Board of Directors (Public)

The Rotherham NHS Foundation Trust

Schedule	Friday 12 January 2024, 9:00 AM — 12:00 PM GMT
Venue	Boardroom, Level D
Organiser	Angela Wendzicha

Agenda

9:00 AM	PROCEDURAL ITEMS	
	P1/24.	Chairman's welcome and apologies for absence For Information
	P2/24.	Quoracy Check For Assurance
	P3/24.	Declaration of interest For Assurance
	P4/24.	Minutes of the previous meeting held on 3 November 2023 For Decision
	P5/24.	Matters arising from the previous minutes For Assurance
	P6/24.	Action Log For Assurance
9:05 AM	CULTURE	
	P7/24.	Staff Story Presented by Daniel Hartley

	P8/24.	Freedom to Speak Up Quarterly Report - Tony Bennett presenting For Assurance - Presented by Helen Dobson
9:25 AM	OVERVIEW AND CONTEXT	
	P9/24.	Report from the Chairman - Verbal For Information - Presented by Mike Richmond
	P10/24.	Report from the Chief Executive For Information - Presented by Richard Jenkins
	P11/24.	Board Committees Chairs Reports - Committee Chairs and Lead Executives - i. Quality Committee - Chair's Log ii. People Committee - Chair's Log iii. Finance & Performance Committee - Chair's Log For Information
9:45 AM	SYSTEM WORKING	
	P12/24.	SYB ICS and ICP Report For Information - Presented by Michael Wright
	ASSURANCE	
9:55 AM	P13/24.	Integrated Performance Report For Assurance - Presented by Michael Wright
10:05 AM	P14/24.	Operational Performance Report For Assurance - Presented by Sally Kilgariff
10:15 AM	P15/24.	Maternity and Neonatal Safety Report inc. Maternity Clinical Negligence Scheme for Trusts (CNST) Final Approval For Approval - Presented by Helen Dobson

10:25 AM	P16/24.	Safe Staffing and Establishment Nurse Review (six monthly) For Assurance - Presented by Helen Dobson
10:35 AM	BREAK	
10:45 AM	P17/24.	Annual Health & Safety Report Presented by Steve Hackett and Linda Martin
10:55 AM	P18/24.	Emergency Preparedness, Resilience and Response (EPPR) Annual Statement of Compliance For Assurance - Presented by Sally Kilgariff
11:05 AM	P19/24.	Safeguarding Annual Report For Assurance - Presented by Helen Dobson
11:15 AM	P20/24.	Finance Report For Assurance - Presented by Steve Hackett
11:25 AM	P21/24.	Board Assurance Framework For Decision - Presented by Angela Wendzicha
11:30 AM	P22/24.	Corporate Risk Register For Decision - Presented by Angela Wendzicha
11:35 AM	REGULATORY AND STATUTORY REPORTING	
	P23/24.	Quarterly Report from Responsible Officer For Assurance - Presented by Jo Beahan
	P24/24.	Guardian of Safe Working Quarterly Report - Dr Gerry Lynch presenting For Assurance
11:45 AM	GOVERNANCE	

	P25/24.	Governance Report - TO FOLLOW For Assurance - Presented by Angela Wendzicha
11:55 AM	BOARD GOVERNANCE	
	P26/24.	Any Other Business For Discussion
	P27/24.	Questions from Members of the Public For Noting
	P28/24.	Date of next meeting - 8 March 2024

DRAFT until approved at the 5th January 2024 BoD meeting

The Rotherham NHS Foundation Trust

MINUTES OF THE BOARD OF DIRECTORS
Friday, 03 November 2023, 09:00 – 13:00
Held in the Boardroom

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

In Attendance:
Mrs J Roberts, Director of Operations / Deputy Chief Operating Officer
Mrs L Tuckett, Director of Strategy Planning and Performance
Mrs Z Ahmed, Associate Non-Executive Director
Ms A Wendzicha, Director of Corporate Affairs
Mr A Wolfe, Deputy Director of Corporate Affairs (minutes)
Ms S Petty, Head of Midwifery (For item P170/23)
Mr J Taylor, Learning from Deaths & Mortality Manager (For item P161/23ii)
Dr G Lynch, Guardian of Safe Working (For item P161/23iii)

Observer:
Mr Paul Stewart, General Manager Medicine
Ms Amarjit Gill, Divisional Finance Manager for Clinical Support Services and Family Health

Apologies:
Mr I Hinitt, Director of Estates and Facilities

ITEM	PROCEDURAL ITEMS	ACTION
P/149/23	**Chairperson's welcome and apologies for absence** KM welcomed members of the Committee and noted apologies for absence.	
P/150/23	**Quoracy Check** The meeting was confirmed to be quorate.	
P/151/23	**Declaration and conflict of interest** RJ's and AW's interest, in terms of their joint roles as Chief Executive and Director of Corporate Affairs of both the Trust and Barnsley Hospital NHS Foundation Trust, was noted.	
P/152/23	**Minutes of the previous meeting** The minutes of the meeting held on the 08 September 2023 were **approved** as a correct record.	

P/153/23	**Matters Arising (not covered elsewhere on the agenda)** There were no other matters arising.	
P/154/23	**Action Log** The Committee **received** the Action Log and closed the actions recommended to close.	
	CULTURE	
P155/23.	**Patient Story** HD introduced the patient story which concerned a discharge to assess story, one of the Therapists had produced a YouTube video which was shown to the Board members. The initiative had been launched at the end of last year, 2022, was being led by the Director of Operations / Deputy Chief Operating Officer with the intention to get patients home quicker where they would experience the benefits of the home environment and therapy at home. The outcomes experienced were a quicker response, assessment of the patient and a familiar environment The initiative, whilst currently only involving a small number of patients, has been found to be more efficient with it being expected that it will work more efficiently when scaled up and the capacity is already in place to upscale the operation. It was agreed that this was a good example of an issue being identified, a plan put in place with actions taken leading to a positive outcome for the patients and families. Other outcomes noted included a short turnaround time for equipment delivery, currently 4 hours, reduced readmission rates and the shedding of the preconception that it is more risky to be at home rather than in hospital. This misconception is now starting to turn around as risks of being in hospital are seen more clearly now by increased numbers of staff and patients. It was noted that there is a need to ensure when patient goes home the equipment required for the home setting follows quickly with safeguards in place to ensure such delivery and to upgrade any equipment required following reassessment, there is also a dependency on joined up working with social care. HD confirmed that the video is on YouTube and is available for wider use with the hope that it can improve communications to the people of Rotherham and provide increased levels of patient information. The Board noted the presentation	
P156/23	**Yusuf Nazir Report and Action Plan** MW updated the Board on the report into the death of YN and highlighted that following concerns raised about care by family an independent investigation had been commissioned by NHSE and undertaken by Niche a specialist company. The report had covered YN's pathway of care and as such involved a number of external organisations as well as the Trust. The report concluded that unfortunately the outcome would not have changed and in the Trust's case a bed would have been made available if required which the report agreed it was not. There had been however a number of recommendations for all organisations involved. A meeting with the family had taken place involving RJ, CS and JBe. This was the second of two meetings with family involving RJ who confirmed that the family were not happy with report as they feel it doesn't reflect their version of what	

	happened; it was confirmed that the abridged version of the report was 13 pages shorter than the unabridged version. The family are still of the view that he had been admitted he would have survived. RJ noted that the family were extremely reasonable during meeting and confirmed to RJ that their extended family would still come to TRFT for care and treatment, but would like to have what they think would be a more balanced report. RJ added that whilst this was not a report just about TRFT, the Trust do need to address the recommendations and should be constantly striving to improve, investigating areas and themes such as are Trust services efficiently designed for all parts or groups of our community, and we need to ensure that is the case. RJ confirmed that no further meetings have been planned and he intends to write to the family following on from the meeting. The Board were assured with the report and the commitment to address the investigation report's recommendations.	
	OVERVIEW AND CONTEXT	
P157/23.	**Report from the Chairman** KM outlined themes from a recent meeting he attended along with RJ and SH with the NHSE. He recognised the challenges faced recently of tough times and increased pressures on all staff. He stated that in order to get ahead of these challenges the Trust needs to understand productivity and the direction of travel regards inputs and outputs and queried whether or not there was sufficient benchmarking being undertaken. He asked the Board to consider other areas the Board can get ideas from such as digital improvements and artificial intelligence in order to address issues such as inequalities, workforce and EDI. There also needed to be renewed focus on the Fit and Proper Person test. He finally asked that consideration is made to what are the signals as opposed to the noise in order to not be distracted by the noise.	
P158/23.	**Report from the Chief Executive** RJ introduced his report highlighting a query from the Quality Committee that had been raised during a presentation from the Medicine Division. HC sought assurance regarding outliers such as non-stroke patients in ring-fenced stroke ward beds. RJ highlighted that follow on sizing of medical versus surgical beds this should not be happening constantly, however right sizing never stops as surgical practices change and varying seasonal pressures required that operational teams need flexibility to make dynamic risk based decisions and that it doesn't mean we have got it wrong, unless it is constant and high numbers of outliers. RJ believed that it was in fact small numbers of outliers that had been identified and to action this there are additional beds being embedded ensuring that patients are in right place and making sure the flow of the hospital works efficiently. The extra capacity only opened at the end of September 2023 and there had been changes made to strengthen management within the unit alongside intensive ongoing support. With regards to the ongoing issues within the Anaesthetic workforce he updated the Board that there was a very good grip of consultant job planning which is matching demand. There is also further advertising for consultant anaesthetists, Speciality and Specialist (SAS) doctors are being employed, changes being made to anaesthetic cover as well as an external review of the changes made. There was also a time-out session which provided positive feedback from the 14 consultants involved, a reset week in theatres has been implemented in a drive to start theatres on time, reducing loss of resources and along with reducing patients missing operations.	

	RJ reported that this was showing real progress and improvements and the next challenge is seeing the improvements being brought into everyday practice. The offer of psychological support is being taken up at both team and individual level. Improvement work is ongoing and there is insourcing of additional capacity. Morale of surgical teams remains a challenge with a time-out session for general surgery planned, this will be formed by mixed groups which will attempt to outline the support available from the Executive and the Trust. Positive work has been taken with consultant job plans, with only 3 of 41 not signed off. In terms of theatre capacity a more detailed update will be presented to the November 2023 Finance and Performance Committee which will include utilisation metrics, capacity and workforce data. The report will come to Board after FPC.	
P159/23	**Board Assurance Framework** AW presented the paper and noted that there had been little movement since last presentation in terms of scoring of the BAF risks, they were currently quite stable and in terms of assessment all had been reviewed by the Executive lead. The recommendation for all was to remain at same score, previously due to operational pressures BAF risk D5 had been increased to 20, however SK informed the Board that she was anticipating that plans in place will start to deliver in coming months and that will bring the rating down, and she had already seen shoots of recovery. BAF risk D7 was to remain rated at 15, however at time of monthly review in financial month 7 it is possible that the rating will change then. With regards to BAF risk U4 and a positive culture the wording will probably change with new People Strategy, DH stated that he didn't feel the current wording was correct, especially around the mention of insufficient resources. AW confirmed that the wording for each BAF can be reviewed at the next review meeting, RJ agreed noting some descriptors were complex. The matter of Trust deep cleaning and the current gap relating to risks was discussed, it was confirmed that it takes place as per national requirements throughout the year and all clinical high risk areas have has a deep clean in the last year. There is however there is no deep cleaning schedule recognised and this needs to be brought into a business case going forward being written by the Estates Team. There are also checks in place for insufficient cleaning and intervention in place if required. The Board agreed to maintain the current BAF ratings.	
P160/23.	**Corporate Risk Register** AW introduced the paper stating that all risks rated at 15 and above will now feature as with the Assurance Committees. She confirmed that Risk 6723 relating to Anaesthetic Medical Staffing and rated at 16 will be reviewed by the Division with a view to reduce the rating as the majority of the action plan has now completed.	

	AW went on to present the new Issues Register this has been produced in order for the Board to see what risks have developed into issues and how are they being managed, this is a developing report in its first iteration. It was agreed that as with risks that are not being managed sufficiently, this is a useful report for assurance. The report will develop over time and the aim is to mirror the BAF report in showing trend reporting over financial quarters. The Board agreed that the Issues Register should be developed and brought back to Board on a regular basis.	***AW***
P161/23.	**Board Committees Chairs Reports**	
	i. Finance & Performance Committee - Chair's Log MT informed the Board that the FPC felt that progress was generally being made with delivery, however there had been a few issues with the 4 hours which is hitting the national target but not our own internal target. The CIP programme is not hitting target currently and recurrence is a challenge for next year, however again the Committee believe the Trust is in a better position than at this time last year. He went on to highlight that elective recovery continues to be an issue along with Outpatients. The October FPC had discussed cancer performance and the new national targets as an agenda item and following a very clear and useful explanation from LT the Committee felt they now had more clarity and focus on the issue. It was raised that recently there had been increased media coverage regards patient being seen on time but then experiencing longer waits for actual treatments and whether or not the Trust were measuring the data, it was confirmed that this data was being collected and deep dives are ongoing in those areas. MT reported that in terms of Finance the Committee were positive about achieving the year-end targets to plan, however anticipate problems for next year if the Divisions don't deliver over the next 6 months which are critical. It was agreed that the issue of sustainability requires a separate Board session for focus and understanding. MT reported that the October 2023 Committee had also approved the Data Security and Protection Toolkit. A query had also been raised at the same Committee regarding a potential conflict of interest of key decision makers as the Trust starts to work closer with Barnsley and there being a number of joint roles which might be problematic. AW confirmed that this is not an issue and should not stop the Trust undertaking work as there are measures in place, with mechanisms such as Deputies in both camps who could deal with such situations and decisions.	
	ii. Quality Committee - Chair's Log JB introduced her first Chair's log to the Board, she highlighted that the QC had raised some concerns with regards to inaccurate clinical coding and its possible effect on HSMR data as well as the financial implications for the Trust, it was noted that a full risk assessment is to be undertaken. The Committee had discussed at length potential issues relating to Estates,	

	amongst other issues there was infection prevention and control and requests for assurances around planned deep cleans and water safety. JB reported that the Committee had received a helpful presentation from the Medical Division which highlighted the need to obtain more input from medical staff and to not just be nurse focused, this issue is being taken forward by Jbe who has already spoken to Divisional Directors. For the Learning from Deaths item JB introduced JT the Learning from Deaths Manager who went through key points from the report, this included that the Trust was in the lower than expected band for HMSR, and SHIMI was in the middle of the band with pneumonia being flagged, however on investigation there were not many instances of poor care and Improvements are underway led by Dr Eddery With regards to SJRs there has been some work to increase capacity and the ability to complete in a timely manner, whilst not quite at target it is much improved with increased quality and every death is scrutinised by the Medical Examiners and families are contacted if there are concerns of poor care and reported as incident for further investigation. It was agreed that examples of change of practice following SJRs will start to be produced as quality improves, with quarterly thematic analysis reports to come to Board. The process is also being embedded into PSIRF and QI along with the strengthening divisional input following 360 audit recommendations. It was noted that the Trust HSMR level has moved from one of worst in country to top quartile and lowest in Yorkshire. Additionally in terms of further assurance a new ME has been appointed and is working with the other MEs to pick up trends.	
	iii. People Committee - Chair's Log RS introduced the Log, he highlighted the recent cultural event held in the main reception and the level of positive feedback as it was so well received and successful. He believes this type of event should be promoted more as it engenders togetherness within the staff. It was confirmed that DH is working on the new People Strategy, there needs to be further work undertaken regards BAME and disability support with a need to see figures improving, there is continued success with the Covid and flu vaccination programme and although still early days there is improvement in completion of the Staff Survey which is expected to continue. • **WRES & WDES Annual Report & Action Plan** DH confirmed that the reports were for recommendation prior to publication on the Trust website. There had been some additional work required on them leading to a delay in uploading to Convene. The reports set out progress made and challenges to agreed Trust actions set against the national metrics. DH confirmed that although there had been some progress made both reports show a continued gap between the experience of working at the Trust for BAME and disabled colleagues as compared to white and non-disabled staff. This is therefore a key area of focus to deliver improvements for staff and patients.	

	It was agreed that events such as the recent cultural event seem to work well and should be encouraged. DH highlighted that accountability starts with Board who need to encourage the right mix of initiatives and tactical solutions in order to improve the work experience of BAME and disabled colleagues. The People Committee need to see and scrutinise evidence based metrics with a clear framework for the Board and Divisions. • **Guardian of Safe Working Quarterly Report** GL introduced the paper noting that there had been an increase in exception reports, these were mainly from the Division of Medicine, as these were specifically from Ward A3 he felt that the data is somewhat skewed. There have been reports of staff feeling unsupported, missing breaks and having to stay late due to workload. GL confirmed that there would be a number of Guardian of Safe Working fines imposed, these were not financially significant but more of a signal that review is required. He added that one of the reasons for the issue is the CT1 working week being set at 47.25 hours as of last year in order to have more presence at weekend, however this often leads to excess hours being worked. GL assured the Board that following review he could confirm that there had been no adverse events for patients, he is awaiting further access to the Datix system in order to further triangulate the data. He added that in November a new cohort of staff will commence in post and will break down figures in next report for comparison, there is also a new flow doctor to start soon which is expected to ease flow pressures around the hospital. GL continues to visit Ward A3 to check up on doctors, when he does he gets no impression of patient risk, but more of a low grade "grumble of concerns" about not having support. JBe confirmed that Ward A3 has already been flagged as a concern to her and she is following the junior doctor forum, adding that it has been disproportionally affected by the industrial action. Actions include working on improving ward processes, improving accommodation and moving to a consultant of the week model. It is intended to triangulate the data across nursing as well as medical staff through the Quality Improvement process looking at absentee and sickness rates. • **NHSE declaration** JBe informed the Board that the declaration required formal board approval, the Board approved the declaration.	
	iv. Audit & Risk Committee - Chair's Log RS introduced the paper and highlighted that with regards to the lower than anticipated 360 Assure first follow up, the individual action owners need to take action themselves to provide evidence of completion to 360 and not rely on the Corporate Affairs team. Corporate Affairs are awaiting revised compliance figure, which is expected to have improved and will continue to offer support. • **Register of Interests**	

	AW presented the Register of Interests that had also been presented to the Audit and Risk Committee on the 20th October 2023, she confirmed that declaration was an annual requirement and there were 2 new Board members who need to complete their declarations, Corporate Affairs would assist with this. • **Standing Financial Instructions** SH highlighted that the report contained Clarification of financial limits for the procurement of Works, updates to Charitable Funds authorisers, approved at Charitable Funds Committee and updates to references made to policies, guidance and legislation, and changes in job titles The standing Financial Instructions were approved by the Board.	
	STRATEGY & PLANNING	
P162/23.	**TRFT Five Year Strategy Six Month Review** LT's paper provided a year 2 update, she confirmed that at the time of production there were no risks requiring escalation around the implementation of our Delivery Plan. No questions or comments were raised and the Board noted the progress made.	
P163/23.	**Operational Plan - Six Month Review** MW reported that the report and priorities had been shared with the relevant Assurance Committees on a quarterly basis and that so far this year there have been no significant escalations to the plan that may impact on achievement of objectives and benefits the Executive Management Team. No questions or comments were raised and the Board noted the progress made.	
P164/23.	**Winter Plan** SK confirmed that a number of Board sessions had been undertaken, the plan had also been through the Finance & Performance Committee encountering positive check and challenge. Also noted was £1.5m of bed funding which was included in the plan along with £1,3m for other plans with some recurrent schemes yet to start, she warned that next year might be more of a challenge to fund such schemes and that the final version of the plan included all financial reports. SK highlighted that in regards to the assessment scores relating to High impact interventions, these had been assessed by Place and those areas with a lower score will be acted on. The highest risk related to flow and SDEC and there had already been significant improvements in these areas with a number of changes already made including a consultation process with ACP for extended open hours and direct access in to SDEC by the ambulance service as well. Virtual ward occupancy had dropped recently and the ward was waiting for IT support to improve this, however this had been delayed due to the South Yorkshire region procurement programme for the software, this has now been awarded and is to operationalise this winter, although the	

	implementation may require more support and discussions are ongoing. Although delayed SK confirmed that financially nothing changed and resources were still in plan and available. The Board noted the report.	
	SYSTEM WORKING	
P165/23.	**SYB ICS and ICP Report** MW confirmed that a lot of work was ongoing with the local heath select commission, there is a workshop week commencing 06 November 2023 and he will produce a report to be brought back to a future Board. He went on to add that there were challenges to all NHS systems currently. No questions or comments were raised. The report was noted.	***MW***
P166/23.	**Partnership Working** MW highlighted that the partnership working continued to gain traction, with gastroenterology and haematology developing well. There is also a joint senior leader meetings next week, joint roles between the Trusts such as the Chief Executive, the Director of Corporate Affairs and currently the Chief Pharmacist, there are also joint graduate trainees in place. MW invited questions or feedback for the Board, none were raised. The paper was noted.	
	ASSURANCE	
P167/23.	**Integrated Performance Report** MW spoke to the paper commenting that the contents had been already covered in previous agenda items and invited any questions or comments from members, no questions or comments were raised. The paper was noted by the Board.	
P168/23.	**Operational Performance Update** SK highlighted the challenges to recovery, there had been revised trajectories with the forecast to meet the 65 week target by March 2024 and there will be updates to the Finance and Performance Committee which will include the original and new trajectories. The national Patient Initiated Digital Mutual Aid System (PIDMAS) went live on Tuesday 7th November 2023 which offers patients the choice of an alternative location for treatment via emails to patients, at this point the results of this new initiative on the Trust are unknown. Work continues with Barnsley and Doncaster colleagues at the new Mexborough Elective Orthopaedic Centre (MEOC) site. With regards to the most challenged services these remain as Urology and Colorectal from a service improvement perspective as they have lost an entire team in the last 5 months, recruitment is underway with 2 posts filled and 2 to	

	fill, there have been delays to improvement but for the last 2 months they have achieved target. JBe is involved with diagnostic capacity challenge and cancer related tertiary referrals have been pushed back so are not currently an issue for the Trust. The Board welcomed the update and were assured by its contents.	
P169/23.	**Quality Assurance Report** HD outlined that currently the Trust are in a transitional stage with the CQC who would be welcomed back into the Trust and are expected to meet with them in the next month when she hoped more clarity would be provided on the Trust's position. The meeting was cancelled by the CQC last month. HD continues to encourage the CQC to visit the Trust. There is a new CQC relationship manager in place and there has been progress against the old CQC actions with all now complete, with work ongoing to collect evidence and embed changes. The Trust is also being highlighted as an exemplar for certain work streams such as mental health risk assessments and the UECC improvements. It is planned to include Non-Executives preparation information for a CQC visit at an upcoming Strategic Board. The Board noted the use of the Trust as an exemplar to other Trusts and the wish for a repeat inspection, they were assured with this positive picture and welcomed the upcoming Strategic Board session.	***HD***
P170/23.	**Maternity and Neonatal Safety Report** SP was welcomed to the Board and highlighted the following areas from the report, a Saving Babies Lives deep dive had taken place by LMNS and a revised work plan had now been agreed to support full implementation by March 2024. The Trust needs to be at 70% across each element, the Trust expects to be compliant and awaits confirmation by LMNS. The CNST deep dive had been positive and had identified two areas of pressure for Saving babies lives and training. An update had been received confirming that compliance will be reduced to 80%. With regard to Theme 1 benchmarking against three year delivery plan had taken place and actions pulled together to get full compliance. This was a three year delivery plan. Theme 2, workforce gaps had now been reduced due to the commencement of the new midwives. Theme 3, training data and mitigations why compliance has dipped include strike action, staffing gaps and new doctors. Theme 4, no Serious Incidents had been declared although a trend around 3rd degree tears was being investigated further alongside additional training. Drilling down data more and looking at ethnicity and deprivation levels. There had been two formal complaints in September which are being investigated and the complainants supported. The noted the positive report and were assured especially the report of positive feedback regarding Midwifery students from Sheffield Hallam University relating to Theme 3; it was requested for a reduced number of abbreviations in future reports.	***SP***
P171/23.	**Finance Report**	

	SH introduced the report and highlighted the following, at month 6 the position is a surplus to plan of £150K in month with a deficit to plan of £1,068 year to date. It has been reported to NHSE and the Integrated Care Board that the Trust expects to meet financial targets to plan, however going into winter there is nothing left to cover any further losses in income and any future loses would impact the position adversely. SH remains confident that 2nd half targets will be met as they are the same as the 1st half which were affected by industrial action yet still met. With regards to Capital expenditure SH revealed that there appears to be potential for seeing purse strings opened nationally, which if occurred would relieve some pressure off the Trust. It was agreed that there is a need to have forward looking list of projects from divisions for times when capital is available and there is a plan to come back from Estates. It was also agreed that the capital plan should be set prior to the start of the next financial year to allow quicker pace of roll out as well as the need for a strategic plan of bigger capital needs which could also include areas of joint work with the Charity. A paper from SK highlighting the unlocking of the front end changes to Estates and capital priorities is to be presented at ETM and will then come back to Board. Cash flow is on track broadly to meet the cash plan, however if the Trust goes into the next financial year with a sizable deficit then that will start to eat into the cash position. There was appropriate provision in place going into winter 2023/24. The Board noted the report and where assured of the ability to meet the 2nd half targets and also year-end plan.	
	GOVERNANCE	
P172/23.	**Fit and Proper Person Report** Deferred to January/February 2024.	
P173/23.	**Review of Annual Board Planner** The Estates Strategy has been added for January.	
	BOARD CLOSING MATTERS	
P174/23.	**Any Other Business** Nil return.	
P175/23.	**Board Feedback** Nil return.	
	Date of next Board of Directors Meeting Friday 12th January 2024 at 9.00 am.	

Board held in Public : Action Log								
Log No	Meeting	Report/ Agenda Title	Minute Ref	Agenda item and Action	Lead Officer	Timescale	Comment/ Feedback from the Lead Officer	Open/Close
3	03/11/2023	Corporate Risk Register	160/23	Register of Issues to be developed and presented to future Boards	AMW	Mar-24	Revised register will be presented to ETM and Audit Committee prior to Board in March 2024.	Open
4	03/11/2023	Board Committees Chairs Reports	161/23	Register of Interests	AMW	Mar-24	Corporate Affairs to assist with Register of Interest declarations. Next report due March 2024	Open
5	03/11/2023	SYSTEM WORKING	165/23	SYB ICS and ICP Report	MW	Jan-23	Report to be produced following Workshop with SYB ICS and ICB. On agenda for January meeting	Recommend to Close
6	03/11/2023	ASSURANCE	169/23	Quality Assurance Report	HD	Apr-24	CQC preparation to be added to a Strategic Session	Open
7	03/11/2023	ASSURANCE	170/23	Maternity and Neonatal Safety Report	SP	Jan-23	Report to include reduced abbreviations. On agenda for January meeting.	Recommend to Close

Open
Recommend to Close
Complete

Board of Directors' Meeting
12 January 2024

The Rotherham NHS Foundation Trust

Agenda item	P8/24
Report	**Freedom to Speak up Guardian Quarter Two Update**
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	Promoting a culture of Speaking up within TRFT supports all three of the Trust values of ambitious, Caring and Together
Purpose	**For decision** ☐ **For assurance** ☐ **For information** [x]
Executive Summary (including reason for the report, background, key issues and risks)	To provide the Board of Directors with an update of concerns which would be deemed whistleblowing, raised both to the Freedom to speak up Guardian and through other official routes and offer a comparison for TRFT against other local and similar sized organisations To provide an update of how the profile of the Speaking up agenda is being raised and embedded within The Rotherham NHS Foundation Trust. **Summary of Key Points:** The key points arising from the report are • Reduction in number of staff raising concerns • New lead Guardian appointed • Regional NGO meeting attended • New policy drafted on new NGO template and to be submitted for ratification • FTSU sessions held with nurse preceptorship
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	This report was verbally presented to the People Committee in December 2023, with no comments forthcoming.
Board powers to make this decision	N/a
Who, What and When (what action is required, who is the lead and when should it be completed?)	No further action required from the Board

Recommendations	It is recommended that the Board note the Q2 report.
Appendices	None

1. Introduction

The FTSU Guardians initiative was implemented following the Francis report (2015). The aim of Freedom to Speak Up Guardians (FTSU) is to help create a culture of openness within the NHS, where staff are encouraged to speak up, lessons are learnt and care improves as a result.

The Trust introduced FTSU Guardians (FTSUG) in 2015, with a FTSUG lead appointed in October 2016.

2. Background

The report aims to provide the Board of Directors with a high-level overview of the activity undertaken by the FTSUG during quarter one and two 2023-24, highlighting the number of concerns raised, actions taken and resultant learning**.**

3. Reporting and Governance

3.1 Since the last report in April 2023 the FTSUG lead has remained the responsibility of the Chief Nurse. The FTSUG lead during this reporting period was Tony Bennett who covered the role on a 0.4 WTE. The lead role has since been advertised and the successful candidate appointed to the role on an increased 0.6 WTE.

3.2 During this reporting period seven concerns have been raised that relate to bullying & harassment/attitudes and behaviours. Due to the low numbers of concerns raised there are no trends across departments, divisions or staff groups.

3.3 All of these concerns were escalated to line managers/HR and are now closed and the individual who raised the concern informed of the outcome.

3.4 The FTSUG lead meets regularly with the Chief Executive, Chief Nurse and Director of People, which provides an opportunity for discussion regarding issues raised, and potential learning opportunities. The FTSUG lead has also had regular support from the Senior Independent Director regarding issues and themes.

3.5 The Trust has an overall compliance rating of 93.51% for FTSU Mast e-learning training with every division being above the target of 85%.

Division	Conflict Resolution
Clinical Support Services	95.67%
Community Services	96.42%
Corporate Operations	87.07%
Corporate Services	89.77%
Emergency Care	92.35%
Family Health	93.55%
Medicine	92.44%
Surgery	95.67%
Grand Total	93.51%

3.6 In addition to the lead guardian, there are 8 Freedom to Speak Up Ambassadors within the Trust, one of which has also attended the National Guardians training session. In the last eight months, there has been two changes, one due to an ambassador stepping down and the other due to an Ambassador leaving the Trust.

3.7 A further review of the FTSU structure will take place once the new lead has started.

4. Summary of FTSU Concerns for TRFT

Table 1: FTSU Concerns Q1 &2 2023/24

Quarter	Number of concerns	Nature of concern	Investigations completed	Detriment
1	4	Attitudes and behaviours 3 Bullying & harassment 1	4	0
2	3	Attitudes and behaviours 3	2	0
Total	7		6	

4.1 There is no pattern to the division all reporting due to the small number of concerns raised during quarter 1 & 2. So far all the concerns raised have been in relation to attitudes and behaviours with elements of bullying. There have been no concerns raised in relation to patient safety.

5. Feedback following Raising a FTSU concern

5.1 It remains difficult to get feedback from staff who have raised concerns via the questionnaires, as there is a reluctance to respond once the concerns have been addressed.

6. Raising the Profile of FTSU within TRFT

6.1 Work has continued to increase the visibility of FTSU within the Trust. This has included development of promotional information on the role of the guardians.

6.2 The FTSU Ambassadors' have highlighted the role and associated agenda through various forms. The FTSUG lead has continued to work with the equality and diversity lead to increase awareness amongst all staff groups.

7. National Guardian Office Data

7.1 The Trust has submitted data on a quarterly basis to the National Guardian's office.

8. TRFT Comparison with National Data

8.1 The value of comparison between Trusts is difficult to determine as a high or low number of concerns does not necessarily provide assurance regarding the speaking up culture of the Trust. The NGO remains keen for Trusts to avoid comparison.
The staff survey results remains the best indicator of staff confidence in speaking up, the provisional data for the recent staff survey (Nov 2023) shows significant

increase in staff confidence. The full breakdown will be included in a future report once the reporting embargo is lifted.

8.2 The key performance indicator for organisation is that the NGO receive a data return each quarter.

9. National Guardian Office Case Reviews

9.1 There have been no case reviews published during quarter one or two.

10. Conclusion

10.1 There has been a decrease in the number of concerns that have been raised during the first two quarters of 2023/24.The initial responses to the staff survey are extremely encouraging and the guardians will continue to promote a positive speaking-up culture, to prevent harm and improve outcomes for both colleagues and patients.

10.2 It is vital, not only to encourage colleagues to raise issues, but to foster an environment where staff are truly supported to speak up. Managers have an important role to play in supporting a culture within their teams so that speaking up becomes business as usual.

10.3 Our aim remains to be a Trust where everyone from front line care to Board level is committed to supporting a transparent and open culture, where all staff including: agency workers, temporary workers, contractors, students, volunteers, governors and other stakeholders are encouraged and confident that they are able to ‘Speak Up’.

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Board of Directors' Meeting
12 January 2024

The Rotherham NHS Foundation Trust

Agenda item	P10/24
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	No action is required.
Recommendations	It is recommended that: The Board note the contents of the report.
Appendices	None

1.0 Operational Matters

1.1 **Recovery**: The last two months have seen some positive trends from an elective recovery perspective, particularly in November where there were no periods of industrial action. This led to significant increases in activity levels across all points of delivery relative to the previous 8 months of the year which has been, in part due to the recent agreement to fund additional insourcing outpatient activity in addition to insourcing capacity in anaesthetics and theatres. In addition, during the first part of the year we saw a significant reduction in the waiting list and an improvement in Referral to Treatment and diagnostic waiting times (DM01) performance.

1.2 The national expectations for elective recovery in 2023-24 require the Trust to treat all patients waiting over 65 weeks by the end of March 2024, which the Trust has committed to delivering on the assumption that there will be no further industrial action after the early January period. Whilst we currently have relatively low numbers of patients waiting this long for their treatment, we do have two patients waiting over 78 weeks and we are working with NHS Blood and Transplant Services to ensure they receive their treatment as soon as possible. The number of patients waiting over 52 weeks for their treatment has now stabilised but remains well above where we want it to be for our patients, particularly in Gynaecology and Trauma and Orthopaedics which constitute two-thirds of the patients waiting over a year for their treatment.

1.3 **Urgent and Emergency Care Activity:** The Trust has seen an increase in demand on our Urgent and Emergency care pathways over the last couple of months resulting in the Trust operating at OPEL level 3 during peak demands. The demand on paediatrics and maternity services has been high during the last month with progressively rising challenges with influenza and other viruses. Influenza is becoming more prevalent across the country with levels predicted to peak in mid-January; fortunately the circulating strains are ones that the vaccine is well matched to. COVID-19 cases have risen but remain at manageable levels. Norovirus has caused some bed closures but this seems to have settled now. Respiratory syncytial virus levels have peaked and are falling which is welcome given its impact on children. Overall, ambulance handover delays at the Trust remain low in comparison with other organisations but work is ongoing to improve further. The underlying improvement work streams that address the emergency care pathway are continuing.

1.4 **Industrial Action (IA):** The Trust has continued to plan and implement contingency arrangements for the IA that took place in December 2023; discharge arrangements before Christmas worked well and beds remained available through to the end of the Christmas bank holiday weekend. The January six day IA has been a greater challenge due to its duration, the inclusion of a weekend and the timing coincident with peak seasonal operational pressure. Nevertheless, as at 05 January 2024, this has gone according to the plans put in place with Consultants, SAS and other healthcare colleagues working well with management partners to ensure clinical safety is maintained.

1.5 A number of outpatient appointments as well as elective lists had to be cancelled in December 2023 due to the IA to ensure workforce was available to support emergency pathways. The elective programme continues to be adversely affected by the different periods of industrial action; the financial impact of the latest IA is being quantified but will likely lead to a worsening of the Trust's in year financial performance in the absence of external funding.

2.0 Planning

2.1 The NHS usually issues planning guidance in late December for the following financial year. This year there has been a delay in the guidance being shared with the expectation that this will follow in the near future. However, the Trust has started to plan for next year and will not wait until the planning guidance is published as we are already aware of the key requirements such as systems maintaining the increase in core Urgent and Emergency Care capacity in addition to completing the agreed investment plans to increase diagnostic and elective activity and reduce waiting times for patients.

3.0 People

3.1 The Trust received the initial results (which are currently embargoed) from the 2023 National Staff Survey from Picker who administer the survey. The results will be aggregated with all other NHS Trusts and a benchmarked NHS England report will be available over the next two months. The results have been shared with operational and corporate management teams to enable early analysis and planning to commence.

3.2 I am delighted to welcome Linda Martin to the Trust as Interim Director of Estates and Facilities for a six month post. Linda has extensive experience and I am looking forward to working with her. A recruitment process for a substantive Director will take place over the next six months.

3.3 The monthly staff Excellence Awards winners for the months October and November 2023 are as follows:

October 2023
Individual Award: Beka Naylor, Nurse on Ward A5
Individual Award: Rayon Edwards, Security Officer
Team Award: Mortuary Team
Public Award: UECC

November 2023
Individual Award: Steven Cheung, Radiology Systems Manager/Deputy Professional Lead for Medical Imaging, Physics and Illustration.
Team Award: Clinical Practice Educators
Public Award: Audiology

Dr Richard Jenkins
Chief Executive
05 January 2024

Subject:	Quality Committee CHAIR'S ASSURANCE LOG Quorate: Yes	Ref:	QC:

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

Committee / Group: Quality Committee	Date: 29 November 2023 & 20 December 2023	Chair: Ms Julia Burrows

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
1	Patient Experience Committee Report	It was agreed that there needs to be more discussion with divisions about what they have done about complaints and present these changes at QC (through presentations or highlights in the meeting). This could also be highlighted in the Chairs Report so that the board has visibility on positive actions and learning from complaints.	Board of Directors
2	Divisional Reporting on Quality Compliance - Community	The Committee noted that the Virtual Ward had now been running for 12 months, recently remote technology had been procured through a lengthy process and will be available to use at the end of Jan 24. There were also plans to introduce an Acuity tool to evidence patient acuity. The Committee also wanted to highlight to the Board that the Community Contract Baseline still remains as it was when first agreed a number of years ago. The Division reported that there was still no recognition from RCCG (ICB) towards the added acuity/volume pressure for District nursing and this was a real risk to the service.	Board of Directors

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
3	Clinical Effectiveness Committee Report	The Committee welcomed the in depth report that provides them with an up to date review of the Trust's clinical audits. The Committee particularly commended the increased amount of triangulation from the department when dealing with audit actions plans and improvements made as a result.	Board of Directors
4	End of Life Care Six Month Update	The EOLC message system-wide is important, and that it should be acknowledged that the Trust is not where we want it to be. It was noted that the next stage is to look at Power BI to analyse data on AMU to see where patients come from and also that there is other research to look at, such as Marie Curie to identify whether a patient has engaged or not engaged and the gaps that can be identified.	Board of Directors
5	Safe Staffing and Quality	Noting the low ranking of the Trust in National benchmarking data, the Committee highlighted the triangulated approach required when considering and monitoring the Care Hours per Patient Day (CHPPD) data together with staffing data, acuity, patient outcomes and clinical oversight. The Committee felt that it should highlight the improvements made since March 2023 with Nursing levels not being less than 85%.	Board of Directors
6	Health & Safety Quarterly Report (to include update on Food Safety Training, Water Safety and Deep Cleaning)-	The Committee welcomed the paper and noted that Estates were working with Training & Development to launch a 30 minute online training package for fo0od hygiene to be operational in January 2024. With regards to water safety the Committee were assured with the actions taken and the systems in place to provide assurance concerning water quality. As for deep cleaning it was appreciated that whilst there is no pre planned schedule deep cleaning is actioned when called to task by a ward or senior staff as well as supporting audits and evidence in place.	Board of Directors

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
		The Committee also noted that the risk assessments and mitigating actions for remedial work on the residential accommodation were underway and the risk rating had been reduced. Finally the Committee believe that there should be consideration as to which Assurance Committee the H&S needs to report to.	

Subject:	PEOPLE COMMITTEE CHAIR'S ASSURANCE LOG Quorate: Yes	Ref:	Board of Directors:

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

Committee / Group: People Committee	Date: 15th December 2023	Chair: Dr Rumit Shah

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
1	Staff Survey	The Committee believed that the Trust's recent positive performance in staff completing the Staff Survey should be escalated to the Board as it is at 66.9%, the highest performance ever at the Trust and reinforces the hard work that's gone into publicising and promoting the event by various members of senior management and the Executive.	Board of Directors
2	Divisional People Performance Presentations: Family Health Senior Leadership Team UECC Senior Leadership Team	The Committee members felt assured by the presentations of both Divisions and noted a number of feel good factors brought by both Divisional teams in their presentations. It was noted for Family Health the improvements in collaborative working; with a more holistic working environment, staff coming together and working outside of their silos. This is creating the integration desired between the teams. The Committee noted UECC's passionate senior leadership team who have instilled autonomy in staff members bringing ideas through the QI faculty. Both divisions had also achieved good staff survey completion rates.	Board of Directors

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
3	Advance Clinical Practice Framework and Safe Staffing	Both papers were approved by the Committee: Advanced Clinical Practice Framework November 2023 The Committee supported the recommendation of the establishment review as led by the Deputy Chief Nurse (nursing workforce) and agreed with the Chief Nurse.	Board of Directors
4	Industrial Action update	Junior Doctors to strike at the end of December and the beginning of January 2024. Noted by the Committee that previous industrial action had led to disruption to service delivery, training and education with action taken to reschedule as appropriate.	Board of Directors

Subject:	**Finance & Performance Committee CHAIR'S ASSURANCE LOG** **Quorate: Yes**	Ref:	

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

Committee / Group: Finance & Performance Committee	**Date:** 29 November 2023 & 20 December 2023	**Chair: Mr Martin Temple**

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
1	Divisional performance: Medicine Clinical Support Services	The Committee welcomed the helpful presentation, noting improvements made as well as issues with people costs and waiting times which were both being tackled proactively. The Committee could not be assured due to the predicted financial outrun. The Committee agreed that they could not be fully assured as the presentation did not include sufficient performance detail, they could accept that there had been good work undertaken but the presentation concentrated too much on the financial aspects.	Board of Directors
2	Integrated Performance Report and Operational Update (incl. Outpatient Transformation Programme verbal update)	The Committee noted the encouraging improving trends and were assured it was moving in the right direction. The Committee felt that the 4 hours position was disappointing, budgeting back on course, Criteria to Reside okay but challenging, elective looking better but massive improvements needed, Virtual Ward worrying, overall assured that hitting the right areas with the right actions.	Board of Directors

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
		The Committee noted that November 2023 had been a positive month in terms of performance and were assured by this, however they have to remain concerned with the forward challenges, mainly external, that will likely negate this positivity.	
3	EPRR Annual Statement of Compliance	Following explanation of why the Trust is now non-compliant with the standards the Committee felt reasonably assured as it is clear the evidence is there, however according to the new revised standards it needs to be reformatted. The Trust is no less prepared than it was last year, however now the barrier is higher in terms of matching required evidence.	Board of Directors
4	Theatre Improvement Programme Update	There was a lot of good work involving lots of staff, about consistency as well as efficiency, not yet embedded but doable. Big debate re importance of ERF. Assured about long term development, not assured over short term particularly over ERF.	Board of Directors
5	ICB Finance Update	Not assured The Committee could not be assured as they are still unaware of what the future holds due to a lack of clarity from the ICB.	Board of Directors
6	Cost Improvement Plan Update	No real change was noted and the Committee were not assured beyond £10m CIP. The Committee were not assured, however they did note the progress made, feeling it was an encouraging position but not enough.	Board of Directors

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
7	Integrated Financial Performance Report	The ERF is key, assured that have a hand on the figures but not assured on ERF The Committee felt limited assurance due to the unknown factors that could affect the position in the coming months, factors including industrial action and its possible effect on EPR. The Committee agreed that Risk 6801 should be increased in rating to 20 as per the Risk Management Committee. The Committee noted that November 2023 had been a positive month in terms of the financial position and showed what the Trust was capable of, however this was tainted by the possible effect of industrial action	Board of Directors
8	Inventory Management System	The business case was approved	Board of Directors
9	Risk Register (12+ Risks)	Assured There was agreement that the Committee agreed with raising the risk rating of Risk 6886 to 20 and this should be raised at the next Risk Management Committee. The Committee felt assured by the paper and verbal update.	Board of Directors
10	Board Assurance Framework (BAF)	Assured	Board of Directors
11	Cyber Security Update	The Committee felt that this was an interesting paper which along with the recent phishing exercise provided them with assurance.	Board of Directors

Board of Directors' Meeting
12 January 2024

The Rotherham NHS Foundation Trust

Agenda item	P12/24
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: • Junior Doctors undertook three days of strikes in late December with a further 6 days from the 3rd to the 9th of January. • Shared priorities for the Rotherham Place are articulated within the refreshed Place Plan for 2023/25. Delivery will continue against the plan, however partners have collectively identified four key projects for particular focus over 2024/25 that will realise the maximum efficiencies and deliver improvements. The four projects are: Respiratory, Ambulatory Care, Diabetes and Frailty. • Rotherham's Medicines Management Team has recently won a national award for antidepressant de-prescribing. • Medicines Management – it was confirmed that Rotherham continues to ensure cost effective biosimilars are used rather than high cost drugs resulting in savings, with The Rotherham

	NHS Foundation Trust remaining at the top of all the national comparison graphs. • Rotherham Safe Space opened late October 2023, it supports anyone experiencing a mental health crisis in Rotherham and the surrounding areas. It provides a safe place during the weekend and Monday evenings designed for people in crisis to go for support and to prevent avoidable attendances to the Urgent and Emergency Care Centre. • The Health Select Commission requested the Trust run a workshop which was held on the 8th November. The workshop focussed on the Trust's activities / initiatives in addition to a review of the Trust's annual report for 2022/23. Positive feedback on the session was received from the Health Select Commission.
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 November and December 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 A fresh pay offer was made to NHS Consultants which the British Medical Association will put to its members. The offer includes an increase on the current 6% pay increase already in place.

2.2 Junior Doctors undertook three days of strikes in late December and a further 6 days in early January (3rd January to the 9th January).

2.3 New figures published show that spending on agency staff has increased significantly to £3.5bn last year. This compared to around £3bn in 21/22 and £2.4bn for the four previous years. The NHS has long focused on reducing agency spend and has a 'national cap' of £2.8bn for this financial year.

3.0 South Yorkshire Integrated Care Board (SYICB).

3.1 The ICBs in Yorkshire, the South West, the South East and the North East will have another year of statutory joint commissioning between the ICBs and NHS England for 59 specialised services which were originally planned to be fully transferred for April 2023. Twenty ICBs in the East of England, the Midlands and the North West will have fully delegated commissioning as originally planned. NHS England's National Specialised Commissioning Director said that this reflected the differing levels of confidence amongst those ICBs and the NHS England regions, with some areas wanting to take more time to ensure a smooth transition.

4.0 Rotherham Place

4.1 Rotherham Place Board met in November and December, receiving updates on a number of initiatives as well as a detailed review of the Rotherham Place operational performance report. The following provides a summary of some of the key discussions.

- Shared priorities for the Rotherham Place are articulated within the refreshed Place Plan for 2023/25. Delivery will continue against the plan, however partners have collectively identified four key projects for particular focus over 2024/25 that will realise the maximum efficiencies and deliver improvements. The four projects are: Respiratory, Ambulatory Care, Diabetes and Frailty.
- Update on Proactive Care - Proactive Care Planning is a person-centred, thinking ahead approach whereby health and social care professionals support and encourage individuals, their families and carers to plan for any changes in their health or care needs. The aim is to increase people's healthy years by up to 5 more years. Proactive care encourages people to make positive choices about what they should do themselves, and from whom they should seek support, in the

event of a flare up or deterioration in their condition, or in the event of a carer crisis. National guidance indicates that patients with frailty, co-morbidities and/or complex needs should be considered. Learning from the scheme will be used to develop proactive care models which will form part of the Primary Care Network Direct Enhanced Service and link with both the living well workstreams and roll out of ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) outlined in the Rotherham Place Plan.

- Dr Jason Page, the Medical Director for Rotherham Place provided an update on the recent work across Rotherham. Rotherham continues to perform well on Covid and flu vaccinations. Rotherham's Medicines Management Team has recently won a national award for antidepressant de-prescribing. The specialist pharmacy team helped patients who have been on antidepressants for a long time to gradually reduce and stop taking them.
- Rotherham Medicines Management – The Head of Medicines Management confirmed that Rotherham continues to ensure cost effective biosimilars are used rather than high cost drugs resulting in savings, with The Rotherham NHS Foundation Trust remaining at the top of all the national comparison graphs.

4.2 Other initiatives that have provided positive outcomes across Rotherham Place include:

- Rotherham Safe Space opened late October 2023, it supports anyone experiencing a mental health crisis in Rotherham and the surrounding areas. It provides a safe place during the weekend and Monday evenings and is designed for people in crisis to go for support and to prevent avoidable attendances at the Urgent and Emergency Care Centre. It offers a non-clinical alternative, aimed at reducing distress, working with people to resolve or better manage a crisis they are experiencing. The space offers one-to-one support and a social space, where refreshments and hot food are available, as well as opportunities to chat with other people using the service

4.3 Appendix 1 attached is the Rotherham Place news letter which provides further detail of initiatives across Rotherham Place in November and December 2023.

4.4 The Health Select Commission has met twice in the last two months. The key session for the Trust was a workshop on the 8th November which focussed on the Trust's activities / initiatives as listed below in addition to a review of the Trust's annual report for 2022/23. The key areas of focus included:

- Improvement work across the Trust, with emphasis on paediatrics and the Urgent and Emergency Care Centre (UECC)
- Response to recommendations following on from nationally relevant current issues
- Contribution to the advancing of equalities agenda in terms of access, experience and outcomes

- Safety, especially for patients with complex or high needs
- Information regarding how progress towards quantifiable goals is monitored.

The session was welcomed by the Trust as an opportunity to share key developments and gave members of the Health Select Commission the chance to focus on the Trust's activities for a two hour period. Colleagues from the Trust including the Chief Nurse, Chief Operating Officer, Public Health Consultant and Deputy Chief Executive attended the session. Positive feedback on the session was received from the Health Select Commission.

4.5 The Health and Wellbeing Board met in November 2023. The key areas of discussion included a presentation on the Place winter plan. This demonstrated the learning that had been taken from the previous winter and initiatives that are really making a difference including:

- Virtual ward (hospital at home) for people who would otherwise be in an acute bed, utilising remote technology where appropriate to identify changes in condition
- Avoiding unnecessary admissions and facilitating early discharge Urgent Community Response (UCR) 2 hour response standard – 70% of the time

The Health and Wellbeing Board also received an update that builds on the strong tradition of partnership working and Voluntary Action Rotherham's early pioneering of social prescribing. The update was supported by a presentation, highlighting the positive impact of social prescribing. A case study covering a patient who had improved wellbeing and improved mental health as a direct result of social prescribing demonstrated the positive outcome.

4.6 The Trust's Consultant in Public Health, employed jointly by the Trust and the local authority has been in post for nine months. He is leading a programme of work to manage population health within Rotherham, based on tackling health inequalities and developing preventative interventions. Work currently underway with outcomes or emerging outcomes includes:

- Development of a community engagement project in Maltby and Dinnington to explore the needs of members of the community who are living with multiple long-term health conditions, with a longer term view to develop targeted, evidence based and effective interventions. Since the last meeting of the Trust Board, The Maltby and Dinnington PHM intervention has launched, and as of 21st Dec, there had been nearly 500 responses back from the local community about their health needs, the wider determinants influencing their health outcomes and clearly articulated priorities for their ongoing wellbeing. The survey will close in late January and analysis will be shared with patients and partners for discussion and action.
- The QUIT programme is successful in the Trust, with 100% of relevant inpatients receiving stop smoking support, and 50% accepting a prescription of nicotine replacement therapy patches. The next steps are to work with the new

community provider to ensure that patients have the support to sustain their quit attempts beyond their stay with us.

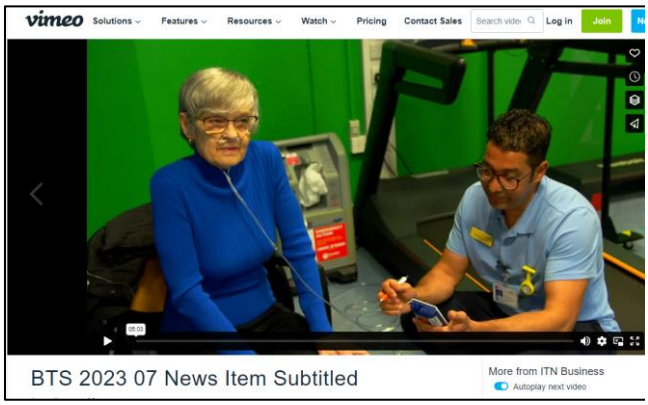
Michael Wright
Deputy Chief Executive
January 2024

Rotherham Place Partnership Update: November and December 2023

Breathing Space: Health Inequalities in respiratory

Respiratory Futures has partnered with ITN Business to explore game-changing innovations and multi-disciplinary cross collaboration, one of the showcases is 'Breathing Better Together'. The programme looks at ground breaking innovations in the sector, and celebrates the multi-disciplinary, cross collaboration approach that defines thoracic care in the UK. **Rotherham Community Respiratory** team features as a shining example of how respiratory is linked to health inequality and what the team are doing to address these concerns.

The news item 'Health Inequalities in Respiratory' can be viewed at the link opposite.



Breathing Space: Health Inequalities in Respiratory

Update on Proactive Care

Proactive Care Planning is a person-centred, thinking ahead approach whereby health and social care professionals support and encourage individuals, their families and carers to plan for any changes in their health or care needs. The aim is to increase people's healthy years by up to 5 more years.

Proactive care encourages people to make positive choices about what they should do themselves, and from whom they should seek support, in the event of a flare up or deterioration in their condition, or in the event of a carer crisis. National guidance indicates that patients with frailty, co-morbidities and/or complex needs should be considered.

Rotherham's primary care case management scheme has been in place for 11 years and has carried out over 10,000 reviews. Learning from the scheme will be used to develop our proactive care model which will form part of the Primary Care Network Direct Enhanced Service (DES) and link with both the living well workstreams and roll out of ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) outlined in the Rotherham Place Plan.

Progress in Rotherham so far includes:

- Evaluation and lessons learnt from Case Management
- Multi-agency 'kick off' workshop held
- Steering group and Task and Finish Groups established post workshop
- Overarching delivery model developed
- Pilot Primary Care Network selected
- Eclipse tool rolled out to practices
- Cohort workshop undertaken and Care Plan agreed

Next Steps will be to:

- Finalise cohorts and build into a risk stratification tool
- Agree social care input required and the approach to multi-disciplinary teams, learning from the pilot
- Test out the model April to September 2024 at Health Village and Dearne and incorporate any lessons learnt.
- Roll out of the model September to December 2024.
- Longer term outcome will be to understand how to share the care plan in Rotherham Health Record with partners

Rollout of the 'Say Yes' campaign

Informed by engagement with over 1,700 people, Rotherham Place partners have developed the 'Say Yes' campaign to engage local people with positive, preventative messaging.

The campaign has been launched through community engagement events such as Rotherham Show and the Tenant Engagement Event and has been used to promote new pages on RotherHive around smoking, eating well and physical activity. The smoking page has received over 10,000 visits since the launch of the campaign.

Rotherham's Place Leadership Team has now agreed an action plan for 2024 which will take forward the campaign with a specific focus on alcohol, cancer, diabetes, loneliness, breastfeeding and winter health.

Launch of the Rotherham Healthwave

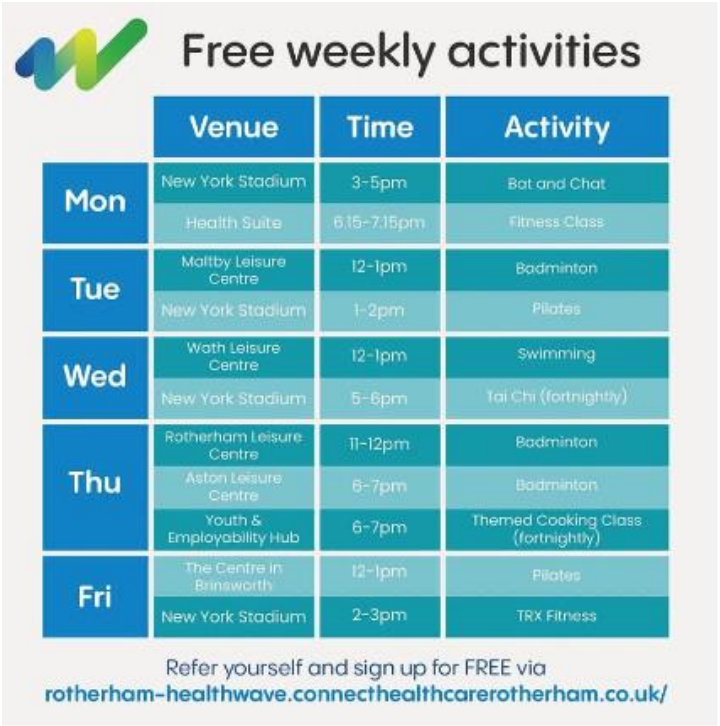
Rotherham's integrated service for smoking cessation and tier 2 weight management was recommissioned in 2023. Through the recommissioning, there was a strong focus on making the service more holistic, sustainable, and considering wider outcomes, including mental health as part of the approach to measuring success.

The new service, Rotherham Healthwave launched in October. Since the launch, the service has received multiple compliments from service-users. One example included:

"We have been with many loss weight programmes before...We have never ever learned or been educated with such ultimate encompassing knowledge, dedication, and striving to help us achieve our goals.

We have achieved better weights, lost many cms from our waists, and compared to all the other weight loss plans, we learned only from her how to maintain our weight."

Compliments have also been received from GPs and other professionals around the new service.



Special Educational Needs and Disabilities (SEND)

An engagement meeting took place at the end October 2023, where a delegation of local authority and South Yorkshire ICB colleagues met with the Care Quality Commission (CQC) and Office for Standards in Education (Ofsted) inspectors.

The engagement meeting went well with discussion around the current context of the Local Area Partnership, Rotherham's demographics and challenges and recognising our strengths and weaknesses.

Colleagues provided assurance around our governance structure linking into Place and key transformational work undertaken with SEND and to reflect the improvements made to the quality and timeliness of health care plans.

Rotherham Safe Space opened late October 2023, it supports anyone experiencing a mental health crisis in Rotherham and the surrounding areas. It provides a safe place during the weekend and Monday evenings designed for people in crisis to go for support and to prevent avoidable attendances at A&E.

It offers a non-clinical alternative to A & E aimed at reducing distress, working with people to resolve or better manage a crisis they are experiencing.

The space offers one-to-one support and a social space, where refreshments and hot food are available, as well as opportunities to chat with other people using the service.

Successful Lipid management in Rotherham

As part of medicines optimisation contribution to the Health Inequalities agenda work has taken place to:

- Produce data that identifies the missed opportunities for practices in the management of lipids and blood pressure (BP)
- Incentivise practice performance in the management of lipids by rewarding practices for reducing the missed opportunities.
- Embed searches into practice systems so that they can identify the patients under treated for BP and lipids.

The North East and Yorkshire Analytics Team examined the information around Lipid Lowering Treatments in Rotherham and provided key data to support our work.

Our findings of % of patients treated to threshold show:

- Rotherham has the highest % of patients achieving treatment threshold in South Yorkshire at 36.45%
- Rotherham is the third highest in achieving % of patients at threshold in Yorkshire and North East
- Rotherham has two Primary Care Networks in the top three for % increase.
- **Rotherham has no inequity in % of patients achieving between the least and most deprived practices.**

Note: The only other areas that have no health inequity (4 in total) have a much lower % of patient's achieving the cholesterol thresholds than Rotherham (Calderdale 29.99%, North Yorks 27.94% and Hull 30.25%)

Board of Directors Meeting
12th January 2024

Agenda item	P13/24
Report	**Integrated Performance Report – November 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 November 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.
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 – November 2023

Board of Directors

Integrated Performance Report - November 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			
Patient Safety	Cancer Care			
Maternity	Inpatient Care			
Patient Experience	Community Care			

CQC DOMAINS

Responsive	Effective	Safe	Caring	Well Led
Planned Patient Care	Mortality	Infection Prevention & Control	Patient Experience	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

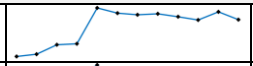
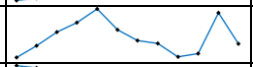
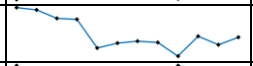
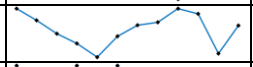
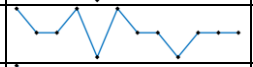
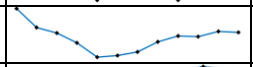
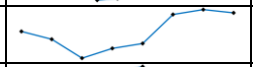
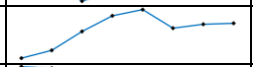
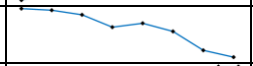
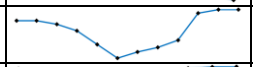
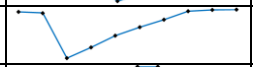
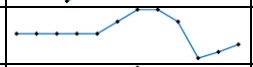
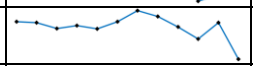
KPI	Reporting Period	Type of Standard	Target 22/23	Benchmark	Previous Month (3)	Previous Month (2)	Previous Month (1)	Current Month	YTD	Same Month Prev. Yr	Trend	Data Quality
Planned Patient Care												
Waiting List Size	Nov 2023	L	**27,200**		32,544	33,235	32,774	30,883	30,883	26,117		
Referral to Treatment (RTT) Performance	Nov 2023	N	**92%**		59.5%	59.5%	61.0%	61.6%	62.5%	68%		
Number of RTT patients waiting 52+ Weeks	Nov 2023	L	**250**		601	706	734	742	742	259		
Number of RTT patients waiting 78+ Weeks	Nov 2023	L	**0**		3	2	1	2	1	5		
Number of RTT patients waiting 65+ Weeks	Nov 2023	L	**146**		40	58	77	76	76	0		
Overdue follow-ups	Nov 2023	L	-		16,004	15,827	15,502	14,514	14,514	14,917		
First to follow-up ratio	Nov 2023	B	**2.4**		2.74	2.63	2.21	2.11	2.50	2.39		
Day case rate (%)	Nov 2023	B	**85%**		86.1%	84.2%	85.9%	85.6%	85%	86%		
Day case rate (%) - Model Hospital	Jul 2023	B	**85%**		83.9%	82.5%	83.3%	85.1%	--	78%		
Diagnostic Waiting Times (DM01)	Nov 2023	N	**1%**		6.9%	4.8%	3.6%	2.3%	5.0%	9%		
Diagnostic Activity Levels - for Key Modalities (from Apr 2023)	Nov 2023	L	**8215**		7,558	8,066	8,264	9,020	9,020	9080		
Capped Theatre Utilisation *(internal data)*	Nov 2023	L	**85%**		80.1%	80.7%	80.5%	79.3%	79.3%			
Emergency Performance												
Number of Ambulance Handovers > 60 mins	Nov 2023	N	**0**		114	28	106	22	548	358		
Ambulance Handover Times % > 60 mins	Nov 2023	N	**0%**		5.8%	1.4%	4.8%	1.0%	3.4%	21%		
Number of Ambulance Handovers 30+ mins	Nov 2023		-		270	152	299	200	1,727	650		
Ambulance Handover Times % 30+ mins	Nov 2023	L	**10%**		13.7%	7.7%	13.6%	9.4%	10.8%	38%		
Average Time to Initial Assesment in ED (mins.)	Nov 2023	N	**15**		26	25	26	24	27	37		
4hr Performance in Dept - against internal target	Nov 2023	N	**76%**		56%	61%	58.3%	62.8%	59.5%			
4hr Performance in Dept - against external target	Nov 2023	N	**60%**		56%	61%	58.3%	62.8%	59.5%			
Proportion of patients spending more than 12 hours in A&E from time of arrival	Nov 2023	L	**2%**		7.2%	4.2%	5.5%	3.2%	4.6%	13%		
Number of 12 hour trolley waits	Nov 2023	N	**0**		0	0	1	0	1	0		
Proportion of same day emergency care	Nov 2023	L	**33%**		40.0%	41.7%	40.9%	42.1%	42.7%	40%		
Cancer Care												
31 Day Treatment General Standard *(new standard from Oct 23)*	Oct 2023	N	**96%**		98.5%	97.3%	97.1%	96.1%	96.5%	93%		
62 Day Treatment General Standard *(new standard from Oct 23)*	Oct 2023	N	**85%**		78.5%	82.1%	75.6%	75.1%	76.6%	72%		
The number of cancer patients waiting 63 days or more after a GP 2ww referral	Nov 2023	L	**60**		46	62	44	58	58	-		
28 day faster diagnosis standard	Oct 2023	N	**75%**		80.3%	77.5%	73.6%	73.5%	70.0%	66%		
Inpatient Care												
Mean Length of Stay - Elective (excluding Day Cases)	Nov 2023				3.21	2.91	2.70	2.22	2.74	2.47		
Mean Length of Stay - Non-Elective	Nov 2023				5.73	5.14	5.40	5.14	5.32	5.93		
Length of Stay > 7 days (Snapshot Numbers)	Nov 2023	L	**142**		162	155	157	161	161	177		
Length of Stay > 21 days (Snapshot Numbers)	Nov 2023	L	**70**		43	46	38	35	35	59		
Right to Reside - % not recorded *(internal data)*	Nov 2023	B	**0%**		8.4%	9.6%	10.3%	8.2%	8.2%	7%		
% of patients where date of discharge is same as Discharge Ready Date	Sep 2023				-	-	-	86.5%	--	0%		
Discharges before 5pm (inc transfers to Community Ready Unit)	Nov 2023	L	**70%**		62.4%	62.1%	58.9%	62.2%	61.2%	60%		
Outpatient Care												
Did Not Attend rate (outpatients)	Nov 2023	B	**6.2%**		9.0%	7.9%	8.1%	8.0%	8.8%	9%		
% of all outpatient activity delivered remotely (via telephone or video)	Nov 2023	N	**25%**		12.8%	13.8%	12.5%	11.9%	12.2%	15%		
Proportion of all outpatient appointments with patients discharged to PIFU	Nov 2023	N	**5%**		1.9%	2.0%	2.3%	2.3%	2.1%			
LUNA Data Quality Score	Nov 2023	N	**99%**		99.1%	99.3%	99.2%	99.2%	--			
% of RTT PTL reported as validated	Nov 2023	N	**90%**		21.0%	78.0%	94.0%	91.8%	91.8%			
Community Care												
MusculoSkeletal Physio <4 weeks	Nov 2023	L	**80%**		28.1%	28.9%	35.7%	26.2%	27.3%	12%		
A&E attendances from care homes	Nov 2023	L	**144**		169	144	145	116	116	136		
Admissions from care homes	Nov 2023	L	**74**		128	111	112	98	98	93		
Urgent 2 hour Community Response	Aug 2023	L	**70%**		83%	83%	74%	75%	79%	89%		
Numbers of patients on virtual ward	Nov 2023	L	**64**		36	25	36	76	76	0		
Number of patients in month accepted onto virtual ward (Total)	Nov 2023				108	130	145	162	162	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)	Aug 2023	B	**As Expected**		105.0	102.9	101.2	102.1	--	104.1		
Mortality index - HSMR (Rolling 12 months)	Sep 2023	B	**As Expected**		92.8	89.7	90.9	90.6	--	100.3		
Number of deaths (crude mortality)	Nov 2023		-		73	74	80	82	579	89		
Infection, Prevention and Control												
C. difficile Infections	Nov 2023	L	**2**		1	2	5	7	30	2		
C. difficile Infections (rate)	Nov 2023		-		30.0	28.1	28.0	30.0	30.0	24.8		
E. coli blood bacteremia, hospital acquired	Nov 2023	L	**4**		5	2	3	6	32	3		
P. aeruginosa (Number)	Nov 2023	L	**1**		0	0	2	0	2	0		
Klebsiella (Number)	Nov 2023	L	**1**		2	4	0	3	14	0		
Patient Safety												
Serious Incidents - one month behind	Oct 2023	L	**0**		4	3	3	5	22	1		
Number of Patient Incidents (including no-harm)	Nov 2023		-		1,015	949	919	943	7,527	-		
Number of Patient Falls (moderate and above)	Nov 2023		-		2	0	2	1	10	2		
Number of Pressure Ulcers (G3 and above) - one month behind	Oct 2023		-		1	0	1	1	4	0		
Medication Incidents	Nov 2023		-		89	98	109	100	796	121		
Readmission Rates (one month behind) - NE - excluding D/Cs	Oct 2023		-		10.5%	9.2%	9.2%	9.3%	10.2%	10.1%		
Venous Thromboembolism (VTE) Risk Assessment	Nov 2023	N	**95.0%**		95.3%	95.6%	95.8%	97.0%	95.4%	96.7%		
Hip Fracture Best Practice Tariff Compliance	Nov 2023	L	**65.0%**		69.2%	71.9%	47.4%	58.8%	58.8%	73.1%		
Patient Experience												
Number of complaints per 10,000 patient contacts	Nov 2023	L	**8**		8.41	11.82	12.92	10.80	10.09	12.61		
F&F Postive Score - Inpatients & Day Cases	Nov 2023	N	**95.0%**		94.2%	97.2%	95.9%	96.7%	97.1%	96.9%		
F&F Postive Score - Outpatients	Nov 2023	N	**95.0%**		97.2%	96.7%	99.0%	97.0%	97.7%	96.3%		
F&F Postive Score - Maternity	Nov 2023	N	**95.0%**		100.0%	97.1%	96.3%	100.0%	98.9%	98.2%		
Care Hours per Patient Day	Nov 2023	L	**7.3**		7.00	7.00	6.80	6.90	6.90	6.3		
Maternity												
Bookings by 12 Week 6 Days	Nov 2023	N	**90.0%**		96.4%	92.3%	93.4%	93.4%	92.9%	94.9%		
Babies with a first feed of breast milk (percent)	Nov 2023	N	**70.0%**		58.5%	60.0%	57.7%	65.8%	60.6%	57.4%		
Stillbirth Rate per 1000 live births (Rolling 12 months)	Nov 2023	L	**4.66**		2.75	2.77	2.77	2.74	2.74	2.71		
1:1 care in labour - One month behind	Oct 2023	L	**75.0%**		100.0%	100.0%	98.6%	100.0%	99.6%	94.8%		
Serious Incidents (Maternity) - One month behind	Oct 2023	L	**0**		0	0	0	0	0	1		
Moderate and above Incidents (Harm Free) - One month behind	Oct 2023		-		0	0	0	0	0	0		
Consultants on labour (Hours on Ward)	Nov 2023		-		62.50	62.50	62.50	62.50	62.50	--		

Trust Integrated Performance Dashboard - Workforce

	Reporting Period	Type of Standard	Target	Benchmark	Previous Month (3)	Previous Month (2)	Previous Month (1)	Current Month	YTD	Same Month Prev. Yr	Trend	Data Quality
Workforce												
Number of WTE vacancies - Total	Nov 2023	L	**285**		257	275	230	273	273	459		
Number of WTE vacancies - Nursing and Midwifery	Nov 2023	L	**98**		95	93	58	84	84	87		
Vacancy Rate - TOTAL	Nov 2023	L	**6.4%**		4.3%	6.8%	5.7%	6.7%	6.7%	10.09%		
Vacancy Rate - Nursing	Nov 2023	L	**7.3%**		7.0%	6.7%	4.3%	6.0%	6.0%	6.35%		
Time to Recruit	Nov 2023	L	**34**		35	36	36	36	36	35		
Sickness Rates (%) - inc COVID related	Nov 2023	L	**4.5%**		6.1%	6.0%	6.4%	6.3%	5.9%	6.62%		
Short-term Sickness Rate (%)	Nov 2023				1.5%	2.1%	2.2%	2.1%	-	-		
Long-term Sickness Rate (%)	Nov 2023				4.6%	4.0%	4.1%	4.2%	-	-		
Turnover (12 month rolling)	Nov 2023		**11%**		11.1%	10.7%	9.8%	9.5%	9.5%	-		
Appraisals complete (% 12 month rolling)	Nov 2023	L	**90%**		78%	86%	87%	87%	87%	86.00%		
Appraisals Season Rates (%)	Nov 2023	L	**90%**		70%	84%	86%	87%	87%	85.00%		
MAST (% of staff up to date)	Nov 2023	L	**85%**		93%	90%	91%	91%	91%	92.00%		
% of jobs advertised as flexible	Nov 2023		-		66.2%	55.2%	70.2%	37.0%	65.2%	n/a		

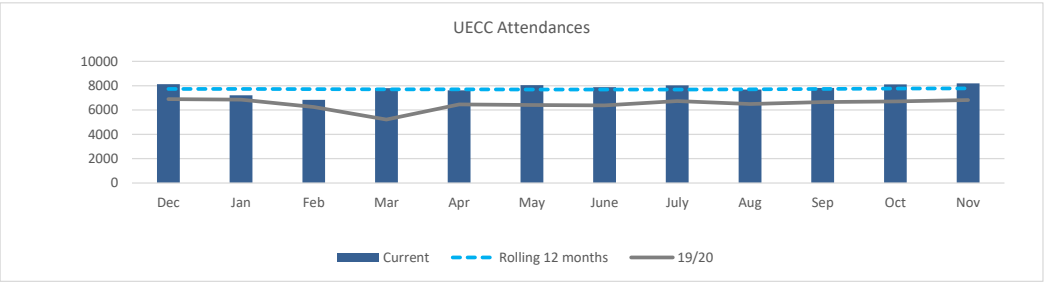
The Rotherham NHS
NHS Foundation Trust

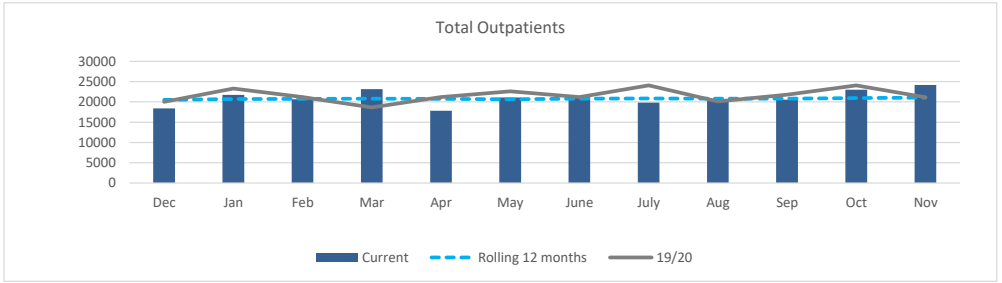
Trust Integrated Performance Dashboard - Finance

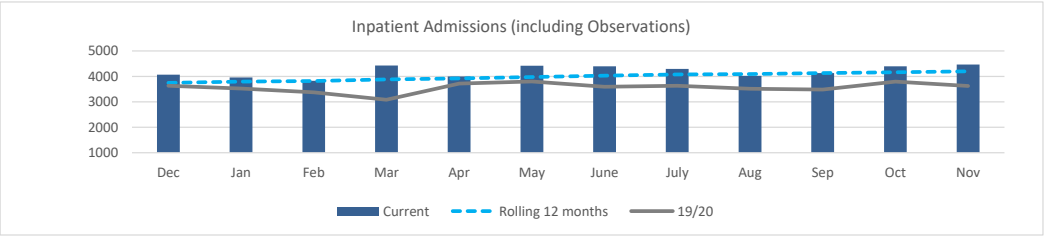
Apr 23 - Nov 23

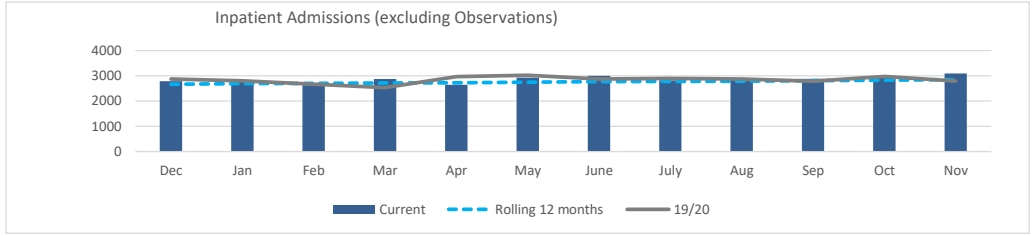
	In Month Plan £000s	In Month Actual £000s	In Month Variance £000s	YTD Plan £000s	YTD Actual £000s	YTD Variance £000s	Forecast V £000s
I&E Performance (Actual)	(515)	(665)	(149)	(5,084)	(6,189)	(1,106)	(3,890)
I&E Performance (Control Total)	(453)	(602)	(149)	(4,585)	(5,690)	(1,106)	(3,890)
ciency Programme (CIP) - Risk Adjusted	1,099	910	(189)	7,275	4,197	(3,078)	(2,883)
Capital Expenditure	1,225	1,003	221	6,798	3,107	3,691	0
Cash Balance	(981)	220	1,200	17,314	19,503	2,189	(248)

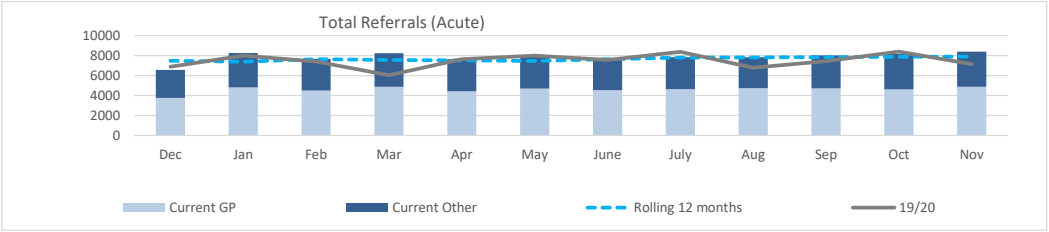
Trust Integrated Performance Dashboard - Activity

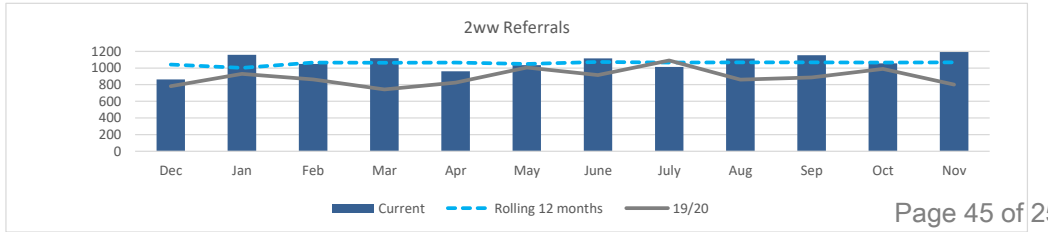












Trust Integrated Performance Dashboard - Activity

ACTIVITY

OUTPATIENTS			
	170	167	
	Activity 19/20	Activity 23/24	As % of 2019/20 WDA
November	19,822	24,406	**118%**
YTD monthly average	20,794	20,973	**103%**

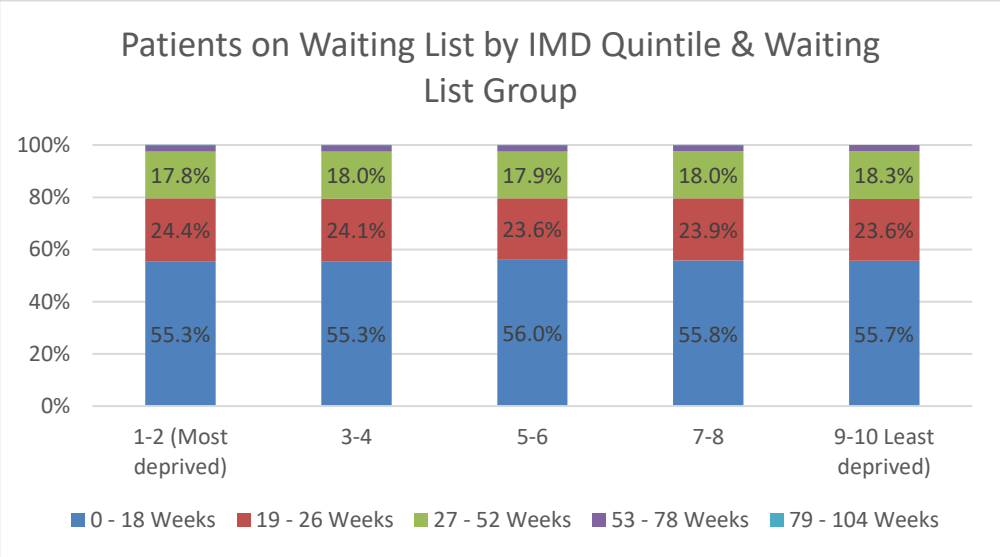
DAYCASES			
	Activity 19/20	Activity 23/24	As % of 2019/20 WDA
November	2,146	2,232	**99%**
YTD monthly average	2,222	1,984	**91%**

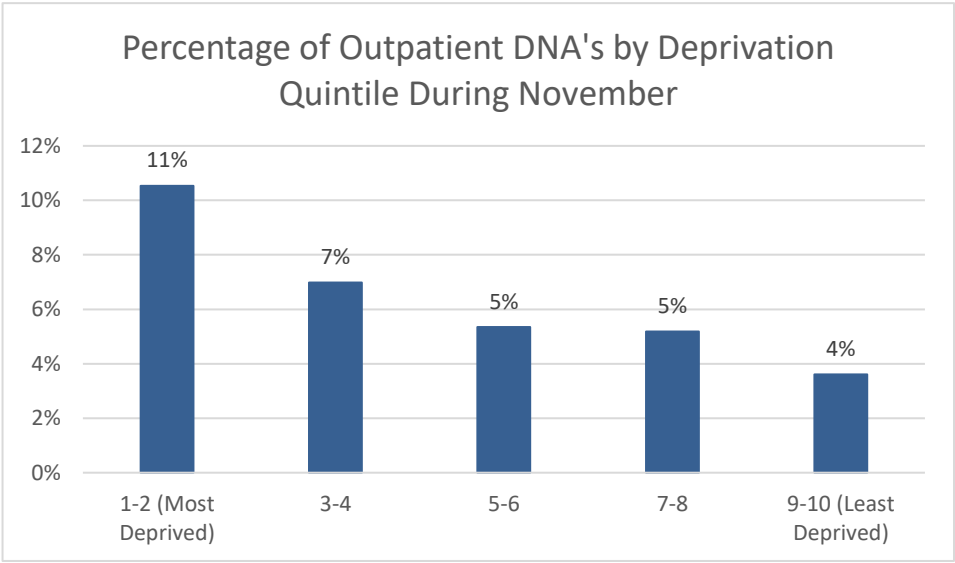
ELECTIVE ACTIVITY			
	Activity 19/20	Activity 23/24	As % of 2019/20 WDA
November	445	365	**78%**
YTD monthly average	421	342	**83%**

Trust Integrated Performance Dashboard - Health Inequalities

RTT Snapshot 26/11/23

IMD Quintile	Patients on Waiting List	Median Wait (Wks)	% of All RTT Patients	% of Rotherham Poulation	% Proportion Difference to Rotherham Population
1-2	9,613	13	37%	36%	1.2%
3-4	5,989	13	23%	23%	0.0%
5-6	4,021	13	16%	15%	0.4%
7-8	4,713	13	18%	20%	-1.3%
9-10	1,496	13	6%	6%	-0.2%
Total	**25,806**	**13**	**100%**	**100%**	**0.0%**





Safer Staffing

Trust Wide Scorecard Rolling 12 Months & Year End position 21/22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
Daily staffing -actual trained staff v planned (Days)	84.9%	87.5%	82.9%	84.1%	84.8%	88.0%	91.0%	90.0%	89.0%	86.0%	86.0%	87.0%	90.0%
Daily staffing -actual trained staff v planned (Nights)	83.9%	84.5%	85.0%	88.3%	90.9%	94.0%	98.0%	95.0%	92.0%	90.0%	88.0%	90.0%	92.0%
Daily staffing - actual HCA v planned (Days)	82.1%	81.4%	84.3%	81.8%	80.0%	85.0%	90.0%	89.0%	90.0%	90.0%	89.0%	91.0%	91.0%
Daily staffing - actual HCA v planned (Nights)	90.7%	85.5%	94.8%	92.0%	90.0%	94.0%	97.0%	102.0%	102.0%	100.0%	93.0%	102.0%	103.0%
Care Hours per Patient per Day (CHPPD)	6.3	6.4	6.4	6.4	6.5	7.1	8.0	7.4	7.3	7.0	7.0	6.8	6.9

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

Statistical Process Control Charts
Fact Sheet

The Rotherham
NHS Foundation Trust

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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.

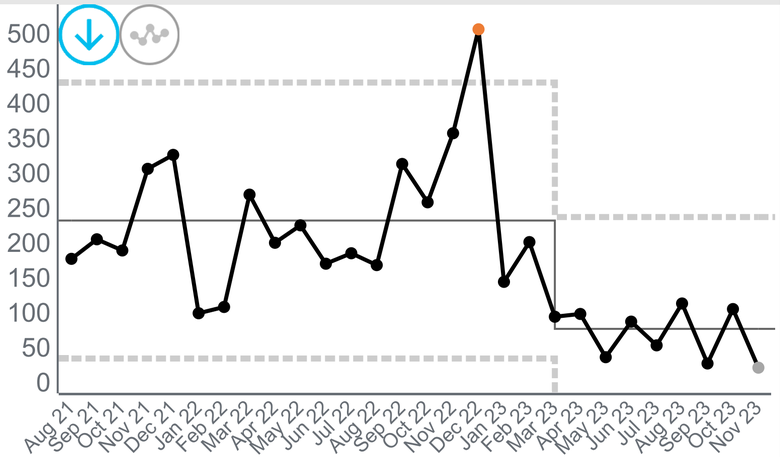
Two out of three points close to the process limits

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

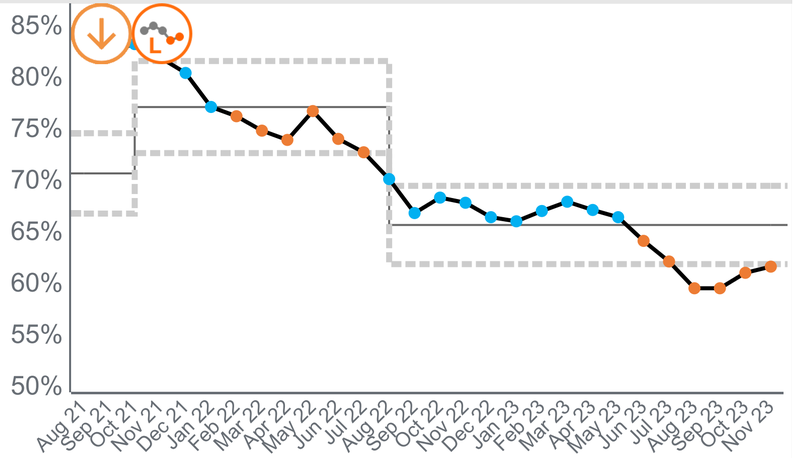
Statistical Process Control Charts
Operational Performance Page 1

The Rotherham
NHS Foundation Trust

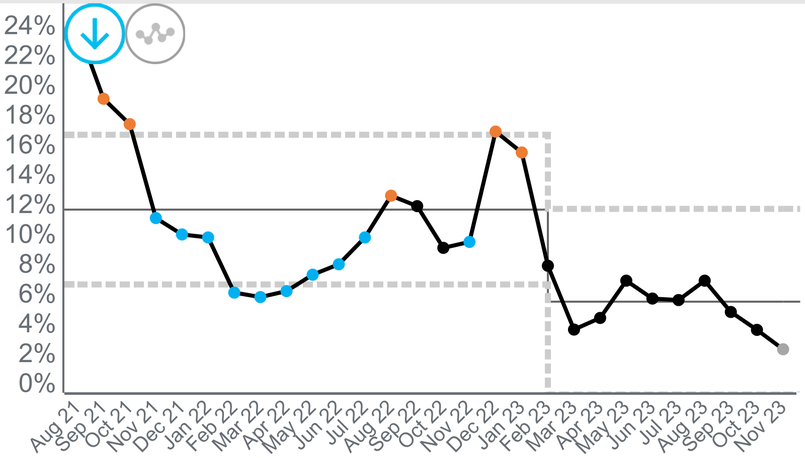
Ambulance Handovers by Date



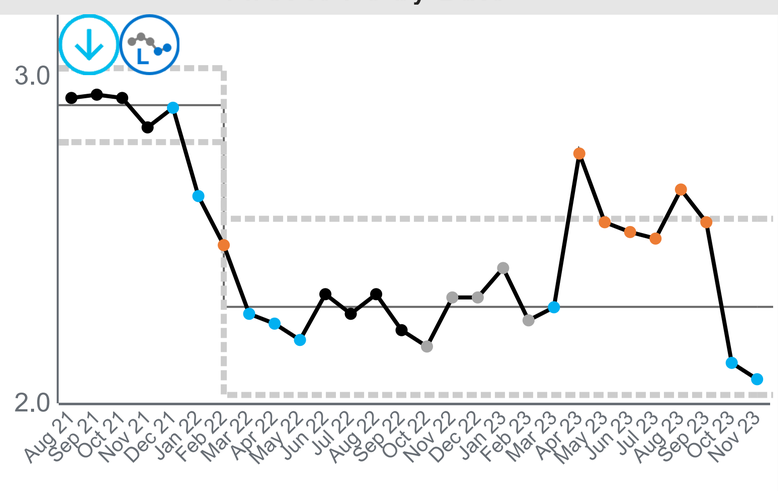
RTT by Date



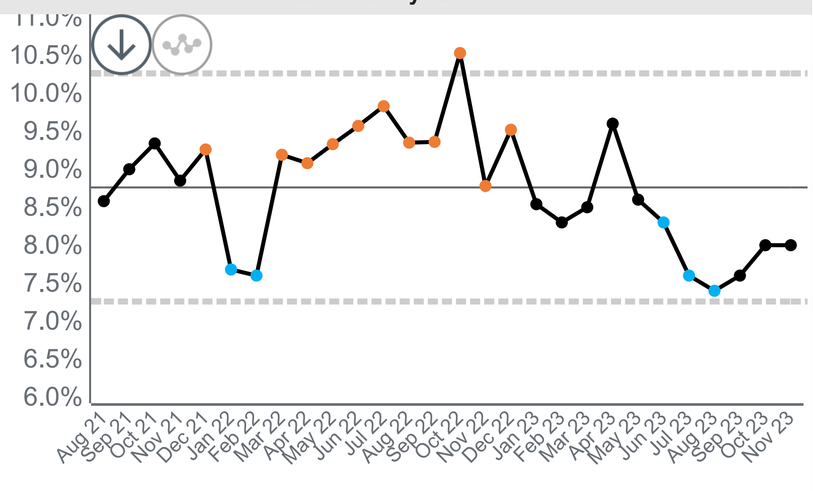
DM01 by Date



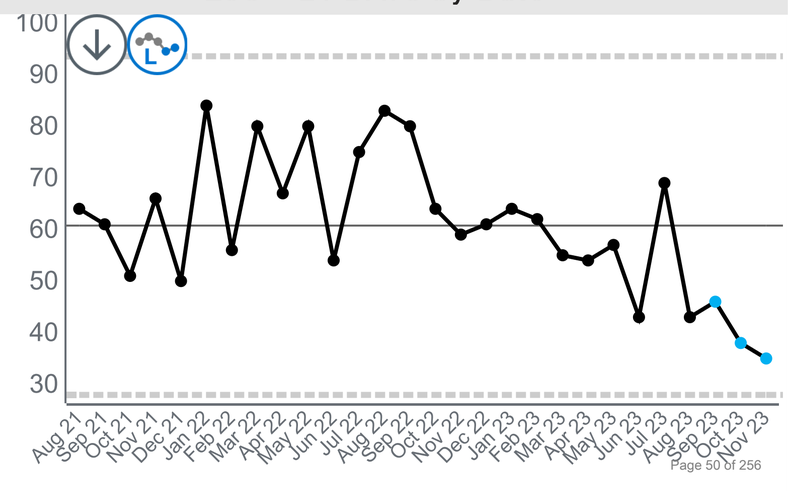
First to FU by Date



DNAs by Date



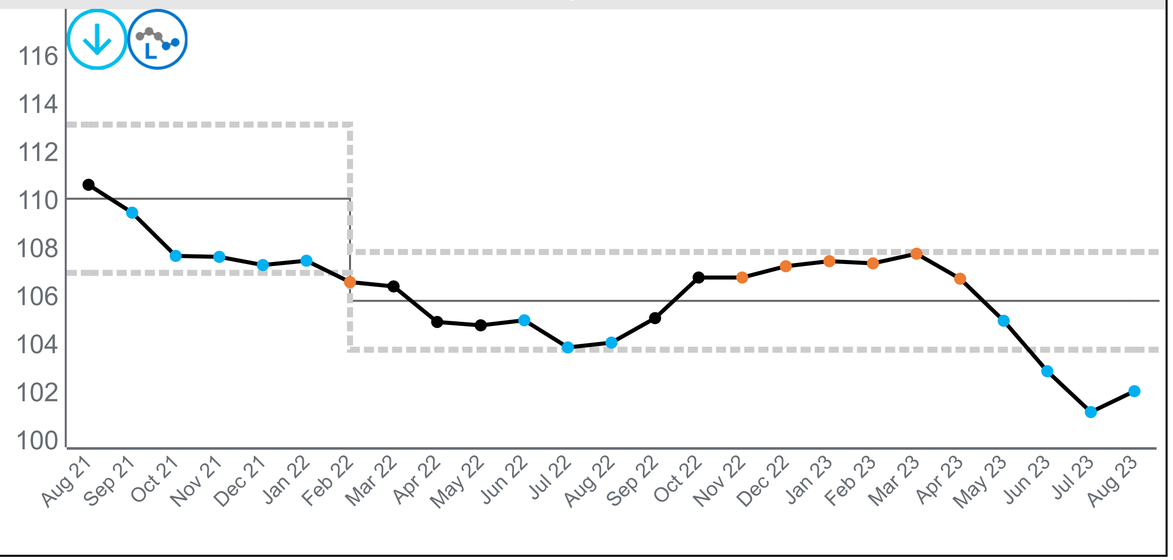
LOS > 21 DAYS by Date



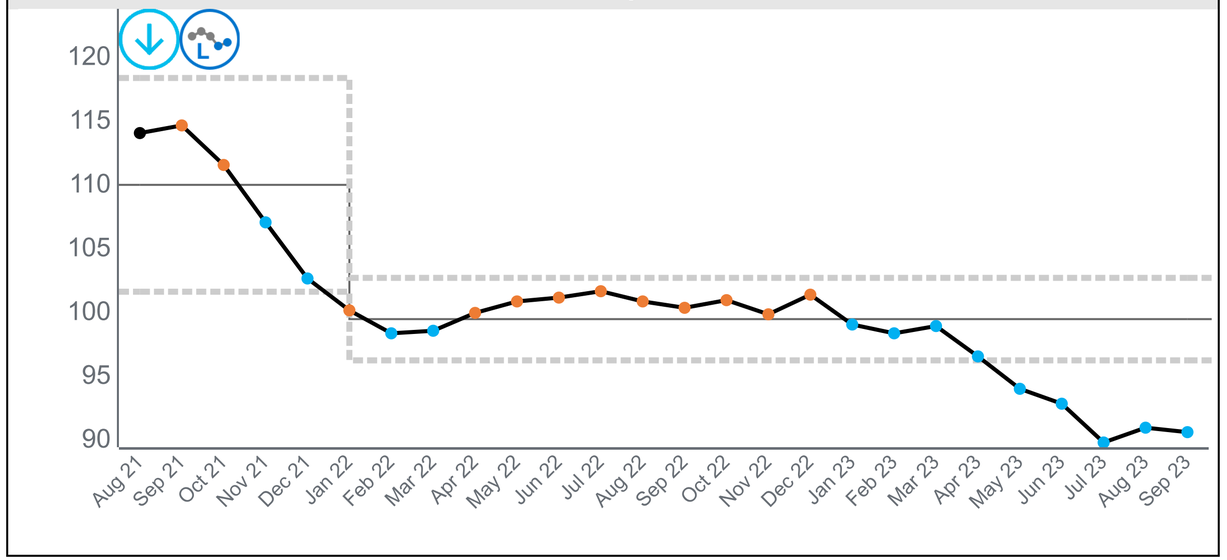
Statistical Process Control Charts
Quality Performance Page 1

The Rotherham NHS Foundation Trust

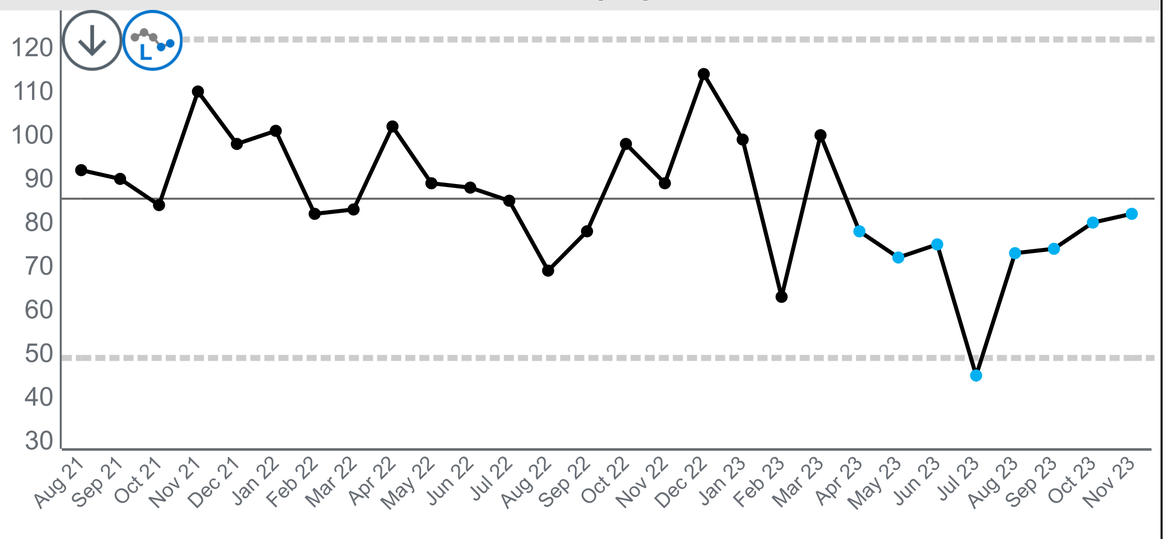
SHMI by Date



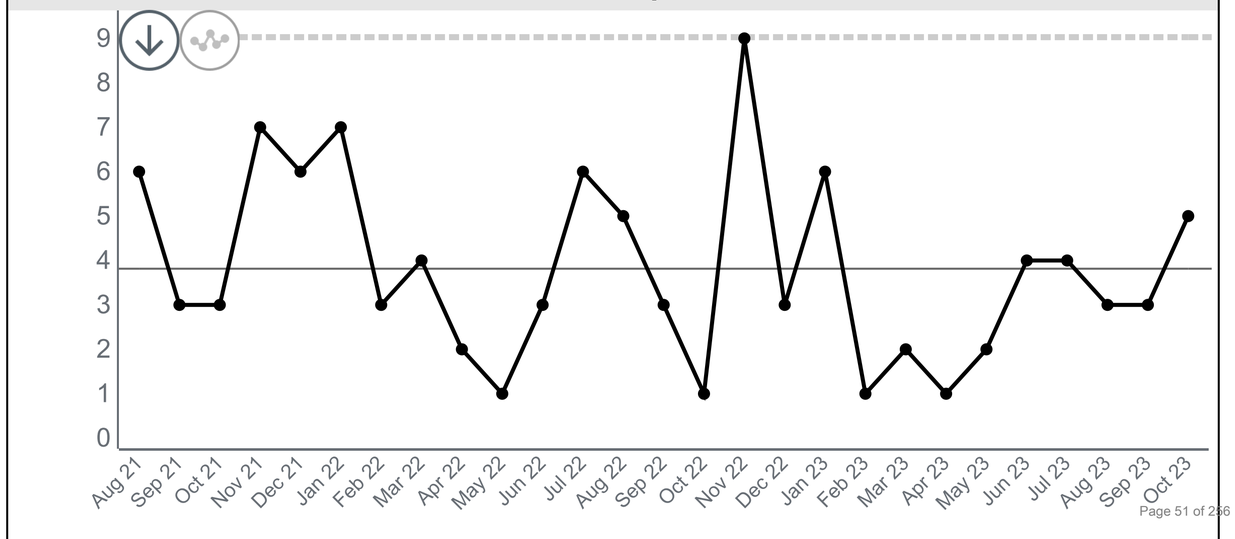
HSMR by Date



Crude Mortality by Date



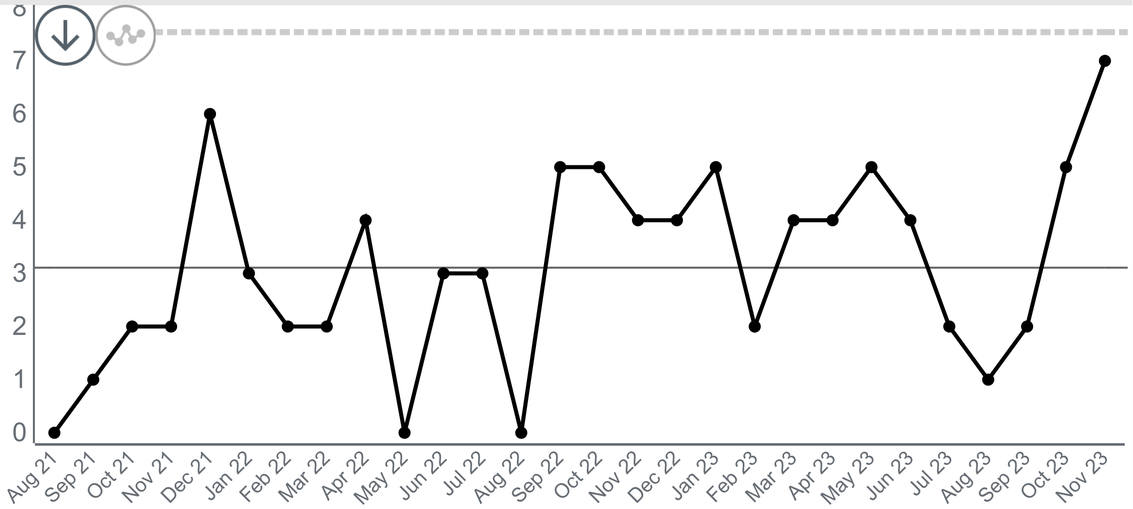
Incidents by Date



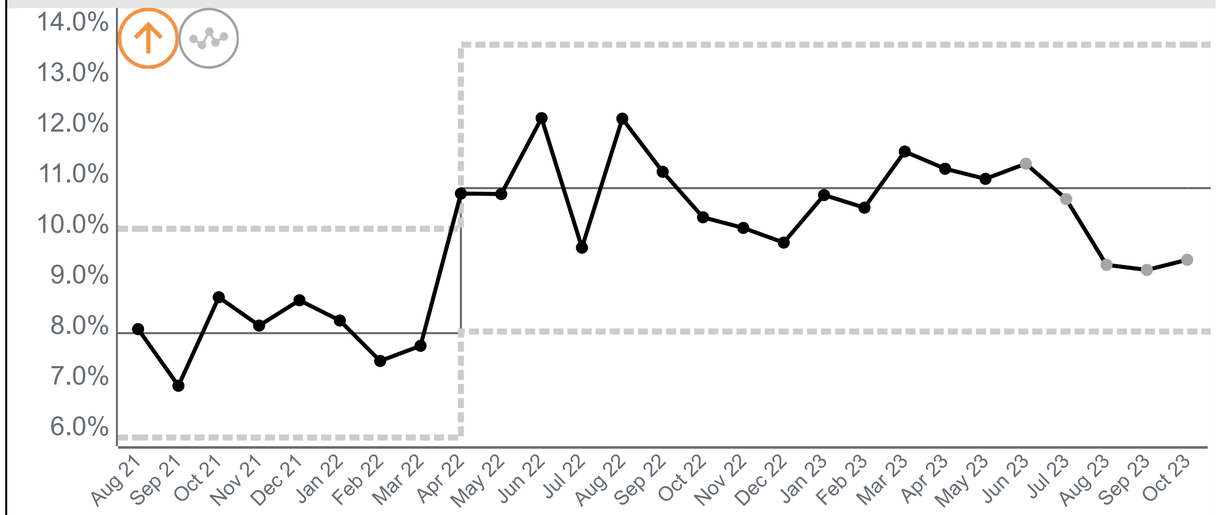
Statistical Process Control Charts
Quality Performance Page 2

The Rotherham NHS Foundation Trust

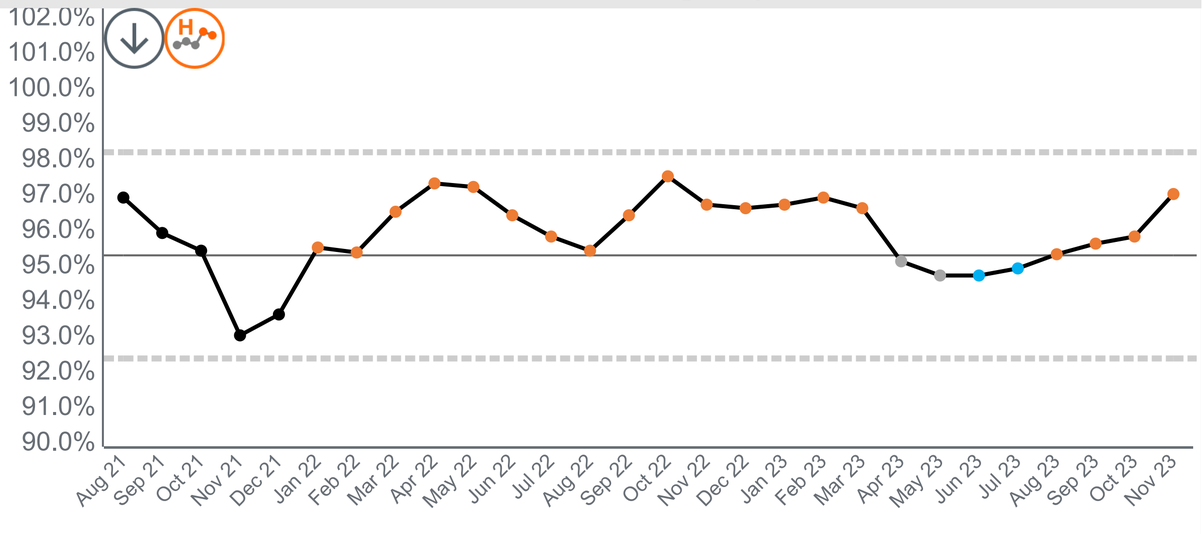
Clostridium-difficile Infections by Date



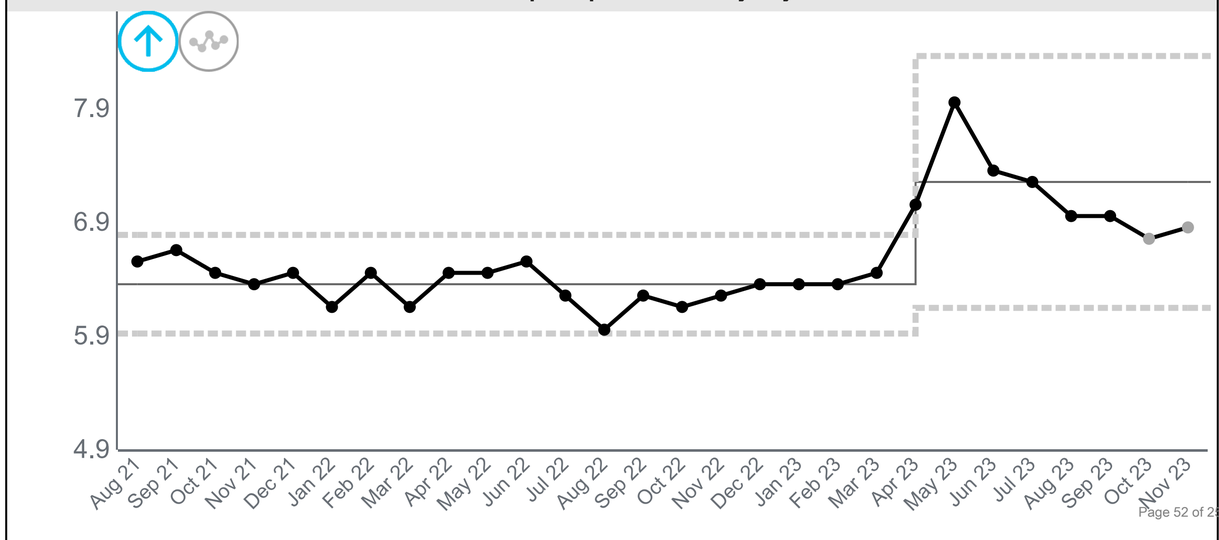
Readmissions by Date



VTE and First VTE Target by Date



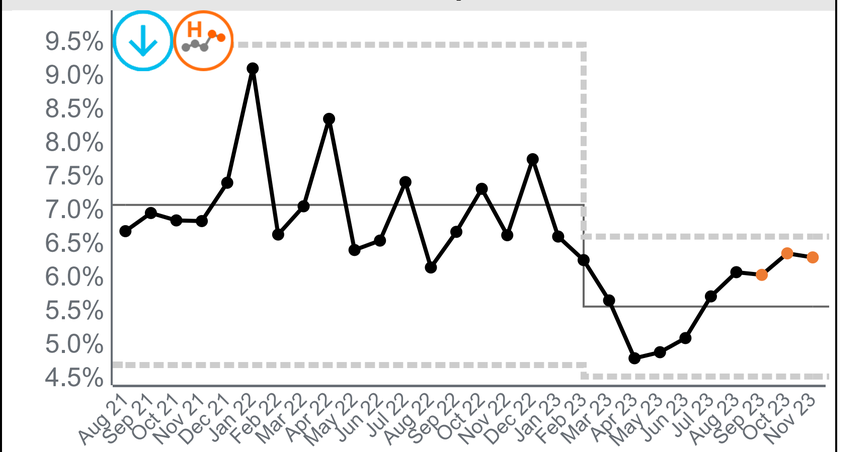
Care hours per patient day by Date



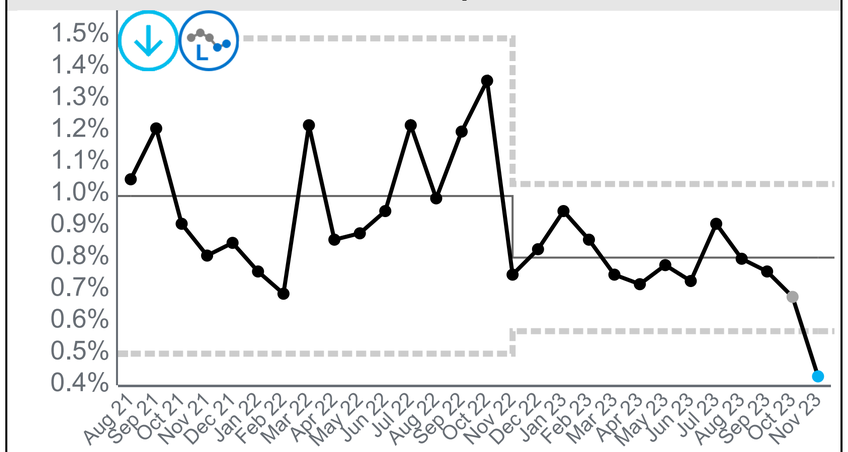
Statistical Process Control Charts
Workforce Performance Page 1

The Rotherham NHS Foundation Trust

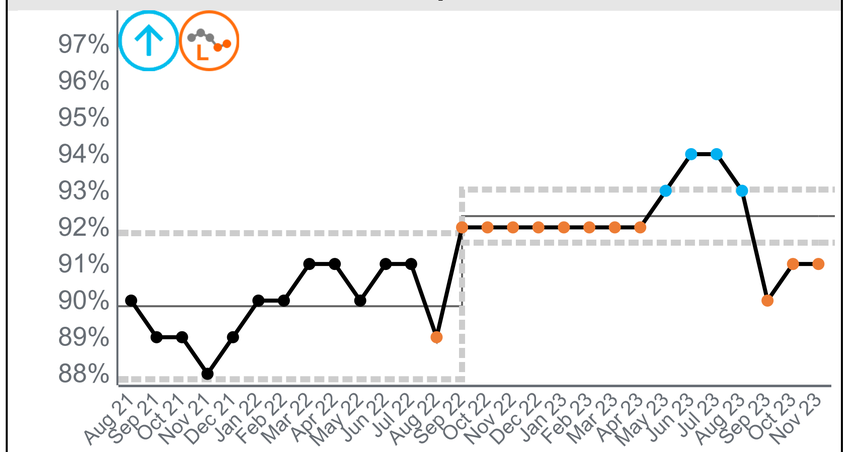
Sickness by Date



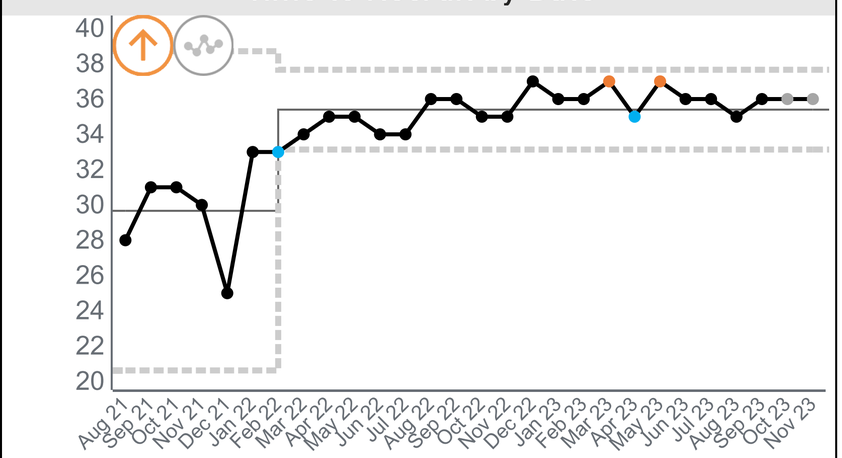
Turnover by Date



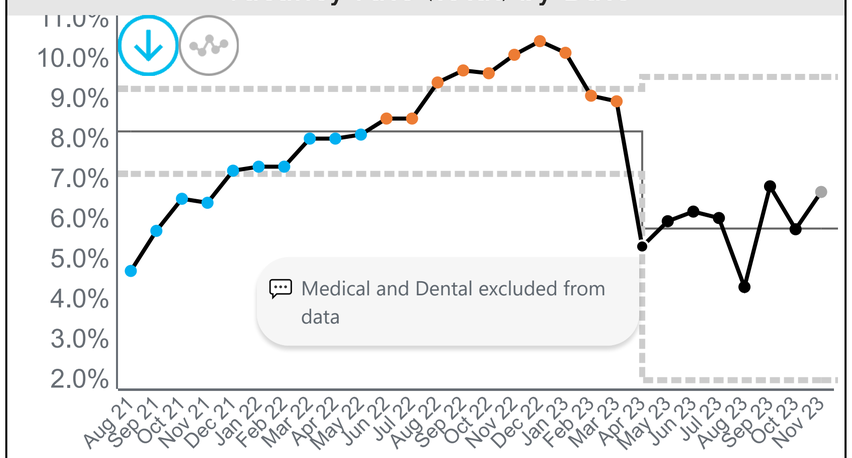
MAST by Date



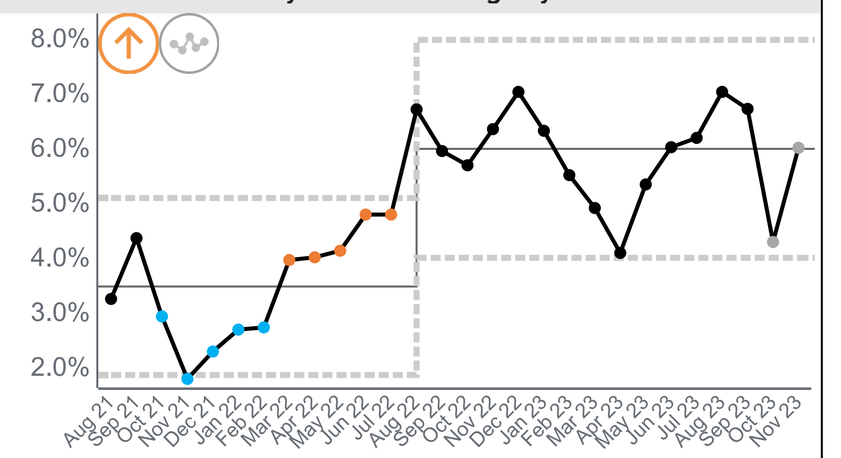
Time to Recruit by Date



Vacancy rate (total) by Date



Vacancy rate (nursing) by Date



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Statistical Process Control Charts
Operational Performance Page 1

The Rotherham NHS Foundation Trust

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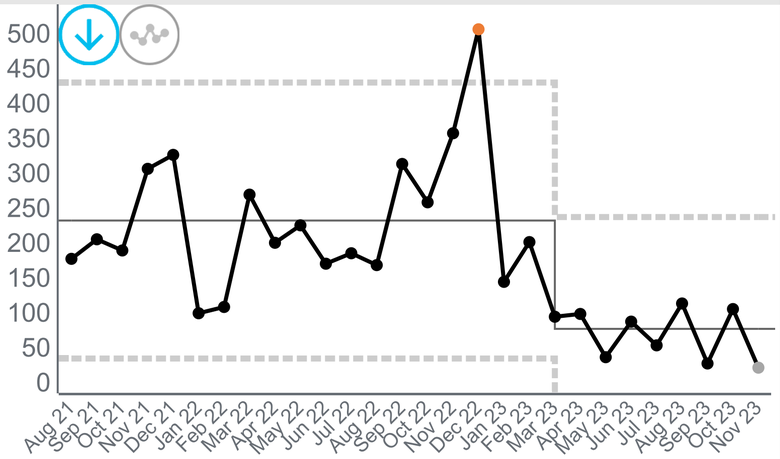
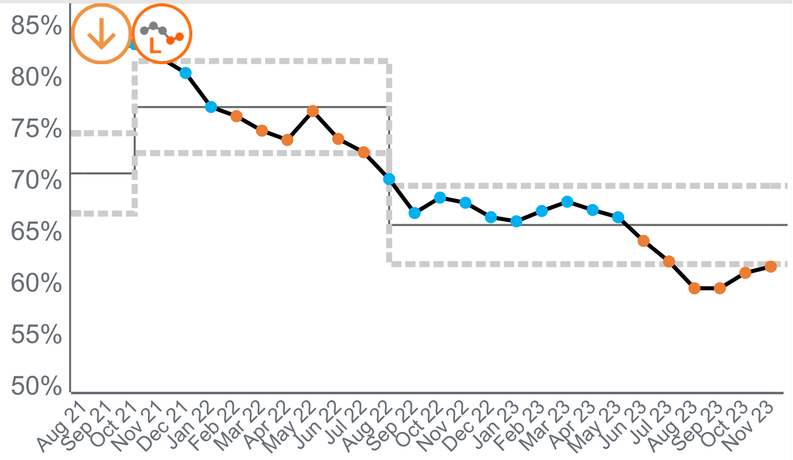
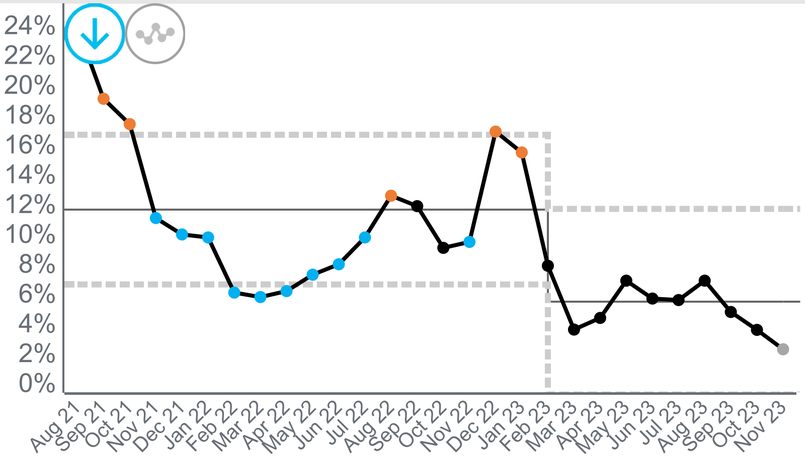


RTT by Date



DM01 by Date



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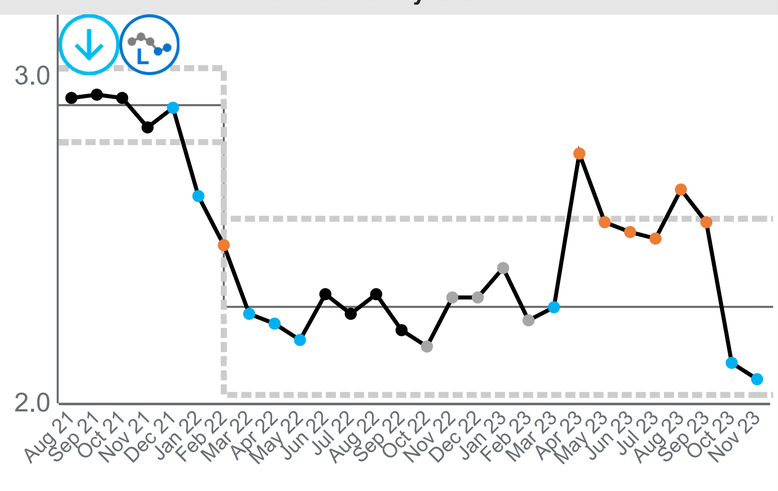

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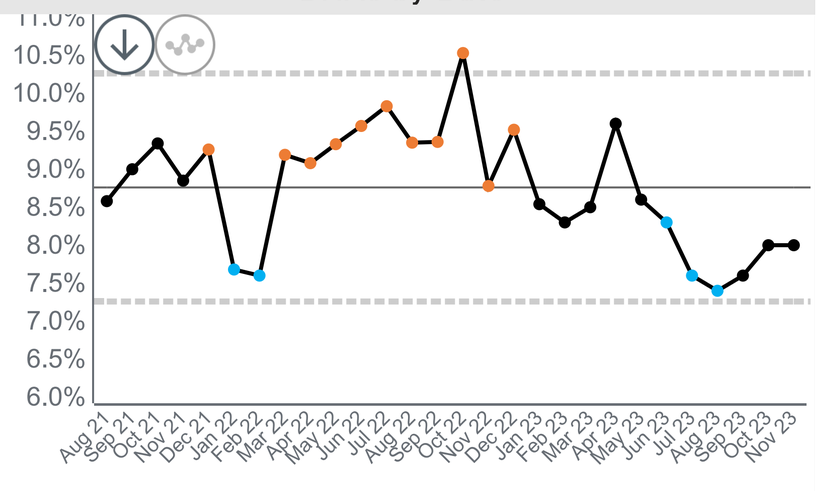

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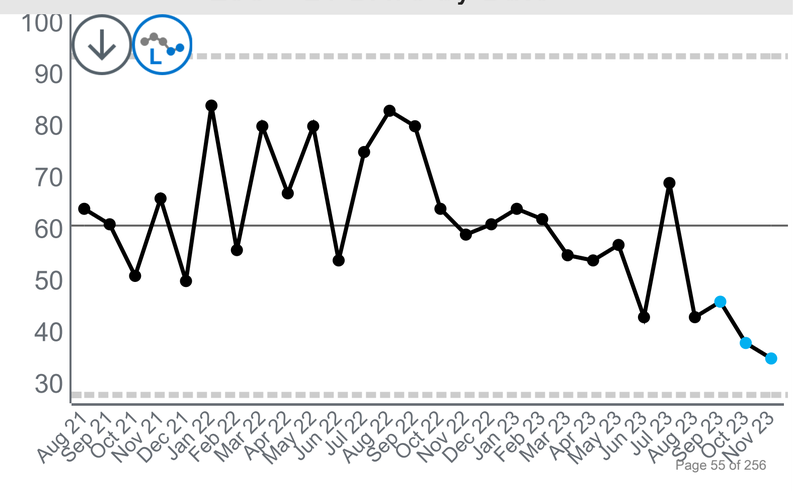
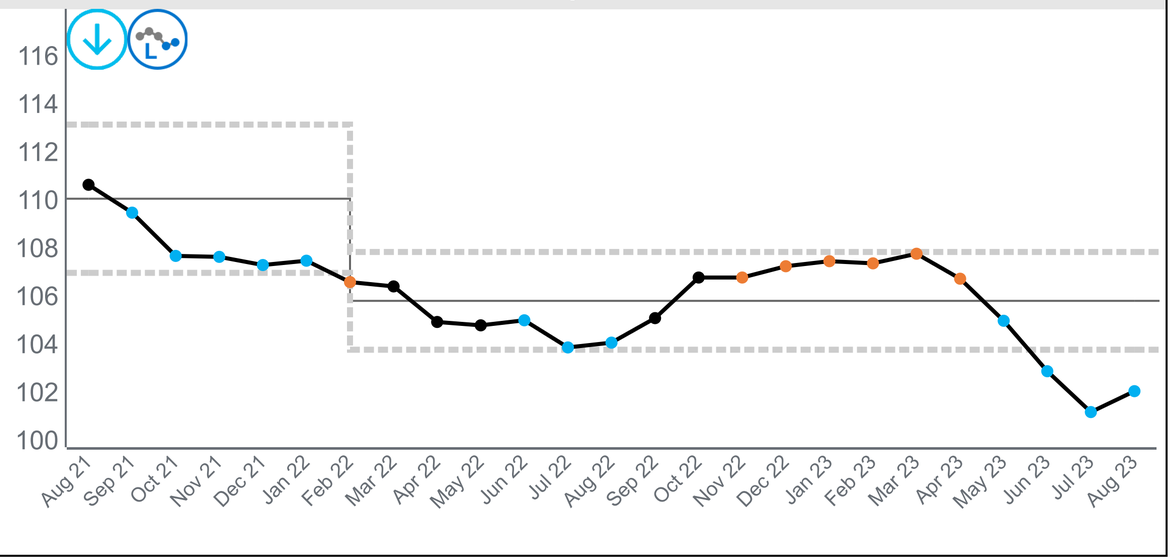


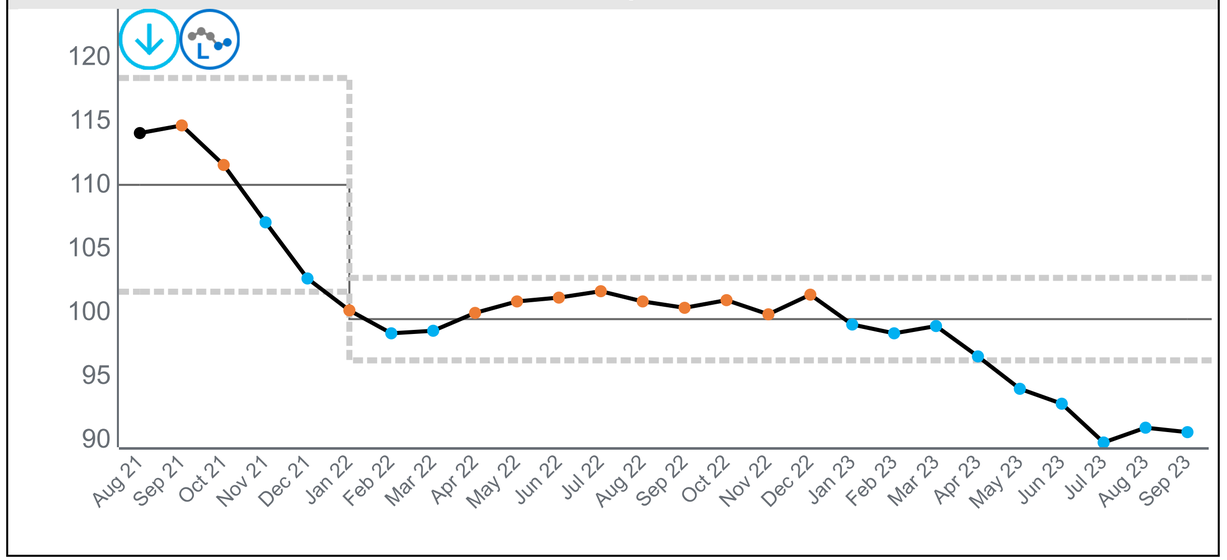
Statistical Process Control Charts
Quality Performance Page 1

The Rotherham NHS Foundation Trust

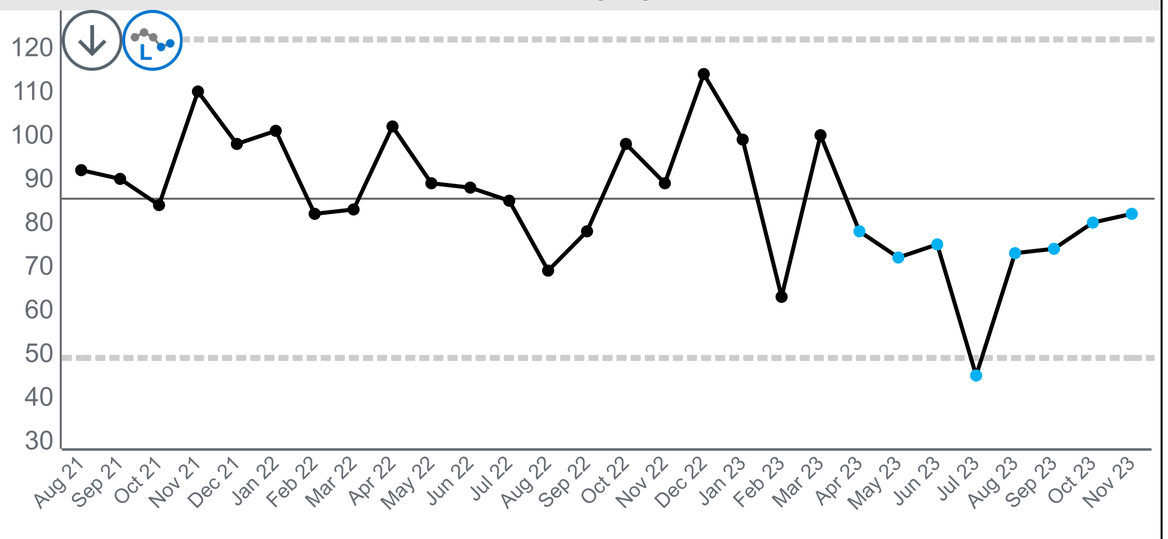
SHMI by Date



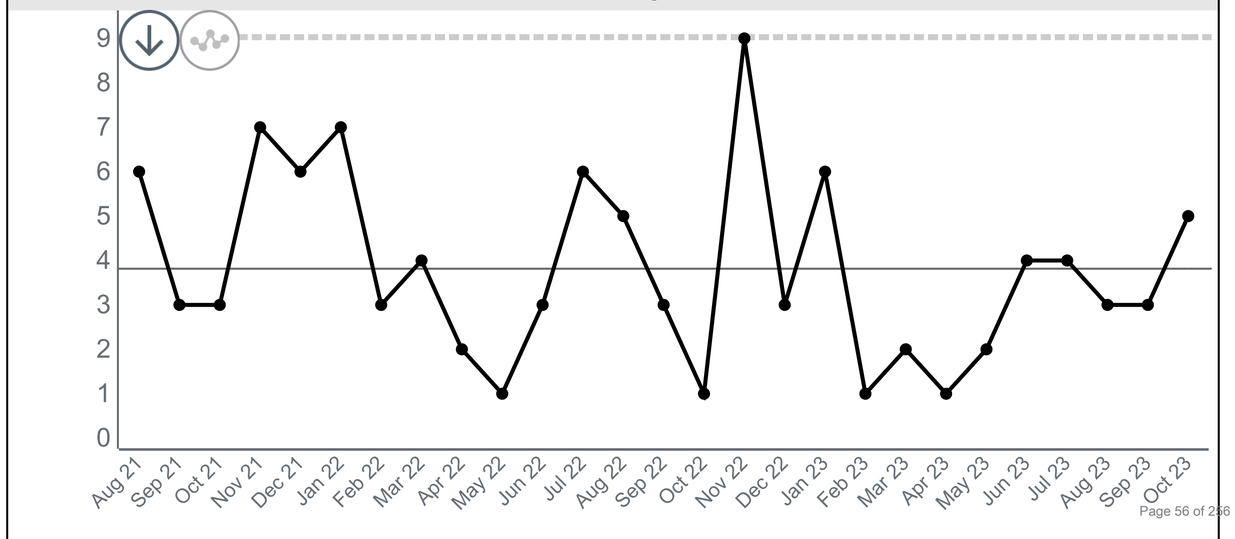
HSMR by Date



Crude Mortality by Date



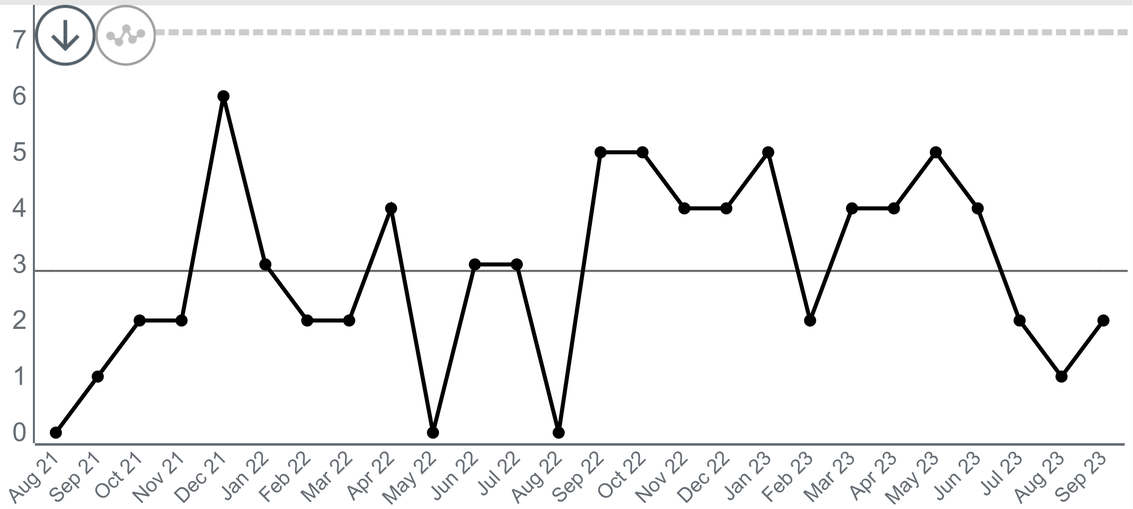
Incidents by Date



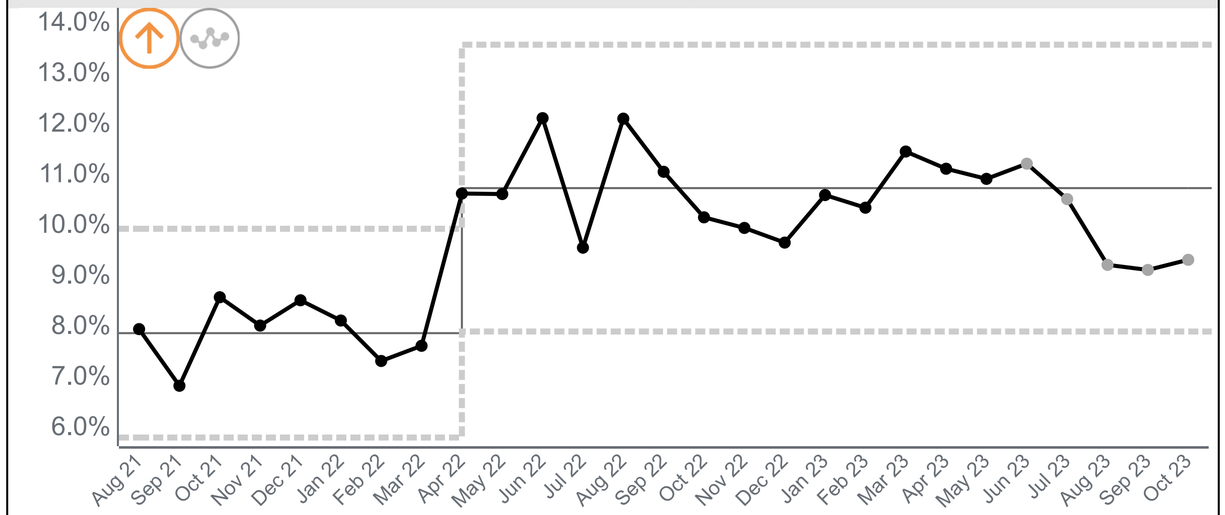
Statistical Process Control Charts
Quality Performance Page 2

The Rotherham NHS Foundation Trust

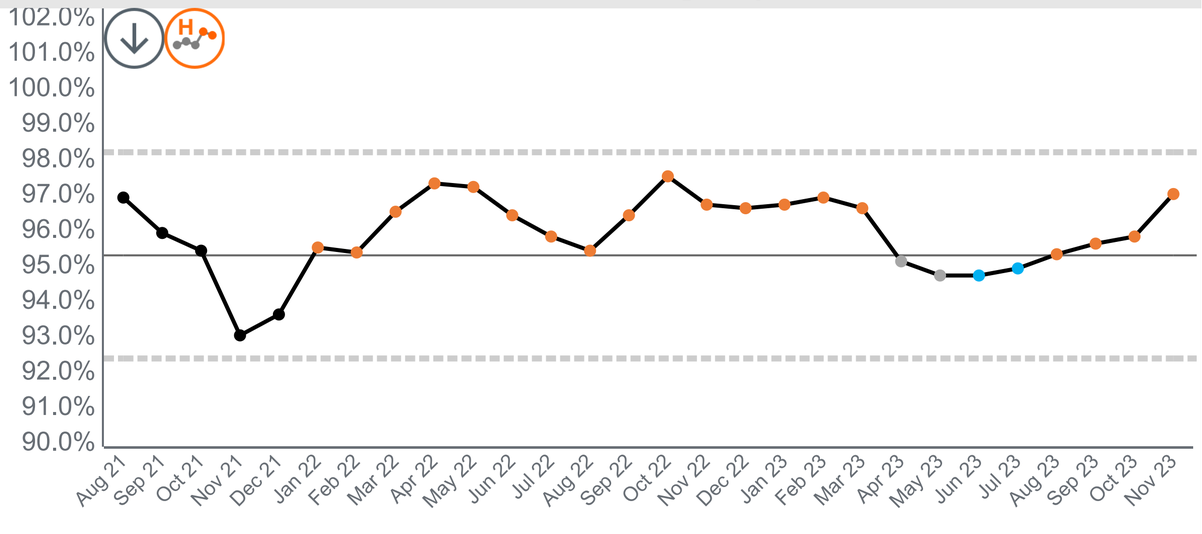
Clostridium-difficile Infections by Date



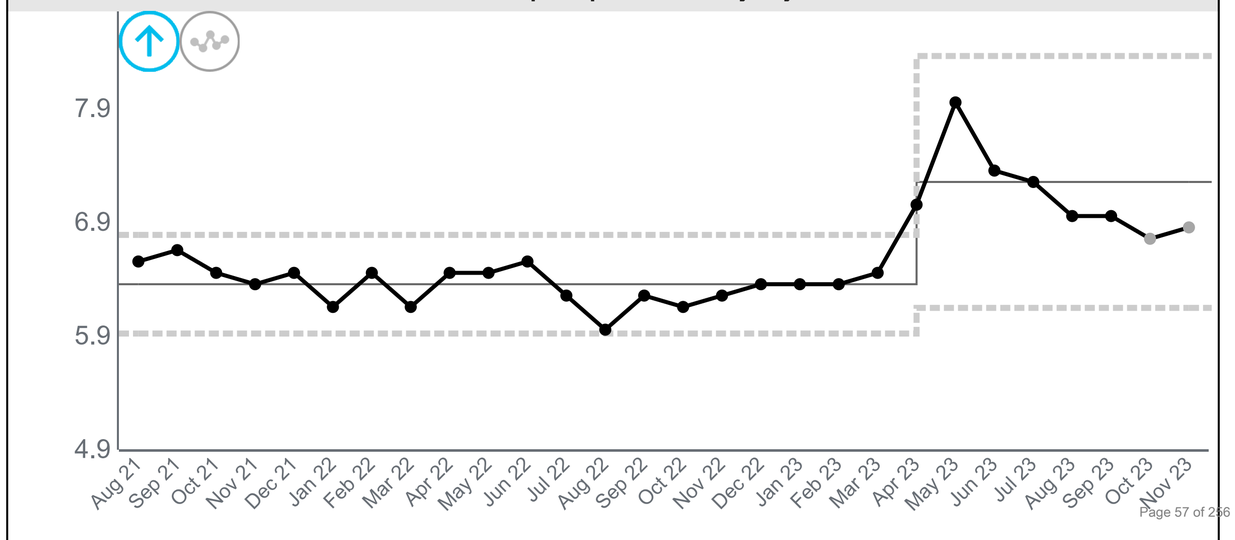
Readmissions by Date



VTE and First VTE Target by Date



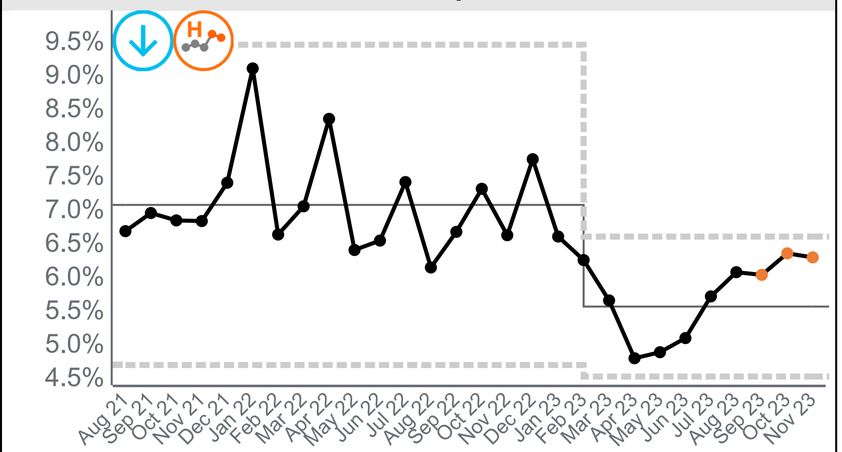
Care hours per patient day by Date



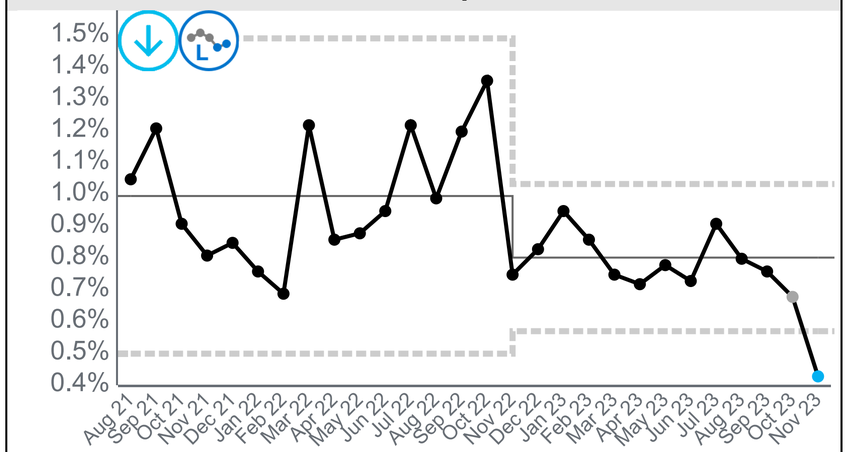
Statistical Process Control Charts
Workforce Performance Page 1

The Rotherham NHS Foundation Trust

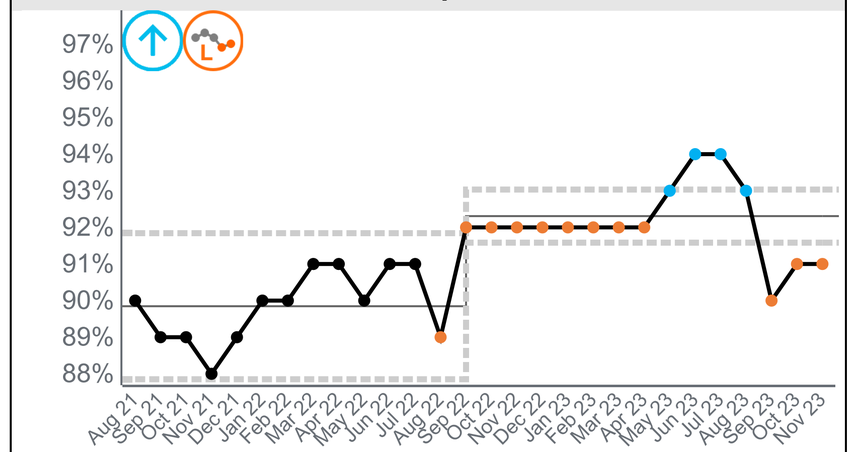
Sickness by Date



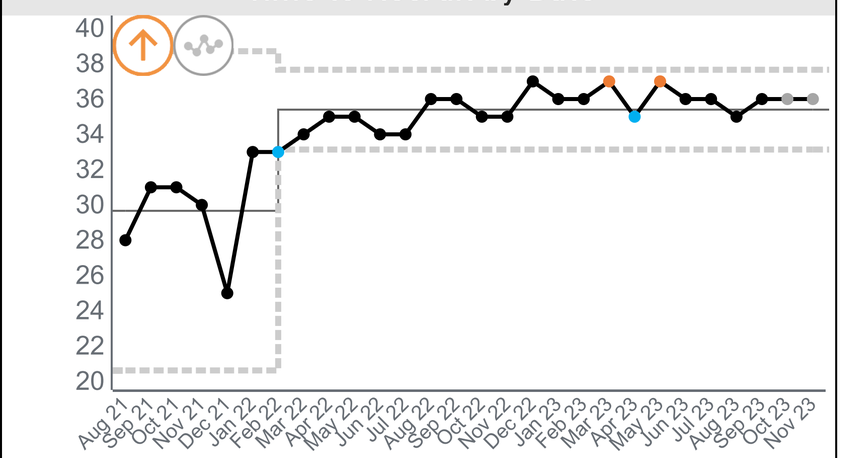
Turnover by Date



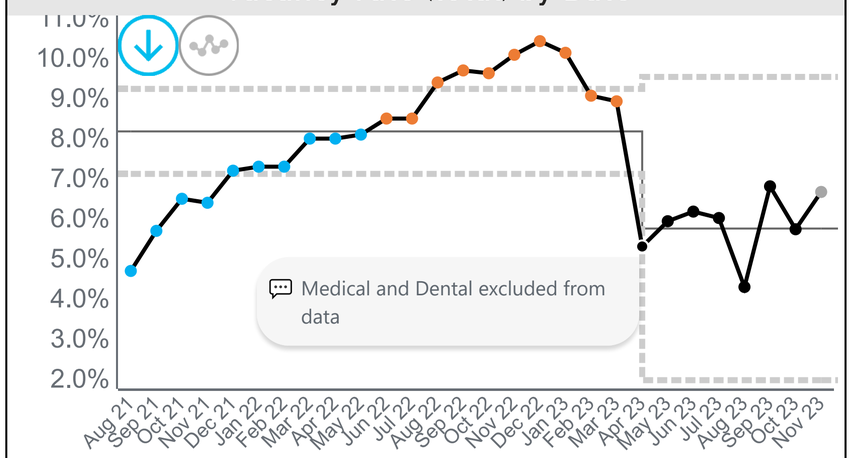
MAST by Date



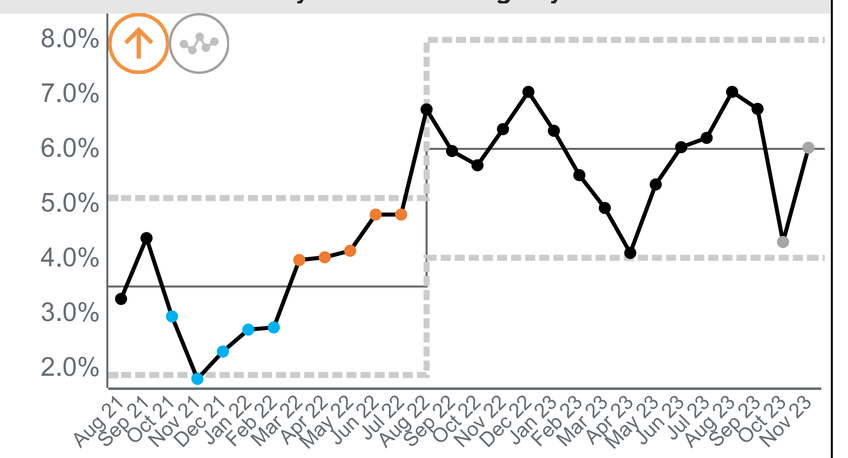
Time to Recruit by Date



Vacancy rate (total) by Date



Vacancy rate (nursing) by Date



QUALITY SUMMARY

Mortality

- Both the SHMI and the HSMR continue to be as “as expected” with performance improving further over the last few months. The latest HSMR value is due to the number of deaths within the Trust falling to just over 800 in the latest 12 month period (compared to closer to 900 six months ago), with the number of expected deaths remaining just under 900. The SHMI has also improved to 102, with the number of expected deaths against this measure increasing over the last several months based on the acuity and demand seen.
- The new SJR process continues to be embedded, with learning taken to the Learning from Deaths group.

Patient Safety

- There were 5 incidents deemed to be severe or above in October, which is line with performance over the past several months. 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.
- VTE assessments have been above target for four consecutive months following focussed efforts by Clinical Leads within areas that were non-compliant.
- Hip Fracture best practice tariff compliance has been highly variable over the last 12 months, due to a number of factors including trauma capacity in theatres and the availability of the Ortho-geriatrician Consultant out of hours. Discussions are underway regarding ring-fencing of beds on our Fitzwilliam Orthopaedic Ward to ensure there is appropriate capacity for relevant patients at all times.
- Patient complaints have increased over the past several months, peaking in October at 12.9 complaints per 10,000 patient contacts. Despite this, the Trust’s Friends and Family Positive Score remains positive, with all domains exceeding their target of 95%.
- Care Hours per Patient Day has been variable over the period, fluctuating around 7 against a target of 7.3. However, the latest data shows the Trust continues to benchmark very poorly on this metric compared to other organisations. This is despite good performance in the Safer Staffing assessment with all four assessed areas at over 90% of planned levels in the most recent data for the first time.

WORKFORCE SUMMARY

Retention and Recruitment

- Over the last 12 months TRFT has seen a 130 WTE increase overall for fixed term and permanent staff (as at the end of November 2023). All bands have seen an increase in WTE with the exception of band 4, which has fallen slightly. These figures include both clinical & non-clinical staff. Rolling voluntary turnover has decreased by 2.6% when compared with November 2022.
- The Trust welcomed 58 new starters for the month of November 2023. Of these, 21 were nursing & midwifery staff and 17 were Nursing Support.
- Highest eligible retirees due now (based on the age of 60) remain within the Estates & Facilities and Integrated Medicine CSUs.
- Analysis shows that of the 23 voluntary leavers for November 2023, 14 had less than 5 years' service with TRFT. All leavers completed an exit questionnaire through ESR, with divisional colleagues reviewing feedback provided to ensure any learning can be taken forward. The top reason for leaving in November 2023 was Work life Balance.

Attendance

- Monthly sickness absence rate for the month of November 2023 decreased slightly but remained well above target. The increase in the overall sickness rate was driven by long term sickness which remained above 4% in month. However, within this picture there was some really positive performance in Urgent and Emergency Care which was below the Trust target at 4.4%, with improvements also seen in Clinical Support Services (CSS) and the Surgery.
- Medicine continues to have the highest sickness absence for the 10th consecutive month (7.9%) and has also had the highest increase when compared to other divisions against October 2023.

Appraisals and Mandatory Training

- Overall appraisal (rolling 12 months) compliance for the month of November 2023 was 87%. Urgent and Emergency Care, Surgery, Community Services and Family Health are above the Trust target of 90%.
- Core MaST compliance has increased by 0.9% and remains above the Trust target of 85%. All divisions remain above target for both Core and Job Specific combined.

Board of Directors
12 January 2024

The Rotherham NHS Foundation Trust

Agenda item	14/24
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 (including reason for the report, background, key issues and risks)	This report is presented to the Board of Directors for information regarding the Trust's performance against key operational performance metrics, along with the recovery actions as at the end of November 2023. The attached report includes a high-level overview of the operational issues during the last month, along with detail on the key operational indicators which NHS England and the ICB are using to monitor the performance of the Trust. The main headlines: • The Trust saw increased operational pressures throughout the month of November 2023, operating at OPEL level 2 and at times level 3. • The winter plan was enacted in November as planned, with surge capacity being utilised as required. • Performance against the 4-hour standard was 62.8% against an agreed trajectory with NHSE of 60%. • The Trust achieved the re-profiled trajectory for patients waiting over 65-weeks, with 78 patients waiting against a trajectory of 148. An update on the current position with Corneal Grafts is included. • The Trust has continued to plan and implement contingency arrangements for the periods of Industrial action in December 2023 and January 2024. • Outpatient Programme – work continues to progress the streams of work within the Outpatient Programme stream. • An assessment of the Trusts bed modelling has taken place

	• An internal critical incident was declared on the 20 November 2023 when the Trust lost power to our IT and telephone systems. • An update on EPRR Activities has been included including submission of the Annual EPRR compliance with core standards.
Due Diligence (include the process the paper has gone through prior to presentation at the meeting)	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 December, 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 (what action is required, who is the lead and when should it be completed?)	A monthly report is provided to the Finance and Performance Committee and to the Board of Directors and any actions required are the responsibility of the Chief Operating Officer with support from colleagues.
Recommendations	It is recommended that the Board of Directors note the report.
Appendices	1. Operational Update Report 2. Performance against National Key Metrics

Operational Update Report – November 2023

1.0 Operational Pressures Escalation Level (OPEL) & Urgent Care

The Trust saw more heightened operational pressures throughout the month of November, with the Trust operating at OPEL Level 3 at peak times. The Trust has started to see an increased demand on UECC as expected during the Winter months. The demand on paediatrics and maternity services has been high during the last month. Surge capacity is being utilised as required, in line with the winter plan.

The Trust 4-hour performance target for the month was 62.8% which achieved the Trust's trajectory with NHSE of 60%. Improvement work continues in line with the Acute Care Transformation Programme, with a focus particularly on flow out of UECC and discharge. Work continues to embed the new ways of working across UECC and medicine which commenced last month to achieve and sustain 4-hour performance. The Trust continues to perform well on Ambulance handover times.

The Trust achieve the trajectory for the number of patients with no right to reside – with 51 patients against a trajectory of 56 at the end of November. There has been an increased focus on length of stay and ward processes.

2.0 Elective and Cancer Care

The operational teams continue to focus on elective recovery and prioritise long waiting patients being seen; however, as previously highlighted the elective programme has been impacted adversely due to industrial action throughout the year and with the periods of industrial action for doctors in training in December and January, there will be further impact on the elective recovery.

The Trust achieved the revised elective trajectory for the month of November for the number of patients waiting over 65 weeks, with the number of patients waiting at the end of November 2023 being 78 against a target of 146.

There are two patients waiting over 78 weeks, both are awaiting a corneal graft. The Trust is receiving support from Sheffield Teaching Hospitals for patients requiring this procedure as tissue becomes available. These patients are both awaiting tissue from NHS Blood and Transplant Authority, with tissue only being allocated nationally to the longest waiting patients.

The Trust achieved its trajectory for the number of GP referred patients waiting over 62 days on the cancer PTL, with 58 patients over 62 days against a trajectory of 60.

The national Patient Initiated Digital Mutual Aid System (PIDMAS) is now live. There are currently 21 patients that have requested to be seen by an alternative Trust. Divisions are working through the requests and liaising with the ICB around any requests that can be treated elsewhere.

3.0 Doctors in Training - Industrial Action

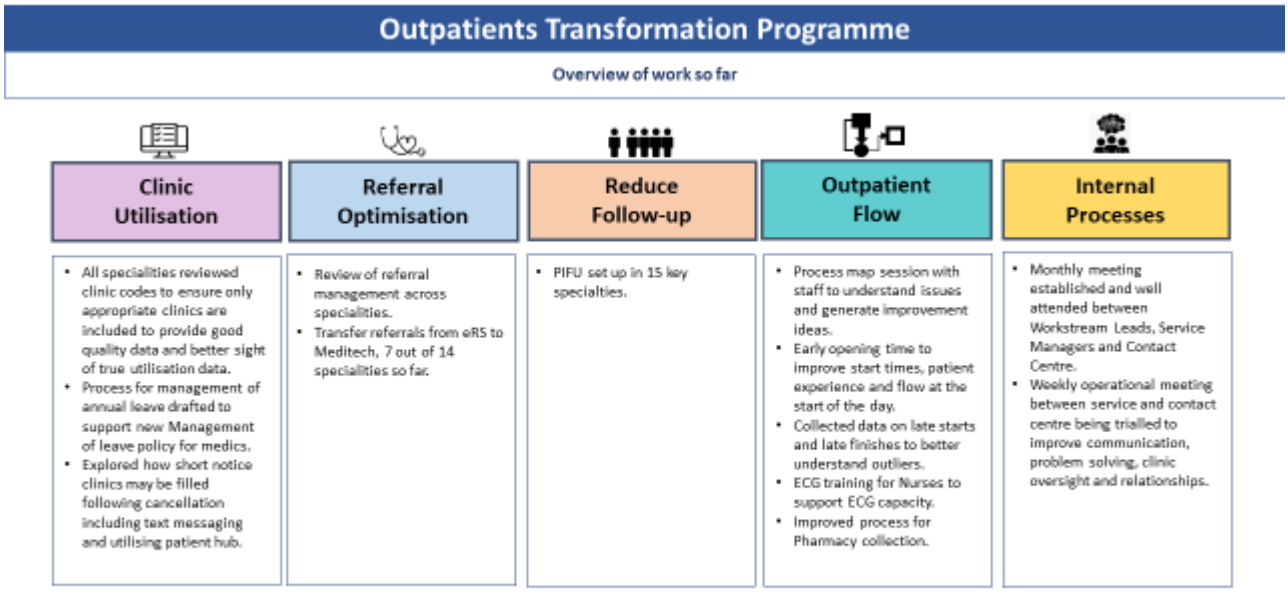
The Trust has continued to plan and implement contingency arrangements for the periods of industrial action from 20 to 23 December 2023 and 03 to 09 January 2024. This will be longest period of action and at a particular challenging time of year, following the extended bank holiday periods. Significant planning and

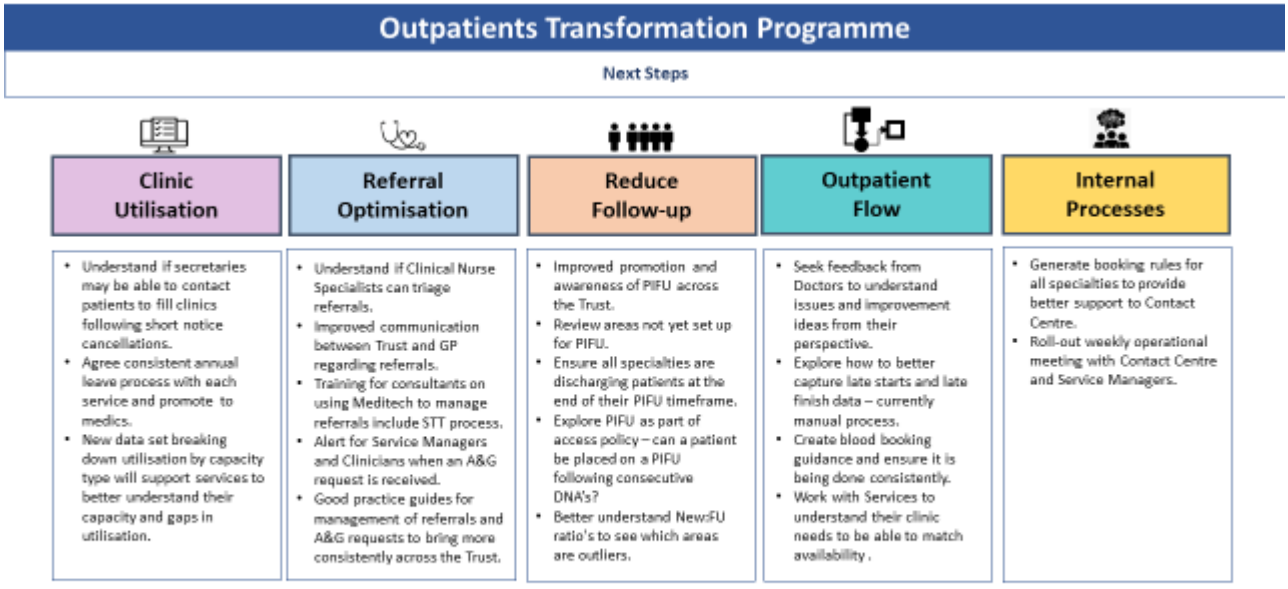
preparation takes place prior to all periods of industrial action to mitigate the impact to patient care as much as possible. During the industrial action, command and control arrangements are in place with twice daily tactical and strategic meetings taking place.

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.

4.0 Outpatients Transformation Programme

Work continues to progress the Outpatients Transformation Programme. Below highlights the key actions taking place to drive improvement, with a summary of the work undertaken so far, along with the next steps.





4.0 Bed Modelling

A re-assessment of the Trust's bed modelling has taken place following the reconfiguration of the bed base. The re-assessment has indicated the following:

- The number of beds is appropriate and we currently have the right sized bed base for the majority of the time.
- The right sizing of the bed base has impacted positively with medicine now having the correct bed base, however, surgery capacity may be pressured at key times.
- Looking ahead the bed base may not meet any further increases in demand if other measures are not taken to manage occupancy (such as reduced length of stay, same day emergency care and hospital avoidance).

5.0 Power Outage

An internal critical incident took place on the 20 November 2023. The Trust lost connection to its IT and telephone systems. A business continuity incident was declared resulting in Divisions activating their business continuity plans to ensure the delivery of critical services was maintained before systems were restored later in the day and normal service levels resumed. A hot debrief took place immediately after the incident which will be followed by a series of more detailed debriefs over the coming weeks. Unfortunately, on the morning of the incident we did have to cancel some activity as we dealt with the incident.

6.0 EPRR

The EPRR team completed the annual core standards self- assessment process which was reviewed by the Local Health Resilience Partnership.

The Trust Evacuation & Shelter plan review has now been completed which details arrangements to manage an incident requiring a partial or full evacuation of the main hospital building. A training and exercising programme will be delivered throughout next year.

The team facilitated a debrief following an incident on ward B10 in August where a loss of power led to disruption to services. Another debrief was facilitated by the team following Storm Babet. Learning has been identified from both incidents which will be incorporated into planning arrangements.

The team facilitated an exercise to test the response to the Place winter plan which focussed on how a number of foreseen risks including adverse weather, industrial action and a spike in seasonal illnesses would be managed as a local health and social care system in addition to anticipated operational pressures.

Sally Kilgariff
Chief Operating Officer
December 2023

National Key Metrics - Performance Against Trajectories

Adult G&A bed Occupancy - based on KH03 Submission

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Target	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%
Actual	90%	89%	91%	90%	91%	89%	90%	89%				

Data run monthly from Live Bed State and based on Adult G&A only (predicted position for KH03)

Number of RTT 65 Week waiters

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Target	40	50	60	60	60	50	78	146	148	106	37	0
Actual	27	30	28	24	40	58	76	76				

Data taken from Monthly RTT Submission.

Patients with no R2R

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Target	58	58	58	60	62	56	56	56	62	62	60	54
Actual	53	61	40	47	58	44	66	51				

Total number of patients with no R2R as at the last day of the month (reporting day after month end for completeness)

Cancer Patients waiting over 62 days following a GP Referral

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Target	60	60	60	64	64	64	60	60	64	64	60	54
Actual	59	67	52	41	46	62	44	58				

Data taken as at the last day of the month.

Daily Average Hours lost from Ambulance Handovers

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Target	10.8	10.8	10.8	10.8	10.8	10.8	10.8	10.8	10.8	10.8	10.8	10.8
Actual	8.1	4.4	7.3	5.13	8.71	4.3	9.6	6.7				

Data taken from YAS report - total number of Hours lost divided by number of days in the month for the average.

4-hour UECC performance

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Internal Plan	45%	50%	55%	60%	65%	70%	76%	76%	76%	76%	76%	76%
National Submission	45%	45%	50%	50%	55%	55%	60%	60.0%	65.0%	65.0%	70.0%	70.0%
Actual	55%	60%	58%	64%	57%	61%	58%	63%				

Data taken from Monthly Submission - subject to change following further validation but unlikely)

Urgent Community Response Standard

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Target	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%
Actual	86%	83%	83%	74%	75%							

Data reported 1 month behind following national submission. (National data not updated since Aug 2023)

Number of Patients on Virtual Ward

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Target	12	16	24	24	32	40	56	64	72	80	80	80
Actual	14	14	23	31	36	25	36	76				

Number of patients on the Virtual Ward as at the last day of the month.

Board of Directors
12 January 2024

The Rotherham NHS Foundation Trust

Agenda item	P15/24
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 The Maternity Incentive Scheme (MIS) update and request for CEO sign off is shared in the paper. **Theme 1: Listening to and working with women and families with compassion Key commitments.** An update on the newly published Maternity and Neonatal Voice Partnership guidance and the recommendations is discussed, TRFT have been nominated to be the pilot site for this in the South Yorkshire Local Maternity System. **Theme 2: Grow, Retain and support the workforce.** The nominal role demonstrates the improvements to the workforce gaps and it is anticipated that these will improve further. The acuity data for November is shared, staffing meeting acuity for 86% of the time period in November. **Theme 3: Developing and sustaining a culture of safety, learning and support:** The Division is currently engaged and undertaking the NHS England perinatal Leadership and culture SCORE survey which commenced on the 16th October 2023. The Perinatal quality oversight data and Maternity dashboard data is included and represents no significant change in maternity outcome data. No serious incidents were declared in November 2023. **Theme 4: Standards and structures that underpin safer, more personalised and more equitable care:** The adjusted perinatal mortality rate is 2.35 per 1000. The Avoiding term admission rate to the neonatal unit (ATAIN) was 4.4%
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 and Quality Committee
Board powers to make this decision	The Trust Board and Quality Committee 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 and Neonatal 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. Board Declaration form Maternity incentive scheme (MIS) year 5 2. MIS presentation 3. November Birth-rate plus acuity data

Maternity Safety

1. Maternity Incentive Scheme update:

1.1. The Maternity incentive update is highlighted below demonstrating that the Division has achieved all ten safety actions following the Saving Babies Lives "Deep Dive". The South Yorkshire Maternity and Neonatal system assessed the evidence submitted for each element of The Saving Babies lives Care Bundle and assessed the evidence submitted to demonstrate 71% overall. The requirement is to:

Evidence adequate progress against this deliverable by the submission deadline in February, providers are required to demonstrate implementation of 70% of interventions across all 6 elements overall, and implementation of at least 50% of interventions in each individual element. These percentages will be calculated within the national implementation tool.

Action No.	Maternity safety action	Action met? (Y/N)
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Yes
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	Yes
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes
6	Can you demonstrate that you are on track to fully implement all elements of the Saving Babies' Lives Care Bundle Version Three?	Yes
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Yes
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Yes
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	Yes
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 to 7 December 2023?	Yes

Table 1: MIS Board update:

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	80%	Partially implemented	90%	CNST Met
Element 2	Fetal growth restriction	Partially implemented	60%	Partially implemented	65%	CNST Met
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 4	Fetal monitoring in labour	Partially implemented	40%	Partially implemented	80%	CNST Met
Element 5	Preterm birth	Partially implemented	67%	Partially implemented	67%	CNST Met
Element 6	Diabetes	Partially implemented	50%	Partially implemented	67%	CNST Met
All Elements	TOTAL	Partially implemented	64%	Partially implemented	71%	CNST Met

Table 2: Saving Babies lives TRFT self-assessment:

1.2. Standard 8 was updated from the 11th October 2023 by the Maternity incentive scheme (MIS) collaborative advisory group following feedback from providers on the current pressures with the industrial action and the Trusts ability to meet the 90% standard in the required time frame.

The CAG remains committed to ensuring that Trusts achieve MIS actions to drive improvements in maternity safety, and Trusts must do all they can to continue to achieve these actions. However, in recognition that Trusts have requested some flexibility with the reporting time scale during industrial action, and the importance of maintaining safe levels of staffing in the delivery of direct maternity care, the following has been agreed: Action 8 - Training: 80% compliance at the end of the previously specified 12-month MIS reporting period (December 2022 to December 2023) will be accepted, provided there is an action plan approved by Trust Boards to recover this position to 90% within a maximum 12-week period from the end of the MIS compliance period.

1.3. This update has enabled the Division to achieve safety action 8 training requirements as per table 3 with a plan to achieve 90% by the end of January 2024:

MATERNITY DASHBOARD DATA Post Mast Dec 23 Total Compliance	Obstetric Consultants	Obstetric Registrars (ST3-7)	Obstetric Trainees (ST1-2)	Midwives (All bands)	NHSP Midwives	Clinical Support staff	Anaesthetists
Total Attendance Day 3 (Module 3 PROMPT)	92%	100%	88%	88%	100%	86%	94%
Overall Compliance (day 2 and 3 only) Module 2 FS is reported on separately	87.5%	100%	88%	88%	100%	84.5%	NA

Table 3

1.4. The Trust Board must give their permission to the CEO to sign the Board declaration form prior to submission to NHS Resolution (Appendix 1). The Trust Board declaration form must be signed by the Trust's CEO. If the form is signed by another Trust member this will not be considered. In addition, the CEO of the Trust will ensure that the Accountable Officer (AO) for their Integrated Care System (ICB) is apprised of the MIS safety actions' year 5 evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the compliance submission to NHS Resolution. The declaration must be submitted to MIS between 25 January 1st February 2024 at 12 noon.

1.5. For the Board to give permission for the Chief Executive to sign off the Board declaration form, the following assurance process will be followed as agreed at Trust Board on the 8th December 2023. The progress with the MIS scheme presentation (Appendix 2) was presented at Executive Team on the 21st December 2023. An Executive Lead has been assigned to each safety action to go through the data for further quality assurance of the evidence for each safety action.

1.6. The Divisional Director Consultant Obstetrician and Gynaecologist Radhika Gosakan will present the feedback from the assurance process to request the Trust Board give Dr Richard Jenkins permission to sign off 10 out of 10 safety actions at Trust Board on the 12th January 2024.

1.7. The Trust assurance for sign off will then feed through to the Local Maternity System collaborative board meeting, so that the Accountable Officer for the Integrated Care System (ICB) is apprised of the MIS assurance for TRFT. This has been designated to Cathy Winfield, Chief Nurse for the ICB.

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

2.1. In November 2023 Guidance was published on the role of The Maternity and Neonatal Voice Partnership (MNVP) https://www.england.nhs.uk/long-read/maternity-and-neonatal-voices-partnership-guidance. This guidance has been produced to reduce the variation currently experienced in Maternity and Neonatal services regarding the role of the MNVP recommending the following key principles:

2.2. The Integrated Care Systems (ICB'S) will have responsibility for Commissioning and funding MNVPs leads, to cover each trust within their footprint, reflecting the diversity of the local population.

2.3. They should represent the service user voice, MNVPs listen to and reflect the views of local communities ensuring that all groups are heard, including bereaved families.

2.4. MNVPs should have a strategic influence which is embedded in decision-making.

2.5. MNVPs should have the infrastructure they need to be successful. Work plans are required to be funded.

2.6. MNVP leads, formerly MVP chairs, should be appropriately employed or remunerated and receive appropriate training, administrative and IT support.

2.7. From 2024/25, responsibility for commissioning neonatal critical care services will be delegated to ICBs. In preparation for this, it is recommended that local service users are co-production partners in maternity/neonatal quality and transformation: the voices of neonatal parents can be heard through either an MNVP or PAG (parent advisory group). The LMNS is required to ensure that there is a clear process for hearing from parents who have received neonatal care and for involving them in co-production work as appropriate.

2.8. TRFT have been nominated to be the pilot site for the implementation of the MNVP lead role in the South Yorkshire LMNS.

2.9. The work continues to engage with local communities in Rotherham, the community Midwifery Lead and Vulnerabilities Midwife have been working with Rotherham Ethnic Maternity Alliance (REMA) and Clifton Learning Partnership to explore how Midwifery services can work with local charities to build trust in the community, sign posting women and families to the services that they have to offer such as food banks and emergency baby equipment.

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

3.1. Table 4 demonstrates the nominal role for Maternity Midwifery staffing reflecting that the Early Career Midwifery (ECM) recruitment has supported the reduction of the workforce gaps. It is anticipated that these should reduce further once all new starters have commenced in post. As we are awaiting a start date for x1 ECM and x2 Band 6 midwives.

Table 4

30/11/2023												
	2023/24											
Trajectory	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Contracted Vacancies	**2.53**	**0.44**	**1.40**	**-0.15**	**2.15**	**1.72**	**-5.20**	**-7.70**	**-7.70**	**-7.70**	**-7.70**	**-7.70**
Maternity leave	1.23	2.03	3.99	4.95	5.59	6.59	6.59	6.59	6.59	7.23	5.04	5.68
Long term sickness	4.12	5.12	4.88	4.88	5.99	2.07	1.07	3.63	4.59	1.60	1.60	0.00
Upcoming Leavers	0.20	0.00	0.81	1.76	0.00	1.64	0.00	0.00	3.86	4.58	4.58	4.58
Other - see detail	1.60	1.60	1.60	1.60	1.60	1.60	1.60	1.60	1.60	1.60	1.60	1.60
Total Gaps	**9.68**	**9.19**	**12.68**	**13.04**	**15.33**	**13.62**	**4.06**	**4.12**	**8.94**	**7.31**	**5.12**	**4.16**
New Starters (reducing gaps)	-2.40	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-0.96	-1.92	-1.92	-3.84
New Starters - students/NQM's	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-0.80	-0.80	-0.80	-0.80
Trajectory - for planning	**7.28**	**9.19**	**12.68**	**13.04**	**15.33**	**13.62**	**4.06**	**4.12**	**7.18**	**4.59**	**2.40**	**-0.48**
% Workforce Gaps	**7.4%**	**9.3%**	**12.9%**	**13.3%**	**15.6%**	**13.8%**	**4.1%**	**4.2%**	**7.3%**	**4.7%**	**2.4%**	**-0.5%**

3.2. Appendix 4 highlights the Birth Rate Plus acuity data for November 2023. Demonstrating that staffing met the acuity for 86% of the time. The occasions highlighting where the acuity was up to 2 midwives short, actions were taken to support the team and ensure that safe staffing was maintained.

3.3. Table 5 below represents November 2023 workforce data; short term Sickness rates have increased slightly in November and there has been a marginal decrease in long term sickness rates. There were 10 red flags reported for delays in Induction of labour. Table 6 and 7 represent the performance for maintaining supernumerary Coordinator status and 1:1 care in labour.

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	21	Birth rate plus Acuity (Occasions)
Redeploy staff from Community	0	Birth rate plus Acuity (Occasions)
Matron Working Clinically	2	Birth rate plus Acuity
Delay in Induction of Labour	10	Birth rate plus Data and Datix
Supernumerary labour ward co-ordinator	100%	Data from Birth-rate Plus® acuity tool/Maternity Dashboard/Datix
Staff absence	2.13% 4.16%	HR reports November data 2.13% short term 4.16% long term
Obstetric compliance at mandatory consultant escalation	100%	No Datix incidents reported
Compliance with twice daily face to face ward round	100%	Datix

Table 5

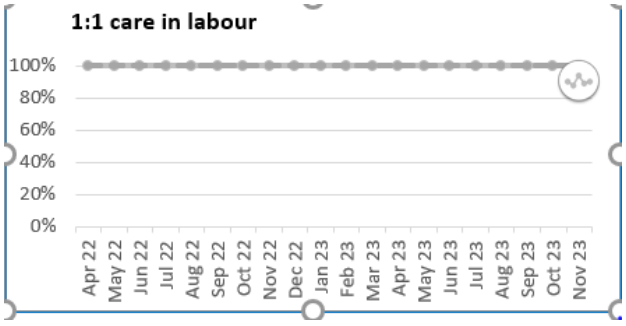


Table 6

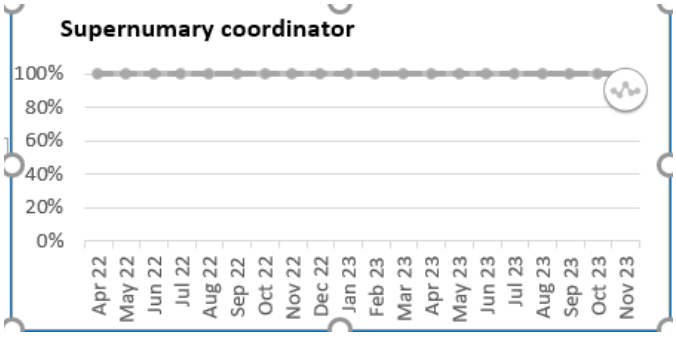


Table 7

Grade	No of Shifts	Reason	Internal / External
ST1/2	4	2 x Sickness 2 x Vacancy	4 x internal
ST3/7	7	2 x Vacancy 5 x reduced duties	5 x Internal 2 x external
CONSULTANT	68	7 x Vacancy 10 x Annual/Study Leave 27 x Additional clinics 3 x Additional theatres 11 x entrustability 10 x sickness	68 x Internal

Table 8

3 Obstetric cover gaps: Table 8 above illustrates the locum breakdown for November 2023. Entrustability is currently being supported in the Division for some of the trainees. The outstanding action from the medical staffing audit which was reported in the October 2023 paper has now been completed ensuring that Medical rotas reflect compensatory rest for consultants and Speciality and Specialist doctors.

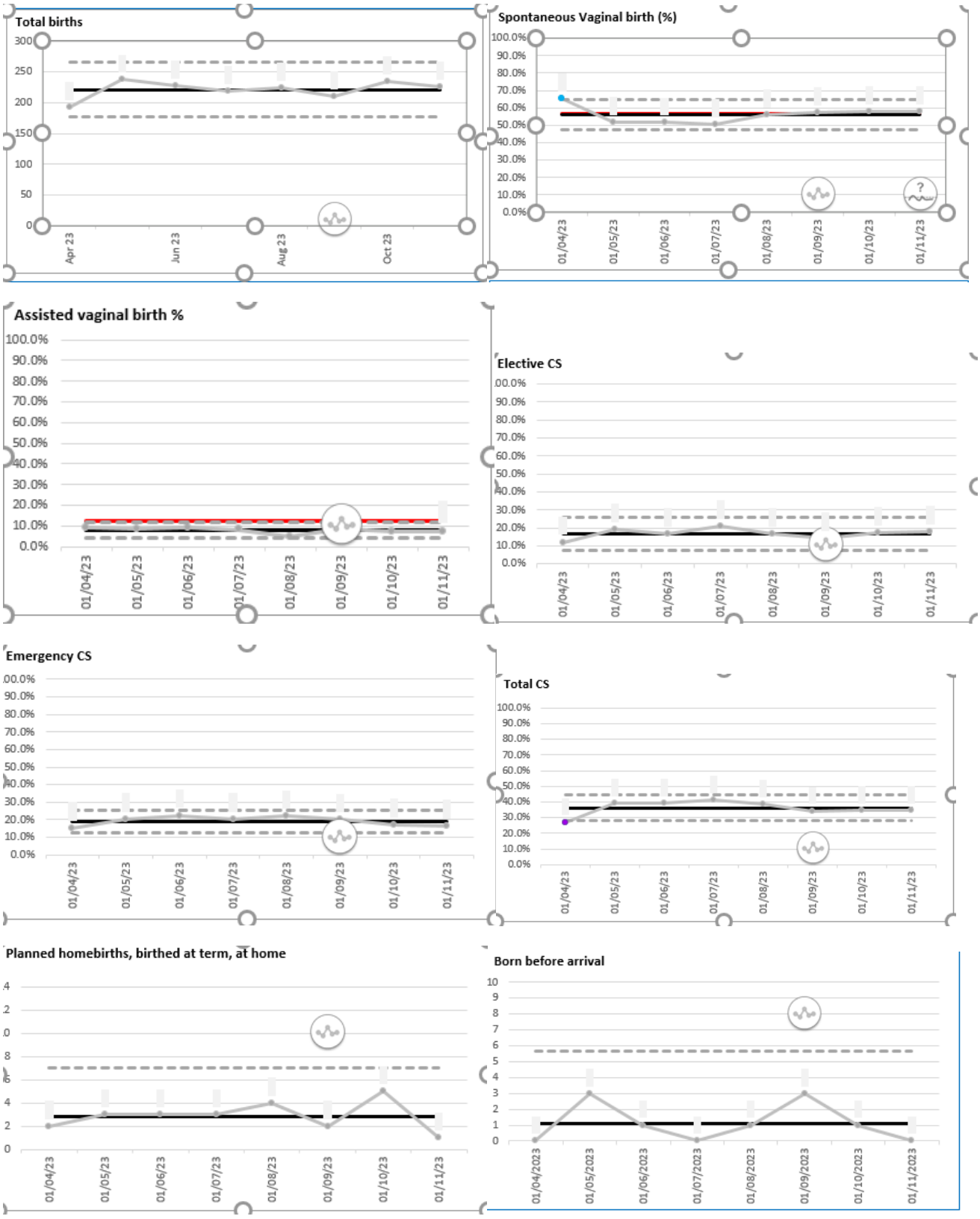
4. **Theme 3: Developing and sustaining a culture of safety, learning and support**

4.1. The Division is currently engaged and undertaking the NHS England perinatal Leadership and culture SCORE survey which commenced on the 16th October 2023. The aim of the survey is to provide insights into how it feels to work at TRFT in Maternity and Neonatal services, helping the Quadumvirate team to identify strengths and opportunities for improvement. The survey has now closed and the next steps are for the Maternity and Neonatal Quadumvirate to meet and engage with the Trusts appointed culture coach. The team will have a series of leadership development sessions with the coach to support the review and analysis of the score survey results which will be published on the 30th January 2024.

4.2. The response rate for the National Staff survey for Family Health was encouraging at 66 %. Responses for Maternity services overall showed a positive improvement from last year. Improvement with the neonatal unit staff survey responses will be key area focus for 2024. The Division plans to await the findings and this will be triangulated with the Score survey results to work on the continuous improvements in Maternity and Neonatal services to improve culture, safety, staff retention and wellbeing.

4.3. Learning from Incidents:

Table 9 represents the birth data for November 2023 in total there were 226 births.



4.4. During November 2023, there were 121 incidents reported on Datix for Obstetrics, of which 19 were graded as moderate harm at the time of the incident. All cased have had an MDT review and have later been downgraded to low or no harm as it was noted that appropriate care management was given. No Serious incidents were declared in November 2023. Table 10 provides the moderate incidents for November including the deprivation rank and

ethnicity (Table 11 and 12). The data for November represents that those from the lower deprivation had a higher incidence of moderate incidents.

4.5. The statistical process control charts (SPC) table 13 below represents the Perinatal Quality oversight matrix including the themes reported in the previous papers, third degree tears and massive obstetric haemorrhage to demonstrate that there has been no significant change in the outcome data. The HIE data represents the current Maternity and Neonatal Safety investigation case (MNSI) (formerly HSIB) case.

November 2023 moderate incidents	
Incident	Number
Massive Obstetric haemorrhage	5
Third Degree tear	4
Shoulder Dystocia	4
Low Cord Ph	5
Low Apgars	1

Table 10

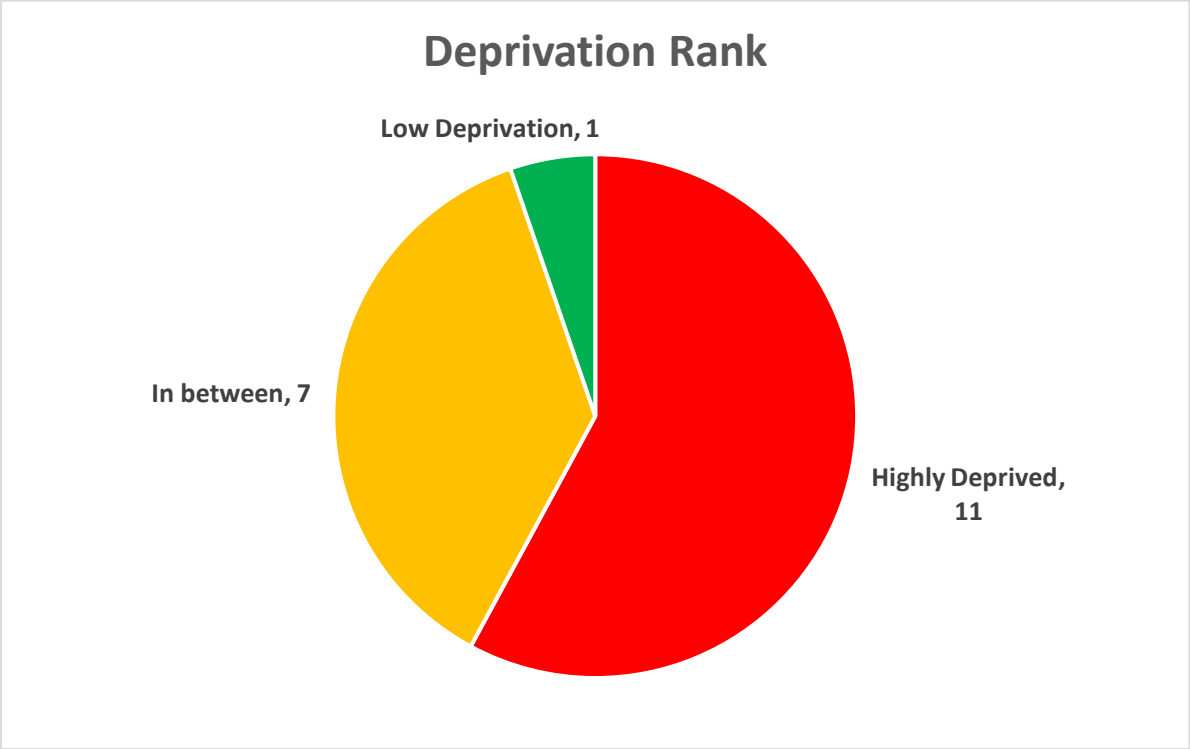


Table 11

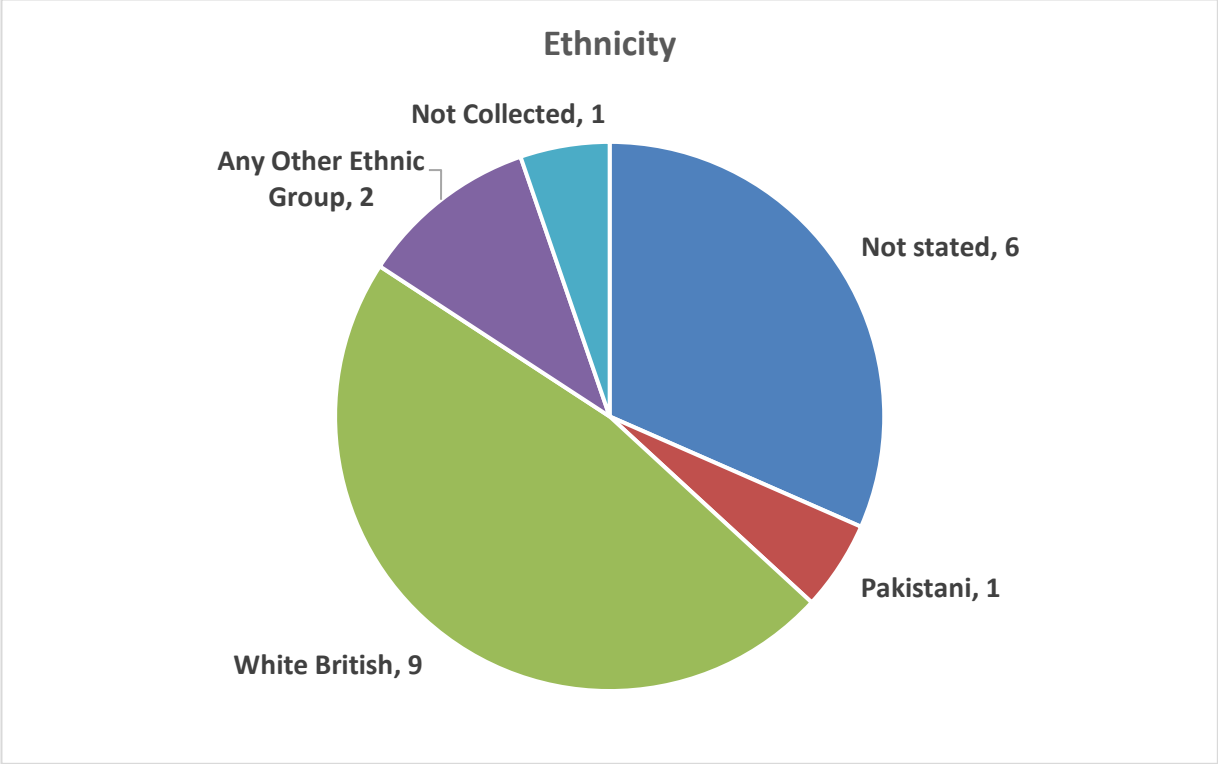
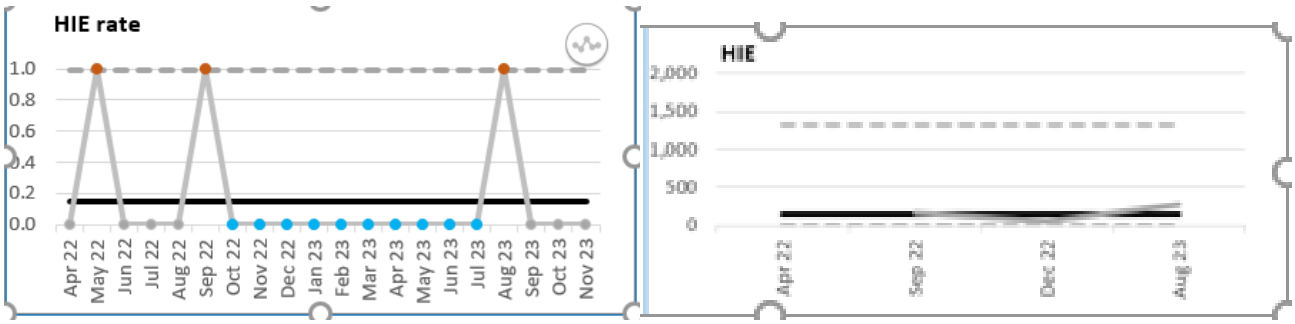


Table 12

Average days between HIE 150.2



In 2022, the HIEs reported were following premature birth and HIE 1

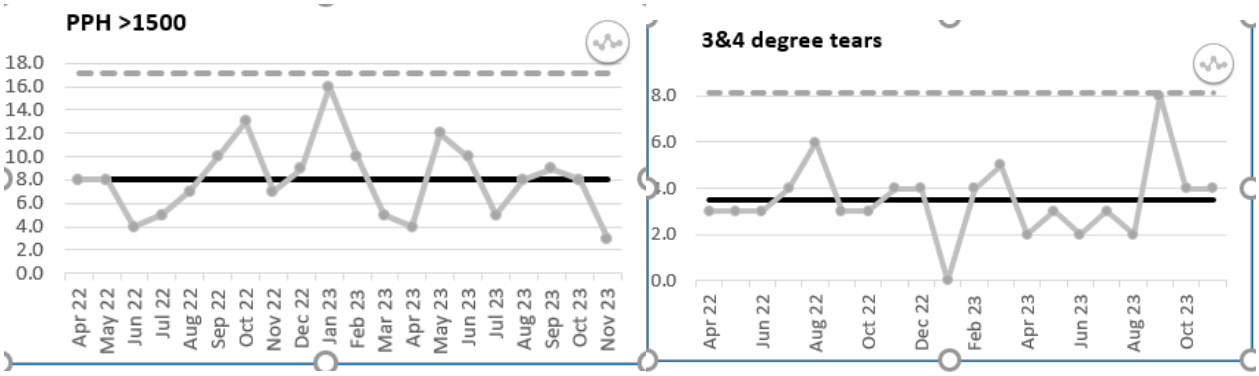


Table 13

4.6. **Listening to issues raised by staff or service users**: In November 2023 no complaints were received in maternity services, feedback is shared with teams through moments of excellence and the monthly matrons report which is shared through Maternity governance and Safety Champions. A further complaints meeting was held with the Head of Midwifery and General Manager regarding a reopened complaint received by the service in July 2023.

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

5.1. In November there was one Stillbirth at 36+1, which met criteria for the perinatal mortality review tool (PMRT). Table 14 illustrates the data on stillbirth and neonatal deaths for TRFT highlighting no significant trends and the days between stillbirth and neonatal deaths.

5.2. The Rolling 12 month data is illustrated below

Dec 2022 – Nov 2023
Number of births - 2551
Number of Stillbirths in Nov 2023 (adjusted) – 1
Number of neonatal deaths in Nov 2023 (adjusted) - 0

5.3. Perinatal mortality All deaths (including congenital anomalies)

Type of death	Number	Rate per 1000 births	
Stillbirth	7	2.74	
Neonatal death	3	1.18	

Total perinatal 3.92/1000 births

5.4. Adjusted Perinatal Mortality (excludes deaths due to congenital anomalies and Medical Termination of Pregnancy MTOP)

Type of death	Number	Rate per 1000 births	
Stillbirth	6	2.35	
Neonatal Death	0	0	

5.5. Adjusted Total Perinatal (stillbirths and neonatal deaths) 2.35/1000 births

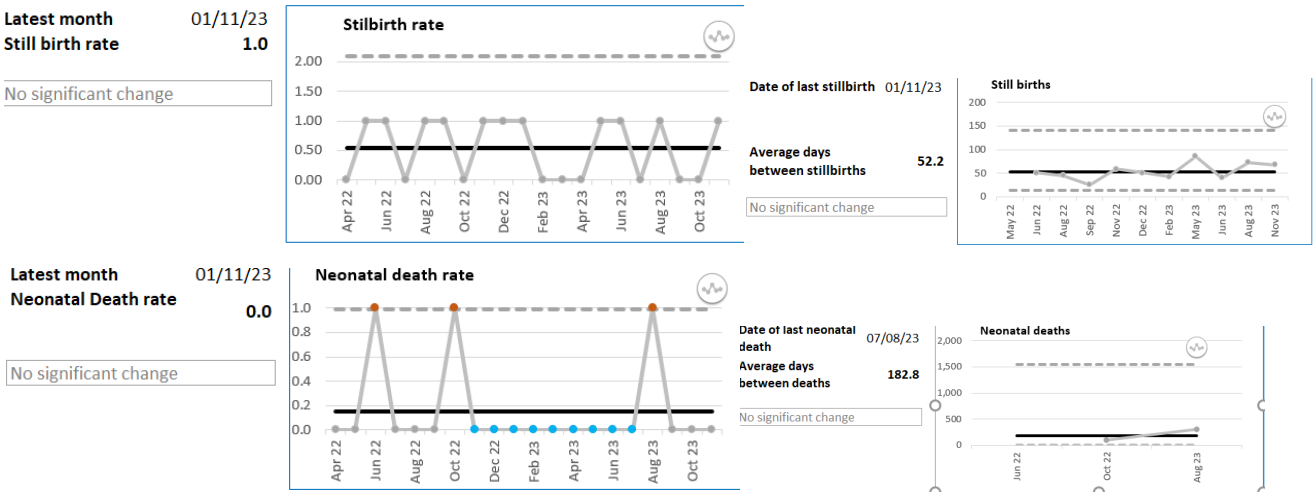


Table 14

5.6. **Avoidable Term Admissions into the Neonatal unit (ATAIN) Table** 16 shares the ATAIN data for the year to date. The data highlights that currently TRFT average no significant change for avoidable (unexpected admissions) to the neonatal unit.

5.7. There were ten term admissions in November to the Neonatal unit, 4.4 % of all live births. All cases are reviewed at the weekly MDT ATAIN meeting. One case was excluded from the review due to a congenital condition and another was concluded to be avoidable - Delivered at Jessops. Admitted to the neonatal unit vomiting via UECC. Table 15 reflects the reasons for neonatal admission in the eight cases were reviewed and assessed to be unavoidable.

Number	Reason for NNU admission
4	Respiratory distress syndrome (RDS)
2	Jaundice requiring exchange transfusion
1	Transient tachypnoea of the newborn (TTN)
1	RDS and Suspected sespsis

Table 15

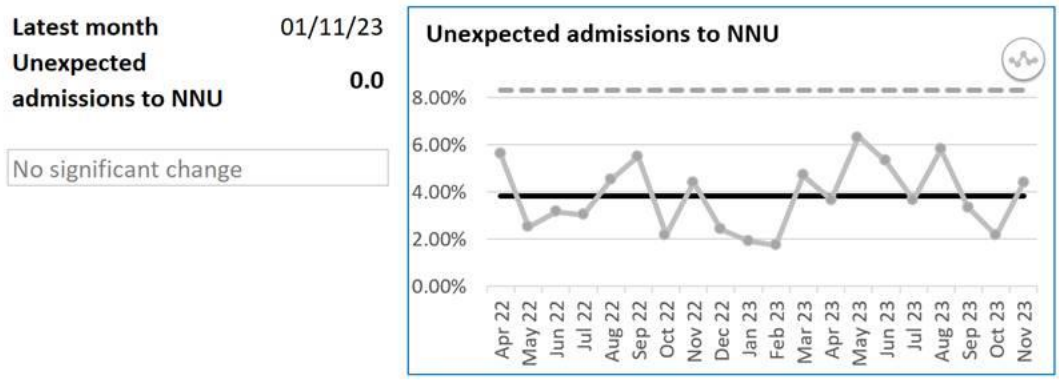


Table 16

Sarah Petty
Head of Nursing and Midwifery
Family Health Division

Board of Directors' Meeting
12 January 2024

Agenda item	P16/24
Report	**Safe Staffing and Establishment**
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 – aiming to achieve full compliance against national standards for safe staffing Caring - supporting health and wellbeing of staff to improve retention and providing a set of metrics to ensure patients are safe and have a positive experience Together – the actions and recommendations are Trust wide to support all areas employing clinical staff
Purpose	**For decision** ☒ **For assurance** ☐ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	The National Quality Board (NQB) publication: Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: Safe, Sustainable and Productive Staffing (2016) outlines expectations and the framework. In addition improvement resources have been published to support and underpin this approach in 2018 for adult inpatient wards in an acute hospital, children and young people, neonatal units and maternity services. This paper has used the SNCT tool to thoroughly review the acuity and dependency of adult inpatients, adult assessment areas, children's wards and emergency departments. There has been some historical management of establishment changes in divisions, without understanding of the risks to RN skill mix. The risks of this are reiterated at the establishment reviews. All the ward managers applied professional judgement to their establishments and confirmed when planned staffing met actual staffing the areas were safe. The only exceptions were UECC adults and paediatrics which are outlined in section 4.7. The Medicine Division, who carry the largest amount of inpatient beds had SNCT data with a variance of - 10.89 WTE. The surgical division had the biggest difference between funded establishments and SNCT average data WITH ++ 24.62 WTE but after

	adding professional judgement, there are no recommended changes. These wards are smaller areas and therefore more expensive to run. For Children's ward and Children's UECC, there is opportunity to consider dropping the funded establishment on Children's ward and increasing the funded establishment on Paediatric UECC. Work has also commenced with the implementation of the Community Nursing Safe Staffing Tool (CNSST), the results of which will be included in future papers. The Trust Board are asked to support the recommendation of the establishment review as led by the Deputy Chief Nurse (nursing workforce) and agreed with the Chief Nurse. Current establishments are assessed to be safe and daily professional judgement is used to redeploy as needed to maintain this.
Due Diligence (include the process the paper has gone through prior to presentation to the meeting)	The Chief Nurse has reviewed the proposed establishments and supports the recommendations in the paper. This paper was presented to People Committee on 15 December 2023.
Powers to make this decision	
Who, What and When (what action is required, who is the lead and when should it be completed?)	
Recommendations	The Board of Directors are assured by the process of collecting the SNCT data and using professional judgement to collate proposed establishments The Trust Board are asked to agree to maintain existing establishments whilst further data is collected, particularly in Community where sufficient data is not yet available.
Appendices	Appendix 1 – SNCT for assessment areas Appendix 2 – SNCT for Surgical Wards (excluding ASU) Appendix 3 – SNCT for Medical Wards (excluding AMU) Appendix 4 – SNCT for Paediatrics Appendix 5 - UECC Appendix 6 – SNCT Forward Plan

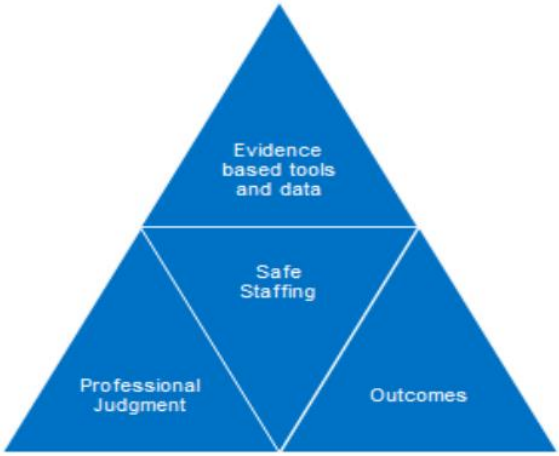
1. Introduction

1.1 The National Quality Board (NQB) publication: Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: Safe, Sustainable and Productive Staffing (2016) outlines expectations and the framework. In addition improvement resources have been published to support and underpin this approach in 2018 for adult inpatient wards in an acute hospital, children and young people, neonatal units and maternity services.

1.2 These resources have been used to support establishment setting, approval and deployment from the ward sisters and charge nurses through to the Chief Nurse.

1.3 There has been a refreshed approach to setting the Nursing establishments in the Trust since November 2022, to ensure compliance with the National Quality Board Standards and Developing Workforce Safeguards. This included the implementation of the Safer Nursing Care Tool (SNCT), an evidence based tool which will support and inform the establishment setting process. SNCT is an objective tool which utilises acuity and dependency scoring to support workforce planning. The tool had been recognised for supporting safe staffing on in-patient wards, and received NICE endorsement in 2014.

Figure 1: Principles of safe staffing



1.4 Four cycles of acuity and dependency data collection using SNCT were outlined for 2023 and all of these have been completed for this report.

1.5 Intensive care and high dependency were excluded as staffing is in line with the Guidelines for the Provision of Intensive Care Services (GPICS, 2019).

1.6 Hard Truths commitments regarding the publishing of staffing data (Care Quality Commission, March 2014) states ‘data alone cannot assure anyone that safe care is being delivered’. However research demonstrates that staffing levels are linked to the safety of care and that fewer staff increase the risk of patient safety incidents occurring’.

1.7 In order to assure the People Committee of safe staffing on our wards, this paper sets out the outcome of the strategic staffing review which has been undertaken in line with national guidance. The review has been a comprehensive assessment of each ward, with the ward manager, matron, head of nursing and management accountant, to take into account the following;

- Ensuring professional judgement is applied to staffing and is representative of activity requirements whilst ensuring the appropriate skill mix of staff.

- Benchmarking ward level CHPPD data from peer organisations is incorporated into each review.
- Nurse/midwifery sensitive indicators are aligned to each review such as pressure ulcers, falls, medication incidents and complaints relating to nursing care.
- The financial impact to setting of budgets is considered.

1.8 With each staffing review our compliance against the SNCT guidelines is reviewed to ensure validity of the data. The assessment can be found in appendix 1 (adult assessment areas, appendix 2 and 3 (surgical and medical adult wards), appendix 3 (Children's ward), appendix 4 (UECC).

2. Compliance against national standards

2.1 A gap analysis on the Trust compliance with the workforce safeguards was presented to the Board of Directors in January 2023. There were recommendations within the paper to further improve full compliance with NQB guidance and workforce safeguards.

2.2 To support full compliance with the workforce safeguards, work has been completed in the following areas;

- Updating of the safe staffing policy, ratified in December 2022.
- Training 70 staff on the use of the SNCT to ensure inter-rater reliability.
- The start of the roll out of the community nursing safe staffing tool (CNSST)
- Formal reporting of safe staffing and quality to the Quality Committee from April 2023.
- Progression of a Trust wide safety and quality dashboard.
- Implementation of a clear Retention of Nurses plan across TRFT

2.3 The new Safe Staffing and Quality Paper, reported every other month to the Quality Committee, includes a detailed analysis of the Care Hours Per Patient Day (CHPPD), triangulated with patient outcomes, reported incidents and the progress on the plan to retain the whole nursing workforce.

2.4 The report is grounded in the need to ensure safe nurse and midwifery staffing levels and has been underpinned by the following publications/resources:

- NHS improvement – developing workforce safeguards, supporting providers to deliver high quality care through safe and effective staffing, October 2018.
- National Quality Board – Safe, sustainable and productive staffing - An improvement resource for adult inpatient wards in acute hospitals Edition 1, January 2018.
- National Quality Board – Safe, sustainable and productive staffing - An improvement resource for neonatal care, Edition 1, June 2018.
- National Quality Board – Safe, sustainable and productive staffing - An improvement resource for children and young people's inpatient wards in acute hospitals, Edition 1, January 2018.
- National Quality Board – Safe, sustainable and productive staffing - An improvement resource for Maternity, Edition 1, January 2018.
- National Quality Board – Safe, sustainable and productive staffing (SSPS). An improvement resource for adult inpatient wards in acute hospitals 2016 (2017 approved).
- Hard Truths – The Journey to Putting Patients First 'Hear the patient, speak the truth and act with compassion'. Published by the Department of Health 2014.
- National Quality Board report – How to ensure the right people, with the right skills, are in the right place at the right time. Published by NHS England 2013.

- The Model Hospital Portal - a new digital information service provided by NHS Improvement to support the NHS to identify and realise productivity opportunities; key nursing information is contained within the portal. https://improvement.nhs.uk/news-alerts/updates-model-hospital/

3. Feedback to Divisions

3.1 The Division Heads of Nursing and Midwifery received their SNCT data, once collected and verified. A detailed feedback session was then arranged with every ward manager, matron, head of nursing/ midwifery and management accountant in November 2023.

3.2 The Deputy Chief Nurse (Nursing Workforce), Matron for Safe Staffing and lead for Healthroster led the feedback. During the session, the funded establishment was confirmed, the current funded skill mix, the average of four SNCT data collections and ward manager supervisory time of 1.0 wte per inpatient ward also confirmed.

3.3 Adding in the professional judgement of each ward manager, matron and head of nursing a proposed establishment was then agreed.

4. Analysis

4.1 Following the addition of professional judgement to the SNCT average data results, the explanation was given to divisions that establishments shouldn't stay static and should be amended and updated, subject to the rigour of the SNCT process.

4.2 The purpose of the feedback sessions in some instances, this meant an increase in the funded establishment and in some instances this meant a decrease in funded establishments.

4.3 The full data collections are in the appendices 1 – 4 and the UECC data in appendix 5 and the headlines by division are below:

4.4 Medicine

Ward	Bed Numb	Funded Establishment plus WM	SNCT Average Nov 23 data incl WM 0.4 incl 22% headroom	SNCT average plus 0.6 WM time	Funded S
Medicine					
AMU	38	45.41	52.45	53.05	62.00%
A1	33	38.68	39.2	39.8	54.00%
A2	24	35.07	36.1	36.7	57.00%
A3	33	39.52	43.4	44	54.00%
A4	33	40.36	43	43.6	54.00%
A5	33	38.48	40.1	40.7	54.00%
A7	12	20.87	14.6	15.2	63.00%
B5 (1 audit)	24	32.22	33.2	33.8	52.00%
CCU	8	20.91	14.6	15.2	83.00%
Stroke Unit	24	35.34	37.9	38.5	57.00%
SSU	27	38.4	35	35.6	54.00%
Total	**289**	**385.26**	**389.55**	**396.15**	**58.54%**

4.4.1 The current funded establishment for medicine including the ward managers is 385.26 WTE for the inpatient wards and assessment area. The recommended establishments after four SNCT data collections is 396.15 WTE. This includes a 22% headroom on average across all the areas as the SNCT tool will not allow a recommended establishment below this head room. This is a variable of -9.89WTE nursing staff.

4.4.2 The current funded Registered Nurse (RN) and Registered Nursing Associate (RNA) skill mix (column 6 above) is variable with an average of 58.54% across all areas. The evidence base for Inpatient wards should be a 65% RN skill mix and for assessment areas 70% RN skill mix.

4.4.3 At the establishment reviews with ward managers, matrons and heads of nursing, medicine confirmed their funded establishments (where the planned staffing matches the actual) is safe.

4.4.4 AMU and Short Stay separated out the budgets in November 2023 which has helped to report a more accurate CHPPD. SDEC staffing remains separate although is currently a joint roster with AMU.

4.5 Surgery

Ward	Bed Numb	Funded establishment plus WM	SNCT Average Nov 23 data incl WM 0.4 incl 22% headroom	SNCT average plus 0.6 WM time	Funded
Surgery					
Sitwell (1 audit)	14	20.94	16.6	17.2	62.00%
B10	22	29.81	24.1	24.7	56.00%
Rockingham 6 extra beds in winter	22	31.6	22.1	22.7	57.00%
Fitzwilliam	28	38.94	38.5	39.1	52.00%
ASU	33	48.93	41.3	41.9	57.00%
	119	**170.22**	**142.6**	**145.6**	**56.80%**

4.5.1 The current funded establishment for Surgery is 170.22 for the inpatient wards and the recommended establishments after four SNCT data collections 148.6 WTE. This would give a 22% headroom on average across all the areas but is only an average. This is a variance of + 24.62 WTE nursing staff. Professional judgement was applied in addition to the data. The surgical wards are all smaller than the medical wards, so still need adequate hands per shift, despite their being less patients. No changes to the establishments were proposed hen professional judgement applied.

4.5.2 The current funded Registered Nurse (RN) skill mix is variable with an average of 56.80% across all areas. The evidence base for Inpatient wards should be a 65% RN skill mix and for assessment areas 70% RN skill mix.

4.5.3 At the establishment reviews with ward managers, matrons and heads of nursing, surgery confirmed their funded establishments (where the planned staffing matches the actual) is safe.

4.5.4 ASU does not have a separate budget for the assessment area, so this is staffed and included in this funded establishment.

4.6 Family Health

Ward	Bed Numb	Funded Establishment plus WM	SNCT Average Nov 23 data incl WM 0.4 incl 22% headroom	SNCT average plus 0.6 WM time	Funded S	Establishment va
Family Health						
B11	14	18.25	11.95	12.55	60.00%	5.7
Children's Ward	22	39.6	32.55	33.15	72.00%	6.45
Total	**36**	**57.85**	**44.5**	**45.7**		**12.15**

4.6.1 The current funded establishment for Family Health is 18.25 WTE for ward B11 with the SNCT data showing 12.55 WTE. This would give a 22% headroom. When professional judgement applied – the small number of beds on the ward meant that the RN hands per shift could not fall below the minimum requirement so no changes to establishment proposed.

4.6.2 For Children's ward, the recommended establishments after four SNCT data collections was 32.55 WTE. This would give a 22% headroom. Professional judgement was applied in addition to the data with concern around the amount of RN time being used for safeguarding and mental health issues.

4.6.3 The current funded Registered Nurse (RN) skill mix is 72% for Children's ward and 60% for B11. The evidence base for Children's wards should be a 67% RN skill mix but this area is also an assessment area so the 72% funded skill mix is appropriate.

4.6.4 At the establishment reviews with ward managers, matrons and heads of nursing, medicine confirmed their funded establishments (where the planned staffing matches the actual) is safe.

4.6.5 When using professional judgement with the wards in Family Health, there are no proposed changes to the funded establishments for B11.

4.7 UECC

Ward	average at	Funded Establishment	SNCT Average 22% headroom	Funded S	Establishment va
UECC					
Paeds UECC	21169.5	18.49	24.4	73.00%	-4.91
Adults UECC	72217.5	83.05	83.1	70.00%	0.05

4.7.1 There are different options to assessing UECC attendance and both are included in the appendices. After meeting with the relevant teams, the average attendance used is the average nationally and the data from 3 years ago excluded as this was during the pandemic.

4.7.2 A headroom of 25% was applied for UECC due to the amount of regulatory training needed for the Registered Nurses.

4.7.3 For adult UECC, adding professional judgement – there was a proposal to share the current hands per shift which is currently higher in the day and lower at night to even out to be the same 24/7 (11 RN and 5 CSW). Although the same number of people will be needed, there will be a cost implication of having more staff on the unsocial hours of night duty. There are also 2.75WTE B7 RNs who work non-clinically to support clinical education, clinical governance and safe staffing. All of these changes are being costed up by the division's management accountant.

4.7.4 Paediatric UECC has demonstrated a gap in funded establishment and SNCT data of 4.91 WTE. When adding professional judgement, the division felt an additional 1.35 WTE would help increase the current hands per shift to make the department safe.

5. Community Nursing

Community Nursing	Funded Establishment 2023	CNSST July 2023	CNSST Oct 23	FTE Average	Variance
Unplanned					
Urgent Response and Virtual Ward	36.3	Not completed	41.25	41.25	-4.95
Out of Hours	26.88	Not completed	11.56	11.56	15.32
Totals	63.18			52.81	10.37
Planned					
South	31.3	No data available	28.52	28.52	2.78
Central North	31.28	27.88	26.14	27.01	4.27
Central South	27.76	32.31	29.48	30.89	-3.13
North	30.30	29.72	26.22	27.97	2.33
Totals	120.64			114.39	6.25

5.1 The community nursing safe staffing tool (CNSST) was used for the first time this year. Not all localities completed the first data collection in July, therefore there is only one full data collection for October included.

5.2 No recommendations for changing establishments have been made for community nursing as further data collections across all areas are needed.

6. Recommendations

6.1 The People Committee are assured of the process undertaken in the establishment review, in conjunction with the ward in line with the national recommendations.

6.2 There has been some historical management of establishment changes in divisions, without understanding of the risks to RN skill mix. The risks of this are reiterated at the establishment reviews. All the ward managers applied professional judgement to their establishments and confirmed when planned staffing met actual staffing the areas were safe. The only exceptions were UECC adults and paediatrics which are outlined in section 4.7.

6.3 The Medicine Division, who carry the largest amount of inpatient beds had SNCT data with a variance of - 10.89 WTE. It has helped to separate out the AMU and Short Stay Unit rotas and the bed reconfiguration after ward B5 moved to medicine has helped realign budgets to allow for where the medical patients are.

6.4 The Surgical Division had the biggest difference between funded establishments and SNCT average data WITH ++ 24.62 WTE but after adding professional judgement, there are no recommended changes. These wards are smaller areas and therefore more expensive to run.

6.5 For Children's ward and Children's UECC, there is opportunity to consider dropping the funded establishment on Children's ward and increasing the funded establishment on Paediatric UECC. When applying professional judgement, there was a concern that reducing Children's ward establishment would not be safe but an acknowledgement that Paediatric UECC needed a bigger establishment.

6.6 Work has also commenced with the implementation of the Community Nursing Safe Staffing Tool (CNSST), the results of which will be included in future papers. Preliminary feedback on one data collection shows the need for more data for this to include any recommendations.

6.7 The Board of Directors are asked to support the recommendation of the establishment review as led by the Deputy Chief Nurse (nursing workforce) and agreed with the Chief Nurse.

6.8 The Board of Directors are asked to note that work started in August 2023 on new, standardised job descriptions for the B2 healthcare support worker (HCSW) and the B3 clinical support worker (CSW). This is to align the roles and responsibilities to the revised national profile (updated 2019). A task and finish group has started, involving trade union representatives and a plan being built up for potentially 40% of HCSW needing to move to the B3 CSW role.

6.9 Licences for the SNCT have been updated to include where patients are receiving 1:1 supervision and 2:1 supervision. The new licences are currently being sought for use at TRFT and revised training for ward managers being planned prior to the January data collection.

APPENDIX 1

Assessment Units	Funded Bed Number	Funded Establishment 2022 incl WM	SNCT – Jan 23	SNCT – April 23	SNCT – July 2023	SNCT – Oct 23	SNCT Average	SNCT average plus 0.6 WM	Variance	Average Bed occupancy	Bed Occupancy Variance
AMU	29	46.41	62.1	51.1	49.7	46.9	52.45	53.05	-6.64	33.2	87%
ASU	33	48.19	49.4	38	38.5	39.2	41.3	41.9	6.29	32	97%
SDEC		Included in ASU									
Bed Number							62				
Bed Occupancy							65.2				
SNCT WTE inc WM							94.95				
Establishment WTE inc WM							94.6				
Variance							-0.35				

SNCT and establishments are reflective of the total staff time spent on direct patient care. This excludes student (nurses and midwives), specialist nurses, housekeepers, discharge liaison, ward clerks and play leaders.

The suggested SNCT establishment includes the Ward Manager. Minimum supervisory time for ward manager is 0.4 wte but this will be confirmed at the check and adjust meeting after the data collection.

SNCT Multiplier's	**Assessment units**
0	1.27
1a	1.66
1b	2.08
2	2.26
3	5.96

APPENDIX 2

Surgery (Excluding ASU)	Funded Bed Number	Funded Establishment 2022 incl WM	SNCT – Jan 23	SNCT – April 23	SNCT – July 2023	SNCT – Oct 23	SNCT Average Plus WM 0.6	Variance	Average Bed occupancy	Bed Occupancy Variance
Sitwell	14	20.94				16.6	16.6	4.3	14	100%
B10	22	29.81	23.2	23	25	25.1	24.1	5.71	20.75	94.3%
Rockingham	22+6flex	31.6	22.3	24	19.7	22.5	22.7	8.9	16.2	73.6%
Fitzwilliam	28	38.94	38.9	41.2	37.4	36.6	39.1	-0.16	26.2	93.6%
ASU	33	48.93	49.4	38	38.5	39.2	41.9	6.29	32.65	98.9%
Bed Number	119	170.22					145.6	23.88	109.8	92.3%

SNCT and establishments are reflective of the total staff time spent on direct patient care. This excludes student (nurses and midwives), specialist nurses, housekeepers, discharge liaison, ward clerks and play leaders.

The suggested SNCT establishment includes the Ward Manager. Minimum supervisory time for ward manager is 0.4 wte but this will be confirmed at the check and adjust meeting after the data collection.

SNCT Multiplier's	**Adult Inpatient**
0	0.99
1a	1.38
1b	1.72
2	1.97
3	5.96
SNCT Multiplier's	**Assessment units**
0	1.27
1a	1.66
1b	2.08
2	2.26
3	5.96

Surgery (Excluding ASU)	Funded Bed Number	Funded Establishment 2022 inc WM	SNCT – Jan 23	SNCT – April 23	SNCT – July 2023	SNCT – Oct 23	SNCT Average plus 0.6 WM	Variance	Average Bed occupancy	Bed Occupancy Variance
B11	14	18.65 plus 0.92 incl B4 Preg Assessment	11.4	11.2	12.3	12.9	12.55	5.7	12	85.7%
Bed Number							14			
Bed Occupancy							12			
SNCT WTE							12.55			
Establishment WTE							18.65			
Variance							5.7			

SNCT and establishments are reflective of the total staff time spent on direct patient care. This excludes student (nurses and midwives), specialist nurses, housekeepers, discharge liaison, ward clerks and play leaders.

The suggested SNCT establishment includes the Ward Manager. Minimum supervisory time for ward manager is 0.4 wte but this will be confirmed at the check and adjust meeting after the data collection.

SNCT Multiplier's	**Adult Inpatient**
0	0.99
1a	1.38
1b	1.72
2	1.97
3	5.96

APPENDIX 3

Medicine	Funded Bed Number	Funded Establishment 2022 Inc WM	SNCT – Jan 23	SNCT – Apr 23	SNCT – July 23	SNCT Oct 2023	SNCT Average plus 0.6 WM	Variance WTE	Average Bed Occupancy	Bed Occupancy Variance
A1	33	39.68	43.7	38.5	37.8	36.9	39.8	-0.12	32.25	97.72%
A2	24	36.07	34.6	33.6	44.1	32	36.7	-0.63	23.8	99%
A3	33	40.52	43.5	41.3	45.4	43.5	44	-3.48	31.5	95.4%
A4	33	41.36	43	42	44.1	43.1	43.6	-2.24	31.8	96.36%
A5	33	39.48	41.2	38.8	41.7	38.6	40.7	-1.22	32.2	97.57%
A7	12	21.87	15.3	15	14.2	14.1	15.2	6.71	10.45	87%
CCU	8	21.91	13.8	14.7	14.7	15.1	15.2	5.71	6.71	97.5%
Stroke Unit	24	36.34	38.2	37.1	38.6	37.6	38.5	-2.16	26.3	109.6%
Short Stay (not assessment tool)	27	39.4	33.3	33.3	36.1	37.3	35.6	3.8	25.8	103%
B5 (1 partial audit)	24	33.22				33.2	33.8	-0.58	30	125%
Totals inc B5	287	349.85					343.1	5.79	284.1	98.98%
Totals minus B5	243	316.63					309.3	6.37	254.1	104.56%

SNCT and establishments are reflective of the total staff time spent on direct patient care. This excludes student (nurses and midwives), specialist nurses, housekeepers, discharge liaison, ward clerks and play leaders.

The suggested SNCT establishment includes the Ward Manager. Minimum supervisory time for ward manager is 0.4 wte but this will be confirmed at the check and adjust meeting after the data collection.

SNCT Multiplier's	**Adult Inpatient**
0	0.99
1a	1.38
1b	1.72
2	1.97
3	5.96

APPENDIX 4

Paediatrics	Funded Bed Number	Funded Establishment Jan 2023	SNCT – Jan 23	SNCT – April 23	SNCT – July 2023	SNCT – Oct 23	SNCT Average plus 0.6 WM	Variance	Average Bed occupancy	Bed Occupancy Variance
Childrens ward	22	39.6 inc B7	35.2	31.3	25.7	38	33.15	6.45	16.7	75.9%
Bed Number							22			
Bed Occupancy							16.7			
SNCT WTE							33.15			
Establishment WTE							39.6			
Variance							6.45			

SNCT and establishments are reflective of the total staff time spent on direct patient care. This excludes student (nurses and midwives), specialist nurses, housekeepers, discharge liaison, ward clerks and play leaders.

The suggested SNCT establishment includes the Ward Manager. Minimum supervisory time for ward manager is 0.4 wte but this will be confirmed at the check and adjust meeting after the data collection.

SNCT Multiplier's	**Childrens Inpatient**
0	1.90
1a	2.32
1b	2.38
2	2.59
3	5.89

APPENDIX 5

UECC Acuity and Dependence data	Average attendees	Funded Establishment 2023 Excluding 2.75 quality roles	SNCT – Jan 23	SNCT – April 23	SNCT – July 2023	SNCT – Oct 23	SNCT Average	Variance
UECC Adults (3 yrs average 22%	67660	83.05	69.8	70.2	75.9	73	72.2	10.85
UECC Adults (2 yrs average) 22%	72217.50	83.05	74.5	74.9	79.6	77.9	76.7	6.35
UECC Adults (2 years 25%)	72217.5	83.05	76.5	76.9	77.5	80	77.7	5.35

UECC Attendance data	Average attendees	Funded Establishment 2023 Excluding 2.75 quality roles	SNCT – Jan 23	SNCT – April 23	SNCT – July 2023	SNCT – Oct 23	SNCT Average	Variance
UECC Adults (3 yrs average 22%	67660	83.05	75.8	75.8	75.8	75.8	75.8	7.25
UECC Adults (2 yrs average) 22%	72217.50	83.05	80.9	80.9	80.9	80.9	80.9	2.15
UECC Adults (2 years 25%)	72217.5	83.05	83.1	83.1	83.1	83.1	83.1	-0.05

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UECC Acuity and Dependency Data	Average attendees	Funded Establishment 2022	SNCT – Jan 23	SNCT – April 23	SNCT – July 2023	SNCT – Oct 23	SNCT Average	Variance
UECC Paediatrics (3 yrs average	17426	19.49	17.6	17	16.6	17.3	17.1	2.39
UECC Paediatrics (2 yrs average 22%)	21169.5	19.49	20.7	20.6	20.2	21.1	20.6	-1.11
UECC Paediatrics (2 yrs average 25%)	21169.5	19.49	21.3	21.2	20.8	21.6	21.2	-1.71

UECC Attendance data	Average attendees	Funded Establishment 2022	SNCT – Jan 23	SNCT – April 23	SNCT – July 2023	SNCT – Oct 23	SNCT Average	Variance
UECC Adults (3 yrs average 22%	17426	19.49	19.5	19.5	19.5	19.5	19.5	-0.01
UECC Adults (2 yrs average) 22%	21169.5	19.49	23.7	23.7	23.7	23.7	23.7	-4.21
UECC Adults (2 years 25%)	21169.5	19.49 incl WM	24.4	24.4	24.4	24.4	24.4	-4.91

SNCT and establishments are reflective of the total staff time spent on direct patient care. This excludes student (nurses and midwives), specialist nurses, housekeepers, discharge liaison, ward clerks and play leaders.

SNCT Multiplier's	**Emergency Departments**
0	0.294
1a	0.461
1b	0.439
1c	0.454
2	0.698
3	1.033

Appendix 6 – Safer Nursing Care Tool Forward Plan

- Data analysis, feedback and Inpatient Establishment Setting November 2023

  Start 11th December all Community Nursing Teams
- Board Report with results and establishment proposal January 2023
- **SNCT January 2024 (all areas)**
- Data sharing March 2024
- **SNCT June 2024 (all areas)**
- Board paper July 2024
- Data analysis, feedback and Inpatient Establishment Setting September 2024
- Board Paper January 2025

Public Board of Directors' Meeting

The Rotherham NHS Foundation Trust

12th January 2024

Agenda item	P17/24
Report	**Annual Health and Safety Report**
Executive Lead	Steve Hackett
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	Supports the Trust values in being ambitious in management of accommodation, creating a safe, compliant environment for our staff patients and visitors, Caring about the environment we provide and working together with the clinical teams recognise opportunities when they arise.
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	The report informs the Board of its H&S performance in order that it can be assured that it continues to comply with corporate policy/standards, legal and best practice requirements. The report identifies both proactive and reactive measures, that are monitored and reviewed to ensure that effective health and safety management is maintained across the Trust.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	Trust Health and Safety Committee Trust Quality 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 Board is asked to note the content
Recommendations	The Board of Directors is requested to receive and consider the report for assurance purposes.
Appendices	Health & Safety Annual Report

The Rotherham NHS Foundation Trust

Annual Health and Safety Management Report 2022/23

Joint report covering fire risk management, sharps safety, moving and handling, estates and facilities, ionising radiation and security.

Report compiled by:

Theresa Tomlinson — Head of Health and Safety

Supporting information provided by:

Rachel Bell	Professional Lead/Senior PRS Medical Imaging
Duncan White	Consultant Physicist
Rachel Bell	Clinical Radiology, Medical Physics and Medical
Jenny Hilton	Lead Nurse for Infection Prevention and Control
Glyn Brown	Fire Safety Advisor
Anthony Bennett	Trust Security Manager
Kris Goodwin	Security Trainer
June Cadman	Waste Management & Environmental Services Officer
Lesley Westwood	Moving and Handling Lead

Contents

Figures

1. INTRODUCTION

This annual report updates the Board of Directors of The Rotherham NHS Foundation Trust (TRFT) on Health and Safety (H&S) performance across the Trust sites. The report informs the Board of its H&S performance in order that it can be assured that it continues to comply with corporate policy/standards, legal and best practice requirements.

The report identifies both proactive and reactive measures, that are monitored and reviewed to ensure that effective health and safety management is maintained across the Trust.

This report has been prepared using data from the Datix reporting system covering all areas of health and safety reporting. The annual health and safety report forms part of the corporate assurance process for the Board of Directors.

In addition, the report also fulfils the following requirements:

- To comply with the Health and Safety Executive (HSE) requirements for Boards to receive an annual health and safety report.
- To provide evidence for the CQC assessment process.

Health and safety, fire safety, security, sharps, ionising radiation, ergonomics and carriage of dangerous goods are all non-clinical topics covered in this report, which fall within the remit of the Health and Safety Committee. This report details non-clinical risks and incidents over the period April 2022 to March 2023.

1.1 Royal Society for the Prevention of Accidents (RoSPA) Occupational Health & Safety Awards 2023

RoSPA external Awards Adjudication Panel has awarded the Trust with its tenth consecutive Gold Award for Occupational Health and Safety. This is a tremendous achievement for the Trust, which demonstrates our continued commitment to managing health and safety.

In recognition of our continued commitment to health and safety, RoSPA has also awarded the President's Award for 2023; the highest tier award available.

1.2 Executive summary

In the last reporting year, there have been no HSE enforcement actions for health and safety related fatalities or safety related non-compliance.

Incidents requiring reporting under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) have remained low with 18 reported in 2022 and one in 2023. However, this is an increase of seven reports over the 2021 to 2022 reporting period.

There have been no Fire and Rescue Authority enforcement actions or fires reported within the main hospital site. There have been 29 unwarranted fire alarm activations, demonstrating a decrease of 27 activations over the previous 12 months. Revised fire safety and awareness training implemented by the Trust's Fire Safety Advisor and the replacement of aged fire and smoke detectors are attributed to the improvements.

Ionising radiation safety continues to perform with no material risks reported.

Conflict resolution training has improved to 91% of all staff and benchmarks with the national average for conflict resolution training, which is also at 91%. This improvement is attributed to the temporary suspension of face-to-face training during the Covid-19 pandemic.

The 2021–24 Health and Safety Strategy implementation continues and responses from departmental health and safety self-assessments show no significant identified trends and indicate good overall management processes for health and safety risks.

2. HEALTH AND SAFETY MANAGEMENT FRAMEWORK

The Trust's health and safety management framework reflects the HSE guidance 'Managing for Health and Safety (HSG65)'. The principles of this guidance and the framework for this report are depicted in Figure 1.

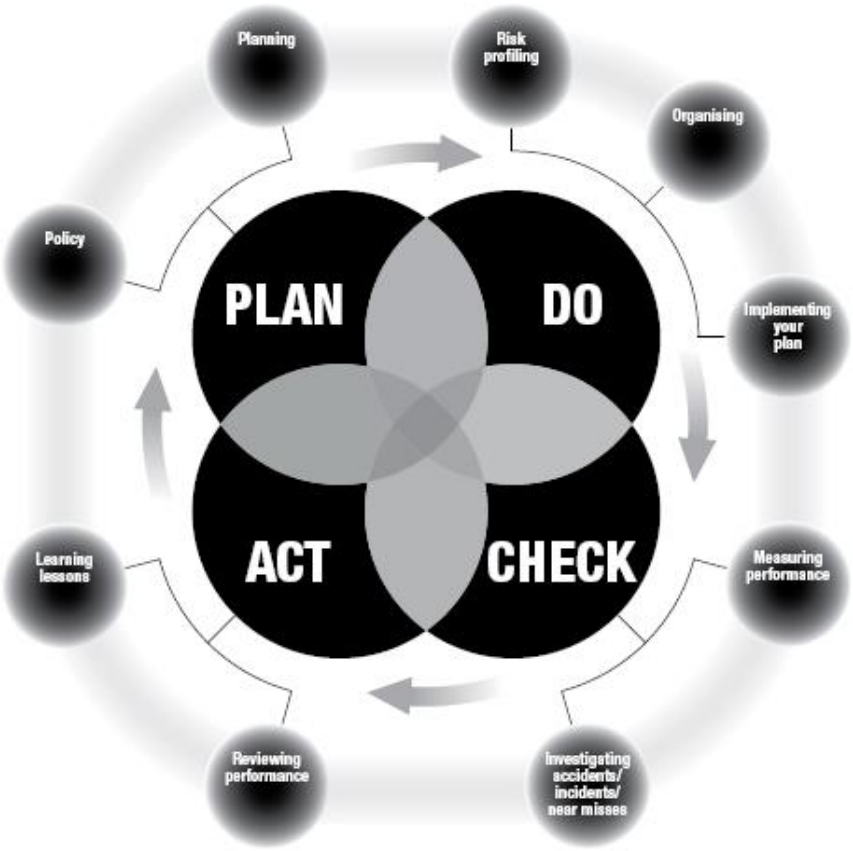


Fig 1. Health and Safety Management Framework

2.1 Trust's Health and Safety Committee

The Trust's Health & Safety Committee has met on four occasions within the reporting year. Attendance has been quorate in accordance with the committee's Terms of Reference, with significant support from staffside representatives.

The committee considers health and safety related reports and matters arising from general business activity and from staff safety representatives and other stakeholders where co-operation and co-ordination between the Trust and stakeholders is required.

Standing agenda items include incident trends, risk assessments and issues of concern such as musculoskeletal disorders, needle stick injury rates, slips, trip and falls and violence against staff.

3. INTERNAL HEALTH AND SAFETY AUDIT REPORT

3.1 Self-assessment questionnaires

The Health and Safety Strategy 2021 - 2024 requires 24 departmental health and safety self-assessments be undertaken. In the current reporting period, 96% of departments and wards have returned their completed questionnaire. Analysis of the returned questionnaires shows there are two minor trends identified, these being missing Health & Safety Law posters and staff completion of Display Screen Equipment (DSE) assessments; both of which have been addressed.

3.2 Inspections/Audits

In the reporting period seven audits of community facilities, including Health and Safety, Fire Safety and Waste, have been undertaken at Brookfields, Kimberworth Medical Centre, Kiveton Park, Maltby Medical, Rawmarsh Joint Services Centre, Wath Medical Centre and Wickersley Medical Centre.

3.3 Incident audits

Health and Safety incidents reported via Datix are reviewed to ensure that the information including incident grades are reported in a consistent manner and that all incidents are reported in the agreed Trust format.

4. INCIDENT REPORTING

4.1 Incidence rate

The incidence rate for employees reporting Health and Safety incidents is calculated by using the total number of reported incidents in the period divided by the number of employees, multiplied by 100.

508 employee have reported Health and Safety related incidents for the 2022/23 period.

Based on the data collated in this report, the Trust's Health and Safety incidence rate has continued to decrease over the last 12 months as shown in Figure 2 below.

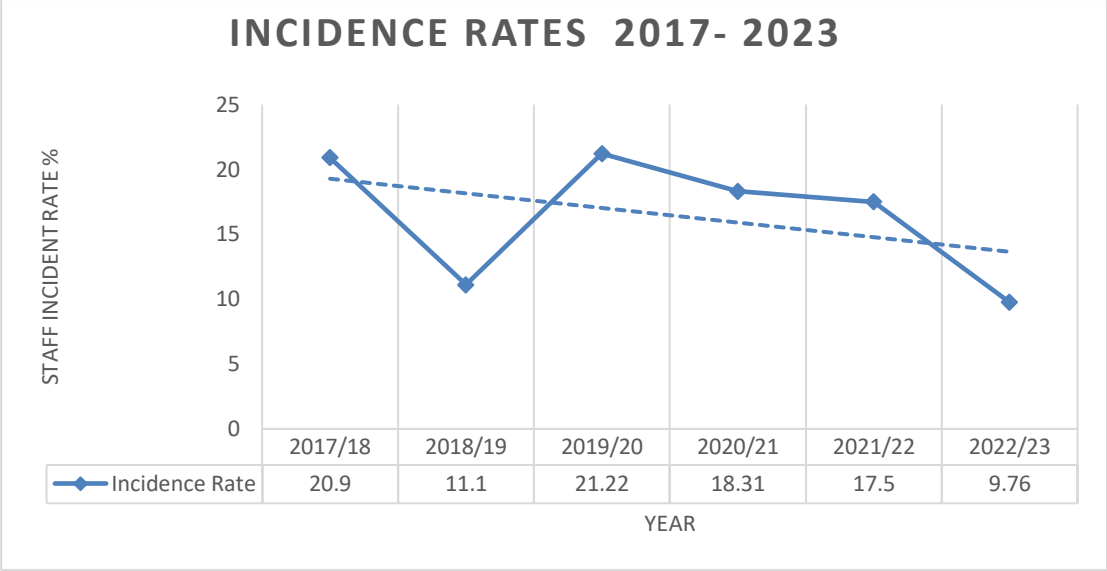


Figure 2. Health and Safety Incidence Rate

NB: The incidence rate is shown for employees and contractors, and reflects incidents recorded in Datix.

On average there are 42 health and safety Datix recorded incidents reported each month; these include employee, public and fire/security incidents. The incidents refer to injury, loss or near miss incidents and deal with all incidents outside the clinical risk reporting process. Figure 3 below shows the number of incidents broken down by incident that required reporting under RIDDOR.

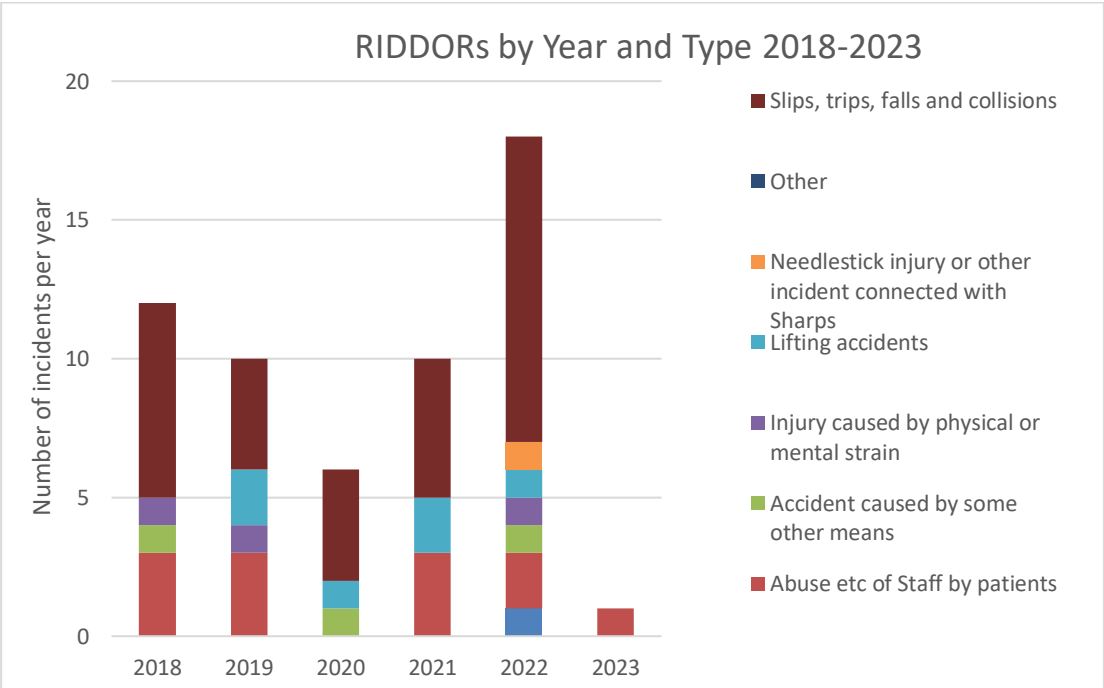


Figure 3. RIDDOR Report Incident Types

Reports of abusive behaviour towards employees have increased and continue to be monitored. There has been a continued high level of slips, trips and falls in 2022/2023, which in the main is due to a change in reporting and the number of community staff falls reported. Comunications were sent out to staff in the community advising them of the importance of wearing foot wear suitable for the weather conidtions.

4.2 Abuse against employees

Figure 4 below shows the number of abuse incidents against staff by patients, relatives or visitors that have been reported in the period 2022/23.

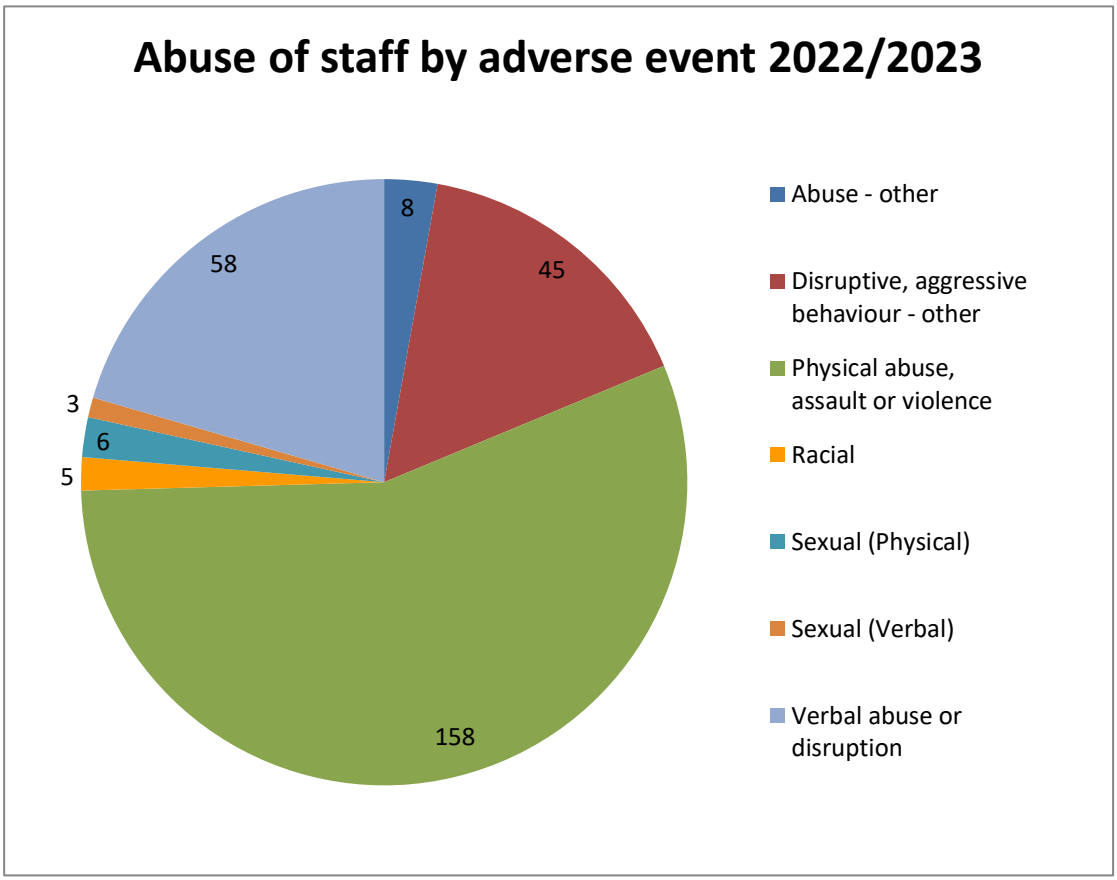


Figure 4. Abusive incidents by patients against staff

Physical abuse or verbal aggression towards Trust staff form the majority of these incidents and represent a 93% increase in the number of incidents reported, from 146 in 2021/2022 to 283 incidents in 2022/2023. We are continuing to train staff in Conflict Resolution as part of their mandatory and statutory (MaST) training but this now includes breakaway techniques. We are now also offering staff in higher risk areas a full course on physical intervention and breakaway techniques.

4.3 Accidents that may result in personal injury

Accidents that may result in personal injury in the 2022/23 reporting period, shown in Figure 5 below, detail the category of personal injury.

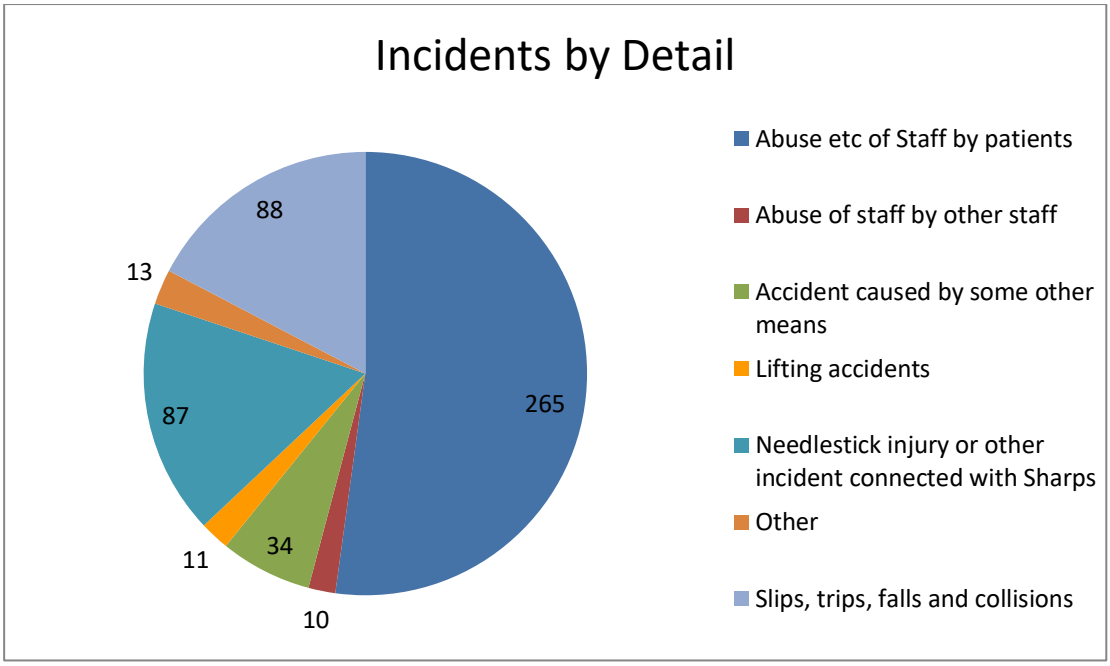


Figure 5. Incidents by detail

Figure 5 shows that the highest number of incidents are in the Abuse of staff by patient, Slips, trips and falls, and Needle stick categories.

4.4 Slip, trips and falls incidents

Figure 6 shows the number of staff and visitor incidents reported in the 2022/23 period for slips, trips and falls.

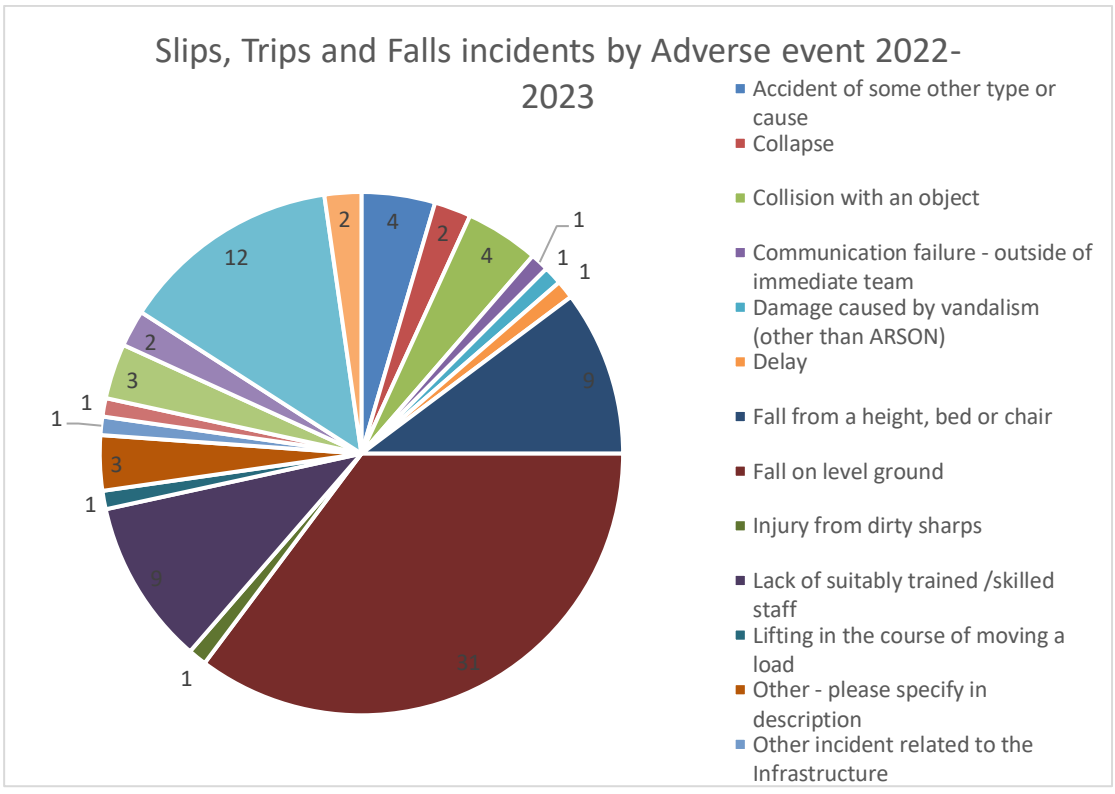


Figure 6. Slips, trips and falls incidents

There were 88 incidents relating to slips, trips and falls. Four of the incidents are due to a 'collision with an object'. These incidents are where employees have walked into an object such as a trolley, however due to the setup of Datix these fall under the category of falls.

32 of the incidents are due to falls 'on level ground' however, there is no identified trend or single location of concern for these incidents. 12 incidents of 'tripped over an object' will be a focus of the Health and Safety MaST training for 2023 as a preventative measure. The generic risk assessment for slips, trips and falls was reviewed and revised in March 2023. The 4 falls from height were 3 staff falling off wheeled chairs and 1 from a pathway curb. We did review the use and communicated with staff the importance of taking care when sitting on wheeled chairs in clinical settings.

4.5 Sharp incidents

Figure 7 below shows that of the 87 sharps incidents, 60 involved dirty sharps. Whilst there is no national benchmark with which to compare the Trust's incident rate, the Health and Safety Committee monitor these incidents.

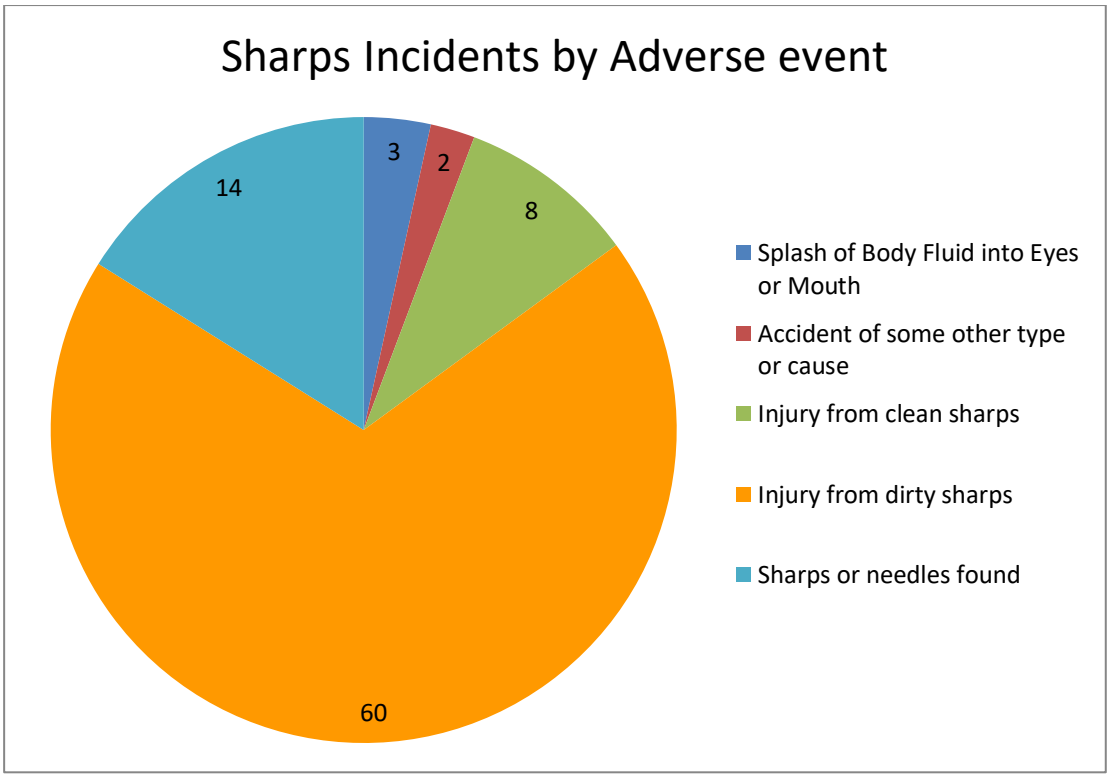


Figure 7. Sharps incidents by adverse event

The Occupationl Health Department provide a quarterly report on sharps incidents and have reported an increase in the number of incidents where safer sharps where not used. This is borne out in the incidents involving sharps data where 47% were other sharps, 18% Butterfly, 10% Cannula, 10% Scapel, 7% Subcutaneous, 5% Insulin pen and 3% IM.

All sharps injuries are investigated. Following the increase in sharps injuries a communication went out to all staff about the importance of sharps safety and the safe disposal of sharps. The increase in Insulin pen injuries was due to

staff removing the sharp from patient use pens. It was communicated with staff that patients should be removing this as it is a self administered injection.

4.6 Moving and Handling

There have been a total of 12 moving and handling incidents recorded during this period as shown in Figure 8. This is an decrease of five incidents from the same period last year.

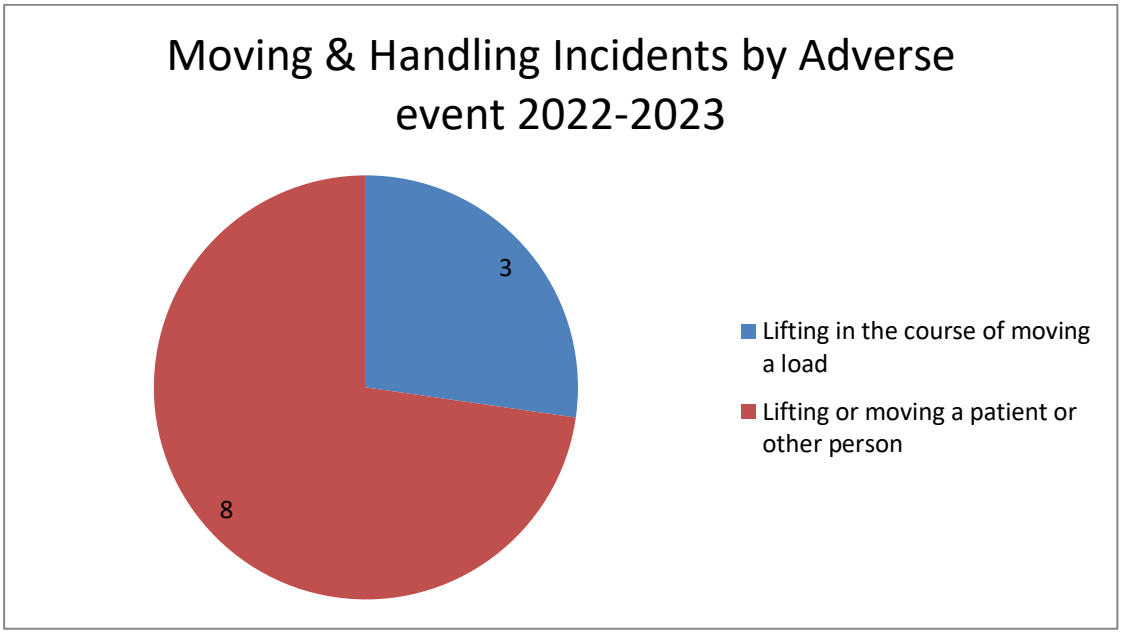


Figure 8. Moving and handling incidents by adverse event

All Datix recorded incidents are fully investigated in accordance with the Policy for the Reporting, Investigation, Management and Analysis of Incidents. The outcome of the incidents and investigations assist in identifying any trends that help in the development of training packages, the Health and Safety Strategy and annual work programme, so lessons can be learned and disseminated. The Trust also uses the analysis as evidence for external sources and awards such as the RoSPA award.

4.7 Radiation safety incidents 2022/23

The Radiology Department ensures and demonstrates the management of radiation protection is fully compliant with the IRMER and IRR legislation.

There have been 18 incidents reported in the Trust during 2022-23, none of which required reporting to the CQC under the IR (ME) R 2017 Regulations. This represents a small decrease in incidents compared to the previous year's 22 incidents.

4.8 Staff monitoring of medical imaging and physics

154 staff in the Medical Imaging and Medical Physics Department were provided with 498 personal dosimeters during the 2022 calendar year by Birmingham RRPPS Approved Dosimetry laboratory, as shown in Table 1.

	X-Ray Dept. 4030	Nuclear Medicine 4031	Breast imaging 4032	Cardiology 4033	Total
Total staff supplied/2-mth	98	13	11	32	154
TLD ≥0.2 mSv/2-mth	8	7	0	1	16
Max. dose per year mSv	2.8	0.6	0	0.3	
Number of staff > 1mSv/yr.	2	0	0	0	2
Number of TLD lost or spoilt	22	1		1	24

Table 1. Personal dosimeters

All staff members received an annual whole-body effective dose foreseeably below 6mSv (the dose level at which staff must be classified, which is also three-tenths of the annual dose limit). One member of staff is registered as a classified worker.

Two members of staff received more than 1mSv (the dose limit for 'members of the public'). One staff member (classified Sept/Oct 2018) has a recorded cumulative whole-body dose of 2.8mSv for 2022. The same staff member also had extremity doses recorded which are available for the January-September period only with cumulative doses recorded at 6.7mSv to the left hand and 6.6mSv to the right hand (Classification level >150mSv).

Eye dose measurements were monitored for the classified staff member with an annual dose of 0.0mSv recorded after a correction factor of x0.5 was applied.

No other staff members had eye dose monitoring carried out in the 2022 period.

The conclusion from this monitoring is that annual eye doses fall well below the level for classification (16mSv). Routine eye dose monitoring is not considered necessary at this time but will be kept under annual review.

The thermoluminescent dosimeter (TLD) lost/spoiled figure is 4.8%, which is slightly higher than the figure of 2.3% from 2021. Staff are reminded of their legal responsibility to look after and return their badges in a timely manner.

Finger dosimeters, supplied by the Sheffield Extremity Dosimetry Service, gave annual doses for five staff involved (12.26 mSv average per extremity and <5% of dose limit for 12 monthly users), as shown in Table 2.

Staff	CD	CL	JM	KP	PR
Right Hand	10.1	2.9	8.9	15.5	19.8
Left Hand	17.2	4.1	11.8	17.7	14.6

Table 2. Finger dosimeters

The values are in line with previous years and slightly lower than last year. The values are well below the annual dose limit of 500mSv and do not cause any concern.

The HSE have stated that any member of staff who systematically fails to wear, use and return their monitoring badges is committing an offence under Section 7 of the Health and Safety at Work etc. Act 1974, and it has been reiterated that employees must comply with instructions for their monitoring.

5. STRESS MANAGEMENT STANDARDS

Work related stress is now in the 2022/23 work plan for the HSE. The Trust uses the annual staff survey results as an indicator to identify areas of concern and to assist in the development of the Trust-wide risk assessment.

The annual survey is not an assessment of stress; it is purely an indicator of causative factors. A Trust-wide general/generic assessment of work related stress was undertaken in August 2012 and is reviewed yearly. The Stress policy will be reviewed in 2023/2024 and a new Stress policy published by November 2023.

6. RIDDOR REPORTS TO THE HEALTH AND SAFETY EXECUTIVE

Under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR), the Health & Safety Executive (HSE) require all employers to notify them when there is a specified accident or incident resulting in a fatality, major injury, disease or notifiable dangerous occurrence (whether or not anyone is injured).

It is a requirement for managers on behalf of the Trust to inform the Head of Health and Safety or Health and Safety Advisor of such incidents or occurrences so that the Trust complies with this legal requirement as identified in the Trust policy.

Three community staff fell on patients' premises when doing house calls. All three falls resulted in fractures to staffs limbs. Two slips and falls were outside and house and one was inside the house where the floor was uneven.

Summary of Trust RIDDOR reportable incidents

	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	Total
PATIENT	1	0	0	0	0	0	0	0	0	0	0	0	1
STAFF	2	3	0	1	1	1	1	3	3	0	0	1	16
VISITOR	0	0	0	0	0	0	0	0	0	0	0	0	0

Table 3. Summary of RIDDOR reportable incidents by month

The Trust continues to identify key risk areas for incidents that lead to RIDDOR reporting. The single patient incident reported under RIDDOR was due to a fall in the carpark; they stumbled backward and fell, resulting in a lower limb fracture.

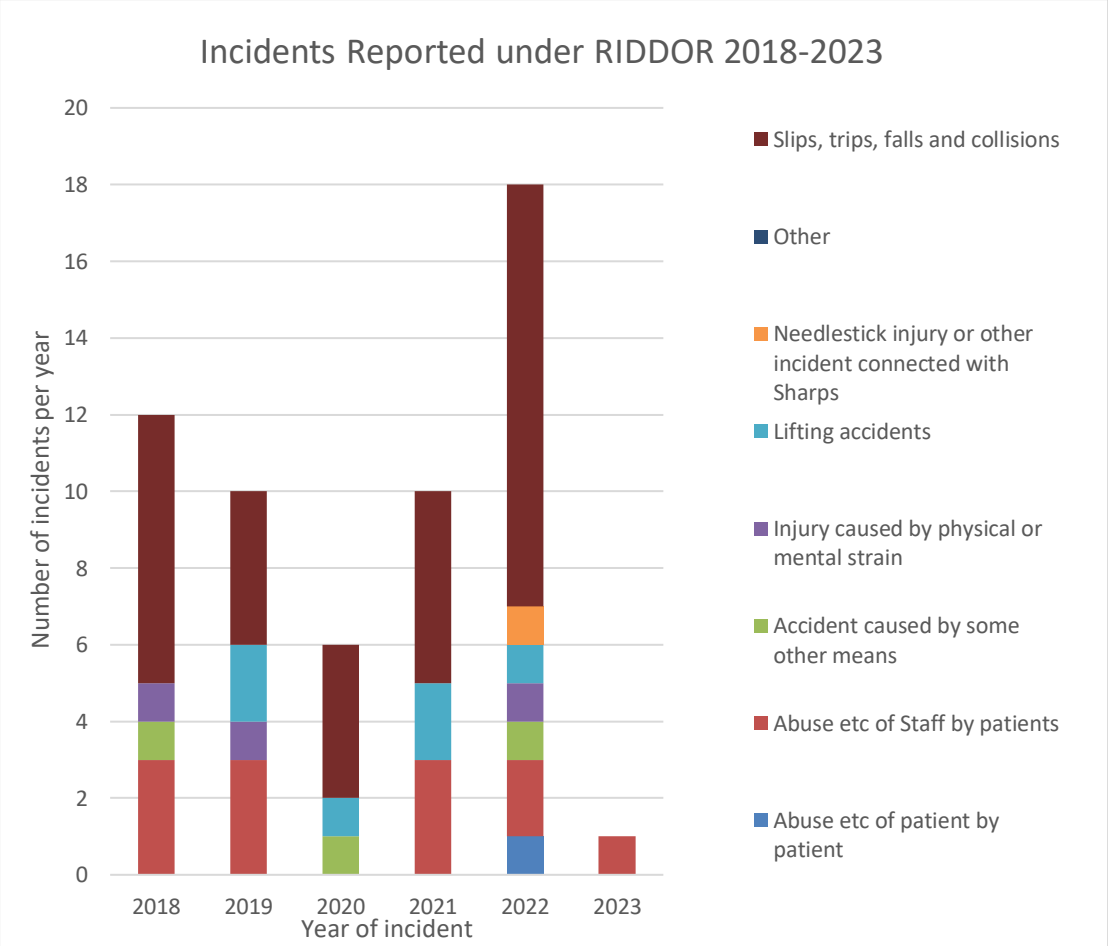


Figure 9. RIDDOR incidents by type 2018 – 2023

7. TRAINING

7.1 Risk assessment and risk management training

During 2022/23, over 60 staff received their Risk Assessor training and there are now over 100 general risk assessors trained as a result of hosting two courses per month. Staff are also trained in the risk assessment of violence and aggression, ligature, pregnancy and stress risk assessments through online Teams sessions. All staff that complete the general risk assessor course are invited to these sessions.

7.2 Fire safety training

90% of the workforce are currently in date for their fire safety training as shown in Figure 10. Fire safety training sessions are being offered face-to-face, via Teams or e-learning. This is a 4.30% increase on the MaST fire training compliance from 2021-2022.

Division	Core Fire Safety - 1 Year
Clinical Support Services	92%
Community Services	90%
Corporate Operations	90%
Corporate Services	83%
Emergency Care	89%
Family Health	91%
Medicine	90%
Surgery	94%
Grand Total	90%

Figure 10. Fire Safety Training compliance %

8 MOVING AND HANDLING

Moving and handling training is below the required standards due to training staff long-term absence from work.

8.1 Moving and handling training

People handling sessions are face-to-face with the life size manikin.

Group sizes have increased to eight per session for all face-to-face training for induction and update.

Theory and legislation training is planned to be provided on an e-learning platform and staff will complete this element prior to booking onto a practical session.

Concerns remain about the practical people handling training updates being at three yearly intervals and this is under review awaiting confirmation.

Training course attendance has improved, with many sessions booked to capacity.

8.2 Moving and handling link workers

There are currently 10 link workers who deliver moving and handling training and all require training skills refresher training in the next year.

Two three-day link worker courses have been delivered and one course has been cancelled due to lack of attendees.

No further dates are planned due to capacity of the team.

8.3 Training figures 1 April 2022- 31 March 2023

Training figures for moving and handling are not currently available.

The mapping for all MaST elements of moving and handling were submitted to Learning & Development on 13 July 2023 for mapping on ESR. This has been a lengthy project as all Divisions reviewed and approved their mapping for moving and handling and Display Screen Equipment (DSE). The Level 1 moving and handling has since gone live, and by the end of 2023 it should be mapped onto ESR. In January 2024 we will be able to present MaST compliance for DSE and all levels of patient and load handling training.

8.4 Moving and handling equipment

Slide sheets

The Moving and Handling team reviewed an optional tube slide sheet from Elis. This was much more suitable. These are continuing to flow into the slide sheet stock. There are still ongoing issues relating to slide sheet availability. The Moving and Handling team and facilities managers are monitoring.

Hoists and slings

Discussions are still ongoing with procurement reviewing the current hoist slings. This should be complete by November 2023.

Mobile hoist

The current hoists are now 10 years of age across the acute Trust.

Plans are in preparation to review any replacement required.

Bariatric equipment

Work has begun relating to the availability and current condition of the Trust bariatric equipment. Five bed bases and only one compatible mattress have been identified. This has been escalated and plans are being made for all bariatric equipment and management. Bariatric mattresses are currently being rented from Arjo 1st Call.

9 SHARPS

Sharps safety forms part of the Health and Safety Committee agenda.

Sharps incidents reported via Datix are on automatic alert to the Lead Nurse/Assistant Director for Infection Prevention and Control, and the the Head of Health and Safety who review all incidents reported on a monthly basis and share the information with the Health and Safety Committee.

All incidents are investigated locally in accordance with Trust policy. Reports that are related to disposal or incorrect disposal are forwarded to the Waste Officer for investigation.
From March 2022, the Occupational Health (OH) contract moved to Sheffield Teaching Hospitals (STH) with a new Standard Operating Procedure (SOP) put in place for staff to get the appropriate support at the time of any injury.

9.1 Incident reports

There were 87 reported employee sharps related incidents between 1 April 2022 and 31 March 2023, as shown in Figure 11. This is an increase of 7 on the previous 12 months.

There was no identified trend from the information on Datix to suggest any single procedure or item of equipment has a higher risk than others. Although there is an increase in the Occuptional Health (STH) quarterley reported that there are more incidents with safer sharps not used.

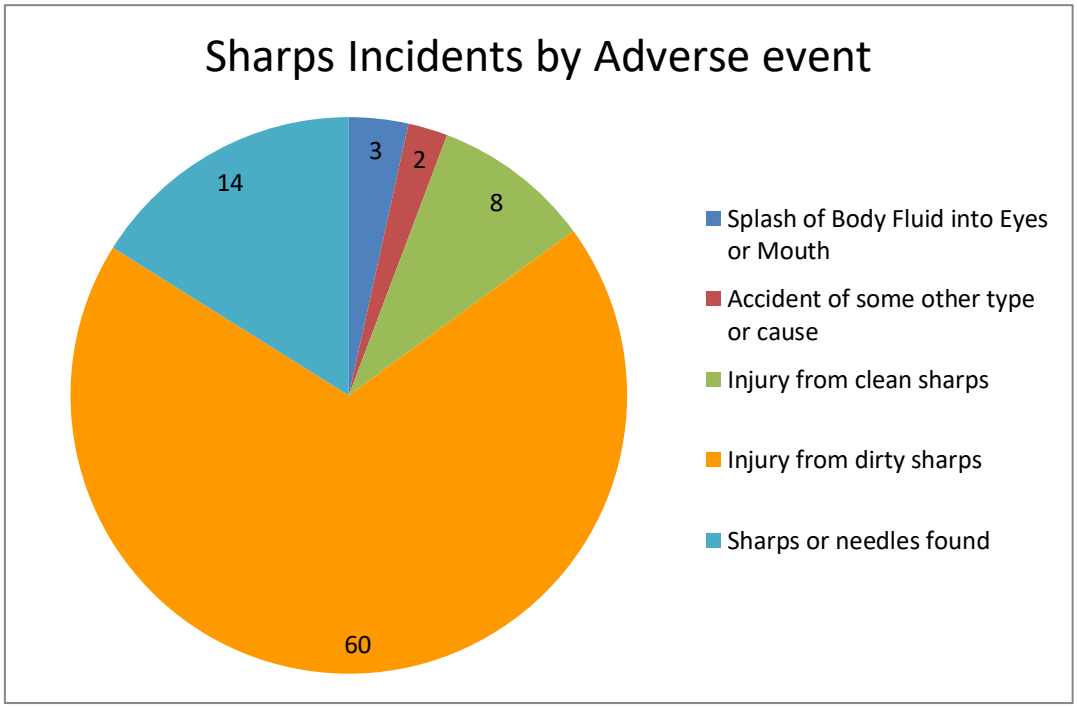


Figure 11. Sharps incidents by adverse event

These incidents have been broken down to Division in Figure 12.

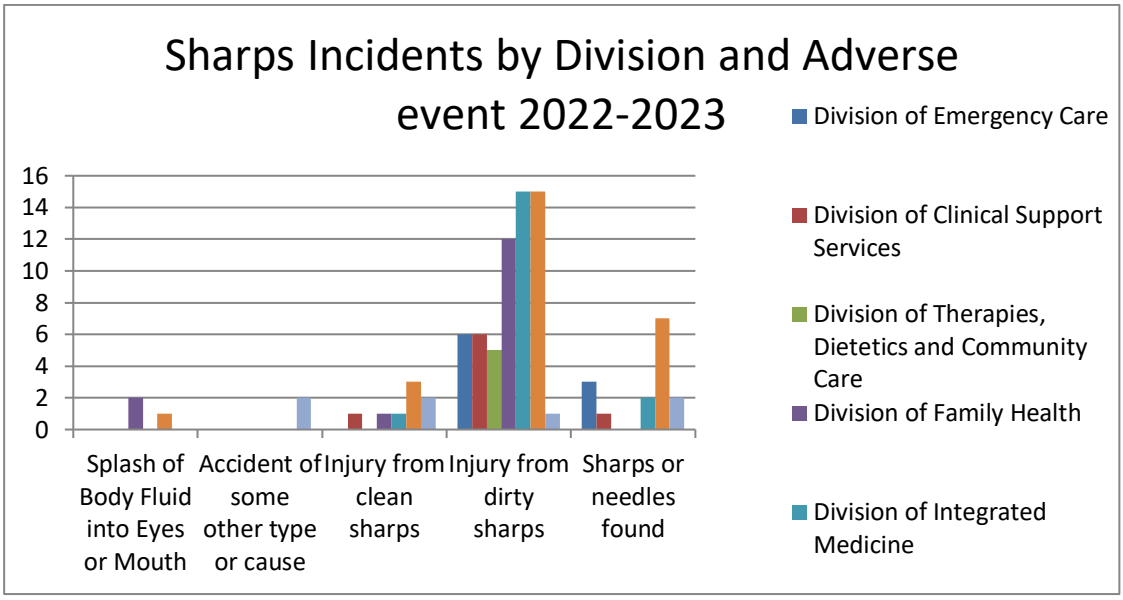


Figure 12. Sharps incidents by Division

Surgery have seen an increase of 1 over the 12 month period, Integrated Medicine has seen the greatest increase in incidents from 8 dirty sharps to 15, and Family Health has seen an increase from 5 to 12 incidents.

9.2 Safety products

The regulations for preventing sharp injuries in the hospital (Health and Safety (Sharp Instruments in Healthcare) Regulations 2013) came into force on 11 May 2013.

Work has continued during 2022/23 to identifiy any new safety devices that have become available that would support the regulations.

Sharpsmart waste disposal continues to be used on the main hospital site. Standardised disposable sharps bins are used at all other Trust sites ensuring compliance with the carriage of dangerous goods (ADR 2019).

Where the waste contract is managed by another organisation, the choice of bin remains with the service, however this has not been raised as a risk by any staff groups who work at these various sites.

9.3 Risk management

New legislation and HSE bulletins are reviewed as issued to reduce risks to staff, patients or the public. Risk assessments are carried out as required to improve safety and to manage cost effectively.

10 FIRE SAFETY

It is a statutory requirement for all public bodies to take the necessary precautions to ensure that their premises are safe, suitable and sufficient concerning fire management. Failure to provide adequate fire management can lead to public prosecution, including imprisonment or fines for the Trust's Responsible Person/s, enforcement orders from the fire authority and an increased risk of fire.

The Trust has a statutory responsibility to ensure that all of the premises owned and/or operated by it comply with current fire safety legislation. The Trust has to ensure that suitable and sufficient arrangements are in place for the management of fire safety and for the implementation of any necessary improvements relating to increased fire safety measures as required under the Regulatory Reform (Fire Safety) Order 2005 (RRO).

Health Technical Memorandum (HTM) 05-01 Managing Healthcare Fire Safety (2013) DH, describes that an Annual Report should be undertaken and presented to the Trust Board.

The Chief Executive Officer is responsible for ensuring that, through appropriate delegation of responsibility within the organisation, current fire legislation is met and that, where appropriate, Fire code guidance is implemented in all premises owned or occupied by the Trust.

This section has been developed in accordance with HTM 05-01: Managing Healthcare Fire Safety.

The following summary gives brief details of the Trust's development towards compliance with the mandatory requirements for the NHS in England (considered as best practice for NHS Foundation Trusts).

REQUIREMENT	PROGRESS	R	A	G
Clearly defined fire policy.	Compliant			✔
Board level Director accountable to the Chief Executive for fire safety.	Compliant			✔
Fire Safety Manager to take the lead on all fire safety activities.	Compliant			✔

Have an effective fire safety management strategy, which enables:

REQUIREMENT	PROGRESS	R	A	G
Preparation and upkeep of the organisation's fire safety policy.	Fire Safety Committee - responsible for the monitoring and review of fire policy and protocols. Fire Policy last reviewed in November 2022		✔	
Adequate means for quickly detecting and raising the alarm in case of fire.	Estates - Compliant			✔

REQUIREMENT	PROGRESS	R	A	G
Means for ensuring emergency evacuation procedures are suitable and sufficient for all areas, without reliance on external services.	Fire Safety Dept. - Compliant			✔
Staff to receive fire safety training appropriate to the level of risk and duties they may be required to perform.	MaST training ensures all staff have access to correct fire safety training required for their place of work. Additional training sessions for fire wardens and evacuation aids provided to improve resilience in community premises.			✔
Fire risk assessments are carried out and reviewed.	Department Managers and Fire Safety Dept. - Compliant			✔
Fire drills are carried out in all departments and wards.	Department Managers and Fire Safety Dept. - Compliant			✔
Reporting of fires and unwanted fire signals.	Fire Safety Dept. - Compliant			✔
Partnership initiatives with other bodies and agencies involved in the provision of fire safety.	Compliant			✔

10.1 Fire safety procedures

All employees are aware of the importance of good communication and a good relationship has been established between them and the Fire Safety Advisor. Any concerns or problems have been freely communicated and dealt with by all concerned.

All requirements under the Regulatory Reform (Fire Safety) Order 2005 (RRO) are being met; this includes full fire risk assessments for all wards and departments. The maintenance of the fire alarm system, emergency lighting and firefighting equipment are also being met.

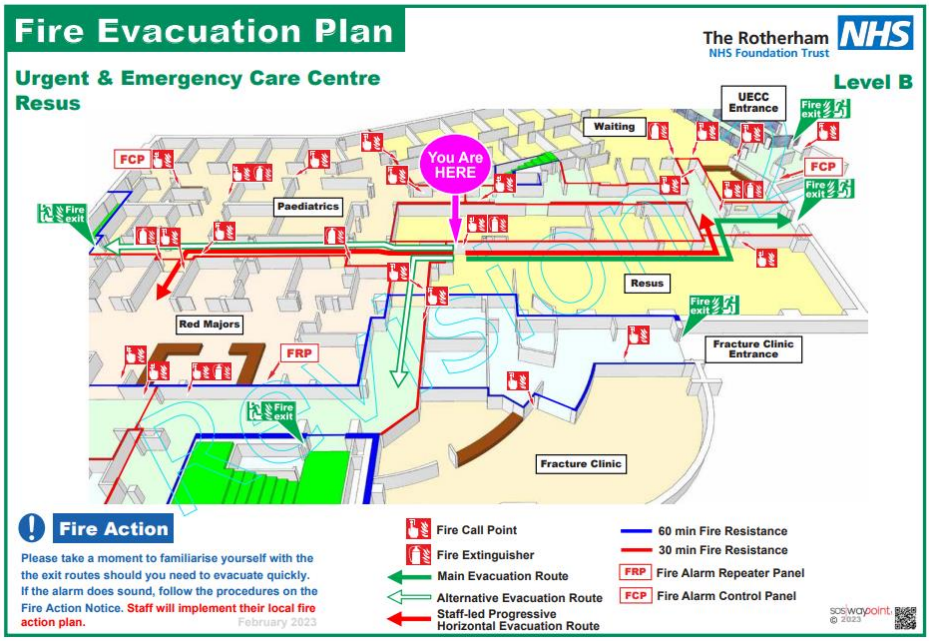
10.2 Trust fire risk assessments and strategy

Fire risk management is an integral part of the risk management process and, as such, remains a priority for the Fire Safety Advisor.

The Department of Health Document ‘Managing healthcare fire safety’ (HTM 05-01) requires that a Fire Risk Assessment Programme be put in place. This programme is in place with full reference to the Firecode Health Technical Memorandums (HTM) and the RRO. All wards and departments have a full fire risk assessment and an annual audit process is now in place. All risk assessments were fully reviewed and rewritten in 2022-2023. The Fire Safety Advisor continues to use HTM 05-03 Part K risk assessment, as this type of assessment continues to be the best practice for healthcare premises.

The new advisor has been in place since July 2022 and has made excellent progress in updating risk assessments, maintaining a risk log and reintroducing fire marshals with the support of the Governance training team. They have

trained fire marshals on all community sites and have started training marshals on the hospital site. This also involves a practical in the used of fire extinguishers. Below is a template of the new 3D fire evacuation plan that will be going up around the Trust in 2023.



10.3 Issues raised and improvements made 2022/23

After hospital ward restructuring, a significant amount of work was actioned to relocate and refurbish wards. All work was completed ensuring the Trust fire strategy was not compromised.

The major work for this year included:

- Refurbishment of Keppel Ward, now Stroke Rehabilitation Ward
- Installation of fire doors on stairwells and main corridors.

Staff continue to operate from a variety of shared premises in the Rotherham, Barnsley and Doncaster regions, which are managed either by single ownerships or within Joint Service Centres. To ensure compliance with Regulatory Reform (Fire Safety) Order 2005, an up to date copy of the fire risk assessment is kept in liaison with the relative landlords. Fire risk assessments have been carried out by the Fire Safety Advisor in a number of locations that are owned by NHS Property Services. All of these properties have Trust staff located in them.

Both the fire alarm system and the fire extinguishers are an important part of fire safety within the Trust and have been maintained and tested by the Trust's approved contractors during the reporting period. A new tender process has been undertaken for all fire safety components, ensuring all testing and servicing is carried out to correct specification and ensuring the Trust is compliant with all legislation and guidance.

10.4 Planned major improvements for 2023/24

The major developments for the coming year will be:

- New IPS/UPS installation for theatres
- Refurbishment of Special Care Baby Unit
- Refurbishment of Sitwell ward
- Fire stopping improvements site wide
- Turnkey project to repair one MRI scanner on C Level.

10.5 Fires and unwanted fire signals

Any fire is serious within the Trust environment and no matter how small can have a big impact on the organisation as a whole. No fires took place within the hospital or community sites in this period.

The total number of unwanted false calls during the year was 29 (see Figure 13), a decrease of 27 over the same period last year. As a large organisation, the Trust is still committed to reducing the amount of unwanted calls and all staff must ensure that they keep calls to a minimum.

Of these 29 false alarms, 6 were due to faulty detectors, which is down 11 from the previous 12 months. The Trust is continuing with a program to have all detector heads that are coming to the end of their life span replaced, but this has already proven to reduce activations.

Due to the size of the alarm system, the faults that occur cannot be prevented but are still monitored by the Fire Safety Advisor and the Estates Department. The hospital has its own Fire Response Team that reacts to all fire calls and South Yorkshire Fire & Rescue Service are only called if there is a confirmed fire or exceptional reason. The Fire Service was not called for any of the false alarms as the Fire Response Team and staff dealt with them promptly.

After recent liaison meetings with South Yorkshire Fire & Rescue Service, they have once again congratulated the Trust in the attitude towards unwanted calls and the way the Trust deals with them.

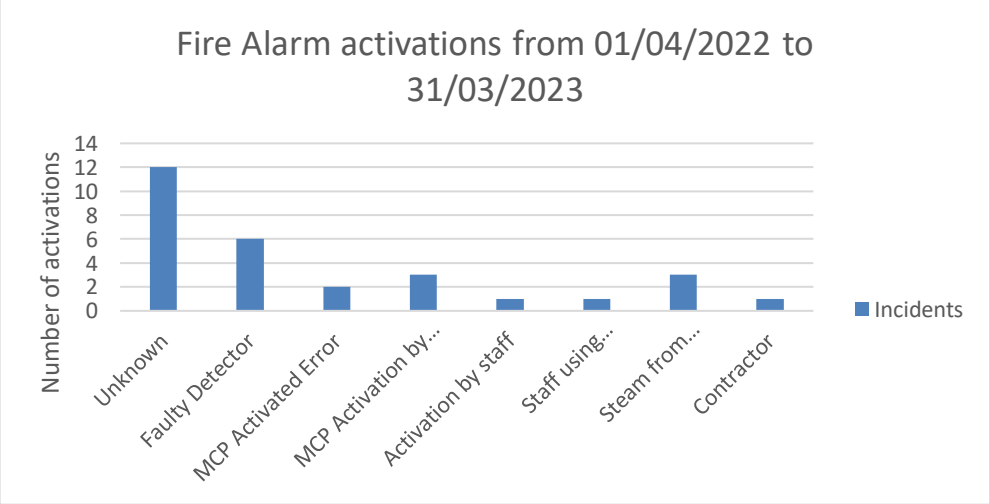


Figure 13. Unwanted fire alarm activations

11 SECURITY

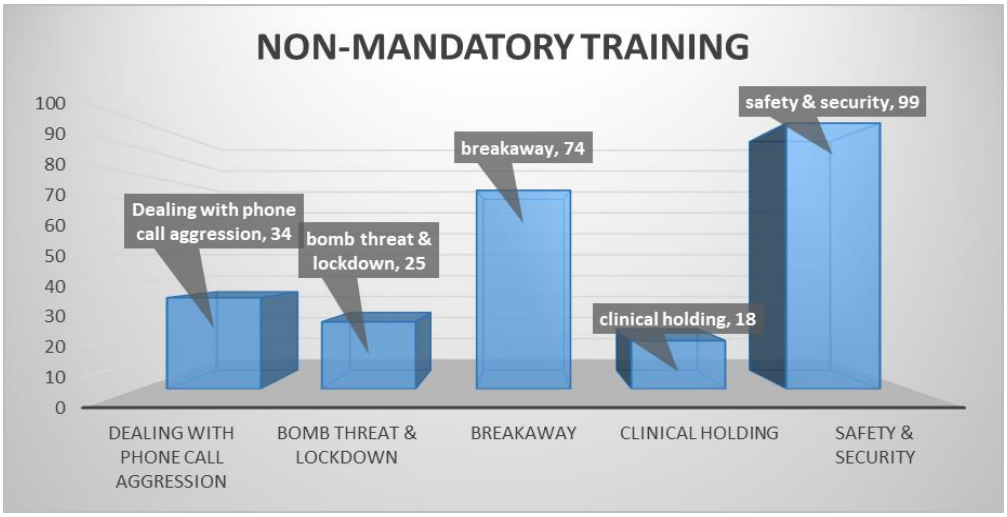


Figure 14. Non-mandatory security training

11.1 Security new installs / upgrades 2022/23

This year, the Trust has continued with the improvements of security within the hospital and wider community locations. The below table identifies areas of improvements to the security systems.

DATE	ITEM	LOCATION
July	Door access	Pharmacy
6.09.22	Panic alarm	Breathing space first floor
27.09.22	Door entry system	Endoscopy
Aug-22	New barriers	Site all car parks & RCHC
Aug-22	X3 new additional POF machines	Internal LEVELS A,C,E
Oct-22	Camera	Ambulance liaison
Dec-22	Door access	UECC drug cabinets
Dec-22	Camera	Maternity main entrance
Mar-23	x2 cameras	Children ward entrance's
Mar-23	x4 cameras	Oxygen stores

Table 4. Areas of improvement to security systems

11.2 Security personnel

The Trust has continued to contract Outsourced Client Solutions (OCS) to meet the physical security and CCTV monitoring requirements of the hospital, Woodside and Park Rehabilitation/Breathing Space sites.

The Security team continue to play a huge part in supporting the Children's Ward and medical staff with patients being admitted and placed on a Mental Health Section 3 due to an eating disorder. The Security team are trained in Clinical Holding (restraint) and to the current standard of the Restraint Reduction Network (RRN). By providing this support to medical staff, it ensures

that patients still received safe and effective care and in the best interest of the patient.

The Security team also monitors out of hours alarm activations, such as:

- Pharmacy fridge alarms
- Mortuary fridge alarms
- Winter temperature alarms
- Park Rehabilitation intruder alarm
- Woodside intruder alarm

All OCS staff are holders of the required Security Industry Authority (SIA) licences. This is a legal requirement in England and Wales for all individuals working in security and public space surveillance CCTV.

The security staff attended refresher training in the following subjects this period:

- Conflict resolution training (CRT)
- Clinical holding (restraint)
- Breakaway intervention
- Hand hygiene
- Autism awareness
- Autism and learning disabilities
- Roof top training

11.3 The Criminal Justice and Immigration Act 2008

The NHS continued to deal with low-level anti-social behaviour through Sections 119–120 of the Criminal Justice and Immigration Act (CJIA) 2008. This is used when attendees are causing a nuisance or disturbance on NHS hospital premises and refusing to leave. It provides the power for authorised NHS staff to remove a person suspected of committing this offence. The offence and power of removal apply only to NHS hospital premises. Physical removal must be the last resort and not a substitute for established verbal conflict resolution techniques to persuade a disruptive individual to leave voluntarily. The Trust currently has one Authorised Officer.

11.3.1 Datix violence and aggression incidents 2021/2022

There were 208 reports of non-physical assaults, which include:

- Abuse – other
- Staff to patient
- Patient to patient
- Staff by patient
- Staff by staff

A further 200 reported incidents of physical assaults were recorded through Datix.

April 2022 – Mar 2023	Non Physical Abuse	Physical Abuse	Total Abuse
Abuse - Other	19	0	19
Staff To Patient	2	1	3
Patient To Patient	9	13	22
Staff by Patient	161	186	347
Staff by Staff	17	0	17
Totals	208	200	408

Table 5. Total non-physical and physical abuse by type

11.3.2 Datix proven alleged or suspected theft reports 2022/2023

There were also 27 reported incidents of "proven, alleged or suspected thefts" recorded through Datix, which is a decrease of 22 thefts from the previous year.

		Apr 2022 - Mar 2023	Total
Proven, alleged suspected theft	**Related to personal property**	21	**21**
	Related to equipment	4	**4**
	Related to vehicles	2	**2**
	Totals		**27**

Table 6. Incidents of proven, alleged and suspected theft

All staff are given crime prevention advice and, after each incident, an email is sent to all email users reminding them not to leave property on view. In some cases, a security safety and awareness training course has been provided to several departments.

11.4 Security serious incidents

19.08.2022: Theft of a staff member's motorbike by five individuals whilst the vehicle was parked outside of the Trust I.T. building. These individuals became violent and physically threatening with a screwdriver towards I.T. staff when approached. This incident was caught on the Trust's CCTV system and provided to South Yorkshire Police (SYP) for further investigation.

11.11.2022: Patient with a query of Mental Health problems climbed scaffolding which was in place in a car park of the hospital, and threatened to jump. Fortunately, the patient was talked down and referred back to the Mental Health team for further assessment. A full investigation was carried out as to how the patient gained access to the secure scaffolding compound.

19.11.2022: Theft of oxygen cylinders from the A level oxygen cylinder store. The offenders managed to get away with approximately 15 cylinders. The incident was caught on one of the external CCTV cameras and passed to South Yorkshire Police for further investigation. Since this theft, security has been enhanced on the storage of the cylinders.

11.5 Monthly security incidents based on Daily Occurrence Book (D.O.B)

As of May 2018, the Trust Local Security management specialist (LSMS) has been provided with a monthly security report, which is based on the Security Daily Occurrence Book (D.O.B). This information provides a more accurate account of security incidents that have occurred at the Trust, due to staff not always reporting via Datix. A summary of these incidents is set out in the chart below:

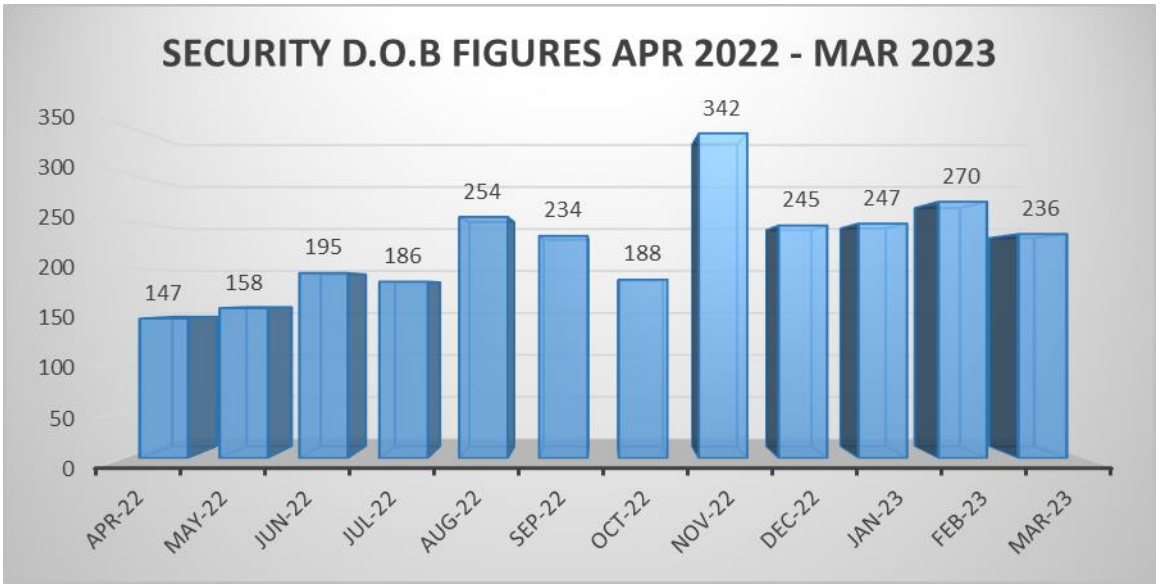


Figure 15. Security daily occurrence figures

12 RADIATION

12.1 External assurance reports

This annual radiation protection and assurance report by the Professional Lead /Senior Radiation Protection Supervisor (RPS) is based on the Radiation Protection Advisors annual report and covers aspects of ionising and non-ionising radiation protection from April 2022 to March 2023.

12.2 Legislation and regulation

Regular meetings with Radiology staff are scheduled, in addition to biannual X-ray radiation protection meetings, to ensure all matters of regulatory compliance and actions required are followed up systematically. The Radiation Protection Advisors and Medical Physics Experts use these meetings to provide updates and explanations of any new regulatory developments. These meetings are minuted, evidencing the advice supplied. Other ad hoc meetings are scheduled with a range of staff to discuss and address any specific advice or regulatory matters raised.

12.3 IRR17 updates taken from the annual RPA report

HSE stated that all staff who enter active controlled areas must be monitored using electronic or passive radiation detectors, however this may be revised due to challenges and therefore it is recommended that identification of non-

radiology staff working in controlled areas is made when the HSE guidance is clarified

Other occupationally exposed staff (i.e. theatres, etc.) represent large groups who are managed across multiple directorates/departments. Trusts will have to work through their corporate governance structures to identify these staff and arrange monitoring, should it be determined necessary by the HSE.

All staff who work in the vicinity of warning signs should have mandatory training to ensure they are aware of the hazard and comply with signage safety requirements (X-ray, lasers, Magnetic Resonance (MR), unsealed sources, etc.)

There is presently insufficient published explicit guidance on what would represent compliance. This has been evidenced in an increase in the number of Notifications of Contravention, Improvement Notices and Prohibition Notices.

12.4 IR(ME)R17 updates taken from the annual RPA report

In April 2023, the CQC issued revised clinically significant accidental and unintended exposures (CSAUE) guidance with new Complementary Notification codes, categories and criteria.

TRFT's Employer's Procedure 12 will need revising to ensure that they include the updated definition of Clinically Significant, this will be done and included in the updates for the health and safety annual report 2023/24.

12.4.1 Diagnostic imaging

During 2021-22, the CQC IR (ME) R Inspectorate around the country found 21 cases of non-compliance with the regulations in diagnostic imaging and made 47 recommendations following inspection activity. Seven Improvement Notices were issues as a result.

12.4.2 Key trends, concerns and recommendations

- Inadequate checks about the patient's identity by both the referring clinician and the operator were common causes of errors.
- There was a need to ensure that procedures, protocols and guidance for staff are up-to-date and effective, and to improve processes when investigating incidents.
- Many of our regulatory recommendations involved the need to improve the quality and availability of training records for staff.
- Some recommendations involved improvement of equipment audit trails for quality assurance records, faults and associated actions.
- We also made recommendations to employers to improve how they monitor the risks posed by the shortage of medical physics experts.

12.5 Staff monitoring of Medical Imaging and Physics

154 staff in the Medical Imaging and Medical Physics Departments have been provided with approximately 498 personal dosimeters during 2022 calendar year by Birmingham RRPPS Approved Dosimetry laboratory.

One member of staff is registered as a classified worker. All staff members received an annual whole-body effective dose foreseeably below 6mSv (the dose level at which staff must be classified, which is also three-tenths of the annual dose limit).

	X-Ray Dept. 4030	Nuclear Medicine 4031	Breast imaging 4032	Cardiology 4033	Total
Total staff supplied/2-mth	98	13	11	32	154
TLD ≥0.2 mSv/2-mth	8	7	0	1	16
Max. dose per year mSv	2.8	0.6	0	0.3	
Number of staff > 1mSv/yr.	2	0	0	0	2
Number of TLD lost or spoilt	22	1		1	24

Table 7. Incident by type and exposure

Two members of staff received more than 1mSv (the dose limit for 'members of the public'). One staff member (classified Sept/Oct 2018) has a recorded cumulative whole-body dose of 2.8mSv for 2022.The same staff member also had extremity doses recorded which are available for the January-September period only with cumulative doses recorded at 6.7mSv to the left hand and 6.6mSv to the right hand (Classification level >150mSv).

Eye dose measurements were monitored for the classified staff member with an annual dose of 0.0mSv recorded after a correction factor of x0.5 was applied.

No other staff members had eye dose monitoring carried out in the 2022 period.

The conclusion from this monitoring is that annual Eye Doses fall well below the level for classification (16mSv). Routine Eye Dose monitoring is not considered necessary at this time but will be kept under annual review.

The TLD lost/spoiled figure is 4.8%, which is slightly higher than the figure of 2.3% from 2021. Staff are reminded of their legal responsibility to look after and return their badges in a timely manner.

Finger dosimeters supplied by the Sheffield Extremity Dosimetry Service gave annual doses for five staff involved as follows (12.26 mSv average per extremity and <5% of dose limit for 12 monthly users).

Staff	CD	CL	JM	KP	PR
Right Hand	10.1	2.9	8.9	15.5	19.8
Left Hand	17.2	4.1	11.8	17.7	14.6

Table 8. Incidents by hands

The values are in line with previous years and slightly lower than last year. The values are well below the annual dose limit of 500mSv and do not cause any concern.

The HSE have stated that any member of staff who systematically fails to wear, use and return their monitoring badges is committing an offence under Section 7 of the Health and Safety at Work Act 1974. It was reiterated that employees must comply with instructions for their monitoring.

Radiation safety incidents 2022/23

There have been 18 incidents reported in the Trust during 2022-23 of which zero required reporting to the CQC under the IR (ME) R 2017 Regulations. This represents a small decrease in incidents compared to the previous year's 22 incidents.

Where exposure of staff or an over/unnecessary exposure of a patient has been suspected, as defined in Significant Accidental and Unintended Exposures (SAUE) CQC Guidance for employers and duty holders June 2019, it is necessary to notify the CQC. Where the CQC believe a reported incident may involve IRR17, they will report it to the HSE directly.

The following incidents have been reported locally and logged on the Radiology local database during the year 2022-2023 financial year for TRFT Radiology.

Date of incident reported	Patient dose	Reportable		
	mSv	HSE	CQC	Brief explanation
01-Apr-22	10.9	No	No	A patient recently attended the department for a chest-abdo-pelvis CT examination on 01/04/22. However, the patient already had a neck-chest-abdo-pelvis CT examination performed on the 31/03/22 and the Operator did not check for previous images before performing the second requested examinations (same indications as the first request). The patient therefore received an unnecessary dose of radiation from the repeated chest-abdo-pelvis CT examination.
04-Apr-22	0.04	No	No	A patient recently attended the department for a chest AP examination on 19/03/22. The Operator successfully performed the examination but had inadvertently imaged under the wrong patient's demographics. As the images were not observable to the ward for the patient, the patient was re-sent to the x-ray department. However, on this occasion, for which it is not made clear, the patient was imaged in the PA orientation. The patient therefore received an

Date of incident reported	Patient dose	Reportable		
	mSv	HSE	CQC	Brief explanation
				unnecessary dose of radiation from the chest PA examination.
04-Apr-22	0.013	No	No	A patient recently attended the department for a PA chest examination on 11/03/2022. The erect Bucky and x-ray tube were tracked into place, but the red warning light remained, correctly not allowing an exposure. A soft restart was undertaken but this failed to clear the warning light. After a full restart, the warning light had changed to a green light, which allowed the exposure to be undertaken. However, the resulting image was only that of a preview image; no complete diagnostic image was produced on the system. Regardless of restarting NX Viewer or attempting to resend the image packet to PACS, no diagnostic image was forthcoming. The entire room equipment was restarted and a test exposure performed with a successful diagnostic image produced. Accordingly, the patient was reimaged successfully. The patient therefore received an unnecessary dose of radiation from the equipment fault PA Chest exposure.
11-Apr-22	0.7	No	No	A patient recently attended the department for an AP lumbar spine examination on 31/03/2022. The room 5 was prepared and green ready for exposure. The radiographer performed the exposure for the AP lumbar spine. The image appeared and the monitor froze as though the image was going to enter a recovery file. After waiting ten minutes, the radiographer asked a senior colleague what to do if the image does not go into a recovery file. The senior radiographer looked at the screen, which was frozen. The only option was to turn the monitor on and off again, where the image was lost when they turned it back on. The patient was taken into x-ray room 1 and the AP lumbar spine exposure has been repeated successfully. The patient therefore received an unintended dose of radiation due to the equipment fault in room 5.
21-Apr-22	0.06	No	No	A patient on a ward received an AP chest X-ray in error after the radiographer incorrectly identified the patient on 11/04/2022. As a result, the patient received an unintended dose of radiation from the AP chest exam.
30-May-22	5.7	No	No	A patient recently attended the department for an angiogram (aorta) CT examination on 29/05/22. However, the operator

Date of incident reported	Patient dose	Reportable		
	mSv	HSE	CQC	Brief explanation
				incorrectly performed an Angiogram (pulmonary) CT exam instead. Once the error was recognised shortly afterwards, the patient underwent the correct examination the same day. The patient therefore received an unnecessary dose of radiation from the initial incorrect CT examination.
14-Jun-22	0.0001	No	No	An inpatient was referred for chest and lateral right knee X-ray on 14/06/2022. The referral correctly requested the right knee but inaccurately stated that the right knee had undergone surgery, when it was the left knee that had the surgery. The patient was unable to confirm which knee required an X-ray and the Operator incorrectly assumed the left knee due to visible signs of surgical intervention. The correct referral information of "? Right knee septic arthritic was eventually confirmed and the correct knee was imaged.
11-Jul-22	9.3	No	No	A patient recently attended the department for a CT urogram on 11/07/22. However, the Operator unnecessarily included the patient's chest in the scan and did not cover the pubic symphysis. Once the error was realised, an additional scan of the patient's pubic symphysis from Iliac crest to the trochanter of femur was performed to include the missing anatomy from the initial scan. The patient therefore received an increased dose of radiation from the incorrectly performed CT urogram and for the repeated scan to include the missing anatomy.
01-Aug-22	0.001	No	No	On 15 July, whilst cleaning down Fluoroscopy Room 4 after a case, a nurse leaned over the in-room control console and accidentally stepped on the foot switch causing the c-arm to expose. A radiographer and another nurse who were both behind the protective screen of the main control console, alerted the first nurse to the exposure and it was quickly terminated. The incident was reported to a senior radiographer.
09-Sept-22	0.37	No	No	A patient recently attended the department for a pelvis (AP view) and right hip (lateral view) examination on 8/8/2022 overnight. In the morning, the patient was referred for additional views and accidentally had the hip and pelvis re-requested. The radiographers didn't identify that these images had been retaken 10 hours ago

Date of incident reported	Patient dose	Reportable		
	mSv	HSE	CQC	Brief explanation
				prior and accidentally repeated the exposures.
03-Oct-22	0.0001	No	No	A patient was referred by their GP for X-rays of their hands and feet and this was correctly performed on 31/07/2022. A second referral was received on 02/09/22 and the Operator performed the exam after failing to note there was recent relevant imaging. As such, the patient received an additional unintended radiation exposure.
04-Oct-22	5.8	No	No	A patient recently attended the department for a chest CT examination on 01/09/2022. However, the scan was intended to be a 3-month follow-up exam and should not have taken place for another two months. This was not noted either at the booking stage or at the time of the exam. The patient therefore received an unnecessary dose of radiation from the CT chest examination. It is presumed that a follow-up scan will still be required after the intended time period.
10-Nov-22	0.0002	No	No	A patient was referred for a left knee X-ray exam on 26/10/2022 following total knee replacement surgery. Unfortunately, the Operator, a student radiographer, incorrectly performed the exam on the right knee before recognising the error and correctly performing the requested imaging
10-Nov-22	0.0001	No	No	A patient was referred for a left knee X-ray exam on 26/10/2022. Unfortunately, the Operator incorrectly performed an AP view of the right knee before recognising the error and correctly performing the requested imaging.
10-Nov -22	0.007	No	No	A patient was referred for a right shoulder X-ray exam on 03/11/2022. Unfortunately, the Operator, a student radiographer, incorrectly performed an AP view of the left shoulder before recognising the error and correctly performing the requested imaging.
14-Nov-22	0.012	No	No	A patient was referred for a left shoulder X-ray exam on 25/10/2022. Unfortunately, the axial shoulder image failed to appear on the viewer and, despite waiting for 15 minutes; it did not arrive in the recovery folder either. The unit was restarted, and a test image satisfactorily carried out. The patient was brought back into the room and imaging continued. The axial image was acquired but due to suboptimal alignment, a repeat was undertaken. This image also failed to appear. No further imaging was undertaken, and the equipment was taken out of use.

Date of incident reported	Patient dose	Reportable		
	mSv	HSE	CQC	Brief explanation
05-Dec-22	0.16	No	No	A patient was referred from the Emergency Department for a left hip X-ray exam on 02/12/2022. Unfortunately, after correctly performing the AP view, the Operator incorrectly performed the lateral hip exposure on the right hip. Once the error was recognised, the patient was recalled and the requested imaging was correctly performed.
17-Jan-23	0.017	No	No	A paediatric patient attended for a chest x-ray using CR. Operator did not think exposure had been made so repeated on same cassette. The operator realising error then returned to acquire a successful third image. The patient therefore had 2 unnecessary doses.

No other incidents have been reported locally. This represents a low level of incidents taking place. The feedback from the Trust's Radiation Protection Advisor states that the Trust should assure itself that this represents a good and effective reporting culture, to ensure compliance with CQC reporting requirements.

- **Certain trends can be seen from the above which are:**

  1. Human errors:

     Operators failing to identify the correct site for X-ray.

     Operators failing to check for previous imaging.

- **Learning outcomes to be worked on:**

  1. Staff engagement sessions on radiation incidents and reporting to CQC.
  2. Multipoint checks made at all stages of the procedures including pre/post examination e.g. questioning/computer checks about previous imaging, stop, pause and check, electronic alert on DR systems before exposure have now been added. Notices place in all rooms, not just ionising radiation. Stop, pause and check before assigning patient to database.
  3. Spot IRMER checks have been instigated.

12.5.1 Radiation protection assessment for new installation

Plans were reviewed for Radiographic room 2.

Site visits were undertaken as required and protection assessments in compliance with IRR17 Regulations 8, 9 and 10 have been sent to the appropriate Radiology manager, architects and /or Estates departments**.**

12.5.2 Routine quality assurance

Fluoroscopy, radiographic units and CT units are checked annually. Mobile radiographic and dental units are checked biennially.

At TRFT, there are 34 X-ray units in situ including four viewing monitor workstations and one CR reader. 45 visits were made for QA purposes at TRFT from 1 April 2022 to 31 March 2023.

Any minor issues commented on within the annual radiation report have been dealt with by the RPS concerned within that field of speciality in collaboration with the manufacturers.

12.5.3 Acceptance testing

There was one critical inspection and three commissioning visits performed between 1 April 2022 and 31 March 2023.

12.5.4 Breast screening

The responsibility for organisation of QA rests with the Screening Quality Assurance Service (SQAS) (North). Following national guidelines, checks on all mammography and Ultrasound units are made at six-monthly intervals. Primary reporting monitors and specimen cabinets are tested annually. In general, the equipment was found to be reliable with dose and other QA aspects meeting the published national standards.

Within Breast Screening, quality control checks are performed on the mammography machines by radiographers in accordance with the NHSBSP recommendations. Routine testing of Stereotactic accuracy is now a requirement.

Equipment performance was all found to be satisfactory.

The Breast Screening service are aware that where any action points are indicated in the reports, the SQAS require that a response be emailed back to the medical physics service and the SQAS, using the front page of the SQAS mammography summary form.

12.5.5 Departmental quality assurance comments

The department has a substantial quality control programme with the Quality Assurance (QA) Programme for the Diagnostic Imaging Systems manual specifying the tests to be performed. QA results are routinely discussed at the bimonthly radiation protection meetings.

12.6 Patient dosimetry

12.6.1 Dose Area Product (DAP) meters

DAP meters are fitted in all rooms and used in the recording of routine patient doses. All diagnostic reference levels (DRLs) are regularly audited against national values and displayed in all the X-ray rooms.

The RPA provides calibration values for DAP meters in the QA reports, which are used when comparing DRLs between rooms.

12.6.2 Patient dose estimates

There were 16 patient dose estimates required as seen in the incident reporting to CQC/HSE table 12.5.1.

There was one staff dose assessment required also seen within the table under 12.5.1.

12.6.3 Foetal dose assessments

No foetal dose assessments were required since the last report.

12.6.4 Research

No research ethics approvals were requested in 2022-23.

The key points from the Trust's Radiation Protection Advisor (RPA) included in the annual Radiation Protection Report to ensure TRFT compliance are:

Radiation doses to staff are well within acceptable levels so statutory requirements of the Ionising Radiations Regulations 2017 are being met within the Radiology department.

There is a well-established departmental QA programme, which is reported to the department bi-monthly. Audits of clinical governance are performed regularly.

The department reviews and maintains its regulatory policies and procedures to a high standard by ensuring these are communicated to staff, and that they represent actual practice within the department. The annual staff IR (ME) R assessment provides such assurance and ongoing audit continued.

The Trust must be able to individually identify all staff who act as referrers (including GPs), practitioners and operators, and ensure they maintain their competencies through various training routes. This should include all non-medical referrers – all evidence of training and names are kept on the local database in Medical Imaging. Medical Imaging and Physics keep evidence of all staff training.

Other departments with referrers, practitioners and operators must maintain records for their own staff who hold these roles.

The Trust needs to ensure IR(ME)R procedures to appoint and train non-radiological staff as practitioners and operators are followed and identify where in Trust management the responsibility for this will be placed. This is relevant for Cardiology and some surgeons in Theatres where the responsibility lies with their respective directorates.

Advice from the Department of Health IR(ME)R Inspectorate recommends that the Trust communicate its IR(ME)R policy to all GPs and other referrers external to the Trust on an annual basis, to ensure that any revisions to practice are communicated and that any new staff into the area receive appropriate information. iRefer is one route by which this may be achieved and is to be implemented during 2023 at TRFT.

Compliance with IRR17 Regulations 2016, 'Cooperation between Employers' requires that the hospital identify where staff employed from outside the hospital are receiving radiation monitoring badges, that the supplier of these is aware that the staff concerned may receive exposure from activities other than those in their employment.

Target 'Diagnostic Reference Levels' are reviewed for all equipment and procedures listed in the 2016 National DRL Guidance. Patient doses so far received have been audited against these values. DRLs are reviewed after each occasion a major software upgrade is undertaken.

The Trust will need to ensure that all policies, procedures, risk assessments and local rules are revised to reflect the requirements of IRR17 and IR (ME)

R17. This includes updates of guidance references as soon as the guidance is published to ensure that staff are directed to the most current guidance.

12.7 Nuclear Medicine Department

12.7.1 Radiation protection report

General

The department has registration under IRR17 for:

- Working with artificial radionuclides and naturally occurring radionuclides which are processed for their radioactive, fissile or fertile properties.

Consent under IRR17 for:

- The deliberate administration of radioactive substances to people or animals for medical or veterinary diagnosis, treatment or research.
- The deliberate addition of radioactive substances in the production or manufacture of consumer products or other products, including medicinal products.
- Discharging significant amounts of radioactive material into the environment.

A new process for renewal of consents required by the Ionising Radiations Regulations 2017 (IRR17) being implemented by the HSE has been delayed but should be implemented by October 2023. To clear the backlog associated with renewing existing consents over the next five years, HSE will be contacting 20% of existing consent holders each year. Existing consent holders will be selected at random and invited to submit an application to renew their consents. Further advice will be provided by the RPAs when more details are known.

The likely cost for HSE to process these applications is between £2,000 and £5,000 for each consent an organisation holds and the costs are largely dependent on how much time is spent by HSE inspectors reviewing each application. The Trust currently holds two consents; one for the administration of radioactive substances to patients and the other for the deliberate addition of radioactive substances in the production or manufacture of medicinal products, so the Trust will need to budget for renewal of these consents.

They will require the submission of a safety assessment to HSE; templates to assist with the submission are currently being developed. Other documentation will need to be submitted in addition to the safety assessment (local rules and contingency plans may be required, but this has not been confirmed). The inspectors will then review the safety assessment and the requested documentation. If they consider the safety assessment to be satisfactory then they will visit the site. If the review the inspector completes at site is also successful, once the appropriate fee is paid, the consents will be renewed. There is some uncertainty in what will happen if the inspectors are not satisfied with their findings but it is likely that the applicant will be given a specified period of time to rectify the deficiencies identified by the inspector.

1. Currently there is one ARSAC holder for the Trust. She has a licence issued on 11/01/2019. The site also requires a licence, which was issued on 19/03/2019. Both licences are valid for 5 years. We no longer have facilities to undertake non-imaging nuclear studies so these procedure codes have been removed from the Trust licence.
2. Local rules are in place. They have been reviewed and are going through governance processes.
3. Risk assessments for all activities relating to nuclear medicine are in place and have been reviewed recently and updated in line with IRR17.
4. The Trust has appointed corporate RPA and Radioactive Waste Advisor (RWA) services through Sheffield Teaching Hospitals Radiation Protection Services.
5. The Trust has a Medical Physics Expert (MPE) for nuclear medicine; the Consultant Physicist in Medical Physics. The MPE has registered as required under IR (ME) R 2017.
6. The department has two Radiation Protection Supervisors. These individuals have had their letters of appointment formally updated to reflect IRR17.
7. IR(ME)R 17 has placed additional requirements on the Trust as follows:
    - Requirement for information on benefits/risks attached to a radiation exposure to be provided to the individual wherever practicable, before the exposure takes place.
    - Communication requirements following “significant” unintended exposure with referrer, practitioner and patient.
    - Establishment of dose constraint for comforters and carers.

    Policies and procedures are in place to address these requirements.

12.7.2 Facilities and equipment

The Symbia-S gamma camera was taken out of commission in January 2023 and is in the process of being replaced with an Intevo Bold SPECT/CT system. We no longer have facilities to undertake non-imaging nuclear studies.

The facility for the mobile PET/CT service operated by Alliance Medical to come on site is no longer in place, having been replaced by the ‘CT in a box’. Alliance Medical have not visited the site for a number of years, preferring to scan patients at the fixed facility in Sheffield.

12.7.3 Staff doses

Classification of staff

a) Body doses

During 2022/23 measurable whole body TLD doses were recorded in line with that expected for the work undertaken for Nuclear Medicine Technologists, the highest dose received for 2022 was 0.6 mSv.

The cardiology nurses who staff the stress sessions for myocardial perfusion scans have been included in the routine personal dose monitoring. There have been changes in personnel at the end of 2022 due to retirement. Normally, cardiology nurses are not expected to receive measureable doses. For the wear period (four months from November 2021 to February 2022) one of the cardiology nurses recorded a dose of 1.3 mSv, an investigation was carried out and although we did not find a conclusive root cause, we do not believe it to be a true dose. She has not received a dose since.

(b) Classification of staff

Despite never recording doses close to those requiring that staff be Classified Workers under IRR17, the HSE has decided that there is a foreseeable risk that any nuclear medicine worker handling unsealed radioactive sources could exceed a dose limit in the event of a contamination incident. They are therefore pushing for all nuclear medicine staff in the country to be classified. This will introduce a cost pressure as we may have to pay more for extremity dose monitoring from an approved centre (rather than Sheffield Teaching Hospitals) and for annual health monitoring of staff. The Consultant Physicist, in consultation with the RPAs, is developing a business case to classify nuclear medicine staff.

Contingency plans

There was no requirement to invoke any of the department's contingency plans as defined in the local rules.

The next contingency plan rehearsal is planned to take place as part of staff training in July 2023.

This should be done as a requirement of IRR17.

12.7.4 Radioactive materials, waste and transport

The receipt and accounting for radioactive isotopes received documentation are up to date.

The control, accounting and disposal records of waste are up to date.

The annual audit for routine monitoring of contamination and check of closed sources at the end of the day showed a compliance of 99% for closed source checks and 96% for environmental contamination checks, which maintains the high standards of recent years. The importance of this task is included as part of induction training, staff are regularly reminded about the importance at departmental meetings and the Radiation Protection Supervisors (RPSs) check that these tasks are being carried out as part of their supervisory duties.

The Trust also holds an authorisation certificate from the Environment Agency (EA) to accumulate and dispose of radioactive waste. Detailed records of

disposals are maintained, and the annual statutory return was submitted in February. The Trust has worked within the limits of the certificate of authorisation during 2022/23.

The Trust had an inspection by the South Yorkshire Police on 13/04/2022. No significant issues were identified.

The Trust only engages in very limited radioactive transport operations.

These were reviewed by the Trust's appointed DGSA during an annual audit, which found generally good compliance and security.

12.7.5 Radon

In 2018, radon monitors were sourced from Public Health England (PHE) and placed in hospital and community locations identified by the Health and Safety Advisor. None of the levels in any areas are of concern, with a maximum annual average estimate of 83 Bq m^{-3} (from a community site in Barnsley) compared with the action level of 300 Bq m^{-3}. No further action is required.

12.7.6 PET/CT service

The mobile PET/CT service operated by Alliance Medical, has not visited the site for a number of years and the pad is no longer available. Procedures relating to this service have been removed.

Incidents

There was one radiation incident in February 2023. A patient attended for a MUGA scan and an Isotope injection of 800MBq via a cannula failed as the cannula was not in a vein. The staff were unable to acquire any images. The staff explained the situation to the patient and rebooked the scan. The ARSAC holder signed the request authorising additional isotope administration. This incident was recorded on Datix.

12.7.7 Research

There are no current research project involving radioisotopes.

12.7.8 Procedural audits

The following procedural audits took place in May 2021:

- Administered activity versus DRL
- Request justification / last menstrual Period (LMP) and breast feeding checks

Results for both of these audits were satisfactory. They were fed back to staff at staff meetings and reported at the annual Radiation Safety Committee meeting.

12.7.9 Quality assurance

A quality assurance programme is in place for the equipment within the department. This includes the gamma cameras, SPECT/CT, autogamma counter, isotope calibrators and contamination meters.

The annual calibration exercise for the isotope calibrators against NPL secondary standard was undertaken in September 2022. Results are confusing and we are arranging to carry out the calibration exercise again.

The new CT scanner had its critical examination carried out in April 2023. The CT component of the older SPECT/CT system is due to be carried out at the end of June 2023.

12.8 Non ionising safety protection report 2022-2023

12.8.1 Dermatology

The Laser Protection Advisor (LPA) audit found no issues to report.

Both lasers were serviced in the last year, and both have output power within tolerance.

The local rules and risk assessments have been reviewed and updated by the clinical team.

12.8.2 Ophthalmology

The manual door lock into the laser room was not working at the time of the visit.

There was no removable mandatory health and safety eyewear protection signage.

There is still no laser blind for the door window. This advice was given over two years ago.

The lasers have been serviced in the past year and our own measurements indicate the output of the lasers is within specification.

The LPA has updated local rules and risk assessments for both lasers.

12.8.3 Theatres

The LPA audit report was carried out in September 2022. The laser has since been serviced. There was an incident regarding laser fibre breaking which resulted in the surgeon suffering burns. An update is awaited from the LPS for theatres.

12.8.4 Phototherapy

All the equipment was tested on 8 September 2022. The Tl01 cabin was also tested on 25 April 2022.

In April 2022, the dermatology nurses reported unusually large treatment time values for some patients having TL01 therapy. Our own measurements could not replicate this cabin behaviour. We asked the dermatology staff to audit their TL01 treatments over one week and record the patient dose entered and the treatment time displayed by the cabin.

Subsequent discussions with the clinical staff have indicated that the issue has resolved itself and no more high treatment time incidents have occurred.

12.8.5 Mammography ultrasound

Two ultrasound scanners in the Mammography department have regular quality assurance checks in accordance with NHSBSP guideline Report 70 and PHE governance. Both scanners are now located in the Mammography department.

Monthly user QA was performed regularly from April 2022 to March 2023, with a 92% completion rate.

There have been no issues with either the scanners or the probes.

12.8.6 General ultrasound

The Radiographer-led QA programme for ultrasound is working well.

Seven new ultrasound machines have replaced outdated equipment.

Two probes need replacing and two are being monitored.

No other issues.

12.9 MRI safety report 2022-2023

This safety report covers non-ionising (Magnetic Resonance Imaging) Radiation Protection services provided to Rotherham Hospital between 28 February 2022 and 6 April 2023.

Scanner 1: Siemens MAGNETOM Avanto 1.5T

Full scanner performance testing and fringe field confirmation measurements was performed on 22/08/2022.

On this occasion, all QA test results were within tolerance. New QA methods have meant that action levels for signal–to-noise ratio (SNR) are yet to be set for the scanner but results were within 10% of previous measurements, which is normal for this make of scanner.

Scanner 2: Siemens MAGNETOM Sola 1.5T Commissioned (20 April 2022)

Full scanner commissioning performance testing and a full magnetic field plot for both 0.5 and 3 mT iso-contour fringe fields was performed on 19/04/22.

On this occasion, all QA test results were within tolerance.

Implant safety policies covering many commonly encountered implants have been provided. In many instances these mean that make and model details do not have to be found and provide clear guidance on the conditions for safe scanning. Of the 23 implants queried, 48% were answered within the same day, 87% were answered within two days, and all we answered within one week.

Updated and/or annually reviewed policies have been provided in April, July, and October 2022, and January 2023.

A safety audit conducted on 11 January 2023 for both scanners found a number of non-compliant and partially compliant issues. All of these have now been dealt with and are now fully compliant; no outstanding issues remain.

13 ESTATES AND FACILITIES

13.1 Compliance and risks

The high rated risk assessments have been reviewed and completed for the directorate and added to the Datix Risk Register.

The maintenance of a safe workplace, access/egress, safe systems of work, safe storage and transportation of materials, supervision, training and maintaining records are all being met.

The Directorate has continued to update its Control of Contractors and Permit to Work Systems, which are issued to all staff and contractors. A contractor's

induction programme is undertaken on a twice-weekly basis ensuring full on-site awareness of health, safety and welfare precautions and procedures. A total of 69 companies and 273 individuals have attended in this reporting period, which is having a positive impact on the reduction of accidents, near misses and untoward incidents to the Trust.

The Estates and Facilities risk assessments and safe working systems have been reviewed with departmental managers being kept up to date on a monthly basis of all risk score of eight and above. The Estates and Facilities Department has listed three new risk assessments with a 12 risk score, which is one more than last year. The risk assessments are:

1. Absence of an isolated power supply (IPS) within all Theatres.
2. Loss of electricity to equipment in all theatres.
3. Fire safety

14 EXTERNAL HSE VISITS

There were no external routine visit carried out by the HSE (Health and Safety Executive) within this period.

15 POLICIES, SOPS and OTHER DOCUMENTS

The Health and Safety Policy and related policies are reviewed in light of any changes to health and safety legislation and other requirements e.g. revised Health Technical Memoranda (HTM). The Risk and Ratification group is ratifying policies and the appropriate updates made. New Estates and Facilities policies, SOPs and other documents will be available on the Hub with the older documents being archived.

15.1 Estates and Facilities policies reviewed and ratified during 2022/23:

Document title	Ratified
Policy for the Management of Asbestos	22/04/22
Display Screen Equipment	20/05/22
Mechanical Policy	30/09/22
Fire Safety Policy	30/09/22
First Aid at Work Policy	30/09/22
Employee H&S Policy for New and Expectant Mothers/Birthing Parents	30/09/22
Policy for the Management of Lone Workers	28/10/22
Cleaning Policy	28/10/22
Policy for Slips, Trips and Falls Involving Staff and Others	25/11/22
Lifts Policy	16/12/22
Pressure Systems Policy	16/12/22
Natural Gas	27/01/23
Policy Governing Estates Works and Associated Infection Protection and Control	23/03/23
Medical Gas Pipeline Systems (MGPS)	24/03/23

15.2 Policies currently under review:

Document title	Review due
Mobile Communication Equipment Policy	16/05/23
Guideline for Staff in the Event that Police use a Taser or Irritant Spray on an Inpatient whilst Responding to an Incident	16/05/23
Environmental Sustainability Policy	30/06/23
Health & Safety Policy	05/10/23
Pest Control Policy	23/10/23
Waste Management Policy	30/10/23
Policy for Undertaking RIDDOR Notifications	20/11/23
Safe Operation of Ventilation Systems	19/11/23
Water Safety Policy	19/11/23
Moving and Handling Policy	18/03/24

15.3 Other Estates and Facilities documents reviewed and ratified during 2022/23:

Document title	Ratified
Asbestos Management Plan	22/04/22
Facilities Services Business Continuity Plan	30/04/22
Estates Governance Business Continuity Plan	30/04/22
Security & Car Parking Business Continuity Plan	31/05/22
Concordant for the Care of Prisoners Admitted to the Rotherham NHS Foundation Trust	01/06/22
UECC Lockdown Plan	22/07/22
Bomb Threat Plan	22/07/22
Trust Lockdown Plan	22/07/22
Estates Services Business Continuity Plan	31/08/22
Medical Gas Pipeline System (MGPS) (EPD 106)	05/10/22
Infection Prevention & Control Guidelines for Estates Works (EPD 105)	05/10/22
Key Environmental Objectives (EPD 108)	17/02/23

15.4 Other documents for future review:

Document title	Review due
Facilities Services Business Continuity Plan	30/04/23
Estates Governance Business Continuity Plan	30/04/23
Security & Car Parking Business Continuity Plan	31/05/23
Concordant for the Care of Prisoners Admitted to the Rotherham NHS Foundation Trust	20/06/23
Trust Travel Plan	30/06/23
UECC Lockdown Plan	01/08/23
Bomb Threat Plan	01/08/23
Trust Lockdown Plan	01/08/23
Health & Safety Information and Guidelines for Contractors/Consultants and Sub-Contractors	30/08/23
Estates Services Business Continuity Plan	30/08/23

Health & Safety Strategy	05/10/23
Water Safety Plan	19/11/23
Security Strategy Work plan	02/12/23
Fire Safety Strategy	03/12/23

15.5 Estates and Facilities Standard Operating Procedures (SOPs) reviewed and ratified during 2022/23:

Document title	Ratified
Delivery & Collection of SharpSmart Bins	12/04/22
Face Fit Testing – Use of Equipment	09/06/22
Management of External Visits	22/06/22
Safe Transportation of Dangerous Goods	28/06/22
Emergency Minor Spillage Control	08/07/22
Procedures for Locking & Unlocking Breathing Space	08/07/22
Safe Transport of Dangerous Goods	21/07/22
Decontamination in the Event of CBRN Incident	27/07/22
Patient Transfer	06/09/22
Management and Maintenance of Lifting Equipment	06/09/22
Electric Tow Truck Training SOP	15/09/22
Safe Use of Equipment when in use for Working at height	16/09/22
Safe Access and Egress of Confined Spaces	20/09/22
Reporting / Removal of Asbestos / Suspected Asbestos Material	27/09/22
Hormann High Speed Power Assisted Door	27/09/22
Safe Use of Flo-Jac Air Mats	14/10/22
Medical Gas Cylinder Check	19/10/22
Wall Washing Following Maintenance in Theatres	28/10/22
Reporting of Non-Compliant Waste Incidents	31/10/22
Disposal of Confidential Waste	31/10/22
Control of Contractors	15/11/22
Car Parking & Parking Charges	25/11/22
Site Winter Maintenance Snow/Ice Removal SOP	06/12/22
Control of Contractors	07/12/22
Mercury Spillage	05/01/23
Standard Bed Cleaning & Isolation Cleaning	27/01/23
Bed Fault & Maintenance	30/01/23
Riverside RVM 500 Cardboard Baler procedures	05/02/23
Electric Powered Floor Cleaner	07/02/23
Body Worn Camera Pilot SOP	13/02/23
Procedure for Use in the Event of Lift Entrapment	13/03/23
Procedure for Use in the Event of Loss of Air Flow on Critical Ventilation Plant SOP	13/03/23
Safe Use of Roof Hoists	29/03/23
Drainage Pipeline Access SOP	31/03/23

15.6 SOPs for future review:

Document title	Review due
Parking Charges (Appendix 1)	30/07/23
Basic Battery Maintenance	05/08/23
Estates & Facilities Annual Leave Procedures	22/09/23
Fire Safety SOP	30/09/23
Estates & Facilities Lone Worker SOP	30/09/23
Electric Tow Truck Training (Amendment)	30/09/23
Facilities Services Wet Mopping SOP	30/09/23

16 RISK REGISTER

The continuous review and implementation of the Datix web risk register has seen a decrease in the number of risks recorded as live, in accordance with the Trust approved Risk Management Strategy. The total number of health and safety risk assessments on Datix now stands at 273, which is down from 381 in the last report. This is primarily down to the work of the Risk Manager and compliance leads removing duplications and bring other risks together.

The system is an integral part of producing corporate risk registers for a number of committees throughout the organisation.

17 CARRIAGE OF DANGEROUS GOODS

The Carriage of Dangerous Goods and Use of Transportable Pressure Equipment Regulations 2009 and (Amendment) Regulations 2011 (carriage regulations) came into force on 1 July 2009 and 24 October 2011 respectively.

The Carriage of Dangerous Goods Regulations main purpose is to identify dangerous substances and articles (liquid or solid) and to place controls on these dangerous goods when they are being conveyed by any mode of transport i.e. road, rail, sea or air. This is to protect personnel in the transport chain (i.e. the driver) from exposure to the dangerous goods and ensures in the event of an accident, emergency services personnel attending the scene can identify contents of the vehicle's load and take precautionary action.

In line with the above Regulations, specific duties are imposed on the Trust to ensure that the dangerous goods consigned or carried are presented for carriage correctly, identified by use of a Proper Shipping Name (PSN), classified to establish their hazard characteristic(s) and contained in suitable performance tested packaging, which must display marks and labels to indicate the contents. Documentation may be required as well, as evidence of appropriate training for drivers. Dangerous goods consigned or carried include clinical waste, diagnostic specimens, medical gases, chemicals, and some pharmaceuticals.

The Trust has statutory duties as both 'consignor' and 'carrier' under the carriage regulations.

The Trust appoints Independent Safety Services Limited (ISSL) to act as Dangerous Goods Safety Adviser as per its statutory duty. It is accepted that articles and substances falling in scope of the 'Carriage Regulations' are moved from or conveyed to the Trust.

The remit of the Dangerous Goods Safety Adviser is to advise on the Regulations concerning the transport of dangerous goods. This activity does not extend to advising upon other legislation such as The Hazardous Waste (England and Wales) Regulations 2005, or waste issues in general. This will normally only be done where waste is classified as a dangerous good for transport under the Carriage Regulations or where the Trust has made specific request for information.

The annual dangerous goods audit took place in November 2022. The summary of the audit reports the level of compliance has consistently been found to be of a high standard.

An action plan produced resulting from the audit highlights 15 actions. These are mainly concerning the marking and labelling of some biological specimens. All actions are completed.

18 AREAS FOR FUTURE HEALTH and SAFETY DEVELOPMENT

Priorities for 2023/24

- Continued implementation and monitoring of the 2021/24 Health and Safety Strategy.
- Continue the delivery of the health and safety training programme for COSHH and risk assessment through 2023/23 including provision of support to staff.
- Continue to embed risk registers across the Trust through the support and training of the risk assessors to ensure resources and development of the risk assessments across the Trust.
- On-going work to review moving and handling training, and continued introduction of new moving and handling link workers in all areas including non-clinical areas.
- Continue to ensure the Trust is working to achieve the Board approved security management work plan for 2023/24.
- Continued review of policies and SOPs for 2023/24 as necessary.

19 SUMMARY

19.1 Health and safety

Continued development and implementation of the third year of the Health and Safety Strategy 2021/24 has assisted in identifiying and advancing the Trust's position with regard to the appropriate management of health and safety risks.

Regular health and safety audits are aligned with the approved Health and Safety strategy 2021/24 and continue to assist in ensuring the continuous improvement.

Revised training arrangements for the appointment of staff health and safety risk assessors across Trust has improved awareness of health and safety risk management, compliance and assurance across all Trust departments.

Being awarded the RoSPA Gold Award for the tenth year running and gaining the President's Award is a milestone achievement for the Trust recognises and demonstrates our long standing commitment and partnership working to ensure a safe working environmenyt for our staff, patients and visitors.

N.B: All data used to populate the annual health and safety management report for the period of 2022/23 is attributed to the Datix risk management database.

19.2 Security

The Trust remains committed to providing a safe non-violent/non-threatening environment for all its employees, patients and visitors, and will take all reasonable steps to secure the health and safety of staff that may be exposed to the risk of aggression, violence or abuse in the workplace.

The Trust does not tolerate any form of violence or aggression, including verbal abuse against its staff, visitors or patients. The Trust response to violence and aggression is underpinned by the principle that prevention is better than cure. Our public health approach recognises that there are opportunities to be preventative even after a problem has emerged. Violence is not something that just happens, nor is it normal or acceptable in our care settings. Many of the key risk factors that make individuals, families or communities vulnerable to violence are changeable, including exposure to adverse experiences in childhood and subsequently the environments in which individuals live, learn and work throughout youth, adulthood and older age.

Having an understanding these factors means the Trust can develop and adopt new public health based approaches to tackling violence. Such approaches focus on the primary prevention of violence through reducing risk factors and promoting protective factors over the life course. Interventions to achieve these goals have been tested and are beginning to form part of the Trust's response to violence and aggression. The impact of violence on the health of individuals and the costs it imposes on health care systems are substantive and are akin to those for other major public health priorities such as smoking and alcohol.

Together with these longer-term strategies, the Trust continues to invest in its short to medium term physical security with increased door access control, CCTV and body worn cameras.

The Trust has also invested in lone worker technology in the last year to increase the safety of our community teams.

The most fundamental change in the last year has been the formation of a Violence Reduction Group chaired by the Deputy Chief Executive, which meets quarterly, with representation from all areas. The group considers best practice from around the world, and will work in collaboration with partner organisations to encompass any learning into a new revised security strategy.

19.3 Fire

There has been a significant decrease of unwanted fire alarm activations within the hospital over the previous reporting period from 56 false alarms in 2021/22 to 29 false alarms in the current reporting period 2022/2023.

This improvement is attributed to the continuing programme of replacing aged detectors and the successful delivery of MaST fire safety training.

The Trust Fire Response Team has attended every fire incident promptly, ensuring that every incident is managed effectively and efficiently in ensuring staff, patient and visitor safety.

19.4 Sharps safety

The focus for sharps safety for 2023/24 is in ensuring continued compliance with the UK sharps legislation.

A review of disposed sharps by the Trust's sharps disposal contractor, SharpSmart, is programmed for 2024 and will look to provide assurance that safety devices are being activated prior to disposal and that no non-safety devices are in use when there is a safe alternative available.

Board of Directors' Meeting
12 January 2024

The Rotherham NHS Foundation Trust

Agenda item	18/24
Report	**EPRR Annual Assurance Core Standards Process**
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 is being presented to the Board of Directors for assurance, outlining the Trust's annual submission against the Emergency Preparedness, Resilience and Response (EPRR) core standards. A full report was presented for assurance to the Finance and Performance Committee in December 2023, this included further detail of compliance against each core standard. Prior to this, the submission was discussed at the Executive Team Meeting in advance of a check and challenge meeting with South Yorkshire Integrated Care Board colleagues in November 2023. The Trust position on compliance has been submitted to both the regional and national teams and the Trust is required to take this and the action plan to the Board of Directors for assurance. The attached report also includes the full core standard submission template for the Trust and the Annual statement of compliance signed by the Chief Operating Officer as the Accountable Emergency Officer for the Trust.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	The updated core Standards process and the Trust's compliance rating were presented to the Executive Team Meeting on 16th October 2023. Confirm and challenge session held by the South Yorkshire Integrated Care Board on the 27th November 2023. The Trust's compliance rating and improvement plan were presented to the Finance & Performance Committee on 20th December 2023.
Board powers to make this decision	It is a requirement of the Annual Core Standards submission that the compliance statement and action plan is discussed at the Board of Directors for assurance.

Who, What and When (what action is required, who is the lead and when should it be completed?)	The Chief Operating Officer will keep both the Executive Team and Finance and Performance Committee updated on the progress against the action plan. The Director of Corporate Affairs will ensure that Trust's EPRR statement of compliance is reported in the organisation's annual report for 2023/24.
Recommendations	It is recommended that the Board of Directors: 1. Note the core standards template, statement of compliance and action plan for improvement. 2. Note the rationale behind the change to Core Standards assurance outside of national arrangements.
Appendices	1. Completed core standards submission template, including dashboard and improvement plan 2. Statement of Compliance 3. NHS England EPRR Core Standards Overview for Boards report

Emergency Preparedness, Resilience and Response (EPRR) core standards

1.0 Background

The attached report contains the full core standard submission template for the Trust, a dashboard outlining the current position and action plan for improvement (Appendix 1), the Annual statement of compliance signed by the Chief Operating Officer as the Accountable Emergency Officer for the Trust (Appendix 2) and an NHS England report for Boards outlining the rationale behind the change to this year's process (Appendix 3).

Trusts have previously self-assessed compliance against nationally agreed core standards, providing a return to the Integrated Care Board (ICB) where evidence was considered, challenged where necessary and subsequently forwarded to the regional NHS England EPRR team in consideration of the overall compliance position.

This year's process has seen the introduction of an evidence based check and challenge process led by the regional EPRR team including a significantly higher standard for compliance in comparison to last and previous years processes. This has required Trusts to submit plans, policies and supporting evidence, assessed for compliance by the regional team which is out with of national arrangements in all but one other region who piloted the process last year.

The NHS England EPRR Core Standards Overview for Boards paper (Appendix 3) outlines the NHSE NE&Y rationale from stepping outside of national arrangements referring to the EPRR world experiencing significant disruption and change. Following learning from recent incidents and inquiries e.g. Manchester Arena, Covid 19 and Grenfell, the bar for providing evidence of robust governance, proactive planning and tried & tested plans has been raised dramatically, hence the more rigorous evidence assessment in this years and future assurance of the EPRR Core Standards.

2.0 Trust Submission

The Trusts' initial assessment with supporting evidence indicated an overall compliance rating of 'Partial' with 85% of the 62 core standards fully compliant. Following review, NHSE assessed the Trust as non-compliant with 19% of the standards fully compliant. A second submission and review of evidence resulted in the same compliance rating being returned, albeit 35% of the standards were fully compliant.

Following the second review of evidence, the Trust initially challenged 6 core standards assessed by NHSE to be partially compliant. Following further discussion at ICB level, it was agreed to accept NHSE's assessment with these 6 standards assessed as partially compliant.

The Trust's overall final position is 'non-compliant' with 22 fully compliant standards, 39 partially compliant and 1 non-compliant with an associated improvement plan to work towards achieving fully compliant status over the next two years which will be included in the EPRR work programme .

The non-compliant standard refers to the evacuation and shelter plan. A draft plan was subsequently prepared and was approved by the Executive Team at its meeting on the 21st December 2023.

3.0 Ongoing Assurance / Next Steps

In line with the increased requirements for compliance, a number of steps have already been taken to strengthen oversight and provide additional assurance in relation to the Trust's preparedness and EPRR activities.

As part of this, it has been agreed that EPRR updates including the core standards submission will be discussed at the Finance and Performance Committee for assurance as a sub-committee of the board. In addition, trust-wide emergency plans will be signed off by the Executive Team following approval at the Trust EPRR group to ensure wider executive oversight. Regular updates on EPRR activities and issues are now included on a monthly basis in the Chief Operating Officer's monthly Operational Update report.

The ICB will formally review progress against the improvement plan on a quarterly frequency and the Chief Operating Officer will keep both the Executive Team and Finance and Performance Committee updated on the progress against the action plan.

The Trust is also required to publish its statement of compliance reported in the organisation's annual report.

4.0 Conclusion

Despite the non-compliant EPRR Core Standards rating going into the next review period, the Trust is compliant in fulfilling its statutory duties as a category 1 responder as stated in the Civil Contingencies Act 2004.

The Board of Directors are asked to note our submission, including the scoring, overall level of compliance and action plan.

Sally Kilgariff
Chief Operating Officer
December 2023

Version Control
1.3 13/06/23 -

Please choose your organisation type

Domain	Total Applicable Standards	Fully Compliant	Partially Compliant	Non Compliant	Not Applicable
Governance	6	3	3	0	0
Duty to risk assess	2	1	1	0	0
Duty to maintain plans	11	1	9	1	0
Command and control	2	1	1	0	0
Training and exercising	4	0	4	0	0
Response	7	6	1	0	0
Warning and informing	4	0	4	0	0
Cooperation	4	1	3	0	3
Business continuity	10	6	4	0	1
Hazmat/CBRN	12	3	9	0	7
Total	**62**	**22**	**39**	**1**	**11**

Deep Dive	Total Applicable Standards	Fully Compliant	Partially Compliant	Non Compliant	Not Applicable
EPRR Training	10	6	3	1	0
Total	**10**	**6**	**3**	**1**	**0**

Interoperable Capabilities for NHS Ambulance Service Providers only

Interoperable Capabilities	Total Applicable Standards	Fully Compliant	Partially Compliant	Non Compliant
HART Capability	3			
HART Human Resources	8			
HART Administration	10			
HART Response time standards	4			
HART Logisitics	7			
SORT Capability	4			
SORT Human Resources	10			
SORT Administration	13			
SORT Response Times	14			
MassCas Capability	7			
MassCas Equipment	7			
Gen C2	4			
Resource C2	6			
Decision Making C2	3			
Recording Keeping C2	3			
C2 Learning Lessons	1			
Competence C2	19			
JESIP	13			
Total	**136**	**0**	**0**	**0**

Percentage Compliance	**35%**
Overall Assessment	**Non-Compliant**

Assurance Rating Thresholds
- Fully Compliant = 100%
- Substantially Compliant =99-89%
- Partially Compliant = 88-77%
- Non-Compliant = 76% or less

Calculated using the number of FULLY COMPLIANT EPRR Core Standards.

Notes
- Please do not delete rows or columns from any sheet as this will stop the calculations
- Please ensure you have the correct Organisation Type selected
- The Overall Assessment excludes the Deep Dive questions
- Please do not copy and paste into the Self Assessment Column (*Column T*)
- The Action Plan copies all 'Partially Compliant' and 'Non Compliant' standards

TRFT EPRR Core Standard Compliance and Action Plan 2023-2024

Ref	Domain	Standard Name	Standard Detail	TRFT	Action to be taken	Lead	Timescale
1	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.				
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.				
3	Governance	EPRR board reports	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements		To provide 6 monthly reports to Trust Board and to state its readiness in annual reports	EPRR Team	Sep-24
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.		To develop and publish an annual EPRR work programme. Reflecting current guidance, good practice, lessons identified, identified risks and outcomes of any assurance and audit processes. Documented within EPRR policy	EPRR Team	31/01/2024
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.		Review further Resource requirements and requirement to sign off EPRR documents at board	EPRR Team	Sep-24
6	Governance	Continuous improvement	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.				
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.		Schedule regular review and updates of relevant EPRR Risks held on Trusts Risk Register into the work programme inline with review of EPRR risk register.	EPRR Team	Sep-24
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally				
9	Duty to maintain plans	Collaborative planning	Plans and arrangements have been developed in collaboration with relevant stakeholders stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.		To document the existing consultation and collaboration processes in place with stakeholders in the development of emergency plans	EPRR Team	Sep-24

10	**Duty to maintain plans**	**Incident Response**	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.		To review the Major incident plan particularly the response to burns specific incidents	EPRR Team	Feb-24
11	**Duty to maintain plans**	**Adverse Weather**	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.		Combine the current Heatwave and Sever Adverse Weather Plans to align with the National plan	EPRR Team	Sep-24
12	**Duty to maintain plans**	**Infectious disease**	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.		Review response, training and exercising and recover arrangements associated with an infectious disease	IPC Team	Sep-24
13	**Duty to maintain plans**	**New and emerging pandemics**	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic		Review the Trust plan with reference to national pandemic influenza guidance and lessons learned from Covid 19	IPC Team	Sep-24
14	**Duty to maintain plans**	**Countermeasures**	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment		Review current arrangements to support the response to an incident requiring counter measures or a mass counter measure deployment. To include testing and exercising associated with the plan both internally and externally, documented on the EPRR work programme.	IPC Team	Sep-24
15	**Duty to maintain plans**	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.		To review the Major incident plan particularly the response to burns specific incidents and review arrangements for creating capacity in both G&A and Critical Care beds	EPRR Team	Feb-24
16	**Duty to maintain plans**	**Evacuation and shelter**	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.		Finalise draft plan Procure SMART triage Packs Develop and implement training and exercise programme.	Craig Patchett	Sep-24
17	**Duty to maintain plans**	**Lockdown**	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.		To include testing of plan in work programme. Maintain attendance records for the training.	EPRR Team	Apr-24
18	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.				
19	**Duty to maintain plans**	**Excess fatalities**	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.		To review Trust mass fatality planning arrangements aligned to the Major Incident response and Mass Fatalities planning national guidance.	EPRR Team	Sep-24
20	**Command and control**	**On-call mechanism**	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.				
21	**Command and control**	**Trained on-call staff**	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions		Develop training and delivery plan to ensure on call managers receive training aligned to the national occupational standards, evidenced in portfolios	EPRR Team	
22	**Training and exercising**	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.		-Develop the accessibility of EPRR courses availability on ESR. -Develop and implement PDP's in collaboration with ICB colleagues	EPRR Team	Sep-24

23	**Training and exercising**	**EPRR exercising and testing programme**	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)		Training & Exercising to be included into the EPRR work programme. Provide Training and Exercising details within board reports.	EPRR Team	Sep-24
24	**Training and exercising**	**Responder training**	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role		Develop training and delivery plan to ensure on call managers receive training aligned to the national occupational standards, evidenced in portfolios		
25	**Training and exercising**	**Staff Awareness & Training**	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.		Develop and implement communications plan to promote EPRR training across the Trust. Provide staff EPRR training data (by division to board) utilising ESR.	EPRR Team	Sep-24
26	**Response**	**Incident Co-ordination Centre (ICC)**	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.				
27	**Response**	**Access to planning arrangements**	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.				
28	**Response**	**Management of business continuity incidents**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).				
29	**Response**	**Decision Logging**	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker		Schedule 1/4 exercises (In and OOH's) to assess loggist availability.	EPRR Team	Mar-24
30	**Response**	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.				

31	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.				
32	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)				
33	Warning and informing	Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.		Review the requirement for on call arrangements within the Communications team. Review the training needs for on call colleagues, develop and deliver	Damian Staples	29/09/2024
34	Warning and informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.		To develop a incident communications plan with inclusion to the EPRR/Training and Exercising programme	EPRR Team	Sep-24
35	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.		Develop a communications plan. Deliver training to on call colleagues	Damian Staples	Sep-24
36	Warning and informing	Media strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media		To develop a incident communications plan with inclusion to the EPRR/Training and Exercising programme	EPRR Team	Sep-24
37	Cooperation	LHRP Engagement	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.		The AEO or Director Level representative to attend 75% of LHRP meetings.	EPRR Team	Sep-24
38	Cooperation	LRF / BRF Engagement	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.				
39	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.		Develop a specific EPRR mutual aid process to be included in the Major Incident plan	EPRR Team	Sep-24
43	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.		Develop a Trust specific information sharing agreement to complement the LRF ISA already in place.	EPRR Team	29/09/2024

44	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.				
45	Business Continuity	Business Continuity Management Systems (BCMS) scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.				
46	Business Continuity	Business Impact Analysis/Assess	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).		Review Trust wide BIA against recently published NHS BC toolkit	EPRR Team	Sep-24
47	Business Continuity	Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure				
48	Business Continuity	Testing and Exercising	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.				
49	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.				
50	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.		KPI's to be monitored quarterly and annually and reported to board.	EPRR Team	Sep-24
51	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.				.
52	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.		To develop and implement a robust process to assess the effectiveness of the BCMS identifying corrective action to continue improvement. To be monitored quarterly and annually and reported to board.	EPRR Team	Sep-24
53	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.		Develop & implement a robust process, assessing the effectiveness of BC arrangements of commissioned providers and suppliers.	EPRR Team	Sep-24

55	**Hazmat/CBRN**	**Governance**	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented		Review Trust governance arrangements associated with CBRN/ Hazmat planning. Incorporating relevant updates into the EPRR policy	EPRR Team	Sep-24
56	**Hazmat/CBRN**	**Hazmat/CBRN risk**	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type		To document relevant Hazmat/CBRN risks. Reporting through CBRN/Hazmat governance arrangements	EPRR Team	Sep-24
57	**Hazmat/CBRN**	**Specialist advice for Hazmat/CBRN exposure**	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents				
58	**Hazmat/CBRN**	**Hazmat/CBRN planning arrangements**	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangments, and which are supported by a programme of regular training and exercising within the organaisation and in conjunction with external stakeholders				
59	**Hazmat/CBRN**	**Decontamination capability availability 24 /7**	The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s) The organisations also has plans, training and resources in place to enable the commencement of interim dry/wet, and improvised decontamination where necessary.		To review and clarify arrangements to meet the requirements to decontaminate a minimum of 4 pt's per hour. Dip sampling of rota's to be scheduled in 1/4 into the EPRR Work programme	EPRR Team	Sep-24
60	**Hazmat/CBRN**	**Equipment and supplies**	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf		To update current equipment checklists to us the NHS England standard checklist going forward. Document process through CBRN/Hazmat Governance arrangements	EPRR Team	Sep-24

61	**Hazmat/CBRN**	**Equipment - Preventative Programme of Maintenance**	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident, where applicable. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for completing these checks		To review and develop existing CBRN/Hazmat Arrangements and documented in CBRN/ Hazmat governance arrangements.	EPRR Team	Sep-24
62	**Hazmat/CBRN**	**Waste disposal arrangements**	The organisation has clearly defined waste management processes within their Hazmat/CBRN plans				
63	**Hazmat/CBRN**	**Hazmat/CBRN training resource**	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments		To document minimum CBRN/Hazmat training standards & instructor capacity. Develop and review a CBRN/HAZMAT TNA. Refresh CBRN/Hazmat instructor Training records.	EPRR Team	Sep-24
64	**Hazmat/CBRN**	**Staff training - recognition and decontaminatio n**	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented		The Trust CBRN/Hazmat risk assessment will include potentially contaminated pt's presenting at locations other than ED and identify proportionate staff training delivered to ensure preparedness,	EPRR Team	Sep-24
65	**Hazmat/CBRN**	**PPE Access**	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS availbile for immediate deployment to safetly undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7		All current and new CBRN/Hazmat trained staff to have FFP 3 Fit testing and annual refreshers.		
66	**Hazmat/CBRN**	**Exercising**	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme		CBRN/Hazmat training & exercising to be incorporated in EPRR work programme.	EPRR Team	Sep-24

North East & Yorkshire Emergency Preparedness, Resilience and Response (EPRR) assurance 2023-2024

STATEMENT OF COMPLIANCE

The Rotherham NHS Foundation Trust has undertaken a self-assessment again st required areas of the EPRR Core standards self-assessment tool v1.0

Where areas require further action, Sally Kilgariff, Chief Operating Officer / AEO will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Non-compliant (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board/governing body along with the enclosed action plan and governance deep dive responses.

Signed by the organisation's Accountable Emergency Officer

10.11.23

Date of Board/governing body meeting	Date presented at Public Board	Date published in organisations Annual Report

NHS England EPRR Core Standards Overview for Boards

Applicable to – NHS organisations in the North East & Yorkshire and North West regions

Content – Overview of changes to the NHS England EPRR Core Standards assurance process in the North East & Yorkshire and North West for the 2023/24 assurance cycle

Version – 1.0 FINAL

Contact – england.eprrney@nhs.net or england.eprrnw@nhs.net

Publication reference: NEY&NWEPRRAssurance2023

The rationale for change

Over recent years the Emergency Preparedness Resilience & Response (EPRR) world has seen both significant disruption and major change – from our exit from the European Union to the COVID-19 pandemic, Manchester Arena attack, and the recent series of industrial action. The demands on Accountable Emergency Officers, EPRR professionals and Boards in ensuring robust, resilient systems for patients and communities, has never been greater.

In the wake of lessons identified from recent incidents and a number of public inquiries (Manchester Arena, Grenfell & the ongoing COVID-19 inquiry – as well as the recent verdict in the Letby trial and the announcement of the Thirlwall Inquiry), it is clear that the standard which organisations must achieve, and the burden of proof in regard to robust governance, proactive planning and tried & tested plans is one which requires a dedicated assurance framework which can ensure our collective system resilience

The 2023/24 EPRR Assurance model

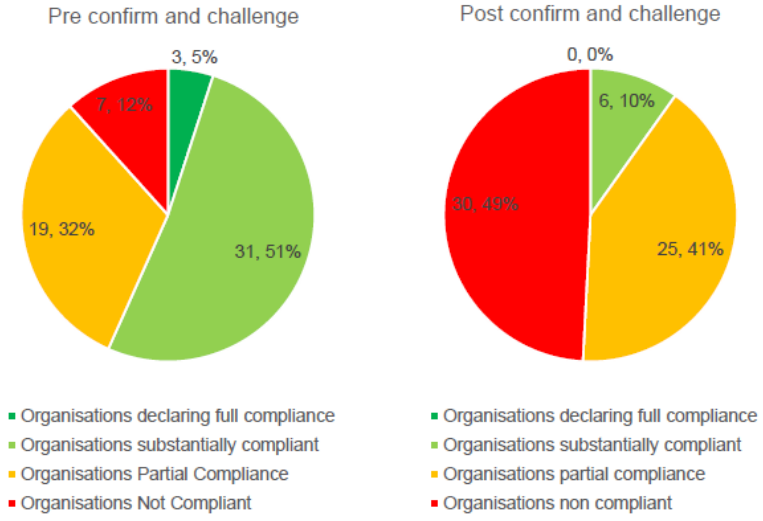
In 2022, colleagues in the Midlands Region undertook an amended EPRR assurance process. This pilot, involved a new and detailed analysis of compliance evidence against each core standard, alongside the organisations self-assessment.

This model required providers of NHS commissioned care to submit evidence, which went through a formal review and subsequent check and challenge, whereby they were given the opportunity to submit supplementary evidence against any challenges before finalising their assurance position.

The Midlands results, as detailed in the diagrams below, clearly demonstrated that despite the efforts of organisations in delivering their EPRR responsibilities, there were substantial differences between the self-assessment results and the evidential review of the organisations documentation.

NHS England Midlands

Levels pre and post confirm and challenge



The position before and after the confirm and challenge shows the value in this step of the process in assuring the wider NHS of the positions being self reported.

NHS England recognises several organisations were already very open with the positions they had with 5 organisations not moving in position.

The highlighting of issues assists the whole of the system manage and improve.

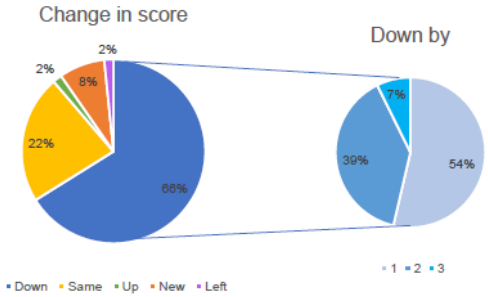
The maximum of accepted challenges to an organisational assessment was 30 standards.

OFFICIAL – SENSITIVE

Change from 2021/22

Breaking down the change into positive or reduced positions.

- 8% of organisations had a first assessment
- 2% increased in position
- 22% remained in the same assessment position
- 66% decreased on the previous assessment, of these:
  - 7% dropped three compliance levels (full to non compliance)
  - 39% dropped two compliance levels (full to partial or Sub to non)
  - 54% dropped one compliance level (Full to Sub, Sub to partial or Partial to Non)



The changes in assurance levels indicated that there were areas of collective and individual action which would improve resilience at both an organisational and system level for patients and communities. This enabled Midlands colleagues to identify areas for collaborative working in delivering key actions associated with their resilience.

Implementation of the same model within the North East & Yorkshire and North West regions was agreed with the intention to undertake an open, honest and transparent, review of evidence associated with the core standards in order to assess evidential compliance with the objective of improving our collective resilience for patients and communities.

NHS England worked with ICB colleagues through the summer to provide guidance and clarity on the assessment requirements and highlighted that it was likely we may see the same compliance shift that Midlands colleagues had seen in 2022.

Introducing this model in the regions was about establishing a baseline compliance level – a hard reset of our readiness following protracted periods of response and in order to identify greater opportunities for collaboration and system improvement.

The way forward

Following completion of the evidence reviews, provider organisations will undertake a check & challenge via their Local Health Resilience Partnership (LHRP), this will give an opportunity for peer discussion and for ICBs to seek assurance ahead of their own system level check & challenge via the Regional Health Resilience Partnership (RHRP).

Organisations will be required to participate in ongoing assurance against their action plans, this will follow pre-existing arrangements that are well established across both regions –

- **Fully compliant** – formal updates annually, with any changes or reduction in compliance reported 6 monthly.
- **Substantially compliant** – formal updates against action plans every 6 months.
- **Partially compliant** – formal updates against action plan every 3 months.
- **Non-compliant** - formal updates against action plan every 3 months, and monthly progress discussions to take place between the provider and their lead ICB.

The intention of the revised process is absolutely intended to be constructive, and to allow organisations to reflect on the robustness of the plans they have in place, what more they could or should be doing to improve their resilience, and to demonstrate that position to their Boards.

The collective focus over the coming months, will be to identify common themes and the NHS England EPRR teams will continue to proactively support opportunities to collaboratively address areas for improvement in order to enhance system preparedness, patient outcomes, and opportunities to share best and notable practice. This will deliver greater resilience at provider level, for place based systems and across the regions, with greater interoperability and opportunities to undertake collective planning.

It is recognised that the change in process has come at a very difficult time for EPRR professionals across organisations given the competing pressures, and that Boards may be concerned by the reduction in compliance ratings. However, it is important to note that this does not signal a material change or deterioration in preparedness but should be considered as a revised and more rigorous baseline in which to improve plans for preparedness, response and recovery.

Following completion of this years process, it is important to take time to come together and reflect on the lessons identified through this process. This will enable opportunities to collectively provide greater guidance to colleagues where questions have been raised (e.g. annual review of plans and policies), ensure that areas which have worked well in this process are embedded in future years, and to identify improvements in the assurance process ahead of next year’s assurance cycle.

Board of Directors' Meeting
12 January 2024

The Rotherham NHS Foundation Trust

Agenda item	P19/24
Report	**Safeguarding & Vulnerabilities Team Annual Report**
Executive Lead	Helen Dobson, Chief Nurse
Link with the BAF	P1: There is a risk that we will not embed quality care within the 5 year plan because of lack of resource, capacity and capability leading to poor clinical outcomes and patient experience for our patients.
How does this paper support Trust Values	This paper supports the Trust in being ambitious to continually improve the quality of safeguarding practice through the delivery of robust safeguarding arrangements. At the core of safeguarding activity, is the importance of giving the best possible care for patients, with safeguarding embedded within all care. The safeguarding team provide care and support to staff who can be exposed to difficult situations. For safeguarding to be impactful and successful requires partnership working together, and this report highlights the strength of the Rotherham Safeguarding partnerships.
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	The Annual Report provides a summary of the safeguarding activity undertaken across the Trust, and wider Safeguarding Partnerships during this annual period of 2022-23. This report provides assurance that all statutory duties have been undertaken in accordance with legislation, including all NHS England priority safeguarding issues; • Modern Day Slavery • PREVENT (counter terrorism) • Child Exploitation • Female Genital Mutilation (FGM) • Deprivation of Liberty Safeguards (DOL's) and Mental Capacity Act (MCA) • Domestic Abuse • Looked After Children
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	Presented to Safeguarding Committee 18th October 2023 Presented to Quality Committee on 30th August 2023
Board powers to make this decision	NHSE safeguarding assurance The Children Act 1889 & 2004 section 11 compliance The Care Act (2014) compliance

Who, What and When (what action is required, who is the lead and when should it be completed?)	No actions required
Recommendations	It is recommended that: Board of Directors' accept this paper as providing assurance that TRFT are appropriately discharging their safeguarding duties in line with legislative and contractual obligations.
Appendices	Safeguarding Annual Report 2022-23

Safeguarding & Vulnerabilities Team

Annual Report

2022 / 2023

CONTENTS

INTRODUCTION & OVERVIEW

As we move into 2023/2024, the Safeguarding & Vulnerabilities Annual Report provides an opportunity to reflect on our achievements in 2022/2023 and where we need to focus our efforts in the year ahead. Despite the impact of Covid-19 and the challenges faced over the last twelve months this report offers assurance that there has been no disruption to safeguarding provision and service provision across the Trust.

The Rotherham NHS Foundation Trust (TRFT) recognises that one of the most important principles of safeguarding is that it is 'everyone's business'. Safeguarding children, young people and adults at risk cannot be done in isolation. It is only truly effective when we work collaboratively and restoratively with our partner agencies to 'Think Family' and protect all those at risk of harm, abuse or neglect.

This Trust-wide approach continues to be embedded across all of our services, whilst focusing on developing evidence-based approaches to safeguarding practice that balances the rights and choices of an individual with the Trust duties to act in their best interest to protect the patient, the public and the organisation from harm. This means that our service is patient-centred, fair, collaborative and accountable and is in accordance with the Trust's vision, to be an outstanding Trust, delivering excellent care at home, in our community and in hospital, and the Trust's mission to improve the health and wellbeing of the population we serve, building a healthier future together.

The Safeguarding & Vulnerabilities Team wishes to thank all our dedicated staff, Divisional Leads, the Executive Team, Trust Board and our partners who continue to work so positively with us to make TRFT a safer place to work, and Rotherham a safer place to live.

This Annual Report seeks to inform the Trust Board of the safeguarding activity within TRFT during the period 2022/2023. Additionally, the report aims to:

- Provide assurance to the Trust Board that the Trust is fulfilling its statutory obligations
- Assure service commissioners and regulatory bodies that the Trust's activity over the year has developed in terms of preventing abuse and reducing harm to vulnerable service users
- To inform the Board and wider Trust staff of the activities and function of the Safeguarding & Vulnerabilities Team, and of the progress with the Safeguarding work plan, which enables the TRFT Strategy for Safeguarding

Vulnerable Services Users (Appendix 1) to be fully realised and embedded within the organisation.

The report incorporates Adult and Children Safeguarding, the Learning Disability Service and the Looked After Children service. The Named Professional from each specialist area has inputted to the content. The Integrated Safeguarding & Vulnerabilities Team is managed by the Head of Safeguarding with executive leadership of the Chief Nurse and Deputy Chief Nurse (Refer to Appendix 3 - Management and Professional Leadership Chart). The governance and assurance arrangements within Safeguarding remain robust and are outlined within Appendix 4 (TRFT and Partnership Organisational Governance Structure).

The recovery from Covid 19 has continued, with the gradual resumption of face-to-face training being delivered and progression of the Improvement Plan, which sought to address the issues highlighted by CQC and move beyond this to aim for excellence in safeguarding. As we continue into recovery, we have seen an increase in the reporting of hidden harms across both adult and children's safeguarding, including neglect, self-harm and exploitation.

This Annual Report will identify and describe the key risks that were managed during the year and provides a summary of some the key activities undertaken in the reporting period. In addition, it describes the key priorities and areas identified for improvement in relation to safeguarding activity for implementation during 2023/2024.

The Report provides an overview of activities over the last 12 months in relation to:

Adult Safeguarding Activity

Learning Disability Service

Child Death Review

Children Safeguarding Activity

Looked after Children

Governance

Risks and Mitigations

Partnership Working

Jean Summerfield, Head of Safeguarding

Safeguarding & Vulnerabilities Team

Lynda Briggs, LAC Lead

Elaine Jeffers, Deputy Director of Governance & Quality Improvement

ADULT SAFEGUARDING ACTIVITY

A blended approach to training delivery was in place during 22/23 with the offering of internal face-to-face training, e-learning and external taught sessions with Rotherham Metropolitan Borough Council (RMBC).

Bespoke training sessions have been delivered throughout the Trust with the Safeguarding Champions, ward staff and community teams to ensure that key messages are delivered in a useful way to support implementation of improvements.

Adult Safeguarding Training Compliance – Figures at 31/03/2023

Adult Safeguarding Training	Percentage Achieved 2022/2023	Percentage Achieved 2021/2022	Percentage Achieved 2020/2021
Level 1	95%	91%	100%
Level 2	94%	88%	82.42%
Level 3	100%	100%	100%
Level 4	100%	100%	100%
Prevent L 1 & 2	94%	94%	91.13%
Prevent L 3	94%	94%	89.72%
MH L1	92%	94%	98%
MH L3	92%	53%	26.09%

Mental Health Act training is provided in partnership with Rotherham, Doncaster & South Humber NHS Foundation Trust (RDaSH).

A robust training programme is in place for Prevent; This is included in the Trust Induction programme. Training arrangements for this are regularly updated, in line with Government guidance. The Trust provides a return to the National Prevent Data Set quarterly to demonstrate compliance with the national requirements.

The allocation of staff training requirements is regularly reviewed, in line with the safeguarding adults Intercollegiate document. This is done in partnership with Learning & Development department to ensure that TRFT staff Mandatory & Statutory Training (MaST) requirements appropriately reflect their roles and give staff the appropriate knowledge, skills and competence to fulfil them.

Training compliance is monitored via Safeguarding Key Performance Indicators and the Safeguarding Standards set by the Clinical Commissioning Group (CCG), now the Integrated Care Board (ICB). These are reviewed at the monthly Operational Safeguarding Group which reports to the Safeguarding Committee, held quarterly and chaired by the Chief Nurse.

2022/2023 saw an increase in patients admitted both with, and due to, poor mental health. TRFT have continued to work in partnership with RDaSH to ensure that, for this group of patients, there is parity of esteem between their mental and physical health needs. This reflects the national picture and may be linked to the aftermath of Covid 19.

The Safeguarding Team are members of the Mental Health Steering Group, which continues to work to develop and implement an action plan to underpin the Mental Health Strategy.

KEY PERFORMANCE INDICATORS (KPI) & STANDARDS

Adult Safeguarding is required to satisfy the requirements of KPIs and Safeguarding Standards, as set by the ICB. These include offering assurance on a diverse range of safeguarding activity throughout the Trust.

Both the Safeguarding Standards and the Key Performance Indicators are reported quarterly to the Trust Safeguarding Committee and Partners. Membership includes representation from the ICB, RMBC, Rotherham Safeguarding Children Partnership (RSCP) and Rotherham Safeguarding Adult Board (RSAB). This demonstrates TRFT's commitment to partnership working.

With additional assurance provided regarding two of the standards, agreement was given at the April 2023 Safeguarding Committee that there was sufficient evidence to judge these as achieved. This meant that all standards were achieved in 22/23.

A new means of providing evidence against the standards set has been agreed in partnership with the ICB. This will be completed annually and will be overseen by the Operational Safeguarding Group and the Safeguarding Committee.

An exception report is included at Appendix 5.

SAFEGUARDING ADULTS REVIEWS (SAR)

Three Rotherham SARs were agreed in 22/23. As two of the cases present similar themes, these will be managed as a joint investigation. Authors have been appointed and will take these cases forward. All learning from reviews is shared appropriately across the Trust, either by being incorporated into training or by the use of 7-minute briefings.

DOMESTIC HOMICIDE REVIEWS (DHR)

The statutory requirement related to domestic homicide reviews came into force in April 2011. The purpose of a DHR is to establish what lessons can be learned from the circumstances of the death and the way in which local professionals and organisations worked individually and together to safeguard victims (the victims also include bereaved children, parents and other kin). The focus is a multiagency approach with the purpose of identifying learning.

There were no new DHRs in the reporting period. The Sheffield case from 2021/2022 is now reaching its conclusion, with no recommendations for TRFT. The Trust is represented at the Domestic & Sexual Abuse Priority Group by the Head of Safeguarding.

PARTNERSHIP WORKING – ADULT SAFEGUARDING

The Trust is represented at the RSAB by the Chief Nurse. Her deputy is the Head of Safeguarding.

There is representation at all four sub-groups of the Board to ensure that TRFT has a voice in shaping adult safeguarding arrangements across Rotherham.

The Adult Safeguarding Team continues to work in partnership with RMBC to provide 'health' input for safeguarding investigations. This involves offering support to RMBC colleagues around investigations, Decision Making Meetings and preparations for Outcomes Meetings (OM), even where there is no TRFT involvement. This represents the Trust's continued commitment to partnership working.

As per RSAB Procedures, the Trust receives concerns raised about the safety and well-being of adults at risk (of neglect or abuse). For 2022/2023, 626 were received, equating to

approximately 52 per month. This represents a 12% decrease on figures for 21/22 (711).

RMBC have reviewed their arrangements for referring adult safeguarding concerns. The initial phase of this is completed and has caused no impact on TRFT arrangements. Going forward, TRFT will be included in further development work, ensuring that Rotherham arrangements fully capture all adult safeguarding concerns and can demonstrate compliance with the Care Act 2014.

In 2022/2023 no safeguarding concerns involving Trust services required progression to an OM. This means that these concerns were managed and resolved in the initial concern stage.

The Adult Safeguarding team produce a monthly newsletter to inform staff of any new developments in practice within adult safeguarding. This has been well received.

The Trust is represented at the Rotherham Multi-Agency Risk Assessment (MARAC) meetings. The HARK (Harassment, attack, rape, kick) form is now established in Urgent & Emergency Care Centre (UECC) and has been positively received. This was a specific measure taken to abbreviate the form which has resulted in better reporting within UECC. It is supported by a 60-second briefing. The use of this form is being reviewed to ensure staff are supported to provide reliable information which will enable our partner agencies to protect victims of domestic abuse. Further development has taken place to design and agree a template on the Electronic Patient Record.

A recent change to the Domestic Abuse Act 2022 introduced new offences related to non-fatal strangulation and non-fatal suffocation. The safeguarding team have developed and initiated a programme of awareness raising for those clinical areas likely to see such patients, for example UECC.

A young adult woman attended due to significant facial injuries. She declined to disclose to staff who had caused the injuries and maintained she had fallen.

UECC staff and ward staff worked sensitively with the woman to provide access to external domestic abuse support and to gain consent to involve RMBC children's services to ensure the impact on the children could be considered fully.

This was an excellent example of 'Think Family' in practice, demonstrating consideration of the presenting concerns and the wider issues involved.

TRFT staff were praised for their vigilance and professional curiosity, and the case shared across the Trust to promote learning from good practice.

The ALT had significant contact with a 33-year-old known through repeated ED attendances. This patient accepted support from ALT with a plan to support him back to work. His alcohol use had increased due to significant life stressors. ALT were aware of this patient's vulnerability, of his sudden drop in phone contact/engagement, and the increase of significant concerns from his family. As SYP declined to conduct a visit for social reasons 2 outreach staff visited and had to call 999 and Fire Brigade to gain entry. The patient was found unrousable on initial presentation, in severely neglectful conditions which had resulted in pressure damage. He was taken to UECC by ambulance, and while there had a joint assessment with RDaSH Mental Health Liaison and ALT. On discharge he was supported in the community and now has an employment review April 23.

The next stage of this will be to work with partners to agree pathways of managing such cases safely.

The adult safeguarding team works closely with specialist teams across the Trust to provide support and advice to staff, not only for acute safeguarding issues, but also related to the wider safeguarding agenda. The Alcohol Liaison Team (ALT) work in partnership with safeguarding to support patients and provide

both reactive and proactive care which takes into account the patient group's particular needs and vulnerabilities. This wider consideration of safeguarding extends across all departments, including HR, the Patient Experience team and Sexual Health Services.

The management of patients who lack capacity to consent to care and treatment in the community and within the hospital continues to be a priority for TRFT. Work continues to embed improvements made regarding the implementation of the Mental Capacity Act (MCA).

Following the decrease noted in last year's report, in 22/23 Deprivation of Liberty Safeguards (DoLS) requests increased to 457, a 7% increase. Of the DoLS requests, only three were authorised by RMBC.

The Adult Safeguarding Team continue to provide leadership and support to ensure the processes are embedded fully across the Trust.

The MCA was reviewed and amended (MCA(A) 2019). In preparation for the implementation of this, which included the new process of Liberty Protection Safeguards (LPS) to replace the current DoLS arrangements, a business case was presented. This was partially approved and TRFT has successfully recruited to a 0.5 WTE Band 8A MCA Lead Nurse post, which will lead on the continued improvements and will add resource to the adult safeguarding team.

An announcement made in late March 2023 from the Department of Health & Social Care indicated that the expected change from DoLS to LPS has been delayed, at least until after the life of the current parliament. In the meantime, TRFT will continue to work to embed and improve the implementation of the MCA & DoLS across the Trust.

LEARNING DISABILITY & AUTISM SERVICE (LD/A)

The Learning Disability and Autism (LD/A) service at TRFT continues to grow and strives to deliver excellent standards of care for people with LD/A. As a Trust we have a Strategy for people with LD/A (Appendix 2). Within the Team we now have one Nursing Associate and one Assistant Practitioner, who both specialise in LD/A.

The work streams of the team include;

- Inpatients
- Outpatients
- UECC
- Maternity
- Transitions
- Planned surgery pathways
- Reducing readmissions to hospital in the community.

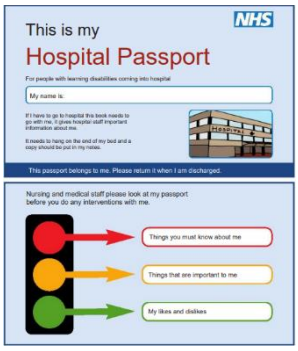
The skill mix within the team allows us to visit, review and assist more people who are using the Trust services, in turn, improving the standard of care they receive and improving the experience for them. The team works in partnership with general medical, nursing and therapy staff to ensure we are understanding the needs of our patients and achieve the optimum physical health outcome for that individual. On average we have 8 -10 inpatient admissions per week. Our patient group is one of the most complex within the Trust and on average this patient group can stay 4-7 days longer for a health admission compared to someone without a learning disability or autism.

The Team, and Trust, have continued to develop bespoke pathways, making individual 'reasonable adjustments' for people coming into the Trust. These are especially successful with patients coming through our day surgery pathways, with patients and their teams/families giving excellent feedback. These bespoke pathways help to reduce health inequalities for people with both learning disabilities and autism, as without the much-needed reasonable adjustments we provide, they would not be able to tolerate coming to hospital in the majority of cases. The planning for coming through our specialist surgical pathways is a multi-disciplinary team (MDT) model of support and can sometimes take many weeks. We can on average have around 2-3 bespoke admissions per week.

The support that our team gives during outpatient appointments (OP), can vary depending upon the needs of the person. In some cases, people are physically unable to attend the hospital for the appointment, so the LD/A practitioner will act as an informal advocate by providing information in an accessible format and collecting the necessary information for the OP staff.

The Team also visits people who have been discharged from hospital, to plan, prevent or minimise repeat admissions to hospitals, working with our colleagues in the community, e.g. General Practitioners, Community Matron services and RDaSH specialists. The Matron for LD/A is an Independent Nurse prescriber which also helps to minimise readmission and aids a more robust community plan for this patient group.

In addition to our established flagging system for people with LD/A, we have successfully implemented a flagging system for patients with autism, to ensure they have the necessary reasonable adjustments to their care pathway. The flagging also champions the use of the Hospital Passport. This gives a holistic overview of the person's needs.



To support the use of the Hospital Passport, we are currently implementing a traffic light magnet system which will be placed at the back of the patient headboard for a patient with a learning disability and also on the main patient board in the nursing office. This will identify to our general colleagues that the individual has a LD and that they should read the patient's hospital passport.

The LD/A Team are supporting our UECC to gain autism accreditation. This scheme is through the National Autistic Society and will help to raise the standard of care and the experience we give to patients and visitors with autism. All of the autism awareness training that will be associated with this programme will be delivered by 'experts with experience'. This is also a project we aim to extend through all wards and departments. We are also supporting our UECC colleagues by creating a low stimulus room for people with learning disabilities, autism and other complex presentations who would benefit from a low stimulus environment.

Within our UECC department and across all wards and departments we have sensory boxes which can be accessed. Within the boxes there are pieces of light therapy equipment, which can help to lower the raised anxiety that some individuals may feel when they come to hospital. We also have some larger pieces of sensory equipment in both adult and paediatric UECC, which some patients find really useful in lowering their levels of anxiety in what can be an overstimulating environment.

The Trust continues to progress how we develop from feedback given to us from our patients, families and carers. There is representation on our LD/A sub-group from the parent of an individual with neuro-

diverse needs and autism. We continue to develop and welcome new members to this group. It is vital that patient experience directly shapes and improves the services within the Trust. This group feeds directly into the Trust Patient Experience Group.

Around the Trust, the LD/A team have also increased the amount of information boards there are in relation to LD/A. These act as a visual reminder to staff and visitors to the Trust regarding the LD/A team and give information about the hospital passport, how to contact the team, and how we can give help and support. In addition to this, the team has created a staff resource file around LD/A. These are a much-needed resource, particularly out of hours, to enable staff to have information for example, around communication tools. They have useful picture cards and information about the hospital passports for people with both a learning disability and autism.

As a Trust we annually complete the Learning Disability Standards for Acute Trusts. These include a self-assessment data collection around various health sections. These standards also include data around people with autism.

Our Team is involved with the LD Mortality Review programme (LeDeR). These are reviews of life and deaths of people with Learning Disabilities, and since April 2022 this includes the deaths of people with autism. This is a national reporting programme covered by NHSE, which forms part of the wider health inequalities agenda for this demographic of people. It is positive that the Trust can learn from the thematic data this produces and improve our services accordingly. This work is done in partnership across our newly formed ICB.

The LD/A team at TRFT continues to work in partnership with local organisations within the third sector. We work closely with Speak Up, service providers such as Voyage, Exemplar, Mencap. We also work closely with RDaSH and our Local Authority.

Planning and managing the complex transitions of individuals with LD/A who are transitioning from child to adult services is done in partnership with our ICB partners. This may include providing wider care planning to prevent unnecessary admissions to hospital or forming robust community support plans.

We also continue to work closely with our local ICB within the Dynamic Support Register programme work. This applies to both people with a learning disability and autism who may be at greater risk of reaching crisis. This programme gives a multidisciplinary team oversight and action plan for each individual.

H has a severe learning disability, uses non-verbal forms of communication and is fully reliant on those around him to assist him in all of his daily living activities. Concerns regarding his health meant he required bowel investigations.

H does not have mental capacity to consent to any care and treatment and has no insight into his own care needs. All investigations and treatment are needed to be carried out in his Best Interests, under the Mental Capacity Act 2005.

H was unable to tolerate the pre-operative assessment, so a dynamic assessment was completed. Every step of his journey into Trust was planned for using a holistic MDT approach. The Hospital Passport for people with an LD was used effectively, so allowing our general colleagues to gain an in-depth insight into H as an individual and his particular care needs.

It was agreed that Client H would only tolerate sedation prior to getting out of the car, following his journey from home. This required dynamic anaesthetic assessment on the day to maintain the safety of Client H.

Without this bespoke specialist pathway into the Trust, Client H would never have been able to access the care he required. Due to his high level of complexities, the standard admission pathways into the Trust would not have met his needs. This is a positive example reasonable adjustments being made.

This pathway for our complex patient group is a gold standard example of excellent practice, without which this vulnerable patient group's needs might not be met effectively.

The team continues offers bespoke training within the Trust around LD/A. This training offer also extends to our local universities, for both undergraduate adult nursing programmes, postgraduate nurse training and trainee nursing associate programmes. The team delivered training to Trust colleagues across the surgical pathway and paediatric areas, and facilitated the delivery of bespoke training from Speak Up, our local advocacy organisation in Rotherham for people with LD/A. The training was delivered by 'experts by experience'. As a Trust we are awaiting the implementation of the Oliver McGowan training, which will be mandatory training for all Health and Social Care professionals on LD/A.

Future plans for the service include the appointment a medical lead from the Trust for the LD/A service. Having expert medical oversight will be a hugely positive achievement for patient care at TRFT and will provide clinical guidance for the team.

There continues to be workforce development plans, in line with the wider workforce strategy for the Trust, to enable the team to give support to our complex patient group after standard working hours and over the weekend period.

CHILD DEATH REVIEW (CDR)

The death of a child is a devastating loss that profoundly affects bereaved parents as well as siblings, grandparents, extended family, friends and professionals who were involved in caring for the child in any capacity. As a Trust, we pride ourselves on delivering a high standard of care and support for bereaved parents and families. The role of the Keyworker has been fundamental for us achieving our aim of offering timely, appropriate and compassionate support to all bereaved parents. This role is integrated into the Paediatric Liaison Nurse role and has worked well, providing availability of the service as recommended in Child Death Review (CDR) Statutory Guidance 2018. In July 2022 we appointed a CDR Administrative Assistant 18.75/hrs week, a role previously hosted by the RSCP Child Death Overview Panel (CDOP) admin.

Review and analysis of all children who have died and resident in Rotherham.

In 2022/2023 Rotherham recorded 17 child deaths in total, 6 fewer deaths than the previous year and more in line with previous Rotherham averages for the year. There are currently 34 active cases progressing through the child death review process as Coronial inquests, specialist pathology reports, criminal investigation and changes to RSCP administrative arrangements delay the review process.

Number of Rotherham child deaths on a financial yearly basis from 2016

2022/23	2021/22	2020/21	2019/20	2018/19	2017/18	2016/17
17	23	11	13	22	20	15

Rotherham Child Deaths 1st April 22 – 31st March 23

Expected deaths	Q1	Q2	Q3	Q4	Unexpected deaths	Q1	Q2	Q3	Q4
Rotherham	0	4	2	0	Rotherham	3	0	1	2
Died out of area	1	1	1	0	Died out of area	0	0	2	0

Joint Agency Response (JAR)

The Trust has responsibility for coordinating and chairing JAR meetings. The meetings are held virtually and as a result continue to be well attended, with excellent engagement from health, police, social care and education; all meetings have been held within the required timescale. The JAR meeting frequently receives feedback from attendees highlighting the meeting has not only been beneficial in putting a multi-agency plan of support in place for bereaved families, but is also supportive and empathetic to professionals involved in care of the child/family.

Child Death Review Meeting (CDRM)

The Trust is responsible for coordinating and chairing CDRMs and gathering information from external Trusts where a child may have died. Not all external Trusts are as developed as our Trust in their CDR services and obtaining such information has, at times, been problematic, contributing to unnecessary delay in Rotherham cases being presented at Rotherham CDOP.

The Lead Nurse for CDR has worked to ensure pathways are now in place to gather such information and an escalation pathway is in place when information is not shared in a timely manner.

Case Presentation at Rotherham CDOP

For reasons beyond the Trust's control a backlog of cases for presentation at Rotherham CDOP has developed over the last year. The Trust has liaised with the partner agencies and worked extensively in partnership to address the issues identified. Exceptional CDOPs have taken place during 2023 to reduce the backlog, which will continue to be monitored through Rotherham CDOP.

TRFT achievements

Rotherham CDOP hosted its first on-line Learning Event in October 22. It was well attended and received positive feedback. The Trust was influential in agenda setting and liaising with external speakers from National Child Mortality Team, The Royal Society for the Prevention of Accidents and The Sudden Unexpected Deaths in Childhood charity.

The topics discussed were child deprivation, bereavement support following suicide, poverty and child death. All issues pertinent to our local area.

Coroner's Officers are now invited to all JAR meetings and meeting minutes of JAR and CDRM are shared with the Coroner in line with statutory guidance.

A pathologist has attended all Child Death Review meetings (CDRM) when a post-mortem has been performed. This has received positive feedback from pathology services and their contribution at the CDRM has been of value. The CDRMs for all child deaths have worked effectively in terms of attendance and participation.

The work of the keyworker has proved insightful into the worries, fears and issues parents hold onto following the unexpected death of their infant/child. The service continues to be available Monday–Friday, 9am – 4.30pm. The keyworker is the "voice of the parent" at all professional meetings. Standards are now in place for the keyworker role to ensure that there is consistency of delivery.

Direct contact and liaison with the National Child Mortality Database Programme has proved valuable in supporting the child death review service to remain compliant with CDR statutory guidance e.g., a grading system used to identify modifiable factors; reporting death occurring overseas.

As a result of learning from a specific child death and audit, there has been increased awareness of the CDR process in TRFT's UECC and maternity services, resulting in timely initiation of relevant processes.

An effective pathway has been developed for sharing learning from CDOP within TRFT and the wider partnership.

The Lead Nurse continues to offer bespoke training within the Trust about the CDR process and supports paediatric and obstetric medical induction days and the appointment of new Consultants in these fields.

Work has begun to clarify role of the medical examiner and impact of *"National Medical Examiners Good Practice Series: Medical examiners and child deaths"* (The Royal College of Pathologists, 2022), on the child death review process within the Trust.

Key professionals in the Trust CDR team are members of the Association of Child Death Review Professionals, keeping the Trust current and forward thinking in national child death policy, procedure and learning.

Challenges

The unpredictability and nature of working in child death places an exceptionally high level of stress on the key members of the team and highlights the need for access to quality clinical psychological support.

What are our plans for 2023-2024

Our plans for 23/24 include:

- The facilitation of an on-line CDOP Learning Event for multi-agency front line professionals working with children and families.
- Review of the pathway for children where death is expected and they are brought to Rotherham Hospital.
- To review and implement pathways so the Trust is complaint with *"National Medical Examiners Good Practice Series: Medical examiners and child deaths"* (The Royal College of Pathologists, 2022), with reference to non-coronial child deaths in the Trust and community.
- To continue to improve communication with, and understanding of, the Coroner's service. This will include identifying learning opportunities and supporting practitioners to improve knowledge and understanding of the Coroner's service.
- To participate in further thematic reviews with our regional partners.
- TRFT, as part of the CDOP will consider how we support and influence future strategies to reduce the harm of social deprivation.
- Lead Nurse CDR will continue to contribute to the TRFT self-assessment in relation to Bereavement Care Standards and identify actions for TRFT.

SAFEGUARDING CHILDREN ACTIVITY

Mandatory training remains a key priority. The delivery of 'Think Family' training continued across 22 - 23, with joint training for children's and adults' competencies, meaning staff can acquire competencies in level 2 (adults) and level 3 (children) at the same time, dependent on job role and requirements. This

face-to-face training has been particularly well-received by staff, with positive comments related to understanding of safeguarding and partnership working following the course. Overall, training compliance at levels 1, 2 and 3 has shown a positive, sustained improvement. All levels are now showing above 90% compliance.
The monitoring of training compliance continues via the Operational Safeguarding Group and the Safeguarding Committee. Assurance is provided to the Quality Committee from the data provided by Electronic Staff Record (ESR).

Safeguarding Children Training Compliance - Figures at 31/03/2023

Children Safeguarding Training	2022/2023	2021/2022	2020/2021
Level 1	94%	88%	76%
Level 2	91%	83%	84%
Level 3	92%	86%	84%
Level 4	100%	100%	80%

All TRFT E-learning packages and face to face training is compliant with intercollegiate guidance. As a Trust, we have continued to utilise a blended approach to learning with 'bespoke' opportunities including attendance at safeguarding meetings, face-to-face training, practitioner learning events, tailored feedback supervision sessions, incident review, 'stop the shift' presentations and Safeguarding Awareness Week.

Following a joint review of staff MaST competencies with the Learning and Development team, the use of 'Learning Logs' has been promoted. This recognises the many different ways of achieving competency over the three-year period and gives additional flexibility to staff to demonstrate their competence. The use of the 'Learning Log' is underpinned by the renewed training strategy.

During this annual report period there have been 254 initial Child Protection Case Conferences and 491 Review Child Protection Case Conferences that health staff have contributed to.

Legal statements were completed on 95 children by TRFT colleagues. The Safeguarding team have reviewed and updated the guideline for safeguarding legal statements and attendance at court. Further work is to be undertaken to refresh the bespoke training package, to support the staff with legal statements and quality-assuring skills

SAFEGUARDING CHILDREN DEVELOPMENTS

In 2022/2023 the key focus on the development and upskilling of the TRFT work force continued. Improved engagement from divisional leads supported the achievement of Trust-wide MaST compliance in excess of 90%.

A key achievement has been the agreement of standards for body-mapping in UECC. This was done in partnership with UECC staff and will greatly help support staff to practise safely when working with young children. Audit demonstrates that this process is now being embedded into routine practice.

The team continues to reinforce with paediatric and UECC medical and nursing staff the pathway for non-mobile children when they present with an injury to TRFT, in line with national guidance.

In addition to the Safeguarding Champions, the team have also provided training to support additional staff to become Safeguarding Children's Supervisors. This serves to complement the safeguarding supervision offer across the Trust and support compliance for staff working with children. This work and training will continue annually, due to the changing workforce.

The embedding of daily Safeguarding Children Huddles across the children's pathway was extended to include the fracture clinic, Special Care Baby Unit and community children's services. Huddles are proving to be effective in maintaining safeguarding as a priority. The huddles are also supporting staff to develop their confidence and competence in safeguarding.

Electronic safeguarding documentation has now been embedded within acute maternity areas, with progression to electronic safeguarding huddle templates from the paper version. Furthermore, maternity care records have been process-mapped to align the current community electronic offer to TRFT's Meditech system. The safeguarding team have been instrumental in considering the processes proposed to ensure all safeguarding elements have been considered.

Significant changes to the referral process to children's social care were implemented in May 2022, leading to a wide range of communications and training changes to reflect these. In addition to communications going out to ensure staff were aware of the changes, strategies such as 7-minute briefings, stop the shift sessions and updating of the relevant training packages were all instigated. The Hub page was updated so staff could easily access the information, and changes made to the documentation within the recording systems, MediTech and SystmOne to support staff with documentation in the records. This highlights the effect changes in our partner agencies' can have on TRFT arrangements, and the detail necessary to ensure a safe process is in place.

Safeguarding 7-minute briefings continue to be produced on a monthly basis, providing an opportunity to disseminate key, current information across the Trust. Alongside these, appreciative enquiries are also produced which highlight areas of good practice to share across the workforce. This allows the safeguarding team to promote positive safeguarding messages to engage and encourage staff with the safeguarding processes.

The safeguarding team are responsible for reviewing and updating safeguarding policies. All safeguarding-related policies were reviewed in a timely manner, including Children and Pregnant Women Missing, Was not Brought and assessment of fractures under 2 years. The significant changes to the referral to children's social care process created a requirement for a new Standard Operating Procedure. Policies are also updated to reflect changes in national guidance and service developments. The Trust's Child Protection Medical Assessment Policy, Female Genital Mutilation policy, Surrogacy Policy and the Suspected Child Abduction policy were updated to reflect changes in national guidance and service developments. The new and innovative policy developed following the CQC inspection for 16 and 17-year olds admitted to adult wards is showing improvements in compliance with the required safeguarding checks.

The new starter training package for medical colleagues has been reviewed and updated to reinforce multiagency processes. This is co-delivered with RMBC Children's Social Care, service manager and safeguarding team, and is well-received by our medical colleagues.

In October 2022 the Trust appeared at Sheffield Magistrates' Court charged by the CQC in relation to a number of safeguarding children cases that occurred in 2019. The Court focussed on failures in the Trust's policies, training and oversight of safeguarding. The Trust fully accepted the findings of the Court, which noted that it was clear that the failings were not the result of actions of clinical staff and that no child had come to harm as a result of the failings. It was acknowledged that, since 2019, the Trust had made extensive changes to children's safeguarding processes. Robust action was taken to

improve policies, training and oversight, with the introduction of a range of initiatives including safeguarding huddles and closer partnership working within our teams and with wider partners.

In order to provide assurance to the Trust and others, NHSE were invited to, and conducted an independent review our children's safeguarding arrangements in October 2022. The feedback provided was positive, with suggestions made to support continued improvement and acknowledgement of effective practice, i.e. Safeguarding Huddles and the Think Family agenda. The report noted an opportunity to improve some adult safeguarding arrangements, which they felt were less well developed than the children's arrangements. This work is currently being progressed.

KEY PERFORMANCE INDICATORS (KPI) & STANDARDS

Children's safeguarding are required to provide assurance through the KPIs and Safeguarding Standards, as set by the CCG, now ICB. These include offering assurance on a diverse range of safeguarding activity throughout the Trust, including supervision and training, division specific activity, e.g. LAC health assessments, Child Sexual Exploitation referrals and Child Protection Medicals.

Both the Safeguarding Standards and the KPIs are reported quarterly to the Trust Safeguarding Committee. This meeting includes representation from the ICB, Local Authority, RSCP and RSAB.

SAFEGUARDING PRACTICE REVIEW

There have been no TRFT serious incidents (SIs) involving children in this reporting period. However, action plans from SIs from the last reporting year have been progressed and learning disseminated across the Trust and any actions formally closed by SPRG.

In addition to this, the team have reviewed SIs which have occurred regionally and nationally, conducting 'true for us' reviews'. These show that the arrangements within the Trust are robust and would suggest that such incidents would be unlikely within Rotherham. These reviews are presented to the Operational Safeguarding Group.

SAFEGUARDING SUPERVISION

During 2022/23, following the review of the safeguarding supervision policy, the model continues to be embedded across the Trust with compliance being reported via ESR. The safeguarding team have coordinated 1:1 supervision, group and adhoc sessions. The group supervision following Covid 19 restrictions are offered virtually and face to face.

Compliance with the safeguarding supervision requirement continues to be monitored through the Operational Safeguarding Group. There have been continued challenges with this related to the accuracy in recording staff who require supervision on ESR. This is acknowledged as a risk on the safeguarding

An expectant mother receiving care was known to be suffering significant mental illness. TRFT midwifery teams and the safeguarding team liaised with MH colleagues to ensure an appropriate plan of care was in place for both Mum and baby. Staff also required support in managing this case as due to the complexities and the involvement of the legal team. This was a very complex process, involving three organisations, all working to ensure the needs of Mum and baby were anticipated and met.

risk register. There is ongoing work to complete a training needs analysis review of the supervision requirements for the staffing groups to ensure that the requirements are correctly aligned.

The Children's Safeguarding Supervisors' training was provided to create additional supervisors. This supports the offer of safeguarding supervision across the Divisions with more scope for additional sessions within the departments, which will subsequently support compliance. To reflect staff movement and changes in role, the team aim to provide at least 2 sessions a year to train new supervisors and maintain the pool of staff available.

The safeguarding supervision of medical colleagues continues to be a priority with an offer of a monthly session provided by the Named Doctor and supported by a Named Nurse. The Paediatric Consultants supervision compliance figures have consistently improved, with an ongoing focus in promoting the benefits to the Trust and the patients. Further work is being completed with UECC towards improved compliance offering some additional bespoke group supervision sessions which will continue in 23/24.

Child Protection Medical Assessment Peer review continues to provide an additional layer of support and supervision to medical paediatric colleagues of all different training and competence levels. This reinforces the national standards for child protection medicals and creates a positive learning experience, reinforcing the 'Think Family' approach and promoting a wider consideration of multiagency processes and safety planning at the point of discharge.

PARTNERSHIP WORKING – SAFEGUARDING CHILDREN

Partnership working, as directed by Working Together to Safeguard Children (2018), and the Children Acts (1989 & 2004), underpins the ethos and values of the Safeguarding Children's Team.

The Trust is represented at executive level by the Chief Nurse, or her deputy, the Head of Safeguarding, who attend the RSCP meetings.

The Safeguarding Named Nurses and Named Midwife attend the safeguarding delivery groups of the RSCP, in line with Section 11 of the Children Act 2004 requirements. Information and actions are reported back to TRFT's Safeguarding Operational Meeting. Future plans for single and/or joint agency action include the review of the current arrangements around Child Protection Medical Assessment, discharge planning for children and supervision of parents/carers in the hospital setting. In the reporting period the Children's Safeguarding Team have continued to work closely with our RSCP and Local Authority colleagues to improve the outcomes for children and young people. This has enabled joint priority setting, supporting the Partnership to respond to emerging themes, thereby ensuring safeguarding processes are robust and effective.

The Multi-Agency Safeguarding Hub (MASH) 'baby clinic' continued to function positively during this period with good evaluation from professionals. This process provides an early opportunity to identify those families who required either additional Early Help (EH) support or a social care assessment based upon the history and identified risks. Alongside this, the bespoke 'Early Help Early Identification' Pathway was launched, which allows for universal families to be identified and signposted to local children's centres early, but also for those families with additional vulnerabilities requiring extra support to be recognised and signposted to the most appropriate agency to complete the full EH Assessment.

This partnership initiative received much praise and attracted national attention, being nominated by RMBC for an award. It was also nominated for a Royal College of Midwives award.

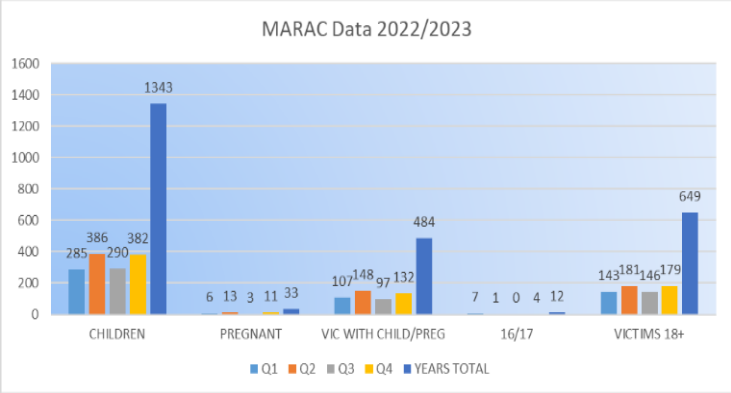
The Rotherham Maternity Hope Box initiative which was launched in February 2022 to provide support to women who are having (or are at risk of having) their baby taken into care following birth. The initiative positively acknowledges that the women have become mothers even without the presence of their child. All women who are potentially at risk of having their unborn baby removed are offered a box which contains items to support positive memories of their child. Bespoke leaflets are provided with the boxes in order to support the needs of the mother and promote their own wellbeing. In addition, referrals can be completed to 'The Pause' project to support the mother where required.

TRFT Partnership arrangements are evidenced by TRFT's engagement with our Local Authority partners as well South Yorkshire Police, Rotherham CCG, now ICB, and other health providers.

The Trust is represented at MARAC for both adult and children's cases by the Safeguarding Children's Team, who provide health representation in high risk domestic abuse cases which involve children, pregnant women and victims aged 16-17yrs.

A total of 1343 children were discussed at MARAC, overall, 766 victims in 22/23.

Approximately 40 cases were discussed per fortnightly meeting, and information about the family reviewed and shared to enable the multi-agency management of the risk related to each case. This represents an increase on last year's figures. MARAC meetings continue to be held virtually through 'Teams' meetings. This ensures continuity of risk assessment and safety planning for the high-risk cases.



LOOKED AFTER CHILDREN

The Looked After Children and Care leavers service sits within Family Health and is made up of a dedicated team of doctors, nurses and admin staff. There are strong, positive links with the safeguarding team, and performance reporting is provided for the Safeguarding Committee.

- **Performance**

The achievement of the 20-working day target for Initial Health Assessments (IHA) is reliant on joint working with our partners, in particular, prompt notification of a child becoming looked after from RMBC. Significant partnership work has taken place, and is on-going with partner agencies to support the timeliness of Looked After Children (LAC) accessing IHAs.

Throughout a child's time in care following the IHA, Review Health Assessments (RHAs) are undertaken 6 monthly on those children under 5 years and annually for those over 5 years. Performance over the past year has been maintained for RHAs with 97-100% completed each month within timescale.

For IHAs there has been a reduction in compliance against the 20 day target, this has had many factors beyond TRFTs control e.g. cancelling due to court hearings and children being placed out of Rotherham which we have no control over. Factors within TRFT have affected compliance, this is related to increased demand for clinic slots. There has been a significant increase in the number of unaccompanied asylum-seeking children brought into care by Rotherham or placed in Rotherham by other Local Authorities. To enable a thorough and child focussed IHA double slots are allocated and interpreters are present. Currently there are 40 unaccompanied asylum-seeking children within the 545 LAC brought into care by Rotherham.

Some of the children who decline health assessments are in long term foster placements, have stability and therefore do not want to feel different to their peers. However, if they do have a specific health need, a specific piece of work around that particular health need may be completed instead.

There are children who become Looked After due to receiving 75 nights or more respite. Their parents may decline the assessment as other health professionals are already involved and their health needs are being met by the usual reviews of their often complex health needs.

For some children/young people, they are not in the right place, emotionally, and therefore not engaging well. If there is no access when visited, our nurse will offer several further appointments, or may request consent from the young person to speak with carers to review their health needs. All children and young people, their carers and associated professionals have open access to health advice and support from the nursing team. There are now drop-in sessions set up within the Care Leaver building on a monthly basis where young people and their support staff can access health advice and support. This is to develop further to targeted health topic sessions that are of priority to our young people.

Service update

The LAC Nursing Team has developed to full capacity during this year, with a diverse and broad skill set and high-level experience the team. New staff have made a wonderful contribution to the team.

Role specific training has continued for the team with attendance at regional Looked After Children, Care Experienced, and Adoption training. These were all powerful sessions utilising the lived experience of care experienced and adopted adults, carers and adopters. This personal experience and insight confirms the need for our team and the privileged position we are in to support Looked After Children, their carers and the support network around them.

A significant project that the Looked After Children's nursing team and the Health Improvement Team have worked on is the dental project for Looked After Children. In

Feedback from Foster Carer

N has an abundance of amazing qualities e.g. excellent listener, empathy, caring, sense of humour and commitment to patient advocacy. N's advice is invaluable to me, she listened and believed in me when professionals didn't, N was so supportive to me and got me the referral that I had been fighting for a long time.

Being a foster carer can be lonely at times, especially when caring for small babies. N always makes time for me and I have never felt like our visits have been rushed. I feel so privileged to have xxx as my LAC nurse, caring for all health needs for children on placement

partnership with foundation dentists, the ‘Smile’ dental project was developed

where Looked After Children in Rotherham were referred to a

newly qualified dentist within specific practices across Rotherham. This project has enabled some of our most vulnerable children and young people to access a dental service. Since commencement 150 referrals have been made with 111 of these coming from the LAC Nursing Team. The success of this is being continued and adapted to ensure that Looked After Children are prioritised by referral to flexible commissioning dental practices across Rotherham. This service has now been extended to include those who are part of the Pause project, which works with women who have had, or are at risk of having multiple children removed from their care and are often care experienced themselves. The Speech and Language screening at IHA is now well embedded in practice, and at a recent multi-agency meeting the therapists fed back that a significant number of LAC were identified through this pathway and seen by the speech therapists who had not had previous intervention.

The LAC Nursing Team supported the planning and development of a summer festival for Rotherham’s LAC and Care Leavers along with their carers. This took place in July 2022 and was a huge success. Planning is in place to repeat and further develop the festival for summer 2023. TRFT’s Hospital Charity supported this event with funding to have a “smoothie bike” at the event that children, using pedal power blended fruit to make smoothies. This has been requested to return to the next festival by young people who attended. It created some racing challenges and lots of fun and healthy drinks. Nurses supported the event by attending and assisting. We also arranged for an ambulance to visit that the

Testimonies

Feedback from young people after the VIP Summer Festival

Dear Rotherham Hospital Charity, We are the Rotherham Looked After Children’s Council members and we would love to thank you for your generosity in funding some of our VIP Summer Fest 22. Together we loved the experiences given to us and the young people who attended the event. You helped connect Looked After Young People with family and friends who may have not seen each other for a while as well as create new connections between us. The LAC Council are very grateful for the amazing activity you gave us and hope that you may support our event in the future.

Feedback from young people after the VIP Summer Festival

The Rotherham Looked After Children’s Council would like to thank all of our fabulous Volunteers who came out to support the delivery of this magnificent event last Friday. The LAC Council worked tirelessly over the months running up to the event, deciding and planning what activities they wanted, designed Festival Passes, how the tents should look, creating waterproof bunting, writing invites to Foster Carers and other young people, designed Logos, designed and created signage etc. The group could not have done all this alone and called upon the enthusiasm and dedication of a mixed team of individuals from Social Care, NHS, Affinity to support the party planning and who found and secured funding to pay for the whole event. The effort from our workers to chase Foster Carers and young people to remind them of the event and the unwavering enthusiasm, innovation and hard work to support the event from our wonderful team of volunteers on the day, working in all weathers, all conditions and doing anything and everything necessary that all contributed to the overall success of the event. We Thank You All

children enjoyed sitting in and making full use of the blue lights and sirens! Our presence also created some conversations in relation to future careers.

This has been another exciting, challenging and positive year for the Looked After Children and Care Leavers' Nursing Team, and we are passionate about the specialist care we deliver, and are committed in continuing to develop and improve in our service delivery.

SAFEGUARDING AWARENESS WEEK

For the fifth year running, the Safeguarding Team have contributed to the multi-agency safeguarding awareness week by providing a number of seminars, briefings and webinars on a wide variety of safeguarding topics, both established and emerging themes. Communications were distributed daily with key messages and themes, as well as a stand in the main entrance to engage both patients and staff in the safeguarding agenda. This was supported by external partners, such as Apna Haq, Rotherham Rise and RMBC. This reinforced the key message that safeguarding is everybody's business and demonstrated strong partnership working.

SAFEGUARDING GOVERNANCE ARRANGEMENTS

Over the last 12 months the focus on a robust Trust safeguarding and external governance structure has been maintained (Refer to Appendix 4).

The responsibilities of all staff employed by the Trust for safeguarding children, adults and those with vulnerabilities are documented in the TRFT Safeguarding Policy. In addition to this there are several supporting policies and procedures which guide and support Trust staff.

The Chief Executive is the accountable officer. The Safeguarding Executive lead is the Chief Nurse and the Corporate/Operational Lead for Safeguarding is the Head of Safeguarding.

The Trust has two specific Safeguarding meetings: a monthly Operational Safeguarding Group, chaired by the Deputy Chief Nurse and a quarterly Safeguarding Committee, chaired by the Chief Nurse. The Safeguarding Committee reports to the Quality Committee. The arrangements for the chairing and governance of both groups are reviewed regularly and attendance and quoracy monitored.

An improvement in the divisional ownership of safeguarding issues is demonstrated in the Safeguarding Committee. Divisional leads present patient stories, which show the embedding of learning within divisions and the impact on patient care. This highlights further progress in our journey to achieve excellence in safeguarding practice.

The role of the Safeguarding Committee is to ensure processes within the Trust are in line with the current legal framework and national guidance, promoting the well-being and safeguarding of

vulnerable patients and those at risk whilst in the care of the Trust. In addition to Trust colleagues, membership includes representation from external partners from the ICB, the RSAB, the RSCP, RMBC Children and Adult Safeguarding and Public Health. This group seeks to provide assurance on all matters relating to safeguarding and reports to the Board of Directors via the Quality Committee.

TRFT are represented on the RSAB and on the RSCP by the Chief Nurse. The deputy for these meetings is the Head of Safeguarding.

There are several Safeguarding Board/Partnership delivery groups that have TRFT representation from named professionals within the team. The Performance and Quality Sub-group of the Rotherham Safeguarding Adult Board is chaired by the Head of Safeguarding.

A summary report regarding key points from these delivery groups is submitted to the Operational Safeguarding Group to share information and to provide transparency and joined up working.

The current safeguarding strategy is being reviewed to ensure that it reflects the priorities of the Trust and maintains the excellent progress in safeguarding. This is expected to be completed in 2023 and will be underpinned by a robust work plan.

The Trust is required to satisfy the requirements of the Safeguarding KPIs and Safeguarding Standards, as set by the ICB. These include offering assurance on a diverse range of safeguarding activity throughout the Trust and are reported quarterly. Over the year the ICB has commended the Trust for the development of such a robust assurance system and process.

The ICB has reviewed the standards set. New arrangements will be implemented in 23/24 which will see an annual requirement for assurance and will allow this document to be used for several purposes, including the joint S11 Assessment, conducted by the RSCP and RSAB.

There have been no safeguarding related Serious Incidents since February 2020. The safeguarding team review all datix related to safeguarding issues and provide a monthly report to the Operational Safeguarding meeting. This report identifies any learning, good practice, any escalations and identifies any themes for training and support.

A new system of audit was introduced through the year. Tendable allows the safeguarding team to have oversight of safeguarding knowledge and practice across ward areas, thus enabling targeted support and training to be provided where identified.

CARE QUALITY COMMISSION

As reported in the 2021/22 Safeguarding Annual Report, considerable improvement work has been initiated within the Urgent and Emergency Care Centre to raise the awareness of possible safeguarding concerns. Despite this, a further condition relating to safeguarding systems and processes within the department was issued in August 2022 requiring the submission of evidence of improvement each month between September 2022 and March 2023.

The Trust CQC Relationship Team provided constructive and positive feedback following each submission, with the Trust demonstrating that all issues set out in the condition have been addressed. The systems and processes evident across UECC provide ongoing assurance that the improvements are well-embedded and firmly established within business as usual across the Department. The

Governance processes in place at Divisional and Trust level are sensitive enough to identify when an issue or shortfall in performance arises and appropriate remedial action is quickly taken.

A particular criticism of safeguarding processes within UECC in the May 2021 Inspection Report was the difficulty the Trust had in engaging with the wider external safeguarding networks. The Trust is now seen as a key stakeholder within the wider Rotherham Place and a key partner in ensuring safe and effective Safeguarding Practice across the community.

UECC have been required to address three specific areas of safeguarding. These are set out in order as follows:

Safeguarding Training compliance - there has been a considerable improvement in the training compliance against all safeguarding mandatory training modules across the Department. The evidence provided for each of the five submissions demonstrated the compliance, by staff group, to give the full performance position. UECC now report compliance consistently above 90% for all safeguarding modules, which is well above the Trust standard of 85%. The UECC Clinical Educator receives a MaST compliance update each week and as such is able to address any non-compliance at the earliest opportunity.

Safeguarding support to UECC - the Safeguarding Team – both adult and children, have a daily presence across the Emergency Department enabling advice, support and guidance to be available every day, although currently this is restricted to Monday to Friday.

A daily Safeguarding Huddle takes place, attended by senior staff from UECC and the Safeguarding Team, where immediate issues arising from the previous 24-hour period are discussed and issues addressed quickly where required. The Huddle provides an excellent opportunity for ongoing learning such as, reviewing referrals and identifying any potential missed opportunities. This has significantly improved the working relationships between the two teams.

Missed opportunities to identify a possible safeguarding concern - for further assurance, a monthly audit to identify whether any opportunities have been missed to respond appropriately to a safeguarding concern, has been conducted for both adults and children.

Each audit is formally recorded with the Trust Clinical Effectiveness Team and the outcome of each audit reported through the UECC Divisional Governance meeting and the Safeguarding Operational Group, chaired by the Deputy Chief Nurse.

Between September 2022 and January 2023, 50 adult patient records have been reviewed and 50 records of children have been reviewed. A summary of the Audits is outlined below:

Missed Opportunity Audit Adult Patients - findings of the audit(s) have shown evidence of a Think Family approach being routinely taken. There are also multiple occasions when additional referrals have been made to other support services. In these cases, this has been a proportionate response to meet the additional support needs of the patients audited.

Missed Opportunity Audit Paediatric Patients - zero missed opportunities to safeguard children were noted over the audit period. Conversely, there have been a number of complex safeguarding cases identified, where the documentation evidenced excellent safeguarding practice. Positive feedback has been shared with staff and some of these positive cases have been discussed at the UECC

Safeguarding Huddle and the weekly case discussion meeting to promote learning from this good practice.

The CQC accepted the evidence provided within each monthly submission and as a consequence removed the requirement for further submissions by removing the condition from the Trust Certificate of Registration on 27 March 2023.

Risks & management of risks

1. Safeguarding MaST Training Compliance

The risk was identified in relation to TRFT colleagues not accessing the required level of safeguarding training, which may impact on their competence when required to assess safeguarding risk for children and adults. This is now viewed as a managed risk, with a current risk score 6 (moderate risk).

Mitigations: The Safeguarding Team continue to receive monthly compliance reports. Colleagues receive a three monthly reminders to complete their training from ESR prior to the expiry date. The safeguarding team follow-up those who do not complete at this point and send emails to the staff and their manager as per the MaST escalation process.

Training provision now included a 1-day Think Family Course, provided monthly. The E-learning package remains in place to provide core competency updates for safeguarding children and adults, with the complementary packages to support the additional hours required.

Training compliance is monitored and escalated via the Operational Safeguarding Groups and the Safeguarding Committee, and Divisional Leads have sight of compliance data.

2. Recording arrangements of Safeguarding Supervision compliance is unreliable.

This risk lies in the unreliability of the information produced by ESR related to Safeguarding Supervision compliance and was added in June 21.

This is now viewed as an approved risk, with a risk score of 12 (high risk).

Mitigations: The Safeguarding Supervision Policy has been reviewed.

There have been ongoing difficulties in allocating the correct supervision requirement to individual staff, however, work has been ongoing with our colleagues in Learning & Development to improve this and the team is continuing to review and amend allocation in partnership with divisional leads to improve reporting.

Additional Safeguarding Supervision training has been provided to increase the Trust's ability to implement the supervision programme and a robust supervision programme is available for staff who require safeguarding supervision.

Advice is available on the Hub for staff in how to access a supervision session. The safeguarding team work closely with colleagues to ensure information and learning is shared appropriately.

3. Management of injuries to infants under 2 years, including non-mobile babies

There is a risk of injuries in infants under two years, including non-mobile babies, being inappropriately clinically managed and not giving appropriate consideration to wider safeguarding issues which may be present.

This is now a managed risk, with the target score of 4 having been achieved.

Mitigations: The 'Bruising in non-mobile babies' pathway has been developed and agreed with our partner agencies. This is now included in the Rotherham M/A procedures which have been updated and recirculated. The M/A threshold descriptors have been revised and updated with the Partnership to ensure they are concise and easy to follow for our staff.

The safeguarding team continues to provide significant expert advice and support to staff regarding the appropriate management of these cases. The daily huddles now review all injuries to non-mobile babies to ensure there has been appropriate management, thereby providing a safety-net for such cases and additional assurance that arrangements in place are robust.

There has been significant work to embed the use of body-mapping across services. Standards were agreed following an in-depth audit which will add further rigour to the assessment process, particularly within UECC.

TRFT new starter training has been refreshed and delivered for medical colleagues and use of case scenarios to reinforce multiagency safeguarding procedures.

4. Providing appropriate care for patients with complex mental health needs

This risk refers to concerns that TRFT do not have a workforce with the skills, knowledge and competence to manage patients who present with complex mental health needs. There is a risk that the mental health needs of the patient may not be recognised and appropriate support may not be provided in a timely manner.

This may result in worsening of the patient's mental health, and an increase in behaviours that challenge the skills and knowledge of TRFT staff, potentially resulting in harm to the patient. This will also impact on staff. This is being managed as a new risk, with a risk score of 9 (high risk).

Mitigations: The Trust has embedded a Mental Health Steering Group (MHSG) which is driving forward work to ensure staff are able to recognise and respond to those people who may be experiencing poor mental health.

A Mental Health Strategy has been agreed, and the MHSG will continue to develop an action plan to underpin the implementation of this.

TRFT are working in partnership with the Rotherham, Doncaster & South Humber (RDaSH) Trust to improve awareness of poor mental health and how this may manifest in patients, allowing staff to implement appropriate care strategies. Bespoke training has been agreed, to be delivered in UECC, with the aim of improving the confidence and competence of staff to recognise and manage mental distress.

5. Lack of availability of S136 beds for under-18s.

This risk refers to the lack of S136 provision locally for children. This may mean that the child is cared for on the children's ward, which is not a suitable environment for patients requiring the specialist assessment and treatment provided by MH units.

This potentially puts the patient, other patients and our staff at risk and, may result in compromising existing bed provision as beds may have to be closed to accommodate the needs of the young person experiencing acute MH difficulties.

Mitigations: Work is ongoing to review the provision of S136 facilities for under 18s.

This has been raised with ICB colleagues and is reviewed regularly at the Mental Health Steering Group.

SUMMARY AND CONCLUSION

TRFT Safeguarding and Vulnerabilities Team continue to engage with Trust services and partner agencies throughout the Borough to develop and progress the safeguarding service to ensure our organisation, staff and patients are safe at all times. The workload continues to increase across adults and children's work streams in relation to changes to legislation and national statutory guidance, but also due to the increased demand locally for safeguarding input across a wide range of areas, the actions required to implement the CQC Improvement Plan and accommodating the continued demands placed on our service, and the NHS, by Covid-19.

In spite of these challenges, the Safeguarding & Vulnerabilities Team have continued to improve the support available across the Trust, assisting TRFT staff to incorporate safeguarding into their daily work load and ensuring good outcomes.

The Safeguarding team's commitment to leading improvement throughout the Trust and ensuring all systems and processes support the early identification of safeguarding concerns has continued apace. The approach, which has the voice of the child or adult at risk at the forefront of care delivery throughout the Trust has shown continued and sustained improvement in safeguarding arrangements. The improved engagement and ownership of safeguarding matters across all Divisions of the Trust is supporting the improvements.

Governance arrangements are reviewed regularly, ensuring that safeguarding meetings deliver on their objectives and can offer assurance on safeguarding activity throughout the Trust.

The impact of Covid-19 has continued, somewhat erratically, throughout the year, compounded at time by the 'flu' outbreak. The team have adapted to the constraints and adopted positive strategies to ensure the continued progress of the safeguarding agenda, both within our Trust and externally with our partners.

The positive aspects, improved attendance at meetings and stronger links with our LA and multi-agency partners, are continuing and support robust arrangements to safeguard children and adults at risk.

What were last year novel training approaches, are now embedded, with virtual safeguarding supervision, Teams training and Teams meetings now 'business as usual', ensuring that the business of safeguarding within TRFT continues to be seen as a priority and maintains the focus in the coming year.

Whilst Safeguarding, LD/A, CDR, Prevent, Mental Capacity and Mental Health agendas all continue to be a challenging area for all health agencies and multi-agency partners, the Trust continues to actively respond and contribute to regional and national developments. This annual report demonstrates that

safeguarding vulnerable people remains a significant priority for the Trust and offers assurance that the annual work programme has been delivered, and the Trust continues to meet its statutory duties as well as proactively developing safeguarding provision and implementing learning from adverse events into frontline practice. However, we recognise there is much more to achieve and to this end the development and delivery of the future priorities will help ensure that the Trust is fully engaged in the effective prevention of and response to safeguarding concerns. The underpinning message, however, remains the same in that safeguarding is everyone's business irrespective of role or position. It is everyone's responsibility to safeguard and protect the most vulnerable adults and children and young people in our society. The person at risk must remain at the centre, and be the motivation of, our actions

The Rotherham NHS Foundation Trust
Strategy for Safeguarding Vulnerable Services Users

The Rotherham NHS Foundation Trust prioritises the safety and welfare of children, young people and vulnerable adults across all commissioned and contracted services.

Safeguarding Children and Young People

The Children Acts 1989 & 2004 outline statutory duties relating to safeguarding and promoting the welfare of children for NHS organisations and partner agencies. These are summarised in **Working Together to Safeguard Children, Department of Health (DoH) 2018 and Statutory Guidance** on making arrangements to safeguard and promote the welfare of children.

Safeguarding Adults

The Care Act (2014) is the most significant change in social care law in 60 years. It clearly sets out the arrangements necessary when working with adults (aged 18 years and over) who are, or may be, at risk of abuse or neglect.

What will we do?

- Comply with statutory requirements nationally and locally including quality standards set by the Care Quality Commission, Local Safeguarding Boards, Clinical Commissioning Group and also contractual standards
- Provide leadership for safeguarding across The Rotherham NHS Foundation Trust
- Have robust monitoring, accountability and governance arrangements for safeguarding
- Work in collaboration with the Local Authority and other partner organisations

How we will do it?

- Have executive level leadership and membership of both Rotherham Safeguarding Children Partnership and Rotherham Safeguarding Adults Board
- Work in collaboration with the Local Authority and other partner organisations to provide joined up services
- Have appropriate internal Safeguarding Polices in place, including safe recruitment of staff and whistle blowing policies, and adhere to Rotherham Safeguarding Children Partnership and Safeguarding Adults Board Policies and Procedures
- Have a positive influence on, and proactive attitude to, Safeguarding arrangements across the NHS and Partner Organisations
- Provide opportunities for the views and experience of the most vulnerable to inform service planning
- In partnership with the Rotherham Safeguarding Children Partnership and Safeguarding Adults Board, review serious incidents locally and nationally to identify lessons to improve practice and service provision.
- Provide evidence of learning from case reviews
- Continually monitor and evaluate the effectiveness of Safeguarding Training
- Ensure that all service users at the first point of contact are assessed using a common vulnerability assessment tool to identify triggers for alert, further risk assessment and referral
- Have clear lines of accountability and appropriate escalation for support rather than abrogation of responsibility, keeping assessment at the point of contact with the service user
- We will have a Safeguarding Supervision policy, and monitor compliance with this
- Capture data and share information as appropriate between relevant information systems
- Review and evaluate service delivery via audit and monitoring

How success will be measured

- We will achieve our contractual obligations, and demonstrate this through our KPIs and Standards
- Our patients will have a better experience of healthcare, and be safe in our care
- Our staff will feel confident and be competent to contribute towards safeguarding vulnerable people

V 4 June 2020 JS

The Rotherham NHS Foundation Trust
Strategy for People with a Learning Disability/and or Autism

The Rotherham NHS Foundation Trust is committed to providing excellent standards of care to people with a Learning Disability/and or Autism. Providing person centered holistic care, based on individual needs.

What is a Learning Disability?

It can be defined as a significant reduced ability to understand new or complex information, to learn new skills (significantly impaired intelligence). Coupled with a reduced ability to cope independently (Impaired social/adaptive functioning), which started before adulthood (onset before aged 18) – with a lasting effect on development.

National drivers

- **Progress on improving nursing for people with Learning Disabilities (DOH 2014)**
- **The Equalities Act 2010, MCA 2005, DOLS 2007 & The Bubb report 2014.**
- **NHSi Learning Disability Improvement Standards for NHS trusts 2018 & NHS long term plan 2019**

What we will do?

- We will comply with statutory requirements nationally and locally including quality standards set by the Care Quality Commission, Local Safeguarding Boards and Clinical Commissioning Groups
- We will provide leadership and support for patients with a Learning Disabilities/and or Autism within The Rotherham NHS Foundation Trust
- We will ensure that our Learning Disability Service has robust performance monitoring systems, through the Safeguarding Groups, to ensure we are delivering a high quality service
- We will ensure reasonable adjustments are made for people with a Learning Disability and/or Autism

How we will do it?

- Have executive level leadership via the Chief Nurse as the Executive Lead for vulnerable people.
- Work in collaboration with the Local Authority and partner organisations such as RDaSH, Advocacy groups and provider services, enhancing joined up working.
- Have appropriate internal Safeguarding Polices in place including whistle blowing policies and adhere to the Trust Learning Disability/and or Autism policy.
- Have a positive influence and proactive attitude on improving health and well-being outcomes for people with Learning Disabilities/and or Autism across NHS and Partner Organisations
- Provide opportunities for the views and experience of people with a Learning Disability/and or Autism to inform service planning and development, linking in with partnership agencies.
- Ensure all individuals with a diagnosed Learning Disability have an Hospital Assessment in place and has input/advice on their individual care pathway from the Lead Nurse in Learning Disabilities
- Provide evidence of learning from serious case reviews associated with patients with a Learning Disability and/or Autism.
- Continually monitor and evaluate the effectiveness of Safeguarding Training
- Ensure that all service users at the first point of contact are ; identified as having a Learning disability/and or Autism, that reasonable adjustments are made, that risk assessments are completed and a that a referral to the Lead Nurse in Learning Disabilities is made.
- To continue to promote the role of the Learning Disability Champion on each ward and Department, to advocate for and ensure the additional needs of a person with Learning Disability/and or Autism are met.
- Provide regarding Learning Disabilities/and or Autism and monitor the effectiveness of this.
- To ensure the information we provide to people with a Learning disability/and or Autism is in an accessible /appropriate format for that individual.
- Review and evaluate service delivery via audit and monitoring to ensure we are providing a high quality service.

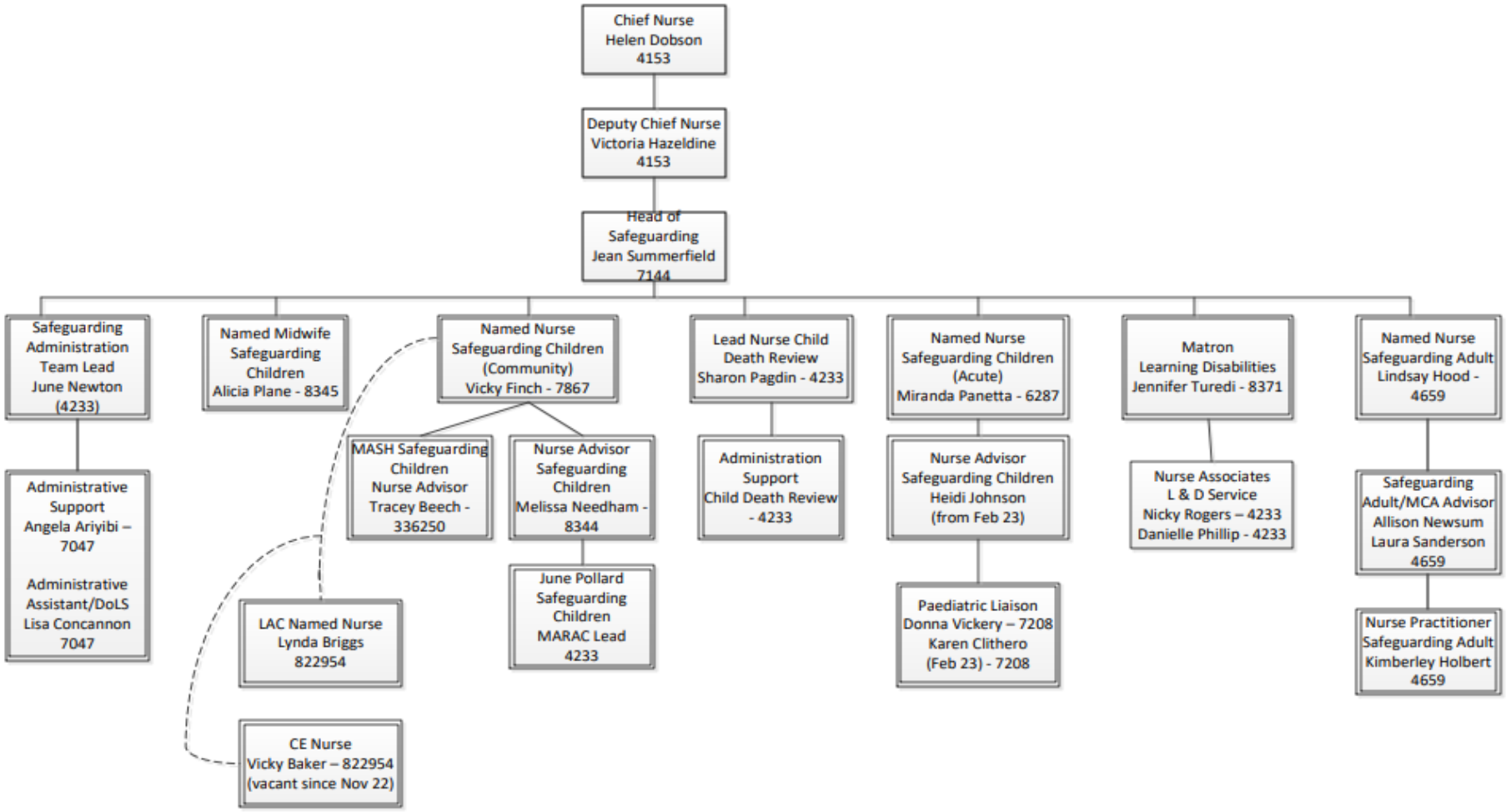
How success will be measured

- We will achieve our contractual obligations, and demonstrate this through our KPIs and Standards
- Our patients will have a better experience of healthcare, and be safe in our care
- Our staff will feel confident and be competent to care for patients who have a Learning Disability and/or Autism

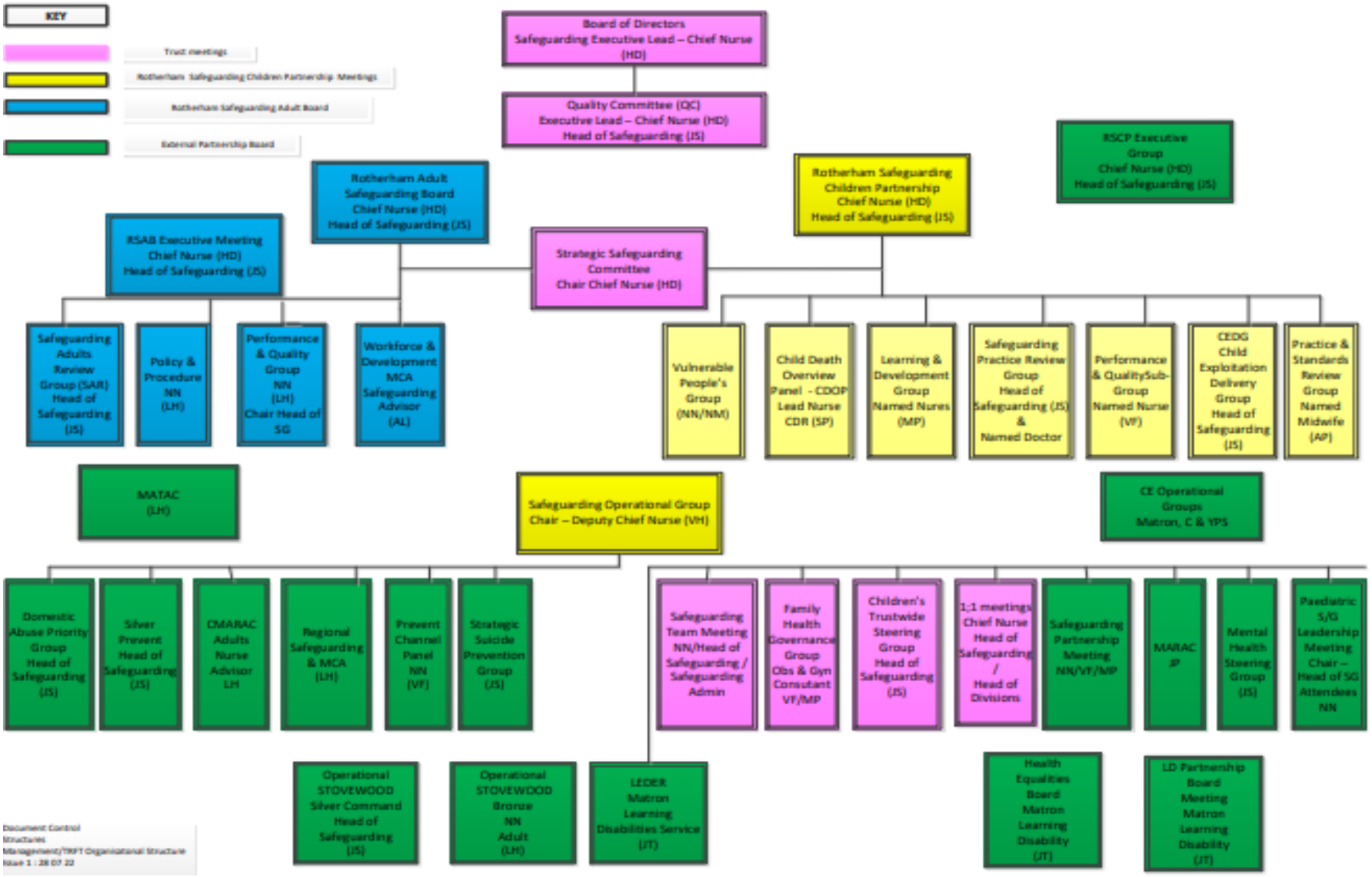
V 4 June 2020 JS & IT

APPENDIX 3

MANAGEMENT AND PROFESSIONAL LEADERSHIP – SAFEGUARDING & VULNERABILITIES TEAM



APPENDIX 4


KEY
Trust meetings
Rotherham Safeguarding Children Partnership Meetings
Rotherham Safeguarding Adult Board
External Partnership Board
Board of Directors
Safeguarding Executive Lead – Chief Nurse (HD)
Quality Committee (QC)
Executive Lead – Chief Nurse (HD)
Head of Safeguarding (JS)
RSCP Executive Group
Chief Nurse (HD)
Head of Safeguarding (JS)
Rotherham Adult Safeguarding Board
Chief Nurse (HD)
Head of Safeguarding (JS)
Rotherham Safeguarding Children Partnership
Chief Nurse (HD)
Head of Safeguarding (JS)
RSAB Executive Meeting
Chief Nurse (HD)
Head of Safeguarding (JS)
Strategic Safeguarding Committee
Chair Chief Nurse (HD)
Safeguarding Adults Review Group (SAR)
Head of Safeguarding (JS)
Policy & Procedure
NN
(LH)
Performance & Quality Group
NN
(LH)
Chair Head of SG
Workforce & Development
MCA Safeguarding Advisor
(AL)
Vulnerable People's Group
(NN/NM)
Child Death Overview Panel - CDOP
Lead Nurse CDR (SP)
Learning & Development Group
Named Nurses
(MP)
Safeguarding Practice Review Group
Head of Safeguarding (JS)
&
Named Doctor
Performance & QualitySub-Group
Named Nurse
(VF)
CEDG
Child Exploitation Delivery Group
Head of Safeguarding (JS)
Practice & Standards Review Group
Named Midwife
(AP)
MATAC
(LH)
Safeguarding Operational Group
Chair – Deputy Chief Nurse (VH)
CE Operational Groups
Matron, C & YPS
Domestic Abuse Priority Group
Head of Safeguarding (JS)
Silver Prevent
Head of Safeguarding (JS)
CMARAC Adults Nurse Advisor
LH
Regional Safeguarding & MCA
(LH)
Prevent Channel Panel
NN
(VF)
Strategic Suicide Prevention Group
(JS)
Safeguarding Team Meeting
NN/Head of Safeguarding / Safeguarding Admin
Family Health Governance Group
Obs & Gyn Consutant
VF/MP
Children's Trustwide Steering Group
Head of Safeguarding (JS)
1:1 meetings Chief Nurse
Head of Safeguarding /
Head of Divisions
Safeguarding Partnership Meeting
NN/VF/MP
MARAC
JP
Mental Health Steering Group
(JS)
Paediatric S/G Leadership Meeting
Chair – Head of SG
Attendees
NN
Operational STOVEWOOD
Silver Command
Head of Safeguarding
(JS)
Operational STOVEWOOD
Bronze
NN
Adult
(LH)
LEDER
Matron Learning Disabilities Service
(JT)
Health Equalities Board
Matron Learning Disability
(JT)
LD Partnership Board Meeting
Matron Learning Disability
(JT)
Document Control
Structures
Management/TRFT Organisational Structure
Issue 1 : 28 07 22

SAFEGUARDING STANDARDS – EXCEPTION REPORT APPENDIX 5

This exception report includes areas of non-compliance over the financial year 22/23. It serves to demonstrate progression, and identifies areas for future development, which will be incorporated into the work streams.

Safeguarding Standards	Q1	Q2	Q3	Q4	
Standard 5 - Training					
3.7 Embed effective governance around record keeping, sharing information and understanding of consent (2.4) (CLAS CQC Recommendation 1.1, 2.3, 2.4, 3.3 & 3.4)					The Safeguarding Policy, MCA policy and Record Keeping Policy all guide and support staff in keeping appropriate records. All contracts of employment require staff to practice in accordance with Trust policies and their Professional Code. Work is planned to strengthen the recording of consent in adult areas. The consent to treatment policy has been updated. Work is ongoing to embed the 'Making Safeguarding Personal' agenda throughout the adult workforce, particularly related to safeguarding and MCA. There has been a newsletter, a 7-minute briefing, bespoke training and this is also included in the face-to-face training. Information has been shared with the Adult Safeguarding Champions, with a plan to use MSP and consent as the focus of a future Champion's meeting. In children's safeguarding work, there is clear reference to obtaining consent prior to making referrals. All training refers to consent in adults, the use and implementation of the MCA and reference to Fraser guidelines and Gillick competence for children.
5.3 The Provider will ensure that all colleagues undertake safeguarding training in line with national and local expectations. This includes s/g updates, minimum of 3 yearly + an annual written update. The provider will ensure that all Board level staff receive additional S/G level 1 requirement, as per Intercollegiate documents.					Ref 574 Safeguarding Vulnerable People Policy Provision is in place for all relevant training for all colleagues. There has been significant improvement in MaST compliance. The Training strategy has been reviewed and updated. Face to face Think Family training has been promoted in all divisions. Training KPIs are reported to safeguarding Operational group by all divisions. Additional sessions have been delivered in order to increase compliance figures. The Safeguarding team are working with learning and development to ensure the correct groups that require additional knowledge skills and competencies (level 3) are monitored on ESR via a learning log (Level 3 Plus). Additional bespoke training children's packages are being updated - quality referral and court report training. There has been a number of opportunities circulated out to the divisions. Following discussion at the January Safeguarding Committee, the group agreed that there was sufficient evidence of sustained improvement to accompany the mitigations in place.

GLOSSARY

ALT	Alcohol Liaison Team
CCG	Clinical Commissioning Group
CDR	Child Death Review
CDOP	Child Death Overview Panel
CDRM	Child Death Review Meetings
CQC	Care Quality Commission
DHR	Domestic Homicide Reviews
DoLS	Deprivation of Liberty Safeguards
EH	Early Help
ESR	Electronic Staff Record
HARK	Harassment, attack, rape, kick
ICB	Integrated Care Board
IHA	Initial Health Assessment
JAR	Joint Action Review
KPI	Key Performance Indicator
LAC	Looked After Child
LD/A	Learning Disability and/or Autism
LeDeR	People with an LD/A - Research
LPS	Liberty Protection Standards
MARAC	Multi Agency Risk Assessment Conference
MaST	Mandatory and Statutory Training
MCA	Mental Capacity Act
MDT	Multi-disciplinary Team
NHSE	National Health Service England
OM	Outcome Meetings
OP	Out Patient
RDaSH	Rotherham Doncaster and South Humberside NHS Trust
RHA	Review Health Assessment
RMBC	Rotherham Metropolitan Borough Council
RSAB	Rotherham Safeguarding Adult Board
RSCP	Rotherham Safeguarding Children Partnership
SAR	Safeguarding Adults Review
SCBU	Special Care Baby Unit
SI	Serious Incident
TRFT	The Rotherham NHS Foundation Trust
UECC	Urgent Emergency Care Centre

Board of Directors' Meeting
12 January 2024

Agenda item	P20/24
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 November 2023 (Month 8 2023/24): ○ A summary of the key performance metrics linked to income and expenditure, capital expenditure and cash management. • Section 2 – Income & Expenditure Account for November 2023 (Month 8 2023/24):

	○ Financial results to November 2023. - A deficit to plan of £149K in month and £1,106K year to date; - The same deficit to the (external) control total of £149K in month and £1,106K deficit to plan year to date. The Trust's performance is measured against its control total with NHS England, having adjusted for depreciation on donated and right of use assets (£499K year to date). • Section 3 – Income and Expenditure Account Forecast Out-Turn ○ An initial forecast out-turn up to 31st March 2024 of £3,890K 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. ○ The impact of the planned periods of Industrial Actions from December 2023 have not been factored into this position and will be a significant risk to delivery. • Section 4 – Capital Expenditure for November 2023 (Month 8 2023/24) ○ Expenditure for the eight month period ending November 2023 is £3,107K against a budget of £6,798K: an under-spend of £3,691K (54%) against the external plan. ○ 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 November 2023. A month-end cash value as at 30 November 2023 of £19,503K, which is £2,189K better than plan.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	This report to the Board of Directors has been prepared directly from information contained in the Trust's ledgers and is consistent with information reported externally to 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 will next be discussed at the monthly performance meetings being held on 30 January 2024. • CIP performance was discussed at the Efficiency Board meeting held on 5 December 2023. • Capital expenditure is reviewed by the Capital Monitoring Group. • Detailed discussions have also taken place at the meeting of Finance & Performance Committee on 20 December 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			YTD			Forecast variance £000s	Prior Month Forecast variance £000s
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s		
I&E Performance (Actual)	(515)	(665)	(149)	(5,084)	(6,189)	(1,106)	(3,890)	(3,908)
I&E Performance (Control Total)	(453)	(602)	(149)	(4,585)	(5,690)	(1,106)	(3,890)	(3,908)
Capital Expenditure	1,225	1,003	221	6,798	3,107	3,691	0	0
Cash Balance	(981)	220	1,200	17,314	19,503	2,189	(248)	(278)

1.2 The Trust has over-spent against its I&E plan in November 2023 and cumulatively there remains an overspend of £1,106k year to date. The Trust's performance is measured against its control total with NHS England, which is after adjusting for depreciation on donated and right of use assets, this is showing the same adverse variance. These figures do not include an adjustment for the full amount of underperformance on elective recovery activity, £4m is assumed to be covered within the current level of reserves. The cost pressures resulting from pay awards are within the position.

1.3 The forecast out-turn is a deficit to plan of £3,890K, an improvement of £18K from month 7. The Trust will be reporting delivery of the plan externally.

1.4 Capital expenditure is behind plan in month and year to date, with cumulative spend of £3,107k against a budget of £6,798k. Capital spend is forecast to fully deliver against plan.

1.5 The cash position at the end of November 2023 is £19,503K. This remains a strong cash balance and is in line with plan.

2. Income & Expenditure Account for November 2023 (Month 8 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 November 2023 of £149K and a year to date deficit to plan of £1,106K.

Summary Income & Expenditure Position	Annual plan £000s	Month			YTD			2023/2024 Monthly Trend / Variance
		Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	
Clinical Income	324,655	27,158	27,437	279	216,788	213,445	(3,343)	
Other Operating Income	24,876	2,151	2,366	215	16,928	17,939	1,011	
Pay	(236,861)	(20,409)	(20,799)	(390)	(158,248)	(162,275)	(4,028)	
Non Pay	(95,879)	(8,792)	(9,598)	(806)	(67,436)	(69,922)	(2,487)	
Non Operating Costs	(3,969)	(331)	(279)	51	(2,646)	(2,354)	293	
Reserves	(19,547)	(292)	210	501	(10,469)	(3,022)	7,447	
Retained Surplus/(Deficit)	(6,726)	(515)	(665)	(149)	(5,084)	(6,189)	(1,106)	
Adjustments	748	62	62	(0)	499	499	(0)	
Control Total Surplus/(Deficit)	(5,977)	(453)	(602)	(149)	(4,585)	(5,690)	(1,106)	

2.2 Clinical Income is ahead of plan in-month due to transacting the 1% target reduction on the Elective Recovery Fund (ERF), and is behind plan year to date mostly due to under performance on elective recovery activity. ERF divisional targets are included in budgets. £4m of this underperformance is currently offset in reserves.

2.3 Other Operating Income is ahead of plan in month and year to date with increased income from staff recharges (£333K), which will be an offset to the pay over-spend, increased research, development and education income (£339K), and other non-clinical income (£469K).

2.4 Pay costs are over-spending by £390K (2%) in month. The main contributory factors in month are £103K under-delivery of cost improvement targets and agency costs which are not budgeted for. The year to date performance is also being influenced by undelivered cost improvement targets of £2,767K.

2.5 Non Pay costs are over-spending by £806K in-month and by £2,487K year to date. The main categories of overspends are on drugs £375K, premises £1,358K, general supplies and services £203K and under-delivery of cost improvement targets of £313K.

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

2.7 £7,447K 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 2024

3.1 The table below shows the forecast out-turn position for the financial year 2023/24. The Trust is forecasting to deliver a £3,890K deficit to plan.

Summary Income & Expenditure Position	Annual plan £000s	Forecast (Full Year) £000s	Actual Variance (YTD) £000s	Forecast Variance £000s	Total Variance £000s	2023/2024 Monthly Trend / Variance
Clinical Income	324,655	321,601	(3,343)	289	(3,054)	
Other Operating Income	24,876	26,417	1,011	529	1,541	
Pay	(236,861)	(243,142)	(4,028)	(2,253)	(6,281)	
Non Pay	(95,879)	(99,860)	(2,487)	(1,494)	(3,981)	
Non Operating Costs	(3,969)	(3,532)	293	145	437	
Reserves	(19,547)	(12,100)	7,447	0	7,447	
Retained Surplus/ (Deficit)	(6,726)	(10,616)	(1,106)	(2,785)	(3,890)	
Adjustments	748	748	(0)	(0)	(0)	
Control Total Surplus/ (Deficit)	(5,977)	(9,868)	(1,106)	(2,785)	(3,890)	

3.2 Within Clinical Income, the estimated ERF YTD under delivery against divisional targets is reflected. £4m of the underperformance is currently offset in reserves and any underspends against the latest targets will be clawed back. No further under-delivery of ERF is forecast at this stage in line with NHSE's monthly reporting guidance. Additional income is forecast from other variable activities.

3.3 Other Operating Income is forecasting increases in income from research, development, education & training (£579K) and staff recharges (£606K). 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 £4,658K and agency costs.

3.5 Non Pay costs are similarly showing a significant deterioration in performance linked to continued increasing costs, most notably within premises £2,101K, undelivered CIPs £855K and drugs £375k.

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. The impact of the planned periods of Industrial Actions from December 2023 have not been factored into this position and will be a significant risk to delivery.

3.8 Cost reduction and CIP delivery is continuing to be managed proactively across all services, with clear action plans being implemented. This remains a significant risk to the Trust delivering against its overall plan.

4. Capital Programme

4.1 As at November 2023 the Trust has incurred capital expenditure of £3,107K against a budget of £6,798K representing an under-spend of £3,691K (54%).

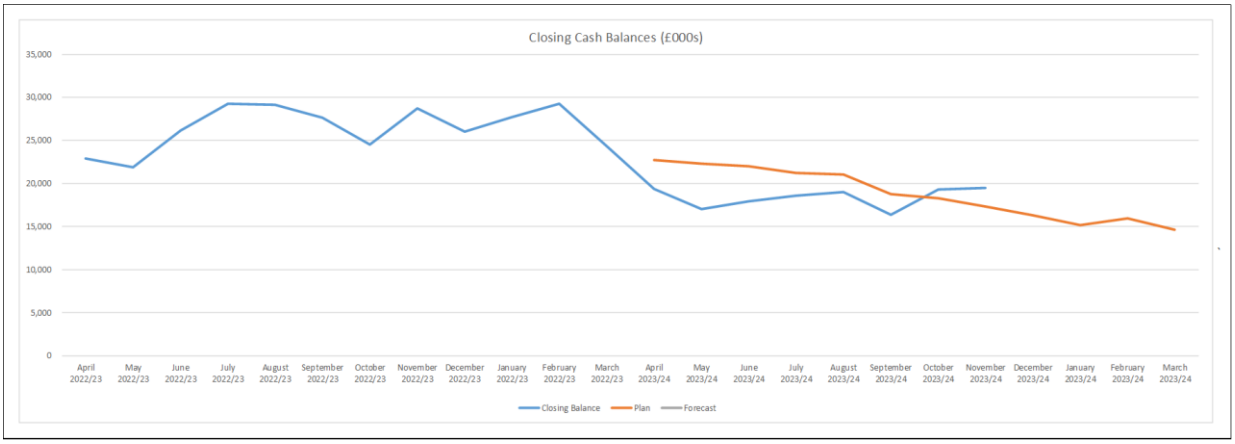
Capital Expenditure	Month			YTD			Forecast	Prior Month Forecast
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Variance £000s	Variance £000s
Estates Strategy	580	292	288	2,503	666	1,838	0	0
Estates Maintenance	90	385	(295)	998	863	135	0	0
Information Technology	113	151	(38)	1,424	1,028	396	0	0
Medical & Other Equipment	(73)	175	(248)	866	550	316	0	0
Other	515	0	515	1,006	0	1,006	0	0
TOTAL	1,225	1,003	221	6,798	3,107	3,691	**0**	**0**

4.2 'Other' is the re-profiling of the internal budget against the capital plan submitted to NHSE. Against the re-profiled internal plan the under-spend is £2,685K (46%).

4.3 The capital programme is monitored at the Capital Monitoring Group, chaired by the Director of Finance. Capital expenditure is expected to fully deliver against plan of £10,355K and additional PDC of £1,050K.

5. Cash Management

5.1 Compared to plan, there is a favourable variance in-month of £1,200K and year to date variance of £2,189K. Cash remains strong with a closing cash balance of £19,503K as at 30 November 2023.



5.2 The cash position has allowed the Trust to earn interest on its daily cash balances of £115K in-month (£809K year to date), which will help contribute towards the Trust's cost improvement target for 2023/24.

Steve Hackett
Director of Finance
2nd January 2024

Board of Directors' Meeting

12 January 2024

The Rotherham NHS Foundation Trust

Agenda item	P21/24
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 end of Quarter 3 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 and D5 where this risk impacts on our People; **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 been 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 early November 2023, the relevant sections of the Board Assurance Framework has been discussed at the relevant Board Committees during November and December 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 remain at 20; and ➢ The score for BAF Risk D7 to increase to 20
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 the end of Quarter 3 of the financial year. Furthermore, the report provides as summary of the discussion and decisions that have taken place at the relevant Board Assurance Committees during November and December 2023.

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 November and December 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 November and December 2023, additional commentary has been added to the controls and assurance and gaps in assurance sections, highlighted in red for ease of reference.

Controls and assurances

2.2 No additional controls have been added to BAF Risk P1 during this review period.

Gaps in controls

2.3 The one significant change to the gaps in controls for this review period was the announcement and subsequent industrial action taken by junior doctors during December 2023, this followed a period of no industrial action earlier in the quarter. This industrial action was mitigated by the processes previously put in place, however the full effect on patient experience is yet to be realised.

2.4 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).

Ongoing progress continues to be made in relation to closing the gaps in controls and as such 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 that has continued during Quarters 2 and 3.

3.2 Review of the risk score

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 supported by the 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 A joint leadership programme focused on the Triumvirate from the Trust and Barnsley has been commissioned and the company commenced this work in October 2023.

4.4 Review of the risk score

It is recommended that the score remains at **8.**

5 U4: There is a risk that we will 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.

5.1 Strategic BAF Risk U4 is aligned to the People Committee and was discussed at the meetings in October and December 2023 along with the gap linked to challenges around sufficient workforce to support the recovery plan (including industrial action). The Health & Wellbeing report quarterly update is expected at the February 2024 People Committee. Further support for senior leaders and management is currently being developed.

5.2 Review of the risk score

Following the outcome of the review at People Committee in December 2023, it is recommended that the score remains at **12.**

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.

6.2 Review of the risk score

Following the monthly review during November and December 2023 it is recommended that the score remains at **20.**

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.

7.2 Review of the risk score

Due to the continuing work around the financial plan and the potential adverse financial impact of the industrial action it was recommended at the December 2023 Finance and Performance Committee that the risk rating is increased to **20** and will be further reviewed when we have further clarity on the system wide financial position and financial effect of the industrial action.

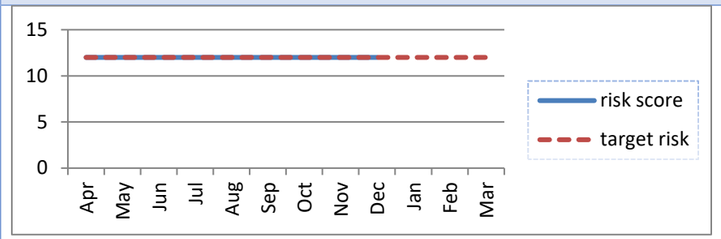
Recommendations

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;
  - The score for BAF Risk U4 to remain at 12;
  - The score for BAF Risk D5 to remain at 20; and
  - The score for BAF Risk D7 is increased to 20.

Angela Wendzicha
Director of Corporate Affairs
05 January 2024

Ambition	Strategic Risk			Original Score LxC	Score Q1	Score Q2	Score Q3	Score Q4	Target Risk Score	Movement	Risk Appetite/
	There is a Risk that….	Because…..	Leading to…..								
Patients: *We will be proud that the quality of care we provide is exceptional, tailored to people's needs and delivered in the most appropriate setting for them.*	P1: we will not embed quality care within the 5 year plan	..of lack of resource, capacity and capability	..poor clinical outcomes and patient experience	4(L)x 4(C)=16	12	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	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	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.	3(L)x4(C)=12	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	4 (L)x3(C) = 12	12	20	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	20		4(L)x5(c) =20	⇑	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**	**12**	
BAF Risk Description						**Linked Risks on the Risk Register & BAF Risks:** **RISK6623, RISK5761, RISK6809, RISK6800, RISK6630, RISK6762, RISK6627, RISK6886, RISK6284, RISK5238, RISK6723, RISK6958, RISK6857, RISK6801, RISK6888, RISK6718 and RISK6421**				**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	December 2023	Deputy CEO	Level 1 & Level 3
		Quality Assurance Report to Quality Committee (Quarterly)	October 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	September 2023	Chief Nurse	Level 2 – Medication Safety Audit completed
		Monthly Quality Dashboard reported to Divisional Performance Meetings.	December 2023	Chief Nurse	

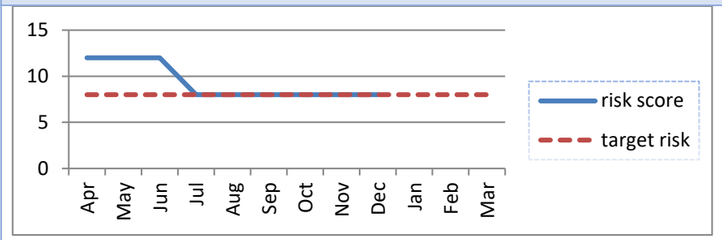
		Published Patient Experience Annual Report on Trust website.							
C3	Agreed 2023/24 Quality Priorities in place	Progress reports received by Quality Committee quarterly Monthly metrics dashboard now presented for quantitive data. Clinical Effectiveness is a priority, Clinical Effectiveness Manager now in post.	December 2023	Chief Nurse	Level 1 Progress reports on Quality Priorities presented within each quarter Quarter 2 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.	December 2023	Chief Nurse	Level 1				Recent inpatient survey results not as expected, an action plan has been developed and is in place
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 and Board in November 2023. HSMR continuing to track downwards	May 2023 December 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 signed off by the Medical Director - Policy gone through Document Ratification Group and published on 24th November 2023. Last 6 months HSMR showing downward trend and now lowest in Y&H region				
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. Pharmacy in Barnsley have had a recent CQC report and TRFT are developing a plan to assure Medication Management. A paper will be presented to Quality Committee via the Medication Safety Committee.				
C7	Quality Improvement & Quality Governance Assurance Priority within Operational Plan	Quarterly updates to Quality Committee	October 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 October 2023.				Presented quarterly. Next January 2024
C8	Implementation of PSIRF	Monthly meetings established	October 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. Agreed priority themes for Patient Safety related to PSIRF. Quarterly PSIRF update to Quality Committee as part of Patient Safety reporting. PSIRF plan for approval at Board of Directors January 2024 360 undertaken review of PSIRF implementation, report awaited at next Audit & Risk Committee				
C9	Implementation of agreed Strategy for Journey to CQC Outstanding rating	Quarterly progress reports to Quality Committee (links with Gap 14), next was October 2023 Meeting with CQC to discuss expectations 25/01/24	October 2023	Chief Nurse	**Level 1**				

C10	Implementation of Safeguarding Improvement plan in conjunction with NHSE	Reports to Safeguarding Committee was July 2023	October 2023	Chief Nurse	External review NHSE paediatrics and maternity occurred on 01/06/2023, report sent to TRFT August 2023 with positive assurance 12-17/07/2023 – Rotherham Adult Safeguarding Peer Review took place Adult plan commences in February 2024, NHS team attending Strategic Board February 2024.						
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 Recruit to x2 further roles in QI team	Chief Nurse & Medical Director Chief Nurse & Medical Director Chief Nurse & Medical Director Chief Nurse		August 2022 March 2023 September 2023 Recruitment process commenced	~~September 2022~~ June 2023 ETM 8 June 2023			Recruitment for MD for Quality Improvement (2PA's) to be completed Revised JD for Patient Safety & QI Lead Advert now closed for bands 5 and 7 with good quality applicants. QI Medical Lead to advert shortly. 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 going through final sign off	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. Development of lessons learned resource to be undertaken 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~~ Extend to March 2024			~~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	**Archived – see version 2.2 2023/24 – Superseded by G27**								
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	Potential 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 and Board of Directors September 2023	Medical Director and Chief Nurse	January 2023 September 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. NACEL to be four times per annum from 2024 New End of Life Nurse to commence in post January 2024. Paper to ETM regards restructure of team - December 2023	
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. Patient representative to be agreed. Went live with PSIRF beginning of November – Operational plan and	

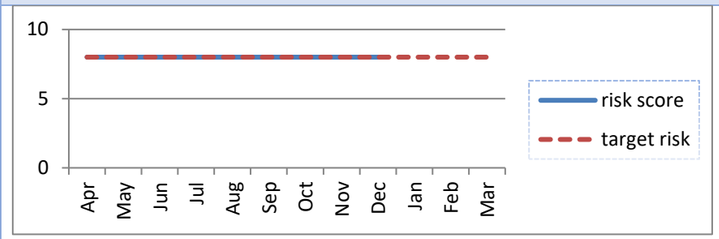
		360 Assure audit on PSIRF assurance to commence Qtr3.	Chief Nurse	March 2024	March 2024			Policy to Patient Safety, then Quality Committee October 2023 and finally Board in January 2024.	
G21	**Archived – see version 1.1 2023/24**								
G22	**Archived – see version 1.1 2023/24**								
G23	Plan to introduce an Exemplar accreditation programme	Strategic planning session with Heads of Nursing	Chief Nurse	19/06/2023	December 2023			To go live from April 2024, with raising awareness sessions to be held January to March 2024. Lead wards in three divisions identified.	
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	On hold pending recruitment of Assurance Lead 8c				
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	Completed January 2024				Submitting retrospective data, not as much of a risk as initially thought as data is being submitted. Qtr3 will see a 360 Audit of National Audits & NICE Guidelines process.	
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 and D5) 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 & FPC Director of Workforce & FPC Director of Operations & FPC Director of Workforce & FPC Chief Operating Officer & FPC	Ongoing Completed 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. To be reviewed for 2024/25. 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 Watchful eye on external factors patient harm being monitored and not believed to be at a level to increase risk rating at this time.	

		Monitoring of all incidents for possible link to industrial action. Monitoring of cancellation of elective work leading to increased waits for treatment	Chief Nurse & QC Director of Operations & FPC	Ongoing Ongoing				Next round of junior doctor IA to commence over Christmas and New Year period	
G28	GAPS in National Audit work	360 Assurance to audit in Qtr3, will also be looking at compliance with NICE Guidelines	Medical Director & QC	January 2024					
Archived Controls within month- Completed									
Archived Gaps within month - Completed									

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 at the end Q4 thus reaching score.**	**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**	**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 2023	Board minutes		Level 1					Control remains ongoing	
C2	Trust is a member of Prevention and Health Inequalities Group		**July**			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**	
C6	Meeting with PLACE colleagues to review IDT position.	Meet three times a week to review integrated discharge position.	**October 2023**			Level 1						
C7												

Gaps in Controls or Assurance Quarter 1 2022-23		**Actions Required**	**Action Owner**	**Date Action Commenced**	**Date Action Due**			**Progress Update**	
G1	Trust to be a member of the PLACE Committee of the ICB once established.		Deputy Chief Executive	Ongoing				Awaiting final confirmation from external source	
G2	Unknown entity around the ICB governance		Deputy Chief Executive	Ongoing				Paper expected for the September Board No change to position	

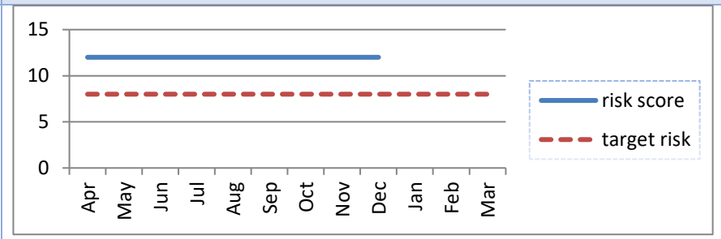
	which is continuing to evolve and mature.								
G3	Incomplete data driven identification of Health Inequalities across elective and non-elective pathways.		Deputy Chief Executive		End Quarter 1			Data relating to access to services available in Trust Integrated Performance Report – suggest close this 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)**						
Link to Operational Plan: P3: Our Partners: Work together to succeed for our communities.											
							Previous score Q4 2022-23	**Q1**	**Q2**	**Q3**	**Q4**
							12	**8**	**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 Chief Executive & Deputy Chief Executive**	

Controls and Mitigations ***(what have we in place to assist in securing delivery of our ambition)***		**Assurance Received** *(what evidence have we received to support the control)*	**Date Assurance Received**	**Confirmed By:**	**Assurance Level** *Level 1 = Operational* *Level 2 = Internal* *Level 3 - Independent*
C1	The Trust is a member of the South Yorkshire & Bassetlaw Acute Federation and Chaired by the Trust Chair	Monthly Reports received by the Trust Board	**December 2023**	**Minutes of the Trust Board**	Level 1
C2	Shared Chief Executive function between the Trust and Barnsley NHSFT	Completed	**01 September 2022 substantive**	**N/A**	Level 1
C3	Existing collaboration with Barnsley on some clinical services	Reports to the Joint Strategic Partnership Group and respective Boards	**November 2023 December 2023**	**Minutes of JSP and Board**	Level 1
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.	**December 2023**	**Reports to Boards on progress**	Level 1

Gaps in Controls or Assurance		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
G2	Triumvirate Joint Leadership Programme	**Company commissioned to deliver programme**	**Deputy CEO**	**October 2023**	**October 2024**			**Programme commenced**	

BAF Risk U4

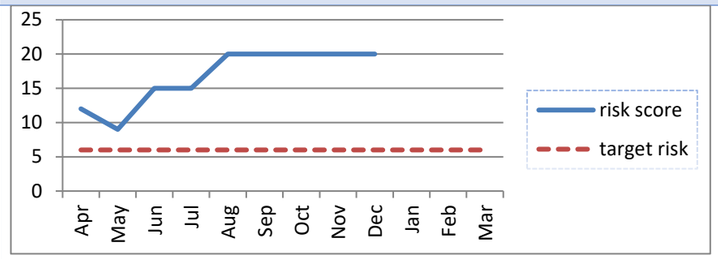
Strategic Theme: Us	**Risk Scores**											
	BAF Risk Ref	**Initial Score**	**Current Score**	**Target Score**	**Risk Appetite/Risk Tolerance**	**Risk Movement**				**Board Assurance 2023-24**		
Strategic Ambition: **Us:** ***We will be proud to be colleagues in an inclusive, diverse and welcoming 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**	**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 (2020-23)	Reports on progress against the People Strategy inclusion of BELL Framework	Nov 22	Paper to PC and ETM PC agenda template		Level 1								
C2	Archived – see version 2.1 Quarter 2													
C3	**Archived – see version 2.2 Quarter 2**													
C4	WDES, and WRES action plans	WRES and WDES action plans submitted to NHSE and People Committee WRES and WDES action plans submitted to Board of Directors Progress against action plans monitored via Operational Workforce Group and People Committee All Divisions attended Joint Partnership Forum to detail action plans	October 2023 November 2023 Agreed at Oct22 Board 21 July 2022	Board minutes Board minutes Reports to People Committee Board minutes		Level 2 Level 1 Level 2							**Completed** **Ongoing** **Completed**	

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 outcomes and scores including Medical engagement Divisional Action Plans to PC on a rolling basis	Q4 2023/4 Q4 2023/4		Level 3 Level 1				**Director of People & Medical Director**
C14	Delivery of the Nursing and AHP retention and recruitment programme	Reports to People Committee	~~October 2023~~ Q3/Q4	Quarterly report to PC	Level 1				**Chief Nurse**
C15	**Gap removed as duplicate of G14 above**								
C16	Senior Medical Leadership Development Programme	Reports to People Committee	October 2023	Quarterly report to PC	Level 1				**Director of People & Medical Director Ongoing quarterly report**
C17	Leadership Programme in place for Divisional Triumvirate leadership teams	Identify suitable leadership development programme provider. Tender documentation signed off by Deputy CEO. Procurement exercise scheduled 18/07/23. Scope to be revised and intensive programme to be agreed. Delivery partner Value Circle identified and commissioned, began engagement work and launched programme Friday 10th November 2023	November 2023		Level 1				**Deputy Chief Executive & Director of People**

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~~	**Gap moved to control (C17) - See version 3.2 2023/24**							

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 On track			Early internal engagement underway, People Committee session to be planned Q3 On track – report to PC October 2023, PC Session to be held December 2023 ETM agreed scope Nov'23	
G4	Development of a workforce plan aligned to ~~clinical, operational, financial plans etc.~~ Acute Care Transformation (ACT) programme & Theatres Transformation Programme (ETM agreed scope)	Consider scope Priority areas Proposal to take forward Engagement and work	Director of People	To begin Q3	End March 2024 On track			Future dated. On track, work began Q3, discussion at PC ETM agreed scope Nov'23	
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 D5 and P1)	Divisional Leads & FPC	Ongoing				Director of Corporate Affairs discussed with Director of Workforce and will further assess need for a new BAF risk relating to a sustainable workforce. 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.	
		Ongoing negotiations with JLNC regards extra contractual payments for medical and dental staff.	Director of Workforce & FPC	Completed	Ongoing			Completed On the July FPC agenda for endorsement in respect of Extra Contractual work. To be reviewed for 2024/25.	
		Regular industrial action meetings to mitigate impact.	Director of Operations & FPC	Commenced	Ongoing			Discussion has taken place resulting in the agreement that the Assurance Committees has sight of the BAF Risk and has oversight of the actions to mitigate this gap once confirmed with the Divisional leads.	
		Clear rates of pay established for strike cover	Director of Workforce & FPC	Completed	March 2023				
		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 & FPC					Papers sent to FPC Impact of Industrial Action paper sent to September FPC Phase 1 deep dive undertaken. Phase 2 has commenced which involves an independent review.	

		Financial allocation identified in plan for 2023/24 – risk in allocation of ERF given overall financial position. Impact on staff as a result of industrial action. Support health & Wellbeing of staff. Increased stress leading to increased sickness/absence and burn out.	FPC Director of People & PC	September 2023 Ongoing	September 2023 December 2023			Quarterly update on Health & Wellbeing report to PC August 2023 which covered Q4 and Q1. Monthly performance meetings. Support for senior leaders and managers during industrial action. Further support for senior leaders and management being developed & presented at December'23 PC. (update now due at February'24 committee) Impact on staff and teams, need to support wellbeing of staff dealing with increased stress, sickness absence and impact on team dynamics	

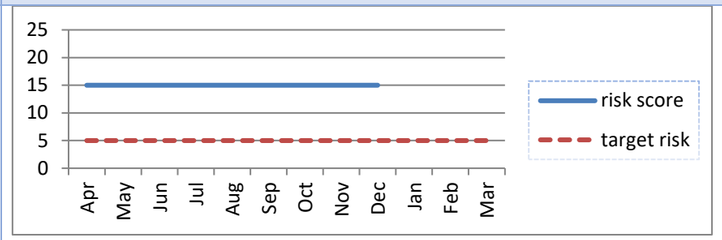
Strategic Theme: Delivery	Risk Scores										
	BAF Risk Ref	Initial Score	Current Score	Target Score	Risk Appetite/Risk Tolerance	Risk Movement				Board Assurance 2023-24	
Strategic Ambition: Delivery: We will be proud to deliver our best every day, providing high quality, timely and equitable access 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**	**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, RISK6755 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	**December 2023 IPR** **December 2023 IPR** **December 2023 IPR** **December 2023 IPR**	**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	**December 2023 IPR**	**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. Now includes Medical Director	**December 2023 IPR** **December 2023 IPR** **December 2023 IPR**	**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	**December 2023 IPR** **December 2023 IPR**	**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.	**December 2023 IPR**	**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	**December 2023 IPR** **December 2023 IPR**	**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	**December 2023 IPR**	**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. New weekly PTL for Elective and Cancer week commenced 27/11/2023	**December 2023 IPR**	**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. Beds now open w/c 25.09.23 in line with plan. Bed modelling rerun. Bed base right, bed occupancy improved to below 92% standard.	
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 underway, awaiting outcome. Validation of waiting list over 90% requirement. Awaiting formal report and verbal feedback provided 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	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. Text validation and also admin validation. Weekly diagnostic information available, forecasting of month end position to be introduced. Weekly data provided to weekly Access meeting	
~~**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.	Divisional Leads Director of Workforce Director of Operations	Ongoing Commenced Commenced	 Ongoing Ongoing			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. 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	

		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.	Director of Workforce Chief Operating Officer	Completed June 2023	March 2023			mitigate this gap once confirmed with the Divisional leads. Impact of IA paper to go to ETM and then Confidential Board, as well as FPC, QC and PC. 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. Further paper to ETM w/c 18.09.23 outlining further work to be undertaken. Good visibility through job plans. Phase 2 of work to be undertaken with external expertise - plans agreed. Further IA dates confirmed as Christmas and New Year period	
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	Chief Operating Officer					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. Plan in place for recovery schemes and investment in line with ERF allocation in 2023/24 plan - now being implemented. Positive impact on both activity and waiting times.	

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~~ 4(L) x 5(C) =~~15~~ 20**	**1(L)x5(C) =5**	**Low (6-10)**						
Link to Operational Plan: D7: Implement sustainable change to deliver high quality, timely and affordable care								**Current**	**Q1**	**Q2**	**Q3**	**Q4**
								15	**15**	**15**	**20**	
BAF Risk Description							**Linked Risks on the Risk Register & BAF Risks**				**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.							**RISK6886, RISK6755 and RISK6801** **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 December 2023**		L1					
C4	Winter funding allocated in reserves of £2m.				**Trust Board December 2023**		L1					
C5	Elective recovery fund £5.2m				**Trust Board December 2023**		L1					
C6	TRFT received access to growth money allocated to PLACE.				**Trust Board December 2023**		L1					
C7	Financial plan sign off to NHSE by 04/05/2023	Submitted on time, still awaiting sign off by NHSE			**Trust Board December 2023**							
C8	Service developments held in reserve of £2.5m.				**Trust Board December 2023**							
C9	Finance and Performance	Budget reports presented to Finance and Performance Committee		December 2022	Minutes of F&P		Level 1					

	Committee oversee budget reports								
C10	System wide delivery of Recovery On plan with mitigations in place to manage winter pressures.	Director of Finance attends South Yorkshire DoF Group	December 2022		Level 1				
		Monthly Finance Report to CEO Delivery Group	December 2022	Minutes	Level 1				
		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	**Trust Board November 2023**	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	**Trust Board October 2023**	**Report**	Level 3				
		360 Assure Head of Audit opinion presented to Risk and Audit Committee initial indications show Significant Assurance overall	October 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				
C17	Regular meetings with ICB on a bi-monthly basis following Single Oversight Framework (SOF) status from 2 to 3.	Awaiting meeting set up Target of SOF status of 2 by Quarter 4. Met three times, twice as RTFT and then once alongside Doncaster and Barnsley. Initial conversation about return to financial balance within 2 years.		Director of Finance					

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 8 financial position year to date £1.1 million adverse variance position, with adverse position of £150,000 in month. With a forecast of £3.9m variance at year end, however it is still believed a break even position can be achieved by management action and the use of reserves. November 23 was the first month elective recovery fund met monthly target	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. Anticipated loss based on month 1 to month 6 achieving £3.5m ICB notified. Financial Plan predicted on no further loss.	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. 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.	Director of Finance. Divisional Leads & FPC Director of Workforce & FPC Director of Operations & FPC Director of Workforce & FPC Chief Operating Officer & FPC	Reports to F&P 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. To be reviewed for 2024/25. 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 Industrial action for junior doctors confirmed for Christmas and New Year period	
G11	National calculation of ERF performance including amendments linked to IA	Letter has been sent to ICB requesting clarification of in-year performance given discrepancies between national calculations and local calculations. Trust has received a further £511,000 reduction to the ERF target. However ICB have requested the Trust to improve its financial plan by the same amount. No further funding for costs of Industrial Action will be given to the Trust.	Director of Finance	September 2023 letter sent	Awaiting ICB response				
G12	Revised Financial Plan is now £4.47m	Board approved revised Financial Plan with 3 actions on 20/11/2023	Director of Finance	November 2023	Monthly reviews to 31/03/2024				

	deficit which is an adjustment of £1.26m								

Board of Directors' Meeting
12 January 2024

The Rotherham NHS Foundation Trust

Agenda item	P22/24
Report	**Corporate Risk Register Report**
Executive Lead	Angela Wendzicha, Director of Corporate Affairs
Link with the BAF	The following paper links with all BAF Risks
How does this paper support Trust Values	This paper supports all Trust values. By having up to date information on the Trust's risks we can use and evaluate this information to take actions and decisions that improve both patients' and staff experience.
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	The purpose of the Corporate Risk Register Report is to provide to the Board of Directors an overview of all risks rated at 15 or above across the Trust, all of these risks have been discussed and approved at the trust Risk Management Committee. • Of the 20 approved risks 3 fall outside of review date. • All of the risks except Risk6602 have action plans, this is due to be added this month • The slippage in review dates or the risks and action plans is likely due to the holiday period and all risk owners have been advised to maintain risks on the Datix system in line with policy.
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 Risk Management Committee and shared with the Audit & Risk 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?)	Once presented, the Director of Corporate Affairs, as Executive Lead will continue to ensure that risks are appropriately identified, recorded, reviewed and managed.
Recommendations	It is recommended that the Trust Board: • Note the content of the Report

	• Note the progress made in progressing the risk management process.
Appendices	Corporate Risk Register

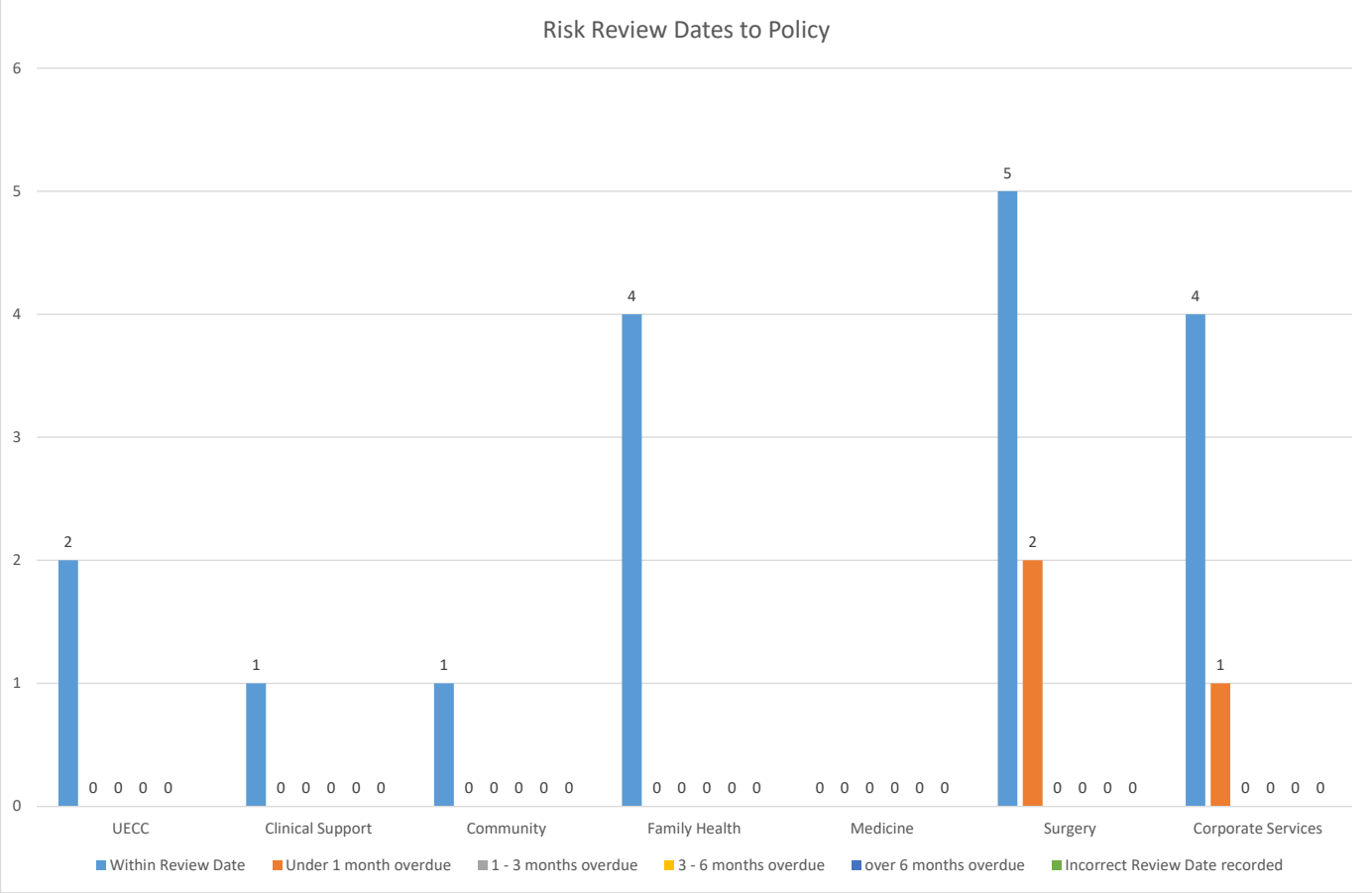
Corporate Risk Register

1. Introduction

The following report provides an update to the Board of Directors for the review of all risks scoring 15. The risks contained within this report includes all risks rated at 15 or above recorded on Datix on 04/01/2023. Please note that all of these risks have been approved at Divisional level and also approved by the Risk Management Committee. Appendix 1 contains further details of the risks.

2 Risk Review dates

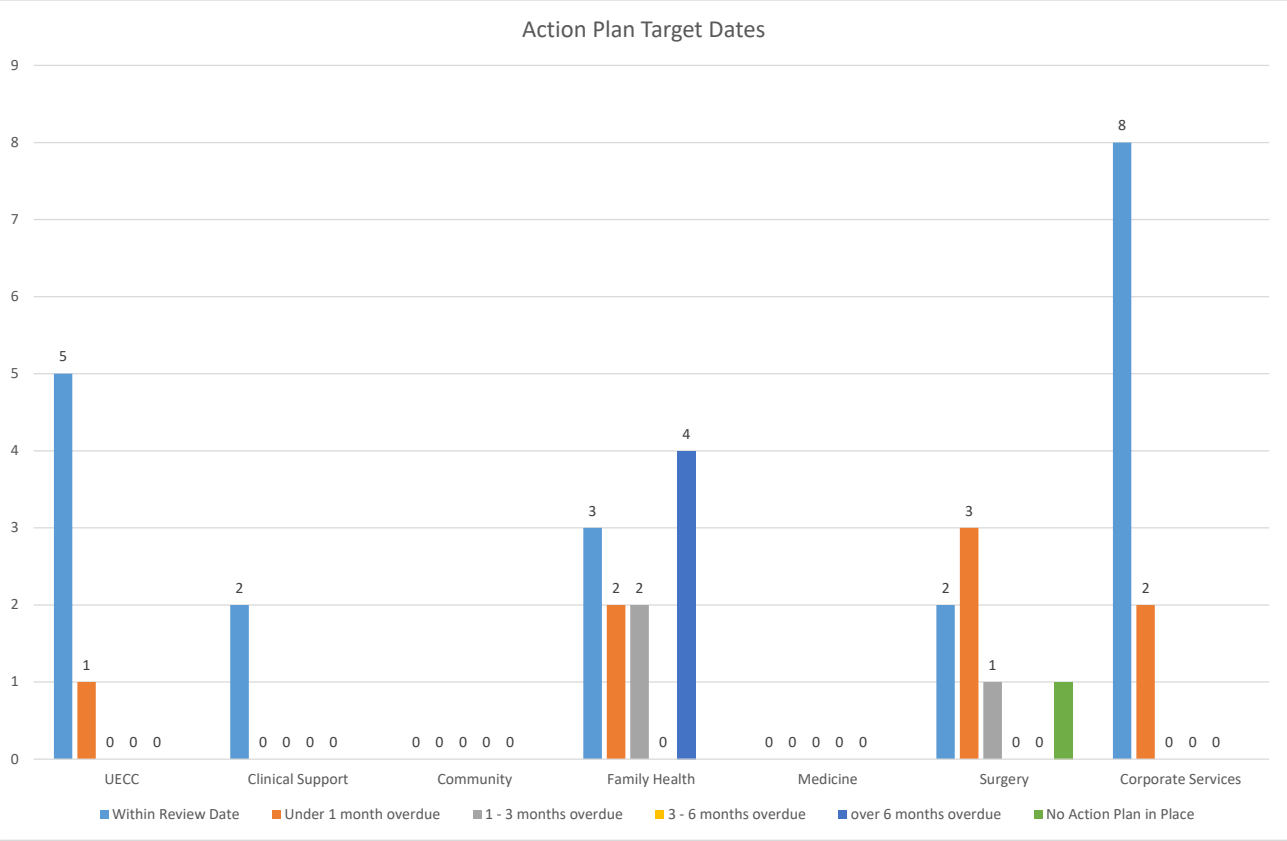
In terms of compliance with risk review dates, the graph below shows all risks rated at 15 and above for all Divisions. This graph is to provide the Board with an overview regarding the current Trust position for the management and review of these high level risks.



The risk owners and Divisional Management have been requested for updates of the three out of date risks and it is anticipated these will be updated the week commencing 08/01/2024. Please note that at time of report publication the Division of Medicine had no risks rated at 15 or above.

3 Risk Action Plans

All risks rated at 15 or above have current action plans, the Corporate Affairs Department are in the process of reviewing these action plans and working with the risk owners where applicable to review the actions. There are currently 6 risks that have action plans logged in Datix with only 1 action, there will be a review of appropriateness and whether additional actions are required to mitigate the risk.



As can be seen in the graph above there are currently 20 risks rated at 15 or above and from these there is a total of 75 individual actions. Of the individual actions 36 are still to be completed, the graph shows that currently all but 11 individual actions are within target dates.

There are 2 risks that show as all actions have been completed, however the risk owners believe the risks are still valid and open. Further clarity is being sought around this position.

4. Emerging Risks

The Audit & Risk Committee has previously requested that the Trust identify emerging risks to the divisional services going forward. These are seen as risks that are not

already recorded on Datix and could arise due to potential changes in service delivery, funding or national changes in regulations or NHSE/CQC initiatives.

The following have been identified by the divisional representatives at the Risk Management Committee, who monitor the risks monthly, and were noted by the October 2023 Audit & Risk Committee:

- Second Medical Opinion (Martha's Rule)
- Primary care struggles over winter 2023/24
- Advanced Clinical Practitioner roles
- Surgical misogyny
- Significant fall of training nurses and AHPs (Allied Health Practitioner) at Sheffield Hallam University resulting in a substantial shortfall in staff coming through in 2-3 years' time.

This is not a limited or completed list and the Divisions are asked to discuss and submit further examples with the Divisional Governance Leads and the Corporate Affairs Department, either directly or in the RMC.

Alan Wolfe
Deputy Director of Corporate Affairs
January 2024

15+ Risk Register January 2024

ID	Opened	Handler	Division	Title	Description	Risk level (initial)	Risk level (current)	Risk level (Target)	Date REVIEWED	Review date	Progress notes	Approval status	Description	Start date	Due date	Done date	Responsibility ('To')
6755	20/07/2022	Vasey, Benjamin	Division of Surgery	Ability to Achieve Financial Control Total	There is a risk of the Division not achieving it's agreed financial control total for the financial year 23/24	Significant 12	Extreme Risk 20	Moderate 4	28/11/2023	31/01/2024	[Vasey, Benjamin 28/11/23 18:56:01] Reviewed 28/11 - agreed at Nov RMC. wording to be considered to reflect FOT/ERF rather than original control total, which excluded ERF	Approved Risk	CIP Delivery Plan	01/04/2023	31/10/2023		Vasey, Benjamin
													FOT Recovery Plan	27/09/2022	31/03/2023	16/04/2023	Vasey, Benjamin
6886	23/03/2023	Hackett, Steve	Corporate Services	Ability to deliver 2023/24 Financial Plan	Non delivery of the financial plan which is currently a £6.0m deficit. Caused by inability to deliver a £12.2m cost improvement programme or under recovery of elective recovery income (current target 103% of 2019/20 activity)or cost pressures exceed amounts set in reserve. Resulting in cash deficiencies limiting ability to pay suppliers and potential regulatory actions for failure to live within financial resources made available.	Extreme Risk 25	Significant 20	Moderate 5	03/01/2024	02/02/2024	Wallett, Val 03/01/2024 13:24:57 [Steve Hackett - 03/01/24) Due to the announcement of further industrial action for December 2023 and January 2024, Finance & Performance Committee requested that the risk score be increased to 20.	Approved Risk	Theatre improvement programme.	23/03/2023	23/02/2024		Kilgariff, Mrs. Sally
													Outpatient utilisation programme.	23/03/2023	23/02/2024		Kilgariff, Mrs. Sally
													Cost improvement Efficiency Board.	23/03/2023	23/02/2024		Hackett, Steve
													Development of robust capacity plans.	23/03/2023	23/02/2024		Hackett, Steve
													Development of Winter plan.	23/03/2023	23/11/2023	03/11/2023	Hackett, Steve
					Unavailability of Anaesthetists due to				1/7				Interview 2x shortlisted consultant candidates	10/01/2023	31/01/2023	16/04/2023	Shuker, Katy
													Agree temporary alignment of additional on call rate with UECC colleagues	01/12/2022	31/01/2023	16/04/2023	Vasey, Benjamin
													Extend use of insourcing support	05/06/2023	29/09/2023	18/07/2023	Thurman (No longer in the Trust), Mr Simon
													External review of the Anaesthetic rotas	19/06/2023	31/12/2023		Vasey, Benjamin
													Develop an options appraisal	22/06/2023	31/07/2023	18/07/2023	Vasey,

ID	Opened	Handler	Division	Title	Description	Risk level (initial)	Risk level (current)	Risk level (Target)	Date REVIEWED	Review date	Progress notes	Approval status	Description	Start date	Due date	Done date	Responsibility ('To')
													paper for review at ETM.				Benjamin
6723	10/06/2022	Vasey, Benjamin	Division of Surgery	Anaesthetic Medical Staffing Availability	long and short term sickness. Caused by long and short term sickness. Resulting in lack of availability of Anaesthetists results: Gaps in the on call rota Loss of operating lists in theatres potential burn out for staff picking up on call shifts.	Significant 12	Extreme Risk 16	Moderate 6	11/10/2023	30/11/2023	[Timms, Deborah Mrs. 23/11/23 14:01:12] 22.11.23 - Reviewed to combine with 4094 - Risk 4094 now closed	Approved Risk	Advertise agency locum at all tiers and recruit as appropriate	01/08/2022	30/09/2022	02/10/2022	Thurman (No longer in the Trust), Mr Simon (Inactive User)
													Reduce elective operating for August - Review for September	01/08/2022	31/08/2022	02/10/2022	Thurman (No longer in the Trust), Mr Simon (Inactive User)
													Full departmental roster review led by SLT	22/09/2022	30/09/2022	23/09/2022	Vasey, Benjamin
													Confirm insourcing arrangement for 6 week period	05/09/2022	05/09/2022	02/10/2022	Thurman (No longer in the Trust), Mr Simon (Inactive User)
													SCH joint recruitment	01/08/2022	31/10/2022	22/06/2023	Thurman (No longer in the Trust), Mr Simon
6421	31/03/2021	Wilman, Mrs. Johanna	Division of Family Health	Backlog of children waiting to be seen for assessment Community Diagnostic Centres (CDCs)	Delay in assessment and formulation of a care plan for children aged 0-5yrs with additional needs. This will impact on long term outcomes including health and fulfilling educational/developmental potential	Significant 15	Significant 15	Moderate 6	27/12/2023	31/01/2024	[Wilman, Johanna Mrs. 27/12/23 16:18:44] Meetings with the commissioners continue. we have agreed to the following: 1. Changes to the neurodevelopmental pathway from the 1st January 2024 to be more in line with the RDASH 5-19 pathway for school aged children 2. Referral form to be updated and approved with more joined up working and support between services. 3. A decision on how to manage the current backlog and the impact on new referrals in to the service to be agreed. 4.A list of 250 children aged over 5 to be handed over to the Commissioners who will collate information from schools and a decision will then be made as to whether the child is CDC or CAMHS responsibility. Next meeting 3rd January 2024.	Approved Risk	Support without referral Pathway	18/09/2023	30/12/2023		Wilkinson, Jo
													Funding for further staff	18/09/2023	30/11/2023		Wilman, Mrs. Johanna
													Psycology Funding	18/09/2023	30/11/2023		Wilman, Mrs. Johanna
													Joint working with RDASH	18/09/2023	30/11/2023		Wilman, Mrs. Johanna
					Cardiac Physiology Staffing Levels consistently unable to meet all the needs of the service. This includes				2/7		20:03:26] 19/12/23 - Update by LB. Challenge persists. Vacancies & latest staff turnover: 1.0 WTE B6 Cardiac Physiologist handed in notice (only 3 months post qualification - moving to private sector) 2.0 WTE B2 Admin staff moving into new posts (within same dept) 1.0 WTE B7 Echocardiographer requested career break in Nov 24 for 6months 1.0 WTE B7 device Physiologist approved for career break in Nov 24 for 6months Ongoing locums: 2.0 WTE Device B7 - mat leave and vacancy. Vacancy has been advertised 7 times unsuccessfully. readvertised Dec 23 1.0 WTE Echo B7 - mat leave New requests at ECF meeting 19/12/23: 1.0 WTE Echo locum approved 1.0 WTE B6 physiologist locum approved 91.5hrs bank cover for admin team		Further outsourcing July 2023	17/07/2023	17/09/2023	05/09/2023	Broadhurst, Miss Lucy
													Plan for forthcoming vacancies in Echo team	05/09/2023	07/11/2023	19/12/2023	Broadhurst, Miss Lucy
													Proactively address potential burnout in the team	05/09/2023	10/10/2023	05/09/2023	Broadhurst, Miss Lucy
													Cardiac Physiology	20/06/2023	24/01/2024		Broadhurst,

ID	Opened	Handler	Division	Title	Description	Risk level (initial)	Risk level (current)	Risk level (Target)	Date REVIEWED	Review date	Progress notes	Approval status	Description	Start date	Due date	Done date	Responsibility ('To')
6284	16/09/2020	Broadhurst, Miss Lucy	Division of Clinical Support Services	Cardiac Physiology Staffing Levels	performance against waiting list targets, staff wellbeing, training of students and governance responsibilities. The staffing challenges affect all sections of Cardiac Physiology (Echo, Devices, Non-Invasive Cardiology, Reception). The current establishment of the department is 36.17 WTE (June 2023).	Significant 15	Significant 15	Low Risk 3	19/12/2023	19/01/2024	approved ECFs approved to go back to advert for 2.0 WTE B2 admin staff plus a further 19hrs admin staff. Admin teams under pressure due to significant staff turnover. Outsourcing arranged to start in Jan/Feb 2024 to address breaches within the echo service. However this is being delivered at the wkend and we have challenges delivering these lists without admin support. Echo waits now ~10weeks 48hr monitor wait 8weeks 7day ECG wait ~6wks Overtime ongoing for analysis New B7 Echo (2days) not sue to start until May 24 2 staff expected back from mat leave in April 24 (then due to take A/L) - we are expected flexible working requests. B8A Echo trainer post (fixed term contract) due to expire June 24 Some students filling vacant B7 posts as issues with recruitment & retention. LB to approach HR regarding contract amendments to discourage staff leaving so soon after qualifying. Non-DM01 demand and capacity exercise ongoing. No change to current risk score.	Approved Risk	Recruitment	20/06/2023	24/01/2024		Miss Lucy
													Prioritise training and retention of students/ existing staff	01/03/2023	31/05/2023	01/06/2023	Broadhurst, Miss Lucy
													Use of Echo locums & Elective Services	01/03/2023	31/05/2023	01/06/2023	Broadhurst, Miss Lucy
													Echo staffing	06/03/2023	31/03/2023	20/06/2023	Broadhurst, Miss Lucy
													Cardiology Staff recruitment	30/01/2023	30/03/2023	20/06/2023	Broadhurst, Miss Lucy
													Business case to increase staffing	01/07/2022	23/01/2024		Broadhurst, Miss Lucy
													Maintain grassroots development using external funding schemes	01/09/2022	31/01/2023	20/06/2023	Broadhurst, Miss Lucy
													Maintain efforts to fill staffing vacancies	01/06/2022	31/03/2023	20/06/2023	Broadhurst, Miss Lucy
6602	09/12/2021	Fletcher, Michelle	Division of Surgery	Change to non surgical oncology pathways for breast and UGI services which may impact on other oncology services	There is a risk of poor patient experience with the changes of referrals into non-surgical oncology at WPCC. This is currently impacting on breast oncology input and is affecting the representation at MDT from a core member. There are also new referral guidelines from the UGI oncology team and lung SABRE follow ups via TRFT that colleagues have been asked to commence by 6TH mARCH	Extreme Risk 20	Extreme Risk 20	Low Risk 1	13/12/2023	22/01/2024	[Wolfe, Alan 21/12/23 16:09:16] The Dec23 Risk Management Committee approved the rating increase to 20 but recognise it may reduce to 15 or 16 once reviewed.	Approved Risk					
6800	05/10/2022	Kilgariff, Mrs. Sally	Corporate Services	Delays in urgent care pathway due to challenges with patient flow	Patients do not always receive timely access to urgent care due to delays due to challenges with patient flow. Caused by the absence of access to alternative urgent care pathways that avoid patients being seen in UECC and delays in discharge that result in lack of beds for patients to be admitted to. This results in delays to be seen by a clinician in UECC or by a specialty and delays in patients being admitted to a bed in a timely way.	Extreme Risk 20	Extreme Risk 16	High Risk 8	28/12/2023	28/01/2024	[Butler, Helen 28/12/23 13:33:47] [Jodie Roberts] Consultation underway for SDEC which will see Medical SDEC opening longer. Continuing to implement frailty pathway and introduction of virtual wards.	Approved Risk	ACT programme of transformational work	01/01/2022	29/03/2024		Kilgariff, Mrs. Sally
													Improving pathways including expansion of SDECs, implementation of the frailty pathway and introduction of virtual wards	01/01/2022	01/02/2024		Kilgariff, Mrs. Sally
													Improving discharge pathways, particularly ward processes - inlcuding 100 day discharge challenge	01/01/2022	29/03/2024		Storer, Cindy
6324	23/11/2020	Petty, Sarah	Division of Family Health	Delays to 18 Week Wait and 52 week breaches	There is a potential risk to delayed treatment due to the 18ww currently our performance for RTT incomplete is 59.8% against a target of 92%.	Significant 15	Significant 15	Moderate 6	06/12/2023 3/7	06/01/2024	[Wolfe, Alan 21/12/23 16:11:30] The Dec23 RMC approved the risk rating at 15.	Approved Risk	Weekly waiting list meetings	01/04/2021	01/04/2023		Marshall, Miss Faye
													Additional theatres and reutilising theatres during leave	01/04/2021	01/04/2023		Marshall, Miss Faye

ID	Opened	Handler	Division	Title	Description	Risk level (initial)	Risk level (current)	Risk level (Target)	Date REVIEWED	Review date	Progress notes	Approval status	Description	Start date	Due date	Done date	Responsibility ('To')
													Monitor through Governance	13/06/2022	13/06/2023		Marshall, Miss Faye
6718	08/06/2022	Taylor, Ms. Katie	Division of Therapies, Dietetics and Community Care	Hospital heart failure patients not being seen or reviewed by heart failure specialist nurse in a timely manner due to capacity	Delay in patients being reviewed by heart failure specialist Delay in patients being cared for on cardiology wards Longer length of stay due to none or less frequent reviews Poorer clinical outcomes Higher heart failure morbidity Cannot facilitate discharges resulting in patient deterioration when an in patient High staff stress, sickness, burnout and turnover	Significant 15	Significant 15	High Risk 9	03/01/2024	02/02/2024	[Hitchman, James 03/01/2024] It is my understanding from our initial meeting 28/11/23 that Sue Barrow (Cardiology Nurse Specialist) has written a business case. Since the above meeting there have been a number of aborted attempts (cancelled due to operational pressures and annual leave) to go through the business case, the next meeting is scheduled for 12/01/24	Approved Risk	Review of risk requested by general manager	10/06/2022	17/06/2022	21/06/2022	Fisher, Penny
6801	10/10/2022	Ferrie, Mr. Paul (Inactive User)	Corporate Services	Industrial action and effect upon Trust activity	A number of trade unions have recently announced further details on their intention to proceed with statutory ballots These so far include: The Royal College of Nursing (RCN) Royal College of Midwives Junior Doctor Committee of the BMA Chartered Society of Physiotherapists NHS Staff Council trade unions: GMB UNISON Unite This would provide a risk to patient safety due to a lack of suitably qualified staff. There is also the added financial impact on the trust, the net pay costs of each industrial action varies, however we estimate the two instances of junior doctors action has resulted in a £300k cost pressure. A potential risk to patient safety has also been raised in recent months.	Extreme Risk 16	Extreme Risk 20	Moderate 4	19/12/2023	18/01/2024	[Wolfe, Alan 21/12/23 16:07:07] Agreed at Dec23 RMC to increase rating to 20	Approved Risk	Negotiations with local staff side	10/10/2022	29/12/2023		Ferrie, Mr. Paul (Inactive User)
													Strategic meeting to be scheduled by the EPRR Team	10/10/2022	30/12/2022	03/07/2023	Patchett, Craig
													Further central government negotiations - monitor and action as and when	10/10/2022	29/12/2023		Ferrie, Mr. Paul (Inactive User)
6762	23/07/2022	Short, Mrs. Sally	Division of Surgery	Inpatient beds in the trolley area ASU	ASU trolley area not operating as surgical SDEC due to unfunded inpatient beds in both bays. Preventing flow from UECC for non ambuatory surgical patients to be managed in ASU. Caused by preventing SDEC operating due to inpatients in 10 non funded beds. Medical and surgical patients in ward surgical beds. Resulting in Increased admissions to hospital due to all patients managed in waiting area sometimes for long periods. Preventing streaming/flow of non ambulatory patients from UECC.	Moderate 6	Significant 15	Moderate 6	13/12/2023	13/01/2024	[Rimmer, Claire 13/12/23 13:30:57] Progress notes copied from NOTES: [Mrs. Sally Short 07/11/2023 13:39:28] 4.9.23 Discussed at CSU , for further review when bed configuration completed 7.11.23 No changes. Discussed at the board visit with a date of December to work towards	Approved Risk	Surgica SDEC Task and Finish Group	01/11/2022	01/12/2023		Nield (No Longer in the Trust), Tom (Inactive User)
													Amend Sepia to reflect 23 IP beds and 10 trollies	14/11/2022	09/12/2022	09/12/2022	Thurman (No longer in the Trust), Mr Simon (Inactive User)
													Complete Trust bed modelling work	01/04/2022	31/03/2023	18/07/2023	Vasey, Benjamin
									4/7				Monitoring of medical staffing levels	07/04/2021	11/05/2021	16/05/2023	Reynard, Jeremy
													Ensure medical staffing levels are improved within UECC	08/06/2021	30/09/2021	16/05/2023	Reynard, Jeremy
													Recruitment process for UECC substantive Consultants	01/01/2021	31/03/2021	08/03/2021	Reynard, Jeremy

ID	Opened	Handler	Division	Title	Description	Risk level (initial)	Risk level (current)	Risk level (Target)	Date REVIEWED	Review date	Progress notes	Approval status	Description	Start date	Due date	Done date	Responsibility ('To')
5238	18/06/2017	Reynard, Jeremy	Division of Emergency Care	Insufficient provision of medical cover within the UECC	Unable to fill the MG rota, especially at night. Not achieving the new 4 hour target. Delay to be seen by a clinician.	Significant 15	Significant 15	High Risk 8	20/12/2023	20/01/2024	[McAuley, Heather 20/12/23 17:42:35] reviewed at Divisional Governance still applies and remains high risk.	Approved Risk	demand and capacity model	10/10/2022	27/02/2023	16/05/2023	Hammond, Lesley
													recruitment of additional consultants	01/05/2023	30/09/2023	02/11/2023	Reynard, Jeremy
													winter plan	01/11/2023	31/03/2024		Reynard, Jeremy
													senior clinical fellows	01/11/2023	30/08/2024		Reynard, Jeremy
													Review of rota	01/11/2023	30/04/2024		Reynard, Jeremy
													Workforce plan from ACT work	01/06/2023	30/08/2024		Reynard, Jeremy
6888	23/03/2023	Short, Mrs. Sally	Corporate Services	Lack of clinical psychology support for risk reducing surgery patients.	Treatment delays for patients who are gene positive requiring breast surgery.	Significant 15	Significant 15	High Risk 9	07/11/2023	07/12/2023	[Wallett, Val 22/11/23 10:53:12] The risk was approved at November 2023 RMC, along with a move to V Hazeldine corporately	Approved Risk	Lack of Psychological support for the breast cancer patients	31/08/2023	28/12/2023	31/08/2023	Timms, Mrs. Deborah
6630	28/01/2022	Windsor, Claire	Division of Surgery	Lack of Critical Care Follow Up Clinic	Critical illness leaves patients at highly significant risk of long term physical, cognitive and psychological problems. This has the potential for considerable residual impact on patients morbidity and longevity. Caused by no Critical Care follow up service. Resulting in failure to provide vital support following discharge resulting in the inability to identify any complications relating to critical illness which require effective management and ongoing treatment or onward referral including significant mental health / psychological sequalae and physical disability. Failure to meet GPIC's V2 standards.	Significant 15	Significant 15	Moderate 6	04/12/2023	04/01/2024	[Windsor, Claire 04/12/23 10:43:24] Changes made to the business case, awaiting outcome from exec team	Approved Risk	Lack of Critical care Follow-Up	01/08/2022	31/12/2023		Nield (No Longer in the Trust), Tom (Inactive User)
6809	20/10/2022	Culham, Helen	Division of Surgery	Lack of Local Safety Standards for Invasive Procedures (LocSSIPs)	Risk of patient safety incidents and reduced delivery of safe care during invasive procedures.	Significant 15	Significant 15	Moderate 6	03/01/2024	02/02/2024	Culham, Helen 03/01/2024 10:47:19 Theatres Transformation Programme ongoing. Development of LocSSIPS included in the Patient Safety and Clinical Governance workstream (5). No change to risk at present, work ongoing, meeting arranged with KS and SD to discuss.	Approved Risk	Lack of Local Safety Standards for Invasive Procedures (LocSSIPs)	13/04/2023	29/03/2024		Timms, Mrs. Deborah
6958	02/08/2023	Agger, Joanne	Division of Surgery	Lack of Rheumatology Consultants to meet service need	Failure to provide a consultant led Rheumatology Service	Extreme Risk 20	Extreme Risk 20	High Risk 9	08/11/2023	12/12/2023	[Wallett, Val 22/11/23 10:53:56] The risk was approved at the November 2023 RMC.	Approved Risk	consultant recruitment	02/01/2023	01/01/2024		Agger, Joanne
									5/7				Place to review the potential				Kilgariff, Mrs.

ID	Opened	Handler	Division	Title	Description	Risk level (initial)	Risk level (current)	Risk level (Target)	Date REVIEWED	Review date	Progress notes	Approval status	Description	Start date	Due date	Done date	Responsibility ('To')
													for Covid Positive Bed Based Capacity across the Place	03/10/2022	30/11/2022	06/10/2022	Kilgariff, Mrs. Sally
													Chief Nurse to review with IPC and Region a review of Covid 19 swabbing guidance in light of increased prevalence	03/10/2022	07/11/2022	06/10/2022	Dobson, Helen
6627	03/01/2022	Kilgariff, Mrs. Sally	Corporate Services	Patients that are Medically Fit for discharge needing Pathway 1-3 have an increased length of stay	Patients that are Medically Fit For Discharge and require Pathway 1-3 face the potential of increased length of stay after being declared Medically Fit For Discharge. There is evidence to suggest that increased length of stay in hospital can be associated with increased risk of infection, low mood and reduced motivation, which can affect a patient's health after they've been discharged and increase their chances of readmission to hospital	Extreme Risk 20	Extreme Risk 16	High Risk 8	28/12/2023	27/01/2024	[Butler, Helen 28/12/23 13:36:25] [Jodie Roberts] Focus on complex discharges and long stay patients to ensure they are reviewed in a timely manner. Community also supporting. Focus on internal delays	Approved Risk	Daily reporting/dashboard to identify delays and ensure overight	06/10/2022	31/03/2023	21/03/2023	Hepworth, Tracey
													Escalation meetings with place partners and senior executive level support	06/10/2022	31/03/2023	21/03/2023	Kilgariff, Mrs. Sally
													Implement discharge to assess pathways to support assessment of ongoing care in needs in patients own home	06/10/2022	01/02/2024		Fisher, Penny
6873	20/12/2022	Stables, Sarah	Division of Family Health	Risk of losing patient paper medical records due to the introduction of plastic wallets and the removal of stronger card folders	Maternity patient paper records are required to be safely stored for 25 years in case of any legal request from the families we care for. The risk is that CTG's and paper records may be lost leaving the Trust compromised at a later point in time.	Extreme Risk 16	Extreme Risk 16	Moderate 4	18/12/2023	18/01/2024	[Wolfe, Alan 21/12/23 16:10:44] The Dec23 RMC approved the risk rating at 16	Approved Risk	In talks with the patient records department to attempt to find a solution	23/02/2023	23/05/2023		Stables, Sarah
													Working with RMBC and school to identify a suitable space	18/09/2023	31/10/2023	27/10/2023	Dean, Kim
													Monthly liaison with RMBC for updates on progress	14/09/2023	02/02/2024		Dean, Kim
6572	15/10/2021	Dean, Kim	Division of Family Health	Special school accommodation	Disruption to current service delivery for children attending Newman special school. There is a risk that services will no longer have access to suitable accommodation within the school in which to work. This issue will potentially affect the following services: speech and language therapy, occupational therapy, physiotherapy, orthotics, community paediatrics, special education nursing	Significant 15	Significant 15	High Risk 9	14/12/2023	31/01/2024	[Dean, Kim 14/12/23 15:38:36] Update from Mark Cummins (RMBC Transformation Projects Lead) "the application has been approved and a grant agreement is now with the school who are looking at a timeline with contractors. I'll keep you updated once Newman can give a start and completion date."	Approved Risk	Liaison with RMBC to complete minor works	14/09/2023	02/02/2024		Dean, Kim
													Refurbishment of the 'Bungalow' building	02/11/2023	03/01/2025		Dean, Kim
													ACT programme	01/10/2021	03/04/2023	03/07/2023	Hammond, Lesley
													volunteers	04/04/2022	13/10/2022	13/10/2022	Farrow, Lindsay
					Overcrowding in the UECC leading to the UECC not being able to function				6/7		[Reynard, Jeremy 29/11/23 09:03:58]		intentional rounding	07/03/2022	30/09/2022	30/09/2022	Farrow, Lindsay

ID	Opened	Handler	Division	Title	Description	Risk level (initial)	Risk level (current)	Risk level (Target)	Date REVIEWED	Review date	Progress notes	Approval status	Description	Start date	Due date	Done date	Responsibility ('To')
5761	14/12/2018	Reynard, Jeremy	Division of Emergency Care	UECC patient safety due to overcrowding	the UECC not being able to function efficiently or effectively. 1. Unable to see patients. 2. Unable to offload ambulances 3. Dangerous overcrowding in the Main Waiting Room. 4. Delay to time critical treatment 5. Delay to time critical medication.	Extreme Risk 25	Extreme Risk 20	Extreme Risk 16	19/12/2023	30/01/2024	1. Embed 4 hour standards 2. Embed Acute Care standards 3. Provide additonal accomodation for non ED patients (SDEC capacity) 4. Work with Medicine to improve flow for medical patients 5. Look at additional capacity in UECC	Approved Risk	Nursing and Medical staffing to be reviewed	31/12/2021	01/04/2022	13/03/2022	Farrow, Lindsay
													Yellow area: Nursing and Medical staffing to be reviewed	31/12/2021	01/04/2022	13/03/2022	Farrow, Lindsay
													new staffing tool to be implemented	13/03/2022	31/12/2023		McAuley, Heather
													transformational work T&F Group	01/01/2022	01/02/2024		Kilgariff, Mrs. Sally

Board of Directors' Meeting
12th January 2024

The Rotherham NHS Foundation Trust

Agenda item	P23/24
Report	**Responsible Officer Report – Q2 2023/24**
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 and GMC have set out how the new GMP should be used when it comes to force on 31st of January 2024.
	• Appraisal as to be changed over to the new system by 2025.
	• The evaluation of appraisal platforms is due to take place in October 2023.
	Second quarter 2023/24 appraisal performance:
	  • 53 doctors were due their appraisal.
	  ○ 46 held their meeting within this reporting period, and the others have booked appointments outside of the reporting period, reasons for which were understood and accepted.
	  ○ The doctor who was a cause for concern has left the trust.
	
	The Statement of Compliance has been signed and returned to NHS England. The document was signed by the Chair / 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 Q2 2023/24

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. Appraisal forum meetings are taking place quarterly. The last meeting had to be cancelled due to the junior doctor strikes.

2.2 We currently have 24 appraisers and 4 appointed recently who are yet to train with a target of 28.

2.3 Appraiser refresher course online has been procured for all appraisers and will take place later this year once the changes have been made to the appraisal forms under the guidance from NHS England.

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. The team is also copied into coroner request emails. This information in all cases is shared with the doctors involved at the same time. Complaints about colleagues from other colleagues does not follow this pathway at the moment. The divisional directors of Surgery and Family health have started sending these to the appraisal team to ensure that there is appropriate reflection at the Appraisal meetings. The other divisions will be contacted to ensure this process is followed. Three months prior to the appraisal month the appraisal team send the doctors a reminder of any complaints, compliments, incidents and coroners requests and ask they reflect appropriately within their appraisal form.

2.6. Mentorship course has been well advertised and received a lot of interest. It will now take place on the 14th of March 2024 to support the Trust policy of offering all new permanent doctors appointed to the trust an opportunity to have a mentor.

2.7 Procurement process of a new appraisal platform is underway, with demonstrations from several companies to be planned. ICS is also looking to procure a new appraisal, job planning and erostering system which TRFT may benefit from. At present an update is still awaited on the progress of TRFT procurement process.

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 has now resumed.

3.0 Conclusion

3.1 Appraisal figures for this quarter are at a reasonable rate considering the challenges our doctors have faced with the industrial strikes.

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
January 2024

Appendix 1

Indicator		Q2 01/07/2023 – 30/09/2023
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.	53
1.1	Number of those within ♯3 above who **held an appraisal meeting** in the reporting period	46
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]**	7
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**	7
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**	

Board of Directors' Meeting
12th January 2024

Agenda item	P24/24
Report	**Guardian of Safe Working Report - Q2 2023/24**
Executive Lead	Dr Jo Beahan, Medical Director
Link with the BAF	
How does this paper support Trust Values	**Ambitious** - for improvement in working conditions and patient safety. **Caring** - for colleagues and patients. **Together** - solutions are proposed after discussion has identified problems.
Purpose	**For decision** ☐ **For assurance** ☐ **For information** ☒
Executive Summary (including reason for the report, background, key issues and risks	Under the 2016 Junior Doctor Contract, a quarterly report from the Guardian of Safe Working is required to provide assurance to the Board that working in the Trust is safe. The Contract specifies maximal shift durations, total hours per week and hours worked without breaks. Based on exception report numbers, there is as yet no easing of the pressures in Respiratory Medicine, although a surge in winter viruses will be a confounding factor. Guardian fines have been levied on the medical division, based on the last quarter's ER, due to breaches of the 48-hour maxima and missed breaks.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	The Report collates information from the Allocate system for exception reporting, the monthly Junior Doctors' Forum (JDF) meetings, the Datix system, personal communication and assorted email correspondence. It has been prepared by Dr Gerry Lynch, Rotherham Foundation NHS Trust's Guardian for Safe Working, and sponsored by Dr Jo Beahan, Medical Director.
Board powers to make this decision	
Who, What and When (what action is required, who is the lead and when should it be completed?)	Dealing with the issues raised in Junior Doctor Forum which takes place monthly. JDF attendees include medical staffing, Medical Director, Director of Medical Education and Guardian for Safe Working.
Recommendations	It is recommended that the Board notes this report.
Appendices	

Exception Report (ER) Quarterly updates

In Quarter 3, as of 30th December 2023, 36 doctors, (18 FY1, 3 FY2, 5 CT1, 1 CT2, 6 ST1,1 ST3, 1 ST5, 1 Fixed-term ST) submitted 158 exception reports related to hours worked/rest/breaks. 4 exception reports related to pattern and there were 11 for missed educational opportunities.

Total overtime hours claimed for were 117.66 for normal time and 10.33 for premium time hours.

Medical workforce and the Guardian for Safe Working have dealt with most exception reports for payment.

Guardian Fines

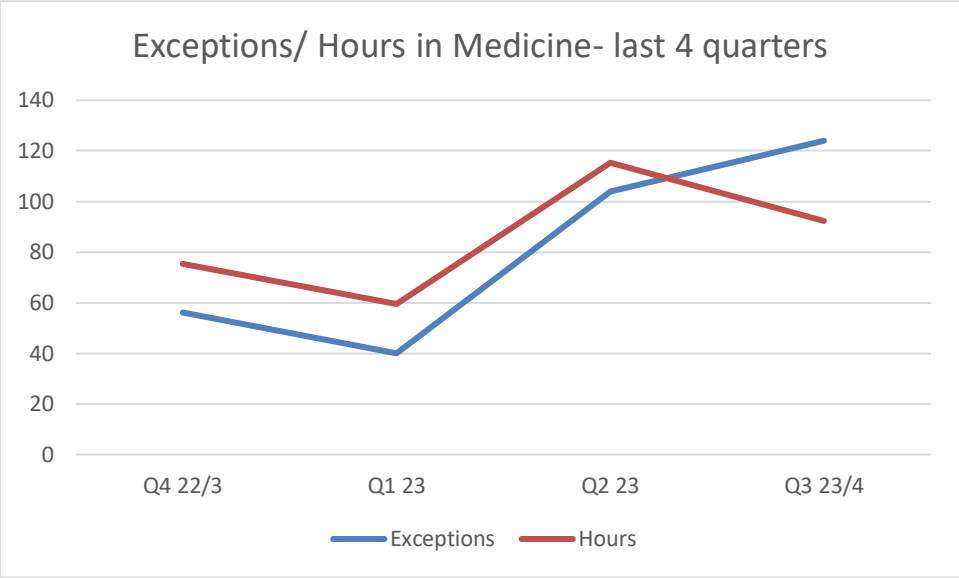
Guardian fines totalling £217.79 total to two doctors and £626.69 to the Guardian for Safe Working cost centre have been levied on the medical division. The cost centre funds to be used for benefit of the trainee doctors' cohort.

Exception Report Quarterly details (as of 30/12/23) by ward/specialty

Working hours:

(Sub) Specialty	Exceptions	Daytime Hours	Nightime hours
A1 Cardiology	11	5.25	
A1 HCOP	20	14.25	
A2 HCOP	2	0	
A4 HCOP	2	1.25	
B5 HCOP	4	3	
A3 Respiratory	56	38.75	
A5 Diabetes	3	3	1.5
A5 Gastro	3	6	
GUM	4	1	
AMU	18	19.33	
B5 Gen med	1	0.5	
Medical Division total	124	92.33	1.5
General surgery ASU	25	15.25	7.58
General Surgery B10	7	6.58	1.25
ED	1	1	
Paediatrics	1	2.5	
Total	158	117.66	10.33

Exceptions and hours by quarter



Triangulation with Datix system

Search of Datix system reveals 2 Datix completed by trainees in the last quarter which mention lack of medical staff- 1 from Paediatrics on 29/11/23 and a second from A3 on 6/10/23. Both were graded as no harm incidents.

Qualitative examples from Exception reports

"*Not sufficient senior doctor support so Ward round finished late. Not sufficient junior doctors to complete ward tasks".*

"No break due to heavy workload due to understaffing"

"Not able to take break due to constant heavy workload and unwell patients and no one available to handover bleep to."

Actions to mitigate

As always, medical workforce and management teams manage rota gaps to the best of their ability, moving trainee doctors to where need is greatest on a daily basis, factoring in absences and patient numbers.

The rota hours for medical trainees will be adjusted downwards, meaning breaches of the 48-hour maxima should be less likely going forward.

Ward A3 appears to be fully staffed for the majority of shifts.

Regular discussion of all concerns at the Junior Doctors' Forum attended by senior representatives from medical workforce, divisions, Medical Director, Director of Medical Education and Guardian for Safe Working include missed inductions, availability of IT and printers, patient flow, rotas and staffing.

	The Guardian for Safe Working is liaising with Estates and Deputy General Manager regarding finding suitable ward-based workspaces for trainees in medicine, commencing with A3- I hope to make progress this in the new year. The Guardian for Safe Working, Director of Medical Education and Foundation Director are all instrumental in raising issues coming to their attention and all have open door availability to trainees for support.

Dr Gerry Lynch
Guardian for Safe Working
January 2024