The Rotherham NHS Foundation Trust

Board of Directors (Public)

The Rotherham NHS Foundation Trust

Schedule	Friday 8 September 2023, 9:00 AM — 12:00 PM BST
Venue	Boardroom, Level D
Organiser	Angela Wendzicha

Agenda

9:00 AM	PROCEDURAL ITEMS	
	P123/23.	Chairman's welcome and apologies for absence For Information - Presented by Kamran Malik
	P124/23.	Quoracy Check For Assurance - Presented by Kamran Malik
	P125/23.	Declaration of interest For Assurance - Presented by Kamran Malik
	P126/23.	Minutes of the previous meeting held on 07 July 2023 For Decision - Presented by Kamran Malik
	P127/23.	Matters arising from the previous minutes For Assurance
	P128/23.	Action Log For Assurance - Presented by Kamran Malik
9:05 AM	OVERVIEW AND CONTEXT	
	P129/23.	Report from the Chairman - Verbal For Information - Presented by Kamran Malik

	P130/23.	Report from the Chief Executive For Information - Presented by Richard Jenkins
	CULTURE	
9:15 AM	P131/23.	Staff Story - Presentation by Purple Butterfly Volunteers - Hannah Dutton For Information - Presented by Helen Dobson
	SYSTEM WORKING	
9:35 AM	P132/23.	Integrated Care Board & Rotherham PLACE Report For Information - Presented by Michael Wright
	STRATEGY	
9:45 AM	P133/23.	Mental Health Strategy For Approval - Presented by Helen Dobson
9:55 AM	P134/23.	End of Life Care Strategy For Approval - Presented by Helen Dobson
	ASSURANCE	
10:05 AM	P135/23.	Integrated Performance Report For Assurance - Presented by Michael Wright
10:15 AM	P136/23.	Operational Performance Update For Assurance - Presented by Sally Kilgariff
10:25 AM	BREAK	
10:35 AM	P137/23.	Finance Report For Assurance - Presented by Steve Hackett

10:45 AM	P138/23.	Quality Assurance Report Presented by Helen Dobson
10:55 AM	P139/23.	Maternity Safety including Ockenden Report Presented by Helen Dobson
11:05 AM	P140/23.	Board Committees Chairs Assurance Logs - Committee Chairs and Lead Executives - i. Finance and Performance Committee ii. Quality Committee iii. Audit and Risk Committeee iv. People Committee
	GOVERNANCE	
11:10 AM	P141/23.	Corporate Governance Report - To Follow For Information - Presented by Angela Wendzicha
11:20 AM	P142/23.	Board Assurance Framework For Decision - Presented by Angela Wendzicha
	REGULATORY AND STATUTORY REPORTING	
11:30 AM	P143/23.	Quarterly Report from the Responsible Officer For Assurance - Presented by Jo Beahan
11:40 AM	P144/23.	Emergency Preparedness, Resilience and Response (EPRR) Assurance Process Sign Off For Assurance - Presented by Sally Kilgariff
11:50 AM	BOARD GOVERNANCE	
	P145/23.	Escalations from the Council of Governors - None Presented by Kamran Malik

P146/23. Review of Annual Board Planner
For Assurance

P147/23. Any Other Business

P148/23. Date of next meeting - Friday, 03 November 2023

The Rotherham NHS Foundation Trust

MINUTES OF THE PUBLIC BOARD OF DIRECTORS MEETING HELD ON FRIDAY, 07 JULY 2023 IN THE BOARDROOM, LEVEL D

Present:
Mr M Havenhand, Chairman
Dr J Beahan, Medical Director
Dr J Bibby, Non-Executive Director
Mrs H Craven, Non-Executive Director
Mrs H Dobson, Chief Nurse
Mr S Hackett, Director of Finance
Mr D Hartley, Director of People
Dr R Jenkins, Chief Executive
Mrs S Kilgariff, Chief Operating Officer
Mr K Malik, Non-Executive Director
Dr R Shah, Non-Executive Director
Mrs D Sissons, Non-Executive Director
Mr M Temple, Non-Executive Director
Mr M Wright, Deputy Chief Executive

In attendance:
Mrs Z Ahmed, Associate Non-Executive Director
Ms L Fox, Deputy Director – Data and Insights
Ms R Gosakan, Divisional Director Family Health
Mr I Hinitt, Director of Estates and Facilities
Mr J Rawlinson, Director of Health Informatics
Mrs L Tuckett, Director of Strategy Planning and Performance
Ms A Wendzicha, Director of Corporate Affairs (Partial)
Mr A Wolfe, Deputy Director of Corporate Affairs (minutes)

Apologies: Mrs J Roberts, Director of Operations/Deputy Chief Operating Officer

PROCEDURAL ITEMS

P95/23 CHAIRMAN'S WELCOME AND APOLOGIES FOR ABSENCE

Mr Havenhand welcomed all those present, with apologies for absence noted.

P96/23 QUORACY CHECK

The meeting was confirmed to be quorate.

P97/23 DECLARATIONS OF CONFLICTS OF INTERESTS

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

Mr Havenhand interest in terms of YAS, was noted.

Mrs Tuckett's interest in terms of her part-time secondment at the Department of Health and Social Care as the Expert Adviser on Elective Care, was noted.

Ms Wendzicha's interest in terms of her role as Director of Corporate Affairs of the Trust and interim Director of Corporate Affairs at 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.

P98/23 MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting held on 05 May 2023 were agreed as a correct record.

P99/23 MATTERS ARISING FROM THE PREVIOUS MEETING

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

P100/23 ACTION LOG

The Board of Directors reviewed the action log, and agreed closure of log number 26.

With regards to log number 41 amendments are to be made to the constitutional document in line with the revised Code of Governance that has been published, it will go through the Assurance Committees and ETM before being presented at the Board in October.

Action log 16 remains open in relation to ongoing discussions around the IPR and should be brought to the next Public Board in September 2023.

Action log 23 relating to the Health Inequalities Programme will also be included in the next update report to the September Public Board.

OVERVIEW AND CONTEXT

P101/23 REPORT FROM THE CHAIRMAN

The Chairman confirmed there was no formal written report to the Board and further informed the Board that the Governors had interviewed for two new Non-Executive Directors with the recommendations being put to an extra ordinary meeting of the Council of Governors.

P102/23 REPORT FROM THE CHIEF EXECUTIVE

The Board of Directors received the report from the Chief Executive, with a number of matters covered in greater detail in later reports. Dr Jenkins wished to raise a few points, the first being that the Trust approach to elective recovery is ongoing with mutual aid process with Sheffield in place with an agreed Standard Operating Procedure. The Trust's approach to the reintroduction of

the urgent care 4 hour wait is progressing with a plan on track and aiming to achieve 76% by the end of October 2023. There have been a number of new A&E Consultants appointed into post. Industrial action remains challenging, with a 5 day junior doctors strike arranged for the week commencing 10 July 2023 and this is to be followed by a 2 day Consultant industrial action.

Dr Jenkins reported good news in that a number of new consultants had recently joined the Trust, illustrating the increased attractiveness to staff of working at TRFT following recent improvements made. He also talked about the recent Trust Proud Awards that were held in June, and how it was a very enjoyable evening to celebrate the excellent work done by staff. The Board were reminded that this week is the 75th birthday of the NHS and a number of Trust staff were invited to attend the national celebration held at Westminster Abbey.

The South Yorkshire and Bassetlaw Acute Federation annual report for 2022/23 has been published and is included for information showing the range of achievements for patients and staff and the clinical strategy has also been approved, Mrs Craven commented on its sensible approach and that it was a good report to read. Mr Havenhand agreed and added that it is a positive step in providing context as to how our clinicians can start to think about ways of working and progress in the future.

Mr Havenhand asked Dr Jenkins to expand a little on the 6 key priorities identified by the National Team, especially priorities 5 and 6 which he had not seen before. Dr Jenkins noted that Mrs Kilgariff was leading on these, he confirmed that choice in NHS for elective care had been working for some time but can be limited due to geographical issues. Patients are looking for and need shorter waiting times and we are looking at certain areas to improve on, but for example specialties that are dependant for neurosurgery are limited to neurosurgery at Sheffield, whilst gall bladder interventions can be undertaken at all adult services in the region, so options of choice can be limited.

Mrs Kilgariff confirmed that in terms of choice, cross region work was ongoing and there is also mutual aid in place, however there have been some issues with patients at the end of a pathway. Mrs Kilgariff expanded on priority 5 and the need to increase activity attempting to get back to 2019/20 activity levels, there is a lot of work being undertaken with a number of work streams in train to develop this internally, including theatre improvement programme which aims to see more patients coming through. She advised that it was in fact two different programmes with Mrs Tuckett leading on the General Managers and Ms Roberts leading on Out-patients. Regular updates are going through the Finance and Performance Committee.

Mrs Craven requested further detail on the level of assurance on patient choice, especially for patients who are between two Trusts where it can be difficult for patients to navigate between the two hospitals. Mrs Kilgariff acknowledged that it can be difficult with different systems and referrals, and that from an operational perspective they are trying to put in safeguards, such as Patient Tracking list management to ensure patients are seen and followed up. There is also the digital aspect of this with shared records, already live at TRFT and the possible future convergence of records across a South

Yorkshire EPR. Mr Temple asked if this process counts against TRFT performance, Mrs Kilgariff confirmed that there were SOPs in place across the organisations that covered this in regards to waiting lists, PTL and targets so it did not adversely affect TRFT.

Mrs Sissons asked if this had gone through a public consultation, or public feedback, Dr Jenkins confirmed that locally all is undertaken with the consent of the patient, with some even opting to wait longer for treatment as they want to be treated locally.

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

CULTURE

P103/23 **PATIENT STORY - Disability and Autism Reference Folder (in attendance Nurse Levi Swain and Nurse Matt Timms**

The Board of Directors welcomed to the meeting Nurses Swain and Timms to present the patient story.

Mrs Dobson introduced the story by noting that since Covid there had been an increase in the number of children with mental health needs, the outcome of this being that the acute sector is having to pick these patients up and as such there has been huge progress made over last couple of years in how the Trust deals with children's mental health needs.

Nurse Swain highlighted the lack of Tier 4 specialist provision, leading to more children that have been sectioned under the Mental Health Act being cared for in the paediatric wards hence the introduction of the calming kits. These are shoeboxes size and included in the welcome pack for young people, along with other items such as hygiene packs and mindfulness workbooks. Further explanations were provided in terms of how the calming kits are utilised within the ward environment.

The Board heard the positive results from having the kits such as helping to build confidence, reduce anxiety, panic, violence and aggression, with proven results on wards. There has also been a marked reduction in the number of young persons who try to leave ward. Recently the team presented a poster to the Critical Care Network and won a national award. Nurse Swain now has one day a week to focus on mental health of the young persons and noted that future improvements included ideas such as it would be good for them to have a mental health passport, the team require increased funding, they are focusing on a calming room on ward, and the playground redevelopment included a young person's outdoor shack. Nurse's Swain and Timms were advised to put a charity bid together for potential funding and Mrs Sissons offered to take this outside of the meeting as well as congratulating the team on its award.

Mrs Kilgariff queried whether there was any cross over to adult mental health and possibly dementia patients and that it could be valuable to expand to other areas of the Trust, such ideas have already been introduced on UECC with

positive results, it was agreed that Ward A1 would be an ideal location to expand this as they host dementia patients currently.

Also noted that Nurse Swain had been nominated and successful in receiving a Cavell Nurse's award.

The Board of Directors noted the patient story and the innovative approach taken which where possible should be shared with other organisations.

P104/23 **Patient Experience Annual Report**

Mrs Dobson led on this report and confirmed that it had been through the Quality Committee and that it included the metrics for the year. There is a vast amount of positive feedback but need to work on negative feedback. There is therefore 9 key areas for improvement in a calendar for the year, so each month there is an area of improvement in a specific identified area.

National patient survey, data is from last year due to time lag in receiving data Small steps in improvement but anticipate results will be clearer over time as improvements embed into business as usual.

Mrs Craven commented on the large amount of work already undertaken and completed, with it going from "nothing to a lot in short order", which she believed was a great achievement. She noted that she had received feedback from her last walk around regarding hydration and what was in place for patients on restricted fluids, this was an issue raised by a nurse, Mrs Dobson confirmed that different colour jugs were being introduced and put in place for this group of patients.

Dr Bibby noted a great report, she queried data in section 6 of the report regarding medical care being the highest number of complaints and had any themes or trends been identified. Mrs Dobson highlighted that now Dr Beahan was in place there had been increased work to engage with medical colleagues, and a number of medics were now attending the Patient Experience Committee. Dr Jenkins also added that the categorisation is too broad and not very helpful with the category options being medical care and nursing care only, these needed to be at a more granular level to work out actions.

Mrs Dobson did say that popular themes were communication, discharge planning and underlying themes affecting patient experience such as staffing levels, general efficiency should start to improve over time. She added that there was now a process for review of themes via a method of triangulating all incidents, claims, inquests and risks, which is a more thematic review and links in to PSIRF also. Often the theme of communication is more multi-factoral, previously staff levels had been an issue but should now be improved. There was an effort to provide a more holistic approach with the patient at the centre of what we do, and the reintroduction of the 4 hour target should lead to a better experience for our patients.

Mr Malik commented that he had completed a review of complaints about six months previously and agreed that there was not enough granularity to truly

show improvements made. He said that going forward he would like more cause and effect narrative and evidence for assurance.

Mrs Ahmed asked if the Trust needs to increase work to encourage people from an ethnic background to complain as there appeared to be low numbers identified in the report. Mrs Dobson stated that actually only one third of the complaints stated their ethnicity, with all complaint leaflets already in multiple languages and work is ongoing with engagement team to increase awareness of how to complain generally.

Mr Wright noted that in the year 2022/23 when the Trust and community were suffering from high levels of Covid affecting both patients and staff the Trust still hit 100% complaint responses within target and there were also a high level of compliments received by various divisions and specialities.

Mrs Sissons stated that it is important to have the correct processes in place and currently the Trust has no PALS in place which would have huge impact on decreasing complaints levels with the number of concerns not being raised into complaints. Mrs Dobson confirmed that a business case for PALS was in the process of being developed.

Mr Temple confirmed that he had also just undertook review of complaints as well for his assurance in the process and found that he was very assured of effectiveness with Dr Jenkins signing nearly every letter himself showing the high level of scrutiny

The Board of Directors:

- Approved the Patient Experience Annual Report.

P105/23 **<u>End of life report</u>**

Mrs Dobson confirmed that this was the first time this report had been undertaken and acknowledged that previously the matter had not been given the attention it required. She also added that the strategy would be presented to the Board in September. Issues raised included our record keeping, we self-assessed incorrectly but this highlighted the requirement to focus on and improve.

An area of positivity in this area has been the launch of the Butterfly volunteer programme with agreement that further detail would be presented at the next full Board meeting. As well as the new strategy we have improved our training and resources as well as tightened up on documentation for end of life which could be up to 12 months or 12 weeks and this has now been better understood. It was reported that up to 50% of the Trust's end of life patients actually are discharged as they would prefer to go home and we are actively trying to help support patients to stay in the environment of their choice. Mrs Dobson informed the members that it had been the Trust Dying Matters week in June, where the aim was to try to normalise conversations about death and give the patients increased choice.

Mrs Craven commented that it was really good to shine a light on the journey to improvement and would be good to triangulate with previous reports and

look at the number of complaints about end of life. She went on to praise the last day of life care plans, however she also pointed out that we need to monitor those in order to be assured the plans are being used and followed correctly. Mrs Dobson confirmed that if the patient's plan indicates that they want to be at home then the Trust does get them home and that is part of the audit.

Further discussion ensued in relation to evidence that nationally doctors and nurses are still not comfortable with conversation about death and end of life and that is to be part of training to develop staff for these conversations. She confirmed that the patient end of life plans have been reinforced across TRFT and also at Barnsley to make sure patients are where they want to be.

Closing the discussion Mrs Sissons reminded the members that this end of life care strategy will take 3-5 years to develop and is reliant upon partnership working, the data in the report is a baseline for what is not an easy journey as communication is key to success and even the experts requiring retraining every few years in communications skills.

It was agreed that the report will be published and added to the website with the Strategy expected at the September Board.

Action : Mrs Dobson

Angela Wendzicha left the Board meeting at this point.

STRATEGY

P106/23 **Estates strategy**

Mr Hackett introduced the Estates strategy and an important key in supporting the overarching Trust strategy, it had been to Board and Finance and Performance Committee. He handed over to Mr Hinitt to go through the strategy and answer any questions.

Mr Hinitt confirmed that it was a 5 year strategy and there had been an exceptional level of consultation of strategy including workshops and Strategic Board in February and public stakeholder conversations and consultation which was presented to the Finance and Performance Committee in May 2023. The strategy is fully aligned to the Trust strategy and Trust Proud values. The Finance and Performance Committee has requested to look at a further level of planning including a short to medium term strategic delivery plan and how capital might be applied to investment over the next 3 years.

Mr Temple confirmed that the Finance and Performance Committee recommends approval for sign off for what is a good strategy and picks up what is the direction for the Trust. Mr Havenhand added that it should be reviewed on an annual basis in light of other strategic plans.

Mrs Craven would like to see consideration of a longer horizon plan for areas such as the Charity where a 1-2 year operational plan is required. She also raised the thought that it would be helpful if there was a list of 'ready to go' projects for times when funding becomes available. Mr Hackett confirmed that

the ward refurbishment work was underway, with wards to be refurbed or repurposed in sequence but if national resources become available then will move forward as quickly as possible and sequence would be amended accordingly.

Item to be added to the Forward Work programme with inclusion of the need to have a list of future schemes that are ready to go if and when additional funding becomes available. Agreed that this should be three months after discussion at the Finance and Performance Committee, so to be presented at the November 2023 Board.

The Board of Directors:

- Approved the Estates Strategy

SYSTEM WORKING

P107/23 Integrated Care Board

Mr Wright is leading on this for the Trust and presented the draft report that includes the ICB and the Rotherham Place. He wanted to raise three points from the report, which was taken as read.

The first was the joint role of the Public Health Consultant which is starting to gain traction now as three months in. There was also the Rotherham Place who met recently to consider how to work together to expedite discharge from hospital and support care closer to home, Mr Wright informed the members that this had been a successful meeting. The final point raised was regards the digital inclusion work that is ongoing following national funding that was received a few years ago. Mr Rawlinson expanded on this to talk about the inclusion team which is ran by Rotherham Council, that it was now fully established and working with local colleges and schools offering free data schemes across Rotherham. It was agreed that Mr Rawlinson should report back to the Board in August. **Action : Mr Rawlinson**

Dr Bibby asked about the PLACE plan and referred to the charts on page 164 of the pack, health behaviours and disease prevention that the Rotherham data against the national data, for example data for drinking in excess of 14 units per week of alcohol nationally is 22% whilst in Rotherham it is 32%, which is a very big difference. Dr Bibby queried why it had not been more in the report as alcohol is the biggest risk factor after smoking, she asked why the Council were not doing more to tackle it. Mr Wright confirmed that it is pulled out in another document which the Alcohol Outreach Team had provided. Mrs Tuckett also confirmed that low level alcohol advice is also given to patients by the Smoking Cessation Team.

Mrs Ahmed queried whether the plan supports black and minority communities, raising the fact that hookah in the Pakistani community and hashish in the Yemeni community are widely used but not considered to be smoking within the communities themselves. Mr Wright confirmed that he would feed that back. Mr Havenhand asked for comments on the draft report to be sent virtually from members to Mr Wright and the report is due to go back to the next Place board in two weeks.

The Board of Directors:

- Noted the content of the report.

P108/23 Partnership Report

Mr Wright stated that we are committed to undertake a number of joint meetings across Trusts, with joint roles in place, TRFT supporting Barnsley with pharmacy, joint procurement, four new graduate trainees now working across both organisations and all plans so far have been delivered.

Mrs Kilgariff added that it was a good overview, and in terms of benefits to patients an example being gastroenterology and joint working is making a real difference to the service with patients who have GI bleeds now being able to be treated locally and not at Sheffield. It was good to see this good work flourishing in other areas of the Trusts as well.

Dr Jenkins added that whilst the report talks about ongoing schemes and top down working, it is now clear that people are starting to compare approaches in a more positive way rather than looking for obstacles. Mr Havenhand felt that it would be good to track these joint developments for reporting to both Boards. The gastroenterology work has been a real concern for the Board for a long time now and where we have got to is a really positive story and a report to the Board would be welcomed with details on the positive impact on patients, preferably presented by one of the consultants involved.

The Board of Directors:

- Noted the progress made.

ASSURANCE

P109/23 Integrated Performance Report

The Board of Directors received the Integrated Performance Report (IPR), which provided an overview of the organisational position, and was to be read in conjunction with other reports presented to the Board.

Mr Wright took the opportunity to specifically highlight the HSMR data which is still strong when compared to the rest of the country, Care Hours with the Patient has shown significant improvement and also sickness absence rates have reduced.

Mr Havenhand agreed that those were three areas of positive direction, however queried what Mr Wright considered to be areas of concern. Mr Wright felt that one is RTT, we have had a strong position for a number of months and years but now not so much, Mrs Kilgariff agreed that overall RTT is a concern especially with growing waiting lists. We are seeing progress in delivering national asks, despite that we are still in the upper quartile, waiting list position is growing nationally. It is a case of balancing how much we can invest in delivery with financial restriction, effectiveness of the use of resources is an area of focus.

There are real challenges across services, however the sickness rate that has impacted on care is now showing improvement, another impact is the industrial action and whilst we are maintaining emergency work there has been more of an effect on elective.

Mrs Craven raised that where the SPC charts are showing that an intervention is required, are there any areas of concern and what is being done, Mrs Tuckett pointed out that readmission rates are benchmarked nationally and although TRFT is not as good as others there is monthly review from a care perspective at divisional performance reviews. Asked why is the benchmark worse, Mrs Tuckett pointed out that not all benchmarking is done consistently across the country, there was an ask to find out why we are not as good at benchmarking and Dr Beahan agreed benchmarking was important and is to pick up with Ms Fox. There is a need to keep under review and bring back to Board. **Action : Dr Beahan**

Dr Shah queried Referral To Treatment (RTT) and bearing in mind the challenges financially with plans for industrial action where are the discussions held regarding targets, is it at the South Yorkshire level or is it the national level, as all organisations seems to be in the same position and it seems that this needs a change on direction as no one is going to be able to meet targets. Dr Jenkins confirmed that the focus nationally is on reducing waiting lists and these are being managed by prioritising the longer waiting patients first, not particularly the patients waiting on 18 week targets. He confirmed that there was continued discussion at ETM in order to get a better local understanding on how to achieve targets and there was debate about how funding and targets play out at the national level where the belief is that funding is sufficient to meet the targets.

It was queried how the industrial action plays into this and it was noted that there was a financial impact on providing cover. It was queried where FPC felt the Trust will get to this year on finance and it was noted that there were trajectories in place and this will be taken back through in terms of modelling and Mrs Kilgariff will continue to update Board on this.

The Board of Directors:

- Noted the content of the report and
- Sought further clarity on benchmarking

P110/23 **<u>Operational Performance Update</u>**

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

Mrs Kilgariff explained that the 4 hour performance target for A&E has been re-introduced. Work is taking place around pathways and with elective capacity. A further period of industrial action is due next week and planning work on this continues.

It was appreciated that the national metrics had been included and it was felt that it made the report very clear. Theatre utilisation was queried and it was noted that this would be added on as it is included in the pack that is presented

to FPC and Mr Havenhand felt that the Board only needed to see high level data.

With regard to Virtual Wards, the patient figures were slightly below the trajectory but there is some really good work on-going, with numbers increasing. Work is also taking place on step up and step down and it was felt that this would be in a better position by the end of the year with assisted technology support and the trajectory should be achieved.

It was felt that it would be a good idea to receive a patient perspective presentation and include how the clinical hub is effective in supporting/linking all community services and try to link this further with other areas such as UECC.

The Board of Directors:

- Noted the content of the report.

P111/23 **Infection Prevention and Control Annual Report**

The Board received and noted the report.

Mrs Dobson explained there is a requirement for the report to be published on the Trust's website. The key issues include more business as usual and less Covid dominated.

With regard to the C-Diff infection rate, the Trust performance against the trajectory was 27 cases against a trajectory of 19 but the Trust was not an outlier and it was felt that the trajectory of 19 was very ambitious. The Trust was a good performer regionally and national trajectories were not thought to be reflective of a true position. The Trust had met its trajectory for MRSA Bacteraemia.

However, there had been no outbreaks or linked cases and the Antimicrobial Stewardship Group continues to oversee all activities in relation to antimicrobial prescribing.

Quality Improvement work on Infection, Prevention & Control is in line with best practice and has identified potential risks, including issues with Microbiology joint cover with Barnsley, some estate problems, tight bed base, limited toilets and work is ongoing on these issues.

It was noted the report had been through Quality Committee and the Board approved the report for inclusion on the website.

P112/23 **Safe Staffing and Establishment**

The Board of Directors received the report.

Mrs Dobson explained a six months review had been undertaken using the national tools to assess funded establishment against patient acuity and dependency. The Trust had built in 21% headroom for annual leave, study

leave etc., however, the national tool's headroom is 22%. There had been no impact on the findings with different tools used for different areas, e.g. Paediatrics.

A detailed review is undertaken every three months for every patient and their needs and support.

The establishment is very close to where it should be and is safe but there will be some changes to ensure staff are in the right areas but, overall, the conclusion is to leave the establishment the same as at present. One example is that there are too many staff in Surgery and not enough in Medicine.

Mrs Sissons confirmed that ward walkabouts to triangulate staffing and staff moves are covered in a bi-monthly report to Quality Committee. Mr Temple queried whether there is a similar tool for use with medical staff and it was noted that there is no such tool and there is no similar same way of calculating cover. Dr Jenkins explained that this is a gap and the Trust can report on what is funded against what is in post but there needs to be horizon scanning for medical staff leaving a service and ensuring that Board is kept informed. Mr Malik explained that staff shortages are consistently raised at divisional presentations to assurance committees and queried where is the difference if the report says the Trust has safe staffing. Mrs Dobson explained that the report looks at a slightly different metric – it looks at establishment against post, taking into account study leave. Going forward this will be monitored closely and care hours per patient has increased to 8 hours whereas in the past it was only in the 6 hour range and needed to be above 7 hours. Nurse staffing is now in a good position and risks have been reduced in the ratings.

The Board of Directors:

- Noted the content of the report;
- Approved the maintenance of existing establishments;
- Agreed that Dr Jenkins and Dr Beahan would pick up the medical staffing workforce tool and add to the forward work plan.

P113/23 **FINANCE REPORT**

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

Mr Hackett confirmed that the financial position had been discussed in detail by the Finance and Performance Committee and explained that both April and May were adverse to plan with the primary reasons relating to pay, Cost Improvement under delivery in months 1 and 2.

This had been fully discussed at FPC with regard to risks, the elective recovery fund at 103% with a national instruction not to expect a change in funding as a result of the industrial action, with a risk to the Trust of c.£1m. With regard to the pay award, the ICB is looking at funding streams for the 2024/25 pay award which is a financial risk.

Capital is traditionally low in the first part of the year and is currently £1.2m short of plan. However, there is not as much expenditure in the final part of

the year which is positive. There was a slight dent in the cash flow at the end of May relating to phasing.

Further updates will be provided to Board regarding risk during the year.

Mr Hackett was asked if he was confident that the Trust will come in against budget and it was noted that he was really concerned about CIP delivery, sufficient schemes are not in place, however, a good start had been made and some improvement was expected in month 3 to month 6.

Overall, it was accepted it was a challenging plan for all organisations. With regard to cash flow, Mr Malik queried, with the uncertainty this year, what would happen if the Trust falls short of cash and it was noted that there are rules in place and there are live conversations across the region about what would happen. Trusts could apply for strategic loans but there is increased scrutiny on loans with regard to increased borrowing from central reserves. Mr Hackett explained he expected some recovery by the end of month 4 in terms of the cash position.

The Board felt that the message for colleagues is to look into the challenge and understand that, whilst it is a challenge, the Trust has to deliver the financial plan.

The Board of Directors:

- Noted the Finance Report.

P114/23 **MATERNITY SAFETY INCLUDING OCKENDEN MONTHLY REPORT**

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

Mrs Petty explained that the Maternity Incentive Scheme Year 5 guidance was circulated at the end of May 2023 and this was a new style report with four key themes. There is a three year delivery plan with technical guidance presented at Quality Committee and has key deliverables to be measured against and there is an action plan for assurance.
Theme 1 – Listening to and working with women and families with compassion - the results and action plan for the CQC maternity survey have been shared with antenatal care highly rated and ranked as “better than plan”. The action plan has been co-produced.

Theme 2 – Grow, Retain and support the workforce - the key highlights include establishment in line with the Birthrate+, there are gaps due to maternity leave due to the younger workforce, sickness and headroom due to a lot of specialist training and other providers are paying incentivised rates. Work continues on recruitment with 17 new staff due to start in October.

Theme 3 – Developing and sustaining a culture of safety, learning and support – listening events are held with staff and there is a recognised poor response rate in maternity and the division is learning from Surgery in order to improve. The trajectory is to achieve 90% training, there were no incidents with moderate harm but there had been a still birth which will follow the review

process. The Maternity Scorecard is a requirement for CNST Year 5 and there were 45 claims made during the period. A deep dive had been undertaken following the PSIRF model looking at the last two years' key themes including perineal complications and one was an SI due to sub optimal care. There had also been one misdiagnosis. The only other theme was a delay on treatment/failure to treat.

Theme 4 - Standards and structures that underpin safer, more personalised and more equitable care – there had been one complaint in May which was addressed with the staff member. With regard to women's choice to free birth, this was a growing trend and legally the midwife needs to notify a birth so this is being raised nationally and the Trust was trying to build trust with the women involved. With regard to the MBRRACE data, neonatal deaths are higher than other similar Trusts but three of these had been due a medical anomaly.

It was felt it was a comprehensive report providing good assurance. With regard to other Trusts paying more, Mrs Dobson reported she had met with Chief Nurses across the region and some Trusts have significant gaps so are paying more but the Trust includes rates to attract staff to ensure safe levels of staff for patients and this is balanced with using NHS funds appropriately including temporary rates for two weeks. Mrs Dobson had been assured by the other Trust that it is a short term issue.

With regard to working with women wanting free birth, the legal framework around legal notification is an issue.

The Board noted that the feedback following the submission of the Maternity Incentive Scheme declarations submitted in February 2023 was still awaited.

The Board of Directors:

- Noted the comprehensive monthly report and were assured of the continued positive progress and plans in place.

P115/23 **2023-24 Operational Plan Priorities**

Mr Hartley introduced the report confirming that it was coming back to board because of minor changes made, the report had been back through the People Committee. He noted that there had been a change tonally throughout the report which now emphasised people not workforce alongside individuals and the need for increased retention and recruitment. Mr Hartley raised the fact that Medical workforce needed to build local relationships and workforce planning presented challenges with the need for increased joint work or integrated workforce planning to be joined up with other Trust strategies.

P116/23 **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 meetings

Mr Temple indicated that there was nothing to add to the report, other than a requirement for the Committee to fully understand the planning arrangements and requirements for 2023/24. Noted that winter is no longer an exceptional period as demand is all year round in terms of performance; although plans to take the Winter Plan to the November Board should be amended as it needs to be reviewed earlier. Agreed that an action should be that it is brought to the September 2023 Board.

ii. Quality Committee

Dr Shah highlighted the Divisional presentation from UECC, acknowledging the unity and improvements now being seen. Dr Shah highlighted the recent Division of Therapies and Community presentation to the committee and the work of the virtual ward. He noted that the service lead is very passionate on how it should work and there is good team working ongoing with matrons attending AMU in order to identify patients who should be on virtual ward rather than physically on AMU. Dr Shah also raised the recent 4 day Transformation event in conjunction of NHSE, this was a Trust wide event which went very well and concentrated on pathways and patient flow.

iii. People Committee

Dr Bibby, highlighted that during the first three months of 2023/24 the committee had been assured of improvements on the rate of sickness absence. She highlighted the presentation from the Division of Family Health and an idea she thinks could be introduced in other divisions as they have taken the concept of "you said we did" further and added in a new "you said we couldn't", which Dr Bibby believes is a good feedback loop for staff who are often not informed of why their ideas are not adopted.

Dr Bibby also raised that the committee had discussed the exclusion report and the need to support staff when involved in events of violence and aggression or sexual assaults on hospitals premises. She also added that the committee had looked and continue to look in depth at the process of end to end recruitment.

iv. Audit & Risk Committee

Mr Malik highlighted the increased assurance from the Trust internal and external audits, with internal audit monitoring three specific 3 categories, with this year being the first time they could issue significant assurance against all three categories.

REGULATORY COMPLIANCE RISK AND ASSURANCE

P117/23 Prover Licence

It was noted that the licence came into force April 1st 2023.

GOVERNANCE

P118/23 BOARD ASSURANCE FRAMEWORK

The Board of Directors received the report detailing the 2022/23 Board Assurance Framework (BAF) quarter one position presented by the Director of Corporate Affairs. It was confirmed that the BAF had now been through a cycle, it had been presented to all assurance committees with the recommendations made included within the report.

The Board of Directors:

- Approved the recommendations within the report

P119/23 CORPORATE GOVERNANCE REPORT

The Board of Directors received and noted for information the Corporate Governance Report.

BOARD GOVERNANCE

P120/23 REVIEW OF BOARD ANNUAL PLANNER

The Board of Directors received and noted its forward work plan. Mr Havenhand requested that anyone had anything to add to planner then please could they discuss with himself and then Ms Wendzicha.

P121/23 Any Other Business

Mr Malik offered his and the Board's thanks to Mr Havenhand, he acknowledged Mr Havenhand's nine years as Chair of the Trust and his contribution to the improvements the Trust and its' patients had seen; he led the Trust through the pandemic, seen the start of the best external reports the Trust had seen in a long time, and for the first time in eight years the Trust had no sanctions against it from CQC.

Mr Malik summarised Mr Havenhand's generous leadership whilst in the post, that he had in fact shown more than compassion and while he shares the big picture, he also at the same time keeps an eye on granularity. He has left a big foot print to help with the next chapter and wished a massive thanks from the Trust. Mr Havenhand summed up by pointing out his belief that it is not acceptable for the people of Rotherham to accept mediocrity, being okay is not enough we need to get the right people in post for the good of the people of Rotherham.

P122/23 DATE OF NEXT MEETING

The next meeting of the Board of Directors would be held on Friday, 8 September 2023, commencing at 9am.

The meeting was declared closed.

Martin Havenhand
Chair Date

Board Meeting; Public action log

Log No	Meeting	Report/Agenda title	Minute Ref	Agenda item and Action	Lead Officer	Timescale/ Deadline	Comment/ Feedback from Lead Officer(s)	Open /Close
		2021						
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~~ ~~31/12/22~~ ~~28/02/23~~ July Board	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. Further information included in agenda item P118/22 (July Board meeting). 02.09.22 - Governance documents to be updated by the end of Q3. The Health and Care Act is now in place; The associated national governance documents are now final and Trust constitutional documents being amended to reflect and will be complete by end February in preparation for February Council of Governors and March Board. Number of revised documents submitted to the March 2023 meeting. Date amended to March ETM and April Board. Reviews ongoing To be closed at July Board. 07.07.23 amendments are to be made to the constitutional document in line with the revised Code of Governance that has been published, it will go through the Assurance Committees and ETM before coming to the Board in October.	**Open**
		2022						
16	09-Sep-22	IPR	P140/22	Refresh of IPR, with Board colleagues to communicate key areas for inclusion	DoSPP	~~03/02/23~~ 07/04/2023	A refresh of the IPR is underway, with a new IPR due to go live for 2023/24 data. A Board session was held in February to discuss a new approach to reviewing data at Board level, with a further session planned for April to review draft IPR options. Work done by PM committee changes are needed adding to the matrix and coming to the Board in June. Not expecting a significant refresh, just minor changes. To be closed at July meeting. 07.07.23 To be reviewed again at the September Board in relation to ongoing discussions about the IPR	**Open**
		2023						
23	03.03.23	IPR	P46/23	To share the audited information related to DNAs as part of the health inequalities programme	DoSPP	07-Jul	To be included in next update report in relation to health inequality programmes 07.07.23 To be reviewed again at the September Board in relation to ongoing discussions about the IPR	**Open**
27	07.07.23	End of Life Report	P105/23	Strategy to come back to September Board after consideration at the Quality Committee	CN	08-Sep	On the agenda for September Board - recommend to close	**Recommend to close**

Log No	Meeting	Report/Agenda title	Minute Ref	Agenda item and Action	Lead Officer	Timescale/ Deadline	Comment/ Feedback from Lead Officer(s)	Open /Close
28	07.07.23	Integrated Care Board	P107/23	Update to be provided to the Strategic Board on digital inclusion work across Rotherham	DoHI	06-Oct		Open
29	07.07.23	Integrated Performance Report	P109/23	Benchmarking of readmission rates to be picked up with Deputy Director of Health Informatics and report back to a future Board	MD	03-Nov		Open
30	07.07.24	Board Committee Chairs Assurance Logs	P116/23	Update on the Winter Plan to be brought back to the September Board	DoOps	06-Oct	Agreed that this will be presented to the October Board	Open

Open
Recommend to close
Complete

Board of Directors' Meeting
08 September 2023

The Rotherham NHS Foundation Trust

Agenda item	P130/23
Report	**Chief Executive Report**
Executive Lead	Dr Richard Jenkins, 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. 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. NHSE NHS Provider Segmentation Letter

1.0 Activity

1.1 **Activity:** The Trust continued to experience significant operational pressures, as have other Trusts both regionally and nationally. Industrial action has meant operational challenges for both elective and non-elective activity, however, teams and services have shown high levels of resilience to maintain good levels of patient care.

1.2 **Recovery**: The national expectations for elective recovery in 2023/24 require the Trust to eliminate all patients waiting over 65 weeks for their treatment. Whilst we have a relatively low numbers of patients waiting this long for their treatment currently (approximately 30), the recent growth in the size of the total waiting list and the number of patients waiting over 52 weeks for their treatment is a concern as we look to the next 18 months of national recovery expectations. Despite these concerns and regarding future performance, the Trust is currently delivering Referral to Treatment (RTT) performance in the top quartile of all Acute Trusts based on the latest published national data. The approach to mutual aid across the SYB for this year is under development and is being led by Chief Operating Officers.

Activity for the first four months of the year was below 2019/20 levels, in part due to the cessation of the additional activity that took place towards the end of 2022/23 but also due to the ongoing gaps within our own teams against 2019/20 availability and a number of periods of industrial action, which impacted heavily on elective capacity. In particular, over the last few months, the Trust has had challenges around ensuring appropriate levels of Anaesthetic staffing to deliver the planned theatre activity. There are some mitigations now in place through insourcing of Consultant Anaesthetists, but further work is needed. In the meantime, significant focus on our operational productivity continues, with the Trust's Theatres Transformation Programme gaining traction since its launch at the start of the year, and the Outpatient Programme being re-focussed to ensure improvements in our clinic utilisation and reduction in outpatient follow-up demand.

1.3 **Urgent and Emergency Care Activity (UEC):** The Trust has seen heightened operational pressures in comparison to previous months with the Trust operating between OPEL level 2 and 3. The Trust has remained focused on the reintroduction of the four-hour access standard and maintaining a positive position with ambulance handover delays, achieving both trajectories in in June and July. Bed occupancy also remained in line with trajectory through June and July with a positive impact being felt from the virtual ward and community in-reach teams.

2.0 Performance

2.1 I am pleased to report that the Trust has been awarded as a National Joint Registry (NJR) Quality Data Provider for 2022/23. The scheme has been devised to offer hospitals public recognition for achieving excellence in supporting the promotion of patient safety standards through our compliance with the mandatory NJR data submission quality audit process. As well as being a fundamental driver to inform improved quality of care for patients, registry data provides an important source of evidence for regulators, such as the Care Quality Commission, to inform their judgements about services.

The NJR, which covers England, Wales, Northern Ireland, the Isle of Man, and Guernsey, collects information on hip, knee, ankle, elbow and shoulder joint replacement surgery, across both the NHS and independent sector and is the largest orthopaedic registry in the world.

2.2 The Trust has also been awarded the Royal Society for the Prevention of Accidents (RoSPA) President's (10 consecutive Golds) award. The RoSPA Health and Safety

awards are the largest occupational health and safety awards programme in the UK and there are almost two thousand entries every year. The programme recognises organisation's commitment to continuous improvement in the prevention of accidents and ill health at work. The Trust joins only a handful of other Trusts who have been awarded the President's award.

3.0 NHS Provider Segmentation

3.1 The Trust has received notification from NHS England (attached) confirming that the Trust will remain in segment 3 of the NHS Oversight Framework. The Trust had been in this segment for some time in relation to prior concerns around a range of quality issues. I am pleased that these are now resolved and the expectation would have been that the Trust would then move to segment 2 however the Trust has remained in segment 3 due to the deficit financial plan for this year. The attached letter outlines a range of criteria that would need to be met in order for the Trust to move to Segment 2. The Director of Finance and I have recently met with the SY ICB Chief Executive and Chief Finance Officer with regard to this.

4.0 Integrated Care Board (ICB), Acute Federation and Rotherham Place Development

4.1 Representatives from the Trust have continued to attend several Place meetings including the Health and Well-Being Board, the Health Select Commission, and the Place Board. A detailed update is provided by the Deputy Chief Executive in his report to the Board of Directors.

4.2 Construction work on the Montagu Elective Orthopaedic Centre (MEOC) has now officially commenced at Montagu Hospital in Mexborough. This will provide a new, dedicated orthopaedic hub for the people of South Yorkshire, with health professionals undertaking a range of procedures. The unit will augment the existing facilities in South Yorkshire and will feature two state-of-the-art theatre units, two anaesthetic rooms and a recovery suite, in addition to twelve inpatient beds. Construction is being overseen by a project team which includes colleagues from this Trust, Barnsley Hospital and Doncaster & Bassetlaw Teaching Hospitals. The project is expected to take approximately six months to complete and is expected to welcome its first patients in January 2024.

5.0 People

5.1 A number of consultants have been offered a post as part of the formal recruitment process and have accepted. The following individuals have commenced in post since my last update:

- Mr S Rajan, Community Dental
- Dr R Gentles, Emergency Medicine
- Dr L Evans, Emergency Medicine
- Miss E Guyett, Obstetrics & Gynaecology

We also have a number of other Consultants that have been offered and accepted posts and due to commence in post in during September 2023.

- Dr M Stafford, emergency Medicine
- Miss M Poothavelil, Obstetrics & Gynaecology
- Dr K Khokhar, Rheumatology

5.2 The monthly staff Excellence Awards winners for the months of June 2023 and July 2023 were:

June 2023

- Individual Award: Averina Abraham, Nurse, A1
- Individual Award: Ricky Garforth, Healthcare Support Worker, UECC
- Team: A2
- Public: Fitzwilliam Ward

July 2023

- Individual: Catherine Richardson, Consultant, Obstetrics & Gynaecology
- Team: IT 2nd Line
- Public: MRI Team, Radiology

6.0 Industrial Action

6.1 The Trust has continued to plan and implement contingency arrangements for the various episodes of Industrial action during June, July and August 2023. Thank you to all colleagues who supported the significant amount of planning and preparation and those colleagues who undertook additional or alternative duties during the action to support the Trust.

6.2 The BMA has rejected the 6% pay increase offered and further industrial action is planned for the Consultant body in September with the ballot for junior doctors to take further action currently open until 31st August 2023. We continue to work together with our local union representatives to plan how services will operate during any period of disruption.

6.3 The impact of the industrial action on patient care and activity is a concern but I would like to reassure the public that they should continue to come forward for emergency services and any planned outpatient or elective procedure unless contacted and informed otherwise during future industrial action. Rotherham Hospital is committed to continue to provide essential services and to keep disruption in affected services to a minimum.

7.0 Countess of Chester Hospital

7.1 You will have seen the extensive media coverage of the trial of the neonatal nurse who has killed and injured a large number of babies. The findings from the trial are truly shocking but I would like to assure you that the Trust has strong protocols in place to support colleagues to raise concerns whether through line management, safeguarding protocols, team briefs or via our Freedom to Speak Up Guardian. Additionally, independent reports can be made directly to the Care Quality Commission.

Dr Richard Jenkins
Chief Executive
September 2023

Date: 16 August 2023

NHS (North East and Yorkshire)
Quarry House
Quarry Hill
Leeds
LS2 7UE

Tel: 0113 823508

Richard Jenkins
Chief Executive
The Rotherham NHS Foundation Trust

Sent by email

Dear Richard

NHS provider segmentation

I write further to my letter of 12 August 2022 which set out the position at that time of the additional assurances required to support The Rotherham NHS Foundation Trust ("the Trust") move from segment 3 of the NHS Oversight Framework to segment 2.

These assurances were i) the removal of CQC conditions in relation to safeguarding to demonstrate evidence of sustained improvement and ii) keeping under review the outcome of the pending CQC prosecution, at that time, and the outcome of the Harm Review into the ERCP service.

As you are aware our regulatory segmentation decisions take account of delivery and governance across the various domains of organisations. On this basis we can confirm that we are now assured in relation to the improvements made in quality governance as evidenced by the actions taken in relation to the assurance set out in the above paragraph.

With regard to the current financial profile of the Trust, however, we do not have the right level of assurance that we can move the Trust into segment 2 at this stage. This assessment is driven by the submission of a deficit financial plan for 2023/24 alongside a relatively high number of high-risk cost improvement programmes.

We do believe however that there are actions in response to this financial position that could be taken by the Trust to provide the basis for an early de-escalation into segment 2. This would be on the basis that no other material risks in other areas of delivery and/or governance in the Trust including in relation to quality, performance and workforce.

The criteria we would require assurance on in response to the current financial challenges are set out as follows:

- Assurance on the delivery of the Trust's approved financial plan for 2023/24 within the South Yorkshire system financial plan;

- Confirmation of plans for in year and recurrent efficiency delivery, in line with national requirements;
- Evidencing organisation compliance with financial requirements set out in the 2023/24 system plan closedown letter, including Annex A;
- Development of a sustainable medium term financial plan (as part of system sustainable plan) in line with national timetable.

It is suggested that we take an assurance point after Q2 2023/24 to consider the level of assurance in place in relation to the above criteria.

NHS England regional and South Yorkshire ICB colleagues will work with you in support of putting the necessary assurances in place in response to what is set out above. This is likely to build on work that is already taking place in response to these risks.

Yours sincerely

Richard Barker
Regional Director
(North East and Yorkshire)

Cc:
Gavin Boyle, CEO, South Yorkshire ICB
Lee Outhwaite, Chief Finance Officer, South Yorkshire ICB
Mark Janvier, Director of Corporate Governance and Board Secretary, ICB
Dr David Crichton, Chief Medical Officer, ICB
Jo Dobson, Interim Locality Director, NHSE
Tim Savage, Regional Director of Finance, NHSE
Leaf Mobbs, Director of Performance & Improvement, NHSE
Margaret Kitching, Chief Nurse, NHSE
Tracey Grainger, Director of Intensive Support, NHSE

Board of Directors' Meeting
08 September 2023

The Rotherham NHS Foundation Trust

Agenda item	P132/23
Report	**National, Integrated Care Board and Rotherham Place 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: this 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 Board of Directors with an update on national developments, developments across the South Yorkshire Integrated Care Board (SYB ICB) and Rotherham Place. Key points to note from the report are: • The Rotherham Joint Strategic Needs Assessment (JSNA) has been refreshed with new data for 2023. • On Wednesday 2 August, representatives from Rotherham's Health and Wellbeing Board, including The Rotherham NHS Foundation Trust, Rotherham Metropolitan Borough Council, South Yorkshire Integrated Care Board, and other health partners, came together to pledge their support to make Rotherham a breastfeeding friendly borough. • South Yorkshire lung checks: As at the end of June this year, around 17,000 patients have been referred with over 4,500 lung health checks undertaken, 259 of which were referred to the screening multi-disciplinary team for follow up. Although it is still early days in Rotherham, as at the end of April, 21 cancers had been found, 13 had been lung cancers and 8 were other cancers.

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 SY ICB 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	Appendix 1 Rotherham Place Partnership Update July and August 2023

1.0 Introduction

1.1 This report provides an update on national developments and developments across the South Yorkshire Integrated Care Board (SYICB) and Rotherham Place.

2.0 National Update

2.1 The trial of the neonatal nurse employed by the Countess of Chester hospital has now concluded with a guilty verdict on the murder of seven babies between June 2015 and June 2016. The government has ordered an independent enquiry.

2.2 NHS England and the government have agreed to the consolidation of the national cancer targets from ten to three. These are:

- 28-day faster diagnostic standard (FDS)
- 62-day referral to treatment standard
- 31-day decision to treatment standard.

3.0 South Yorkshire Integrated Care Board (SYICB).

3.1 A number of organisations across the ICB have been shortlisted for the annual Health Service Journal (HSJ) and other awards as follows:

- The ICB were shortlisted for a wellbeing award for Mission: Menopause: changing the culture in South Yorkshire. The Rotherham NHS Foundation Trust was involved in this work. Linked to menopause, the Rotherham NHS Foundation Trust was also a contributor to two other system award nominations including:
    - The HPMA Excellence in People awards: NHS Employers Award for Wellbeing - Menopause
    - Henpicked: Most open Workplace category – Menopause
- Organisations across Doncaster were shortlisted for the HSJ Integrated Care Initiative for the Doncaster Wound Care Alliance
- Sheffield Health and Social care were shortlisted in the HSJ Mental Health Innovation category for their work with community leaders to reduce Race Inequalities in Mental Health
- The Rotherham NHS Foundation Trust has been shortlisted for a Nursing Times Workforce award under the category of health and wellbeing.

4.0 Rotherham Place

4.1 The Rotherham Joint Strategic Needs Assessment (JSNA) has been refreshed with new data for 2023, and key highlights have been extracted. The following is a summary of these key points. (For a full overview including infographics, please visit: https://www.rotherham.gov.uk/data)

- Life expectancy for Rotherham residents remains lower than the national average, with our residents born today expected to live two years less than the English average.
- Healthy life expectancy remains a critical issue in the borough. A girl born in Rotherham today might live for 81 years, but 25 of these will be lived in poor health.
- In terms of health behaviours, our residents are more likely to smoke; to be admitted to hospital for alcohol related issues; or to die from drugs misuse.
- Long-term unemployment rate in Rotherham is 3.2 per 1,000 compared to a national rate of 1.9
- Rotherham is among the top 15% most deprived local authority areas in the country, with key drivers of deprivation being poor health, education and skills and employment.

The work to tackle these challenges is feeding into the Health and Wellbeing Board and to various other place-based groups (e.g. the Prevention and Health Inequality Enabler Group).

4.2 The Trust Board recently received confirmation that a Public Health Consultant had been employed by the Trust. This is a joint role with Rotherham Metropolitan Borough Council. The post holder shares his time equally between the Trust and Rotherham Metropolitan Borough Council. As well as progressing the Trust's internal work on health inequalities, the post holder is working across the system and has a clear focus on a number of initiatives and now Chairs the Population Health Management Operational group across Rotherham. The group is developing a patient engagement approach to understand the wider needs and perspectives of patients with multiple long-term conditions including poor mental wellbeing, driven by the needs highlighted in the JSNA data.

4.3 As part of work to continue to develop anticipatory care planning, a workshop took place in June to discuss care plans with a focus on having one single care plan across health and social care and for focus on what matters to the patient. The well attended workshop looked at a range of case studies and explored how things could have been done better.

4.4 A Social Value event hosted by Rotherham Metropolitan Borough Council took place on 12th July. The Deputy Chief Executive was one of several presenters who delivered a presentation on being an Anchor Institution. The Trusts Chairman also attended the event.

4.5 On Wednesday 2 August, representatives from Rotherham's Health and Wellbeing Board, including The Rotherham NHS Foundation Trust, Rotherham Metropolitan Borough Council., South Yorkshire Integrated Care Board, and other health partners, came together to pledge their support to make Rotherham a breastfeeding friendly borough.

4.6 The July Rotherham Place Board received an update on the Rotherham Town Centre Transformation Plans. Works are due to commence this winter and the development will include:

- Flagship riverside leisure destination, including an 8-screen state-of-the-art cinema alongside a 69-bed Travelodge hotel
- The site is 100% let and will include six well known food brands.

4.7 Anti-depressant reviews: Rotherham Place has always prescribed a relatively high amount of antidepressants compared to similar areas. The National Institute for Clinical Excellence (NICE) recognises that stopping and withdrawing anti-depressant drugs can be challenging. Recognising this the Medicines Optimisation (MO) team working, with patient engagement colleagues, consulted with various groups across Rotherham to find out the public's opinion about the use of antidepressants. This led to two work streams:

- The Rotherhive website where patients can access practical information and support on life-issues
- A virtual clinic 'opt in' where patients, that have been identified as probably no longer requiring an anti-depressant can work with a clinical pharmacist to reduce and/or stop their anti-depressant drugs

In 2022/23 the clinic sent 8446 patient texts, 692 patients self-referred into the service, 405 stopped their anti-depressant and 252 patients reduced their dose by more than 50%. The virtual clinic was able to accommodate patients at a time that suited them. Patients really appreciated that the service was one stop with dosage adjustments and prescriptions issued without them having to contact their practice.

4.8 South Yorkshire lung checks: As at the end of June this year, around 17,000 patients have been referred with over 4,500 lung health checks undertaken, 259 of which were referred to the screening multi-disciplinary team for follow up. Although it is still early days in Rotherham, as at the end of April, 21 cancers had been found, 13 had been lung cancers and 8 were other cancers.

4.9 For a more complete update on initiatives across Rotherham Place, please see the attached newsletter (appendix 1).

Michael Wright
Deputy Chief Executive
September 2023

Rotherham Place Partnership Update: July /August 2023

The quarterly update on the work of the **Prevention and Health Inequalities group**, included:

- Engagement with 1700 people to develop the prevention campaign
- The development of pages on Rotherhive on food, smoking and physical activity
- Policy for e-cigarettes and a local tobacco control action plan agreed
- Membership of Sustainable Food Places Network achieved
- Impacts of the pandemic research undertaken
- MECC training delivered on cost of living to over 572 people
- Commenced developing anticipatory care model
- NHSE Prevention High Impact Interventions Audit underway
- Anchor Institution action plan developed, supported by Place Board and delivery commenced

South Yorkshire **Lung Health Check Programme**, delivered by Alliance Medical Ltd, went live in Rotherham in October 2022.

As at the end of June this year, around 17,000 patients had been referred with over 4,500 lung health checks undertaken, 259 of which were referred to the screening multi-disciplinary team for follow up. Although it is still early days in Rotherham, as at the end of April, 21 cancers had been found, 13 had been lung cancers and 8 were other cancers. There has been a number of challenges to overcome throughout delivery, including site access issues due to roadworks, sub-contractor staffing pressures, delays in obtaining data due to difficulties recruiting data analyst and preparations required for national screening programme implementation.

Actions being undertaken to address health inequalities include providing easy read booklets, letter amendments, animated videos, one to one support, allowing extra time for health check calls and scans and adjusting search filters to identify those with a learning difficulty.

What do Patients say…..

Sandra's story: https://www.youtube.com/watch?v=tG6fNMLC7ZQ

And read John's story here: Rotherham Advertiser

- *"At my lung scan the attitude of the staff made me feel comfortable and at ease, and by the time I actually had my scan my nervousness had gone."*
- *"Everything is good from the first phone call to having the scan. Everyone was professional & friendly. Excellent service!"*

The **Rotherham Partnership Health and Care Place Plan 2023-25** was approved at the July Place Board, it will now go to the Health and Wellbeing Board for endorsement.

The July Rotherham Place Board heard an exciting update on the **Rotherham Town Centre Transformation Plans**

- Flagship riverside leisure destination, including an 8-screen state-of-the-art cinema alongside a 69-bed Travelodge hotel
- The site is 100% let and will include six well known food brands
- A new footbridge was installed June 2023, and a new canal barrier installed at Forge Island in 2022 as part of the flood defence and enabling scheme, including improvements to the adjacent towpath, high-quality landscaping and new amphitheatre seating overlooking the lock

- A new public space which will form a key gateway to the flagship Forge Island leisure development and wider town centre
- The scheme will include soft landscaped terraces, accessible routes, natural play for children and new seating and dwelling spaces

- Over £16.5m secured to purchase and redevelop derelict and vacant buildings to create a new vibrant leisure destination
- Plans include prime commercial units and high quality residential
- Plans include relocated central library, extensive public spaces, a vibrant new dining area and an accessible and modern market
- Works due to start winter 2023

2023/24 Rotherham Medicine Optimisation Outcomes

Antidepressant Reviews

Rotherham place has always prescribed a relatively high amount of antidepressant's compared to similar areas. NICE recognises that stopping and withdrawing antidepressant drugs can be challenging. Recognising this the Medicines Optimisation (MO) team working, with patient engagement colleagues, consulted with various groups across Rotherham to find out the public's opinion about the use of antidepressants. This led to two work streams:

1. The Rotherhive website where patients can access practical information and support on life-issues
2. A virtual clinic 'opt in' where patients, that have been identified as probably no longer requiring an antidepressant can work with a clinical pharmacist to reduce and/or stop their antidepressant drugs

In 2022/23 this clinic sent 8446 patient texts, 692 patients self-referred into the service, 405 stopped their antidepressant and 252 patients reduce their dose by more than 50%. The virtual clinic was able to accommodate patients at a time that suited them, for example, patients chose to have discussions in their lunch hour, whilst waiting for their children to finish an activity or from a lay-by at the side of the road. Patients really apricated that the service was one stop with dosage adjustments and prescriptions issued without them having to contact their practice.

The service has been referenced in a publication by NHS England and was further referenced in the NHSE National MO opportunities 2023/24. https://www.england.nhs.uk/long-read/optimising-personalised-care-for-adults-prescribed-medicines-associated-with-dependence-or-withdrawal-symptoms/. Since then, it has been shortlisted in the PrescQIPP Awards finals - **https://www.prescqipp.info/community-resources/enter-the-awards-2023/**

In 2024/25 the service will focus on hypnotic and anxiolytic drugs.

Diabetes Management

Rotherham has 18,167 patients with diabetes, this is an increase of 14% over the last 3 years, of these 16,624 (91.5%) have type 2 diabetes where weight loss could form an important part of the patient's management. In 2022/23 Rotherham spent £7,510,513 on drugs to manage diabetes an increase of 11.3% on the previous year. Drugs to manage diabetes accounts for 15.6% of all total prescribing costs and increased by 11.3% over the last 12 months. A transformation strategy has been designed to refocus diabetes management on prevention working with partners to make weight loss the core of future type 2 diabetes management.

Progress to date, includes Dietetic led diabetes clinics for newly diagnosed diabetic patients established. They have seen 397 patients, 91 (23%) of whom are now in remission (no longer classified as diabetic). These clinics have recorded an average weight loss of 4.7Kg/patient, an average HbA1c improvement of 12mmol/mol and an estimated saving of £175K on drugs costs/year.

Patients identified as being on maximum oral therapy that would shortly require insulin therapy to manage their diabetes, have been contacted and invited to participant in a meal replacement weight loss intervention. 51 patients agreed to join this programme with programme capacity being the rate limiting issue.

A team based at the Rotherham GP federation will shortly be contacting all type 2 diabetes patients that meet the criteria and invite them to participate in one of four weight loss programmes (BETTY, DESMOND, The Low-Calorie Diet, and the Digital Weight Management Plan). In the next few months, the following interventions will go live:

- Review of all patients on high doses of insulin
- Diabetes health promotion events
- Diabetes reviews offered via the extended access hubs to capture the working patient.

Infant Feeding Pathway

In response to an increase in the demand for specialist infant formula feeds and to reduce the pressure on the paediatricians, a dietitian led infant feeding pathway was commissioned. The dietitians had observed that infants were often started on specialist formula feeds before they saw a dietitian and queried the accuracy of the diagnoses of cow's milk protein allergy in many infants.

In 2022/23 there were 396 referrals into this pathway, this was 14.3% of all Rotherham new-borns. Only 48% of referrals required a specialist infant formula and less that 5% of referrals were referred to a paediatrician. The pathway has uncovered a need to improve the management of infant reflux and de-medicalise this condition and reduce the need to prescribe medication to manage this condition.

Care Home Hydration Project

Rotherham was successful in obtaining NHSE funding for a care home hydration project as part of a national programme.
Hydration training has been delivered across 24 care homes with 242 staff receiving the training and a further 394 staff enrolled onto the virtual hydration training. Reviews have been very positive.

The data appears to show a reduction in ambulance callouts, laxative use and possibly antibiotic use in the care homes that have received the training. The project is now mapping out how UTI's are managed in care homes and the misuse of barrier creams.

Blatchford who provide **Rotherham's Wheelchair Service** are the first wheelchair service in the country to be awarded GOLD status for the clinical service provided at Rotherham.


CECOPS

THIS IS TO CERTIFY THAT

Blatchford

(Rotherham NHS Wheelchair Clinic)

is a CECOPS

ACCREDITED USER

Accredited against Code Standards:
Part 2: Service Provision
Part 3: Clinical & Professional Responsibilities
Part 4: Peripheral Issues and Specialist Areas

EFFECTIVE DATE: **24th January 2023**

GRADE AWARDED: **GOLD**

This certificate is valid for 3 years from Effective Date

Prof. Mike Bewick MB BS FRCP FRCGP MIPH
Chairman

Brian Donnelly MSc
Chief Executive

Independently verified by: TEQAS

This certificate remains the property of CECOPS CIC, and shall be returned immediately on request. The CECOPS Accredited User Logo™ is a Trade Mark and is subject to copyright law. Any person who does any unauthorised act in relation to this Trade Mark may be liable to criminal prosecution and civil claims for damages.

www.cecops.org.uk

CECOPS is the only standards body representing all assistive technology services including, for example, community equipment, wheelchair and seating services, telecare, telehealth, and communication aids. CECOPS is also unique in that it covers commissioning, provision, and clinical aspects of services. It is formally approved by regulators and professional bodies including the Care Quality Commission (England), Health and Safety Executive and the Association of Directors of Adult Social Services.

To continue Rotherham's development on **Anticipatory Care Planning**, a workshop took place in June to discuss care plans with a focus on having one single care plan across health and social care to focus on what matters most to the patient.

The workshop was attended by a range health and social care colleagues from across the Rotherham Place.

Attendees worked through case studies to understand whether situations could have been prevented.

They discussed whether anticipatory care should look for patients on our lists we do not know who may have needs we are not aware of.

Rotherham launched its **Virtual Ward** in December 2022. The ward currently has a frailty and acute respiratory pathway with capacity of up to 40 beds, depending on acuity levels. New pathways are being developed and capacity will be increased over winter rising to 100 in the new year.

The virtual ward is nurse consultant led and supports people at home, including care homes, who would otherwise be in an acute hospital bed. Patients tell us they prefer this, and national evidence shows better patient outcomes. It also helps with system flow, reducing avoidable ambulance conveyances and admissions and facilitating early discharge if a hospital stay is required. Referral routes include from primary care, community services, Yorkshire Ambulance Service, the Urgent and Emergency Centre and acute wards. Referrals are through the Care Co-ordination Centre in our Transfer of Care Hub on 01709 426600. Your call will be triaged by our re-configured team who will discuss the individual's need's and allocate them to the correct pathway.

Paula Berridge and Vicki Williams, our Nurse Consultants, explained how the ward provides patient level care.

The introduction of the Virtual Ward service has had an immensely positive impact on patient wellbeing. People can be cared for at home, avoiding a hospital stay or check-out of hospital sooner while still receiving regular daily home visits to monitor vital stats and medications. This innovative approach has truly transformed the recovery experience.

Treatment of acutely unwell patients includes investigations, blood tests, enabling care, IV antibiotics, Sub cut fluids, diagnosis and treatment of infections, and management of delirium and acute confusion. The virtual ward team support patients in discussion about advanced care planning and managing conditions when patients want to stay at home.

The team comprises of nurse consultants, community physician, pharmacy technician, nurses, advanced practitioners, and clinical support staff, who combined provide an excellent service to the patients on the virtual ward.

317 people have been supported on the ward between December 2022 – July 2023. 195 of these were community referrals and 122 early discharge from an acute bed, transferring to consultant care in the community. Admissions from the acute setting onto the virtual ward are continuing to increase due to our transfer of care nurse visiting wards daily to identify patients who meet the virtual ward step-down criteria.

The team are presenting at September's PLT event to showcase case studies to our GP colleagues, and its hoped to visit practice across Rotherham in the next few months to get to know our colleagues and answer questions that may arise for individual practices

Board of Directors' Meeting
8 September 2023

The Rotherham NHS Foundation Trust

Agenda item	P133/23
Report	**Mental Health Strategy**
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	**Ambitious** – continuous improvement to support an ambition for outstanding mental health care **Caring** - supporting patients families and colleagues to receive and give outstanding mental health care **Together** – working together across the multi-disciplinary team to improve mental health care across the organisation.
Purpose	**For decision** ☒ **For assurance** ☐ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	The 3 year strategy supports patients who have a mental health difficulty throughout their journey of care though our Urgent and Emergency Care Centre (UECC), Inpatient and Outpatient areas, and community settings. This strategy covers all ages - children, young people and adults. This mental health strategy builds on the work that has been completed over recent years. It provides a clear commitment for continuing this progress, and aims for future development in treating and supporting mental health alongside physical health. It also promotes the positive experiences and outcomes for our patients, families and carers. This mental health strategy will be measurable and be governed through our established mental health meetings for children, young people and adults.
Due Diligence (include the process the paper has gone through prior to presentation to the meeting)	This paper has been presented to the Mental Health Steering Group, ratified at the Safeguarding Committee in July 2023 and presented to Quality Committee on 30 August 2023.
Board Powers to make this decision	The Board of Directors has the authority to approve Trust Strategies.
Who, What and When (what action is required, who is the lead and when should it be completed?)	This Strategy was approved for recommendation to the Board of Directors at Quality Committee.
Recommendations	The Board of Directors is asked to approve the new Trust Strategy for Mental Health.

Ambitious Caring Together

NHS
The Rotherham
NHS Foundation Trust

Mental Health Strategy
2023-2025

CONTENTS

Strategy Overview

The purpose of this document is to set out a 3 year strategy to support patients who have a mental health difficulty throughout their journey of care though our Urgent and Emergency Care Centre (UECC), Inpatient and Outpatient areas, and community settings. This strategy covers all ages - children, young people and adults. At The Rotherham NHSFT (TRFT) we are committed to providing outstanding, patient-centred collaborative care whilst meeting the needs of physical health alongside mental health. It is crucial that our patients feel safe, listened to and have confidence in the knowledge and skills of our staff.

This mental health strategy builds on the work that has been completed over recent years. It provides a clear commitment for continuing this progress, and aims for future development in treating and supporting mental health alongside physical health. It also promotes the positive experiences and outcomes for our patients, families and carers. This mental health strategy will be measurable and be governed through our established mental health meetings for children, young people and adults. Although the mental health of our staff is as much of a priority, it is to be noted that this strategy does not include workforce as this is addressed through the People Strategy.

The Strategy in Context

Good mental health and resilience are fundamental to our physical health, our relationships, our education, our training, our work and to achieving our potential (No Health Without Mental Health 2011). One-in-four adults and one-in-ten children experience a mental health difficulty of some kind each year in England (MIND 2021). During pregnancy and after the birth of a child, women are at higher risk of experiencing mental health problems ranging from low mood to psychosis. At this time a woman who has previously experienced mental health conditions may find they return or worsen. A decline in our mental health can affect anyone of us at any time, and it is recognised that many people accessing care within the UECC, Inpatient and Outpatient areas may require support around their mental health.

A clear link between mental health and physical health has been noted in national drivers, for example; people living with diabetes are two to three times more likely to have depression than the general population and it is estimated that 30% of people with a long term physical health condition (for example diabetes, arthritis and heart conditions) also have a mental health condition (Public Health England 2018). The Department of Health has estimated that 50% of patients in a general hospital are older people and the number of people aged 75 years or over is expected to double in the next 30 years.

On an average day in a 500 bed hospital, older people occupy 330 of the beds, and of these 220 will have a mental disorder of some kind with depression (being the most common illness), psychotic disorders, dementia and delirium. It is noted that depression in later life can be a major factor in suicide (Royal College of Psychiatrists 2018). The Treat as One document (NCEPOD 2017) recognised the

importance of bridging the gap between mental and physical health care in general hospitals. Likewise Mental Healthcare in Young People and Young Adults (NCEPOD 2019) recognises that UECC attendance shows an increased presentation rate due to mental health conditions compared with other health conditions highlighting the need for focus on mental health.

The Kings Fund (2016) highlighted that all health and care professionals have a part to play in delivering closer integration to meet the needs of both physical and mental health. Research recognises the importance of professionals being willing and able to take a 'whole person' perspective, and having the necessary skills to do so. Following the Coronavirus pandemic of 2020, mental health decline has been evident throughout our communities. TRFT is dedicated to understanding the needs of our population and will strive to treat mental health at the same time as physical health.

The National Drivers for Change

In order to achieve best outcomes, the strategy has been aligned to national drivers and aims to support all of our staff to have the right skills and knowledge to provide excellent compassionate care. This document has been designed to be responsive to the needs of our patients; and therefore this strategy is a living document that may evolve over time linking to national drivers.

National drivers and Guidance used to develop this strategy include –

- Bringing together physical and mental health, a new frontier for integrated care (The Kings Fund 2016).
- The Five Year Forward View for Mental Health (NHS England 2016)
- The NHS Long Term Plan (2019)
- Relevant NICE guidelines and Clinical Guidelines (for example: Self-harm in over 8's- short-term management and prevention of recurrence. CG16)
- Saving Lives, Improving Mother's Care (MBRRACE-UK 2018)
- 2019 Surveillance of alcohol-use disorders, NICE guidelines PH 24 and G115 (National Institute for Health and Care Excellence UK 2019)
- Mental Health in General Hospitals: Treat as One (NCEPOD 2017)
- Mental Healthcare in Young People and Young Adults (NCEPOD 2019)
- Medical Emergencies in Eating Disorders: Guidance on recognition and management (Royal College of Psychiatrists, 2023)

Where are we now?

Over recent years, TRFT has focused on mental health alongside physical health, driving service development and ensuring high quality care which is responsive to the needs of our patients. Initiatives have included:-

- Joint working with our mental health providers- RDASH and Child and Adolescent Mental Health Services (CAMHS) to drive forward parallel assessment and treatment (mental health alongside physical health).
- The Section 136 suite is delivered by RDaSH, based at Swallownest Court and our UECC works closely with both South Yorkshire Police and RDaSH to ensure that patients with who are sectioned under 136 with mental health needs are cared for in the most appropriate place of safety to meet their needs.
- We have developed our mental health pathways to ensure that our Acute Medical Unit is able to accommodate patients whilst they await assessment or recover from substance misuse or overdose.
- The Community services for Alcohol and Substance misuse have been re-designed, both Adult and Younger persons services come under the same umbrella of ROADS (Rotherham Alcohol & Drug services) with the same Freephone number of 0808 1753981. The new provider is nationally known as We are With You. The service also offers targeted group work and training for professionals. They offer help and advice with challenges facing young people whether that's drugs, alcohol, mental health or relationships.
- TRFT is one of only 4 Optimum Alcohol treatment sites in the country, and was awarded monies to develop an extended offer for Patients with Alcohol & Mental Health problems.
- Educating our staff in relation to the requirement and benefits of parallel assessment (including assessment, treatment plan, early identification of pathways, care planning and risk management).
- The establishment of multi-agency forums – (for example mental health steering group and UECC Frequent Attender meeting), with clear governance frameworks for reporting and monitoring progress.
- Progression within the Hospital Alcohol Liaison Service (ALS) - ensuring alcohol-use screening is part of an admission process; an alcohol screen adapted for use in pregnancy and embedded referral pathways.
- The development, pilot and implementation of an evidence based, all age Mental Health Risk Tool which promotes collaboration with children, young people and adults experiencing mental health difficulties. A tool which guides collaboration, discussion with families and carers (where involved) and enables us to provide individualised care in the UECC and on Inpatient wards.
- MHLT access and record keeping onto meditech electronic patient notes – ensuring joint working and the ability to document assessment, risks and plan in relation to medication, pathways and support provided by the ward.
- The development of an Enhanced Levels of Care risk assessment (including the supporting of mental health patients) – guiding systematic practice into providing one-to-one, intermittent or general staff support and utilising therapeutic activities.
- A focus on least restrictive practice including review of policy, guidance on helpful strategies (engagement, activities, knowing the patient's likes and dislikes) to reduce the likelihood of restrictions (for example Enhanced Levels

of Care) and ensuring these are in line with legal frameworks (Deprivation of Liberty Safeguards, Mental Capacity Assessment or Mental Health Act).

- Ensuring a culture of learning around mental health – reducing harm through organisational sharing of lessons learned, learning to improve bulletins, and policy development focusing on patient safety and positive patient experience and care that is responsive to individual needs.
- Close working with multi-agency partners in supporting our patients with a mental health difficulty, for example: the police, RDASH and Yorkshire Ambulance Service.
- Perinatal Mental Health – routine screening for mental health at all contacts.
- Within TRFT Maternity Services, the Trust has a Mental Health Specialist Vulnerability Midwife who works alongside the Perinatal Mental Health Team to triage any pregnant Women with any history of mental health concerns, to ensure they are on the most appropriate care pathway to support them during pregnancy.
- A safeguarding process which identifies our young people (16 and 17 year olds) on adult wards and ensures safeguarding and mental health needs are prioritised and supported, and parent/carer and multi-agency working is established (education, local authority, third sector).
- Education has been key throughout our journey so far, recognising that increasing the knowledge and skills of staff enables the delivery of high quality care.

Consultation: Who we have listened to in developing this strategy:

Multi-agency working is identified in The NHS Long Term Plan as a priority area where the importance of the delivery of services through integration and collaboration between organisations is recognised. This multi-agency working has been key for the development of the strategy alongside experts by experience, families and carers. Key people have included;

• The Rotherham Hospital Foundation Trust mental health steering group

• Experts by Experience

• The Rotherham Hospital Foundation Trust Patient Experience group

• Families and Carers

• The Rotherham Hospital Foundation Trust Specialist Teams, UECC, Inpatient and Outpatient multi-disciplinary staff

Strategic alignment

'The population of Rotherham is older than the national average and is getting older still. The town has high levels of deprivation, higher than average unemployment and above average rates of smoking. We must do better to co-ordinate and join up care'

Our mental health strategy is aligned to our overall Trust strategy as it supports delivery of our values and strategic objectives and underpinning strategies such as the ‘Quality Improvement Strategy’, ‘Patient Experience Strategy’ and the ‘Our People Strategy’.

This Mental Health strategy aims to identify how we, across TRFT, can work as one team with our colleagues and multi-agency partners by ensuring the aims of this strategy are in complete alignment with the Trusts overarching strategic direction and ambitions. This strategy is for use in all departments (UECC, Inpatient and Outpatient areas) and specialist teams (for example Nutrition, Discharge Facilitators/ Discharge Assessment Nurses, cancer services, alcohol liaison) recognising that every staff member is crucial in driving high quality standards of care and positive patient experience.

Our Values

Our three values form an acronym “ACT”. Values are about the way we act and how we behave, so this acronym provides simplicity to our approach. Furthermore, “act” is about empowering you, our workforce, to be able to explore and make decisions at appropriate levels, which supports our strategic objective – Colleagues - engaged accountable colleagues

Ambitious seeks to set high standards and expectations, for the services we deliver but also for ourselves. For example, we can be ambitious in terms of quality of care for our patients and clinical strategies. Also, we can be ambitious in terms of changes to our ways of working and patient pathways to develop sustainable services for the population we serve.

Caring reflects overwhelming feedback about what our colleagues and patients would like to see from us, embracing the importance of caring for patients and families. Also, it is important that we care for each other as colleagues, and that we care in other ways, such as about our community, our resources, our environment and our future.

Together represents the importance of working together, whether as clinical, non-clinical and multidisciplinary teams, with patients, carers and families to provide high quality patient-centred care. It is also about working with our partners across Rotherham, South Yorkshire and Bassetlaw and further afield, to improve the health and wellbeing of the population we serve.

What are the needs of our community?

Mental Health problems are a growing public health concern and from every day worries through to long-term conditions with the most common mental health problems being depression and anxiety.

The Rotherham hub data demonstrates mental wellbeing that is split into categories covering: Prevalence and incidence, Risk factors, Protective factors, services and Quality and outcomes.

Headlines

Rotherham residents:

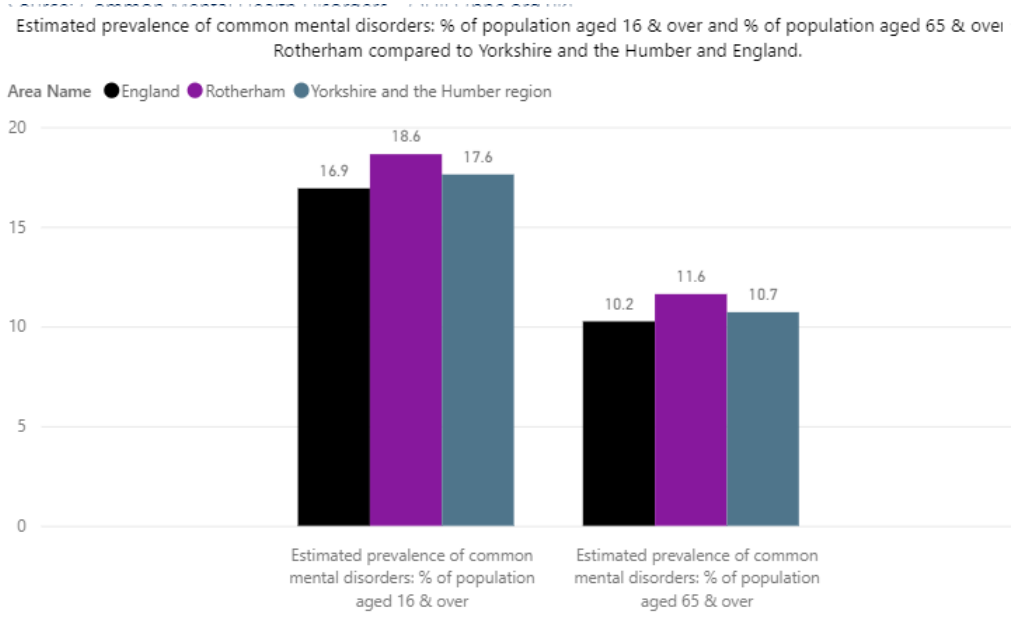
- 18.6% of the population aged 16 and over are living with a common mental health disorder (2017)
- 11.6% of the population aged 65 and over are living with a common mental health disorder (2017)
- 15.9% of adults (aged 18+) are registered with GPs for depression (2020/21)
- 22.1% of adults (aged 16+) had a higher anxiety score (2020/21)
- The suicide mortality rate is 13.2 per 100,000 over 3 years data (2018-2020)
- The rate for emergency hospital admissions for intentional self-harm is 178.0 per 100,000 (2020/21)
- The rate for emergency hospital admissions for intentional self-harm, aged 10-24 years, is 331.4 per 100,000 (2020/21)

Local Picture

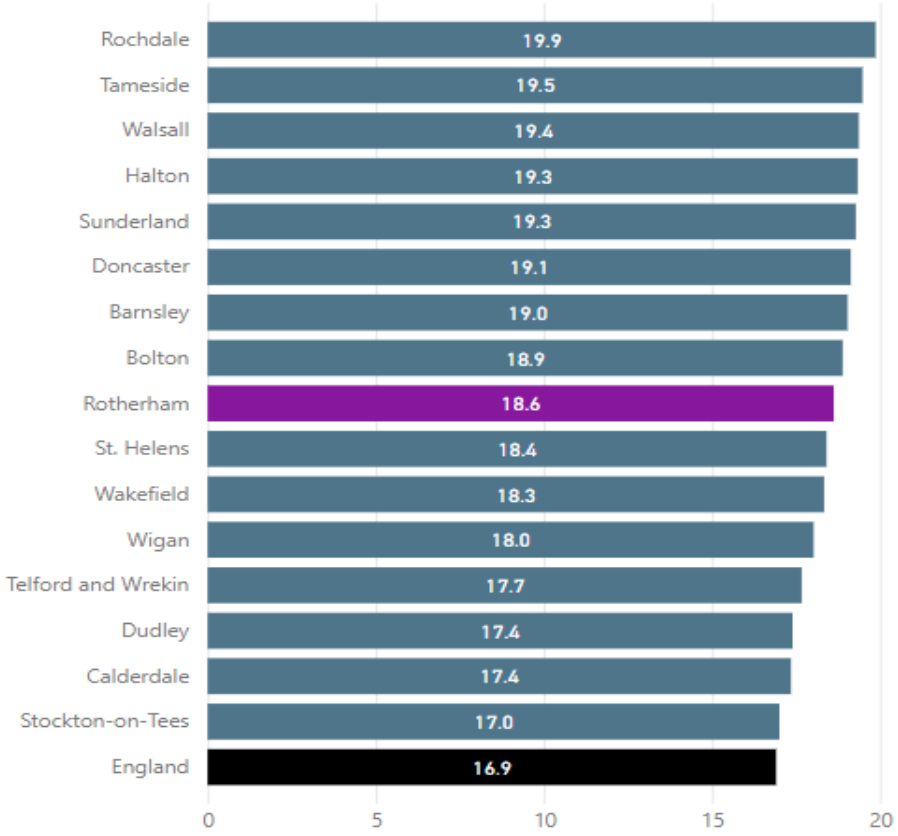
The estimated prevalence of common mental health disorders (CMHD) for Rotherham (2017), is higher than that for Yorkshire and the Humber and England for both those aged 16 and over and those aged 65 and over.

The percentage of people registered with their GP practices for depression have been increasing and Rotherham are in the highest quintile currently.

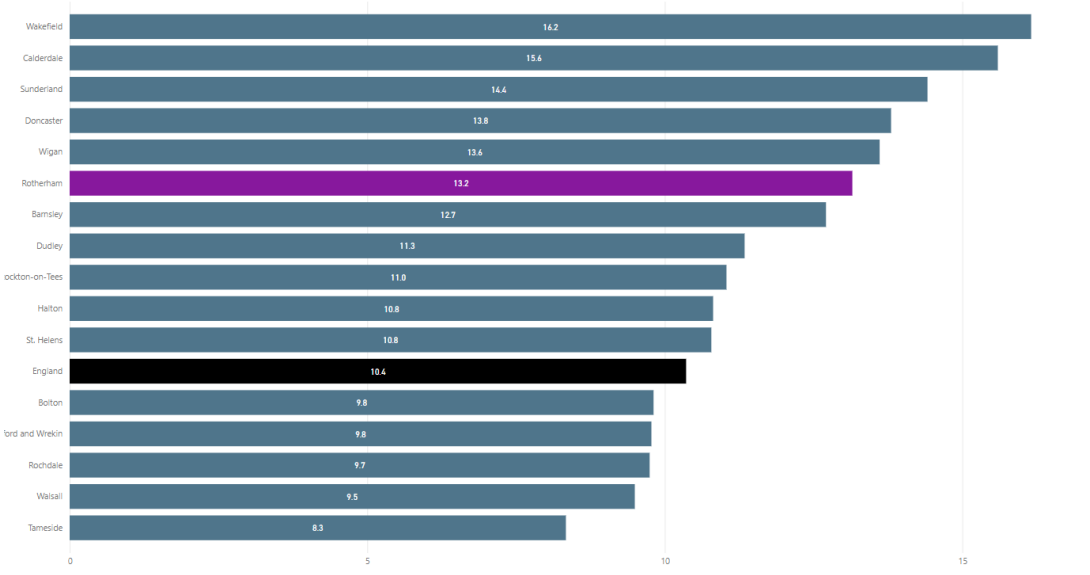
The suicide rate for persons and females, Rotherham 2018-20, are significantly worse than the England average and the suicide rate for males is not significantly different to England.

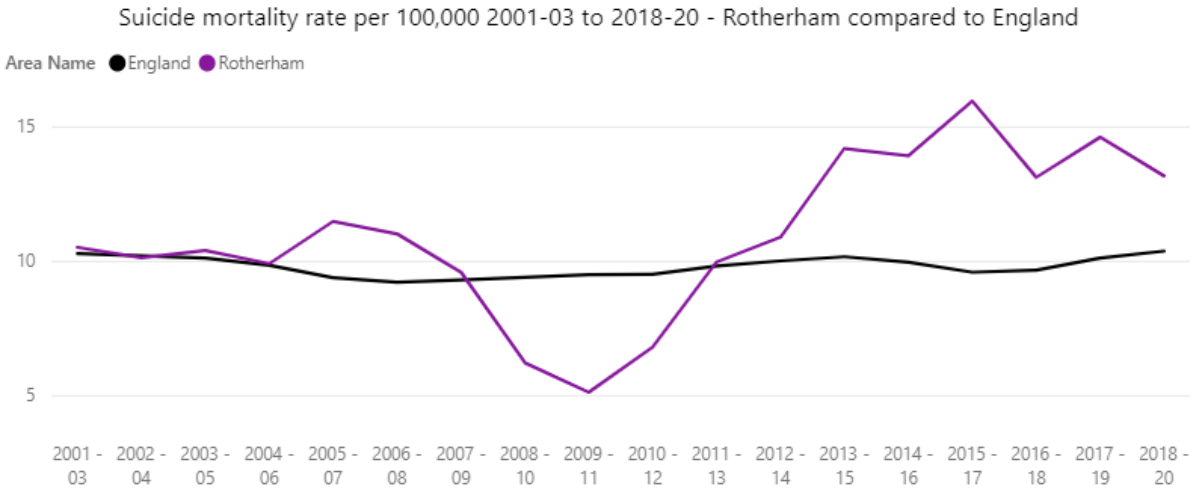


Estimated prevalence of common mental disorders: % of population aged 16 & over, 2017, Rotherham compared to CIPFA nearest neighbours.



Suicide mortality rate per 100,000 2018-20





If 25% of the population are affected by these mental health conditions we should assume that at least 25% of patients accessing our health services every day either in inpatient care, outpatients, diagnostics, maternity etc have other needs over and above the care we provide. Some people will already be receiving care from mental health services but many will not.

Our Pledge

All of the people we look after should be able to say:

• Services and professionals listen to me and do not make assumptions about me.

• Those who work with me bring optimism to my care and treatment, so that I in turn can be optimistic that care will be effective.

• The staff I meet are trained to understand my condition (be it mental, physical or both) and able to help me as a whole person.

• Staff support me to be involved in decisions at the right level. They respond flexibly and change the way they work as my needs change.

• Wherever possible, there are people with their own experience of using services who are employed or otherwise used in the services that support me.

• As far as possible, I see consistency during a crisis.

• I do not have to keep repeating my story to get the help and care I need.

• My culture and identity are understood and respected when I am in contact with services and professionals. I am not stigmatized as a result of my health symptoms, diagnosis or history, or my cultural or ethnic background.

• The strengths of my culture and identity are recognised as part of my recovery. My behaviour is seen in the light of communication and expression, not just as a clinical problem.

How will we change things?

A detailed plan will underpin this strategy to ensure that it is implemented into the day to day practice of all staff in the Trust.

Specifically the goals we aim to achieve are that:

- We will ensure that all people with mental health needs are cared for in the most appropriate environment for their needs with access to appropriate services.
- We will continue to work in collaboration with all partners to improve outcomes for people with mental health needs.
- We will engage with people with mental health needs of all ages who use our services and ensure that their views are taken into consideration when undertaking service development or changing services.
- We get feedback from people with mental health needs about their experience when using our services and act on the issues they raise.
- All policies and procedures are written in such a way that the mental health needs of the patients and staff are taken into consideration as demonstrated by a robust equality impact assessment (EIA).
- The environment of the hospital is appropriate for people with mental health needs and that clinical areas are appropriately risk assessed to reduce the risk of harm.

Key Strategy Priorities

1. Mental health training for staff

- Promote well-being in the form of diet, exercise, alcohol and substance misuse, social networks, social prescribing, the impact of isolation.
- Develop the role of Mental Health Champions to deliver key messages and increase confidence within teams. Mental Health Champions will complement the role of the Dementia Champions, Learning Disability Champions and Safeguarding Champions.
- Develop standard digital records that all staff will be trained to use that support a systematic way of evaluating a patients mental health.
- Develop online resources for staff, patients, carers and their families that describe patient pathways and the help that is available throughout. Make links with statutory services and voluntary sector websites to help patient navigate through the complex variety of services and support that is available.

- Promote early intervention, resilience and recovery through staff being confident and skilled in screening of psychological distress and offering psychological techniques such as problem solving for mild to moderate difficulties. Based on these screening assessments, for staff to refer to appropriate services when greater need is identified e.g. Clinical Health Psychology, Mental Health Liaison Team, Mental Health Services and Third Sector.
- Work with our partners to make best use of their skills and experience to shape our training programmes for example, public health, clinical health psychology, mental health liaison, mental health NHS Trusts, alcohol and substance misuse services.
- Draw on best practice models and effective tools for education and training so that staff have confidence in what to look for and what to do to support people with mental health conditions as well as be able to easily access the resources they need regardless of the environment they are in.
- Develop service specific training for example, UECC staff will require different training to staff in a paediatric environment to those supporting patients with chronic and long term conditions.

2. Meet the needs of our patients

In order that we can meet the needs of our patients we need to be able to quickly identify those patients with a need, respond appropriately and track progress. This requires robust data collection, the right information systems for tracking mental health status and the ability to track referrals to other services.

In an Emergency setting we need to be able to quickly refer to the mental health liaison service, monitor how long patients are waiting for their assessment, admission, onward referral to another service and overall length of stay.

On a ward setting staff need to know that where specialist mental health input is needed that it is being delivered, care plans are in place and discharge planning is coordinated with the hospital clinicians.

In an outpatient setting staff need to know beforehand if there are individual adjustments that may be needed for a patient; this could include the way someone is greeted to how they can be most comfortably accommodated in a busy waiting area. Furthermore earlier knowledge of a mental health need can facilitate better management of the pathway eg multiple appointments can be coordinated to occur at the same time, additional information could be provided at the time of sending the initial outpatient appointment letter.

Improve the learning around compliments, complaints and Family and Friends Test specific to mental health and care, with the LTHTR mental health matron/practitioner working closely with the Patient Experience and PALS team. Continue to thematically analyse the results of the ‘you said, we did’ in relation to mental health.

Ensure patient feedback and learning from incidents are communicated through to our mental health groups for improvements.

Stage engagement events throughout the year to give patients a voice, with progress updates on the strategy ensuring that the document is ‘live’.

With better data both within the Trust and as a system we will be able to plan services, plan activity flows and better meet patient demand. Key things to be developed with system partners moving forward include:

• Data improvement plan that is system owned

• a capacity and demand model developed with commissioners to understand patient flows and ensure that onward capacity within mental health services meet demand; this would need to include community services as well as inpatient mental health services and specialist tier 4 services. Capacity needs to be understood at county level for both adults and paediatrics with supporting commissioning plans to address known gaps.

• Develop a dashboard that enables management of patients with mental health problems to be more visible to support reductions in delays both in assessment and time waiting for onward support.

• Development of a system dashboard that looks at patient pathways and delay throughout the system

Through this programme of work we would expect to be able to demonstrate the benefits and reductions in delay that patients will experience as a result of this strategy.

3. Shared Policies

There is an opportunity to bring together how TRFT and partner organisations work by having a set of shared policies these might include implementation and oversight of the mental health act, rapid tranquilisation, observations, covert medication, restraint etc. A group should be established to consider how to bring together these concepts and have shared ways of working.

4. Targeted interventions for Children and young people

Demand for children’s and young people’s mental health services far outstrip capacity and due to long wait times in Rotherham, families often feel unsupported and unable to get the help they need when they need it. In times of crisis children, carers and families will often arrive at UECC in need of support and care. An acute setting is often not the right environment but as it is the place that many people associate with the place they can guarantee support we need to respond to this. A psychiatric liaison team providing quick assessments (for children with mental health, neurodevelopmental and behavioural conditions) and onward referral and crisis intervention is needed which will require not only the development of an appropriate team but also pathways and crisis response services to meet the needs of both patients and carers and families.

The NHS Long Term Plan specifically highlights the need to think about how we provide services to young people aged 16-25 and feedback from our strategy consultation suggests that there is more to do about how we configure our services

and also the networks that we establish to support our patients. This may impact on how we use our inpatient beds, how we manage our waiting areas and the material we provide to our young people that might need to be different to the material we provide to children and to adults. Suicide prevention and mental health support provided through colleges and Universities should also be considered so that onward pathways are utilised as appropriate. When developing resources for patients, carers and families, this age group should be considered separately.

Children with long term conditions would benefit from access to psychological therapies. We should learn from what works well in one specialty and spread this to others through using existing services as well as considering expanding the current long term condition support on offer. Our plans for enhancing our services for children must take account of patients with mental health conditions, neurodevelopmental disorders, behavioural conditions and learning disabilities.

Develop our care in line with NCEPOD Treat as One and Mental Healthcare for Young People and Young Adults.

Ensure children and young people are asked for feedback on their care.

CONCLUSION

Our patients, staff and partners have responded positively to the development of our Mental Health Strategy. We have further developed our strategy based upon the feedback that we have received making it more ambitious, responsive, wide-ranging and integrated. The most important element of delivery of this strategy will be the care that is ultimately provided to our patients in all of the settings we work within. Mental health care and physical health care will be treated as one in an environment and by a team that focuses on:

- Safety and quality
- Dignity and Respect
- Compassion

This strategy will support our staff and partners to work together to do this and improve the patient experience for our patients, their carer's and their families. It is deliberately ambitious in a world where NHS funding is compromised and where mental health services have been underinvested in for years. Much of this strategy can be delivered through partnership working and co-design but it is also important to recognise that investment is needed throughout the system to fund gaps that have been present for yours. This strategy will help inform system planning and shape new ways of thinking that brings mental and physical health together to address the health inequalities that must be addressed within our patient population.

Board of Directors' Meeting
8 September 2023

Agenda item	P134/23
Report	**End of Life Care Strategy 2023 - 25**
Executive Lead	Helen Dobson – Chief Nurse
Link with the BAF	B1 Standards and quality of care do not deliver the required patient safety, clinical effectiveness and patient experience that meets regulatory standards
How does this paper support Trust Values	**Ambitious** – continuous improvement to support an ambition for an outstanding end of life care service **Caring** - supporting patients families and colleagues to receive and give outstanding end of life care **Together** – working together across the multi-disciplinary team to improve end of life care across the organisation.
Purpose	**For decision** ☒ **For assurance** ☐ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	The national ambitions for palliative and End of Life Care (2021) describe how death and dying is inevitable, therefore good palliative and end of life care must be a priority. The ambitions confirm that the quality and accessibility of this care will affect us all and it must be made consistently better for all of us. The needs of people of all ages who are living with dying, death and bereavement, their families, carers and communities must be addressed, taking into account their priorities, preferences and wishes. We live in a world where local leadership is vital to finding new ways of organising care and support for people. This strategy will require colleagues across The Rotherham Foundation Trust (TRFT) to lead and exemplify new ways of organising care and support for people. The Covid-19 pandemic highlighted the value of palliative and end of life care practitioners and the power of palliative care and end of life care services working collaboratively across all boundaries. It also shone a spotlight on the gaps and weaknesses that need to be addressed collectively if we are to achieve the new six ambitions set out in the new strategy. In order to gain views of the wider public and colleagues across TRFT, a series of focus groups were held in February and March 2023, around the themes of personalised end of life care, staff engagement and support, communication and information, culture and environment. The aims of the strategy have been created from the views of the people who contributed to these groups.

Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	This Strategy was presented to the Quality Committee on 30 August 2023
Board powers to make this decision	The Board of Directors has the authority to approve Trust Strategies.
Who, What and When (what action is required, who is the lead and when should it be completed?)	This Strategy was approved for recommendation to the Board of Directors at Quality Committee.
Recommendations	The Board of Directors is asked to approve the new Trust Strategy for End of Life Care.

The Rotherham NHS Foundation Trust

End of Life Care Strategy 2023-25

Forward

"How we care for the dying is an indicator of how we care for all sick and vulnerable people"

National End of Life Care Strategy 2008

Cindy Storer, DCN 3 April 2023

The national ambitions for palliative and End of Life Care (2021) describe how death and dying is inevitable, therefore good palliative and end of life care must be a priority. The ambitions confirm that the quality and accessibility of this care will affect us all and it must be made consistently better for all of us. The needs of people of all ages who are living with dying, death and bereavement, their families, carers and communities must be addressed, taking into account their priorities, preferences and wishes.

We live in a world where local leadership is vital to finding new ways of organising care and support for people. This strategy will require colleagues across The Rotherham Foundation Trust (TRFT) to lead and exemplify new ways of organising care and support for people.

The Covid-19 pandemic highlighted the value of palliative and end of life care practitioners and the power of palliative care and end of life care services working collaboratively across all boundaries. It also shone a spotlight on the gaps and weaknesses that need to be addressed collectively if we are to achieve the new six ambitions set out in the new strategy.

In order to gain views of the wider public and colleagues across TRFT, a series of focus groups were held in February and March 2023, around the themes of personalised end of life care, staff engagement and support, communication and information, culture and environment. The aims of the strategy have been created from the views of the people who contributed to these groups.

Ambition	Building blocks	Aims/ Trust Priorities	Measurement of Success
1. Each person is seen as an individual. Patients, and the people important to them have opportunities to have honest, informed and timely conversations and to know if they might die soon. Patients are asked what matters most to them.	**1.1 Honest Conversations** Everyone will have the opportunity for honest and well informed conversations about dying, death and bereavement	At least 75% of patients who are approaching end of life are given tailored care through the Individualised Last Days of Life Care Plan. 2023/4 Quality Priority for the Trust.	Monthly data collection of the numbers of patients needing end of life care. Included in quarterly update to the patient experience committee through Quality Priority report. Routinely included in the annual report and 6 monthly update for the supportive care team. Taking part in the National End of Life Care (NACEL) audit (paused for 2023 and will re-commence in 2024). Results and actions taken from findings reported in the annual End of Life Care Report.
	1.2 Person Centred Care We will have effective systems in place to reach people approaching the end of life to ensure effective assessment, care	The locality has an agreed approach to early identify of those at end of life which includes all care settings	IPOS- Integrated Palliative Outcome Scoring – to be included in the annual End of Life Care report and six monthly update

	coordination, care planning and care delivery		
	1.3 Clear expectations People should know what they are entitled to expect as they reach the end of their lives	There is a central information point where people can easily access clear information about 'all ages' local palliative and end of life care services, including details about the level of service that they should expect and what they are entitled to	Development of Trust web page by supportive care team to provide central information where people can easily access clear information. Working with ICB place colleagues to ensure information and services are across Rotherham place.
	1.4 Access to social care People must be supported with rapid access to needs-based social care	The Integrated Discharge Team will work with the supportive care team to respond to social care needs with clear referral process for carers needs.	Annual report (and 6 monthly update) will include information on patients needing rapid access to needs-based social care.
2. Each person gets fair access to care People live in a society where they get good end of life care regardless of who they are, where they live or the circumstances in life.	**2.1 Using Existing Data** Using aggregated data to understand and remedy partial reach of services	Demonstrating a full understanding of the current reach of palliative and end of life care services, and local population-based needs assessments across different diseases, social and ethnic groups. This information is used to plan future services	Collection of demographics for patients referred to end of life care team and analysis included in the end of year report and 6 monthly update along with targeted improvement plan.
	2.2 Gathering new data Collect and report on new palliative and end of life care data to inform ongoing Quality Improvement work, including that of equal access work and meeting the needs of diverse groups.	Build on knowledge collected in the end of life car team annual report to plan Quality improvement, year after year and measure impact.	Team to agree an area of quality improvement following analysis of themes from receiving referrals, lead on the improvement, measure and report outcomes. At least 4 members of the team to complete QSIR by 2025 to pick on one

			element of the new end of Life Care Strategy.
	2.3 Unwavering Commitment To achieve equality in access, provision and responsiveness backed up by local contracts that embed evidenced based measures of equity in provision	Regular attendance at the ICB Place End of Life Care Steering group to ensure contracting is equitable and measures are evidenced based.	Attendance from Supportive Care Team at the ICB place EoL care steering group.
	2.4 Person Centred outcome measurement Independent analysis of a consistent data set to track improvement taken in enabling fair access to care.	The team delivers training on the new Person Centred Care day to include end of life care in the education and development for all staff. This will be held at the AWRC and be for 10 set days over 2023/4. This will include promotion of the individualised plan of care for patients at the end of life.	Independent analysis of person centred outcomes using IPOS
3 Maximising comfort and wellbeing Care is regularly reviewed and every effort is made to have the support, care and treatment that might be needed to help	**3.1 Recognising distress whatever the cause** – this should be done quickly and to assess its extent, cause and what might be done.	The system is in place to recognise and acknowledge physical, psychological, emotional, social or spiritual distress at the end of life	Referral data for the supportive care team is analysed with the main themes and trends identified. These are to be included in the annual report and 6 monthly update, along with the improvement plan for the priority areas.
	3.2 Skilled assessment and symptom management Priorities for care of the dying person – should accord with the priorities	There is a constant approach across all care settings in the locality to anticipatory prescribing	The supportive care team will identify a rolling programme of audit for the inpatient wards, focusing on the quality of care given to end of life care patients.

patients be as comfortable and free from distress as possible.	identified by the Leadership Alliance for the Care of the Dying People		Areas who require improvement are re-audited and an improvement plan made – to be included in the annual report and 6 monthly update.
		A data base of all Trust policies relating to palliative and end of life care is held and reviewed regularly to ensure they are up to date. The breaking bad news policy will be updated to 'breaking significant news'	The supportive care team will review all Trust policies relating to palliative and end of life care and create a data base. Policies that need renewing or writing will be approved in the new End of Life Care Group before publishing.
		There is a clear education plan in place each year, and the education and development delivered by the team is reviewed and reported on. This will include patients with both malignant and non-malignant disease.	There will be an annual Learning Needs Analysis (LNA) each year, prioritised to the themes of distress patients are needing support with. From the LNA, the supportive care team will develop a rolling programme of education for clinicians, including champion roles
	3.3 Specialist Palliative Care – access to specialist palliative care and a clear understanding of how to access medicines and equipment as part of rapidly changing needs.	The Palliative Care Team should be appropriately staffed and the skill mix should be able to meet the needs of complex patients who need rapid assessment and treatment.	Roles and responsibilities within the supportive care team will be confirmed to develop a set of team objectives which will inform the development of individual objectives.
4 Care is coordinated Patients always get the right help at the right time, from the	**4.1 Shared Records** With consent, care records should be shared for all people living with a long term condition to	Road map for the implementation of ReSPECT across Rotherham Place agreed with dates and timescales.	ReSPECT implementation group is formed and ReSPECT process in place across Rotherham by 2025.

right people. Patients have a team around them who know their needs, plans and work together to help achieve them. Patients can always reach someone who will listen and respond at any time of night or day	encompass needs and preferences.		
		Clear identification of those in the last year of life is in place through the use of EPACC's (Electronic palliative Care Coordinating system)	Reporting of EPACCS in annual report and 6 monthly update
	Continuity of partnership Joined up care requires joined up thinking and working by individuals between NHS, Social care and the voluntary sector.	There are active partnerships driving coordinated end of life care across local health, social and voluntary care providers. This includes support for developing community based approaches accessed via social prescribing.	Working closely with the engagement and inclusion lead to continuously improve signposting and support from partners for the benefit of patients – examples to be included in the annual report and the Trust website.
5 All staff are prepared to care Wherever patients are, health and care staff bring empathy, skills and expertise and give me competent, confident and compassionate care	**5.1 Professional Ethos** Ensure people receive the care they need, carers and clinicians will be trained and supported to being a professional ethos to that care	LNA each year to include analysis on education delivered, feedback and internal drivers on themes and trends. Education offer to include End of Life Care champions to spread accreditation to inpatient areas.	Confirm education offer following LNA and promote on new web page. Ensure education is delivered as planned, evaluated and improved with feedback. Re-launch the End of Life Care Champions during Dying Matters Week and develop ward accreditation for areas who release staff to attend training
	5.2 Knowledge based judgement Only well trained, competent and confident staff can bring	Review Learning Needs Analysis (LNA) for staff receiving education on end of life care.	LNA is evaluated each year and renewed based on information gathered.

	professionalism, compassion and skill to the most difficult and intensely delicate physical and psychological caring.		
	5.3 Support and Resilience Provide organisational and professional environments to ensure psychological safety, support and resilience.	Expansion of Professional Nurse Advocate (PNA) Role across TRFT to ensure Restorative Clinical Supervision is available for all staff	Expansion of PNA to 70 RN's to meet the 1 PNA to every 20 RNs by 2025. Annual report on PNA expansion to be delivered to the Board of Directors.
	5.3 Executive governance Clear governance at Board level and environments in which all staff can provide the best of their professionalism and humanity	There is strong and clearly defined leadership for palliative and end of life care across the locality and at regional level	Deputy Chief Nurse to chair the Trust End of Life Care Group and ensure attendance at the ICB Place End of Life Care Strategic Group.
6 Each community is prepared to help Patients live in a community where everybody recognises there is a role to play in supporting each	**6.1 Compassionate and resilient communities** Accelerate public health approaches to people and communities who can give practical help and compassion	Build a dedicated work programme to include promotion of dying well or through the nourishing off compassionate communities.	Create full plan for Dying Matters week each year to continue the education and awareness of EoL care. Increase involvement with local communities in dying matters week. Include in the annual report and 6 monthly update.

other in times of crisis and loss. People are ready, willing and confident to have conversations about living and dying well and to support each other in emotional and practical ways	**6.2 Public Awareness** Those who share our ambition should work to improve public awareness of the difficulties people face and create a better understanding of the help available.	Evidence how to support the promotion of the public discussion around death, dying and bereavement.	Increase public engagement and inclusion with wider and stronger links in the local communities
	6.3 Practical support Local health, care and voluntary organisations should find new ways to give practical support, information and training to enable families, neighbours and community organisations to help	Clear referral process from all key providers to Social Prescribing Link Workers, for all ages	Include all local care and voluntary organisations on Trust web page – promote and update through engagement and inclusion network.
	6.4 Volunteers More should be done locally to recruit, train, value and connect volunteers into more integrated effort to support people, their families and communities	Train and recruit purple butterfly volunteer team for TRFT.	Recruit, train and support Purple Butterfly Volunteers Evaluate themes and trends of support needed to be delivered by Purple Butterfly volunteers to better guide the quality improvement plans for the next year.

References

National Palliative and End of Life Care Partnership (2021) Ambitions for palliative and end of life care. A national framework for local action https://www.england.nhs.uk/eolc/ambitions/

National Institute for Health and Care Excellence (2019) end of life care for adults (NG142) https://www.nice.org.uk/guidance/ng142

National Institute for Health and Care Excellence (2015) Care of dying adults in the last days of life (NG31) https://www.nice.org.uk/guidance/NG31

Board of Directors Meeting
8th September

Agenda item	P135/23
Report	**Integrated Performance Report – July 2023**
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 July 2023 data wherever it is available. It highlights performance against agreed national, local or benchmarked targets. The regular assessment of inequalities of access to care within our elective care portfolio is provided within this report. There are a number of Statistical Process Control (SPC) charts included at the end of this report. A brief explanation of the key elements of the SPC charts is included at the back for reference. Following on from the Internal Audit earlier this year around our Data Quality Assurance, a recommendation was made to include a key to the IPR describing what each of the quadrants in the Kite Mark related to. This is therefore included for information.
Due Diligence	The Finance and Performance, Quality Committee 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.
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 – July 2023

Board of Directors

Integrated Performance Report - July 2023

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 - KPI DQ KEY

Data Quality Key for DQ Icons and Scoring.

S - Sign Off and Validation	Is there a named responsible person apart from the person who produced the report who can sign off the data as a true reflection of the activity? Has the data been checked for validity and consistency?
T - Timely & Complete	Is the data available and up to date at the time someone is attempting to use it to understand the data. Are all the elements of information needed present in the designated data source and no elements of needed information are missing?
A - Audit & Accuracy	Are there processes in place for either external or internal audits of the data and how often do these occur (Annual / One Off)?
R - Robust Systems & Data Capture	Are there robust systems which have been documented according to data dictionary standards for data capture such that it is at a sufficient granular level?

Trust Integrated Performance Dashboard - Operations

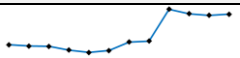
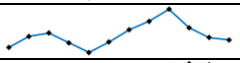
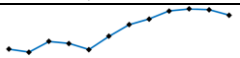
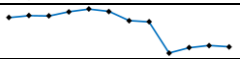
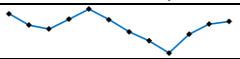
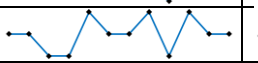
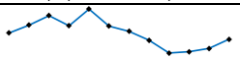
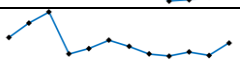
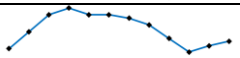
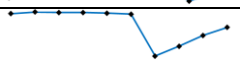
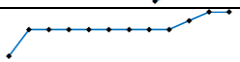
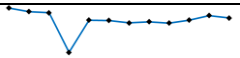
KPI	Reporting Period	Type of Standard	Target 22/23	Benchmark	Previous Month (3)	Previous Month (2)	Previous Month (1)	Current Month	YTD	Same Month Prev. Yr	Trend	Data Quality
Planned Patient Care												
Waiting List Size	Jul 2023	L	**27,400**		28,563	29,158	30,032	31,507	31,507	25,304		
Referral to Treatment (RTT) Performance	Jul 2023	N	**92%**		67.1%	66.4%	64.1%	62.1%	64.8%	73%		
Number of 52+ Weeks	Jul 2023	L	**400**		340	372	363	477	477	151		
Number of 78+ Weeks	Jul 2023	L	**0**		0	0	0	0	0	12		
Number of 65+ Weeks	Jul 2023	L	**60**		27	30	28	24	24	0		
Overdue Follow-Ups	Jul 2023	L	-		14,871	15,100	14,997	15,874	15,874	16,285		
First to follow-up ratio	Jul 2023	B	**2.4**		2.84	2.59	2.56	2.54	2.62	2.31		
Day case rate (%)	Jul 2023	B	**85%**		84.9%	83.4%	84.4%	85.1%	84.4%	86%		
Day case rate (%) - Model Hospital	May 2023	B	**85%**		84.5%	84.8%	83.9%	82.5%	--	78%		
Diagnostic Waiting Times (DM01)	Jul 2023	N	**1%**		4.4%	6.9%	5.7%	5.6%	5.6%	10%		
Diagnostic Activity Levels - for Key Modalities (from Apr 2023)	Jul 2023	L	**8531**		7,391	8,286	8,378	8,020	8,020	8260		
Capped Theatre Utilisation	Jul 2023	L	**85%**		75.4%	77.7%	75.2%	79.6%	79.6%			
Emergency Performance												
Number of Ambulance Handovers > 60 mins	Jul 2023	N	**0**		99	37	88	54	278	186		
Ambulance Handover Times % > 60 mins	Jul 2023	N	**0%**		5.2%	1.9%	4.6%	2.8%	14.4%	10%		
Number of Ambulance Handovers 30+ mins	Jul 2023		-		261	145	231	169	806	461		
Ambulance Handover Times % 30+ mins	Jul 2023	L	**10%**		13.6%	7.3%	12.0%	8.7%	10.4%	26%		
Average Time to Initial Assesment in ED (Mins)	Jul 2023	N	**15**		27	23	25	23	27	26		
4hr Performance in Dept	Jul 2023	N	**60%**		55%	60%	58.0%	63.8%	59.2%			
Proportion of patients spending more than 12 hours in A&E from time of arrival	Jul 2023	L	**2%**		5.9%	3.0%	4.9%	5.0%	4.6%	10%		
Number of 12 hour trolley waits	Jul 2023	N	**0**		0	0	0	0	0	0		
Proportion of same day emergency care	Jul 2023	L	**33%**		43.4%	45.3%	43.9%	44.1%	44.2%	42%		
Cancer Care												
2 Week Wait Cancer Performance	Jun 2023	N	**93%**		86.3%	71.5%	71.3%	81.4%	81.8%	97%		
2 Week Wait Breast Symptoms	Jun 2023	N	**93%**		91.5%	20.0%	40.7%	95.7%	91.1%	95%		
31 day first treatment	Jun 2023	N	**96%**		97.2%	95.7%	90.3%	97.4%	97.7%	93%		
62 Day Performance	Jun 2023	N	**85%**		70.5%	69.1%	56.2%	65.9%	69.1%	72%		
The number of cancer 62-day pathways waiting 63 days or more after an urgent suspected cancer referral	Jul 2023	L	**64**		59	67	52	41	41	-		
28 day faster diagnosis standard	Jun 2023	N	**75%**		77.0%	73.5%	74.6%	72.1%	70.0%	66%		
Inpatient Care												
Mean Length of Stay - Elective (excluding Day Cases)	Jul 2023				2.53	3.08	2.68	2.63	2.74	3.06		
Mean Length of Stay - Non-Elective	Jul 2023				5.55	5.47	5.20	4.90	5.28	5.13		
Length of Stay > 7 days (Snapshot Numbers)	Jul 2023	L	**142**		186	173	162	176	176	235		
Length of Stay > 21 days (Snapshot Numbers)	Jul 2023	L	**68**		54	57	43	69	69	75		
Right to Reside - % not recorded (Internal Performance from May)	Jul 2023	B	**0%**		7.0%	7.8%	6.7%	8.0%	8.0%	7%		
Discharges before 5pm (inc transfers to Dis Lounge)	Jul 2023	L	**70%**		59.7%	60.4%	62.7%	61.3%	61.1%	57%		
Outpatient Care												
Did Not Attend Rate (OutPatients)	Jul 2023	B	**6.2%**		9.6%	8.6%	7.9%	7.4%	8.3%	10%		
% of all Outpatient activity delivered remotely via telephone or video consultation	Jul 2023	N	**25%**		10.9%	12.6%	11.3%	11.6%	11.6%	14%		
Number of patient pathways moved or discharged to PIFU, expressed as a proportion of all outpatient activity.	Jul 2023	N	**5%**		1.8%	2.5%	1.9%	2.2%	2.1%			
Community Care												
MusculoSkeletal Physio <4 weeks	Jul 2023	L	**80%**		26.3%	20.2%	29.1%	23.5%	24.9%	17%		
A&E attendances from Care Homes	Jul 2023	L	**144**		135	124	156	154	154	126		
Admissions from Care Homes	Jul 2023	L	**74**		93	84	101	112	112	84		
Urgent 2 Hour Community Response (one month behind)	May 2023	L	**75%**		82.0%	86.7%	85.8%	82.9%	82.7%	80%		
Numbers of pts on virtual ward	Jul 2023	L	**24**		14	14	23	31	31	0		
Number of patients in month accepted onto virtual ward (Total)	Jul 2023				46	46	68	120	120	0		

The Rotherham NHS
NHS Foundation Trust

Trust Integrated Performance Dashboard - Quality

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
Mortality												
Mortality index - SHMI (Rolling 12 months)	Apr 2023	B	**As Expected**		107.48	107.39	107.79	106.75	--	104.95		
Mortality index - HSMR (Rolling 12 months)	May 2023	B	**As Expected**		98.30	98.87	96.49	93.95	--	100.8		
Number of deaths (crude mortality)	Jul 2023		-		78	72	75	45	270	85		
Infection, Prevention and Control												
Clostridioides-difficile Infections	Jul 2023	L	**2**		4	5	4	2	15	3		
Clostridioides-difficile Infections (rate)	Jul 2023		-		25.8	29.4	30.0	29.3	29.3	19.0		
E.coli blood bactertaemica, hospital acquired	Jul 2023	L	**4**		7	3	3	3	16	6		
P. Aeruginosa (Number)	Jul 2023	L	**1**		0	0	0	0	0	0		
Klebsiella (Number)	Jul 2023	L	**1**		3	1	1	0	5	0		
Patient Safety												
Serious Incidents - one month behind	Jun 2023	L	**0**		2	1	2	4	7	3		
Number of Patient Incidents (including no-harm)	Jul 2023		-		872	906	979	955	3,712	0		
Number of Patient Falls (moderate and above)	Jul 2023		-		0	0	2	3	5	1		
Number of Pressure Ulcers (G3 and above) - one month behind	Jun 2023		-		1	0	0	1	1	2		
Medication Incidents	Jul 2023		-		105	99	100	96	400	111		
Readmission Rates (one month behind) - NE - excluding D/Cs	Jun 2023		-		11.2%	11.1%	10.9%	11.2%	10.6%	12.1%		
Venous Thromboembolism (VTE) Risk Assessment	Jul 2023	N	**95.0%**		95.1%	94.7%	94.7%	94.9%	94.8%	95.8%		
Hip Fracture Best Compliance	Jul 2023	L	**65.0%**		45.0%	52.6%	58.6%	76.0%	76.0%	47.1%		
Patient Experience												
Number of complaints per 10,000 patient contacts	Jul 2023	L	**8**		12.03	7.63	10.49	6.34	9.05	10.77		
F&F Postive Score - Inpatients & Day Cases	Jul 2023	N	**95.0%**		98.5%	97.2%	97.7%	98.6%	98.0%	97.1%		
F&F Postive Score - Outpatients	Jul 2023	N	**95.0%**		98.4%	96.6%	98.1%	98.5%	97.9%	98.0%		
F&F Postive Score - Maternity	Jul 2023	N	**95.0%**		100.0%	100.0%	100.0%	96.6%	99.4%	96.5%		
Care Hours per Patient Day	Jul 2023	L	**7.3**		7.10	8.00	7.40	7.30	7.30	6.3		
Maternity												
Bookings by 12 Week 6 Days	Jul 2023	N	**90.0%**		93.2%	89.1%	93.2%	92.5%	91.9%	92.2%		
Babies with a first feed of breast milk (percent)	Jul 2023	N	**70.0%**		58.9%	59.9%	60.6%	63.6%	60.8%	53.9%		
Stillbirth Rate per 1000 live births (Rolling 12 months)	Jul 2023	L	**4.66**		2.79	2.75	2.71	2.72	2.72	1.95		
1:1 care in labour - One month behind	Jun 2023	L	**75.0%**		100.0%	100.0%	99.1%	97.3%	95.5%	97.4%		
Serious Incidents (Maternity) - One month behind	Jun 2023	L	**0**		0	0	0	0	2	0		
Moderate and above Incidents (Harm Free) - One month behind	Jun 2023		-		0	0	0	0	0	0		
Consultants on labour (Hours on Ward)	Jul 2023		-		62.50	62.50	62.50	62.50	62.50	--		

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	Jul 2023	L	**-285**		-209.96	-237.02	-246.98	-240.37	-240.37	-381.85		
Whole Time Equivalent plan - Nursing	Jul 2023	L	**-98**		-54.89	-72.39	-81.64	-84.00	-84.00	-64.80		
Total Headcount	Jul 2023		-		5,033	5,038	5,036	5,023	5,023	4,955		
Vacancy Rate - TOTAL	Jul 2023	L	**6.40%**		5.31%	5.94%	6.18%	6.02%	6.02%	8.51%		
Vacancy Rate - Nursing	Jul 2023	L	**7.30%**		4.09%	5.34%	6.02%	6.19%	6.19%	4.79%		
Time to Recruit	Jul 2023	L	**34**		35	37	36	36	36	34		
Sickness Rates (%) - inc COVID related	Jul 2023	L	**4.50%**		4.79%	4.88%	5.09%	5.71%	6.00%	7.41%		
Turnover	Jul 2023		**0.63%**		0.71%	0.77%	0.72%	0.90%	0.90%	1.21%		
Appraisals complete (% 12 month rolling)	Jul 2023	L	**90.00%**		77%	73%	75%	76%	76%	72.00%		
Appraisals Season Rates (%)	Jul 2023	L	**90.00%**		8%	25%	44%	58%	58%	50.00%		
MAST (% of staff up to date)	Jul 2023	L	**85.00%**		92%	93%	94%	94%	94%	91.00%		
% of jobs advertised as flexible	Jul 2023		-		64.47%	71.01%	81.16%	75.68%	72.92%	-		

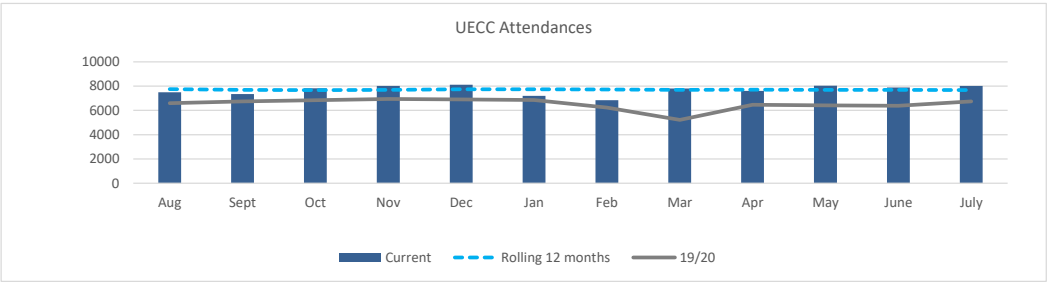
The Rotherham NHS
NHS Foundation Trust

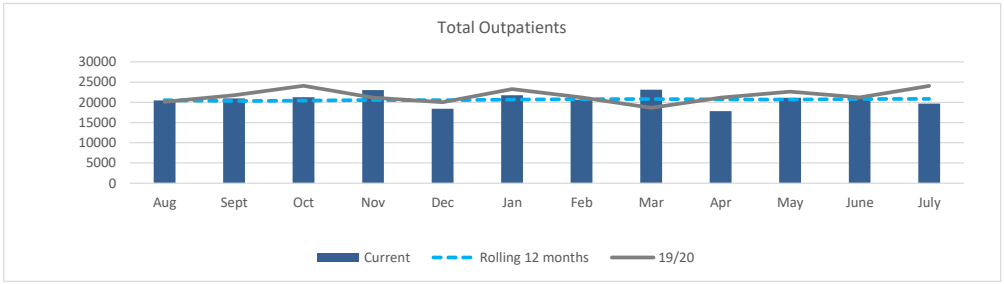
Trust Integrated Performance Dashboard - Finance

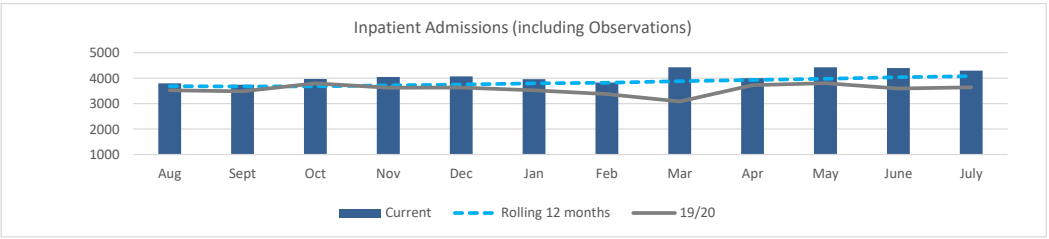
Apr 23 - July 23

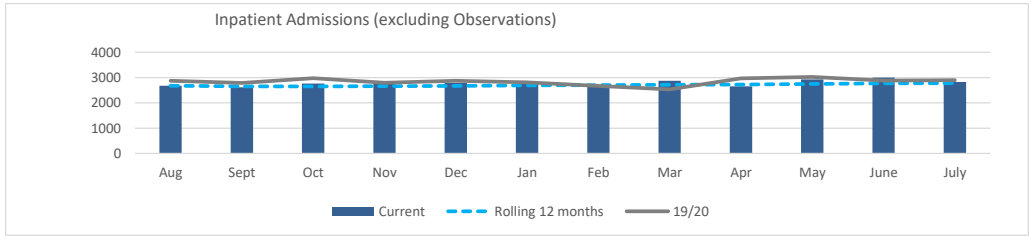
	In Month Plan £000s	In Month Actual £000s	In Month Variance £000s	YTD Plan £000s	YTD Actual £000s	YTD Variance £000s	Forecast V £000s
I&E Performance (Actual)	(627)	(1,079)	(452)	(2,767)	(4,085)	(1,319)	(6,092)
I&E Performance (Control Total)	(565)	(1,016)	(452)	(2,517)	(3,836)	(1,319)	(6,092)
iciency Programme (CIP) - Risk Adjusted	930	441	(489)	3,216	1,225	(1,991)	(5,586)
Capital Expenditure	767	363	398	399	854	2,545	0
Cash Balance	(795)	614	1,412	21,207	18,576	(2,631)	(241)

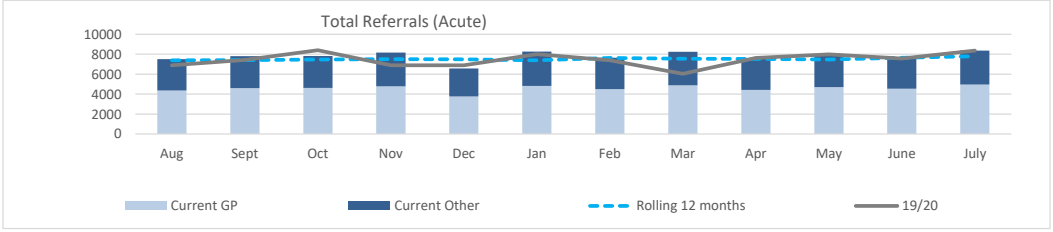
Trust Integrated Performance Dashboard - Activity

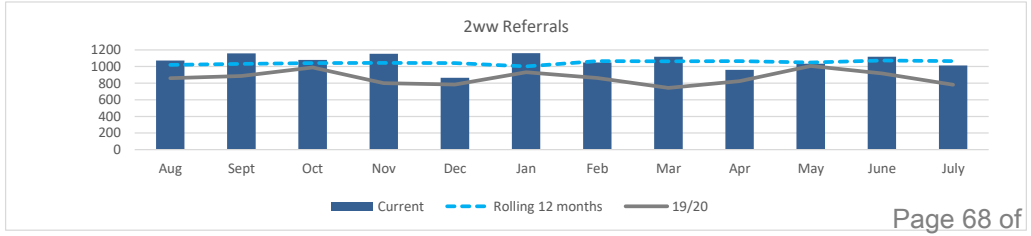












Trust Integrated Performance Dashboard - Activity

ACTIVITY

OUTPATIENTS			
	Activity 19/20	Activity 23/24	As % of 2019/20 WDA
July	24,732	19,866	**88%**
YTD monthly average	22,876	19,864	**90%**

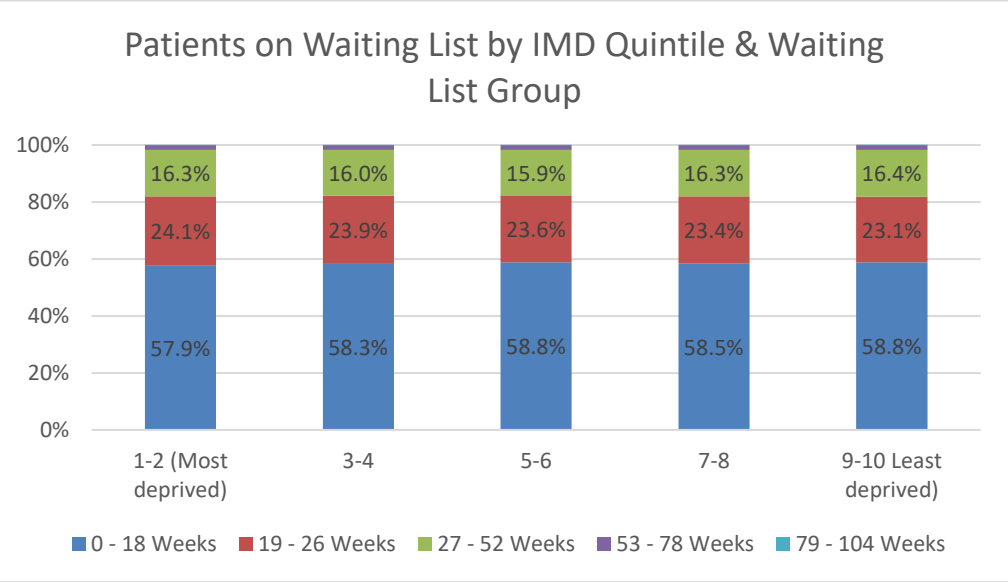
DAYCASES			
	Activity 19/20	Activity 23/24	As % of 2019/20 WDA
July	2,416	1,982	**90%**
YTD monthly average	2,232	1,885	**88%**

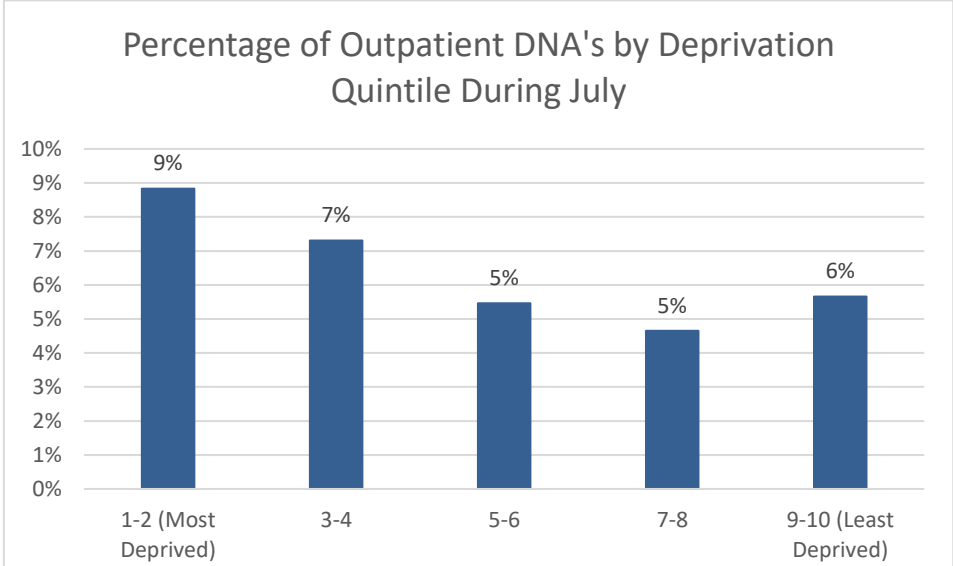
ELECTIVE ACTIVITY			
	Activity 19/20	Activity 23/24	As % of 2019/20 WDA
July	425	309	**80%**
YTD monthly average	415	341	**85%**

Trust Integrated Performance Dashboard - Health Inequalities

RTT Snapshot 30/07/23

IMD Quintile	Patients on Waiting List	Median Wait (Wks)	% of All RTT Patients	% of Rotherham Poulation	% Proportion Difference to Rotherham Population
1-2	9753	13	37.5%	36.0%	1.5%
3-4	6082	13	23.4%	23.2%	0.2%
5-6	3995	13	15.4%	15.2%	0.1%
7-8	4742	12	18.2%	19.5%	-1.3%
9-10	1454	13	5.6%	6.0%	-0.4%
Total	**25999**	**13**	**100.0%**	**100.0%**	**0.0%**





Safer Staffing

Trust Wide Scorecard Rolling 12 Months & Year End position 21/22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
Daily staffing -actual trained staff v planned (Days)	81.92%	83.54%	82.43%	83.69%	84.87%	87.47%	82.86%	84.14%	84.80%	88.00%	91.00%	90.00%	89.00%
Daily staffing -actual trained staff v planned (Nights)	81.28%	84.30%	90.41%	86.89%	83.94%	84.53%	84.97%	88.28%	90.92%	94.00%	98.00%	95.00%	92.00%
Daily staffing - actual HCA v planned (Days)	80.37%	83.13%	83.46%	86.96%	82.06%	81.44%	84.32%	81.81%	80.00%	85.00%	90.00%	89.00%	90.00%
Daily staffing - actual HCA v planned (Nights)	81.54%	83.77%	89.86%	93.64%	90.73%	85.46%	94.75%	92.02%	90.00%	94.00%	97.00%	102.00%	102.00%
Care Hours per Patient per Day (CHPPD)	6.3	6.0	6.3	6.2	6.3	6.4	6.4	6.4	6.5	7.1	8.0	7.4	7.3

Key: < 85% 85-89% >=90%

Statistical Process Control Charts
Fact Sheet

The Rotherham
NHS Foundation Trust

Perform	Assure	Description
H	F	Special cause of a concerning nature where the measure is significantly **HIGHER**. This occurs where there is higher pressure in the system or deteriorating performance. This system is not capable. It will **FAIL** the target without system change.
H	P	Special cause of a concerning nature where the measure is significantly **HIGHER**. This occurs where there is higher pressure in the system or worse performance. However despite deterioration the system is capable and will consistently **PASS** the target.
H	?	Special cause of a concerning nature where the measure is significantly **HIGHER**. This occurs where there is higher pressure in the system or worse performance. This system will not consistently hit or miss the target. (This occurs when target lies between process limits).
L	F	Special cause of a concerning nature where the measure is significantly **LOWER**. This occurs where there is deteriorating performance. This system is not capable. It will **FAIL** the target without system change.
L	P	Special cause of a concerning nature where the measure is significantly **LOWER**. This occurs where there is deteriorating performance. However the system is capable and will consistently **PASS** the target.
L	?	Special cause of a concerning nature where the measure is significantly **LOWER**. This system will not consistently hit or miss the target. (This occurs when target lies between process limits).
	F	Common cause variation, no significant change. This system is not reliably capable. It will **FAIL** to consistently meet target without system change.
	P	Common cause variation, no significant change. The system is capable and will consistently **PASS** the target.
	?	Common cause variation, no significant change. This system will not consistently hit or miss the target. (This occurs when target lies between process limits).
H	F	Special cause of an improving nature where the measure is significantly **HIGHER**. This occurs where there improving performance. However the system is still not capable. It will **FAIL** the target without system change.
H	P	Special cause of an improving nature where the measure is significantly **HIGHER**. This occurs where there is improving performance. The system is capable and will consistently **PASS** the target.
H	?	Special cause of an improving nature where the measure is significantly **HIGHER**. This occurs where there improving performance. This system will not consistently hit or miss the target. (This occurs when target lies between process limits).
L	F	Special cause of an improving nature where the measure is significantly **LOWER** This occurs where there improving performance. However the system is still not capable. It will **FAIL** the target without system change.
L	P	Special cause of an improving nature where the measure is significantly **LOWER**. This occurs where there is improving performance. The system is capable and will consistently **PASS** the target.
L	?	Special cause of an improving nature where the measure is significantly **LOWER**. This occurs where there improving performance. This system will not consistently hit or miss the target. (This occurs when target lies between process limits).

Arrows show direction of travel. Up is Good, Down is Good

SPC Rules

A single point outside the control limits

Whenever a data point falls outside a process limit (upper or lower) something unexpected has happened because we know that 99% of data should fall within the process limits.

Consecutive points above or below the mean line

A run of values above or below the average (mean) line represents a trend that should not result from natural variation into the system

Consecutive points increasing or decreasing

A run of values showing continuous increase or decrease is a sign that something unusual is happening in the system.

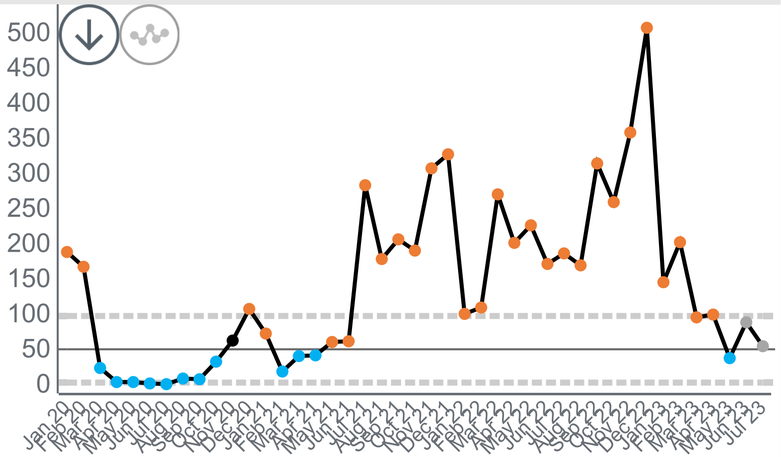
Two out of three points close to the process limits

A pattern of two points in any three consecutive points close (in the outer third to the process limits.

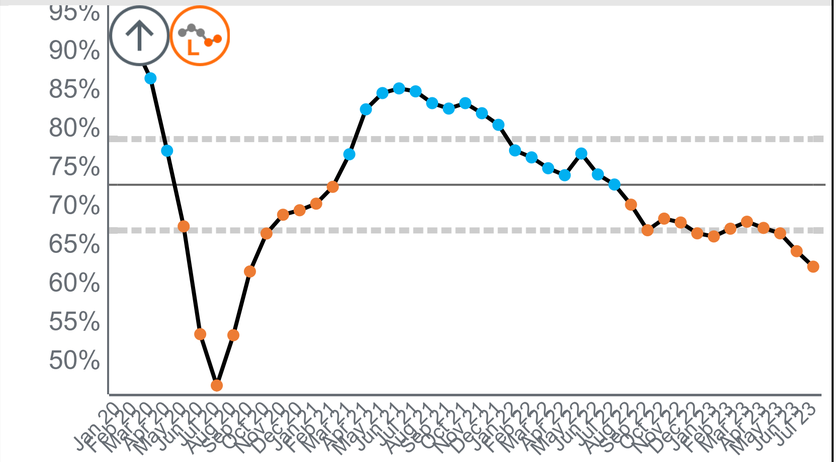
Statistical Process Control Charts
Operational Performance Page 1

The Rotherham
NHS Foundation Trust

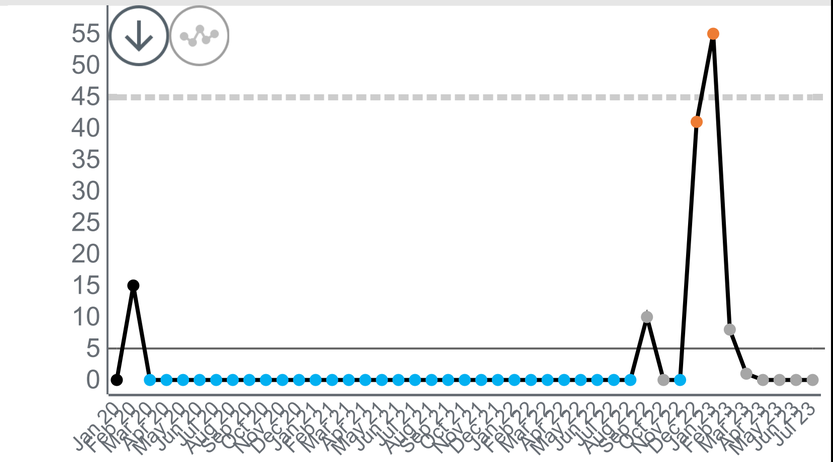
Ambulance Handovers by Date



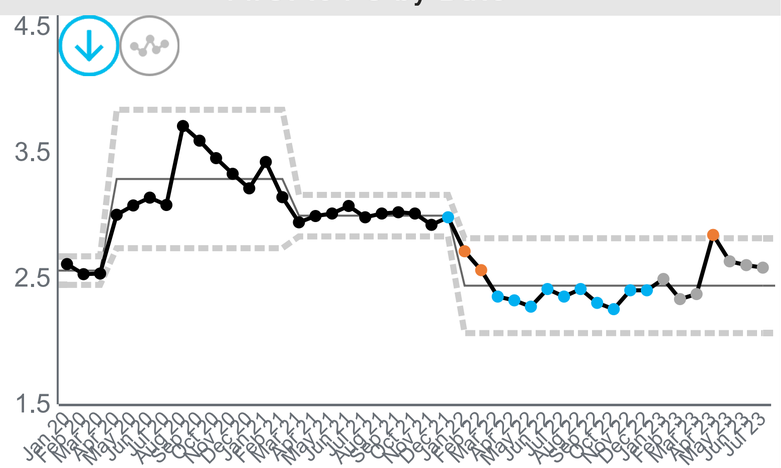
RTT by Date



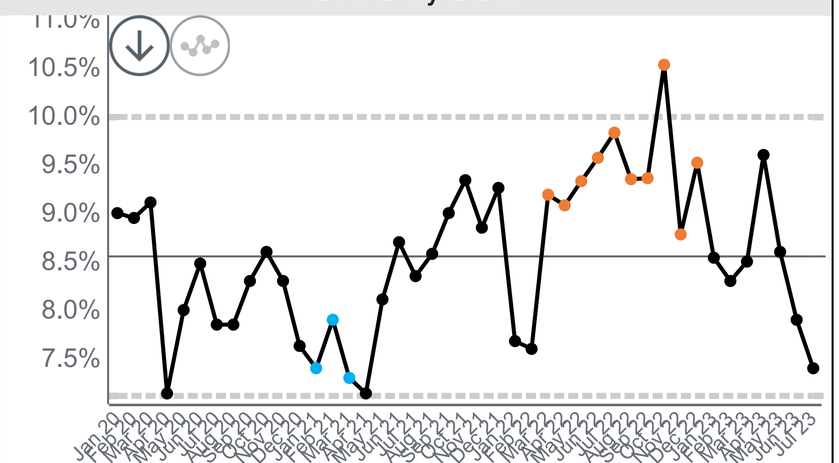
12hr Trolley Waits by Date



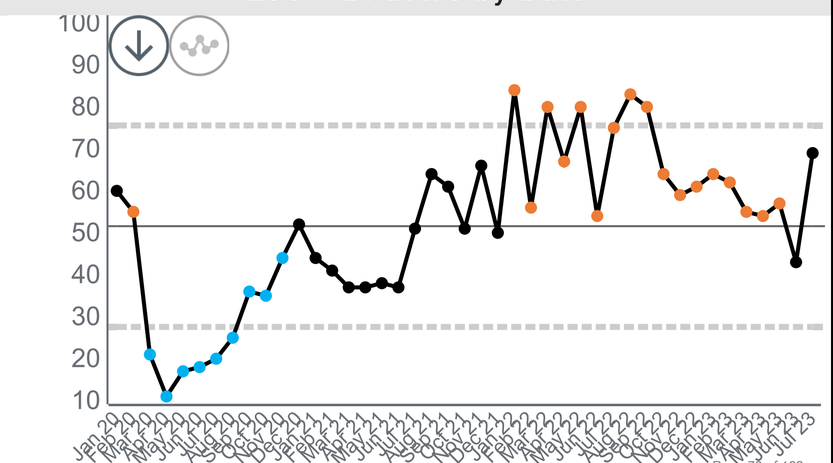
First to FU by Date



DNAs by Date



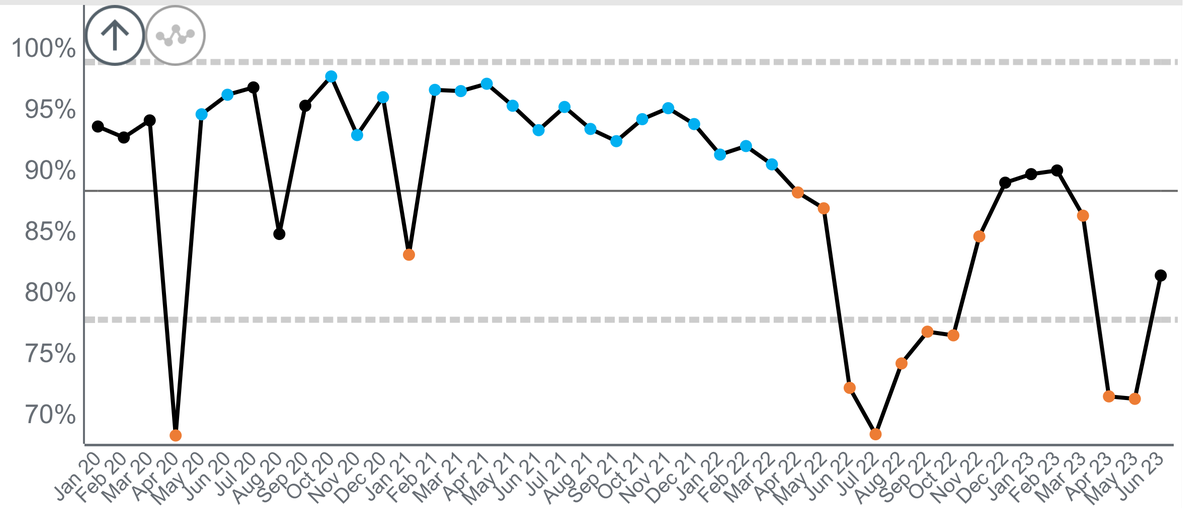
LOS > 21 DAYS by Date



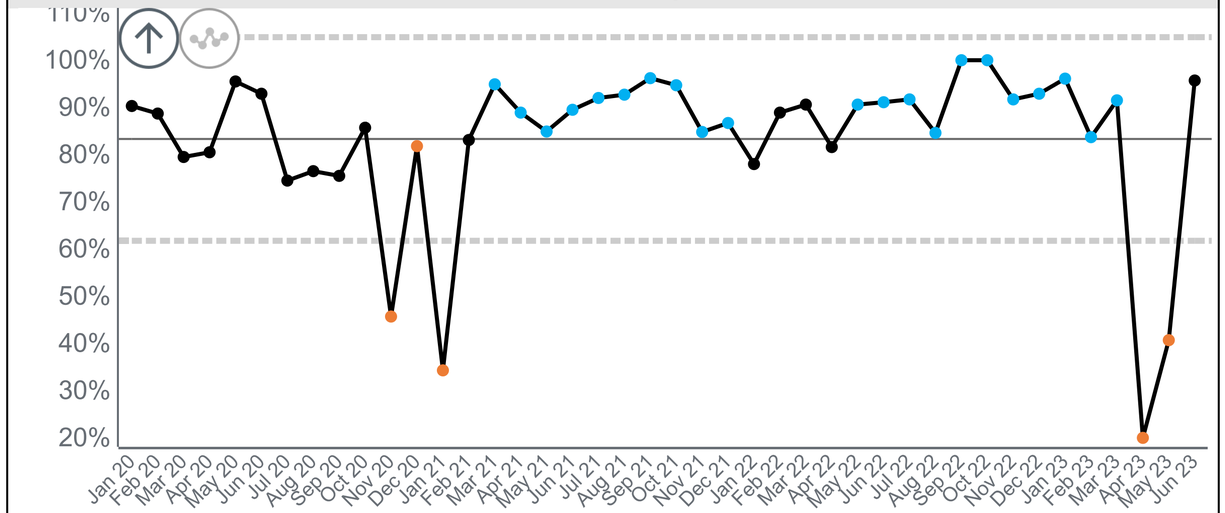
Statistical Process Control Charts
Operational Performance Page 2

The Rotherham NHS Foundation Trust

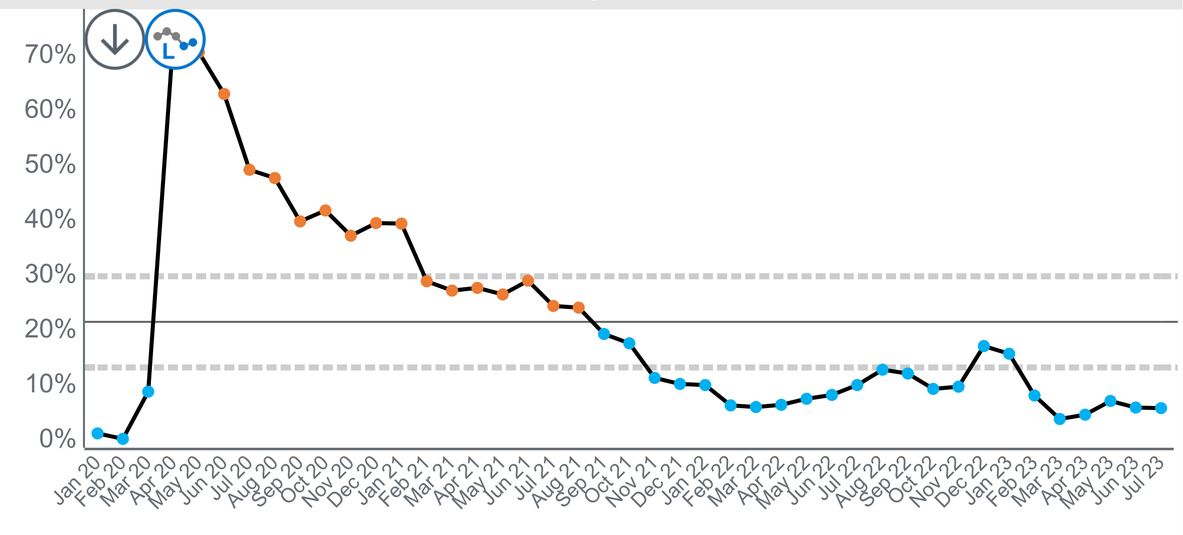
Cancer 2ww by Date



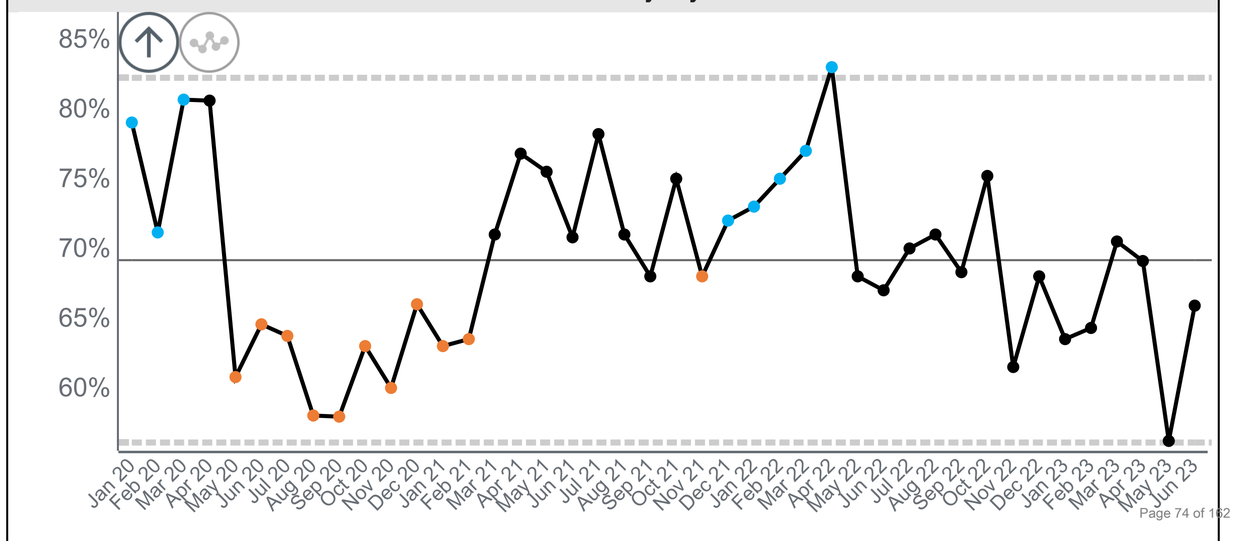
Breast 2ww by Date



DM01 by Date



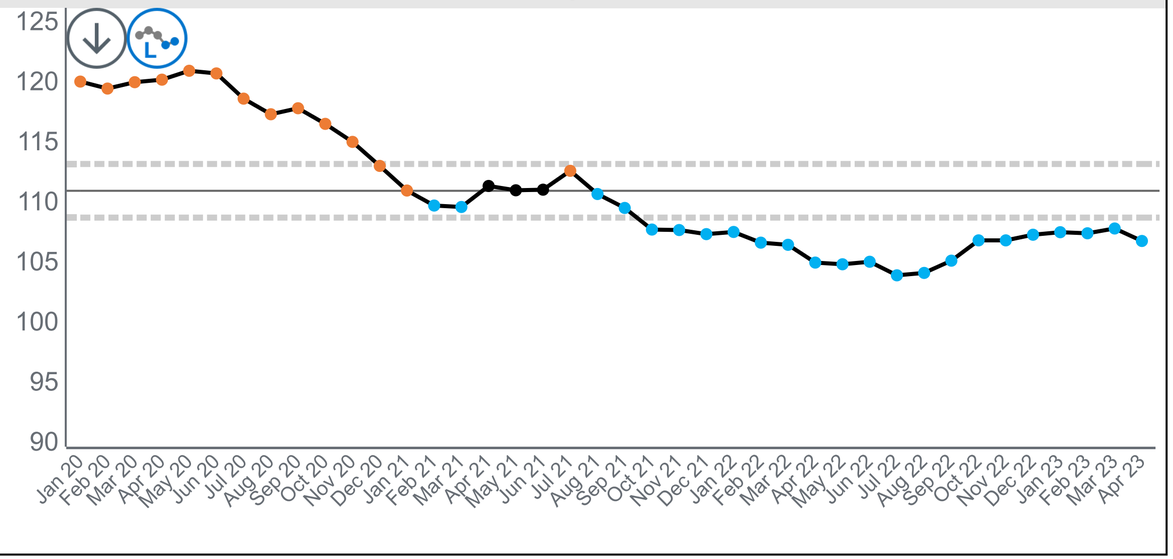
Cancer 62 day by Date



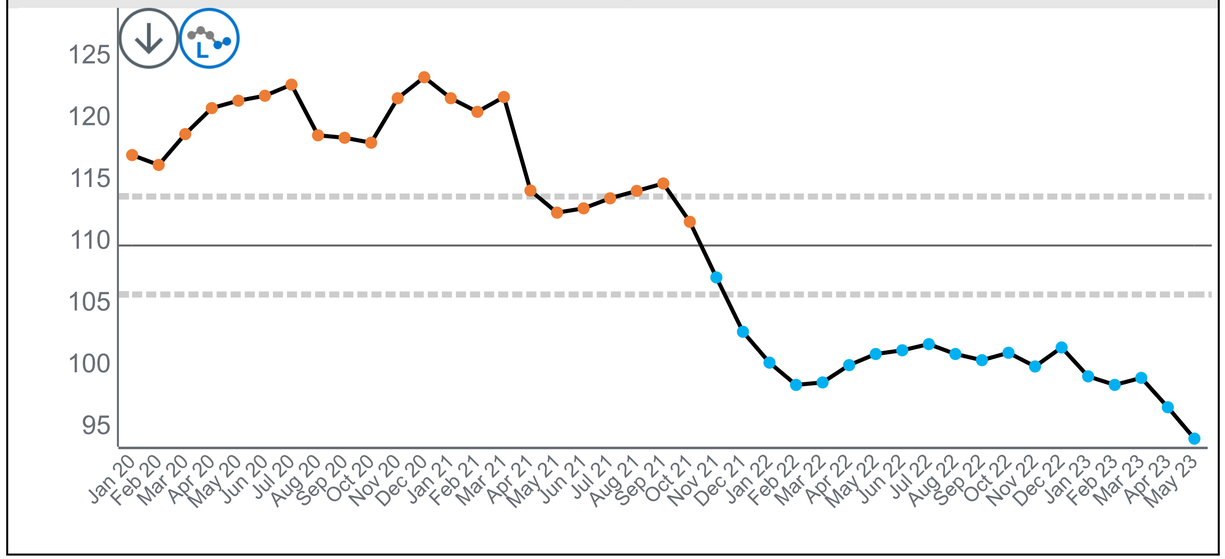
Statistical Process Control Charts
Quality Performance Page 1

The Rotherham NHS Foundation Trust

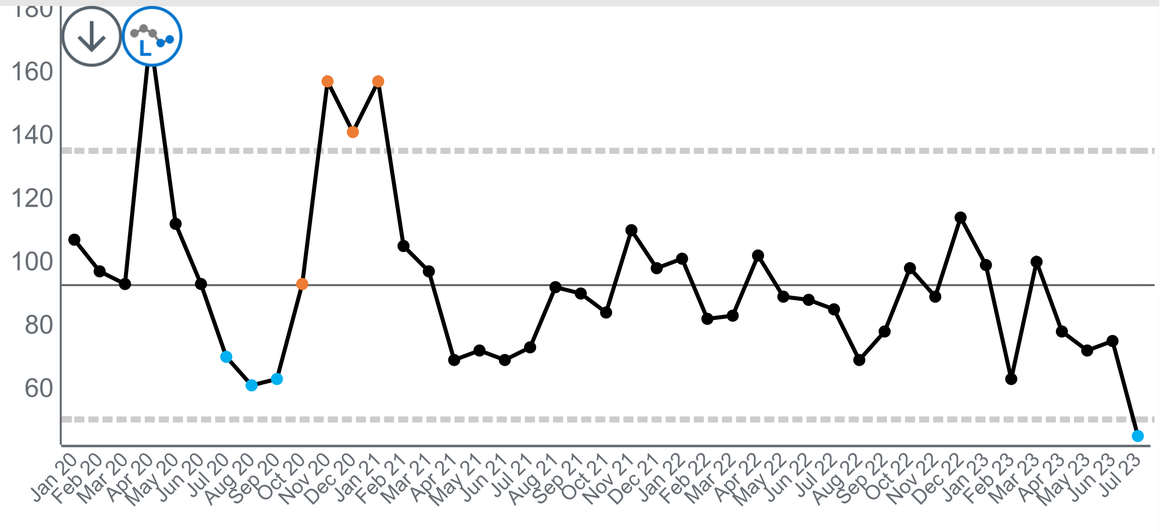
SHMI by Date



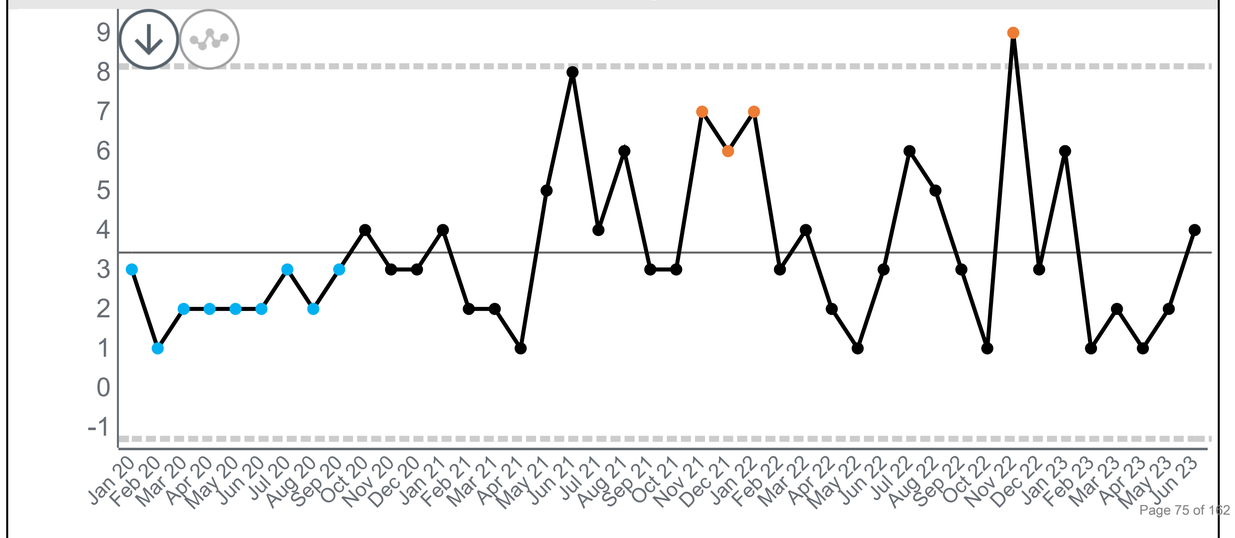
HSMR by Date



Crude Mortality by Date



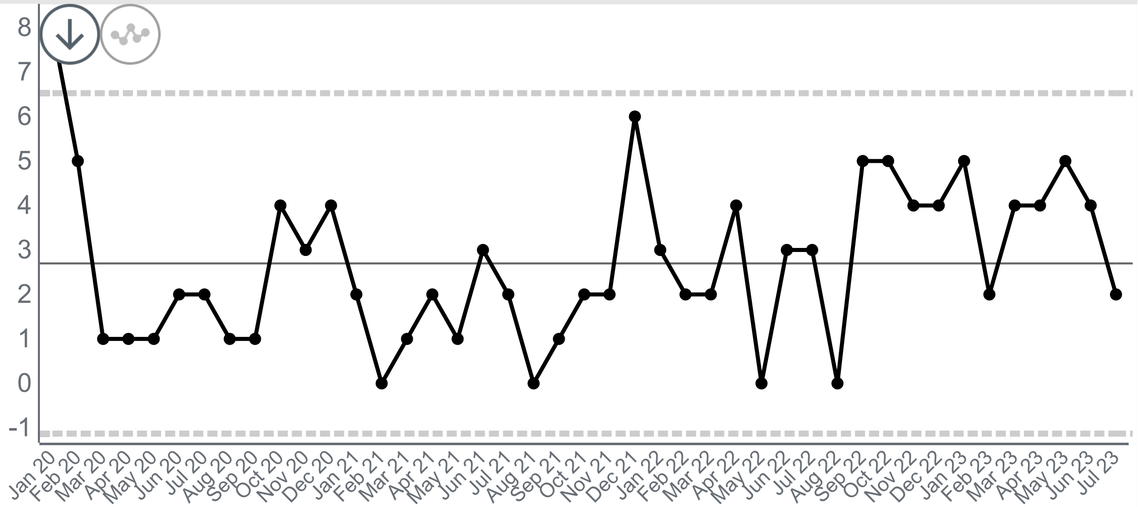
Incidents by Date



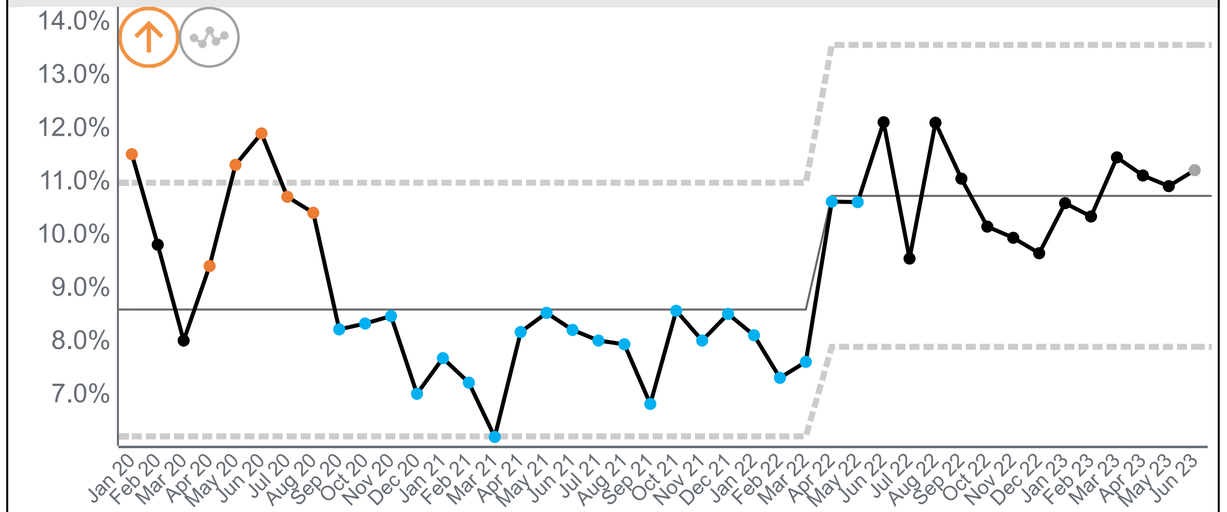
Statistical Process Control Charts
Quality Performance Page 2

The Rotherham NHS Foundation Trust

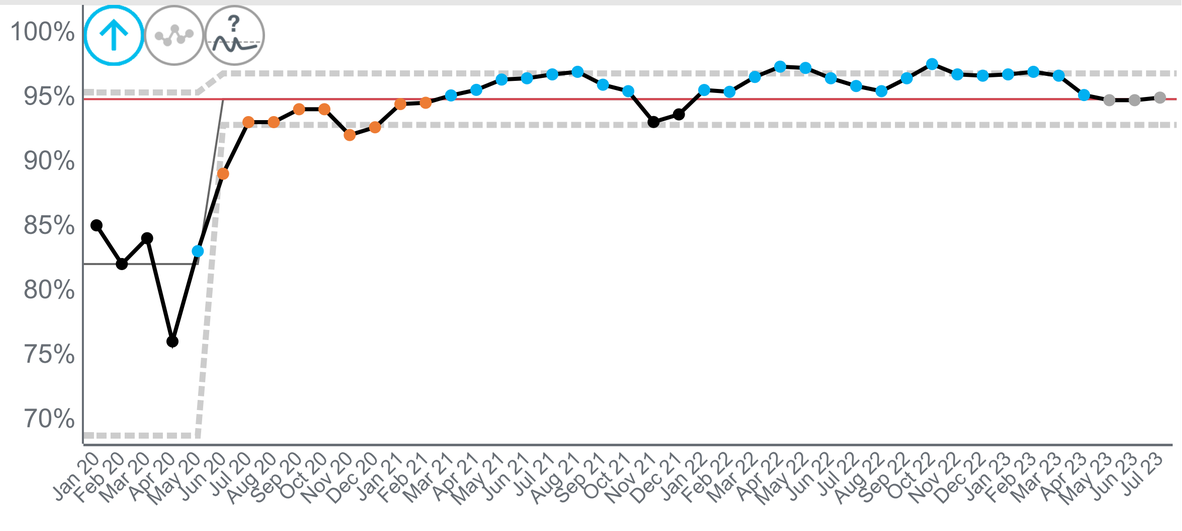
Clostridium-difficile Infections by Date



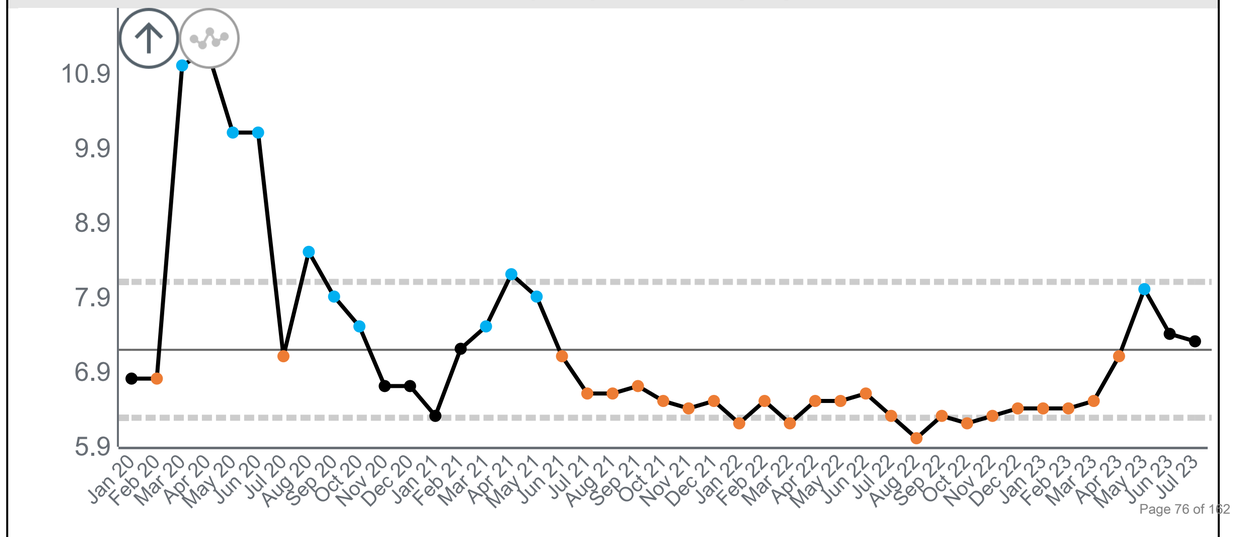
Readmissions by Date



VTE and First VTE Target by Date



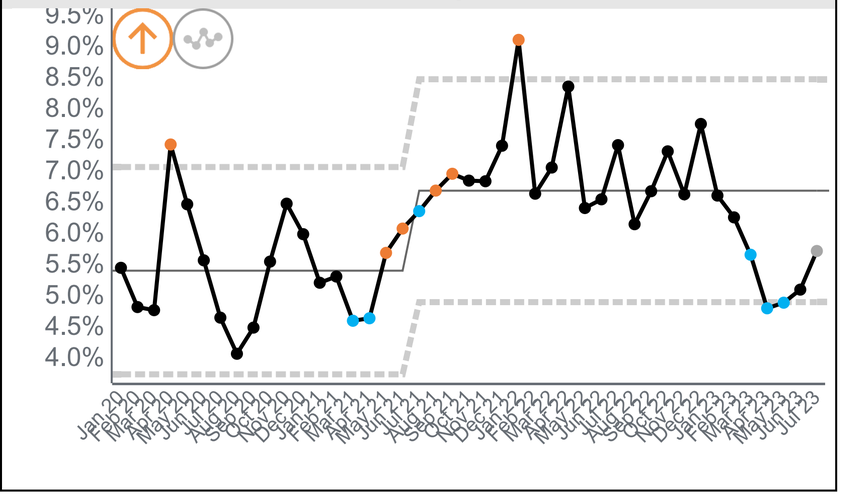
Care hours per patient day by Date



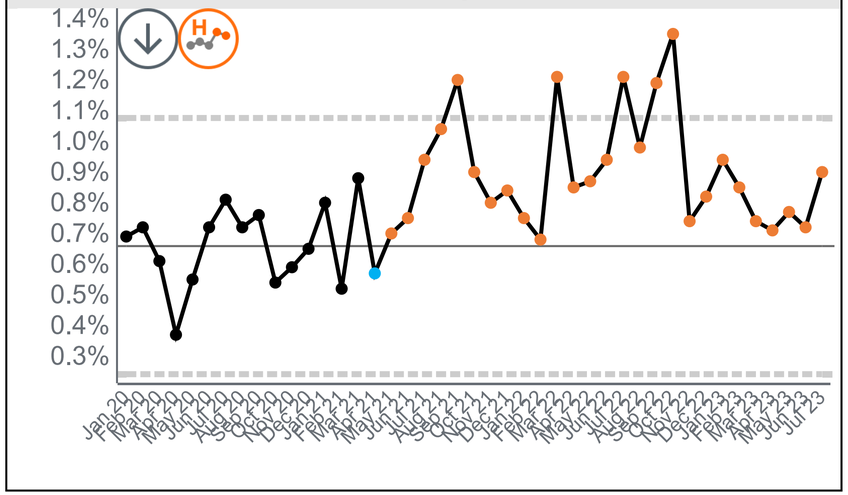
Statistical Process Control Charts
Workforce Performance Page 1

The Rotherham NHS Foundation Trust

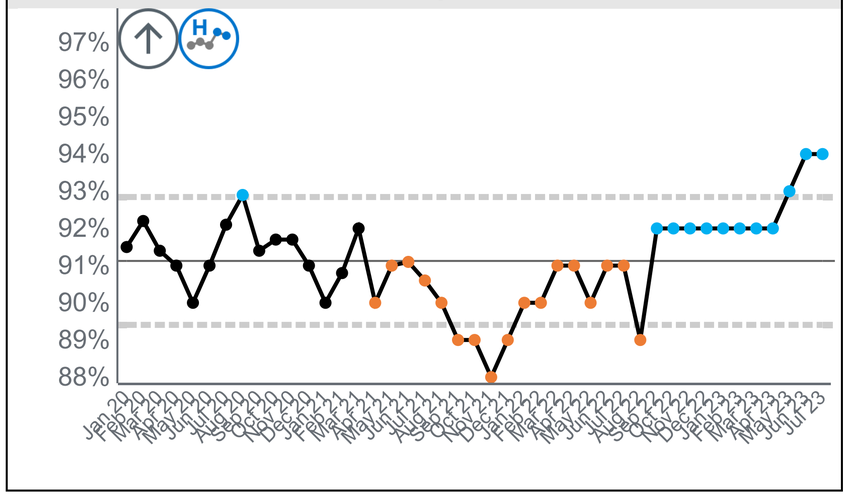
Sickness by Date



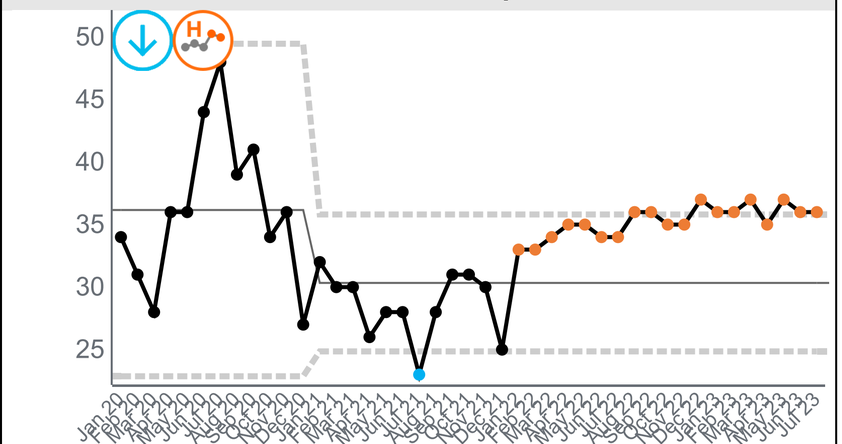
Turnover by Date



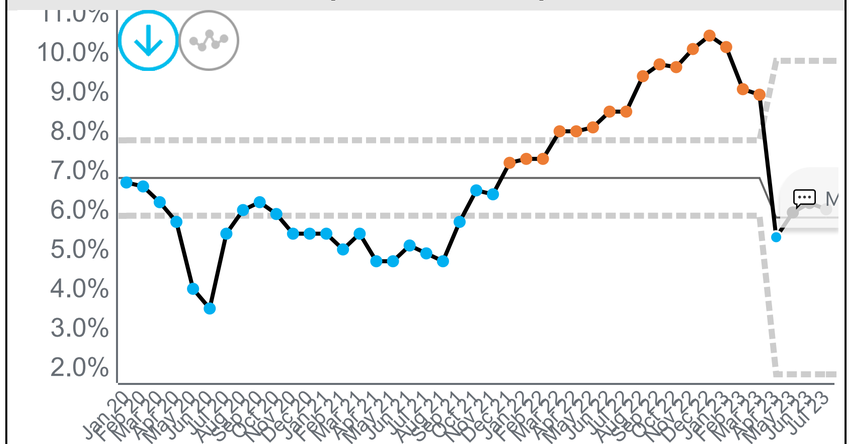
MAST by Date



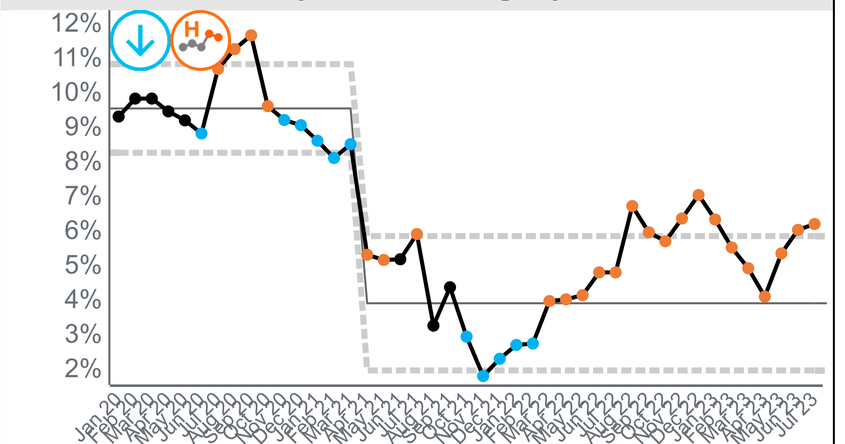
Time to Recruit by Date



Vacancy rate (total) by Date



Vacancy rate (nursing) by Date



Integrated Performance Report Commentary

OPERATIONAL PERFORMANCE

Urgent & Emergency Care and Flow

- Long length-of-stay (21+ day) patients have increased this month, missing target for the first time in several months. This has historically been highly variable so additional attention should be paid to this measure if there continues to be high numbers of long length-of-stay patients. Meetings with system partners continue to take place to allow the escalation of problems and co-ordinate targeted action to address any issues.
- The proportion of ambulances exceeding a one-hour handover has fluctuated over the period, being close to 5% for April and June, and below 2% in May. Performance on this measure has been on a trend of improvement although it does continue to be above target. Despite this, in the most recent available data the Trust is in the top quartile for ambulance handovers within 15 minutes of arrival at 64% (Source: SEDIT). The proportion of patients waiting over 12 hours in A&E increased in July to 5%, stalling a trend of improvement. The Trust is continuing to work toward this eventuality being all-but-eliminated in 2023/24 with the reintroduction of the 4-hour standard.
- This performance continues to show the slight reduction in non-elective pressure experienced in the Trust in recent months, which is due to ongoing work supporting improved flow through the Trust and across placed despite demand at the front door remaining high. The SDEC model has played a key role in streaming patients to an appropriate setting within the Trust or elsewhere and improved our ability to effectively manage the significant demands on our services. There continues to be higher numbers of patients with increased acuity who require additional support.

Elective Care

- The waiting list has begun to grow rapidly with a 10% increase in May 2023 compared to February 2023. There continues to be sustained pressure from high levels of referrals which has contributed to this increase in the waiting list. Medical specialties continue to be the main recipients of this additional demand, although there is ongoing pressure across non-elective emergency and trauma activity which has a significant impact on elective capacity.

- Activity continues to run below the 103% target, achieving 80% of 19/20 for Outpatients and 90% of 19/20 for Daycases, with Outpatients now dropping below the YTD average. There were two periods of industrial action in July, including the first such period involving Consultant colleagues. This led to the majority of our elective activity being cancelled, with only 2 elective theatre lists in obstetrics staffed by our Anaesthetic consultants in total across the two days, and 2 lists staffed by an insourced Anaesthetist. All other activity was cancelled or delivered via local anaesthetic.
- Ongoing industrial action is being managed with the main aim being to reduce its impact on our patients, and to ensure patient safety throughout. However, this has inevitably impacted on capacity, although rigorous planning has reduced the extent of this reduction with the junior doctor industrial action in particular.
- A continuing decline in the RTT position is sitting alongside a growing waiting list, with challenges in increasing capacity to meet this demand leaving the RTT position now at its lowest point since September 2020.
- These challenges have contributed to a significant increase in 52+ week waiters, although the growth in 65+ week waiters has been halted. The Trust continues to collaborate across the region to deliver the national expectation around long-waiters 2023/24.

Cancer

- After several challenging months, performance in cancer has shown some signs of recovery, although in many areas it continues to under-deliver against the national constitutional standards. NHS England are expected to announce changes to national cancer standards in August 2023, with an expectation around a reduction in the numbers of standards as well as increased focus on the Faster Diagnosis Standard (FDS).
- Performance against the Faster Diagnosis Standard (FDS) continues to be variable, only being achieved in April 2023. Whilst the target is still not being consistently met, performance is still improved compared to historical data. The main tumour sites where we are struggling to achieve the standard are Colorectal, Upper GI, Skin and Urology (Prostate). However, the latest unvalidated data shows a significant improvement across a number of these areas for July and August to date. Targeted operational huddles have been introduced to try to ensure clear communication and escalation of patients potentially breaching the 28 day standard, which has already proved effective in minimising unnecessary breaches in particular.

QUALITY SUMMARY

Mortality

- The latest mortality data has now been updated to April and May 2023 for the SHMI and the HSMR respectively. As per the previous position, the HSMR is currently within the 'as expected' category. The in-month HSMR for May 2023 was 88.15, which is statistically within the 'as expected' band. If the national HSMR values are ranked (lowest to highest) the Trust's HSMR is 48th of 122 acute, non-specialist NHS providers with the Trust being 1st out of the 4 regional acute non-specialist NHS providers.
- The SHMI has remained stable at 106.8 (data for April 2023). The coding team continue to improve the accuracy of the coding but we have seen a drop-off in depth of coding since September 2022 when we were no longer able to code previously-coded co-morbidities. Further work is underway to better understand where the most significant changes have occurred, and engagement with clinicians continues to identify opportunities to improve our depth of coding.
- There were no diagnosis groups that were reported as 'higher than expected'.
- Crude mortality was 1.5% over the period, compared to 1.4% regional average (acute, non-specialist Trusts).

Patient Safety

- There were 4 incidents deemed to be severe or above in July, which is an increase on the previous three months but there are no themes of concern within the recent figures. All SIs are investigated via the Harm Free Care Panel, with actions implemented to ensure appropriate learning is shared and mitigating actions put in place.
  A complaint level of 6.34 in July 2023 is the lowest seen in several months despite challenges around activity. That said, there is ongoing fluctuations in the number of complaints per month due to the low absolute volumes. The long-term trend is one of improvement with fewer complaints a month on average compared to the previous quarter.
- Care Hours per Patient Day has achieved target in three out of the four months in this period, continuing a trend of improvement. This shows the ongoing impact of the improved staffing position across the Trust, with the Safer Staffing assessment showing three of the four assessed areas at over 90% planned levels.

WORKFORCE SUMMARY

Retention and Recruitment

- The Trust welcomed 67 (52.08 WTE) new starters for the month of June 2023. 10 (7.66 WTE) were qualified nursing & midwifery staff and 18 (14.42 WTE) were Nursing Support colleagues.
- June 2023 saw a slight decrease in voluntary leavers (29.13 WTE) compared with the previous month (31.06 WTE) and a decrease of 12.87 WTE against June 2022. Further analysis shows that of the 36 voluntary leavers for June 2023, 26 (21.91 WTE) had less than 5 years' service with TRFT, 9 (8.16 WTE) of which were in the nursing and midwifery staff group and 5 (4.41 WTE) were in the additional clinical services staff group. The highest leaving reason for the month of June 2023 was relocation (10.40 WTE) followed by other/not known (5.40 WTE).

Attendance

- Monthly sickness absence rate for the month of June 2023 increased by 0.21%. The increase in the overall sickness rate was driven by short term sickness (1.70%), a 0.11% increase when compared with previous month.
- Sickness absence at the Trust continues to be relatively high, being in the bottom quartile of trusts.
- Medicine continues to have the highest sickness absence for the fifth consecutive month (6.06%), a 0.06% reduction on previous month (6.12%).
- 12 month rolling sickness absence for June 2023 was 6.13%

Appraisals and Mandatory Training

- Overall appraisal (rolling 12 months) compliance for the month of June 2023 was 75% which is an 1.60% increase when compared to June 2022. Rolling 12-month compliance increased by 1.43% when compared with previous month.
- All divisions remain below the 90% target for rolling 12-month appraisal rate.

Board of Directors
08 September 2023

The Rotherham NHS Foundation Trust

Agenda item	**P136/23**
Report	**Operational Update**
Executive Lead	Sally Kilgariff, Chief Operating Officer
Link with the BAF	OP3: robust service configuration across the system will not progress and deliver seamless end to end patient care across the system D5: we will not deliver safe and excellent performance
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 Trust's performance against key operational performance metrics along with a high level update on the key operational issues, as at the end of July 2023. The attached summary shows the position against each of the key operational indicators which NHS England and the ICB are using to monitor the performance of the Trust as part of their Board Assurance Framework. The Finance and Performance committee have received a more detailed update on each of these, along with the actions we are taking to improve our performance and ensure delivery of the year-end targets. The main headlines: • The Trust operated at OPEL level 2/3 throughout the month of July 2023. Whilst operational pressures were increased, the Trust improved 4 hour performance and handover times on the previous month. • Junior Doctors took industrial action for a 5-day period from 13 to 18 August 2023. • Consultants also took industrial action for a 48-hour period on the 20 and 21 August 2023 • The transfer of the neuro-rehabilitation service to the Rotherham, Doncaster and South Humber NHS Foundation Trust (RDASH) has taken place with the service transferring over on the 1st August 2023. • Winter planning is well under way, taking into account national requirements.

	The Trust has received a number of national letters which have been included within the reading pane within Convene. The national letters were discussed at Finance and Performance Committee on the 28 August 2023. The correspondence received is: • National changes to Cancer Waiting Times standards from 1 October 2023. • National request to look at Outpatient Transformation in order to expand elective capacity. • Delivering Operational Resilience across the NHS this Winter.
Due Diligence	This report is a high level of summary of the more detailed operational update that has been discussed at The Finance and Performance Committee in July and August, with key escalations covered by the Chair's log.
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	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 Report 2. Summary of Performance against National Key Metrics

Operational Update Report – July 2023

1.0 Operational Pressures Escalation Level (OPEL) & Urgent Care

The Trust saw more heightened operational pressures throughout the month of July. Predominately operating at OPEL Level 2 but at times the Trust did reach OPEL Level 3. This was mainly after the Junior Doctor strike action. There were spikes in demand which saw period of inpatients being supported in the medical Same Day Emergency Care area (SDEC), which at times had some impact on flow.

The divisions continued to develop and implement their plans to achieve the 4 hour performance target of 76% by October, focusing on flow and the use of the different SDEC areas. The Trust continued to see an improvement in the 4 hour performance target with improvement on the previous month and achievement against trajectory.

The elective programme has been adversely affected by the different periods of industrial action.

2.0 Elective and Cancer Care

Focus remains on elective and cancer recovery. Due to the industrial action a number of outpatient appointments had to be cancelled to support emergency pathways. Minimal cancellations were made to elective lists due to junior doctor industrial action, but significant cancellations have been made in response to the consultant industrial action.

The Trust has been notified of changes to the Cancer standards which have been agreed between NHS England and the Department of Health and Social Care (DHSC) and will come into effect from 1 October 2023. This follows a review of the cancer standards by the National Medical Director. The waiting times for cancer diagnosis and treatment are being simplified and will focus on the measures that matter most for cancer patients and clinical outcomes.

The NHS will move from the 10 different standards in place now to three:

- Faster Diagnosis Standard: a diagnosis or ruling out of cancer within 28 days of referral (set at 75%)
- 31-day treatment standard: commence treatment within 31 days of a decision to treat for all cancer patients (set at 96%)
- 62-day treatment standard: commence treatment within 62 days of being referred or consultant upgrade (set at 85%)

The main changes being announced are:

- Removal of the Two Week Wait standard requiring a first appointment within two weeks
- Combining together the first and subsequent treatment 31-day standards to create one headline performance standard.
- Combining together the Urgent Suspected Cancer GP referral, Urgent Screening and Consultant Upgrade 62-day standards to create one headline performance standard for all patients.

NHS England have also asked all Trusts to review their outpatient activity with a view to providing more elective care. The requests are asking Trusts to:

- review their guidance on outpatient follow-ups.
- support new approaches to increasing wider outpatient productivity, including reducing variation in clinical templates, patient discharge, and following clinically informed access policies.

As part of this process, it has been requested for Trusts to:

- revisit our plan on outpatient follow up reduction, to identify more opportunity for transformation.
- Set an ambition that no patient in the 65-week 'cohort' (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will be waiting for a first outpatient appointment after 31 October 2023.
- Maintain an accurate and validated waiting list by ensuring that at least 90% of patients who have been waiting over 12 weeks are contacted and validated (in line with December 2022 validation guidance) by 31 October 2023, and ensuring that RTT rules are applied in line with the RTT national rules suite and local access policies are appropriately applied.

As part of this process our plans will be reviewed and need appropriate Board discussion in order to be signed off by Trust Chairs and Chief Executives by 30 September 2023.

3.0 Industrial Action

The Trust saw Junior Doctors taking 5 days of industrial action from 13 to 18 August 2023. Consultants also took industrial action for a 48 hour period on the 20 and 21 August 2023. Significant planning and preparation took place prior to all periods of industrial action to mitigate the impact to patient care as much as possible. During the industrial action, command and control was in place with twice daily tactical and strategic meetings taking place.

There are continual debriefs in place to support the planning for future periods of industrial action, where learning is shared and plans and mitigations amended to support teams. The ongoing nature of the industrial action is having significant impact on all teams across the trust.

5.0 Neuro Rehabilitation

The transfer of services from TRFT to Rotherham, Doncaster and South Humber (RDASH) went ahead on the August 1st 2023. Weekly meetings had taken place with the Trust, RDASH and ICB to ensure that the transfer is working for both staff and patients, particularly in relation to in-reach support of patients in acute beds prior to them being ready for transfer. To date no concerns have been raised.

6.0 Winter Planning

Winter planning for 2023/24 is well underway. The Trust has received a letter from NHS England outlining the national approach to 2023/34 winter planning. This focuses on the ongoing delivery of the National UEC Recovery Plan and on 4 key areas for winter:

1. Continue to deliver on UEC recovery plan by ensuring **high impact interventions** are in place
2. Completing **operational and surge planning**
3. ICBs to **ensure effective system working** across all parts of the system
4. Supporting our **workforce**

These requirements have been taken into account as part of the development of the Trusts winter plan.

A workshop was held with the Board of Directors at the Board Strategic session in August as part of the preparation for winter. The first draft of the winter plan was discussed at the August meeting of the Finance and Performance Committee, with the final version due to be discussed at the September meeting and the following Board of Directors in October.

Sally Kilgariff
Chief Operating Officer
August 2023

National Key Metrics – Performance Against Trajectories

Theatre Utilisation (no trajectory submitted)						
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sept-23
Actual	76%	79%	72%	82.6%		

G&A Bed occupancy – based on KH03 submission						
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sept-23
Target	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%
Actual	90.0%	89.0%	90.6%	90%		

Number of Referral to Treatment 65 week waiters						
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sept-23
Trajectory	40	50	60	60	60	50
Actual	27	30	28	24		

Patients with No Right to Reside						
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sept-23
Trajectory	58	58	58	60	62	56
Actual	53	61	40	47		

Cancer patients waiting over 62 days following a GP referral						
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sept-23
Trajectory	60	60	60	64	64	64
Actual	59	67	52	41		

Daily Average Hours Lost from Ambulance handovers						
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sept-23
Trajectory	10.8	10.8	10.8	10.8	10.8	10.8
Actual	8.1	4.4	7.3	5.1		

4-hour Urgent and Emergency Care Performance						
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sept-23
Internal plan	45%	50%	55%	60%	65%	70%
National Submission	45%	45%	50%	50%	55%	55%
Actual	51%	60%	58%	64%		

Urgent Community Response Standard						
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sept-23
Trajectory	75%	75%	75%	75%	75%	75%
Actual	80%	86%	83%*			

Number of Patients on Virtual Ward						
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sept-23
Trajectory	12	16	24	24	32	40
Actual	14	15	14	31		

* Provisional figure

Board of Directors' Meeting
8 September 2023

Agenda item	P137/23
Report	**Finance Report**
Executive Lead	Steve Hackett, Director of Finance
Link with the BAF	D6: We will not be able to deliver our services because we have not delivered on our Financial Plans for 2023/24 in line with national and system requirements leading to financial instability and the need to seek additional support.
How does this paper support Trust Values	This report supports the Trust's vision to always ACT the right way and be PROUD to provide exceptional healthcare to the communities of Rotherham by adhering to the core values – (A)mbitious, (C)aring and (T)ogether and focussing on our strategic ambitions: (a) (P)atients - 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; (b) (R)otherham - We will be proud to act as a leader within Rotherham, building healthier communities and improving the life chances of the population we serve; (c) (O)ur partners - We will be proud to collaborate with local organisations to build strong and resilient partnerships that deliver exceptional, seamless patient care; (d) (U)s - We will be proud to be colleagues in an inclusive, diverse and welcoming organisation that is simply a great place to work; (e) (D)elivery - 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. Exercising strong financial management, control and governance is a key component element in the Trust achieving these ambitions.
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 July 2023 (Month 4 2023/24): ○ 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 July 2023 (Month 4 2023/24):

	○ Financial results to July 2023. - A deficit to plan of £452K in month and £1,319K year to date; - The same deficit to the (external) control total of £452K in month and £1,319K year to date. The control total is what the Trust's performance is measured against with NHS England, having adjusted for depreciation on donated and right of use assets (£249K year to date). • Section 3 – Income and Expenditure Account Forecast Out-Turn ○ An initial forecast out-turn up to 31st March 2024 of £6,092K deficit to plan and equally the control total. ○ The Trust will not be submitting a forecast adverse variance to plan to the Integrated Care Board or NHSE but assumes appropriate management action and the use of reserves will enable the Trust to deliver its overall plan by 31st March 2024, a year end deficit of £5,977K. • Section 4 – Capital Expenditure for July 2023 (Month 4 2023/24) ○ Expenditure for the four month period ending July 2023 is £854K against a budget of £3,399K: an under-spend of £2,545K (75%). ○ The capital programme is being reviewed and monitored at the Capital Monitoring Group, chaired by the Director of Finance. Capital expenditure is expected to fully deliver against plan. • Section 5 – Cash Flow 2023/24 ○ A cash flow graph showing actual cash movements between April 2022 and July 2023. A month-end cash value as at 31st July 2023 of £18,576K, which is £2,631K worse than plan due to slippage on income receipts and increased creditor payments in month.
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 NHS England. ○ 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. ○ CIP performance has been discussed with the Efficiency Board chaired by the Deputy Chief Executive. ○ The capital expenditure position has been discussed and reviewed by the Capital Monitoring Group, chaired by the Director of Finance.

	○ 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?)	• Overall financial performance was discussed at the monthly performance meetings. • CIP performance was discussed at the Efficiency Board meeting being held on 16th August 2023. • Capital expenditure was reviewed at the Capital Monitoring Group held on 21st August 2023. • Detailed discussions have also taken place at the meeting of Finance & Performance Committee on 30th August 2023, including feedback from all of the above. Any issues for escalation from the Committee will be reported at the meeting of the Board.
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	Forecast V £000s	Prior Month FV £000s
I&E Performance (Actual)	(627)	(1,079)	(452)	(2,767)	(4,085)	(1,319)	(6,092)	(8,484)
I&E Performance (Control Total)	(565)	(1,016)	(452)	(2,517)	(3,836)	(1,319)	(6,092)	(8,484)
Capital Expenditure	767	369	398	3,399	854	2,545	0	0
Cash Balance	(795)	617	1,412	21,207	18,576	(2,631)	(241)	(427)

1.2 The Trust has over-spent against its I&E plan in July 2023 leading to a cumulative overspend of £1,319k year to date. The Trust's performance is measured against its control total with NHS England, which is after adjusting for depreciation on donated assets, this is showing the same adverse variance. These figures do not include any adjustment for under or over-performance on elective recovery activity, which is assumed to be covered within the current level of reserves. The cost pressure resulting from the Agenda for Change pay award is now within the position.

1.4 Capital expenditure is behind plan in month and year to date, with cumulative spend of £854k against a budget of £2,545k. Capital spend is forecast to fully deliver against plan.

1.5 The cash position at the end of July 2023 is £18,576K. Despite being below plan by £2,631K, this remains a strong cash balance. The reduction against plan is due to slippage on income receipts and timing of creditor payments largely due to 22/23's capital schemes.

2. Income & Expenditure Account for July 2023 (Month 4 2023/24)

2.1 The table below shows the financial results subjectively (by type of expenditure). The Trust has delivered a deficit to plan in July 2023 of £452K and a year to date deficit of £1,319K.

Summary Income & Expenditure Position	AP £000s	Month P £000s	Month A £000s	Month V £000s	YTD P £000s	YTD A £000s	YTD V £000s	2023/2024 Monthly Trend / Variance
Clinical Income	320,743	27,011	26,357	(654)	107,551	106,129	(1,422)	
Other Operating Income	24,277	2,465	2,248	(217)	8,395	8,590	195	
Pay	(231,591)	(18,734)	(19,023)	(289)	(76,827)	(78,755)	(1,928)	
Non Pay	(88,988)	(8,589)	(9,031)	(442)	(32,744)	(34,240)	(1,496)	
Non Operating Costs	(3,969)	(331)	(301)	30	(1,323)	(1,197)	126	
Reserves	(27,198)	(2,449)	(1,329)	1,120	(7,817)	(4,612)	3,205	
Retained Surplus/(Deficit)	(6,726)	(627)	(1,079)	(452)	(2,767)	(4,085)	(1,319)	
Adjustments	748	62	62	0	249	249	0	
Control Total Surplus/(Deficit)	(5,977)	(565)	(1,016)	(452)	(2,517)	(3,836)	(1,319)	

2.2 Clinical Income is behind plan in month and year to date mostly due to under performance on elective recovery activity. ERF divisional targets were included in budgets. This

underperformance is currently offset in reserves awaiting validation of the performance against target by NHSE.

2.3 Other Operating Income is behind plan in month and ahead of plan year to date with increased income from staff recharges (£120K), which will be an offset to the pay over-spend, and increased research, development and education income (£72K).

2.4 Pay costs are over-spending by £289K (2%) in month. Whilst bank and agency expenditure is being maintained within the gross establishment budget, this is being offset by £461K under-delivery of cost improvement targets in month. The year to date performance is also being influenced by undelivered cost improvement targets of £1,759K.

2.5 Non Pay costs are similarly over-spending by £442K (5%) in month, the main categories of overspends are on drugs £335K and premises £89K. In-month there is £35K under-delivery of cost improvement targets and £264K year to date.

2.6 The positive performance in Non Operating Costs is due to interest receivable and financing costs being better the plan.

2.7 £3,205K has already been released from Reserves year to date, this is specifically to cover the underperformance against ERF and under delivery of CIP.

3 Forecast Out-Turn Performance to 31st March 2023

3.1 The table below shows the forecast out-turn position for the financial year 2022/23. The Trust is forecasting to deliver a £6,092K deficit to plan.

Summary Income & Expenditure Position	AP £000s	FO (Full Year) £000s	AV (YTD) £000s	FV £000s	TV £000s	2023/2024 Monthly Trend / Variance
Clinical Income	320,743	319,864	(1,422)	543	(879)	
Other Operating Income	24,277	24,946	195	474	670	
Pay	(231,591)	(236,635)	(1,928)	(3,117)	(5,045)	
Non Pay	(88,988)	(93,408)	(1,496)	(2,924)	(4,420)	
Non Operating Costs	(3,969)	(3,592)	126	251	378	
Reserves	(27,198)	(23,993)	3,205	0	3,205	
Retained Surplus/ (Deficit)	(6,726)	(12,818)	(1,319)	(4,773)	(6,092)	
Adjustments	748	748	(0)	(0)	(0)	
Control Total Surplus/ (Deficit)	(5,977)	(12,069)	(1,319)	(4,773)	(6,092)	

3.2 Within Clinical Income, the estimated ERF YTD under delivery against divisional targets is reflected. This underperformance is currently offset in reserves awaiting validation of the performance against target by NHSE. No further under-delivery of ERF is forecast at this stage. Additional income is forecast from other variable activities.

3.3 Other Operating Income is forecasting increases in income from research, development, education & training (£255K) and staff recharges (£477K). This additional income will equally be offset by further increases in pay and non-pay expenditure.

3.4 Pay is showing a significant deterioration in performance this is mostly due to undelivered annual CIP budget reductions.

3.5 Non Pay costs are similarly showing a significant deterioration in performance linked to continued increasing costs, most notably within drugs & clinical supplies, premises and undelivered CIPs.

3.6 Non Operating Costs reflect increased income from interest receivable on money deposited with Government banking services that continues to increase due to continued cash balances and increased interest rates.

3.7 The Trust will not be submitting a forecast adverse variance to plan to the Integrated Care Board or NHSE but assumes appropriate management action and the use of reserves will enable the Trust to deliver its overall plan by 31st March 2024, a year end deficit of £5,977K.

3.8 Cost reduction and CIP delivery will need to be managed proactively across all services, with clear action plans being implemented, if the Trust is to deliver against its overall plan.

4. Capital Programme

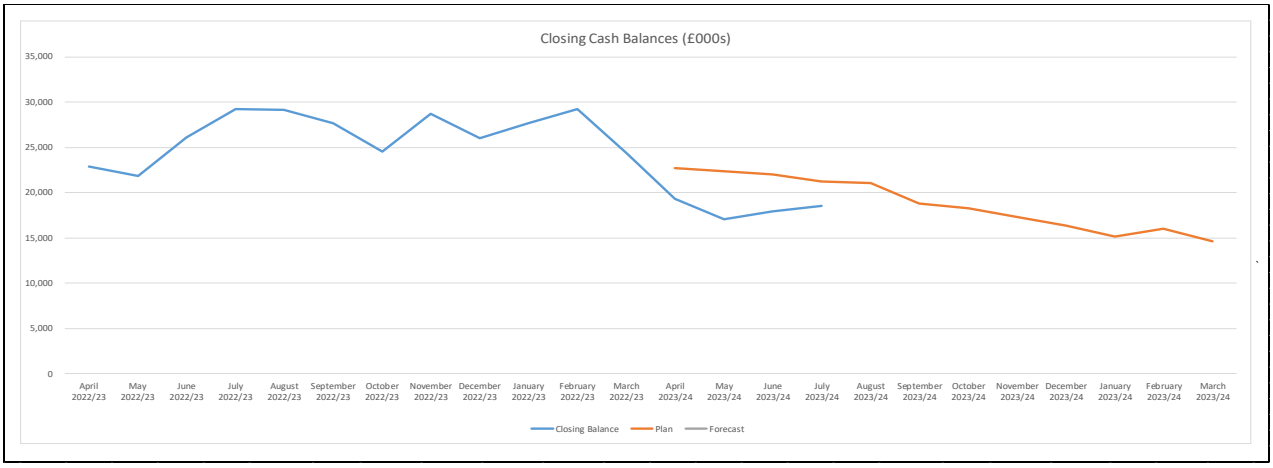
4.1 As at July 2023 the Trust has incurred capital expenditure of £854K against a budget of £3,399K representing an under-spend of £2,545K (75%), this is mostly outstanding commitments agreed during 2022/23.

Capital Expenditure	Month			YTD			Forecast	Prior Month
	P	A	V	P	A	V	V	FV
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Estates Strategy	83	7	76	108	23	85	0	0
Estates Maintenance	15	192	(177)	117	215	(98)	0	0
Information Technology	213	97	116	503	509	(6)	0	0
Medical & Other Equipment	179	73	106	193	106	87	0	0
Other	277	0	277	2,478	0	2,478	0	0
TOTAL	767	369	398	3,399	854	2,545	**0**	**0**

4.2 The capital programme is being reviewed and monitored at the Capital Monitoring Group, chaired by the Director of Finance. Capital expenditure is expected to fully deliver against plan.

5. Cash Management

5.1 The cash balance compared to plan, is an in-month favourable variance of £1,412K and an adverse year to date variance of £2,631K. Cash remains strong with a closing cash balance of £18,576K as at 31 July 2023.as shown in the graph below. This is due to slippage on income receipts and increased creditor payments.



5.2 This has allowed the Trust to earn interest on its daily cash balances of £95K in-month (£386K year to date), which will help contribute towards the Trust's cost improvement target for 2023/24.

5.3 The recent rise in interest rate will further increase interest receivable income throughout the year, albeit it will only be marginal.

Steve Hackett
Director of Finance
14th August 2023

Board of Directors' Meeting
08 September 2023

The Rotherham NHS Foundation Trust

Agenda item	P138/23
Report	**Quality Assurance Report (including Care Quality Commission)**
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	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)	The purpose of the Quality Assurance Report is to provide an overview of all quality activity across the Trust, with a focus on Care Quality Commission requirements, since the last report to the Trust Board in May 2023 and to identify progress against the Quality Assurance Framework, to support our delivery of outstanding care. There are four key elements that collectively describe how the Trust will move forward on its 'Journey to Outstanding'. • Quality Assurance • Quality Governance • Quality Improvement • CQC Relationship/ future inspection methodology All actions within the Quality Improvement Plan (derived from previous CQC inspections) are now complete with the majority being embedded. All divisions have participated in comprehensive self-assessments that are driving their quality improvement agendas. There has been limited engagement with CQC during the reporting period as they have used a risk profile to identify which Trusts to visit. We maintain a positive and open relationship with the engagement team and have responded positively to all enquiries and requests to support other Trusts.

Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	This information has been reviewed through the CQC Delivery Group and shared with Quality Committee, in a different format, on a quarterly basis.
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 Trust Board: • Note the content of the Report • Note the progress made in progressing the Quality Assurance Programme
Appendices	None

1. Quality Assurance

1.1 The Quality Assurance programme continues to be delivered and is monitored through the CQC Quality Delivery Group and Quality Committee. All Core Services across both Acute and Community sites underwent a review in quarter four against the relevant CQC Inspection framework and have built upon this in the current year.

1.2 The activity undertaken in the 4 months since the last report has focussed on self-assessments against the CQC Key Lines of Enquiry for all outstanding areas. This has included Community, Therapies, SLT and Dietetics, Outpatients, Critical Care and Maternity. There continues to be an emphasis on ensuring supportive robust evidence is in place to support the assessments and demonstrate compliance.

1.3 There have been no external peer review visits during the reporting period although the Trust remain committed to this process and will be undertaking further visits. We are especially keen to continue to use our partnership working with Barnsley Hospital NHS Foundation Trust to support this as this has proved beneficial to both organisations.

1.4 Quality Delivery groups have continued to be held monthly with the exception of August and remain quorate. The performance against the Quality Improvement Plan has further improved, driven by a significant number of actions in UECC becoming embedded. The one previous amber action is now green meaning that all actions are now complete with the majority having evidence of embedding submitted. Further evidence is being submitted to the September meeting to increase the number of blue, embedded actions.

	RAG Definitions
	Has failed to deliver by target date/Off track and now unlikely to deliver by target date
	Off track but recovery action planned to bring back on line to deliver by target date
	Completed / On track to deliver by target date
	Delivered and embedded so that it is now business as usual and the expected outcome is being routinely achieved. This has to be supported by appropriate and approved evidence.
	Subject to external input to fully achieve

Core Service	Red	Amber	Green	Blue	Grey
Trustwide	0	0	2	2	0
UECC	0	0	19	10	1
Medicine	0	0	1	17	0
Maternity	0	0	2	4	0
Children and Young People	0	0	4	18	2
Total	0	0 (1)	28 (36)	51 (42)	3 (3)
Percentage	**0%**	**0%**	**34%**	**62%**	**4%**

Table 1.

1.5 The Trust is now in a position to move away from a retrospective, reactive approach, to one of continuous quality improvement. The Improvement Plan needs to align to other quality and safety initiatives – for example, the Quality Priorities and PSIRF, where collectively, change is supported by evidence and intelligence based information that will ultimately deliver the overall Trust Strategy and drive forward the Journey to Outstanding.

2. Quality Governance / CQC Relationship

2.1 Although we have not recently received any external scrutiny from the CQC, we maintain a positive approach to engagement. This has not involved any engagement meetings during the last three months as these have all been cancelled by the CQC due to them not having any concerns to raise. We have received three enquiries and these have all been responded to promptly with no escalations required.

2.2 All divisions continue to address issues raised within their comprehensive self-assessments of their position against each of the CQC core domains (safe, effective, responsive, caring, well-led). This is monitored on a monthly basis by the Quality (CQC) Delivery Group, chaired by the Chief Executive with two divisions presenting their data each month. One area has identified one red (inadequate) issue – this relates to accessing care in a timely way in the responsive domain for CYP Community services and is specifically linked to capacity issues at the Child Development Centre. This is on the risk register. Actions are in place for all amber (requires improvement) domains which are primarily within Community, Children's and Young People (Community) and Critical Care settings.

2.3 The next engagement meeting is scheduled for 28th September.

3. Quality Improvement

3.1 Quality Improvement is now well established within the organisation. Quality Service Improvement and Redesign (QSIR) training is available in two tiers, QSIR Fundamentals 1 day course with 5 cohorts in 2023 and 4 planned during 2024 with 17 staff having undertaken this so far. QSIR Practitioner 5 day course has run 5 cohorts, with 2 more to run in 2023 and 4 in 2024, 89 staff have completed this course to date with projects ongoing.

Examples of some of the current projects include:

- Improving learning bulletins
- Resuscitation equipment storage in UECC
- UECC Medicines management
- TTO changes
- Midwifery PSIRF
- Resuscitation calls
- UECC front door (assessment process)
- CT scan over testing
- Improving medicines communication

3.2 A recognised constraint on the Qi programme to date has been the inability to provide full follow up support to projects such as those listed above. This has meant that benefits to patients and any cost improvements resulting from changes are not being appropriately recorded. The follow up business case was therefore approved in July which supports

recruitment of 1.0 Band 7 and 1.0 Band 5 practitioners to join this team which will significantly strengthen governance, monitoring, reporting and benefits realisation.

3.3 Follow up from the four day rapid improvement event focussed on discharge also continues, out of which 6 workstreams were developed:

- Reconditioning
- Standard work for ward/board rounds
- Identification of outliers
- Patient passport
- Self administration of medication
- Early discharge via Community Ready Unit

Progress has been made in all of these areas and is beginning to impact upon patient experience and length of stay although it is still too early to present significant data to support this. Of particular note, the work on reconditioning has been recognised by NHSE with silver awards being given to 6 of our wards for their improvements in this area.

3.4 To date, attendees as Qi events have chosen their own improvement projects although these are discussed with the Head of Qi to agree suitability. It is proposed, that as we transition to using PSIRF this Autumn, this will identify key patient safety priorities for improvement. This will provide a bespoke list of potential projects for course participants to choose from to ensure we are focussing on agreed priorities. The recently purchased audit system (AMAT) will also be used to register projects and ensure we have a standardised method of measuring progress and outcomes.

4. Future Inspection Methodology

4.1 CQC have announced that they will start to use the new Regulatory Single Assessment Framework in the South of England from November 2023. They will still schedule assessments by considering the level of risk, so not all providers will have an immediate assessment. Other regions, including ourselves, will remain on the current assessment framework for now with an expected roll out to other areas by the end of March 2024.

5. Conclusion

5.1 Although we have not had any external scrutiny, all divisions have been actively assessing their position against CQC requirements and taking action where necessary. The process has moved away from a reactive approach to CQC findings and is now an embedded quality improvement approach driven by peer and self-assessments, PSIRF and feedback from service users.

5.2 There is a need to reinvigorate the peer assessment process to provide further external validation of our current position.

5.3 During the next quarter, it is hoped to work closely with the Communication Team to promote and advertise the ongoing work that is happening in the organisation to drive further improvements in quality.

The Rotherham NHS Foundation Trust

Agenda item	P139/23
Report	**Maternity and Neonatal Safety**
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	• It is a national requirement for The Board of Directors to receive a monthly update on Maternity Safety, which goes through Quality Committee. • Work continues in the Division with the 3-year Delivery Plan and Maternity Incentive scheme year 5. • Theme 1 shares the data trends in the CQC inpatient survey outcome measures that will be used to monitor progress with the 3 year Delivery plan (3YDP). • Theme 2: The NHSP Incentive for midwives to support safe staffing in Maternity services until the 13.04 WTE Early career midwives are in post has highlighted a positive impact on labour ward acuity data. The Birth-rate Plus® data has been submitted and the Division awaits the full report. • Theme 3: No Serious Incidents were declared in July 2023, the Quarter 1 regional perinatal and Quality oversight data is shared in the paper. • Theme 4: The adjusted rolling stillbirth data is 2.33 per 1000. The Adjusted Total Perinatal (stillbirths and neonatal deaths) is 2.72/1000 births. The ATAIN admission rate has improved to 3.7 % for July 2023.
Due Diligence	This paper has been prepared by the Head of Midwifery and shared through Maternity and Family Health Divisional Business and Governance, the Maternity and Neonatal Safety Champions.
Board powers to make this decision	The Trust Board are required to have oversight on the maternity safety work streams.

Who, What and When	Helen Dobson, Chief Nurse, is the Board Executive Lead. The Head of Midwifery attends Trust Board monthly to discuss the Maternity Safety agenda.
Recommendations	It is recommended that the Board of Directors are assured by the progress and compliance demonstrated in paper to date with the Maternity Safety Work streams.
Appendices	1. Birth rate plus Data July 2023 2. Core competency Curriculum Version 2 3. Regional perinatal Quality Surveillance tool All appendices are available in the Convene Reading Room

Maternity Safety

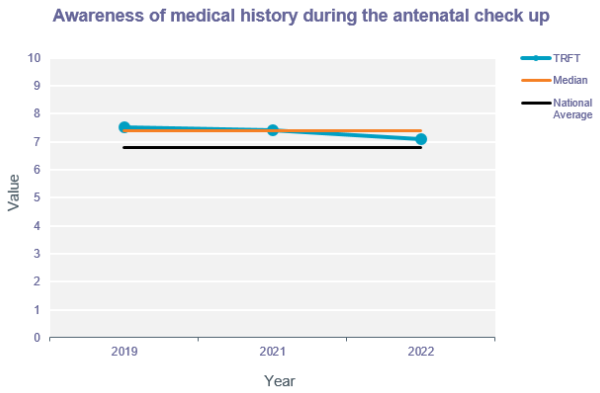
1. Introduction

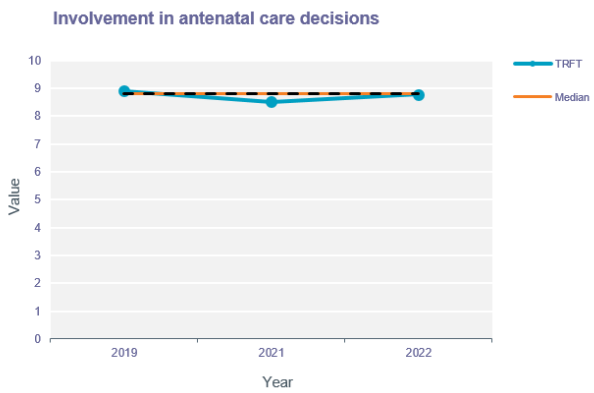
1.1 The Division continues to work on the 3-year delivery plan (3YDP). The benchmarking tool has been shared with providers and the Maternity team are currently reviewing compliance against the plan, this will be completed for the September Quality Committee meeting.

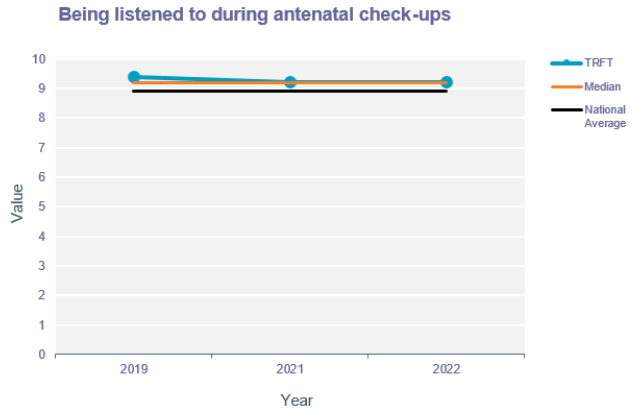
1.2 The Year 5 Maternity Incentive Scheme (MIS) was launched on the 30th May 2023. The Division has refreshed the action tracker with the updated safety actions and recommenced bi-monthly meetings for Divisional oversight. Oversight meetings have been scheduled by South Yorkshire LMNS. Trusts must achieve all 10-safety actions and the Board submission deadline to NHS Resolution is the 1st February 2024.

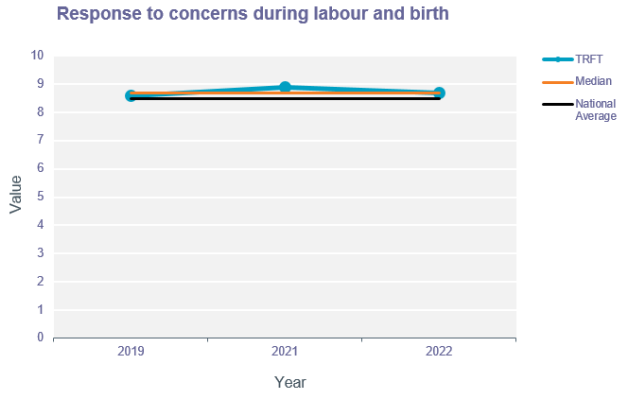
2. Theme 1: Listening to and working with women and families with compassion Key commitments

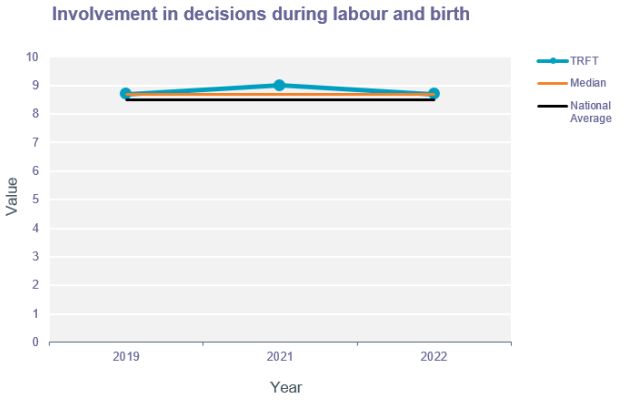
2.1 The Maternity Service continues to work with the Maternity and Neonatal Voice Partnership (MNVP) on the agreed improvements for patient experience highlighted through the CQC in patient survey. The tables below represents the trends in the results for TRFT outlined in the 3YDP technical guidance as agreed outcome measures from the CQC survey from 2019-2022. The data demonstrates that TRFT maternity services have remained consistent with the scores on or above the national average. The x2 areas that has seen a marginal decline are the responses to the postnatal care questions and these are included in the action plan, which has been shared through previous board papers as an area of improvement.

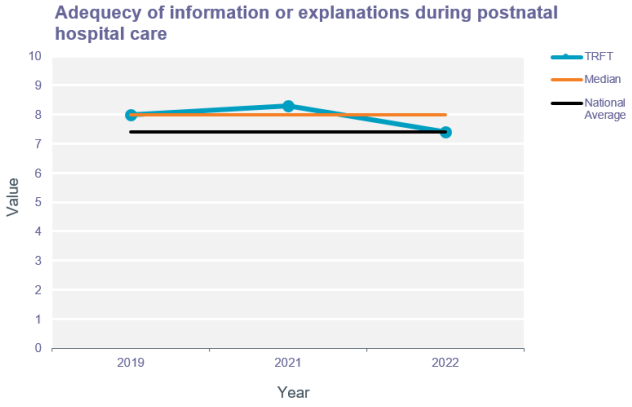


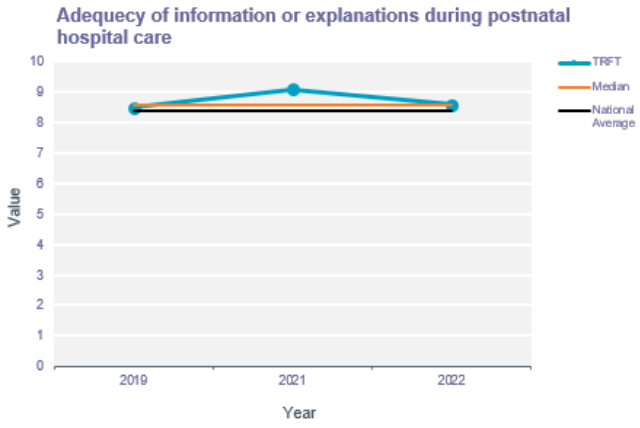












2.2 The Bereavement midwife and Head of Midwifery visited Apna Haq meaning “OUR RIGHT”. An organisation which supports women and girls from black and minority ethnic communities living in Rotherham who are escaping domestic abuse and violence in August. The Visit was organised to listen to the lived experience of recent service users, and to listen to the voices least heard. The experiences shared were humbling and powerful. We have invited the team at Apna Haq to support cultural competency training in Maternity and neonatal services so that we can learn and improve patient experience.

2.3 The Neonatal unit have submitted the evidence for level 1 Unicef Baby Friendly initiative (BFI) accreditation information and are awaiting an outcome meeting at the end of August to see if the evidence has been successful and then we will move on to year 2.

3. Theme 2: Grow, Retain and support the workforce

3.1 The decision to support the incentive for NHSP shifts in line with other providers in South Yorkshire to support safe staffing has had a positive impact on the acuity, demonstrating an improved compliance rate to 82.9 % completion of data entry. Appendix 1 demonstrates that staffing met the acuity for 95% of the care episodes reported. The workforce data for July does demonstrate that internal escalation and use of community midwives has continued to maintain safe staffing. The workforce gaps remain unchanged until October 2023 when the 13.04 WTE commence in post.

All the data has been submitted for the full Birth rate plus establishment review and the Maternity service now awaits the full report.

Table 1

Trajectory	Apr	May	Jun	Jul	Aug	Sep	Oct
Contracted Vacancies	**2.53**	**0.44**	**1.40**	**-0.15**	**-0.15**	**-0.15**	**-0.15**
Maternity leave	1.23	2.03	3.99	4.95	5.59	6.59	6.59
Long term sickness	4.12	5.12	4.88	4.88	2.92	0.00	0.00
Upcoming Leavers	0.20	0.00	0.81	2.62	3.52	5.16	5.16
Other - see detail	1.60	1.60	1.60	1.60	1.60	1.60	1.60
Total Gaps	**9.68**	**9.19**	**12.68**	**13.90**	**13.48**	**13.20**	**13.20**
New Starters (reducing gaps)	-2.40	0.00	0.00	0.00	-0.20	-0.63	0.16
New Starters - students/NQM's	0.00	0.00	0.00	0.00	0.00	0.00	-13.04
Trajectory - for planning	**7.28**	**9.19**	**12.68**	**13.90**	**13.28**	**12.57**	**0.16**

3.2 The table below represents July 2023 workforce data; Sickness rates have seen an increase in July. Long term sickness remains stable at 3.89%, with short term sickness reflecting 1.82% of the sickness rates.

There are no themes identified and sickness and absence is supported in line with the Trust policy.

3.3 In neonates, the workforce updates include the successful recruitment to all the Allied Health Professional (AHP) posts that were funded from the Ockenden neonatal funding. A Scoping exercise across South Yorkshire is currently reviewing how psychology support for families with babies in neonatal units can be provided by all providers.

Funding has also been received the neonatal ODN for a Band 7 governance and educator post for neonates which will be used to support BFI accreditation and joint working with Maternity services.

3.3 Workforce Data – July 2023:

Table 2

Maternity unit closures	0	Datix / Birth-rate Plus®
Utilisation of on call midwife to staff labour ward (Night Duty)	0	Birth-rate Plus® data/ Datix
1-1 care in labour	100%	Data from Birth-rate Plus® acuity tool / Maternity Dashboard

Redeploy staff internally	71%	Birth rate plus Acuity
Redeploy staff from Community	29%	Birth rate plus Acuity
Matron Working Clinically	0	Birth rate plus Acuity
Delay in Induction of Labour	15	Birth rate plus Data and Datix
Supernumerary labour ward co-ordinator	100%	Data from Birth-rate Plus® acuity tool/Maternity Dashboard/Datix
Staff absence	5.71%	July data HR systems long term 3.89% short term 1.82%
Obstetric compliance at mandatory consultant escalation	100%	No Datix incidents reported
Compliance with twice daily face to face ward round	100%	Birth-rate Plus® data, no red flags reported

3.5 **Obstetric cover gaps**: The table below illustrates the locum breakdown for July 2023. One of the Obstetrics and Gynaecology newly appointed consultants has commenced in post in August and the second is scheduled to commence at TRFT in September 2023. The Division has received the GMC NTS survey for 2023 and the Obstetrics and Gynaecology Consultant team are currently reviewing the data.

3.6 The neonatal service is currently recruiting to the medical workforce agreed following the BAPM business case.

Table 3

Grade	No of Shifts	Reason	Internal / External
ST1/2	16	5 x Vacancy 4 x Sickness 7 x Strike cover	11 x internal 5 x external
ST3/7	19	12 x Vacancy 1 x Sickness 6 x Strike cover	19 x internal
Consultant	64	33 x Vacancy 11 x Leave 7 x Additional clinics 4 x Additional theatres 9 x Acting down during strike	64 x internal

4. Theme 3: Developing and sustaining a culture of safety, learning and support

4.1 The plan to achieve the year 5 CNST training requirements continues. The requirement is for 90% attendance of the relevant staff groups for the Core Competency Framework Version 2 (CCF V2) Appendix 2. New Guidance was published July 2023, updating that the relevant time should now be considered from the 1st December 2022 until 1st December 2023 changing from the 12 consecutive months from the end date used to inform the percentage of compliance to meet the standard in Year 4. For Maternity services, this will require an increase in the mandatory training requirements from 4 days including fetal wellbeing training to 5 days.

CNST Training data

Table 4

Obstetric Consultants	July 2023	**95.5%**
Obstetric Registrars		**96%**
Obstetric Trainees		**95.5%**
Midwives		**87.5%**
Clinical Support staff		**95.5%**
Anaesthetists		**90%**

Learning from Incidents:

4.2 During July 2023, there were 109 incidents reported on Datix for Obstetrics, of which 16 were graded as moderate harm at the time of the incident. The table below highlights the moderate harm incidents reported. Following review at the weekly Divisional review panel, 16 incidents were downgraded to low harm due to the appropriate management and actions taken.

Table 5

Incident	Number of Incidents July 2023
3rd Degree Tears	3
PPH >1500ml	5
Shoulder Dystocia	5
Low Apgar's	1
Low cord gases	1
Pre-eclampsia	1
Total:	**16**

4.3 Regional Perinatal Quality assurance data

Appendix 3 Share the Quarter 1 oversight data for the regional perinatal and quality safety report for Quarter 1 2023/24. The report highlights the Year 4 CNST achievements, and overview of themes and trends in incidents, Themes from Perinatal Mortality meetings which have been shared in last month's board paper. The current number of HSIB case (x1 case for HIE/ cooling) Serious incident data for Q1 (x1 for injury sustained and caesarean section). This report is shared through the LMNS to the regional Perinatal and Quality surveillance meeting.

Listening to issues raised by staff or service users

4.4 In July 2023 x1 formal complaint was logged regarding Maternity care and communication during inpatient experience on Wharncliffe leading up to Category 3 elective c/s in June 2023. A meeting has been held with the Acute Matron and Head of Midwifery to listen and learn from the patient's experience.

5. Theme 4: Standards and structures that underpin safer, more personalised and more equitable care:

In the month of July 2023 the perinatal deaths included:

x 1 neonatal death @ 22/40 –extreme prematurity RIP. Met criteria for PMRT

x 1 late fetal loss @ 23/40 RIP. Met criteria for PMRT

x 1 late fetal loss @ 21+1 RIP

x 1 Medical Termination of Pregnancy (MTOP) @ 19+5 RIP

5.1 Rolling 12 month Perinatal data: Aug 2022 – July 2023

Number of births - 2571
Number of Stillbirths in July 2023 (adjusted) – 0
Number of neonatal deaths in July 2023 (adjusted) - 1

Perinatal mortality All deaths (including congenital anomalies)

5.2 Table 6

Type of death	Number	Rate per 1000 births
Stillbirth	7	2.72
Neonatal death	6	2.33

Total perinatal 5.06/1000 births

5.3 Adjusted Perinatal Mortality (excludes deaths due to congenital anomalies and MTOP)
Table 7

Type of death	Number	Rate per 1000 births
Stillbirth	6	2.33
Neonatal death	1	0.39

Adjusted Total Perinatal (stillbirths and neonatal deaths) 2.72/1000 births

Avoidable Term Admissions into the Neonatal unit (ATAIN)

5.6 Table 8 shares the ATAIN data for July which demonstrates and improved position in term admissions to 3.7 % in line with the regional and national target. Of the 6 unavoidable admissions:

- x2 sepsis
- x1 transient tachypnea of the newborn (TTN)
- x1 suspected sepsis + TTN
- x1 raised haematocrit
- x1 suspected Necrotising entercolitis(NEC)

Number of admissions to Neonatal Unit:	**20**
Number of Term Admissions:	**8**
Term Admissions as a Percentage of all Live Births	**3.7%**
Avoidable Admissions:	**0**
Unavoidable Admissions:	**6**
Excluded from ATAIN Review:	**2**

Sarah Petty
Head of Nursing and Midwifery
Family Health Division

Board of Directors' Meeting
08 September 2023

The Rotherham NHS Foundation Trust

Agenda item	P142/23
Report	**Board Assurance Framework**
Executive Lead	Angela Wendzicha, Director of Corporate Affairs
Link with the BAF	The paper relates to all BAF Risks
How does this paper support Trust Values	The Board Assurance Framework is a key element that provides evidence of good governance and supports all three core values Ambitious, Caring and Together
Purpose	**For decision** ☒ **For assurance** ☐ **For information** ☐
Executive Summary	The Board Assurance Framework (BAF) links directly to the Trust's Strategic Ambitions as set out in the 5 Year Strategy (2022-2027) and identifies any strategic risks that could prevent delivery of the Trust's Strategic Ambitions. The following report illustrates the proposed position at the mid-point of Quarter 2 2023-24 (Year 2 of the 5 Year Strategy). The BAF Risks have been discussed at the relevant Board Assurance Committees as follows: **People Committee**: Discussed and approved the position in relation to Strategic Risk U4; **Quality Committee**: Discussed and approved the position in relation to Strategic Risk P1; **Finance and Performance Committee:** Discussed and approved the position in relation to Strategic Risk D5 and D7. BAF Risks R2 and O3 have bene reviewed by the Deputy Chief Executive and the Director of Corporate Affairs in preparation for further discussion at the Board meeting.
Due Diligence	Since presentation at the last Board in July 2023, the relevant sections of the Board Assurance Framework has been discussed at the relevant Board Committees during July and August 2023.
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 the approval of the Board Assurance Framework.

Who, What and When	The Director of Corporate Affairs will continue to work with Executive colleagues in order to review and update the BAF on a monthly basis thus highlighting any risks or issues that have the potential to disrupt achieving our Strategic Ambitions.
Recommendations	It is recommended that the Board: • Discuss and note the progress made in the Board Assurance Framework; • Note and approve the following recommendations; ➢ The score for BAF Risk P1 to remain at 12; ➢ The score for BAF Risk R2 to remain at 8; ➢ The score for BAF Risk O3 to remain at 8; ➢ The score for BAF Risk U4 to remain at 12. ➢ The score for BAF Risk D5 to increase to 20 ➢ The score for BAF Risk D7 to remain at 15,
Appendices	Board Assurance Framework

1. Introduction

1.1 The Board Assurance Framework (BAF) links directly to the Trust's Strategic Ambitions as set out in the 5 Year Strategy (2022-2027) and identifies the strategic risks that could prevent delivery of the Trust's Strategic Ambitions.

1.2 During the financial year 2022-23, the Board provided oversight and approved the positions in relation to an initial total of seven strategic risks on the BAF. The Board will recall that BAF Risk D6 relating to the financial position for the previous financial year has been closed.

1.3 The BAF illustrates the risks to achieving our Strategic Ambitions during Quarter 2 of the new financial year. Furthermore, the report provides as summary of the discussion and decisions that have taken place at the relevant Board Assurance Committees during and up to the middle of Quarter 2 2023-24.

1.4 The Board will note that in order to ensure the BAF remains a workable and accessible document, a number of completed gaps in controls have, following agreement at the relevant Assurance Committees moved to archive; these are readily available should there be a need to refer back to them.

1.5 When considering the scoring of each risk, the 2008 Risk Matrix for Risk Managers is used as a reference guide.

Outcome of the July and August 2023 Reviews

2 P1: There is a risk that we will not embed quality care within the 5 year plan because of lack of resources, capacity and capability leading to poor clinical outcomes and patient experience.

2.1 Strategic BAF Risk P1 is aligned with the Quality Committee and following review in July and August 2023, additional commentary has been added to the controls and assurance and gaps in assurance sections, highlighted in red for ease of reference. The key developments of note are as follows:

Controls and assurances

2.2 C2: Outcome reports received by Quality Committee on a rolling quarterly programme linked to specialist areas. Audit reporting programme now included in Committee report to Quality Committee – on a rolling quarterly programme linked to specialist areas – Patient Safety, Safeguarding, Patient Experience, Infection Control as aligns with work plan. Published Patient Experience Annual Report on Trust website.

2.3 C3: Monthly metrics dashboard now presented for quantative data. Clinical Effectiveness is a priority, with the successful recruitment of a Clinical Effectiveness Manager who is now in post.

2.4 C10 – Safeguarding focused external review by NHSE of our paediatrics and maternity occurred on 01st June 2023, the report was due by 30th June 2023, however not received as of 18th July 2023. Rotherham Adult Safeguarding Peer Review took place 12th -17th July 2023.

Gaps in controls

2.5 G1 - Gained approval at June 23 ETM to proceed to full QI business case and approval at August 23 ETM to proceed to recruitment

2.6 G4: Completed SJRs (18) are being provided to the Divisions Mortality Leads every 4 weeks. Comments from all SJRs are themed and categorised in quarterly Thematic Analysis Reports. A meeting to finalise the Learning from Death Policy is being held on 25th August 2023. This is to be approved by the Trust Mortality Group on 05th October 2023, in order to be approved by the

Patient Safety Committee on 19th October 2023, before finally being submitted to the Trust's Documentation Ratification Group.

2.7 G18 – End of Life Strategy presented to Quality Committee and Board for approval in September.

2.8 G25 - Clinical Effectiveness Manager appointed and commenced in post – gap to be archived and now also included as part of C3

2.9 G26: Emerging concern regards National Emergency Laparotomy Audit.

2.10 G27: Challenges around sufficient workforce to support the recovery plan (including industrial action), has been added due to the increasing risk to patient safety as a result of continued industrial action. This gap can be found also on BAF risks D5 and U4.

2.11 Review of the risk score

The initial score agreed for 2022-23 was **16** whereby the consequence was graded a **4** (Major), defined as noncompliance with national standards with significant risk to patients if unresolved. The initial likelihood score agreed was **4** (Likely) defined as 'will probably happen/recur but is not a persisting issue.'

Following discussion and debate, and taking into consideration the removal of the five Conditions on the Trust's Registration, progress in closing some identified gaps in controls and mitigations, the likelihood was reduced to **3** (Possible) defined as 'might happen or recur occasionally.'

This resulted in the reduction of the overall score to **12.** The Board will note that this is within the target score for the first year of the 5 Year Strategy but remains out with the Boards risk appetite of Very Low pertaining to Quality (score 1-5).

It is recommended that the risk score remains at **12**.

3 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 health inequalities.

3.1 Strategic BAF Risk R2 has been reviewed by the Deputy Chief Executive and the Director of Corporate Affairs. The Trust has developed a strong presence at PLACE and therefore, during Quarter 1, the Board approved the reduction in the likelihood score to a **2** (unlikely) defined as 'do not expect it to happen/recur but it is possible it may do so'. This reduced the overall score to **8** which is within the target score and within the Trust's risk appetite.

3.2 An additional control has been added for Quarter 2 relating to the Population Health Management Operational Group which is now chaired by the shared Public Health Consultant.

3.2 Following review, it is recommended that the score remains at **8.**

4 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.

4.1 Strategic BAF Risk O3 has been reviewed by the Deputy Chief Executive and Director of Corporate Affairs. The Trust has continued to develop and strengthen the partnership working with Barnsley Hospitals NHS Foundation Trust with the continuation of the Joint Strategic Partnership which is now supported by a Board approved Memorandum of Understanding.

4.2 There is now in place an agreed Joint Strategic work plan for the remainder of the financial year, the progress of which is monitored through the established Joint Strategic Partnership.

4.3 The Board agreed to reduce the score to an **8** (likelihood score reduced to a **2** (unlikely). This reduced the overall score to **8** which is within the target score and within the Trust's risk appetite. There is an expectation that as elements of the work plan are completed, the likelihood score will reduce in Quarter 3.

5 U4: There is a risk that we will 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.

5.1 Strategic BAF Risk U4 is aligned to the People Committee and was discussed at the meetings in July and August 2023. The key developments of note are that continued actions to control the identified gaps include the fact that national staff survey results returned an improvement in a number of Trust areas including Equality, Diversity, Inclusion and Compassionate Leadership.

A number of additional controls have been added as follows:

5.2 C1 Started initial stakeholder engagement sessions for new People Strategy

5.3 C2 New template agreed at People Committee in July 2023 and archived at the August 2023 committee– see version 2.1 Quarter 2 .

5.4 C4 Corporate Action Plan to cover trust wide Staff Survey feedback in place

5.5 C5 Network or Networks Event held May 2023 and archived at the August 2023 committee – see version 2.1 Quarter 2.

5.6 The following controls in assurance were archived in August 2023; C6, C8, and C9 and can be located in Version 2.1 Quarter 2 of the BAF.

5.7 C13 Delivery of the People Promise – staff experience, has been added.

5.8 C14 Delivery of the Nursing and AHP retention and recruitment programme, has been added.

5.9 C15 Delivery of the Nursing and AHP retention and recruitment programme, has been added.

5.10 C16 Senior Medical Leadership Development Programme, has been added.

Gaps in controls

5.11 G2 The procurement process for the joint senior leadership development programme has now been completed.

5.12 G3 Development of new People Strategy for 2024/2027, has been added.

5.13 G4 Development of a workforce plan aligned to clinical, operational and financial plans has been added.

5.14 G5 Challenges around sufficient workforce to support the recovery plan (including industrial action) – this gap is mirrored in the gap G6 found in BAF D5.

In addition, the Board will note the addition of the word 'financial' in the descriptor of the risk.
It is recommended that the score remains at **12** which the Board will note remains within the current approved risk appetite.

6 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 times and potential for patient deterioration and inability to deliver our Operational Plan.

6.1 Strategic BAF risk D5 is aligned to the Finance and Performance Committee. Following the monthly review during July and August 2013 and in relation to the future financial position, it was initially recommended for the risk score to remain at 15. However, following detailed discussions at the Finance and Performance Committee in August, the Committee reviewed the consequence score and in light of the ongoing industrial actions and the associated impact both operationally and financially, the Committee recommended increasing the consequence score to **4** (business interruption). This would result in an increase of the overall risk score to **20.**

Controls in Place
Additional clarity has been added to the BAF risk in red as follows:

6.2 Controls C1, C2, C3, C4 and C6 have been updated with the date of latest assurance received and additional forms of assurance confirmation.

6.3 Control C7 has been amended to show that meetings are now held twice monthly rather than weekly as before.

Gaps in Controls

6.4 Gap G1 – A paper supporting investment in additional capacity has been approved at ETM in May 2023 with a paper to ETM relating to the implementation of the bed reconfiguration in July 2023, this paper was subsequently approved at ETM in August 2023 and consultation commenced with implementation due mid-September 2023.

6.5 Gap G4 - Validation of waiting lists was undertaken, planned review with 360 to be scheduled – to commence September 2023 including data quality audit and the scope has now been agreed.

7 D7: There is a risk that we will not be able to sustain services in line with national and system requirements because of a potential deficit in 2023-24 leading to further financial instability.

7.1 Strategic BAF Risk D7 is aligned to the Finance and Performance Committee. Due to the continuing work around the financial plan it is recommended that the risk score remains at **15.**

Controls

7.2 C16 Financial forecast has commenced based on June financial position. Director of Finance in process of agreeing financial recovery plans with each accountable officer – these will be fed into monthly assurance meetings

Gaps in Controls

7.3 G3 Month 4 financial position year to date £1,300,000 adverse variance position. With a forecast of £6m variance at year end, however it is still believed a break even position can be achieved by management action and the use of reserves.

7.4 G10 - Continuing industrial action leading to increased financial outlay in order to cover medical and clinical shifts. Also linked to challenges around sufficient workforce to support the recovery plan (including industrial action); this gap has been added and is mirrored in BAF risks P1, D5 and U4 due to its effect across financial delivery, operational delivery, workforce and people risks and increased risk to patient safety as a result of continued industrial action.

Recommendations

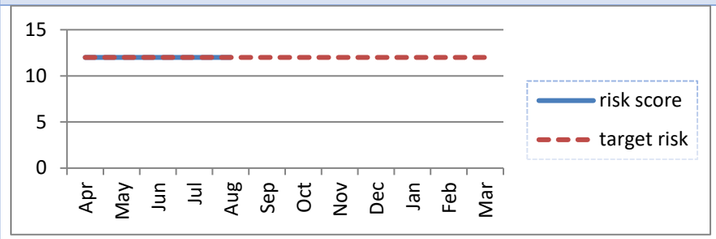
The Board is asked to:

- Discuss and note the current position relating to the Board Assurance Framework;
- Note and approve the recommendations to;
  - The score for BAF Risk P1 to remain at 12;
  - The score for BAF Risk R2 to remain at 8;
  - The score for BAF Risk O3 to remain at 8;
  - Increase the score for BAF Risk D5 to 20;
  - The score for BAF Risk U4 to remain at 12; and
  - The score for BAF Risk D7 to remain at 15.

Angela Wendzicha
Director of Corporate Affairs
30 August 2023

Board Assurance Framework Overview for Quarter 2: 2023-24

Ambition	Strategic Risk There is a Risk that….	Because…..	Leading to…..	Original Score LxC	Score Q1	Score Q2	Score Q3	Score Q4	Target Risk Score	Movement	Risk Appetite/ Risk Tolerance
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**	4(L)x 4(C)=16	**12**	**12**			3(L)x4(C) =12	⇔	Very low (1-5)
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**	2(L)x4(C)=8	**8**	**8**			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	**8**	**8**			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.**	2(L)x4(C)=12	**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.**	4 (L)x3(C) = 12	**12**	**20**			5(L)x4(C)=20	⇑	Low (6-10)
	D7: we will not be able to sustain services in line with national and system requirements	**…of a potential deficit in 2023/24**	**…further financial instability.**	3(L)x 5(C) = 15	**15**	**15**			3(L)x5(c) =15	⇔	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 2023-24**	
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**	**12** **3(L)x4(C)**	**3(L)x4(C) =12**	~~**Moderate (12-15)**~~ **Very Low (1-5)**		**Previous Score Q4 2022-23**	**Q1**	**Q2**	**Q3**	**Q4**
Link to Operational Plan: P1: Empower out teams to deliver improvements in care							**16**	**12**	**12**		
BAF Risk Description						**Linked Risks on the Risk Register & BAF Risks:** **RISK6623, RISK5761, RISK6474, RISK6809, RISK6800, RISK6630, RISK6762, RISK6627, RISK6623, RISK6886, RISK6414, RISK6284, RISK5238 and RISK6723**				**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.										**Quality Committee Chief Nurse and Medical Director**	

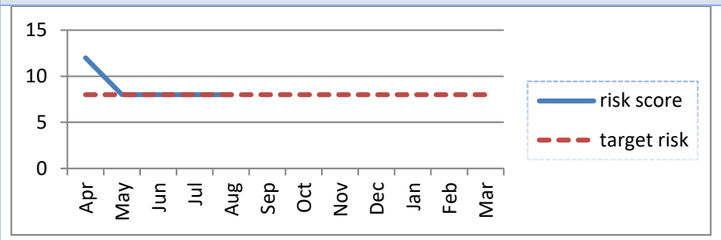
Controls and Mitigations ***(what have we in place to assist in securing delivery of our ambition)***		**Assurance Received** *(what evidence have we received to support the control)*	**Date Assurance Received**	**Confirmed By:**	**Assurance Level** *Level 1 = Operational* *Level 2 = Internal* *Level 3 - Independent*
C1	Quality Delivery Group in place with remit to deliver against CQC standards	Receipt of monthly assurance reports relating to progress against actions	July 2023	Deputy CEO	Level 1 & Level 3
		Quality Assurance Report to Quality Committee (Quarterly)	July 2023	Chief Nurse	Level 1& Level 3
		Monthly reporting to CQC in relation to Conditions on Registration.	Complete	Chief Nurse	Level 1& Level 3
C2	Established Tendable Audit Programme	Outcome reports received by Quality Committee on a rolling quarterly programme linked to specialist areas		Chief Nurse	Level 1
		Audit reporting programme now included in Committee report to Quality Committee – on a rolling quarterly programme linked to specialist areas – Patient Safety, Safeguarding, Patient Experience, Infection Control as aligns with work plan	May 2023	Chief Nurse	Level 2 – Medication Safety Audit completed
		Monthly Quality Dashboard reported to Divisional Performance Meetings.	July 2023	Chief Nurse	

		Published Patient Experience Annual Report on Trust website.							
C3	Agreed 2023/24 Quality Priorities in place	Progress reports received by Quality Committee quarterly Monthly metrics dashboard now presented for quantitive data. Clinical Effectiveness is a priority, Clinical Effectiveness Manager now in post.	June 26 2023	Chief Nurse	Level 1 Progress reports on Quality Priorities presented within each quarter Quarter 1 reports all received by Quality Committee				
C4	Implementation of actions following Patient Surveys	Progress reports received by Patient Experience Committee and monitored via Quality Committee.	June 26 2023	Chief Nurse	Level 1				
C5	Coordinated approach for learning from deaths	360 Assure Report with Limited Assurance – completed 13 of 15 actions from report. 360 Assure re-audit took place May 2023 – Split opinion with partial assurance. One outstanding action against learning from deaths being disseminated at CSU level. However report did note progress made overall. Learning from Deaths Report to Patient Safety Committee and Quality Committee	May 2023	Medical Director	Level 3 Outstanding actions – see G4 below: Learning from deaths at CSU level & Embedding SJR process Learning From Deaths Policy to be completed				
C6	Partnership working with Barnsley NHSFT	Quarterly peer reviews carried out re Quality Assurance (Q1 – Surgery)	Quarter 1	Chief Nurse/Medical Director	Level 1 – Awaiting final outcome report Medicine will be reviewed in December 2022 - revised date Medicine and Outpatients in February 2023, Community in March 2023 (this occurred but was internal only with Barnsley unable to participate), meaning all services will have been reviewed in financial year 2022/23. Reviews now completed External assurance process being reset for 2023/24, will be reviewed in Quarter 2 2023/24.				
C7	Quality Improvement & Quality Governance Assurance Priority within Operational Plan	Quarterly updates to Quality Committee	April 2023	Chief Nurse	Revised Quality Improvement and Quality Assurance Report with new format from October 2022 incorporating the CQC assurance report. 2022/23 report to be signed off April 2023 and 2023/24 report to go to Quality Committee June 2023.				Presented quarterly.
C8	Implementation of PSIRF	Monthly meetings established	April 2023	Chief Nurse	Fully signed off action plan in place and monthly meetings established. Throughout May 2023 multiple PSIRF plan workshops have been held, Strategic Board session planned for 02/06/2023.				
C9	Implementation of agreed Strategy for Journey to CQC Outstanding rating	Quarterly progress reports to Quality Committee (links with Gap 14), next is July 2023	April 2023	Chief Nurse	**Level 1**				
C10	Implementation of Safeguarding Improvement plan in conjunction with NHSE	Reports to Safeguarding Committee was July 2023	June 2023	Chief Nurse	External review NHSE paediatrics and maternity occurred on 01/06/2023, report due to be sent to TRFT by 30/06/2023, however not received as of 18/07/2023 12-17/07/2023 – Rotherham Adult Safeguarding Peer Review took place				
Gaps in Controls or Assurance Quarter 1 2023-24		**Actions Required**	**Action Owner**		**Date Action Commenced**	**Date Action Due**		**Progress Update**	

G1	Lack of suitable Quality Improvement methodology linked to the Operational Plan Developing a sustainable QI faculty and projects with identifiable patient benefits alongside QI methodology.	Review next stage Business Case Submission of next stage business case brief Gained approval at June 23 ETM to proceed to full business case – approved at ETM August 2023 – recruitment to commence	Chief Nurse & Medical Director Chief Nurse & Medical Director Chief Nurse & Medical Director	August 2022 March 2023 September 2023	~~September 2022~~ June 2023 ETM 8 June 2023			Recruitment for MD for Quality Improvement (2PA's) to be completed ETM ~~April~~ June 2023	**Out to advert**
G2	**Archived – see version 1.1 2023/24**								
G3	**Archived – see version 1.1 2023/24**								
G4	Lack of thematic reviews following Structured Judgement Reviews	Implement actions from 360 Assure Learning from Deaths report Process to be agreed to ensure learning from deaths is disseminated at CSU level New Learning from Deaths Policy being drafted	Medical Director Medical Director Medical Director		~~July 2022~~ ~~End December 2022~~ March 2024 End Q4 2023/24 End Q4 2023/24			Positive thematic reviews received for Surgery and Paediatrics. Business case to ETM by end of October 2022, draft received at Mortality meeting w/c 03/10/2022. Business case approved at ETM – awaiting recruitment. Completed recruitment of SJR Roles. Completed SJRs (18) are being sent to Divisions Mortality Leads every 4 weeks. Comments from all SJRs are themed and categorised in quarterly Thematic Analysis Reports. A meeting to finalise the Learning from Death policy is being held on 25/08/2023. This is to be approved by the Trust Mortality Group on 05/10/2023, in order to be approved by the Patient Safety Committee on 19/10/2023, before finally being submitted to the Trust's Documentation Ratification Group.	
G5	**Archived – see version 1.1 2023/24**								
G6	Implementing new ways of working for the Quality Governance & Assurance Team.	Recruit into Quality Governance & Assurance 8c Lead Role to support the central Governance Team	Chief Nurse	August 2022	October 2022 ~~Extend to June 2023~~ Extend to October 2023			~~Business case approved Executive Team Meeting 15 September 2022, follow up paper to identify governance structure to ETM 20/10/2022~~. Business case approved in principle Established Quality Governance Assurance Unit and are recruiting to all posts except the lead role	
G7	**Archived – see version 1.1 2023/24**								
G8	**Archived – see version 1.1 2023/24**								
G9	**Archived – see version 1.1 2023/24**								
G10	**Archived – see version 1.1 2023/24**								

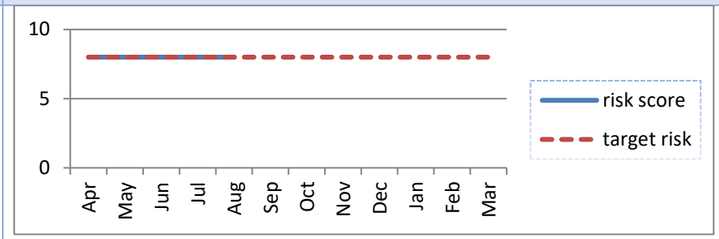
G11	Potential industrial action	Gap in lack of agreed plan at local and national level	Director of Workforce	Planned ballots underway	Ongoing			Mitigations in place, strategic command and control in place	
G12	**Archived – see version 1.1 2023/24**								
G13	**Archived – see version 1.1 2023/24**								
G14	**Archived – see version 1.1 2023/24**								
G15	**Archived – see version 1.1 2023/24**								
G16	**Archived – see version 1.1 2023/24**								
G17	Increased outbreak of CPE Infection	Managed through the Infection Prevention Control of Decontamination Meeting. UKHSA and ICB have been asked to attend site in May 2023 to undertake an assurance visit	Chief Nurse Chief Nurse	Ongoing May 2023	Ongoing May 2023			Weekly oversight meetings have ceased and moved to Heads of Nursing with oversight at ETM. Deep clean process remains ongoing with Executive oversight. Visit complete, report received and will be presented at IP&C, ETM and in the Clinical Effectiveness quarterly and annual report.	
G18	Lack of assurance regards quality of end of life care	Completion of action plan that has been created in response to 360 assurance report and NACEL 2022 alarm outlier status report Strategy went to May 2023 Quality Committee	Medical Director and Chief Nurse	January 2023	~~May 2023~~ September 2023 May 2023			Action plan created and shared internally and with external organisations Awaiting completion of NACEL and 360 audit action plan	
G19	Uncertainty regards referral pathway for some tertiary centre cancer services	Regular discussions between MD, COO, CEO. ICB input required.	Medical Director	March 2023	July 2023			Escalated to ETM and Board of Directors Temporary working arrangement agreed for provision of service	
G20	PSIRF preparation to go live in Autumn 2023.	Action plan developed following national guidance Quarterly reporting to Quality Committee and Patient Safety Committee	Medical Director and Chief Nurse	April 2022	March 2024			Monthly group meeting established	
G21	**Archived – see version 1.1 2023/24**								
G22	**Archived – see version 1.1 2023/24**								
G23	Plan to introduce a Ward accreditation programme	Strategic planning session with Heads of Nursing	Chief Nurse	19/06/2023	December 2023				
G24	As part of the Governance and Assurance Team review, decision required on possible partial centralisation of governance roles.	Paper required for ETM	Chief Nurse	June 2023	December 2023				
G25	**Archived – see version 2.1 Quarter 2**								
G26	Emerging concern regards National Emergency Laparotomy Audit as trust is an outlier which could be flagged to CQC	Update the Executive Team Identification of resources and Submission of data	Medical Director Clinical Effectiveness Manager	August 2023 January 2024					

G27	Challenges around sufficient workforce to support the recovery plan (including industrial action).	Locum and Insourcing arranged Longer term plan required to recruit a sustainable workforce (link with BAF Risk U4) Ongoing negotiations with JLNC regards extra contractual payments for medical and dental staff. Regular industrial action meetings to mitigate impact. Rates of pay agreed with medical staff to provide cover for junior doctor's strike. Specific challenges in relation to anaesthetic cover to support full theatre timetable impacting on elective recovery programme. Deep dive into underlying issues being undertaken with the division.	Divisional Leads Director of Workforce Director of Operations Director of Workforce Chief Operating Officer	Ongoing Commenced Commenced Completed June 2023	 Ongoing Ongoing March 2023			Director of Corporate Affairs discussed with Director of Workforce and will further assess need for a new BAF risk relating to a sustainable workforce. On the July FPC agenda for endorsement in respect of Extra Contractual work. Risk score could be higher than that Gold group determining this based on a risk assessment operationally that Deputy COO is putting together Discussion has taken place resulting in the agreement that the People Committee has sight of the BAF Risk and has oversight of the actions to mitigate this gap once confirmed with the Divisional leads. Development of workforce plan for UECC as a result of Acute Care Transformation work, monthly meetings held with CEO and COO. Improvements seen in nursing, support and doctor recruitment and retention. Paper to ETM outlining issues and anaesthetic, medical workforce review commenced, potential workforce solutions to ETM	
Archived Controls within month- Completed									
Archived Gaps within month - Completed									
G25	Clinical Effectiveness Manager to commence in post	Appointed and commenced in post – gap to be archived and now included as part of C3	Medical Director	June 2023	June 2023				

Strategic Theme: Patients	**Risk Scores**											
	BAF Risk Ref	**Initial Score**	**Current Score**	**Target Score**	**Risk Appetite/Risk Tolerance**	**Risk Movement**				**Board Assurance 2023-24**		
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~~** **2(L)x4(C)=8**	**~~12~~** **8**	**2(L)x4(C) =8** **Expectation to reduce the likelihood score further by end Quarter 3**	**Moderate (12-15)**					**Previous score Q4 2022-23**	**Q1**	**Q2**	**Q3**	**Q4**
Link to Operational Plan: ***R2: Ensure equal access to services***										**12**	**8**	**8**		
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		**~~December~~** July 2023	Board minutes	Level 1				Control remains ongoing		
C2	Trust is a member of Prevention and Health Inequalities Group	Reference included within PLACE report to Board		**~~July~~ August**		Level 1				**Control remains ongoing**		
C3	Trust is a member of the Health and Wellbeing Board			**July**		Level 1				**Control remains ongoing**		
C4	Deputy Chief Executive attends the Health Select Commission			**July**	**Minutes**	Level 3				**Control remains ongoing**		
C5	Shared Public Health Consultant between RMBC and the Trust commences March 2023	Commenced in post		**March**	**In post**	Level 1				**Completed – To be archived**		
C6	Meeting with PLACE colleagues to review IDT position.	Meet three times a week to review integrated discharge position.		**May 2023**		Level 1				**Control remains ongoing**		
C7	Shared Public Health Consultant chairs the Population Health Management Operational Group across Rotherham					Level 1				**Control remains ongoing**		

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		Deputy Chief Executive	Ongoing				Awaiting final confirmation from external source	

	of the ICB once established.								
G2	Unknown entity around the ICB governance which is continuing to evolve and mature.		Deputy Chief Executive	Ongoing				Paper expected for the September Board No change to position	
G3	Incomplete data driven identification of Health Inequalities across elective and non-elective pathways.		Deputy Chief Executive		End Quarter 1			Data relating to access to services available in Trust Integrated Performance Report – suggest close this gap. Gap Closed	

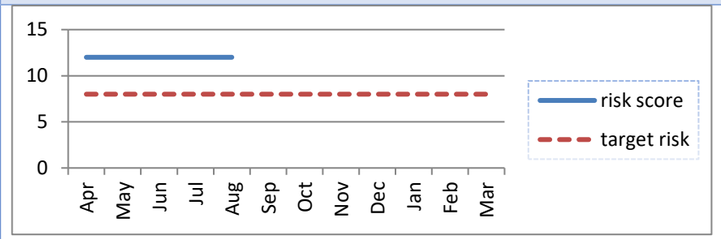
Strategic Theme: Patients	**Risk Scores**										
	BAF Risk Ref	**Initial Score**	**Current Score**	**Target Score**	**Risk Appetite/Risk Tolerance**	**Risk Movement**				**Board Assurance 2023-24**	
Strategic Ambition: **Our Partners: *We will be proud to collaborate with local organisations to build strong and resilient partnerships* that deliver exceptional, seamless patient care.**	**O3**	**~~3(L)x4(C)=12~~** **2(L)x4(C) = 8**	**8**	**2(L)x4(C) =8**	**Moderate (12-15)**		**Previous score Q4 2022-23**	**Q1**	**Q2**	**Q3**	**Q4**
Link to Operational Plan: P3: Our Partners: Work together to succeed for our communities.							**12**	**8**	**8**		
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 on an annual rotation basis	Monthly Reports received by the Trust Board	**July 2023**	**Board minutes**	Level 1				**Ongoing Control**
C2	Shared Chief Executive function between the Trust and Barnsley NHSFT	Completed	**01 September 2022 substantive**		Level 1				**Ongoing Control**
C3	Existing collaboration with Barnsley on some clinical services	Partnership Reports to Board	**July 2023**	**Board minutes**	Level 1				**Ongoing Control**
C4	Existing collaboration with Barnsley around Procurement function	In place. Reports to Finance and Performance Committee	**March 2023**		Level 1				
C5	Joint Strategic Partnership and Joint Executive Delivery Group established for oversight and delivery of partnership plan	Meetings of the Strategic Partnership every quarter, Monthly for Delivery Group.		**Reports to Boards on progress**	Level 1				

C6	Board approved Memorandum of Understanding in place relating to the partnership working between the Trust and Barnsley	Reports to Board to align with detail in MoU									
C7	Four Graduate Trainees across both Barnsley and the Trust										
C8	Interim Joint Chief Pharmacist in place										
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	Deputy CEO		September 2022			Paper to September Board.		Completed	

Board Assurance Framework People Committee: 2023/24 Quarter 2: Version 2.2

BAF Risk U4

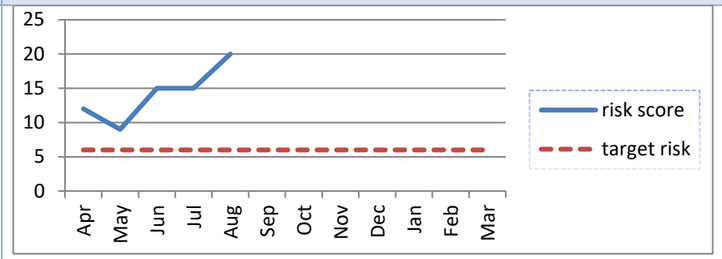
Strategic Theme: Us		Risk Scores										
	BAF Risk Ref	Initial Score	Current Score	Target Score	Risk Appetite/Risk Tolerance	Risk Movement				Board Assurance 2023-24		
Strategic Ambition: **Us:** ***We will be proud to be colleagues in an inclusive, diverse and welcoming organisation that is simply a great place to work.***	**U4**	**3(L)x4(C)=12**	**3(L) x 4(C) = 12**	**2(L)x4(C) =8**	**Moderate (12-15)**			**Previous score Q4 2022-23**	**Q1**	**Q2**	**Q3**	**Q4**
Link to Operational Plan: ***P3: Supporting our People*** ***P2: Improve engagement with our medical colleagues***								**12**	**12**	**12**		
BAF Risk Description						**Linked Risks on the Risk Register & BAF Risks:** **RISK6474, RISK6801, RISK5238 and RISK6723, *RISK 6284***				**Assurance Committee**		
U4: There is a risk that we do not develop and maintain a positive culture because of insufficient financial resources and the lack of compassionate leadership leading to an inability to recruit, retain and motivate staff.										**People Committee Director of People**		
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 inclusion of BELL Framework – Started initial stakeholder engagement sessions for new People Strategy	**tbc**	**tbc**	Level 1							
C2	Archived – see version 2.1 Quarter 2											
C3	Behavioural Framework in place within the Trust	Executive Directors weekly walk rounds Agenda item on Executive Team weekly meetings Included within Appraisal Season review to be evaluated late 2022	October 2022	Report to Execs	Level 1							
C4	Staff Survey Action Plans including: WDES, and WRES action plans	Progress against action plans monitored via Operational Workforce Group and People Committee – Corporate Action Plan to cover trust wide Staff Survey feedback in place.		Reports to People Committee Board minutes	Level 1 Level 2							

		All Divisions attended Joint Partnership Forum to detail action plans WDES and WRES signed off by Trust Board Revised WRES action plan signed off by the Board of Directors	21 July 2022 October 2022 January 2023	Board minutes	Level 2				
C5	Archived – see version 2.1 Quarter 2								
C6	Archived – see version 2.1 Quarter 2								
C7	Archived – see version 1.1 2023/24								
C8	Archived – see version 2.1 Quarter 2								
C9	Archived – see version 2.1 Quarter 2								
C10	Archived – see version 1.1 2023/24								
C11	Archived – see version 2.1 Quarter 2								
C12	Archived – see version 1.1 2023/24								
C13	Delivery of the People Promise – staff experience	NHS Staff survey Including Medical engagement	Q4 2023/4 Q4 2023/4		Level 3				
C14	Delivery of the Nursing and AHP retention and recruitment programme	Reports to People Committee	tbc	Tbc	Level 1				
C15	Delivery of the Nursing and AHP retention and recruitment programme	Reports to People Committee	tbc	Tbc	Level 1				
C16	Senior Medical Leadership Development Programme	Reports to People Committee	Tbc	tbc	Level 1				

Gaps in Controls or Assurance Quarter 1 2022-23	**Actions Required**	**Action Owner**	**Date Action Commenced**	**Date Action Due**			**Progress Update**	
G1	**Archived – see version 1.1 2023/24**							
G2	Leadership Programme in place for Divisional	Identify suitable leadership development programme provider.	Deputy Chief Executive	Scope to be revised and intensive programme to be agreed.	End November 2022			Tender documentation signed off by Deputy CEO.	

	Triumvirate leadership teams							Procurement exercise scheduled 18/07/23	
G3	Development of new People Strategy for 2024/2027	Engagement work Research best practice National regional and local context	Director of People	Q2	End March 2024			Early internal engagement underway, People Committee session to be planned Q3	
G4	Development of a workforce plan aligned to clinical, operational, financial plans etc.	Consider scope Priority areas Proposal to take forward Engagement and work	Director of People	To begin Q3	End March 2024			Future dated.	
G5	Challenges around sufficient workforce to support the recovery plan (including industrial action).	Locum and Insourcing arranged Longer term plan required to recruit a sustainable workforce (link with BAF Risk U4) Ongoing negotiations with JLNC regards extra contractual payments for medical and dental staff. Regular industrial action meetings to mitigate impact. Rates of pay agreed with medical staff to provide cover for junior doctor's strike. Specific challenges in relation to anaesthetic cover to support full theatre timetable impacting on elective recovery programme. Deep dive into underlying issues being undertaken with the division. Financial allocation identified in plan for 2023/24 – risk in allocation of ERF given overall financial position	Divisional Leads Director of Workforce Director of Operations Director of Workforce Chief Operating Officer	Ongoing Commenced Commenced Completed June 2023	 Ongoing Ongoing March 2023			Director of Corporate Affairs discussed with Director of Workforce and will further assess need for a new BAF risk relating to a sustainable workforce. On the July FPC agenda for endorsement in respect of Extra Contractual work. Risk score could be higher than that Gold group determining this based on a risk assessment operationally that Deputy COO is putting together Discussion has taken place resulting in the agreement that the People Committee has sight of the BAF Risk and has oversight of the actions to mitigate this gap once confirmed with the Divisional leads. Development of workforce plan for UECC as a result of Acute Care Transformation work, monthly meetings held with CEO and COO. Improvements seen in nursing, support and doctor recruitment and retention. Paper to ETM outlining issues and anaesthetic, medical workforce review commenced, potential workforce solutions to ETM	
Archived Controls within month - Completed									
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 - New template agreed at People Committee	September 2022	Report to People Committee					
C5	Trust has in place staff Inclusion networks (BAME, LGBTQ+, Disability)	Various meetings take place on regular basis, reporting into Operational Workforce Group	July 2022	Reports to People Committee					

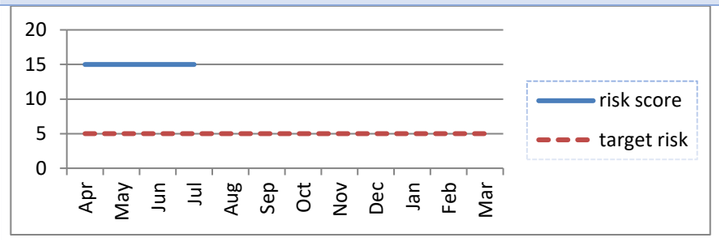
		which in turn reports into People Committee Network or Networks Event held May 2023							
C6	Establishment Control Panel for recruitment of staff	Meets on a weekly basis and reports into the Operational Workforce Group	October 2022	Ongoing activity					
C8	Additional staff engagement sessions	Funding secured and sessions confirmed led by Head of Engagement reporting to the Operational Workforce Group TRFT part of the national 'Flex for the Future' Medical Engagement Programme	July 2022	Ongoing activity					
C9	Reciprocal Mentoring Programme in place	Progress reports to People Committee Workforce Enabling Group Second cohort to include external stakeholders from PLACE Reciprocal Mentoring Workshop completed. Reciprocal Mentoring Workshop Report to Trust Board	8 Sept 2022 November 2022 December 2022						
C11	Executive Team approved funding for protected time for Trade Unions and staff side Chairs	Report to Executive Team	July 2022	Action completed					
Archived Gaps within month - Completed									

Strategic Theme: Delivery	Risk Scores										
	BAF Risk Ref	Initial Score	Current Score	Target Score	Risk Appetite/Risk Tolerance	Risk Movement				Board Assurance 2023-24	
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**	**4(L)x3(C)=12**	**5(L)x~~3~~4=~~15~~20**	**2x3=6**	**Very low (1-5)**		**Previous Score Q4 2022-23**	**Q1**	**Q2**	**Q3**	**Q4**
Link to Operational Plan: D5: Implement sustainable change to deliver high quality, timely and affordable care							**6**	**15**	**~~15~~20**		
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, Risk 6569, RISK6800, RISK6627, RISK6762 RISK6414 and RISK6801**				**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 waiting times of patients in UECC	Metric included in the Integrated Performance Report Weekly report to ETM Daily review of position and weekly through the acute care performance meeting and ETM 4 hour performance has been reintroduced Waiting times have improved in UECC and monitored against trajectory	**May 2023** **May 2023** **July 2023** **August 2023**	**Minutes of F&P** **ETM minutes** **ETM minutes** **ETM minutes**	Level 1					COO	
C2	Divisional Performance meetings chaired by the Deputy CEO.	Monthly reports within IPR to Finance and Performance Committee and Board Divisional Performance meetings with each CSU	June 2023	**Chair's Log**	Level 1					Deputy CEO	
C3	Monitoring right to reside and Length of Stay data	Monthly reports to Finance and Performance Committee and Board Weekly Length of Stay reviews Improvement with regards to right to reside and IDT caseload Escalation meetings with external partners.	**May 2023** **June 2023** **August 2023**	**Minutes of F&P** **Weekly ETM minutes** **Weekly ETM minutes**	Level 1					COO	

		Oversight through the new Rotherham Place Urgent and Emergency Care Group (Previously the A&E Delivery Board) Number of patients with no right to reside and number on IDT caseload has reduced.							
C4	Dental and medical workforce vacancy panel chaired by the Medical Director	Additional sessions for dental and medical workforce Additional sessions to address where there is greater need Report through to People Committee	**June 2023** **August 2023**	**Notes of the panel** **Notes of the panel**	Level 1				Deputy CEO to chair
C5	Admission avoidance work remains ongoing	The Rotherham Urgent and Emergency Care Group established from September 2022 (replaced A&E Delivery Board and Urgent and Community Transformation Group). It is chaired by the Deputy Pace Director and deputy chair COO, part 2 focuses on transformation and is led by TRFT Deputy CEO and Director of Adult Social for RMBC. Internal pathway group chaired by medical director focussing on emergency pathways Step up pathways to virtual ward have been implemented, admission avoidance work with YAS direct to Community Urgent Response has also commenced.	**August 2023**	**Minutes of meeting**	Level 1				Rotherham Urgent and Emergency Care Group Chief Operating Officer ACT Steering Group – emergency pathway workstream Medical Director
C6	Executive Team oversight	Weekly receipt of Performance Report and Recovery Report	**June 2023** **August 2023**	**ETM minutes Weekly** **ETM minutes Weekly**	**Level 1**				Weekly Executive Team Meeting Director of Strategy Planning & Performance
C7	Twice per month Acute Performance Meeting chaired by CEO	Weekly oversight	**August 2023**	**Weekly agenda and action log**	**Level 1**				Twice per month Acute Performance Meeting CEO and COO
C8	Archived as amalgamated into C3– see version 1.2 2023/24								
C9	Weekly access meetings with tracker for elective recovery schemes	To include financial allocation from ERF reserve	**COO**	**Ongoing**	**Level 1**				Elective Review Meeting COO DoF
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 resulting in high bed occupancy	Additional bed capacity utilising additional national G&A capacity funding. Bed reconfiguration to right size medicine and surgery based on bed modelling.	COO	Q1	Q3			Paper approved at ETM May 2023 supporting investment in additional capacity Sitwell to be opened as additional surge following winter de-escalation Bed reconfiguration to be undertaken in advance of winter. Virtual ward development underway. Paper to ETM re implementing bed reconfiguration in July 2023. Paper approved and consultation commenced and implementation due mid-September 2023.	
G2	Archived – see version 1.1 2023/24								
G3	Ring-fence interim frailty assessment beds	ICS SDEC pathways confirmed.	COO	Q1	Q4			Frailty model introduced with frailty service in reach – not dependent on ring-fenced beds. Assessments undertaken in UECC, 'time-out' session with the team to review further development of the service and model. Bed base for frailty to be identified as part of reconfiguration and then this risk can be closed and archived.	
G4	Review of validation and management of waiting lists Includes Diagnostic PTL	360 Assure audit to validate waiting lists planned Weekly position to be included in performance position Information for ETM IPR and development of Diagnostic PTL	Director of Strategy, Planning and Performance Director of Strategy, Planning and Performance	Q2 Q1 Q1	Q4 Q2			Validation of waiting lists being undertaken, planned review with 360 to be scheduled – to commence September 2023 including data quality audit – met with 360, plan being developed and scope agreed. Weekly diagnostic information available, forecasting of month end position to be introduced	
~~**G5**~~	Archived – see version 1.1 2023/24								
G6	Challenges around sufficient workforce to support the recovery plan (including industrial action).	Locum and Insourcing arranged Longer term plan required to recruit a sustainable workforce (link with BAF Risk U4) Ongoing negotiations with JLNC regards extra contractual payments for medical and dental staff. Regular industrial action meetings to mitigate impact. Rates of pay agreed with medical staff to provide cover for junior doctor's strike.	Divisional Leads Director of Workforce Director of Operations Director of Workforce	Ongoing Commenced Commenced Completed	Ongoing Ongoing March 2023			Director of Corporate Affairs discussed with Director of Workforce and will further assess need for a new BAF risk relating to a sustainable workforce. On the July FPC agenda for endorsement in respect of Extra Contractual work. Rates now agreed and implemented. Risk score could be higher than that Gold group determining this based on a risk assessment operationally that Deputy COO is putting together – sessions being undertaken at new rates, risk reduced. Discussion has taken place resulting in the agreement that the People Committee has sight of the BAF Risk and has oversight of the actions to	

		Specific challenges in relation to anaesthetic cover to support full theatre timetable impacting on elective recovery programme. Deep dive into underlying issues being undertaken with the division.	Chief Operating Officer	June 2023				mitigate this gap once confirmed with the Divisional leads. Development of workforce plan for UECC as a result of Acute Care Transformation work, monthly meetings held with CEO and COO. Improvements seen in nursing, support and doctor recruitment and retention. Paper to ETM outlining issues and anaesthetic, medical workforce review commenced, potential workforce solutions to ETM – time out with team planned and insourcing for the interim term.	
G7	Financial investment/resources to support recovery of waiting lists	Financial allocation identified in plan for 2023/24 – risk in allocation of ERF given overall financial position						Agreement on schemes to support recovery for next 2-3 months. Currently being costed and implemented. Paper to ETM and July FPC regarding recovery plan. Paper agreed at ETM for July/August, schemes with an outline of schemes to inform allocation for remainder of the year.	
Archived Controls within month – Completed									
Archived Gaps within month - Completed									

Strategic Theme: Us		Risk Scores											
		BAF Risk Ref	Initial Score	Current Score	Target Score	Risk Appetite/Risk Tolerance	Risk Movement				Board Assurance 2023-24		
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.		**D7**	**3(L)x5(C)=15**	**3 (L) x 5(C) =15**	**1(L)x5(C) =5**	**Low (6-10)**		**Current**	**Q1**	**Q2**	**Q3**	**Q4**
Link to Operational Plan: D7: Implement sustainable change to deliver high quality, timely and affordable care								**15**	**15**	**15**			
BAF Risk Description							**Linked Risks on the Risk Register & BAF Risks** **RISK6886 and RISK6801**				**Assurance Committee**		
D7: There is a risk that we will not be able to sustain services in line with national and system requirements because of a potential deficit in 2023/24 leading to further financial instability.							**Risk**				**Finance and Performance Committee** **Director of Finance**		
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	Improvement of clinical productivity to levels experienced in 2019/20 without central funding for outsourcing clinical activities	Monthly Elective Programme Meeting chaired by Chief Operating Officer		**November 2022**			L1						
C2	CIP Track and Challenge in place			**November 2022**	**ETM minutes**		L1						
C3	Contingency of £1.5m in place.				**Trust Board April 2023**		L1						
C4	Winter funding allocated in reserves of £2m.				**Trust Board April 2023**		L1						
C5	Elective recovery fund £5.2m				**Trust Board April 2023**		L1						
C6	TRFT received access to growth money allocated to PLACE.				**Trust Board April 2023**		L1						
C7	Financial plan sign off to NHSE by 04/05/2023	Submitted on time, still awaiting sign off by NHSE			**Trust Board 28 April 2023**								
C8	Service developments held in reserve of £2.5m.				**Trust Board April 2023**								
C9	Finance and Performance Committee oversee budget reports	Budget reports presented to Finance and Performance Committee		December 2022	Minutes of F&P		Level 1						
C10	System wide delivery of Recovery On plan with mitigations in place to	Director of Finance attends South Yorkshire DoF Group		December 2022			Level 1						
		Monthly Finance Report to CEO Delivery Group		December 2022	Minutes		Level 1						

	manage winter pressures.	South Yorkshire Financial Plan Delivery Group			Level 1				
C11	Suitably qualified Finance Team in place	Team in place	N/A	N/A	Level 1				
C12	Established Capital Monitoring Group	Capital and Revenue Plan signed off by Board	November 2022	Board of Directors minute					
C13	Current Standing Financial Instructions in place	Reviewed and approved by Board	November 2021	Board of Directors minute	Level 1				
C14	Internal Audit Reports	Internal Audit Financial Reports	**July 2022**	Report	Level 3				
		Review of HFMA Improving NHS Financial Sustainability checklist	**December 2022**	**Report**	Level 3				
		360 Assure Head of Audit opinion presented to Risk and Audit Committee initial indications show Significant Assurance overall	April 2023	Report	Level 3				
C15	Monthly challenge on performance	Monthly Divisional Assurance meetings	November 2022	Chair's Log to F&P					
C16	Clarity on Financial Forecast	Financial forecasts completed for Divisional and Corporate areas monitored within Finance Report. Financial forecast has commenced based on June financial position. Director of Finance in process of agreeing financial recovery plans with each accountable officer – these will be fed into monthly assurance meetings.	July 2023	Minutes of F&P	Level 1				

Gaps in Controls or Assurance Quarter 1 2022-23		**Actions Required**	**Action Owner**	**Date Action Commenced**	**Date Action Due**			**Progress Update**	
G1	Unsustainable agency spend (Risk Now)	Weekly Agency Group meets, chaired by Michael Wright	Deputy CEO	Q1	Ongoing				
G2	Recurrently deliver CIP in 2023/24 (Risk Now)	CIP Group Monthly. PMO tracking CIP delivery. CIP report to F&PC monthly.	Deputy CEO	Q1	Ongoing				
G3	Adherence to expenditure Run Rate as per financial plan (Risk Neutral)	Monthly budget reports. Expenditure profile produced monthly throughout year. Reserves Policy in place. F&PC oversight. Internal audit systems budgetary control audit. External audit annual accounts. Month 4 financial position year to date £1,300,000 adverse variance position. With a forecast of £6m variance at year end, however it is still believed a break even position can be achieved by management action and the use of reserves.	Director of Finance	Q1	Ongoing				

G4	Potential reduction of cash balances due to expenditure higher than income which would result in late payments to suppliers. Impact to invest in capital projects. (Future Risk)	Situation acceptable currently, future risk	Director of Finance					For Gaps G4-G7 awaiting further national guidance to fully assess the position.	
~~G5~~	**Archived – see version 1.1 2023/24 - Completed**								
G6	Increased cost improvement programme due to national reductions in funding to the South Yorkshire allocation linked to funding formula suggesting South Yorkshire is overfunded. (Future Risk)	Future income risk	Director of Finance						
~~G7~~	**Archived – see version 1.1 2023/24 - Completed**								
G8	Risk that payment by results returns on elective activity with a lack of understanding of the potential impact on elective activity.	Deputy Director of Finance assessing the potential impact in conjunction with the planning guidance expected by the end Quarter 3.	Deputy Director of Finance						
~~G9~~	**Archived – see version 1.1 2023/24 – Completed**								
	Divisional Budgets signed off	Monitoring via Finance Reports	July 2022	Reports to F&P	Level 1				
	Financial forecasts come to fruition (Future Risk)	Monthly check and challenge with relevant Divisions and Corporate areas.	Director of Finance						
G10	Continuing industrial action leading to increased financial outlay in order to cover medical and clinical shifts. Also linked to challenges around sufficient workforce to support the recovery plan (including industrial action).	Regular industrial action meetings to mitigate impact. Finance team are currently working on a cost per day figure for future forecasting. Locum and Insourcing arranged Longer term plan required to recruit a sustainable workforce (link with BAF Risk U4) Ongoing negotiations with JLNC regards extra contractual payments for medical and dental staff. Regular industrial action meetings to mitigate impact.	Director of Finance. Divisional Leads Director of Workforce Director of Operations Director of Workforce	Reports to F&P Ongoing Commenced Commenced Completed	 Ongoing Ongoing March 2023			**Director of Corporate Affairs discussed with Director of Workforce and will further assess need for a new BAF risk relating to a sustainable workforce.** **On the July FPC agenda for endorsement in respect of Extra Contractual work.** **Risk score could be higher than that Gold group determining this based on a risk assessment operationally that Deputy COO is putting together** **Discussion has taken place resulting in the agreement that the People Committee has sight of the BAF Risk and has oversight of the actions to mitigate this gap once confirmed with the Divisional leads.** **Development of workforce plan for UECC as a result of Acute Care Transformation work,**	

		Rates of pay agreed with medical staff to provide cover for junior doctor's strike. Specific challenges in relation to anaesthetic cover to support full theatre timetable impacting on elective recovery programme. Deep dive into underlying issues being undertaken with the division.	Chief Operating Officer	June 2023				**monthly meetings held with CEO and COO.** **Improvements seen in nursing, support and doctor recruitment and retention.** **Paper to ETM outlining issues and anaesthetic, medical workforce review commenced, potential workforce solutions to ETM**	
Archived Controls within month - Completed									
Archived Gaps within month – Completed									

Board of Directors' Meeting
8th September 2023

The Rotherham NHS Foundation Trust

Agenda item	P143/23
Report	**Responsible Officer Report - Q1 2023/24 and Annual Board Report & Statement of Compliance**
Executive Lead	Dr Jo Beahan, Medical Director & Responsible Officer
Link with the BAF	P1; U4
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 purpose of this report is to present to the Board details of activity related to Medical Appraisal and Revalidation, as per NHS England and GMC regulations.
	
	Key points:
	• NHS England has changed to a more supportive appraisal with less evidence of courses and CPD from the doctor. The focus is on reflections and compliments, complaints, courses and QI projects.
	• Recommendations for Revalidation to the GMC are being made well in advance of the due date, this does not affect the future Revalidation dates.
	• Allocate is soon to end the contract for appraisal with The Rotherham NHS Foundation Trust (TRFT) and the team is working with procurement to look at new platforms.
	First quarter 2023/24 appraisal performance:
	  • 36 doctors were due their appraisal.
	  ○ 32 have completed their appraisals and the others have booked appointments/awaiting outputs.
	  ○ There is one doctor who is a current cause for concern with non engagement and this has been discussed with GMC and the doctor being supported.
	
	The Statement of Compliance is to be signed and returned to NHS England by Tuesday 31st October 2023. The document should be signed by the Chair or Chief Executive of the designated body's Board.

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 a quarterly basis, but no other Committee. However, this report will be presented to the quarterly Responsible Officer's Advisory Group (ROAG) moving forward and has been discussed and approved.
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?)	
Recommendations	It is recommended that the Board notes the quarterly data.
Appendices	1. Medical Appraisal Figures for Q1 2023/24 2. Designated Body Annual Board Report 2022-23 & Statement of Compliance

1.0 Introduction

NHS England has continued to focus on appraisal as being supportive and reflective conversations, with less emphasis on written documentation. The suggested 2020 template incorporates specific additional questions around personal wellbeing. This has been included within our appraisal dialogue. Revalidation information is now available 12 months in advance. Doctors are being sent reminders and only a few have been deferred due to lack of evidence.

2.0 Performance

2.1 The processes of Appraisal and Revalidation are well embedded within the Trust and this is reflected in the figures for 2022/23, which demonstrates continued good engagement.

2.2 We currently have 24 appraisers, with a target of 28. The advertisement will go out in September to recruit more. There has been interest form some colleagues already. The divisions with fewer or no appraisers are being encouraged to get involved more.

2.3 Feedback from completed appraisals for 2022/23 has been fed back to all the appraisers. As stated previously it was excellent. The appraisal group are looking at ways to make it supportive and yet challenge the doctor to perform better whilst being sensitive of the times.

2.5 Flows of information to doctors regarding complaints, compliments and incidents has improved. Regular updates are sent to the appraisal team with the complaints and Si reports. This information in almost all cases is shared with the doctors involved at the same time.

2.6. The Appraisal Policy has been ratified.

2.7 Plans are ongoing to look at bids for a new appraisal platform as the contract with allocate is due to run out. The support received from Allocate has been variable and unsatisfactory.

2.8 The NHS England revalidation checklist is populated by the appraisal Support Managers, checked by the Associate Medical Director for Appraisals and then forwarded to the Responsible Officer for approval. Once a revalidation decision is made, the recommendation is sent to GMC and the document is filed for future reference.

2.9 Communication with the GMC regarding concerns has continued throughout this time via the ELA network.

2.10 The General Dental Council does not require dentists to have an appraisal separate from job planning but the Trust's Dental Clinical Director has agreed to use a supportive appraisal document for the TRFT community dentists and send a copy to the appraisal office to be filed. This had not happened recently as the Clinical Director being off on maternity leave. This has been discussed again and will resume immediately.

3.0 Conclusion

3.1 Appraisal figures for this quarter are at a reasonable rate.

3.2 The highly personalised approach we have taken in appraisal has helped to support doctors during times of great challenge, and feedback suggests it has been valued and appreciated.

Dr Jo Beahan
Medical Director & Responsible Officer
September 2023

Appendix 1

Indicator		Q1 01/04/2023 – 30/06/2023
1	**Number of doctors[1] due to hold an appraisal meeting** in the reporting period Note: This is to include appraisals where the appraisal due date falls in the reporting period or where the appraisal has been re-scheduled from previous reporting periods (for whatever reason). The appraisal due date is 12 months from the date of the last completed annual appraisal or 28 days from the end of the doctor's agreed appraisal month, whichever is the sooner.	36
1.1	Number of those within ♯3 above who **held an appraisal meeting** in the reporting period	32
1.2	Number of those within ♯3 above who **did <u>not</u> hold an appraisal meeting** in the reporting period **[These to be carried forward to next reporting period]**	4
1.2.1	Number of doctors[1] in 3.2 above for whom **the reason is both understood and accepted by the RO/ Appraisal lead**	4
1.2.2	Number of doctors[1] in 3.2 above for whom **the reason is either <u>not</u> understood or accepted by the RO**	0

Board of Directors' Meeting
September 2023

The Rotherham NHS Foundation Trust

Agenda item	Appendix 2
Report	**Responsible Officer's Annual Report & Statement of Compliance**
Executive Lead	Dr Jo Beahan, 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 by Tuesday 31st October 2023. 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 94.8%.* *The number of trained Appraisers is 26 for 272 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 2023

Designated Body Annual Board Report 2023
Section 1 – General:

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

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

Action from last year: Confirm interim RO arrangements with departure of the previous Medical Director/RO, pending appointment of substantive Medical Director/RO replacement.

Comments: The new Medical Director and Responsible Officer (RO) was appointed in December 2022. The Deputy Medical Director has completed the responsible officer training and is now the Deputy RO.

Action for next year: Continue the RO arrangements and complete refresher training as needed.

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

Action from last year: Clarification of resource available within MD/RO budget and creation of a nominal non-pay budget to support RO functions

Comments*:* The Business manager to the Medical Director has reviewed the Medical Director's budget with the Medical Director, Deputy Medical Director and the corporate Finance manager. Funds have been identified within the budget to be used for RO purposes.

Action for next year: continue to ensure that funds are available in the Medical Director budget for RO purposes.

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

Action from last year: The appraisal and revalidation officer routinely receive the "new starters and leavers" list from Medical & Dental Workforce

Comments: This is currently received once a month and gives information on those who have started and left since the last report. It does not currently provide information about the future medical workforce. The medical establishment list can be requested which does include approaching start and end dates for doctors, in order for the team to remain more up to date.

Action for next year: To request the medical establishment list on a monthly basis to be used alongside the 'new starters and leavers' list.

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

Action from last 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.

Comments: The appraisal policy has been amended. The mentorship service has been extensively advertised and supported. The new version of "Good Medical Practice" has been published in draft form and will come into effect on 30th January 2024.

Action for next year: Review appraisal policy to ensure remains current, once the new version of the GMC "Good Medical Practice" comes into effect.

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

Action from last year: Complete external review and implement recommended changes.

Comments: The AMD for appraisal and revalidation and mentorship has engaged with Barnsley NHS Trust to carry out a peer review and this will be completed.

Action for next year: 1. Offer further training where needed and support appraisal colleagues who need to improve. 2. Complete the external review and implement any recommended changes.

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

Comments: This process remains in place.

Action for next year: Ensure that a recent appraisal document is requested for all new starters and locums by medical HR as part of induction process. Medical HR to ensure the Induction for international medical graduates (IMG) is implemented for all new starters.

Section 2a – 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: Appoint Deputy Appraisal Lead. Ensure minimum 3-yearly MSF (peer and patient). Introduce a new pre-appraisal checklist.

Comments: The Deputy Appraisal Lead appointment has been put on hold. A Decision was made in the Responsible officer advisory group (ROAG) for multisource feedback (MSF) to be done within the 3rd year of a doctor's revalidation cycle, and not 3-yearly.

Pre-appraisal checklist reminders are sent 3 months in advance, and include information on any serious incidents, complaints, MSF reminders, reflection reminders if they have been requested at coroner's court or to provide a coroners statement, and a reminder to be up to date with their mandatory training.

Action for next year: Ensure that all doctors have completed MSF and quality improvement (QI) and all requirements to be suitable for revalidation at least one year before the revalidation date. The Trusts newly appointed solicitor to provide additional support where needed to doctors who have been requested at coroners court, or to provide a statement.

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 support for appraisee and appraiser. The implementation of Allocate appraisal system provides a dashboard, which is regularly used to remind colleagues of appraisal dates.

Comments: The pre-appraisal checklist reminder which is sent 3 months prior to appraisal also asks the appraisee to ensure they make contact with their appraiser to arrange a meeting date if they have not already done so.

Action for next year: Current appraisal platform provider contract ends in November 2024. The platform is to be reviewed and a decision made to either keep this platform or to source another provider.

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: Ensure Medical Appraisal Policy is up to date and fully implemented

Comments: Finalised in May 2023.

Action for next year: Review appraisal policy to ensure remains current in line with the new "Good Medical Practice guidance" from the General Medical Council.

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: Continue to appoint Appraisers and appoint a Deputy Appraisal Lead.

Comments: Appraiser recruitment will remain a continuous process. 5 additional appraisers appointed, 3 already trained and 2 are awaiting training (planned for July 2023). The current medical appraisal total is 26, with an additional 2 non-medical appraisers. The Deputy Appraisal Lead role is on hold.

Action for next year: Continue appraiser recruitment and consider "in house" appraiser training.

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 provide 4 appraiser forums a year and ensure attendance at these. Appraiser review once a year.

Comments: Forums continue in person with alternating dates and timings to ensure all have the opportunity to attend. 22-23 appraisal feedback was outstandingly positive and has been shared with appraisers at the last forum.

Action for next year: To ensure that all appraiser review meetings are completed by end of second quarter, to include individual appraisal feedback from previous appraisal 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: Continue quarterly Board reporting.

Comments: process has continued

Action for next year: no change

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation:	
Total number of doctors with a prescribed connection as at 31 March 2023	272
Total number of appraisals undertaken between 1 April 2022 and 31 March 2023	258
Total number of appraisals not undertaken between 1 April 2022 and 31 March 2023	14
Total number of agreed exceptions	12

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: Continue with 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.

Comments: Horizon scan doctors who are a year from their revalidation date to ensure they are on track to have all required evidence. Where they are not the appraisal team will send them a reminder.

Action for next year: Continue with the horizon scan process

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: Continue to discuss and agree deferral recommendations with the relevant doctor prior to recommendation being made.

Comments: This has continued.

Action for next year: Ensure doctor has enough time to fulfil all revalidation criteriaAction from last year: All deferral recommendations are discussed and agreed with the relevant Doctor prior to being made.

Section 4 – Medical governance

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

Action from last 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.

Comments: Access to the centralised system that stores all serious incident (SI) and complaints data would be beneficial and would cut down on storage on the K drive of the complaints and SI emails received and stored so the team can remind doctors in their 3 month reminder.

Action for next year: Ensure that the appraisal team have access to centralised systems for complaints and SIs and that the process continues to work effectively.

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: Continue to strengthen the process for and tracking of, responding to concerns about a Doctors fitness to practice, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practice concerns.

Comments: The Responsible officer is now supported by the Deputy Medical Director as Deputy Responsible officer. This enables RO work to be delegated and give support to the RO. The Trust uses the Maintaining high professional standards policy.

Action for next year: Continue to strengthen the process for, and tracking of, responding to concerns about a Doctor's fitness to practise, supported by the necessary up to date policies.

3. There is a process established for responding to concerns about any licensed medical practitioner's1 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:** Seek and respond to feedback
>
> **Comments:** The Trust has an MHPS (maintaining high professional standards policy)
>
> This follows the national MHPS policy and includes arrangements for investigation and intervention for capability, conduct, health and fitness to practice
>
> **Action for next Year:** To ensure that all relevant policies are kept up to date.

4. 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.[3]

> **Action from last year**: Still very small number who have been involved, limiting the opportunity for feedback.
>
> **Comments**: There continues to be a 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. 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.
>
> **Action for next year**: Provide analysis where possible, accepting that there is still very small number who have been involved.

5. 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[2].

> **Action from last year**: Continue to support information sharing in a timely manner. Ensure that the Medical Practice Information Transfer (MPIT) Form is sent for all leavers and requested for all new medical starters (non-Deanery).
>
> **Comments**: There are variable responses, mainly when dealing with Locum Agencies. The RO does complete MPIT forms for leavers.
>
> **Action for next year**: Ensure that the Medical Practice Information Transfer (MPIT) Form is sent for all leavers and requested for all new medical starters (non-Deanery).

6. 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**: Review of cases to be presented at RO's Advisory Group.
>
> **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

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

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.

The numbers too small currently to comment. There is awareness of national data around this issue.

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: Reinstate monthly reporting and seeking 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 and Dental Workforce

Comments: Pre-employment checks are carried out by the Medical & Dental workforce team. The Head of Medical & dental workforce has left the Trust and this post currently vacant. The Medical and Dental HR team will be managed under the Medical Director and RO going forwards and the processes will be strengthened.

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

Action for next year: Continue to strengthen processes with the Medical and Dental HR team to ensure that all checks are completed in a timely manner.

Section 6 – Summary of comments, and overall conclusion

The Medical Director and Responsible Officer was appointed in December 2022, followed by the appointment of Deputy RO.

The majority of the actions listed in last year's report have been completed.

Although the move from the older MAG form to an electronic platform (eAllocate) form has been welcomed, the appraisal team feel the current electronic platform is not able to fulfil all appraisal expectations. Given that the current contract is up in November 2024 an alternative provider may be sought.

Overall engagement in medical appraisal continues to be very good and reflects the enthusiasm of the current group of appraisers. The Trust has achieved 96% compliance with appraisal. The feedback we have received from our doctors about the appraisal process has been outstandingly positive.

The majority of appraisal meetings have returned to face to face, with the use of the designated appraisal room. Where a face to face meeting is not possible MS Teams is used.

Trained appraiser numbers have increased with the recent recruitment drive, which will remain a continuous process. This increase has improved access and choice of appraisers for our doctors. It has also meant we do not need to regularly ask appraisers to carry out more than the 10 contracted appraisals per year.

The appraisal team is now informed of SI and complaint reports, and are also informed of any doctors who are requested to provide a coroners statement / attend court, which they log and include in the 3 month appraisal reminder to ensure reflections are captured.

Information sharing for new starters from medical HR has improved and the appraisal team is generally informed prior to the start date. Leaver's information remains on a monthly basis.

The appraisal policy has been reviewed and finalised in June 2023. We will continue to review and update this policy, ensuring to include any Trust or national updates.

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 September 2023

The Rotherham NHS Foundation Trust

Agenda item	P144/23
Report	**Emergency Preparedness Resilience & Response**
Executive Lead	Sally Kilgariff, Chief Operating Officer
Link with the BAF	OP3: robust service configuration across the system will not progress and deliver seamless end to end patient care across the system D5: we will not deliver safe and excellent performance
How does this paper support Trust Values	**Ambitious**: Ensuring the Trust is delivering high quality services and a a level of compliance with EPRR core standards **Caring**: Ensuring robust emergency planning arrangements to ensure patients can be seen and cared for in all eventualities **Together**: Working collaboratively with partners to deliver services and achieve the core standards required
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	This report provides an update to the Board of Directors regarding the Trust's Emergency Preparedness, Resilience and Response (EPRR) preparedness. The Chief Operating Officer is the Trust's Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). The report outlines the Trust's EPRR arrangements and a high level summary of the activities undertaken over the last year, along with details of the forthcoming assurance process. Given the increased focus on EPRR nationally and enhanced requirements of the assurance process, it is the Trust AEO's recommendation that the EPRR assurance submission is reviewed by Finance and Performance Committee to ensure robust oversight and scrutiny prior to board sign off.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	This paper is being discussed at the Executive Team meeting on 7th September prior to discussion at the Board of Directors.
Board powers to make this decision	EPRR submissions are currently reported directly to the Board of Directors. The annual assurance process for the EPRR core standards requires formal sign of by the Board of Directors.

Who, What and When (what action is required, who is the lead and when should it be completed?)	The Chief Operating Officer is the Trust's Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). The EPRR assurance process will be submitted in line with national timeframes outlined in the paper with appropriate Board sign off.
Recommendations	The Board of Directors are asked to note the content of this report and support the recommendations in terms of ensuring appropriate Board oversight of EPRR issues, as well the assurance process submission.
Appendices	Report attached – no further appendices

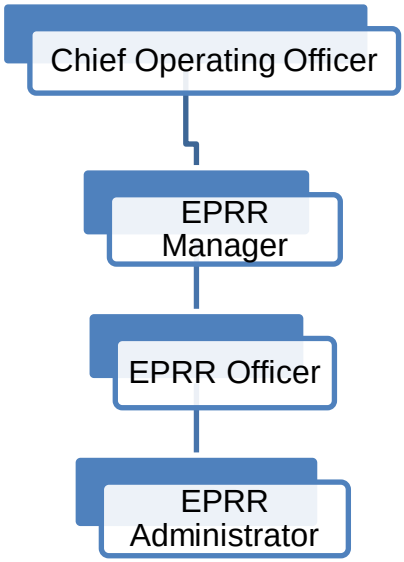
1.0 Background

1.1 The Civil Contingencies Act (CCA 2004) outlines a single framework for civil protection in the United Kingdom. Part 1 of the Act establishes a clear set of roles and responsibilities for those involved in emergency preparedness and response at a local level. As a category one responder, the Trust is subject to the following civil protection duties:

- Assess the risk of emergencies occurring and use this to inform contingency planning
- Put in place emergency plans
- Put in place business continuity management arrangements
- Put in place arrangements to make information available to the public about civil protection maters and maintain arrangements to warn, inform and advise the public in the event of an emergency
- Share information with other local responders to enhance coordination
- Cooperate with other local responders to enhance coordination and efficiency.

1.2 The NHS Emergency Preparedness Resilience and Response (EPRR) Framework (2022)[1] describes how the NHS in England will go about its duty to be properly prepared for dealing with emergencies. The document provides the framework to help NHS Funded Organisations meet the requirements of the CCA 2004, the NHS Act 2006, the Health and Care Act 2022 and the NHS Standard Contract.

1.3 The Chief Operating Officer is the Trust's Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). The Trust's EPRR arrangements are resourced as below;



2.0 Risk Assessment

2.1 The Trust manages a specific EPRR risk register, the content of which is drawn from the national risk register, Local Resilience Forum risk register and the North East & Yorkshire NHS England EPRR risk register. The register is reviewed quarterly by the Trust EPRR group and informs a programme of work. Relevant risks are recorded on the corporate risk register.

[1] B0900_emergency-preparedness-resilience-and-response-framework.pdf (england.nhs.uk)

3.0 Incident Response Plans

3.1 A suite of emergency plans, reviewed annually is in place and are available for all Trust staff to view via the Hub. Hard copies of each plan are retained in the Incident Control Centre. Plans are exercised according to an agreed schedule.

3.2 The planning and exercising process includes collaboration with other resilience partners.

3.3 Each service across the Trust has their own business continuity plan. Plans are reviewed at least annually and following an incident when the plan is activated.

3.4 Response to and recovery from emergencies and business continuity incidents is managed through embedded command, control, coordination and communication (4C) processes which mirror both national, regional and local arrangements.

4.0 Incidents

4.1 A number of incidents have resulted in the Trust activating its 4C processes and business continuity plan over the past year, summarised below;

January to present date – Industrial Action
February – UECC Flooding (Sewage Pipe Burst)
March – Adverse Weather (Snow)
June – Power Outage (external cause)
June – UECC Flooding (Adverse Weather)
August – Power Outage RCHC (external cause)

5.0 Training & Exercises

5.1 Over the past 12 months the following has been delivered;

Training

- Decision Logging
- On Call Induction
- Major Incident Response
- Security Incident Management
- Incident Control room Activation
- Principles of Health Incident Command – This course is mandatory for all colleagues performing the role of Director on call, senior manager on call and the Clinical Site Operations Team. The Trust must ensure colleagues have completed the training by the end of December 2023 which we expect to achieve.

Exercising

- Exercise Trojan - Cyber Security
- Exercise Arkwright - Major Incident Response
- Exercise Parlez - Major Incident Communications
- Business Continuity Incidents
- Lockdown Incidents
- Exercise Arctic Willow – National Winter Preparedness
- Exercise Little Acorn – National Power Outage

6.0 Organisational Learning

6.1 Following each incident resulting in the activation of Trust 4C processes, a structured debrief including colleagues involved in the response and recovery phases of the incident is held with a report produced highlighting both areas of good practice and learning. Debriefs also take place following exercises. Reports are considered by the Trust EPRR group and identified owners assigned to complete approved recommendations. A recommendation and action tracker is maintained by the EPRR team and reviewed by the EPRR group quarterly.

7.0 Audit

7.1 NHS England and Yorkshire Ambulance Service have undertaken an audit of the Trusts' preparedness to deal with a Chemical Biological Radiological Nuclear (CBRN) / Hazardous Material (HAZMAT) incident. The audit outcome stated the Trust is well prepared in being able to deal with any type of CBRN/HAZMAT incident. One recommendation arose from the audit requiring the recently installed decontamination unit to be tested. An exercise is scheduled to take place in Q2 of the current financial year.

7.2 360 Assurance undertook an audit to review the Trust's business continuity arrangements, resulting in an audit opinion of 'significant assurance'. The audit report stated the risk management activities and controls are suitably designed and operating with sufficient effectiveness to provide significant assurance the control environment was effectively managed. Accompanying the assurance were a total of six actions ranging from advisory to medium priority. All actions were completed within the agreed timeframe.

8.0 EPRR Assurance

8.1 The EPRR group has representation from across the Trust, has a Terms of Reference and meets monthly chaired by the EPRR Manager. Relevant matters are escalated to the Chief Operating Officer.

8.2 All NHS organisations are required to complete an EPRR core standards annual self-assessment process of compliance, the minimum requirements commissioners and providers of NHS funded services must meet. The current Trust rating following an independent peer review is substantial compliance with 5 individual core standards from a total of 64 assessed as partially compliant with an accompanying improvement plan.

8.3 The 2023 EPRR core standards assurance process is currently being progressed. The North East & Yorkshire regional EPRR team have made significant changes to the process, the aim being to improve the robustness of the assessment and provide more consistency in the future. This year, Trusts are required to provide NHSE with their initial self-assessment in addition to evidence for each core standard by the end of September. This will then be reviewed, and Trusts will be provided with an opportunity to submit further evidence if needed for a second assessment, resulting in a final statement of compliance to be agreed at the Local Health Resilience Partnership meeting in November. Trusts will then have until the end of December to take the final assessment through internal governance routes including the Board of Directors.

8.4 EPRR assurance assessment guidance issued by the regional team introduces a more detailed and elevated tier of evidence required in order to achieve individual core standard compliance therefore a lower level of compliance can be anticipated.

9.0 Recommendations

9.1 Given the increased focus on EPRR nationally and enhanced requirements of the assurance process, it is the Trust AEO's recommendation that the EPRR assurance submission is reviewed by the Finance and Performance Committee to ensure robust oversight and scrutiny prior to board sign off.

9.2 Moving forward it is proposed to strengthen Board oversight of any EPRR issues, the Chief Operating Officer will include a section in the Operational Update to both the Board of Directors and the Finance and Performance Committee to more formally update on any EPRR issues and exercises undertaken. Currently, these are included in the report, but on an ad-hoc basis as relevant. This will be in addition to an annual update and sign off of the assurance submission.

10.0 Conclusion

10.1 The Board of Directors are asked to note the content of this report and support the recommendations in terms of ensuring appropriate Board oversight of EPRR issues, as well the assurance process submission.

Board Planner

Action tracker log no.	Event/Issue	Lead	2022 Sept M6	2022 Nov 4 M8	2023 Jan 9 M10	2023 Mar 3 M12	May 5 M2	June 20	July 7 M4	Sept 8 M6	Nov 3 M8	2024 Jan M10	2024 March M12
	TRUST BOARD MEETINGS												
	PROCEDURAL ITEMS												
	Welcome and Apologies	Chair	•	•	•	•	•		•	•	•	•	•
	Quoracy Check	Chair	•	•	•	•	•		•	•	•	•	•
	Declaration of Conflicts of Interest	Chair	•	•	•	•	•		•	•	•	•	•
	Minutes of the previous Meeting	Chair	•	•	•	•	•		•	•	•	•	•
	Action Log	Chair	•	•	•	•	•		•	•	•	•	•
	Matters arising (not covered elsewhere on the agenda)	Chair	•	•	•	•	•		•	•	•	•	•
	Chairman's Report (part 1 and part 2)	Chair	•	•	•	•	•		•	•	•	•	•
	Chief Executive's Report (part 1 and part 2)	CEO	•	•	•	•	•		•	•	•	•	•
	STRATEGY & PLANNING												
	TRFT Five Year Strategy 6 month Review	CEO		•			•				•		
	Operational Plan: 6 Month Review	DCEO		•			•				•		
	Annual Operational Planning Guidance	DoF			•							•	
	Winter Plan	COO		•							•		
	Digital Strategy	CEO			•dfd	•dfd			•dfd	•dfd	•		
	Estates Strategy	DoF			•dfd	•dfd			•			•	
	People Strategy	DoW											•
	Quality Improvement Strategy.	CN									•		
	Public and Patient Involvement Strategy	CN											•
	SYSTEM WORKING												
	SYB ICS and ICP report	DCEO	•	•	•	•	•		•	•	•	•	•
	SYB ICS CEO Report (included as part of CEO report)	CEO		•	•	•	•		•	•	•	•	•
	Partnership Working	NED			•		•				•		•
	CULTURE												
	Patient Story	CN		•		•			•		•		•
	Staff Story	DoW			•		•			•		•	
	Annual Staff Survey	DoW				•	•						
	Staff Survey Action Plans	DoW											
	Freedom to Speak Up Quarterly Report	ChN	•		•		•			•		•	
	Gender Pay Gap Report and Action Plan	DoW				•							•
	Workforce Race Equality Standards (WRES)	DoW								• dfd	•		
	Workforce Disability Equality Standard Report (DES)	DoW								• dfd	•		
	Public Sector Equality Duty Report	DoW									•		
	Medical Engagement	MD					•						
	Patient Experience Annual Report	CN							•				
	ASSURANCE												
	Integrated Performance Report:	COO	•	•	•	•	•		•	•	•	•	•
	Quarterly Medical Workforce Data	MD											
	Maternity including Ockenden	CN	•	•	•	•	•		•	•	•	•	•
	Safe Staffing & Establishment Nurse review (6 monthly)	CN			•				•			•	
	Reports from Board Assurance Committees	NEDs	•	•	•	•	•		•	•	•	•	•
	Finance Report	DoF		•	•	•	•		•	•	•	•	•
	Operational Update, Including Recovery and Winter Update	COO			•	•	•		•	•	•	•	•
	ASSURANCE FRAMEWORK												
	Governance Report	DoCA		•	•	•	•		•	•	•	•	•
	Board Assurance Framework	DoCA	•	•	•	•	•		•	•	•	•	•
	Quarterly Risk Management Report	DoCA			•		•		•		•		•
	Annual Review of risk appetite	DoCA									•		

Action tracker log no.	Event/Issue	Lead	2022 Sept M6	2022 Nov 4 M8	2023 Jan 9 M10	2023 Mar 3 M12	Ma 5 M2	June 20	July 7 M4	Sept 8 M6	Nov 3 M8	2024 Jan M10	2024 March M12
	TRUST BOARD MEETINGS												
	Assurance Board Committee ToRs	DoCA											
	Health and Safety Annual Report	DoE							•				
	Quality Assurance Report (1/4)including Care Quality Commission update	CN	•	•		•	•			•	•		•
	Annual Report from SIRO	DCEO							•				
	Safeguarding Annual Report	CN			•							•	
	Health Inequalities	DCEO							•				

	POLICIES													
	Health and Safety Policy (review date Oct 2023)	DoE										●dfd	●	
	Freedom to Speak Up Policy (Updated when National Policy available)	CN												
	Management of Complaints and Concerns Policy (review due 2025)	CN												
	Procurement Policy (due for renewal March 2023)	DoF				●								
	Risk Management Policy	DoCA			●dfd	●								
	REGULATORY AND STATUTORY REPORTING													
	Annual Report and Audited Accounts	DoF							●					
	Audit Committee Annual Report	Com Chair							●					
	People Committee Annual Report	Com Chair							●					
	Finance and Performance Committee Annual Report	Com Chair							●					
	Quality Committee Annual Report	Com Chair							●					
	Nomination and Remuneration Committee Annual Report	Com Chair							●					
	Annual Quality Account (approval)	CN							●					
	Data Security and Protection Toolkit Recommendation Report	SIRO								●dfd		●		
	NHSI: Licence Condition G6(3) certification	DoCA							●					
	NHSI: Licence Condition FT4(8) certification (duty to comply with governance arrangements)	DoCA							●					
	NHSI: Licence Condition re compliance with Training of Governors	DoCA							●					
	Quarterly Report from the Responsible Officer Report (Validation)	MD			●			●			●		●	
	ANNUAL Responsible Officer report (Validation)	MD						●dfd		●				
	Quarterly Report from the Guardian of Safe Working	MD			Q4 ●			Q1 ●		Q2 ●		Q3 ●		
	ANNUAL Report from the Guardian of Safe Working	MD						●					●	
	Quarterly 'how we learn from deaths' report	MD			●			●				●		●
	ANNUAL 'how we learn from deaths' report	MD								●				
	Emergency preparedness, resilience and response (EPRR) assurance process sign off	COO									●			
	Regulatory/Statutory Positions (annual)	DoCA				●		dfd						●
	Serious Incidents and Legal Report	CN / DoCA				●		●			●	●		●
	Controlled Drugs Annual Report	MD										●		
	BOARD GOVERNANCE													
	Executive Team Meetings report	CEO		●	●			●		●	●	●	●	●
	Assurance Committee Chairs Logs	NEDs		●	●	●		●		●	●	●	●	●
	Register of Sealing (bi-annual review)	DoCA			●dfd	●				●				
	Register of Interests (bi-annual review)	DoCA	●			●dfd		●df		●	●dfd	●		●
	Register of use of electronic signature (bi-annual review)	DoCA								●				

Action tracker log no.	**Event/Issue**		**2022**		**2023**								**2024**	
	TRUST BOARD MEETINGS		**Sept**	**Nov**	**Jan**	**Mar**		**May**	**June**	**July**	**Sept**	**Nov**	**Jan**	**March**
				4	**9**	**3**		**5**	**20**	**7**	**8**	**3**		
			M6	**M8**	**M10**	**M12**		**M2**		**M4**	**M6**	**M8**	**M10**	**M12**
	Review of Board Feedback	DoCA				●								
	Review of Board Assurance Terms of Reference	DoCA			●									
	Review of Standing Financial Instructions	DoF			●dfd	●dfd		●dfd		●				
	Review of Scheme of Delegation	DoF			●dfd	●dfd		●dfd		●				
	Review of Standing Orders	DoCA			●dfd	●dfd		●dfd		●				
	Review of Matters Reserved to the Board	DoCA			●dfd	●								
	Constitution	DoCA								●				
	Annual (re)appointment of Senior Independent Director (requires Governor input) included in Chairs Report	Chair								●				
	Annual (re)appointment of Board Vice Chair (part of Chair's report)	Chair		●						●				
	Annual Board Meeting dates - approval	DoCA								●				
	Fit and Proper	DoCA									●			
	Escalations from Governors	Chair			●	●				●		●		
	Remuneration Committee Chair Assurance Report	Chair										●		
	Nomination Committee Chair Assurance Report	Chair												
	Review of Board Planner	Chair	●	●	●	●		●		●	●	●	●	●
	Annual Refresh of Committee membership (part of Chairs Report)	Chair	●					●						
	Audit Committee minutes	Chair			●			●		●			●	

	Quality Committee minutes	Chair		•	•	•		•		•	•	•	•	•
	People Committee	Chair		•	•	•		•		•	•	•	•	•
	Finance and Performance Committee minutes	Chair		•	•	•		•		•	•	•	•	•
	Nomination Committee minutes (ad hoc)	Chair		•	•			•		•	•	•		
	Remuneration Committee Annual Report	Chair			•									
	Remuneration Committee minutes (ad hoc)	Chair		•	•					•		•		
	Business Cases for consideration by Board value in excess of £1m													
	Award Supply Contract: orthopaedic Hips and Knees Prosthesis			•										
	Orthopaedic Centre				•									
	LIMS				•									
	Board feedback				NB	SK		DS		JBe	MT	MW	RS	SH
	NED Review of complaints files (Quarterly)				MT			HC		DS		RS	KM	