assurance' across all 13 audited Assertions. 2. The Trust has performed well against the mandatory IG Training compliance. The target for compliance year on year is 95% and the Trust achieved 96%. 3. FOI requests have increased when compared with the previous year. Response rates from staff have improved and this is reflected in the mandatory compliance of responses being sent within 20 working days, achieving 98% compliance.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	The Trust's Information Governance Committee is chaired by the SIRO, meets on a regular basis and receives updates on all key information governance areas included within the Annual Report.
Board powers to make this decision	N/A
Who, What and When	N/A

(what action is required, who is the lead and when should it be completed?)	
Recommendations	The Board is asked to note this report.
Appendices	None

Introduction

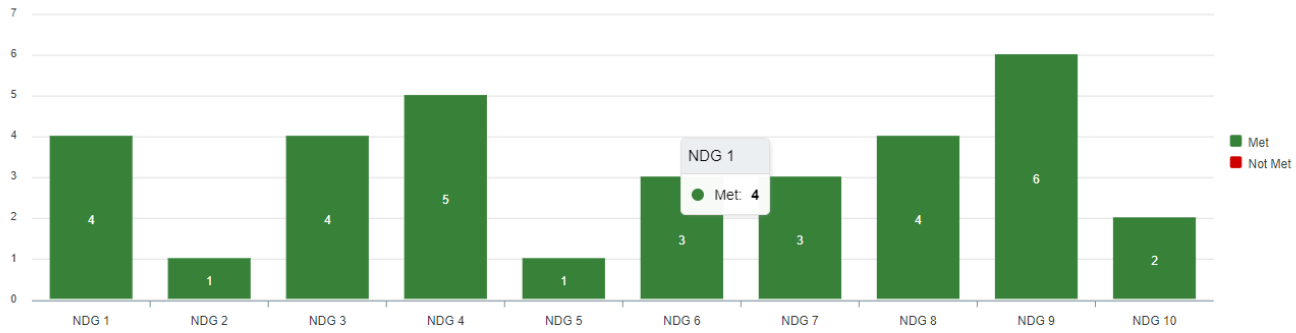
1. The SIRO role has responsibility and accountability for the effective, efficient and compliant management of the Trust's information assets.

2. Data Security and Protection Toolkit (DSPT)

2.1 This is the performance tool produced by NHS Digital. The Toolkit covers areas of IG, IT and Cyber Security and also forms part of CQC inspections within the Well Led Key Lines of Enquiry.

2.2 The Trust has provided satisfactory evidence against all 10 National Data Guardian (NDG) standards equalling 109 mandatory items (and 33 non-mandatory) across 38 mandatory Assertions. This is yet to be confirmed by NHS Digital.

Current status of the Toolkit.



NDG 1 - Personal confidential data
NDG 2 - Staff responsibilities
NDG 3 - Training
NDG 4 - Managing data access
NDG 5 - Process reviews
NDG 6 - Responding to incidents
NDG 7 - Continuity planning
NDG 8 - Unsupported systems
NDG 9 - IT protection
NDG 10 - Accountable suppliers

2.3 An internal audit is carried out annually on the Trust's Data Security and Protection Toolkit (DSPT) submission.

For the year 2021/22, 13 Assertions were selected covering 48 separate items on the Toolkit. Three low risk items were selected for minor improvement to strengthen some of the activities the Trust undertakes and the auditors will monitor the progress on these via the online Tracker.

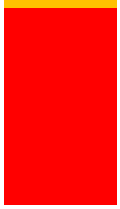
Also included were 2 non-reportable items for observation and information purposes.

The auditors awarded the Trust '**Substantial Assurance**' across all 13 audited Assertions.

2.4 The General Data Protection Regulations (GDPR) Implementation Plan continues to be reported on at the IG Committee (IGC) meeting. The Data Protection Officer (DPO) role has now been made substantive and the role renamed as 'Head of Information Governance and Data Protection Officer'.

Current Status of the GDPR Implementation Plan.

As part of the preparation for the introduction of the GDPR, the Trust created the Implementation Plan, which broke down the various elements of the GDPR into understandable and achievable goals.

Achieved		**96** - Elements of the Plan that have been completed or were already implemented with the Trust.
Ongoing		**21** – Elements of the Plan that are still being implemented. Most of these relied upon the Information Governance Officer post being filled and are now being progressed. These do not impact on the Trust compliance.
Not started		**5** – These are elements of the plan that are 'nice to have' but not essential. As other elements are completed, these may be progressed. These do not impact on the Trust compliance.

2.5 The Trust currently has the following number of 'information governance' risks on its register (this does not include cyber security risks):

- "Approved risks" – 10 risks. These consist of 3 at a score of 12, 6 at a score of 9 and 1 at a score of 6.
- "Risks under control / managed risks" – 5 risks. These consist of 1 at a score of 9, 2 at a score of 6, 1 at a score of 4 and 1 at a score of 3.
- "New risks" – 2 risks, added by the IG Manager and the DPO, 1 at a score of 9 and 1 at a score of 10. The one at a score of 10 has been resolved and is to be updated accordingly.
- One further risk exists and is undergoing refinement/additional analysis. A 3rd party company has been contacted regarding software provision concerning redaction of documents.

Where a risk is shown as **'Approved'**, this has been before the Risk Committee and been accepted. These risks are still open and being progressed.

'Risks under control' are approved risks that the Trust cannot currently influence regarding a resolve or are progressing to conclusion and may ultimately be closed.

A **'New risk'** is a risk that has yet to be accepted by the Risk Committee

2.6 The Trust uses two definitions on Datix for Incidents, which are Information Governance and Confidentiality. Incidents can be assigned to either of these for the attention of the IG Team.

2.7 For the period April 2021 – March 2022 a total of 428 reports mentioning one of the definitions were recorded. 156 incidents were recorded as being Information Governance with 272 being recorded under Confidentiality. This is an increase on the previous year (271).

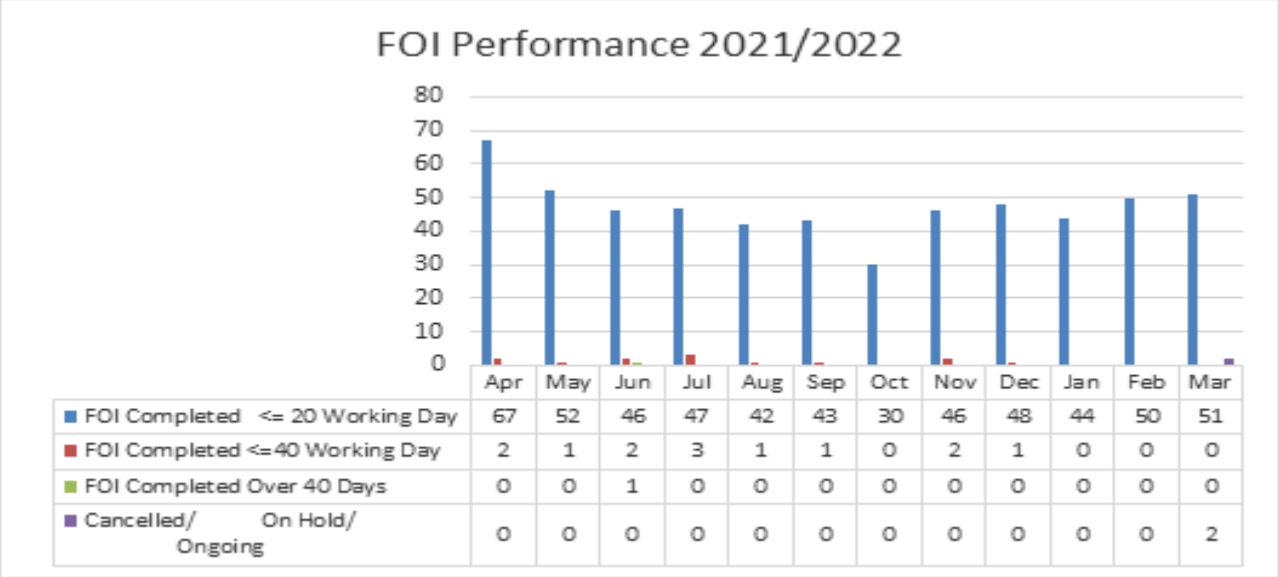
2.8 All reports are considered for investigation by the IG Team with the most serious incidents followed up and some leading to full investigation. Some of the more serious incidents may involve the HR Team. Serious incidents involving data breaches will also be reported to the Information Commissioner's Office via the online Serious Incident Reporting tool.

3.0 Freedom of Information (FOI) requests

3.1 Details of the number of FOIs received, per month, are provided for the period 2019 through to 2022 in the table below. One FOI may contain several questions. The numbers below provide the number of FOIs received, not the number of questions / requests received.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2019-2020	57	53	61	34	36	39	37	41	29	48	46	41	**522**
2020-2021	22	28	34	49	37	47	50	40	36	51	48	50	**492**
2021-2022	69	53	49	50	43	44	30	50	49	44	50	53	**584**

3.2 FOI requests are higher than the previous year. However, requests received during April, May and June 2020-2021, were considerably lower during the first peak of the pandemic.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
FOI Completed <= 20 Working Day	67	52	46	47	42	43	30	46	48	44	50	51
FOI Completed <=40 Working Day	2	1	2	3	1	1	0	2	1	0	0	0
FOI Completed Over 40 Days	0	0	1	0	0	0	0	0	0	0	0	0
Cancelled/ On Hold/ Ongoing	0	0	0	0	0	0	0	0	0	0	0	2

3.3 A new FOI system is being developed by Health Informatics which should improve the FOI function and automate some of the current manual duties. This will also include the automated publishing of FOI responses.

4.0 Subject Access Requests (SARs)

4.1 The SAR team sits under the Patient Access Service. A Subject Access Request is made by an individual for access to information held about them, by the organisation. Most SARs are received from service users, but they have also been received from staff and others.

4.2 The table below shows the number of (SARs) made under Data Protection legislation, which were received by the Trust for 2021/22.

SAR COMPLETE YEAR	SAR COPMPLETED MONTH	TOTAL SAR COMPLETED IN MONTH	TOTAL SAR BREACHES IN MONTH	% SAR TARGET COMPLIANCE
2021	Apr	120	0	100%
2021	May	114	1	99%
2021	Jun	129	1	99%
2021	Jul	94	0	100%
2021	Aug	109	0	100%
2021	Sep	115	2	98%
2021	Oct	95	0	100%
2021	Nov	98	0	100%
2021	Dec	97	0	100%
2022	Jan	82	0	100%
2022	Feb	141	0	100%
2022	Mar	124	5	96%

4.3 Requests which have breached the response deadlines (one month, i.e. a request received on 3 September should be responded to by 3 October), have been due to the complexity of cases involved, seeking apparent gaps in information and the availability of staff members outside of the Information Governance Team.

5.0 Requests for personal information from Law Enforcement Agencies.

5.1 The IG Team and SARs Team continue to support South Yorkshire Police, the National Crime Agency and other law enforcement agencies for requests for confidential and personal information relating to victims of crime and those suspected of committing those crimes.

5.2 Since 2015, the IG team have also been involved in supporting South Yorkshire Police and the National Crime Agency in specific operations.

5.3 During the period April 2021 – March 2022, the following were received by the IG Team:

- Police requests (CID49s, CID104s, misc.): 62
- National Crime Agency requests: 343

During the period April 2021 – March 2022, the following were received by the SARS Team:

- Police requests (CID49s, CID104s, misc.): 286
- National Crime Agency requests: 9

5.4 Over the last 12 months, there has been no decrease in the number of NCA requests being sent to the IG team for processing however, there is an indication now that the NCA may currently have all the information they require and as such, all current enquiries are on hold until this has been verified.

5.5 All requests are reviewed for consent and those without (and some with) are reviewed by the Team involved and the Caldicott Guardian or SIRO with occasional advice being sought from the Data Protection Officer. Whilst every effort is made to assist in investigations, the release of information has to be proportionate and justifiable.

6.0 Serious Incidents Requiring Investigation (SIRI)

6.1 The organisation is required to report on any Serious Incidents (SIRI's) within 72hrs of being notified of the incident. These are notified to the Information Commissioner's Office (ICO) or NHS Digital using the reporting tool on the Data Security and Protection Toolkit.

6.2 For the year 2021/22, the DPO has assessed 4 breaches with action taken as follows:

Incident 24799 – 13/07/2021

This was deemed not reportable to the Information Commissioner's Office by the reporting tool. Investigated internally.

Incident 25200 – 18/08/2021

This was deemed reportable to the Information Commissioner's Office and is currently with them for investigation. This was also investigated internally by Human Resources (HR).

Incident 25534 – 21/09/2021

This was deemed not reportable to the ICO by the reporting tool.

Incidents 26636 and 27183 – 12/01/2022

This was deemed not reportable to the Information Commissioner's Office by the reporting tool but has been investigated internally by Human Resources (HR).

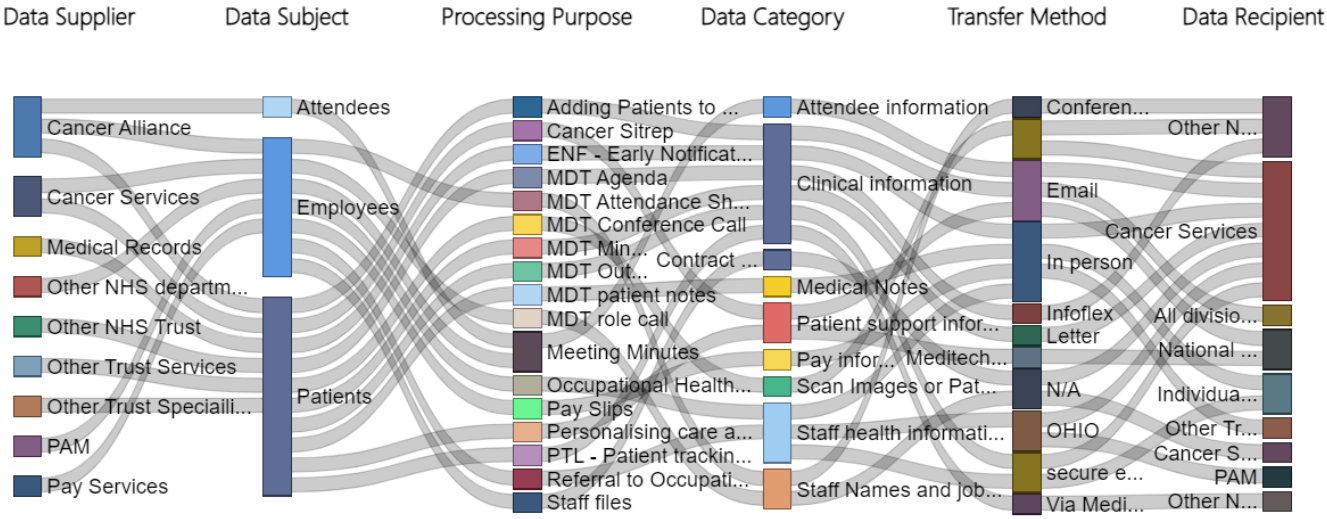
7.0 Data Flow Mapping

7.1 The Trust now has 167 information asset registers across the organisation.

7.2 The data flow mapping tool, developed in Power Bi, a Microsoft® toolset, provides a visual overview of data flows in the organisation, based on the information provided within the asset registers. The way the information is gathered and displayed is currently under review and discussions are underway with Health Informatics colleagues regarding a replacement system which will also include risk.

The tool also enables the IG and Health Informatics teams to quickly view how data is being transferred and whether this can be improved for example, where paper trails may exist, making them digital.

Current Power Bi output showing a single service data flows.



7.3 Despite Covid-19 restrictions, staff maintained their registers and the IG Manager has been in contact with those needing assistance. Even where no change has taken place, this must be indicated on the register as a 'date checked'. Staff changes and service re-organising does have an impact on registers being maintained staff are reminded to change the asset ownership as required.

8.0 Conclusion

8.1 The internal audit is carried out annually by 360 Assurance and has been undertaken ahead of the submission date for the Data Security and Protection Toolkit (DSPT) which is now 30 June year on year. For this year, evidence against all 10 National Data Guardian (NDG) standards equalling 109 mandatory items (and 33 non-mandatory) across 38 mandatory Assertions were assessed and 3 low risk items were selected for strengthening.

The Trust was again awarded 'Substantial Assurance' by the auditors against all 13 audited Assertions.

8.2 The Trust achieved over and above the target of 95% for IG Training, reaching a level of 96% which is excellent and was helped by new initiatives being introduced by some departments such as the '100 Club', which aims to encourage staff to be 100% Mast compliant. Additional training methods were also provided by the IG Manager via the use of Microsoft® Teams which was introduced during the pandemic.

8.3 FOI requests appear to be on the rise although they still remain just below 600 for the year. Response rates from staff internally have improved and compliance with the mandatory 20 working day response back to requestors, is at 98%. A new system is being developed internally by Health Informatics which will also automate some of the reporting function.

Michael Wright
Deputy Chief Executive

Board of Directors Meeting
08 July 2022

The Rotherham NHS Foundation Trust

Agenda item	P116/22
Report	**Health Inequalities Task & Finish Group Update Report**
Executive Lead	Michael Wright, Deputy Chief Executive
Link with the BAF	R2, P1
How does this paper support Trust Values	This paper shows how *ambitious* we are to deliver for our patients and communities and how we're working *together* with other partners to deliver our goals.
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	A Board-level Health Inequalities Task and Finish Group was established in 2021/22 to develop and initiate a programme of work around Health Inequalities, which the Board is committed to delivering on in 2022/23 as per the Operational Plan. This paper provides a summary of the work to date from the Task & Finish Group to establish this programme, based on the evidence around the areas of greatest need wherever possible. It provides an update on the progress to date, and sets out the expectations for the programme going forward.
Due Diligence	This paper has been reviewed at the Board-level Health Inequalities Task & Finish Group.
Board powers to make this decision	In order to be assured of the delivery against our Health Inequalities objectives, the Board needs to be sighted on the progress of the Task & Finish Group.
Who, What and When	The Deputy Chief Executive is the Lead Executive for the Health Inequalities Task and Finish Group, supported by the Director of Strategy, Planning & Performance.
Recommendations	It is recommended that the Board of Directors note the Trust's progress in this programme of work, and are supportive of the plan set out within this paper.
Appendices	Health Inequalities Task and Finish Group Update

Health Inequalities Update

1.0 Introduction

The Covid-19 pandemic has shone a light on the issue of health inequalities within the NHS in particular, and has ensured that a priority has been placed on efforts to reduce health inequalities across the entire healthcare system. The national operational planning guidance for 2022/23 identified addressing health inequalities as one of the ten over-arching priorities for the NHS, following on from the introduction of the Core20Plus5 approach from 2021.

Whilst there is work ongoing across the wider Rotherham Place to address some of these challenges, the Trust wanted to ensure that we had significant internal focus on this work, and so the Board established a Task and Finish Group, chaired by our NED Dr Jo Bibby, to develop and oversee a programme of work to deliver this.

This paper provides an update on the programme of work which has been developed, identifies the key achievements to date and also articulates some of the Trust-specific health inequalities which have been found through the detailed data analysis that has been carried out.

2.0 Background

The Health Inequalities Task and Finish Group was established as a task and finish group of the Board of Directors of The Rotherham NHS Foundation Trust (TRFT) to identify and prioritise key actions in order to reduce inequalities in outcomes from care. This follows the national direction of travel, first indicated in the Long Term Plan, but more recently within the NHS's Operational Planning Guidance. The most recent such guidance supplements the Core20Plus5 approach from 2021, and helps shape the wealth of pragmatic support available to systems looking to focus on this issue.

Recent research by Carnall Farrar and the Institute for Public Policy Research has demonstrated that the South Yorkshire and Bassetlaw ICS has delivered the most effectively on integration and patient outcomes given the level of deprivation across the system[i]. The research showed that our ICS is the 4th most deprived ICS in the country, demonstrating the importance of this area of work for our communities, and we know that there is more that we can do to ensure equity of access to our services, and equity of outcomes.

The Task and Finish Group first met in October 2021, and included 6 colleagues from the Board of Directors, as well as the Public Health lead at Rotherham Metropolitan Borough Council (RMBC) and wider Trust colleagues. Following some early research, a number of key themes emerged as areas of focus for the group:

[1] Revealed: The top-performing ICSs defying deprivation challenges | News | Health Service Journal (hsj.co.uk)

- *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.

As a Task and Finish Group, colleagues were identified to lead each of these areas, and work was undertaken to understand what the key opportunities were to reduce the health inequalities in Rotherham. This work supported a tightening of the scope for the group, and ensured that we appropriately prioritised the many potential options for delivery. It also allowed us to identify where work was already underway within Trust BAU processes, such that we didn't need to duplicate the effort within the Task and Finish Group (for example delivery of the Trust's Green Plan, and financial assistance programmes to support staff). The programme focus could therefore be more clearly defined around specific tasks, with mandates agreed and associated milestones and metrics developed for the priority areas. As a group, we agreed that our plan should fulfil a set of 6 key criteria:

- Based on knowledge of current inequalities in access, experience, outcomes
- The inequality can be measured and we have a baseline
- There are established, evidence-based interventions that will address the inequality
- Any proposed intervention follows the evidence
- The Trust has the capacity and capability to deliver the intervention
- We have an agreed definition of success

3.0 Data Analysis Deep Dive

The release of national evidence which demonstrated a need for systems to address health inequalities has raised awareness of the issues affecting communities' access to care. However, the Trust hasn't utilised demographic information to assess performance to date, and as such, a significant piece of work needed to be undertaken to better understand more about our patients and how this might be

affecting their access to our services, both to our Urgent and Emergency Care Centre, and within elective (planned) care.

Following the appointment of some external support, a deep dive of UECC frequent attenders was carried out, in order to ascertain which patients were most likely to regularly access our emergency care, and therefore what actions we might be able to take to support patients more proactively. The outcomes of this work were presented to the wider Place, as there were some clear trends around which GP practices these patients were registered at. Further work is underway internally to identify how our teams can better support these patients to access the appropriate care when they need it.

Similarly, the full patient-level information of our waiting list was analysed to show where differences in waiting times lie. Our initial analysis showed no significant differences in the average length of wait based on patients' levels of deprivation (drawn from postcode data). Further work was undertaken to identify whether patients from more deprived areas were disproportionately represented within our long waiters, but again, this analysis demonstrated that there is no significant difference for patients from more deprived areas. A more detailed analysis of this is included below, and will now form part of our monthly Integrated Performance Report to our Board.

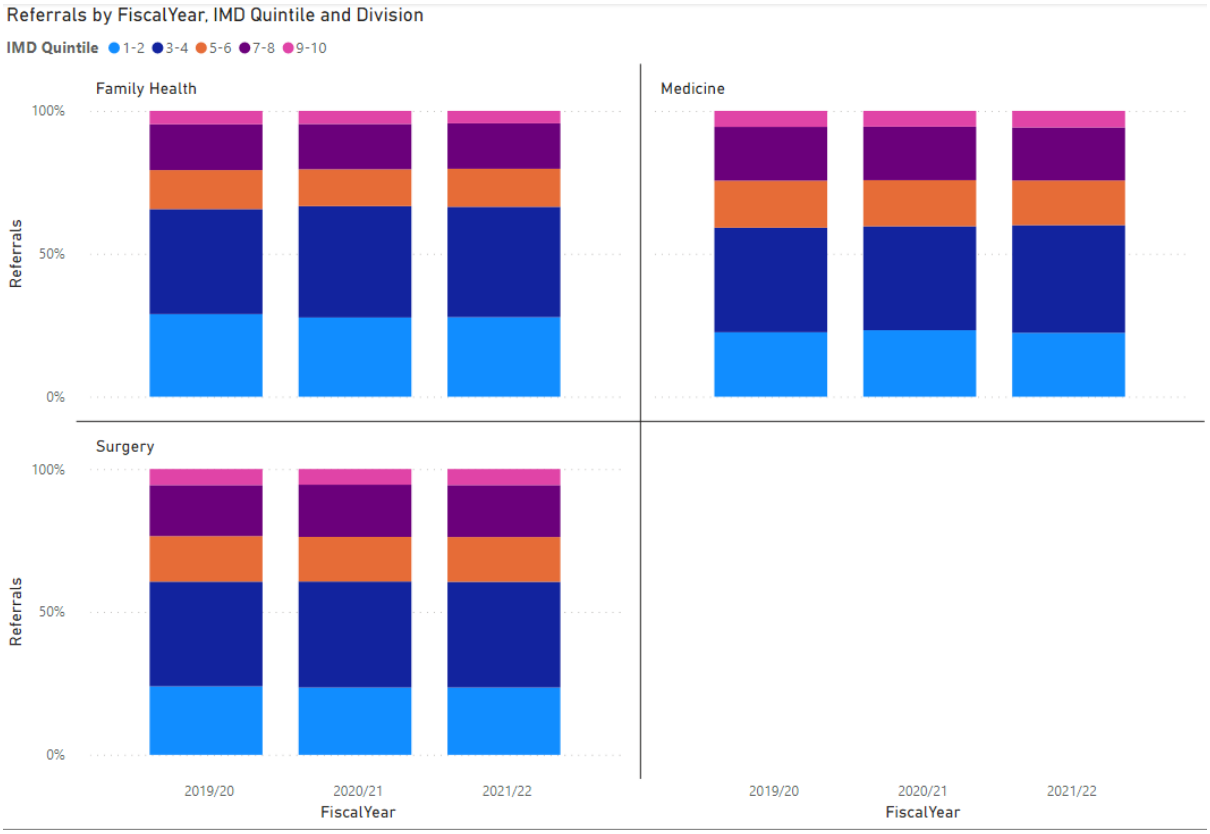
3.1 Key Learnings from Data Analysis

A key element of the work we've carried out so far has centred on utilising the rich data sets we have to better understand our patients and how they access our services, so we can identify any inequalities that exist around access. A summary of the key learnings so far is provided below, and further work is ongoing to review more detail at specialty level, and to ensure this analysis is built into our business-as-usual ways of working.

a) Referrals demographics

One of the concerns over the last two years has been that certain patient cohorts may not have presented to primary care, and therefore have missed necessary secondary care review. However, for TRFT, the proportion of referrals based on IMD quintile have remained very similar for the last 3 years, despite the overall reduction in referrals in the first year of Covid. This is the case for all three of the elective care divisions, as shown below. This is reassuring, as it would suggest that in terms of deprivation, certain cohorts of the population have not been adversely affected by the Covid-19 pandemic in terms of their ability to access primary care services. However, it is also stark to see the proportion of our total referrals which are for patients who are living in the bottom four deciles of deprivation levels. The wider actions at place, system and national level need to drive impact around this most basic measure of inequality in our communities.

Figure 1: Referrals split by IMD quintile as proportion of all referrals, 2019/20-2021/22, split by division

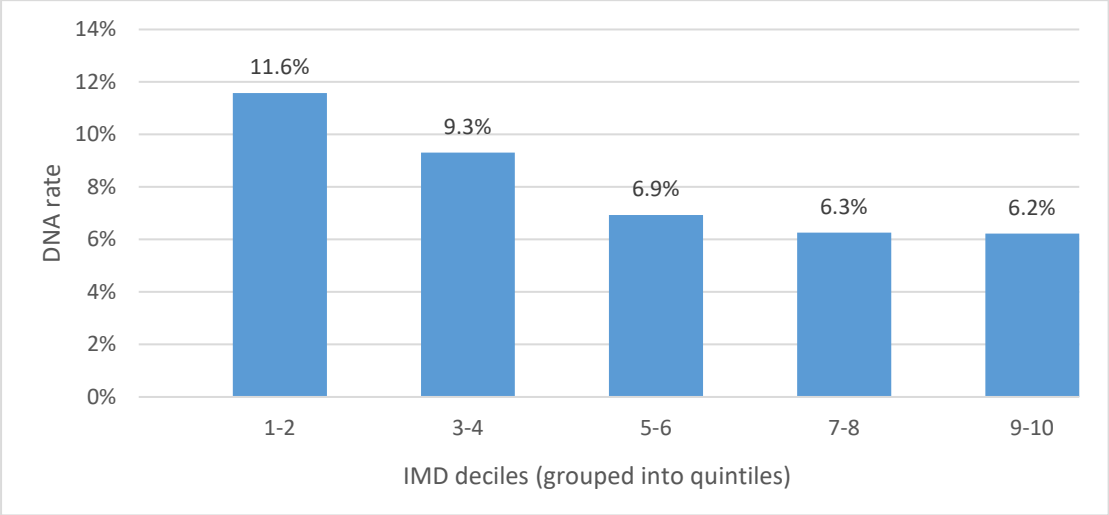


b) Outpatient access

The opposite is the case when we look at patients' ability to attend necessary outpatient appointments, with the DNA rate for patients from the most deprived background being almost double that of the patients from the least deprived areas. It is likely that this is due to patients' ability to attend appointments during working hours, the cost of transport to attend appointments and other caring responsibilities which make it difficult to people to travel to the hospital.

Further analysis of this issue is underway, including to ascertain whether this trend is driven by particular specialties and whether it is related to specific times or days of the week.

Figure 2: DNA rates by IMD decile, January – May 2022



c) Waiting time trends

There are two ways in which we can analyse waiting time trends. We can review the waiting times for patients who have been treated, or we can review the waiting time trends for those on the waiting list. We have analysed waiting times from both angles, which demonstrates no significant differences in waiting times for patients based on their IMD decile.

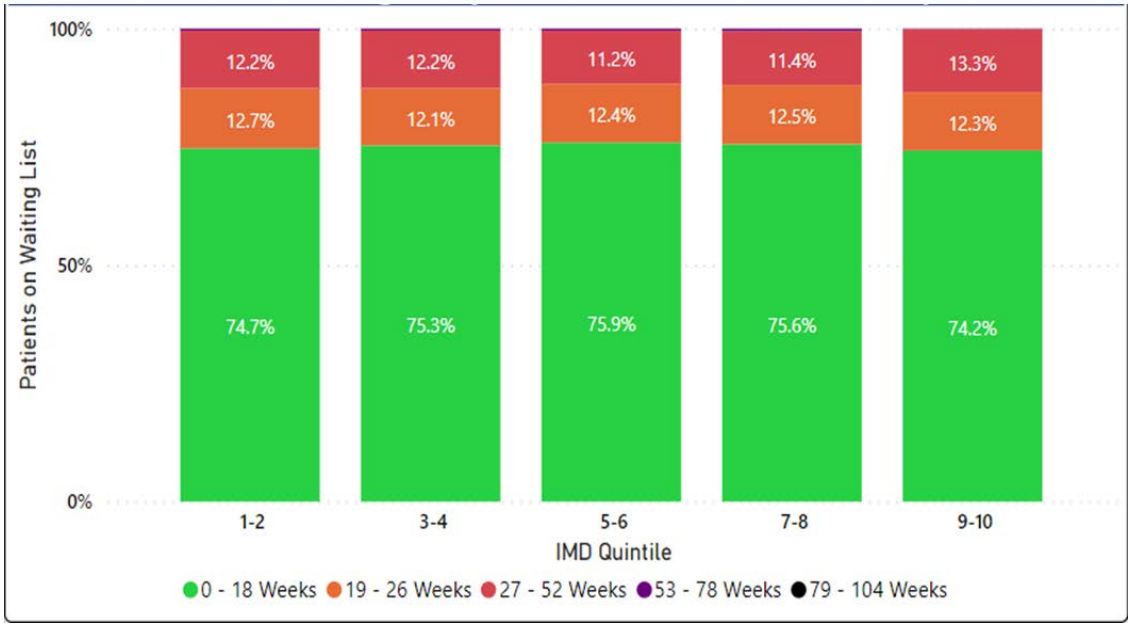
Table 1: Median wait by IMD quintile for all RTT incomplete pathways, June 2022

(Excludes records where the IMD quintile for the patient is not recorded)

IMD Quintile	Patients on Waiting List	Median Wait (wks)	% of All RTT Patients	% of Rotherham Population	% Proportion Difference to Rotherham Population
1-2	6405	10	33.4%	36.0%	-2.6%
3-4	4818	10	25.1%	23.2%	1.9%
5-6	3050	10	15.9%	15.2%	0.7%
7-8	3547	10	18.5%	19.5%	-1.0%
9-10	1372	10	7.2%	6.0%	1.2%
Total	**19173**	**10**	**100.0%**	**100.0%**	**0.0%**

The above table evidences that the mean waits for patients are approximately the same across IMD quintiles.

Figure 3: Proportion of waiting list by waiting time band, by IMD quintile, June 2022



If we look at the current waiting list profile, as above, we can see that a very similar proportion of patients have been waiting less than 18 weeks across all the IMD quintiles, with similar proportions of long waiters in each cohort.

4.0 Planned Delivery

As part of this scoping and prioritisation work, 6 key deliverables were agreed to be taken forward by the group's members, working with other Trust and place colleagues as appropriate. These are:

- Implement a **waiting well programme** for patients waiting for surgery, including developing an approach to segmentation of the waiting list to test personalised approaches to patient communication, piloting this risk stratification with two specialties
- **Personalise our care** to respond to patient needs, including rolling out communication stations and relevant materials to ensure broader understanding and accommodation of different patient needs
- Undertake a data analysis deep dive to better understand specific areas of **inequalities in access** within the Trust, and identify appropriate resolutions; to include an analysis of frequent attenders in UECC, assessments of DNA rates and waiting times; ensure we build regular review of health inequalities analysis into our normal business as usual processes
- Focus on the expansion of our **preventative activities**, such as QUIT, identifying gaps which could be filled by secondary care provision
- Develop a programme of **support for staff** to reduce health inequalities across our population, including financial assistance support for colleagues

- Drive forward our work as an **anchor institution**, including agreement of an anchor charter

The Task and Finish Group has met monthly since the inaugural meeting, and is due to complete its final meeting in June, before all of the above areas of work become integrated into business as usual. Members have fed into the development of the Trust's Operational Plan for the year, to ensure the tasks above have got the appropriate support and representation in our overall priorities for the year.

For each of these areas, a set of milestones and metrics has been agreed for delivery, which is summarised below, along with progress to date. Delivery against these plans will be monitored on a monthly basis.

4.1 Waiting Well

We know that patients are currently waiting longer than pre-Covid-19 for their treatment, and in some cases, this will mean patients waiting several months for their procedures. These extended waits, combined with the impact the pandemic has had on patients' conditions, mean that additional support may be needed for patients whilst they are waiting. A national website called My Planned Care has been developed to support patients with their waits, and the Trust has already designed some helpful online resources for patients.

This programme will further develop our waiting well programme, including launching a 'Ready Rotherham' brand to be able to easily signpost patients to support and assistance. It will identify how we can segment our waiting list based on a simple demographic risk stratification, to ensure patients receive waiting well support personalised to their needs. Implementing this segmentation in two specialties will enable us to learn how we can roll this out more widely, and in particular, what the technical requirements are for such an approach.

Focus	Deliverables	Metric	Improvement target
Waiting Well Programme	• Expansion of health improvement programmes including waiting well/pre-habilitation programme • Implement preferred waiting list segmentation model and corresponding tailored patient offers across 2 specialties	Proportion of patients cancelled for clinical reasons by deprivation quintile (12 month rolling)	Reduction from baseline for quintiles 1 and 2

4.2 Personalised communication and care

Communication Stations:
The most common area mentioned to be improved upon in our Trust's concerns, complaints and patient engagement is communication. The impact that that this has on patient experience and care is profound. Communication Stations will provide staff with resources and training to communicate in a more effective way with anyone with communication needs, as well as other identified vulnerable groups e.g. end of life. The compiling of the resources has prompted cross departmental working, with Speech and Language Therapists, procurement, engagement and inclusion, Consultants, Specialist Nurses and audiology contributing. Interest in implementing this project has led to the Trust presenting this progress nationally to other NHS Trusts.

Translated Bedside Information:
Locally, the non-English speaking population tend to live in more deprived areas of Rotherham. Currently, we offer translation of patient information upon request, however this is almost never requested. Patient engagement in 2021 elicited concerns from the local Pakistani population around non-inclusion at TRFT. Since then, training for staff has been updated to address community concerns. We will be translating the new Bedside Patient Information folders into the top 5 languages of Rotherham (Urdu, Arabic, Slovak/Czech, Chinese, Polish).

Learning Disabilities and Autism Staff Resource Folders:
People with a learning disability have worse physical and mental health than people without a learning disability and are more likely to experience a number of health conditions. On average, the life expectancy of women with a learning disability is 18 years shorter than for women in the general population. The life expectancy of men with a learning disability is 14 years shorter than for men in the general population (NHS Digital 2017).

Autistic people with a learning disability are more susceptible to physical health issues. Autistic people without a learning disability are at higher risk of mental health problems, including higher than normal suicide rates and die 12 years earlier on average, than the general population, with suicide being the greatest cause of this. Overall, Rotherham's rates of autism diagnosis are higher than the national average, and over the next 15 years, a substantial increase in autism diagnoses is expected in the Rotherham area.

At The Rotherham NHS Foundation Trust, we want to ensure staff:

- are referring anyone with a learning disability or autism to the 'Learning Disability and Autism Team' or encouraging self-referral
- are making reasonable adjustments for them
- are equipped to deal more effectively with the particular needs of each individual

Focus	Deliverables	Metric(s)	Improvement target(s)
Personalised Communication and Care	• Launch of Communication Stations across Trust • Implementation of Learning Disability & Autism folders	Referrals to LD & Autism team	5% increase in referrals

4.3 Inequalities in Access

The Trust has a wealth of data around how patients are accessing elective and non-elective care, which can expose inequalities in access, as briefly reviewed above.

In terms of elective care, whilst the Trust's overall median waiting times do not show significant differences across IMD quintiles, there are some nuances at specialty-level that require further investigation and action, including within Urology and Rheumatology. The initial goal of this work is to develop and embed a regular review of waiting times on the basis of demographics, at specialty level. Following this, more detail review may be required if differential access is identified.

One area we can clearly identify inequalities is within outpatient access, which requires a detailed piece of work to better understand the reasons why patients are failing to attend appointments. It is likely this is driven by work restrictions, as well as travel limitations (based on cost and time). Piloting of interventions will be needed to better understand the relative impact of different responses. Public Health colleagues at RMBC are also leading a programme of work to engage with a number of specific patient cohorts within certain Rotherham wards, and we therefore plan to track the core access metrics for these groups, in order to support identification of a wider impact on these individuals' behaviours regarding accessing healthcare.

From an emergency care perspective, frequent attenders currently constitute approximately 2% of total attendances at UECC, with these patients (approximately 180 individuals) spending 750 hours in department each month. This work has already been shared across Place, and has sparked discussion around further work to reduce the reliance that some patients have on our UECC. This will need to be strengthened and closely linked with our own teams in UECC to see how we can better support these patients to manage their health without resorting to accessing emergency care on such a frequent basis.

Focus	Deliverables	Metric	Improvement target
Inequalities in Access	• Work with Place to implement focussed interventions for UECC frequent attenders • Board-level reporting of access standards based on population demographics as appropriate (IMD, BAME) • BAU review of live waiting times data based on demographics • Improved access to outpatient appointments for patients from more deprived areas	% of total attendances from frequent attenders Median waiting times by IMD quintile and BAME Proportion of long-waiters by IMD/BAME cohort DNA rate by IMD quintile	Reduce proportion of attendances to <1.5% (TBC). Retain consistent waiting times across IMD quintiles and BAME cohorts Reduce DNA rate for IMD deciles 1-4 within pilot group to <10%

4.4 Preventative Activities

The Trust's Tobacco Treatment Service has now been rolled out to staff as planned, although with relatively low uptake levels in the first few months. However, the team continue to communicate with colleagues regarding the support available, and it is hoped that those who have benefited from accessing the offer early will encourage others to come forward and make the same decision. Regarding patient cohorts, the Tobacco Treatment Service will be made available to all inpatients, those attending UECC and outpatient areas, including expanding the service to include 12-18 year olds.

The service expansion will significantly increase the number of patient touchpoints available to staff to provide support to our population (given that we deliver approximately 20,000-25,000 outpatient appointments a month). Phased service promotion will be undertaken across all clinical areas.

Alongside the QUIT programme, the expansion of the Healthy Hospitals team should enable us to identify if we can deliver further preventative support to patients attending hospital, for example to support them in achieving a healthy weight. This work is under discussion, but given the demographics of our population and current lack of provision in this area internally, it is expected that there will be a significant opportunity to better support our population by

introducing a programme focussed on healthy weight, replicating the QUIT model that has proved successful to date.

Focus	Deliverables	Metric(s)	Improvement target(s)
Preventative Activities	• Roll out Tobacco Treatment Service to outpatient areas and UECC, including to patients aged 12-18	Number of staff who have a Tobacco Treatment Advisor Inpatients with LoS >1 with a Tobacco Treatment Advisor	2 staff per month >118
	• Implement healthy weight programme based on QUIT model	TBC (programme yet to be scoped)	TBC

4.5 Support for Staff

As described above, our QUIT programme has now been rolled out to staff, with a number of sessions available for staff to come forward and find out more. However, alongside this, the work to scope out a potential healthy weight programme will include a focus on staff, as it is well known that nationally, over half of the NHS workforce is obese.

Given the recent challenges around inflationary pressures affecting energy and fuel prices, it is clear that many of our staff will be financially disadvantaged in the coming months, and may struggle to manage these additional costs. A programme of work is underway, led by our Head of Equality and Diversity, to implement a series of tangible offers to colleagues to support those who need it. In June, we launched our partnership with 'Wagestream', which gives staff access to a proportion of their pay before payday, if and when they need it. It also provides impartial and tailored financial tips for staff, and enables them to save directly from their salary. It is hoped that this programme will eliminate the need for staff to access high-cost loans or utilise other quick cash options, which in the longer-term, will likely leave them in much more difficult situations.

Focus	Deliverables	Metric	Improvement target
Support for Staff	• Implement financial assistance programmes to support staff (Wagestream and the Credit Union)	Number of staff supported by financial assistance programmes	350 staff supported by the end of the year

4.6 Anchor Institution

The majority of our anchor institution work was already part of our BAU operating, with the development of an Anchor Charter falling within the health inequalities programme. Whilst this will likely not have a direct and immediate impact on health inequalities themselves, it establishes the ambition that we are setting ourselves as an organisation, and will help shape our work in this area.

Focus	Deliverables	Metric	Improvement target
Anchor Institution	• Deliver reduction in carbon output within Trust Green Plan	Total Trust Carbon Output	Reduction as defined in Trust Green Plan
	• Support ICB Procurement Programme to ensure shift of suppliers to local area	Proportion of disposable spend within local area	ICS-defined
	• Agree and publish anchor charter		

5.0 Risks and Challenges

As things stand, the work we are undertaking within Health Inequalities does not come with additional resources, so for a number of the deliverables, these are being carried out in addition to colleagues' ongoing roles. This has created challenges over the last few months, whereby it has been difficult for individuals to prioritise this work given the ongoing pressures within the organisation. Opportunities to involve more colleagues in the work are being taken wherever possible, and this will help to mitigate some of the challenges around resourcing.

However, it may be appropriate for there to be consideration around additional resource required to deliver the programme of work set out above.

Similarly, it is likely that some of the solutions to the issues driving health inequalities in Rotherham may require additional investment, and that is at a time when the financial pressures for the Trust are the greatest they have been for several years. This will require us to be innovative and flexible in how we approach identification of solutions, and to work closely with partners across Place to best understand how to implement effective interventions.

6.0 Conclusion and Next Steps

The Health Inequalities Task and Finish Group has enabled a full programme of work to be developed around this really important issue, and has brought colleagues together to drive forward an ambitious agenda. The work has already delivered tangible benefits for patients and staff, and with considerable further interventions planned, it will support the wider Place in reducing the health inequalities that affect our communities.

The Task and Finish Group is due to reduce the frequency of formal meetings from June onwards, with regular touchpoints between the Chair and Deputy Chief Executive and Director of Strategy, Planning and Performance in-between in order to ensure there is ongoing Board-level assurance of the progress being made against the measurable outcomes defined above.

Board of Directors' Meeting
08 July 2022

The Rotherham NHS Foundation Trust

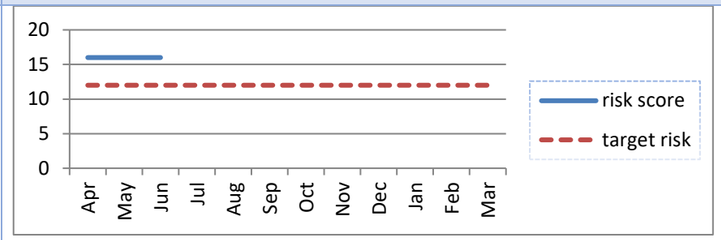
Agenda item	P117/22
Report	**Board Assurance Framework: Quarter 1**
Executive Lead	Angela Wendzicha, Director of Corporate Affairs
Link with the BAF	The paper links with the entire Board Assurance Framework
How does this paper support Trust Values	The Board Assurance Framework is a key element that provides evidence of good governance and therefore supports all three core values, Ambitious, Caring and Together.
Purpose	**For decision** ☒ **For assurance** ☒ **For information** ☐
Executive Summary	The Board Assurance Committees discussed the Quarter 1 position in relation to the Board Assurance Framework and their respective BAF risks during the meetings scheduled throughout Quarter 1. **People Committee:** Discussed and approved the position in relation to BAF Risk U4. **Finance and Performance Committee:** Discussed and approved the position in relation to BAF Risk D5 and D6. **Quality Committee:** Discussed and approved the position in relation to BAF Risk P1. BAF Risks R2 and OP3 will be discussed at the Board meeting on 8 July 2022. The Board is asked to note the slight amendment to the wording of BAF Risk D5 to reflect not just waiting lists but patients attending through UECC as follows : "*There is a risk that we will not deliver safe and excellent performance because of insufficient resource (financial and human resource) leading to an increase in our patient waiting list backlog and potential for patient deterioration and inability to deliver our Operational Plan"* to "There is a risk that we will not deliver safe and excellent performance because of insufficient resource (financial and human resource) leading to an increase in our patient waiting **times** ~~list backlog~~ and potential for patient deterioration and inability to deliver our Operational Plan"
Due Diligence	The Board Assurance Framework ongoing position for Quarter 1 has been discussed at the relevant Board Committees prior to further scrutiny at the Audit Committee in July 2022.

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 continues to work with Executive colleagues in order to develop the revised Board Assurance Framework in order to strengthen the documented levels of assurance and mitigations in addition to the continued identification of any gaps in assurance.
Recommendations	The Board is requested to discuss and approve the position in relation to the Board Assurance Framework for Quarter 1 2022-23.
Appendices	Board Assurance Framework: Quarter 1

Appendix 1

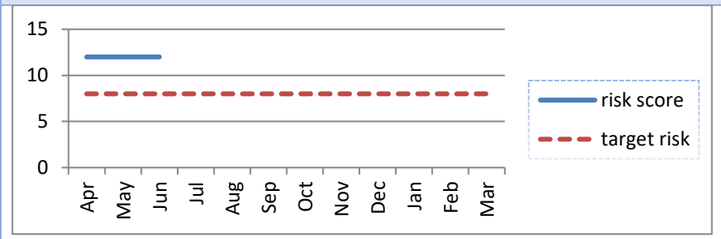
Board Assurance Framework Overview

Ambition	Strategic Risk			Original Score LxC	Current Score Q1	Target Risk Score	Movement	Risk Appetite/ Risk Tolerance
	There is a Risk that….	Because…..	Leading to…..					
Patients: ***We will be proud that the quality of care we provide is exceptional, tailored to people's needs and delivered in the most appropriate setting for them.***	**P1: we will not embed quality care within the 5 year plan**	**..of lack of resource, capacity and capability**	**..poor clinical outcomes and patient experience for our patients**	4(L)x 4(C)=16	**16**	3(L)x4(C) =12		Moderate (12-15)
Rotherham: ***We will be proud to act as a leader within Rotherham, building healthier communities and improving the life chances of the population we serve.***	**R2:we will not establish ourselves as leaders in improving the lives of the population we serve**	**..of insufficient influence at PLACE**	**..increased ill health and increased health inequalities**	3(L)x4(C)=12	**12**	2(L)x4(C) =8		Moderate (12-15)
Our Partners: ***We will be proud to collaborate with local organisations to build strong and resilient partnerships that deliver exceptional, seamless patient care.***	**OP3: robust service configuration across the system will not progress and deliver seamless end to end patient care across the system**	**..of lack of appetite for developing strong working relationships and mature governance processes**	**..poor patient outcomes**	3(L)x4(C)=12	**12**	2(L)x4(C) =8		Moderate (12-15)
Us: ***We will be proud to be colleagues in an inclusive, diverse and welcoming organisation that is simply a great place to work.***	**U4: we do not develop and maintain a positive culture**	**..of insufficient resources and the lack of compassionate leadership**	**..an inability to recruit, retain and motivate staff.**	3(L)x4(C)=12	**12**	2(L)x4(C) =8		Moderate (12-15)
Delivery: ***We will be proud to deliver our best every day, providing high quality, timely and equitable access to care in an efficient and sustainable organisation***	**D5: we will not deliver safe and excellent performance**	**..of insufficient resource (financial and human resource)**	**..an increase in our patient waiting times and potential for patient deterioration and inability to deliver our Operational Plan.**	3(L)x3(C) = 9	**9**	2(L)x2(C)=4		Low (6-10)
	D6: we will not be able to deliver our services	**..we have not delivered on our Financial Plans for 2022-23 in line with national and system requirements**	**..financial instability and the need to seek additional support to deliver our services.**	3(L)x3(C) = 9	**9**	2(L)x2(C)=4		Low (6-10)

Strategic Theme: Patients	Risk Scores							
	BAF Risk Ref	Initial Score	Current Score	Target Score	Risk Appetite/Risk Tolerance	Risk Movement		Board Assurance 2022-23
Strategic Ambition: **Patients:** ***We will be proud that the quality of care we provide is exceptional, tailored to people's needs and delivered in the most appropriate setting for them***	P1	4(L)x4(C)=16	16	3(L)x4(C) =12	Moderate (12-15)		Current / Q1 / Q2	
Link to Operational Plan: ***P1: Empower out teams to deliver improvements in care***								16
BAF Risk Description						**Linked Risks on the Risk Register & BAF Risks**		**Assurance Committee & Lead Executive Director**
P1: There is a risk that we will not embed quality care within the 5 year plan because of lack of resource, capacity and capability leading to poor clinical outcomes and patient experience for our patients.						**Risk 5485; Risk 6614; Risk 6545; Risk 6623; Risk 5950; Risk 6075; Risk 6591; Risk 6668; Risk 4897; Risk 6142; Risk 6638; Risk 5238; Risk 5761; Risk 6569.**		**Quality Committee Chief Nurse and Medical Director**

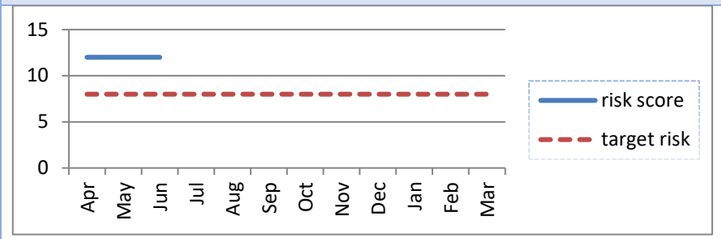
	Controls and Mitigations *(what have we in place to assist in securing delivery of our ambition)*	Assurance Received *(what evidence have we received to support the control)*	Date Assurance Received	Confirmed By:	Assurance Level *Level 1 = Operational* *Level 2 = Internal* *Level 3 - Independent*
C1	CQC Delivery Group in place with oversight of 'must do and should do' actions from the 2021 CQC Report	Receipt of month assurance reports relating to progress against actions		Deputy CEO	Level 1
C2	Established Tendable Audit Programme	Outcome reports received by Quality Committee			Level 1
C3	Agreed Quality Priorities in place	Progress reports received by Quality Committee quarterly	**May 2022**	**Chief Nurse**	Level 1
C4	Implementation of actions following Patient Surveys	Progress reports received by Patient Experience Committee and monitored via Quality Committee			Level 1
C5	Coordinated approach for learning from deaths	360 Assure Report with Limited Assurance			Level 3
C6					

	Gaps in Controls or Assurance Quarter 1 2022-23	Actions Required	Action Owner		Date Action Due	Progress Update	
G1	Lack of suitable Quality Improvement methodology	Complete business case for Quality Improvement Faculty	Chief Nurse	June 2022		Business Case Brief discussed at the Executive Team meeting June 2022	
G2	Lack of Quality Improvement methodology	Agree Quality Improvement methodology	Chief Nurse & Medical Director	TBC			
G3	Embed strengthened Serious Incident Investigation Process	Complete review of the Serious Incident Investigation Process	Chief Nurse & Medical Director	TBC			
G4	Lack of thematic reviews following Structured Judgement Reviews	Implement actions from 360 Assure Learning from Deaths report	Medical Director	TBC			

Strategic Theme: Patients	Risk Scores							Board Assurance 2022-23		
	BAF Risk Ref	Initial Score	Current Score	Target Score	Risk Appetite/Risk Tolerance	Risk Movement		Current	Q1	Q2
Strategic Ambition: **Rotherham:** ***We will be proud to act as a leader within Rotherham, building healthier communities and improving the life chances of the population we serve.***	R2	3(L)x4(C)=12	12	2(L)x4(C) =8	Moderate (12-15)					
Link to Operational Plan: ***R2: Ensure equal access to services***								12	12	
BAF Risk Description						**Linked Risks on the Risk Register & BAF Risks**			**Assurance Committee**	
R2: There is a risk that we will not establish ourselves as leaders in improving the lives of the population we serve because of insufficient influence at PLACE leading to increased ill health and increased health inequalities						**Risk**			**Trust Board** **Deputy Chief Executive**	

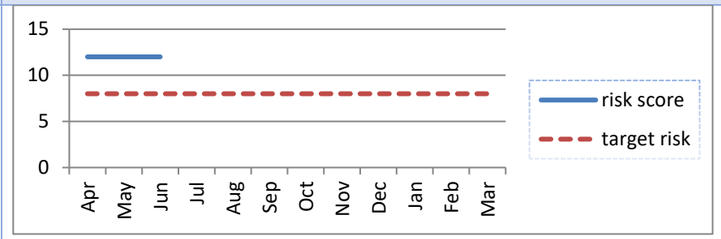
Controls and Mitigations *(what have we in place to assist in securing delivery of our ambition)*		Assurance Received *(what evidence have we received to support the control)*	Date Assurance Received	Confirmed By:	Assurance Level *Level 1 = Operational* *Level 2 = Internal* *Level 3 - Independent*		
C1	Trust is a current member at PLACE Board	Trust Board receives reports from PLACE Board	May	Board minutes	Level 1		
C2	Trust is a member of Prevention and Health Inequalities Group				Level 1		
C3	Trust is a member of the Health and Wellbeing Board				Level 1		
C4	Deputy Chief Executive attends the Health Select Commission						
C5							
C6							
C7							

Gaps in Controls or Assurance Quarter 1 2022-23		Actions Required	Action Owner	Date Action Commenced	Date Action Due	Progress Update	
G1	Trust to be a member of the PLACE Committee of the ICB once established.		Deputy Chief Executive	TBC			
G2	Unknown entity around the ICB governance which is continuing to evolve and mature.		Deputy Chief Executive	TBC			
G3	Incomplete data driven identification of Health Inequalities across elective and non-elective pathways.		Deputy Chief Executive		End Quarter 1		

Strategic Theme: Patients	Risk Scores								
	BAF Risk Ref	Initial Score	Current Score	Target Score	Risk Appetite/Risk Tolerance	Risk Movement		Board Assurance 2022-23	
Strategic Ambition: **Our Partners: *We will be proud to collaborate with local organisations to build strong and resilient partnerships* that deliver exceptional, seamless patient care.**	O3	3(L)x4(C)=12	12	2(L)x4(C) =8	Moderate (12-15)		Current	Q1	Q2
Link to Operational Plan: ***P3: Our Partners: Work together to succeed for our communities.***							12	12	
BAF Risk Description						**Linked Risks on the Risk Register & BAF Risks**		**Assurance Committee**	
O3: There is a risk that robust service configuration across the system will not progress and deliver seamless end to end patient care across the system because of lack of appetite for developing strong working relationships and mature governance processes leading to poor patient outcomes.						**Risk**		**Audit Committee and Trust Board Interim Chief Executive & Deputy Chief Executive**	

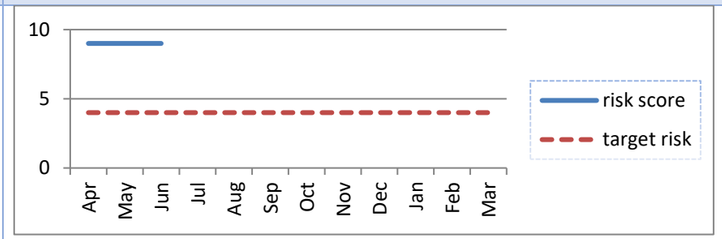
	Controls and Mitigations ***(what have we in place to assist in securing delivery of our ambition)***	**Assurance Received** *(what evidence have we received to support the control)*	**Date Assurance Received**	**Confirmed By:**	**Assurance Level** *Level 1 = Operational* *Level 2 = Internal* *Level 3 - Independent*		
C1	The Trust is a member of the South Yorkshire & Bassetlaw Acute Federation and Chaired by the Trust Chair	Monthly Reports received by the Trust Board			Level 1		
C2	Shared Chief Executive function between the Trust and Barnsley NHSFT				Level 1		
C3	Existing collaboration with Barnsley on some clinical services				Level 1		
C4	Existing collaboration with Barnsley around Procurement function				Level 1		
C5							
C6							

	Gaps in Controls or Assurance Quarter 1 2022-23	**Actions Required**	**Action Owner**	**Date Action Commenced**	**Date Action Due**	**Progress Update**	
G1	ICB becomes a legal entity on 01 July 2022	Confirmation required of emerging governance arrangements	TBC	TBC			
G2							

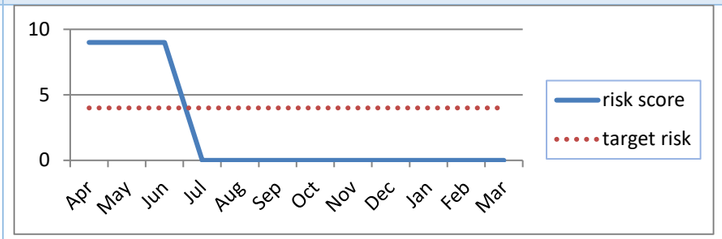
Strategic Theme: Patients	Risk Scores								
	BAF Risk Ref	Initial Score	Current Score	Target Score	Risk Appetite/Risk Tolerance	Risk Movement		Board Assurance 2022-23	
Strategic Ambition: **Us:** ***We will be proud to be colleagues in an inclusive, diverse and welcoming organisation that is simply a great place to work.***	U4	3(L)x4(C)=12	12	2(L)x4(C) =8	Moderate (12-15)			Current	Q1 Q2
Link to Operational Plan: ***P4: Commit to a focus on workplace wellbeing and compassionate leadership***									
BAF Risk Description						**Linked Risks on the Risk Register & BAF Risks**		**Assurance Committee**	
U4: There is a risk that we do not develop and maintain a positive culture because of insufficient resources and the lack of compassionate leadership leading to an inability to recruit, retain and motivate staff.						**Risk 6591; Risk 6142; Risk 5238**		**People Committee Director of Workforce**	

	Controls and Mitigations *(what have we in place to assist in securing delivery of our ambition)*	Assurance Received *(what evidence have we received to support the control)*	Date Assurance Received	Confirmed By:	Assurance Level *Level 1 = Operational* *Level 2 = Internal* *Level 3 - Independent*		
C1	Board Approved People Strategy (2020)	Reports on progress against the People Strategy			Level 1		
C2	Operational Workforce Group in place meeting monthly to support Divisions	Divisional presentations to People Committee on rotation to provide assurance on staff engagement and workforce metrics			Level 1		
C3	Behavioural Framework in place within the Trust	Executive Directors weekly walk rounds			Level 1		
C4	Staff Survey Action Plans	Progress against action plans monitored via			Level 1		
C5	Trust has in place staff Inclusion networks (BAME, LGB ,Disability)				Level 1		
C6	Establishment Control Panel for recruitment of staff.				Level 1		
C7	Internal Audit Review of ESR	Report from 360 Assurance with Significant Assurance	**June 2022**		Level 3		

	Gaps in Controls or Assurance Quarter 1 2022-23	Actions Required	Action Owner	Date Action Commenced	Date Action Due	Progress Update	
G1	Additional staff engagement sessions	Funding application for NHS Charities Together for psychological support	TBC	TBC			
G2	Leadership Programme in place	Identify suitable leadership development programme provider.	TBC	TBC			

Strategic Theme: Delivery		Risk Scores								
		BAF Risk Ref	Initial Score	Current Score	Target Score	Risk Appetite/Risk Tolerance	Risk Movement		Board Assurance 2022-23	
Strategic Ambition: ***Delivery: We will be proud to deliver our best every day, providing high quality, timely and equitable access to care in an efficient and sustainable organisation***		**D5**	**3x3=9**	**3x3=9**	**2x2=4**	**Low (6-10)**		**Current**	**Q1**	**Q2**
Link to Operational Plan: ***D5: Implement sustainable change to deliver high quality, timely and affordable care***										
BAF Risk Description							**Linked Risks on the Risk Register & BAF Risks**		**Assurance Committee & Lead Executive Director**	
D5: There is a risk we will not deliver safe and excellent performance because of insufficient resource (financial and human resource) leading to an increase in our patient waiting times and potential for patient deterioration and inability to deliver our Operational Plan.							**Risk 4897; Risk 6469; risk 5761 and Risk 6569**		**Finance and Performance Committee** **Director of Finance & Chief Operating Officer**	
Controls and Mitigations ***(what have we in place to assist in securing delivery of our ambition)***		***Assurance Received*** *(what evidence have we received to support the control)*		**Date Assurance Received**		**Confirmed By:**	**Assurance Level** *Level 1 = Operational* *Level 2 = Internal* *Level 3 - Independent*			
C1	Monitoring daily mean time of patients in UECC	Metric included in the Integrated Performance Report					Level 1			
C2	Divisional Performance meetings chaired by the Deputy CEO.	Monthly reports to Finance and Performance Committee and Board					Level 1			
C3	Monitoring right to reside and Length of Stay data	Monthly reports to Finance and Performance Committee and Board					Level 1			
C4	Dental and medical workforce vacancy panel chaired by the Medical Director	Additional sessions for dental and medical workforce					Level 1			
C5	Admission avoidance work remains ongoing	Urgent and Community transfer group co-chaired with local authority					Level 1			
C6	Executive Team oversight	Weekly receipt of Performance Report and Recovery Report		**June 2022**		**ETM minutes**	**Level 1**			
C7										

Gaps in Controls or Assurance Quarter 1 2022-23		**Actions Required**	**Action Owner**	**Date Action Commenced**	**Date Action Due**	**Progress Update**	
G1	Insufficient acute inpatient beds	Finalise AGU Business Case	TBC	TBC	Q1		
G2	National programme around Right to Reside on hold	Receipt of National Guidance					
G3	Ring-fence interim frailty assessment beds	ICS SDEC pathways confirmed					

Strategic Theme: Delivery	Risk Scores							
	BAF Risk Ref	Initial Score	Current Score	Target Score	Risk Appetite/Risk Tolerance	Risk Movement		Board Assurance 2022-23
Strategic Ambition: ***Delivery: We will be proud to deliver our best every day, providing high quality, timely and equitable access to care in an efficient and sustainable organisation***	**D6**	**3x3=9**	**3x3=9**	**2x2=4**	**Low (6-10)**		**Current**	**Q1** **Q2**
Link to Operational Plan: ***D5: Implement sustainable change to deliver high quality, timely and affordable care***								
BAF Risk Description						**Linked Risks on the Risk Register & BAF Risks**		**Assurance Committee**
There is a risk we will not be able to deliver our services because we have not delivered on our Financial Plans for 2022-23 in line with national and system requirements						**Risk**		**Finance and Performance Committee**

Controls and Mitigations ***(what have we in place to assist in securing delivery of our ambition)***		**Assurance Received** *(what evidence have we received to support the control)*	**Date Assurance Received**	**Confirmed By:**	**Assurance Level** *Level 1 = Operational* *Level 2 = Internal* *Level 3 - Independent*
C1	Finance and Performance Committee oversee budget reports	Budget reports presented to Finance and Performance Committee			Level 1
C2	System wide delivery of Recovery	Director of Finance attends South Yorkshire DofF Group			Level 1
		Monthly Finance Report to CEO Delivery Group			Level 1
		South Yorkshire Financial Plan Delivery			Level 1
C3	Suitably qualified Finance Team in place				Level 1
C4	Established Capital Monitoring Group	Capital and Revenue Plan signed off by Board			
C5	Current Standing Financial Instructions in place	Reviewed and approved by Board	November 2021	Board of Director minute	Level 1
C6	Internal Audit Reports	Internal Audit Financial Reports			Level 3
C7		Monthly Divisional Assurance meetings			

Gaps in Controls or Assurance Quarter 1 2022-23		**Actions Required**	**Action Owner**	**Date Action Commenced**	**Date Action Due**	**Progress Update**
G1	Lack of final sign off for submitted financial plan	Budget sign off required at System level	Steve Hackett	Revised financial plan approved at Board in June 2022	June 2022	Signed off and complete
G2	Final CIP required	Internal CIP requires final sign off	Steve Hackett	Included within approved financial plan	June 2022	Signed off and complete
G3	Divisional Budget sign off	Complete Divisional Budget sign off	Steve Hackett	SH planning to sign off 24/06/2022	June 2022	SH awaiting last two budgets

Board of Directors' Meeting
08 July 2022

Agenda item	P118/22
Report	**Corporate Governance Report**
Executive Lead	Angela Wendzicha, Director of Corporate Affairs
Link with the BAF	Links with the full BAF
How does this paper support Trust Values	Supports all three Trust values.
Purpose	**For decision** ☐ **For assurance** ☐ **For information** ☒
Executive Summary (including reason for the report, background, key issues and risks)	The following report primarily focuses on two key documents provided by NHS England namely: • Draft Code of Governance for NHS provider Trusts; • System working and collaboration: The role of Foundation Trusts Council of Governors; and
Due Diligence	This paper has not been received elsewhere prior to submission to the Board.
Board powers to make this decision	No decisions required by the Board.
Who, What and When	Further detailed reviews will be undertaken by the Director of Corporate Affairs and any amendments to the Trust constitutional documents will be made in preparation for the publication of the final Code of Governance.
Recommendations	It is recommended that the Board note the content of the paper.
Appendices	None

1. Introduction

The following report provides an overview of some regulatory and statutory developments across healthcare.

2. Draft Code of Governance for NHS Provider Trust

2.1 A draft Code of Governance for NHS Providers was issued by NHS England (NHSE) on 27 May 2022 and is subject to consultation until 8 July 2022. The new Code will be a welcome replacement to the existing NHS Foundation Trust Code of Governance which last received an update in 2014.

2.2 The new Code will apply to all Trust and not just Foundation Trusts and has been updated to reflect the changes made with the introduction of the UK Corporate Governance Code in 2018. In addition, the Code reflects the legal establishment of the Integrated Care Systems (ICSs) in accordance with the Health and Care Act 2022 and reflects the evolving NHS System Oversight Framework, under which organisations will be treated similarly regardless of their Constitution as a Trust or Foundation Trust.

2.3 The general provisions of the draft Code do not differ greatly from the 2014 version since the Health and Care Act 2022 does not change the statutory roles, responsibilities and liabilities of provider Trust Board of Directors. However, there are some thematic changes that can be identified within the draft Code as follows:

2.3.1 Incorporation of the requirement for Boards to assess the Trust's "contribution to the objectives of the Integrated Care Partnership (ICP) and Integrated Care Board (ICB), in addition to Place-based Partnerships" as part of the Trust's assessment of its performance, and 'system and place-based partners' are highlighted as key stakeholders throughout the document.

2.3.2 There is an inclusion of the Board's role in assessing and monitoring the culture of the Trust and taking corrective action as required in addition to "investing in, rewarding and promoting the wellbeing of its workforce". This is a change from the previous Code which only mentioned wellbeing in the context of the finances of the Trust.

2.3.3 There is a new focus on equality, diversity and inclusion (EDI) among Board members in addition to training in EDI for those undertaking Director-level recruitment.

2.3.4 There is the potential for greater involvement from NHSE in the recruitment and appointment processes for Foundation Trusts including the utilising NHSE's Non-Executive Talent and Appointments team in preference to external recruitment agencies.

2.4 The draft Code comprises five sections, namely:

2.4.1 **Board Leadership and Purpose**: The principles have been updated to align with current NHS policy and stress the importance of an effective, diverse and entrepreneurial Board that sets the Trust's vison, strategy and values with regard to the triple aim duty of better health and wellbeing for everyone, better quality services and the sustainable use of resources.

2.4.2 **Division of Responsibilities**: This sets out the role of the Chair and the need for clear division between the leadership of the Board and the leadership of the Trust's operations. The collective responsibility for the performance of the Trust remains the same and the provisions remain largely unchanged save for the appointment and removal of the Company Secretary is now a matter for the Board as a whole rather than the Chair and Chief Executive jointly.

2.4.3 **Composition, succession and Evaluation**: This section relates to the need for formal, rigorous and transparent procedures for Board appointments. There is a new requirement for the Board to publish plans for how the board and senior managers will in percentage terms match the overall black and minority composition of its overall workforce, or its local community, whichever is the higher. Consideration of diversity is now included within the annual board evaluation.

The draft Code refers to the Well-led framework and Competency Frameworks – NHS Senior Leaders On boarding and Support in order to support evaluation of the board's effectiveness. The Code strengthens the fit and proper persons requirement from 'abide by Care Quality Commission guidance' to "have a policy for ensuring compliance".

There is a new provision to describe the Trust's policy on diversity and inclusion and the gender balance of senior management.

2.4.4 **Audit, Risk and Internal Control:** Proposed changes are minimal. This section reflects the principles of having independent, effective internal and external audit functions, in addition to procedures for managing risks and determining long-term risk appetite. The draft Code extends the maximum external auditor contractual period for Foundation Trusts to 10 years whilst still recognising that audit services should be refreshed more frequently.

It is of note that whilst the council of governors continue to have a statutory role in appointing the auditor it is not referred to in the draft Code. In addition, the Audit committee should now report to the Board on how they have discharged their responsibilities and not the Council of Governors.

2.4.5 **Remuneration:** This section deals with suitable remuneration, pay and benefit arrangements, including performance-related pay. The principles now refer organisations to NHSE's pay frameworks for very senior managers further adding that Trusts should await notification and instruction from NHSE before implementing any cost of living increases.

2.5 The draft Code is currently in consultation until 8 July 2022 following which the final Code will be published. It is not anticipated that the draft Code will significantly change following the period of consultation therefore work has commenced on updating the relevant constitutional documents.

3. System Working and Collaboration: The Role of the Foundation Trust Council of Governors

3.1 The draft Addendum to the existing document "Your Statutory Duties – reference guide for NHS Foundation Trust Governors" was published in May 2022. This is the first step in clarifying the role of the Council of Governors' within the context of Integrated Care Systems and the expectation that NHS Foundation Trusts will collaborate with their relevant system partners.

3.2 The key points relate to the follows:

- In order to support collaboration between organisations and the delivery of better, joined up care, council of governors are required to form a rounded view of the interests of the 'public at large'
- The legal duties of the council of governors have been updated insofar as holding the non-executive directors to account
- Representing the interests of Trust members and the public and
- Approving significant transactions, mergers, acquisitions or dissolutions

3.3 The detail of the above document and the potential implication for the way in which they operate going forward will be explored with the Council of Governors at their next meeting.

4. Conclusion

The Board is asked to note the content of the report and note that further detail will follow in terms of direct impact on the Trust's existing constitutional documents.

Angela Wendzicha
Director of Corporate Affairs
July 2022

Board of Directors' Meeting
08 July 2022

The Rotherham NHS Foundation Trust

Agenda item	P119/22
Report	**Board Assurance Committees**
Executive Lead	Martin Havenhand, Chair Angela Wendzicha, Director of Corporate Affairs
Link with the BAF	The detail within the report links to the full Board Assurance Framework
How does this paper support Trust Values	This paper supports all three Trust 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 following paper illustrates the progress made and work to do following the annual review of effectiveness of the Board Assurance Committees. In addition, due to imminent changes within the Non-Executive Director cohort, the proposed changes to the Chairs and membership of the Committees is set out.
Due Diligence	This paper has not been to any other Trust committee or group.
Board powers to make this decision	In accordance with the current Standing Orders and Matters Reserved to the Board.
Who, What and When	Subject to Board approvals the work will continue in strengthening the Quality Committee and re-defining the work programme for the People Committee. The associated Terms of Reference will be updated for future presentation at Board.
Recommendations	1.1 The Board is asked to: a) Note the ongoing development work with the Quality Committee and People Committee; b) Approve the revised Terms of Reference for the Finance and Performance Committee at Appendix 1 c) Approve the standing down of the Corporate Trustee meeting and incorporate Charity reporting into the Board business;

	d) Approve the amalgamation of the Remuneration Committee and Nominations Committee. e) Approve the proposed board membership and chair and vice chair positions for 2022/23 shown at Appendix 2
Appendices	Appendix 1: Terms of Reference Finance and Performance Committee Appendix 2: Summary Table showing board members membership and attendance at Board committees.

1. Introduction

1.2 The Trust has a statutory obligation, as a provider of healthcare to demonstrate that there are systems and processes in place to meet the requirements of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

1.3 In order to comply with the aforementioned Regulation 17, the Trust must have an effective and robust governance framework that operates well. This includes systems of risk management, assurance and performance monitoring with the added duty to continually evaluate and seek to improve our governance and auditing practices.

1.4 In addition, effective corporate governance is a means by which the Board leads and directs the Trust so that decision-making is effective, risk managed and outcomes delivered. As we move towards increased collaboration within the Integrated Care System to integrate care, having regard to the triple aim duty of better health and wellbeing for everyone, better quality of health services for all individuals and sustainable use of NHS resources, robust governance structures that support collaborative leadership. This is largely delivered via an effective assurance committee structure.

2. Review of Board Assurance Committees

2.1 Good corporate governance should remain a dynamic concept where there is continuous evaluation and review to ensure the Trust has robust corporate and quality governance arrangements in place.

2.2 The Trust currently has the following Board Committees:

- Audit Committee
- Quality Committee
- People Committee
- Finance and Performance Committee
- Charitable Funds Committee
- Remuneration Committee
- Nominations Committee

2.3 Audit Committee

2.3.1 The Audit Committee carried out an interactive review of its effectiveness in February 2022 facilitated by the Trust's Internal Audit function, 360 Assure. The outcomes have been incorporated into the Audit Committee Annual Report that will be presented at the next Audit Committee on 29 July 2022.

2.3.2 Following the annual effectiveness review of the Quality Committee, People Committee and Finance and Performance Committee, the Terms of Reference for the Audit Committee have been further amended for presentation and approval at the July Audit Committee and for recommendation to the board.

2.3.3 The current Chair of the Audit Committee is Kamran Malik, Non-Executive Director and it is proposed that he remains as Chair until 30th June 2023

2.4 Quality Committee

2.4.1 The Board will recall the ongoing developments in relation to the Quality Committee and in particular in relation to the number of officer committees that report directly into the Quality Committee resulting in a strengthened focus on patient safety, patient experience and clinical effectiveness.

2.4.2 The annual review of effectiveness of the Quality Committee was carried out via a virtual survey. Following review of the findings there is a need to re-define the business of the Quality Committee, and a successful facilitated development session took place on 30 June 2022. As a result of this a further workshop will take place during the next two weeks with the members of the Quality Committee and the Director of Corporate Affairs to develop and agree the annual work plan going forward and how the Committee will function in future.

2.4.3 The aforementioned work will include the revised terms of reference for approval at the July Quality Committee for recommendation to the board.

2.4.4 The current Chair of the Quality Committee is Rumit Shah, Non-Executive Director and it is proposed that he will continue as Chair of the Quality Committee until 30th June 2023.

2.5 People Committee

2.5.1 The People Committee has also carried out an annual review of effectiveness via a virtual survey. Following a focused review of the findings, as with the Quality Committee, a workshop is planned to be carried out in August with the members of the People Committee and Director of Corporate Affairs to review the work plan and how the business and focus of the Committee will be strengthened going forward. This will result in a revised work plan and Terms of Reference for approval at the September meeting and recommendation to the Board

2.5.2 The Chair of the People Committee is currently Lynn Hagger, Non-Executive Director whose term of office is due to end on 30 September 2022. It is proposed that Jo Bibby, Non-Executive Director commences as Chair from 11th July 2022 for a period of 2 years.

2.6 Finance and Performance Committee

2.6.1 In line with the other Board Assurance Committees, the annual review of effectiveness was carried out via a virtual survey. Following review of the findings, the Terms of Reference have been updated and approved at the Finance and Performance Committee on 30 June 2022. The revised Terms of Reference are attached at Appendix 1 for final Board approval.

2.6.2 The Chair of the Finance and Performance Committee is Nicola Bancroft, Non-Executive Director and it is proposed that the Chair remains until 30 June 2023.

2.7 Charitable Funds Committee

2.7.1 The Charitable Funds Committee is accountable to the Corporate Trustee. The Board of Directors is the Corporate Trustee in relation to the Charity. Historically the Corporate Trustees convened a separate meeting to discuss matters relevant to the Charity.

2.7.2 The Trust commissioned an independent review of the Charity during Quarter 3 and 4 2021-22. One of the areas highlighted was the unusual position of the Trust convening a separate Corporate Trustee meeting rather than incorporating the Charity reporting into the existing business of the Board.

2.7.3 It is proposed that the Charity Committee reports into the Board from September 2022 therefore negating the need for a separate Corporate Trustee meeting.

2.7.4 The current Chair of the Charitable Funds Committee, Michael Smith will leave the Trust on 30 September and it is proposed that Heather Craven takes over as Chair of the Charitable Funds Committee from 01 October 2022.

2.8 Remuneration Committee and Nominations Committee

2.8.1 The Trust currently has two separate meetings namely the Nominations Committee and the Remuneration Committee. It proposed that the two Committees are merged to become one with one set of Terms of Reference. A new terms of reference will be presented to the August Board meeting.

3. Conclusion and Recommendation

3.1 In summary, a full review has been undertaken in relation to the Board Assurance Committees incorporating the findings from the annual effectiveness surveys.

3.2 Following the effectiveness reviews and the annual appraisal processes the proposed board membership and chair and vice chair positions for 2022/23 is shown at Appendix 2.

3.3 The Board is asked to:

a) Note the ongoing development work with the Quality Committee and People Committee;
b) Approve the revised Terms of Reference for the Finance and Performance Committee;
c) Approve the standing down of the Corporate Trustee meeting and incorporate Charity reporting into the Board business;
d) Approve the amalgamation of the Remuneration Committee and Nominations Committee.

Angela Wendzicha, Director of Corporate Affairs
On behalf of
Martin Havenhand, Chair

Appendix 1

The Rotherham NHS Foundation Trust

Finance and Performance Committee
Terms of Reference

Name and Designation of Author	Angela Wendzicha, Director of Corporate Affairs
Approved by	Finance and Performance Committee
Approving evidence	Minutes of the meeting held on 30 June 2022 Minutes of Board meeting held on
Date approved	
Review date	May 2023
Review frequency	Annual
Target audience	Finance and Performance Committee Members and Attendees
Links to other Procedural Documents	Trust Board Terms of Reference
Protective Marking Classification	Subject to FOI Act

Date	Version	Author Name & Designation	Summary of amendments
February 2021	1		
April 2022	2	Angela Wendzicha, Director of Corporate Affairs	Full review:

Version Control

Title	Finance and Performance Committee Terms of Reference
Constitution	1.1 The Finance and Performance Committee ("the Committee") is constituted as a standing committee of the Board of Directors (the Board) of The Rotherham NHS Foundation Trust (the Trust).
Authority	2.1 The Committee is authorised by the Board to consider any matter within its terms of reference and be provided with the Trust resources to do so. 2.2 The Committee has the right of access to all information that it deems relevant to fulfil its duties which may require any Trust colleague to attend a meeting of the Committee to present information or answer questions on a matter under discussion. 2.3 The Committee is authorised to instruct external professional advice and to invite external consultants with relevant experience and expertise to attend if it considers this necessary or expedient to exercise its functions. 2.4 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions. This may include establishing task and finish groups as required to assist in discharging its' responsibilities. 2.5 The Committee has no executive powers other than those set out in these Terms of Reference. 2.6 The Committee is authorised to meet via a virtual/remote meeting. 2.7 The Committee is authorised, in exceptional circumstances to conduct discrete business outside of its scheduled meetings where it is not practicable to convene a full meeting. The process to be followed is set out in the Section 10.7.

Purpose & Duties	3.1 The Board has approved the establishment of the Committee for the purpose of supporting the timely delivery of the Trust's Strategic Ambitions and the Operational Plan giving detailed consideration to the Trust's financial and operational issues whilst being assured as to compliance with appropriate regulatory and statutory requirements. It will discharge this purpose through the following duties:
	
	• Oversee implementation of the Trust's priority in year operational and financial objectives/enablers against agreed milestones;
	• Review in year actual operational and financial performance against plan;
	• Review in year forecast operational and financial performance against plan;
	• Review the Trust's efficiency and productivity plans (including cost improvement performance) and processes;
	• Oversee all aspects of cash management to ensure the Trust discharges its responsibilities in respect of payroll and non-pay costs
	• Oversee the management of cash in respect of payments, receipts borrowing and temporary overdraft facilities and treasury management, as detailed in the Trust's Scheme of Delegation;
	• Oversee embedding and audit of the Financial Governance Action Plan;
	• Review key operational and financial plans/ policies to ensure they are up to date and fit for purpose (including Finance, Procurement, IT and Estates);
	• Oversee and seek assurance on delivery relating to Winter Planning;
	• Oversee and seek assurance that the Trust is delivering against key performance indicators as set out in the Integrated Performance Report;
	• Oversee and seek assurance in relation to the programme of Recovery;
	• Confirm that the Trust manages its' asset base effectively and efficiently and confirm capital projects of significant value whether related to property or other assets, are properly identified, managed and controlled. This relates to both acquisition of assets and their disposal.
	• Seek assurance that the Trust has appropriate strategies relating to environment and sustainability and policies are effectively implemented and monitored; and
	• In accordance with the Trust's Scheme of Delegation:
	  • Review business cases, tenders and contracts for approval by the Board, ensuring that they have been developed within the terms of the business case protocol; and
	  • Review post implementation reviews of the above to agree key action points to inform future decision making.

	The Committee will also: • Review the Board Assurance Framework risks delegated to the Committee for review, and to make recommendations to the Board for any required changes of risk score or content; and • Review the 12+ scored risks from the Risk Register relating specifically to the remit of the Committee, as determined by the Risk Management Committee.
Reporting to	4.1 The Committee is accountable to the Board. 4.2 The Committee shall report to the Board on how it discharges its responsibilities 4.3 The Chair of the Committee will bring to the attention of the Board any items that the Performance Committee considers the Board should be aware of through the Chair's report to the Board in addition to any issues that require disclosure to any regulatory body. 4.4 The minutes of the Committee's meetings shall be formally recorded and submitted to the Board, once approved by the Chair of the Committee. 4.5 The Committee will consider matters referred to it for action by the Audit Committee, People Committee and or the Quality Committee and will report back in writing. 4.6 The Committee, will, on an exception basis, report into the Audit Committee any identified unresolved risks arising within these Terms of Reference. 4.7 The Committee will report to the Board annually on its work in support of the annual governance statement. The annual report should also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee has considered and how these were addressed. 4.8 In addition the Chair of the Committee will provide a quarterly report on the Committee's activities to the Council of Governors.

Committee Membership	5.1 The Committee members shall be appointed by the Board and shall consist of: • Three Non-Executive Directors (one of whom must have relevant and current financial experience); • Executive Director of Finance, who will act as Lead Executive; and • Chief Operating Officer. 5.2 Members who are unable to attend the meeting can send a Deputy with the prior approval of the Chair; such Deputy must have the ability and authority to make decisions and contribute fully to the business of the Committee. 5.3 The Board shall appoint the Chair and Vice Chair of the Committee from its Non-Executive Directors. 5.4 Membership of the Committee will include at least one common Non-Executive Director member of the Audit Committee. This member will act as a conduit of information and assurances across the two Committees in support of the Trust's integrated governance approach.
Attendees	6.1 Attendees to include: • Deputy Chief Executive • Deputy Director of Finance; • Deputy Chief Operating Officer/Director of Operations ; • Divisional General Managers; • Director of Informatics; • Director of Estates and Facilities; • Director of Strategy, Planning and Performance; • Director of Corporate Affairs / Company Secretary; • Corporate Governance Administrative support. 6.2 The Medical Director and the Chief Nurse may be called to attend any meeting as the Chair deems relevant. 6.3 The Chief Executive Officer, other Executive Directors or their colleagues may be invited to attend for specific agenda items so to assist in deliberations.
Quorum	7.1 A quorum shall be made up of three members comprising at least two Non-Executive Directors and one Executive Director. 7.2 No business shall be transacted by the Committee unless a quorum is present. 7.3 Those in attendance or observing do not count towards the quorum.

Observers	8.1 Meetings are not open to members of the public, however two Governors, representing the Council of Governors, may attend Committee meetings as observers, once confidentiality agreements have been signed on an annual basis. As observers Governors may not participate in the meeting unless specifically invited to do so by the Chair of the Committee. 8.2 However, the Chair reserves the right to hold all, or part of the meeting in private without Governors observing if deemed appropriate. 8.3 A copy of the agenda and papers will be provided on the day to Governors who are observing the meeting. All papers will be returned to the secretary of the meeting at the end of the meeting.
Frequency of Meetings	9.1 Meetings shall be held monthly. Additional meetings may be held after consultation with the Chair of the Board. .
Meeting administration	10.1 Notice of meetings will be given at least seven working days in advance unless members agree otherwise. 10.2 The Chair of the Committee, Lead Executive and the Director of Corporate Affairs will meet to agree the agenda for each meeting. The agenda will be based on the Committee Annual Work Plan. 10.3 The Lead Executive Director for the Committee will be the Executive Director of Finance. The Director of Corporate Affairs / Company Secretary will support the Chair of the Committee and Lead Executive Director in the management of the Committee's business and for drawing the Committee's attention to best practice, national guidance and other relevant documents, as appropriate. 10.4 Administrative support to the Committee will be provided by the secretary. The secretary will take minutes. Items for inclusion on the agenda shall be submitted to the secretary at least ten working days prior to the meeting. Agendas can then only be amended by agreement of the Committee Chair and Lead Executive Director. 10.5 The agenda and papers will normally be circulated four working days prior to the meeting to Committee members and regular attendees. 10.6 Draft minutes and action log will be produced by the secretary within five working days, reviewed by the Lead Executive Director and then approved by the Committee Chair within ten working days of the meeting. 10.7 For business to be conducted outside of the scheduled meetings the following must apply:

	• The business to be conducted must be set out in formal papers accompanied by the usual cover sheets clearly setting out the nature of the business to be conducted and the proposal which members are being asked to consider; • The papers will be forwarded to the Committee by the Corporate Governance function; • The Committee will be expected to respond, subject to availability, by e-mail to the full distribution list with their views within 3 working days of receipt of the paper; • For a decision to be valid, responses must be received from a quorum. In the event there is no unanimous agreement, the proposal shall be considered not to be approved; • The Director of Corporate Affairs will summarise the conclusions reached and these will be presented to the next scheduled meeting.
Operational Groups which report into the Committee	The operational groups which report into the committee are: • CIP Efficiency Board; • Digital Transformation Committee • Divisional Performance Meeting; and • Capital Monitoring Group. The Chair from each of the operational groups will provide: • a report to the next meeting of the Committee; and • the minutes from the group's meeting to the Committee following approval of the minutes at the next group meeting.
Monitoring and review	The Committee's Terms of Reference will be subject to annual review. Proposed variations will require approval of the Board. The Committee will undertake an annual review of its performance, via self-assessment by its members and any agreed actions, will be reported to the Audit Committee and Trust Board.

Appendix 2

Board Committee Membership with effect from 11 July 2022

Board Committee	Non-Executive Directors								Executive Directors							
	Martin Havenhand	Lynn Hagger	Nicola Bancroft	Heather Craven	Jo Bibby	Kamran Malik	Rumit Shah	Mike Smith	Chief Executive	Deputy Chief Executive	Medical Director	Chief Operating Officer	Chief Nurse	Director of Workforce	Director of Finance	Company Secretary
Audit Committee						Chair	M	VC					M		EL*	Attendee
Finance & Performance Committee		VC	Chair			M				M		M			EL*	Attendee
Quality Committee				M	VC		Chair				M	Attendee	EL*			Attendee
People Committee		Chair	M		M			VC		M			Attendee	EL*		Attendee
Nomination Committee	Chair	M	M	VC	M	M	M	M	M					EL*		Attendee
Charitable Funds Committee		M		VC				Chair		M	M	M	M		EL*	Attendee

Notes:

1. Executive 'attendees' do not count towards the quorum and neither are they voting members. It is not expected that they will provide regular reports to the committee. However, it is envisaged that their attendance will bring greater depth and understanding to support the assurance role of the committee.
3. The Chairman or Chief Executive may attend any committee meeting as an ex officio, non-voting attendee.
4. The Director of Corporate Affairs/Company Secretary may attend any committee meeting as part of their governance role.
5. EL* = non-member, non-voting committee lead Executive.
6. First four committees on the chart = assurance committees

Board of Directors' Meeting
08 July 2022

The Rotherham NHS Foundation Trust

Agenda item	P120/22
Report	**Vice Chair and Senior Independent Director Roles**
Executive Lead	Martin Havenhand, Chair
Link with the BAF	The paper links with the full Board Assurance Framework due to the nature of the roles within the Board.
How does this paper support Trust Values	The paper supports all Trust Values.
Purpose	**For decision** ☒ **For assurance** ☐ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	The Trust Senior Independent Director role and Vice Chair role are both carried out by Ms Lynn Hagger, Non-Executive Director whose statutory term of office will end on 30 September 2022. The following paper illustrates the Boards powers in agreeing the Non-Executive Director to fulfil the aforementioned roles.
Due Diligence	The appointment of the Vice Chair and Senior Independent Director is a matter for the Board and as such, the paper has not been presented in any other forum.
Board powers to make this decision	Matters Reserved to the Board Trust Constitution
Who, What and When	The Board of Directors is asked to review the recommendation and make a decision.
Recommendations	It is recommended that the Board of Directors agree to the proposal for Miss Nicola Bancroft as Vice Chair and Senior Independent Director from 01 October 2022.
Appendices	None

1. Introduction

1.1 The Senior Independent Director has a key role in supporting the Trust Chair in leading the Board of Directors.

1.2 In accordance with Code Provision A.4.1 of the current NHS Foundation Trust Code of Governance (2014) the Board shall, in consultation with the Council of Governors, appoint one of the independent Non-executive Directors to be the Senior Independent Director. The Senior Independent Director shall, in line with the aforementioned Code provision provide a sounding board for the Chair and to serve as an intermediary for the other Directors when necessary.

1.3 In addition to the Code Provision referred to in paragraph 1.2, the current Trust Constitution at Paragraph 3.10 states:

"*The Board of Directors shall appoint one of the independent Non-Executive Directors to be the Senior Independent Director in consultation with the Council of Governors."*

1.4 In accordance with Paragraph 2.4 of the Trust Constitution, the Council of Governors will appoint a Non-Executive Director to be Vice Chair for such a period, not exceeding the remainder of their term as Non-Executive Director of the Trust.

1.4 In accordance with the current approved Matters Reserved to the Board (2021) the Board agrees the appointment of the Senior Independent Director in addition to the appointment of the Vice Chair with the approval of the Council of Governors.

1.5 There is nothing within the current Constitutional documentation or guidance to suggest that Senior Independent Director and Vice Chair cannot be the same individual. Indeed, Code Provision A.1.4 detailed in Paragraph 1.2 above confirms that it can be.

2. Proposal to appoint Senior Independent Director and Vice Chair

2.1 The current Senior Independent Director and Vice Chair is Lynn Hagger. Ms Hagger's term of office will end on 30 September 2022 following completion of her statutory term of office.

2.2 It is proposed that the Board of Directors approve the appointment of the following:

2.2.1 Vice Chair: Miss Nicola Bancroft until 30 September 2025 subject to annual review
2.2.2 Senior Independent Director: Miss Nicola Bancroft subject to annual review.

3. Next Steps

3.1 Subject to Board approval, the above recommendations will be presented to the Council of Governors on Wednesday 17 August 2022.

Angela Wendzicha, Director of Corporate Affairs
On behalf of
Martin Havenhand, Chair
01 July 2022