Board of Directors (Public)

The Rotherham NHS Foundation Trust

Schedule	Friday 8 March 2024, 9:00 AM — 12:00 PM GMT
Venue	Boardroom, Level D
Organiser	Angela Wendzicha

Agenda

9:00 AM	PROCEDURAL ITEMS
	P29/24. Chairman's welcome and apologies for absence For Information
	P30/24. Quoracy Check For Assurance
	P31/24. Declaration of interest For Assurance
	P32/24. Minutes of the previous meeting held on 12 January 2024 For Decision
	P33/24. Matters arising from the previous minutes For Assurance
	P34/24. Action Log For Assurance
9:05 AM	CULTURE
	P35/24. Patient Story - presentation For Noting - Presented by Helen Dobson

P36/24. Gender Pay Gap Report and Action Plan
For Assurance - Presented by Daniel Hartley

P36/24a. Staff Survey
For Noting - Presented by Daniel Hartley

9:50 AM OVERVIEW AND CONTEXT

P37/24. Report from the Chairman - Verbal
For Information - Presented by Mike Richmond

P38/24. Report from the Chief Executive
For Information - Presented by Richard Jenkins

P39/24. Board Committees Chairs Reports - Committee Chairs and Lead Executives -
i. Quality Committee - Chair's Log
ii. People & Culture Committee - Chair's Log
iii. Finance & Performance Committee - Chair's Log
iv. Audit & Risk Committee - Chair's Log
For Information

10:10 AM SYSTEM WORKING

P40/24. SYB ICS and ICP Report
For Information - Presented by Michael Wright

P41/24. SYB ICS - Wider Needs of Rotherham Community - Andrew Turvey
For Assurance

P42/24. Committees in Common
For Decision - Presented by Richard Jenkins and Angela Wendzicha

10:30 AM ASSURANCE

	P43/24.	Integrated Performance Report For Assurance - Presented by Michael Wright
	P44/24.	Operational Performance Report For Assurance - Presented by Sally Kilgariff
	P45/24.	Maternity and Neonatal Safety Report, presented by Sarah Petty For Assurance
	P46/24.	Safe Staffing and Establishment Nurse Review For Assurance - Presented by Helen Dobson
	P47/24.	Finance Report For Assurance - Presented by Steve Hackett
11:10 AM	BREAK	
11:15 AM	ASSURANCE FRAMEWORK	
	P48/24.	Board Assurance Framework For Decision - Presented by Angela Wendzicha
	P49/24.	Corporate Risk Register For Decision - Presented by Angela Wendzicha
	P50/24.	Quality Assurance Report For Assurance - Presented by Helen Dobson
11:35 AM	REGULATORY AND STATUTORY REPORTING	
	P51/24.	Learning from Deaths Quarterly Report For Assurance - Presented by Jo Beahan

P52/24. PSIRF Operational Plan
For Assurance - Presented by Helen Dobson

P53/24. 2023/2024 Annual Accounts: Going Concern
For Approval - Presented by Steve Hackett

P54/24. 2023/2024 Annual Accounts: Operating Segments
For Approval - Presented by Steve Hackett

P55/24. 2023/2024 Accounts: Accounting Policies
For Approval - Presented by Steve Hackett

12:05 PM BOARD GOVERNANCE

P56/24. Terms of Reference:
i. Quality Committee
ii. People & Culture Committee
iii. Finance & Performance Committee
For Approval - Presented by Angela Wendzicha

P57/24. Any Other Business
- Appointment of External Auditors
For Information

P58/24. Annual Work Plan 2024-25
For Discussion

P59/24. Questions from Members of the Public on the Business of the Meeting
For Noting

P60/24. Date of next meeting - 3 May 2024

Draft until approved at the 8th March 2024 meeting

MINUTES OF THE PUBLIC BOARD OF DIRECTORS MEETING
Friday 12th January 2024, 9:00 am – 13:00 pm
Boardroom

Present: Mr Michael Richmond, Chairman
Mr K Malik 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
Ms H Watson, Non-Executive Director
Mr D Hartley, Director of People
Mr M Wright, Deputy Chief Executive
Dr R Shah, Non-Executive Director
Ms J Burrows, Non-Executive Director
Mrs D Sissons, Non-Executive Director

In attendance: Ms L Martin, Director of Estates and Facilities
Mr J Rawlinson, Director of Health Informatics
Mrs L Tuckett, Director of Strategy Planning and Performance
Ms A Wendzicha, Director of Corporate Affairs
Mrs J Roberts, Director of Operations/Deputy COO
Mrs Z Ahmed, Associate Non-Executive Director
Mr A Wolfe, Deputy Director of Corporate Affairs (minutes)
Dr R Gosakan, Consultant Obstetrician and Gynaecologist and Divisional Director Family Health (For item P15/24)
Mr T Bennett, Head of Security, Transport Planning, Car Parking & Compliance (For item P10/24)
Dr G Lynch, Guardian of Safe Working (For item P24/24)
Ms J Harold, NHS National Graduate Management Training Scheme (GMTS) (For item P7/24)
Miss M Adams, Public Relations & Communications Apprentice (For item P7/24)
Mr G Travis, Apprenticeship Manager (For item P7/24)
Mr M Chadzamira, T Level Student (For item P7/24)

Apologies: Mr M Temple, Non-Executive Director

Item	Procedural Items	Action
P1/24	**CHAIRMAN'S WELCOME & APOLOGIES FOR ABSENCE** The Chairman welcomed everyone to the Board and noted Mr M Temple's apologies.	

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P2/24	**<u>QUORACY CHECK</u>** The meeting was confirmed to be quorate.	
P3/24	**<u>DECLARATIONS OF INTEREST</u>** Dr Jenkins' interest in terms of his joint role as Chief Executive of both the Trust and Barnsley Hospital NHS Foundation Trust, was noted. Ms Wendzicha's interest in terms of her role as Director of Corporate Affairs of the Trust and Director of Corporate Affairs at Barnsley Hospital NHS Foundation Trust, was noted. Colleagues were asked that, should any further conflicts of interest become apparent during discussions, they were highlighted.	
P4/24	**<u>MINUTES OF PREVIOUS MEETING</u>** The minutes of the previous meeting held on 03 November 2023 were agreed as a correct record of the meeting excepting the following: Ms J Burrows was in attendance.	
P5/24	**<u>MATTERS ARISING</u>** There were no matters arising which were not covered by either the action log or agenda items.	
P6/24	**<u>ACTION LOG</u>** The Board of Directors reviewed and approved the action log.	
	<u>CULTURE</u>	
P7/24	**<u>Staff Story</u>** Mr Hartley introduced the Graduate Management Trainees Scheme (GMTS) who provided the Board members with an overview regarding how the Rotherham NHS Foundation Trust (the Trust) attract graduates and T level students, and support colleagues through the use of the apprenticeship levy. Ms Harold, who is on the Health Informatics graduate trainee scheme, explained that she was undergoing a 2 year intense introduction into life in the NHS and that there were various other pathways such as finance and IT which can be followed. Her introduction included a full programme including an induction period involving night shifts in the hospital and work with Community Nursing. She is currently creating a data dashboard for use in critical care as well as work on national competency framework and is really enjoying the work and placement at the Trust. She reported that she has found it a very welcoming hospital to work in, able to undertake very creative work with the autonomy to work on her own. She did admit to	

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	expecting people to be quite unwilling to change but has in fact experienced the opposite with staff welcoming the prospect of improvement through change. Mr Chadzamira explained that he was currently doing T Levels at Sheffield College, he is the first T level trainee to have been placed at the Trust. He had decided on taking T Levels rather than A levels as the T Levels provide him with an opportunity to undertake 20% workplace working and 80% academic classroom based work. His workplace options had included the NHS and he chose this following a successful placement trial at Barnsley Hospital. He stated that this was in fact his first ever job and he's really enjoying his time working at the Trust, where he is mainly shadowing colleagues and setting up laptops for the IT department, he added that his work at school is aimed at reinforcing his workplace role. Miss Adams is currently a Digital Communications Assistant within the Trust Communications Team and she is on a Level 4 apprenticeship. She reported that she is having a really positive experience as an apprentice at the Trust. She already has formal qualifications but the position allows for more practical knowledge and experience, her line manager is extremely supportive and overall she feels that the trust and her team is invested in her and her role, which in turn gives her a lot of confidence. Fresh out of university she finds it helpful to balance her work life balance and prioritise work day to day in line with media work and its ever changing focus. Mr Travis is the Trust Apprenticeship Manager, he explained that the T Levels offer the students access to over 20 clinical and non-clinical subjects with the Trust actively looking at increasing numbers of apprentices over next few years. There are plans to roll out across local colleges with open days, and involvement of the Learning & Development team and Communications. The Board noted that there was always lot of work put into the international network for nurses and it would be good to have something similar for apprentices which could act as a springboard for next step to increase numbers of apprentices in the Trust. The Board thanked the presenters for their inspiring feedback and wished them well for the future.	
P8/24	**<u>Freedom to Speak Up Quarterly Report</u>** Mrs Dobson introduced Mr Bennett, for what was his last appearance as The Trust Freedom to Speak Up Guardian. Mr Bennett took the paper as read, highlighting that the reporting figures had dropped year on year by 50% from 15 to 7, no trends had been identified apart from bullying incidents which have all been actioned through HR. He believed that the data shows increased confidence of staff to talk to line managers and this has been borne out by the Staff Survey results, which is very positive as this was the initial aim of his role. He confirmed that the Trust is an outlier in this regard with the picture both nationally and locally one of increased staff concerns being raised.	

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	The Guardian has now been amended to be a full time role and the new Guardian is also of a clinical background, Mr Bennett will be supporting her to settle into the role and he believes she will be very good fit in the role of Guardian. The Trust will continue to monitor data and learn from reports. Mr Bennett adding that he has really enjoyed the role over the last five years. Mrs Dobson advised the Board that focus of the role is changing with increased focus on patient care. There was agreement that the Trust needs to hold onto the established openness and transparency of those involved in the process especially the Executives. Mr Bennett confirmed that this level of support was not seen at other Trusts in the region. There also needs to be a way developed to obtain written feedback from staff who have gone through the process, previously Mr Bennett gained this informally from staff who always give positive verbal feedback, but this doesn't seem to translate into written feedback, he had been thinking about text alerts for feedback. The Board thanked Mr Bennett for his work which leaves the Trust in a better place than when he commenced in post.	
	OVERVIEW AND CONTEXT	
P9/24	**REPORT FROM THE CHAIRMAN** Mr Richmond expressed to the Board how privileged and honoured he felt to be appointed Chair of the Trust; he has thought a lot about the role and believes that collectively, as a team, we will perform as a high performing Board with the ambition to be the best Board it can possibly be, the ambition to be an exemplar organisation. He feels that the Board needs to be honest, respectful, show compassion, be good at listening, inclusive and staff feel part of the organisation with a team that looks after its people. He sees the year filled with hope, with the wider team that can facilitate the staff being the best they can be and increase the perspective that things are not as bad as they could be, but also not as good as they could be.	
P10/24	**REPORT FROM THE CHIEF EXECUTIVE** Dr Jenkins thanked the Executive Team for the excellent job they had undertaken in keeping Trust colleagues on board and the Trust safe over what has been a difficult part of the year with associated winter viruses, peak influenza, respiratory infections and industrial action. He confirmed that the Trust was still waiting for formal planning guidance which was required in order to start next year's financial planning, however we already know it will be a difficult year. There are already established meetings to work out how as a system we identify efficiencies, as well as working in different ways, to work around issues and set ourselves up for success will be a challenge with the industrial action situation. Dr Jenkins reminded the Board that it should not expect increased funding, and as such there is a need to drive productivity, be more creative and more cost effective, although he acknowledged that it would be difficult to make	

	management savings and maintain improvement and the Executive needed to use existing good relationships with the staff to take them with the Board. He reminded the Board of the progress the Trust has made over last few years and that this needed to continue, this could be through the increased use of Rotherham PLACE, local partners and our partnership with Barnsley. Industrial action and the threat of more walkouts continues with offers on the table still being considered, at the moment strike action is still an option to them and there is also the potential of unsettled nursing groups which could have an adverse effect on elective recovery with management teams unable to plan for recovery due to uncertainty.	
P11/24	**Board Committees Chairs Assurance Logs – Committee**	
i	Finance and Performance Committee meetings	
	Mrs Watson confirmed that the Committee had received presentations from the divisions of Medicine and Clinical Support Services, whilst these were very interesting detailing current initiatives on quality work, there was lots of focus on financial details but not enough about delivery, therefore the Committee could not be fully assured. This need for consistency of presentations with a 50/50 split on finance and performance will be discussed with the divisions going forward. In terms of delivery a very different picture was emerging of the Trust when there is ongoing industrial action and times out of industrial action as shown by the recovery data presented to the Committee. With regards to Emergency Preparedness, Resilience and Response (EPRR) new criteria have been introduced and has meant that the criteria have changed dramatically with the Trust self-assessing now as not compliant due to the different evidence now required. The Committee are however assured that the Trust remains no less prepared than before and the evidence is being collected. Mrs Watson reported that the complex relationship with the ICB continues with a lack of clarity from the ICB regarding how the financial situation will play out. The Committee had doubts concerning recurrent CIPs and whilst they did not feel assured they noted the improved position. The Committee had noted that multiple risks continue to affect the Trust as a result of ongoing industrial action and as a result had agreed to recommend to the Trust Risk Management Committee that the main Trust Financial risk rating be increased. There had been a successful cyber security phishing exercise ran at the Trust in December 2023 which illustrated the importance of secure working practices required whilst working at the Trust as weaknesses are clearly evident with 20% of Trust staff failing the test.	
ii	Quality Committee	
	Ms Burrows highlighted the positive position of the virtual ward and its effectiveness over the past 12 months and the impending introduction of	

	remote technology which will be of benefit to the service. There is also the issue of the Community Services relationship with the ICB and the unchanged over many years Contract Baseline which needs to be raised with ICB. There is also good staff recruitment within Community Services. On a less positive note the long and continuing journey involving Health & Safety was raised, especially the areas of Food Hygiene training, Water Safety, Deep Cleaning of wards and the improvement works of the residential accommodation, whilst improvements had been seen recently discussions are continuing by Executive Team including which Assurance Committee such developments should be fed back to.	
iv	People Committee	
	Dr Shah raised the issue of the industrial action's effect on recovery and the morale of staff, the committee remains supportive to staff and currently there is in place the development of the new People Strategy which will come back to the Board in a few months. Also noted was the Staff Survey, although it remains under embargo the draft results appear to be very positive and possibly the best results achieved by the Trust. In terms of divisional presentations the Committee were very impressed by the attendance of the Family Health and the UECC Divisions who continue to rise to the challenges faced over the last year.	
	SYSTEM WORKING	
P12/24	**SYB ICS and ICP Report** Mr Wright highlighted the two hour workshop delivered by himself along with Mrs Kilgariff and Mrs Dobson at the request of the Health Select Committee. The workshop was positively received by the audience who were also very complimentary about the journey the Trust has been on. They reported on the Trust Annual Report, the narrative around improvements and changes made by the Trust. It was acknowledged that the Trust reputation has been poor in previous years but is now starting to turn around, this turnaround continues with the current documentary television series showing the Trust's good facilities as well as the kind and caring staff. The Board agreed that with regards to the needs of the wider Rotherham community this could be informed by the Public Health Consultant who has now been in role for 9 months, a request will be made for him to bring a presentation to Board.	**Mr Wolfe**
	ASSURANCE	
P13/24	**Integrated Performance Report**	

	Mr Wright highlighted key aspects of the paper, these included the ongoing challenges around sickness, while UECC had seen positive improvements, the Division of Medicine is in a worse position with 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. He also reported an apparent increase in readmissions since April 2022, although this has been based on recalculated data, a national metric published in Model Hospital. How this data is calculated has not been shared so the Trust have been unable to change how our data was calculated to match the national model. Mrs Tuckett is exploring new software which will allow for narrative alongside the data, one such system is a national data system already used for waiting list data returns and this will check on how well the Trust has validated data with feedback provided on accuracy. The data is showing inconsistent DNA rates, questions were asked about what are we learning and what are we putting in place to improve? The Board's Health Inequalities Group had been put in place previously and improvements have been made; however it is acknowledged that the Group did not talk to patients directly and made assumptions about why there could be DNA issues within certain patient groups. A contact telephone number was then put in place for patients to notify the Trust of non-attendance, however no change to DNA rates was seen resulting in a high number of direct calls to these patients asking them for the reasons why they were not attending. It was agreed that the report data shows that there is work to do, with a step by step approach to identifying where there has been improvement leading to Board understanding of the actions taken and those still required to be taken. It was also acknowledged that the levels of performance had been knocked completely by the Covid pandemic which was swiftly superseded by the prolonged periods of industrial action. There is now a strategic review of each metric to identify the underlying enabling factors which will then lead to giving staff the skills required to improve. The Trust had no quality improvement structure only 2 years ago and that is now in place with improvements being made, an example of this is the Trust now achieving the lowest HSMR in the region and it needs to be understood by all that real embedded change takes time.	
P14/24	**<u>Operational Performance Update</u>** Mrs Kilgariff provided context for the Board, explaining that this was a summary of metrics on the key deliverables, detailed slides go to FPC for each metric, however that would be too much information for Board. November 2023 saw increased operational pressures meaning that there remains a challenge meeting the 4 hour delivery targets, as well as delivering the elective recovery position. Looking forward to December 2023 there were be challenges and a different picture with the industrial action taken. The virtual ward is behind trajectory for delivery, the Quality Committee were assured that safety	

	netting and other patient safety aspects are in place, improved IT support has been put in place and the resilience of the workforce has improved with the specific skill set now more in place than when report data was collected. Outpatient transformation programme work continues along with redesign of streams of work and a more detailed update will follow, as will the re-assessment of the Bed modelling. Currently the bed modelling is fine but in future some issues are anticipated relating to a lack of space, therefore the bed modelling was re-ran, increased length of stay in surgery if continues which will have an impact, so work on length of stay and new ward ways of working needs to change. Closer look at are the patients in the right beds, and in the case of some specialities they weren't, so work needs to be done further on how we allocate beds, and also the way consultants work need modernising, an example of this being the introduction of a consultant of the week position being introduced.	
P15/24	**<u>Maternity and Neonatal Safety Report including Clinical Negligence Scheme for Trusts (CNST) Final Approval</u>** Dr Gosakan, the Divisional Director for Family Health introduced the report which was brought for Board approval for delegated sign off by Dr Jenkins. The deadline for report submission is 4th February 2024 and following CEO sign off the report will be sent to the ICB for counter signing. Dr Gosakan highlighted that there are 10 standards and the service is compliant with all 10; two of the standards 6 and 8 are compliant and she expects compliance to increase from the current 71% (Standard 6 requires a compliance level of 70%) to get to 100% compliance by March 24 following completion of related action plan. Similarly Standard 8 requires a compliance level of 70% and is expected to move from the current 80% to 90% by March 2024 The Board complimented the service on the work undertaken, and noted that the assurance process prior to presentation to the Board had been comprehensive. There was also agreement that dividing the 10 Standards up between each member of the Executive Team to lead on had worked well, added scrutiny and assurance as well as being a good example of a unitary Board working together effectively. The Board approved delegated authority for Dr Jenkins as Chief Executive to sign off the report.	
P16/24	**<u>Finance Report</u>** Mr Hackett highlighted the main topics of the report, November 2023 had been a really important month as there was no industrial action, and the challenge was whether the Trust could get back to the desired elective recovery levels without the factor of industrial action, in short he concluded the Trust achieved this target as it was only £100k off. He added that this	

	was an important staging point, as then in December 2023 this recovery continued again even with the factor of industrial action. The Trust are achieving income targets albeit with external support in place to add capacity, there has also been some spikes in expenditure which was identified as a stocking up issue that has now been rectified following an investigation. There is a £1.1m variance year to date, but he confirmed that for the year end the Trust is still on trajectory to meet targets. There will however be a further big impact if there is continued industrial action impact; a report had been put together prior to the last industrial action that estimated the cost of extra covering staffing c£500k, this has to be looked at along with the costs of cancelling elective activity during the same periods to the cost of c£700k worth lost activity. The forecast change to deficit from £6m to £4.7m had previously been agreed by the Board and Mr Hackett still believes this is achievable if there is no further industrial action, and as such the Trust would still be on plan financially. Cash remains strong at £19m, whilst Capital saw a reasonable amount through November 2023 and he still expects to achieve Capital expenditure targets by the end of year. Mr Hackett confirmed that this was not unique to the Trust, there had been a national call on the 23rd December 2023 with the specific request for forecasts of the impact of the industrial action on each Trust as they want to lay bare the costs for use with HM Treasury; it would be remiss if as an organisation we didn't provide this data. Two forecasts had been prepared, one without industrial action and one with industrial action costs included, these are now in the hands of the national negotiations. Mr Hackett remains confident in covering off the £3.8m deficit position and still sees the biggest challenge as delivering elective recovery.	
P17/24	**<u>Safe Staffing and Establishment Nurse Review (six monthly)</u>** Mrs Dobson informed the Board that the Trust had purchased new validation tools to be used for the four times a year collection of data from ward areas. The calculation of the establishment is based on the number of staff on duty and the acuity of patients, currently the funding establishment is safe for the ward work load, barring some minor inconsistencies. For example the Medicine Division is slightly below where they should be, but professionally moving staff around the wards when required covers this. The Division of Surgery has slightly higher figures indicating they are over establishment, again professional judgement is used to move staff around for cover. She went on to add that whilst the review concluded that the wards were safe the Care Hours Per Patient Day (CHPPD) figure currently when benchmarked against other organisations appears very low on the scale which is ideally 7.4. Over the past 12 months there has been increased recruitment, along with decreased numbers of leavers, there has been an above 90% fill rate day and night plus significant reduction of agency spend. So in all areas the data is positive apart from CHPPD, and she believes that this is likely a data anomaly in pulling data from the roster, so a deep dive is to be undertaken by Mrs Tuckett over next few months. Mrs Dobson was looking for Board approval to leave the establishment as was.	

	There were some Board concerns that the deep dive had not yet been finalised and further clarification was required on a number of points, Dr Jenkins advised that the paper was taken out of the Board for further discussion regards how data was collected and reported and an amended version brought back for approval.	**Mrs Dobson**
P18/24	**Annual Health & Safety Report** Mr Hackett introduced the report, he highlighted that the report authors had now left the Trust and there had been a change in senior management managing Health & Safety. The report had been through the Quality Committee for scrutiny and assurance and had involved key staff from various areas of the Trust. It was noted that there had been no HSE enforcement actions during the year, RIDDOR reports were relatively low in 2022 with 18 and in 2023 there was 1; there were also no fire enforcements and low activations of fire alarms, a total of 29 all actioned and finally a good culture of training with compliance at 91%. Mr Hackett was seeking Board support to publicise the report, this was agreed along with the request not to use pie charts in future reports and for more regular in year reports to be produced. There was also discussion about the Trust process for the rise in sexual abuse against women in the current period, Mrs Dobson confirmed that she is the Trust Sexual Safety Lead with the associated Charter being signed up to. There is also a very robust process in place for incidents with the clear message in place that unacceptable behaviour is not tolerated and will be actioned; such disciplinary reports are provided to the People Committee including details of actions taken, disciplinary exclusions and dismissals of staff. There is also going to be a new question included on the Staff Survey in 2024 The Board approved the report.	
P19/24	**Board Assurance Framework** Ms Wendzicha highlighted that the changes to controls and mitigations were included within the report which had been through the Assurance Committees. There were two recommendations for the Board relating to BAF risks D5 and D7 which was the recommendation from the Finance & Performance Committee to increase the rating of both to 20. This was a reflection of the currently high risk in relation to the Trust's operational and financial position. The Board agreed with the increased rating and Dr Jenkins also noted that he felt comfortable with the scrutiny undertaken and the increase makes sense due to the current climate. The Board agreed to increase risk ratings of D5 and D7.	
P20/24	**Corporate Risk Register** Ms Wendzicha outlined that this was a relatively new report to the Board and consisted of information relating to all Trust risks that have been rated at 15	

	and above. She highlighted the Risk 6886 which relates to the Trust's Financial Plan, which also links in with the BAF Risk D7, all of the risks are due to be discussed and scrutinised at the monthly Risk Management Committee on the 16th January 2024. Another of the risks contained within the report Risk 6602 was also discussed with Dr Beahan providing context behind the risk to the Oncology Pathway, in early 2023 Sheffield Teaching Hospitals announced that it would no longer be able to support the service, with a double risk of patients being sent out of region for treatment alongside the current shortage of Oncologists; this is now a Corporate Risk with the Trust in a fragile position, the rating is currently under review. The report also contains information on the Trust's Emerging Risks, one of these being the anticipated shortfall in nursing staff and Allied Health Practitioners in 2-3 years' time due to the decrease in number of students, there was a brief discussion regarding the actions already being taken by the Trust including a range of routes into roles, not just the traditional route via university, but an increase in apprentices and internal training. There is also the work being taken around international recruitment 5 to 10 per year and staff retention, this often being through the option of flexible working. The Board noted the content of the report.	
P21/24	**<u>Safeguarding Annual Report</u>** Mrs Dobson outlined the key messages from the 2022/23 report, which provides assurance that the Trust is compliant against all statutory duties and legislation. She highlighted that significant inroads had been made in safeguarding in recent years and Trust staff are now 90% compliant with training. There is also effective partnership working, with good support and attendance at both internal and external meetings. There is now a new Head of Safeguarding in place, and Mrs Dobson concluded that in terms of Children's safeguarding the Trust was doing really well, in terms of adult safeguarding improvements were still ongoing with NHSE to attend the Trust in order to work with the Trust staff and Terms of Reference have already been agreed for this work. It was pointed out by the Board that the report did not include mention of the prosecution of the Trust which occurred within 2022/23 and Mrs Dobson confirmed that she would be adding this.	**Mrs Dobson**
P22/24	**<u>Emergency Preparedness, Resilience and Response (EPRR) Annual Statement of Compliance</u>** Mrs Kilgariff introduced the paper which details the annual Trust self-assessment against the EPRR standards, she was looking for Board approval for her to sign them as Accountable Officer. Mrs Kilgariff outlined that there had been a change to this year's sign off as the level of evidence required has significantly increased in our region, leading to a more rigorous assessment and check and challenge process. There is now the requirement to provide a portfolio of training evidence for every member of staff on call. It was agreed that there was absolute recognition of the need to increase the work required in order to provide a more robust process following incidents	

	such as the Manchester Arena bombing, however it has been a difficult time to put in place with other pressures such as the ongoing industrial action. The current submission shows that the Trust is 35% compliant, which is significantly different to last year, however the Trust is partially compliant with many of the standards and has the highest compliance level in the region. In fact there is only 1 non-compliant standard which relates to an evacuation plan, this is now however complete and been signed off at the ETM, but this was following submission of the document. It was noted that the Trust is now required to provide quarterly updates on the plan and it had been agreed that this would go through the Finance & Performance Committee for assurance. The Board agreed that the lack of a sufficient transition process into the new and more rigorous process has been unhelpful and makes it look like the area of south Yorkshire is unprepared for an emergency. A letter to commissioners was to be sent on behalf of the regions Trusts due to the potential of adverse media attention and legal challenge if an incident does occur. The Board were reassured that locally the escalation groups of Gold, Silver and Bronze have been subject to a number of table top exercises which are followed by debriefs after which the plan is updated, Dr Jenkins has also spoken to the Regional Director about the issue. The Trust currently self-assessed as non-compliant but indicated there was a 2 year period to be compliant, with substantial compliant in next year and full compliant the year later. In conclusion the FPC has agreed that the Trust was no less prepared than this time last year. Board was as comfortable as they can be with the current position.	
	REGULATORY AND STATUTORY REPORTING	
P23/24	**<u>Quarterly Report from the Responsible Officer</u>** Dr Beahan spoke to the report highlighting that NHS England and the GMC have set out how the new Good Medical Practice (GMP) should be used when it comes into force on 31st January 2024. The doctors' appraisal will be changed over to the new system by 2025. She pointed out that for the first time it now refers to sexual behaviour and to be kind to patients and as such there is a need to change the appraisals to align with the new GMP and for all doctors to be made aware of the change. There is now in place a flow of complaints/compliments/incidents/inquests that are all sent to doctors 3 months before appraisal and there has been good uptake for the mentorship course in March 2024. Dr Beahan is currently working through the new procurement process of a new appraisal platform. Annual appraisal process of medical staff seems to be positive and working as the Staff Survey is showing positive results related to the appraisal questions and these positives should be used as lessons for the wider staff group.	
P24/24	**<u>Guardian of Safe Working Quarterly Report</u>** Dr Lynch reported on the quarterly report ending 30th December 2023, he highlighted that Ward A3 remained a hot spot, with as yet no easing in	

	pressure which was evident in the exception report. This was due to increased illness of both patients and staff leading to redeployment of staff. Dr Lynch had previously been asked by the Board to triangulate the exceptions reported with the incident database, he had identified 2 incidents completed by trainees in the last quarter and both had been graded as no harm. Dr Beahan reported that with regards to Ward A3, a respiratory ward, there had been a spike in code red and resuscitation calls, the opportunity for more training and looking at more modern ways of working, including a consultant of the week are being investigated. As is a plan for the rota to be changed April 2024, this can't be changed mid rota. It was reported that the Junior Doctor Forum continues to be well attended and staff are working on relationships between medical staff and junior Doctors.	
	GOVERNANCE	
P25/24	**Fit and Proper Person Report** Report due May 2024.	
P26/24	**Governance Report** Nothing to note this month.	
	BOARD GOVERNANCE	
P27/24	**ANY OTHER BUSINESS** No other business raised	
P28/24	**Questions from Members of the Public** No questions were received.	
P29/24	**DATE OF NEXT MEETING** The next meeting is Friday 8th March 2024 at 9:00 AM — 12:15 PM	

Chair

Date:

Board Meeting; Public action log

Log No	Meeting	Report/Agenda title	Minute Ref	Agenda item and Action	Lead Officer	Timescale/ Deadline	Comment/ Feedback from Lead Officer(s)	Open /Close
2023								
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. Should read Issues Register which is now included in the Corporate Risk Register report routinely.	Recommend to Close
4	03/11/2023	Board Committees Chairs Reports	161/23	Register of Interests	AMW	May-24	Corporate Affairs to assist with Register of Interest declarations. Next report due to Audit and Risk Committee in April then Board in May 2024	Open
6	03/11/2023	Assurance	169/23	Quality Assurance Report	HD	Apr-24	CQC preparation to be added to a Strategic Session in April 2024	Open
2024								
1	12/01/2024	SYB ICS and ICP Report	12/24	Public Health Consultant (A Turvey) to be invited to present to Board on his work on the needs of the wider Rotherham community	AMW	Mar-24	AT invited to attend and on the agenda.	Recommend to Close
2	12/01/2024	Safe Staffing and Establishment Nurse Review	17/24	An amended report, following discusison on how data is collected and reported, to be presented to the next public Board	HD	Mar-24	On agenda	Recommend to Close
3	12/01/2024	Safeguarding Annual Report	21/24	Annual report to be updated to include the prosecution of the Trust in 2022/23	HD	Mar-24	Safeguarding team amending the report to reflect this prior to uploading to the intranet	Recommend to Close

Open
Recommend to Close
Complete

Board of Directors' Meeting
08 March 2024

Agenda item	P36/24
Report	**Gender Pay Gap Report**
Executive Lead	Daniel Hartley, Director of People
Link with the BAF	U4
How does this paper support Trust Values	This paper is presented to fulfil a statutory responsibility
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	This paper (once published) will fulfil the Trust's statutory duty to publish information regarding its gender pay gap as of 31st March 2023 by 31st March 2024. The paper identifies an improvement in relation to the Trust's Gender Pay Gap. The Trust's Gender Pay Gap (mean and median) as of 31st March 2023 is 27.72% & 17.24%, this has improved since last year when it stood at 30.30% and 25.73% respectively.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	This paper has been shared with ETM and presented to People Committee ahead of submission to the public Board meeting.
Board powers to make this decision	
Who, What and When (what action is required, who is the lead and when should it be completed?)	Once this paper has been through the various assurance stages, it will be published on the Trust website, with data also submitted via the government portal by 31 March 2024.
Recommendations	There is no statutory requirement for either recommendations or an action plan in relation to gender pay gap; however, following discussion at relevant forums it is expected that some associated actions will be added to the Trust's overarching EDI action plan.
Appendices	Appendix 1 - Gender Pay Gap Report – March 2024 Appendix 2 – Content to be uploaded to the Government portal site

CONFIDENTIAL

Gender Pay Gap Report

Data as at 31st March 2023

Publication date: March 2024

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Introduction

The gender pay gap report shows the difference between the average (mean or median) earnings of men and women. This is expressed as a percentage of men's earnings e.g. women earn 15% less than men.

The mean and median are different ways of expressing an average. Mean hourly pay for a group of ten people would be calculated by adding together the hourly rates of all ten people, and then dividing the result by 10. To find the median hourly rate for the same ten people, you would put the hourly rates in order, from lowest to highest, and the median would be a value halfway between the 5th and 6th rate. When used in relation to pay, the mean can be significantly affected by a small number of very high earning staff.

The gender pay gap differs from equal pay. Equal pay deals with the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value. It is unlawful to pay people unequally because they are a man or a woman. The gender pay gap shows the differences in the average pay between men and women. If a workplace has a particularly high gender pay gap, this can indicate there may be a number of issues to deal with, and the individual calculations may help to identify what those issues are.

As a public body employing over 250 staff the Trust is required to publish the following gender pay gap information:

a) Mean gender pay gap
b) Median gender pay gap
c) Mean bonus gender pay gap
d) Median bonus gender pay gap
e) Proportion of males receiving a bonus payment
f) Proportion of females receiving a bonus payment
g) Proportion of males and females in each quartile pay band

Gender Pay Gap Reporting

Data and statistics provided for this report have been created using the national Electronic Staff Records System Business Intelligence reporting tool, specifically designed to allow NHS Trusts to meet the statutory reporting requirements.

As at 31st March 2023, the Trust's workforce included 4166 women, and 871 men. Men made up 17.29% of the overall workforce. The numbers of female and male employees have increased over the last year, however, the proportion of the Trust's workforce who are male has increased very slightly. The national NHS Electronic Staff Record system does not facilitate the recording of genders other than male or female.

As at 31st March 2023, the Trust employed 4653 full-pay relevant employees. Of these, 3823 were women and 830 were men. 17.8% of full-pay relevant employees were men. Employees who are on maternity, maternity support, adoption, or sick leave, or on a career break are not full-pay relevant employees.

(A & B) - Mean Gender Pay Gap and Median Gender Pay Gap

All Staff Average & Median Hourly Rates

Gender	Mean Hourly Rate	Median Hourly Rate
Female	£17.58	£15.97
Male	£24.33	£19.30
Difference	£6.74	£3.33
Pay Gap %	27.72%	17.24%

The Trust's Gender Pay Gap (mean and median) as of 31st March 2023 is 27.72% & 17.24%, this has improved since last year when it stood at 30.30% and 25.73% respectively. There does not appear to be a single explanation for this change, but some of the reasons are explored further in this report.

(C & D) - Mean Bonus Gender Pay Gap and Median Bonus Gender Pay Gap

All Staff Average & Median Bonus Pay

Gender	Mean Bonus Pay	Median Bonus Pay
Female	£6,877.06	£5,567.26
Male	£10,100.69	£9,048.00
Difference	£3,223.62	£3,480.74
Pay Gap %	31.91%	38.47%

* This data excludes Long Service Awards

The only large sums of bonus pay are Clinical Excellence Awards (CEAs) which are paid only to medical staff. During Covid temporary arrangements were introduced and some continued (these involved the amount available for new CEAs being split between all eligible consultants and paid as a non-pensionable lump sum, rather than a bonus). Pre-existing CEAs continued to be paid, although there is an ongoing reduction in the number of staff receiving them due to retirements and resignations.

During 2021-22, the majority of Trust staff received a £200 bonus payment, in recognition of the work they were doing to support the NHS's recovery from the Covid-19 pandemic (all staff in the Trust's employment as of a specific date were entitled to the payment). This is why both the mean and median bonus payments in 2021-22 were much lower than in previous years; however, this bonus payment was not implemented for 2022-23.

Historic CEA processes tended to attract more male applicants nationally. Current CEAs are retained once awarded; however, the CEA process is changing, and Trusts will be required to develop processes for Local Clinical Excellence Awards (LCEAs), which will have to be reapplied for periodically. In designing and implementing a process for LCEAs, the Trust will devote time, energy, and effort into devising an equitable process that supports and encourages female consultants to apply for awards. All elements of the process will be subjected to a rigorous Equality Impact Assessment, and the results of awards rounds will be very closely monitored and checked for consistency.

(E & F) - Proportion of Males Receiving a Bonus Payment and Proportion of Females Receiving a Bonus Payment

All Staff Bonus Payment Ratio

Gender	Employees Paid Bonus	Total Relevant Employees	%
Female	11	4084	0.27%
Male	39	900	4.33%

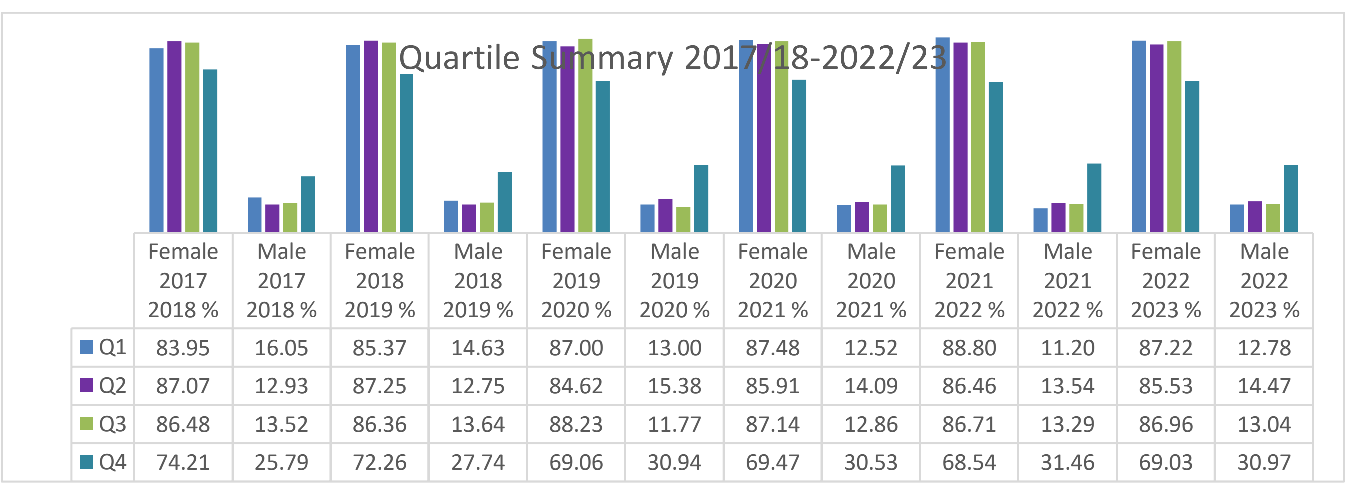
There has been a significant change in the proportion of colleagues receiving a bonus payment this year compared with last. During 2022-23, 4.33% of male colleagues and 0.27% of female colleagues received payments all of which related to CEA's. This is noticeably different from 2021-22 (male 87.33%; and female 95.32%) when colleagues received the £200 bonus payment referenced above which significantly impacted on this metric.

(G) - Proportion of Males and Females in each Quartile Pay Band

Quartile 1 - lowest paid and quartile 4 - highest paid employees.

Quartile	Female	Male	Female %	Male %
1	1010	148	87.22%	12.78%
2	999	169	85.53%	14.47%
3	1007	151	86.96%	13.04%
4	807	362	69.03%	30.97%

The graph below shows data on the proportion of male and female staff in each pay quartile over the last 5 years.

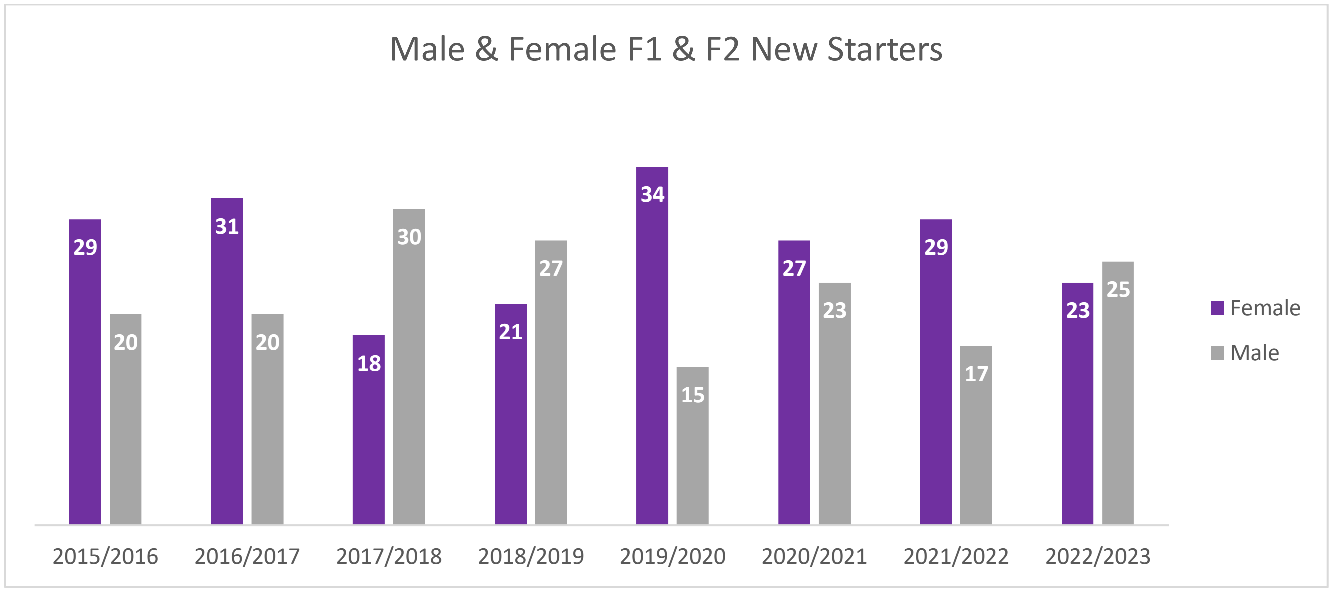


	Female 2017 2018 %	Male 2017 2018 %	Female 2018 2019 %	Male 2018 2019 %	Female 2019 2020 %	Male 2019 2020 %	Female 2020 2021 %	Male 2020 2021 %	Female 2021 2022 %	Male 2021 2022 %	Female 2022 2023 %	Male 2022 2023 %
Q1	83.95	16.05	85.37	14.63	87.00	13.00	87.48	12.52	88.80	11.20	87.22	12.78
Q2	87.07	12.93	87.25	12.75	84.62	15.38	85.91	14.09	86.46	13.54	85.53	14.47
Q3	86.48	13.52	86.36	13.64	88.23	11.77	87.14	12.86	86.71	13.29	86.96	13.04
Q4	74.21	25.79	72.26	27.74	69.06	30.94	69.47	30.53	68.54	31.46	69.03	30.97

The data shows that statistically the Trust pays the male workforce more than the female workforce. Past analysis has shown this to be partly as a result of the highest earners being within the medical workforce, which is a predominantly male workforce. It takes up to 14 years of under and postgraduate training for individuals to achieve the highest grade of consultant and a further 20 years to achieve the top of the consultant salary scale.

1. Trainee Comparison (FY 1&2)

The table below shows number of female and male trainee Foundation Years 1 and 2 new starters for all years since 2015 - 16. Over the period, there have been 212 female new starters within this group, compared to 177 male new starters. Coupled with long-term trends showing increased numbers of female medical students, it is likely that the gender balance of the medical workforce will shift over time, however this may be significantly influenced by the availability or otherwise of flexible working opportunities within hospital medical posts, and no significant shift in gender balance has been seen at Consultant level in the Trust as yet.



2. Comparison of hourly pay rates amongst non-medical and medical staff groups

2.1 Non-medical

Gender	Mean Hourly Rate	*Median Hourly Rate
Female	£16.57	£15.37
Male	£18.09	£16.55
Difference	£1.52	£1.18
Pay Gap %	8.39%	7.14%

The gender pay gap amongst non-medical staff is relatively small compared to the Trust's overall gender pay gap, and both the mean and median hourly rates have improved from last year (10.61% and 11.57%).

2.2 Medical and dental

Gender	Mean Hourly Rate	*Median Hourly Rate
Female	£38.18	£35.90
Male	£40.41	£42.71
Difference	£2.23	£6.82
Pay Gap %	5.51%	15.96%

Although there remains a significant pay gap within the medical and dental workforce, this has almost halved from last year mean of 15.35% and median of 28.43%, to the much-improved position of 5.51% and 15.96% respectively. Some of this change will be due to male colleagues retiring / leaving the organisation, more females progressing and taking on leadership roles, more females entering the medical workforce.

3. Comparison of proportion of non-medical and medical staff in each pay quartile

3.1 Non-medical

Quartile	Female	Male	Female %	Male %
1	1010	147	87.29%	12.71%
2	989	154	86.53%	13.47%
3	990	138	87.77%	12.23%
4	655	159	80.47%	19.53%

Quartile 1 - lowest paid and quartile 4 - highest paid employees.

There continues to be a slight decrease in the proportion of men within the highest pay quartile; and an increase in men in the lower quartile 1 - (12.71% v 11.21% last year).

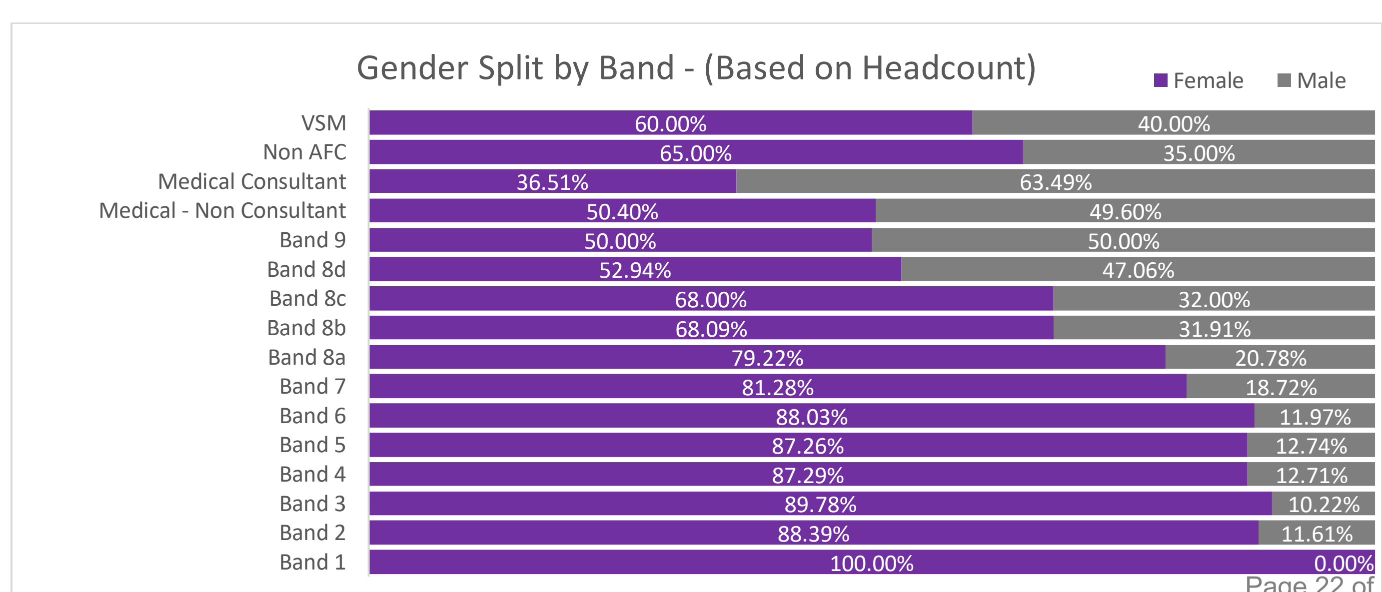
3.2 Medical

Quartile	Female	Male	Female %	Male %
1	0	1	0.00%	100.00%
2	10	15	40.00%	60.00%
3	17	13	56.67%	43.33%
4	152	203	42.82%	57.18%

Quartile 1 - lowest paid and quartile 4 - highest paid employees.

The overwhelming majority of medical staff continue to be in the highest-paid quartile of Trust staff with the majority being male (57.18%).

4. Gender split by pay band



5. Gender pay gap by staff group

Staff Group	**Headcount		Pay Gap
	Female	Male	
Add Prof Scientific and Technic	75	25	15.32%
Additional Clinical Services	860	96	8.49%
Administrative and Clerical	795	162	41.22%
Allied Health Professionals	359	89	14.14%
Estates and Ancillary	184	96	44.34%
Healthcare Scientists	70	39	15.82%
Medical and Dental	179	232	17.91%
Nursing and Midwifery Registered	1292	91	9.90%
Students	9	0	0

The largest pay gaps are within the administrative and clerical and estates and ancillary staff groups.

6. Conclusion

As most staff groups and employees are part of the Agenda for Change framework then this negates a large element of gender pay gap variance; however, the Trust needs to ensure that recruitment processes and career opportunities remain fair and transparent to avoid any potential longer-term problems.

The main contributing factor to the pay gap differential remains with the medical & dental workforce. Some of the issues relate to previous societal norms, e.g. doctors seen as a male career pathway, particularly a few decades ago – however, the impact of this is still visible within the organisation as this cohort generally have senior consultant roles and CEA's which will remain in place until they leave or retire. The robust job planning and consistency checking process that has been agreed should ensure more fairness and recognition of colleague's extra efforts entitled to CEA's. Where appropriate female colleagues should be encouraged to apply for CEA/promotional job opportunities.

There is a need to highlight and promote female leadership within the Trust and also the wider community – actively encourage colleagues to participate in International Women's Day and be part of the ICS women in leadership network (which TRFT participate).

There are a couple of staff groups where the gender pay gap is significantly large (admin & clerical and estates and ancillary); therefore, some further analysis may need to be undertaken to determine what actions can be developed to address this, if it is a concern.

There is no statutory requirement for either recommendations or an action plan in relation to gender pay gap; however, following future discussion at relevant forums it is expected that some associated actions will be added to the overarching EDI action plan.

Paul Ferrie

February 2024

Hourly Pay

Mean GPG for hourly pay	27.7	%
Median GPG for hourly pay	17.2	%

Upper hourly Pay Quarter

Women	69.0	%
Men	31.0	%

Upper middle hourly Pay Quarter

Women	87.0	%
Men	13.0	%

Lower middle hourly Pay Quarter

Women	85.5	%
Men	14.5	%

Lower hourly Pay Quarter

Women	87.2	%
Men	12.8	%

Bonus Pay

Mean GPG for bonus pay	31.9	%
Median GPG for bonus pay	38.5	%

Percentage who received bonus pay

Women	0.3	%
Men	4.3	%

Board of Directors
8th March 2024

Agenda item	P36/24a
Report	NHS Staff Survey results 2023
Executive Lead	Daniel Hartley – Director of People
Link with the BAF	D5: Delivery - inability to deliver operational plan resulting in increase in patient waiting times and reduced quality of care U4: Us - there is a risk that we do not develop and maintain a positive culture because of insufficient resources and the lack of compassionate leadership leading to an inability to recruit, retain and motivate staff.
Purpose	Decision ☐ To Note ✓ For Approval ☐ For Information ☐
Executive Summary (including reason for the report, background, key issues and risks)	The NHS Staff Survey results 2023 are presented to the Board of Directors. The final results were received into the Trust in late February and are embargoed externally until Thursday 7th March at 9:30am. The staff survey results demonstrate strong progress by the Trust in improving staff engagement. The Trust achieved a response rate of 67% (comparator Trust response range 23% to 69%, TRFT 2022 response rate 61%) and has increased the overall engagement score to 7.0 (average comparator Trust 2023 6.9, TRFT 2022 6.7) - both new records for the Trust. Improvements have been seen across all seven areas of the People Promise and these improvements are classed as 'statistically significant – significantly higher' by Picker - the company which runs the survey on behalf of the NHS. This summary paper sets out key areas to note as well as the next steps underway in order to build on this significant achievement for the benefit of staff and patients through 2024. Board members are asked to share any feedback on the staff survey and note the work in train to publicise these results across the Trust; use these results in attraction and recruitment materials and build on these results through 2024 before the next annual survey opens in October 2024.
Recommendations	The Board of Directors are asked to; • note this report, the improved levels of staff engagement across the Trust and next steps set out
Appendices	NHS England Picker - Staff survey results 2023 (reading room)

1.0 Introduction

1.1 This report and appendix provides the latest results of the NHS Staff Survey, conducted October/November 2023 as well as information on next steps for the Trust. The results demonstrate strong progress by the Trust in improving response rates and improving staff engagement, which is a key enabler of our ability to deliver improved outcomes for patients.

2.0 Key areas

2.1 The attached NHS Staff Survey Benchmark report 2023 was received into the Trust in late February and is embargoed externally until Thursday 7th March at 9.30am. It is set out in a standard format by Picker who run the survey on behalf of NHS England and will be published at http://www.nhsstaffsurveys.com , along with the results from other Trusts.

2.2 The staff survey results demonstrate strong progress by the Trust in improving staff engagement. The Trust achieved a response rate of 67% (comparator Trust response range 2023 23% to 69%, TRFT 2022 response rate 61%) and has increased the overall engagement score to 7.0 (average comparator Trust 2023 6.9, TRFT 2022 6.7) - both new records for the Trust. Improvements have been seen across all seven areas of the People Promise which the survey is designed around – 'We are compassionate and inclusive,' 'We are recognised and rewarded,' 'We each have a voice that counts,' 'We are safe and healthy,' 'We are always learning,' 'We work flexibly,' and 'We are a team.'

2.3 As well as improvements in the overarching themes of Engagement and Morale the improvements are classed as 'statistically significant – significantly higher' by Picker in terms of the changes from 2022 to 2023. Overall of the 100 main questions in the survey 90 have improved, one has stayed the same and nine have seen lower scores this year vs 2022. This is the result of a lot of hard work by senior leaders, managers and indeed all staff - improvements which have been made despite the challenging operational context for the NHS.

2.4 Key areas to draw the Board's attention to are as follows;

- Slides 1-7 of the appendix set out how to read and interpret the results and information presented, for those new to format
- Slides 11-16 set out the summary overview of the elements of People Promise, with slide 12 being the key summary slide showing our performance on each area benchmarked against the comparator Trust group (acute and acute and community) in terms of both average and range. In each area we exceed the average and in 5 areas of the people promise we are close to the top of the range
- Slides 18-89 set out trend data for the last 5 years for each area and question
- Slides 90-102 set out questions not directly linked to the people promise themes
- Slides 103 – 120 set out the breakdown results for the Workforce Race Equality Standards and Workforce Disability Equality Standards
- Slides 121 -135 set out the demographic profile of the respondents
- Slide 137 sets out TRFT's response rate over recent years

- Slide 139 shows the 'statistically significant – significantly higher' rating given to the results by Picker.

2.5 Slides 12, 137 and 139 therefore show at a glance the benchmarked overall summary, the response rate improvements and the statistical significance confidence testing.

3.0 Sharing the results and next steps

3.1 The survey results as well as the divisional breakdowns have been shared with the Trust's senior leaders/clinical leadership groups in January 2024. Senior leaders are in the process of creating 'we said, we did' action plans with their teams to take action on the results of the survey.

3.2 In addition to this, organisation wide actions are being put in place to respond to the areas that either require specific focus and/or disproportionately affect a group or groups of staff. This will see the work to counter violence and aggression continue with partners, and further work to promote inclusion and eradicate discrimination. Further progress is needed to ensure that everyone at TRFT has the same high quality experience and in discussion with staff networks these results and actions will feed into Equality Diversity and Inclusion action plans.

3.3 Further work is underway to develop the Trust's approach to appraisal to make sure it meets needs and progress on these actions will be overseen by the People Committee.

3.4 Over 300 free text comments have also being received and these are in the process of being analysed to inform action plans.

3.5 The full results were shared with the People Committee at the February meeting who were assured by the progress being made. Divisional presentations to the People Committee in 2024/2025 will include a strong focus on the delivery of the 'we said, we did' action plans and Divisions as well as corporate directors will be supported in the creation of these plans by the People team.

3.6 Work is underway to update the Trust's attraction and recruitment information to reflect the strong progress in making improvements to staff engagement.

3.7 Further internal communications are planned w/c 4th March including a message from the Chief Executive to all staff celebrating the progress made and encouraging further improvements so that we can make the Trust the best place to work and receive care.

4.0 Recommendation

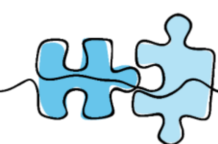
- The Board of Directors are asked to note this report, the improved levels of staff engagement across the Trust and next steps set out

Daniel Hartley
Director of People
March 2024

Survey Coordination Centre

The Rotherham NHS Foundation Trust

NHS Staff Survey Benchmark report 2023



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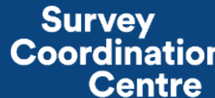

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Survey Coordination Centre

Introduction

Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

About this report

This benchmark report for The Rotherham NHS Foundation Trust contains results for the 2023 NHS Staff Survey, and historical results back to 2019 where possible. These results are presented in the context of best, average and worst results for similar organisations where appropriate. Data in this report are weighted to allow for fair comparisons between organisations*.

Please note: Results for Q1, Q10a, Q26d, Q27a-c, Q28, Q29, Q30, Q31a, Q32a-b, Q33, Q34a-b and Q35 are not weighted or benchmarked because these questions ask for demographic or factual information.

Full details of how the data are calculated and weighted are included in the Technical Document, available to download from the Staff Survey website.

How results are reported

For the 2021 survey onwards the questions in the NHS Staff Survey are aligned to the People Promise. This sets out, in the words of NHS staff, the things that would most improve their working experience, and is made up of seven elements:

In support of this, the results of the NHS Staff Survey are measured against the seven People Promise elements and against two of the themes reported in previous years (Staff Engagement and Morale). The reporting also includes sub-scores, which feed into the People Promise elements and themes. The next slide shows how the People Promise elements, themes and subscores are related and mapped to individual survey questions.

* The data included in this report are weighted to the national benchmarking groups. The figures in this report may be different to the figures produced by your contractor. Please see Appendix C for a note on the revision to 2019 historical benchmarking for Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts, and Community Trust benchmarking groups.

People Promise elements, themes and sub-scores

People Promise elements	Sub-scores	Questions
We are compassionate and inclusive	Compassionate culture	Q6a, Q25a, Q25b, Q25c, Q25d
	Compassionate leadership	Q9f, Q9g, Q9h, Q9i
	Diversity and equality	Q15, Q16a, Q16b, Q21
	Inclusion	Q7h, Q7i, Q8b, Q8c
We are recognised and rewarded	No sub-score	Q4a, Q4b, Q4c, Q8d, Q9e
We each have a voice that counts	Autonomy and control	Q3a, Q3b, Q3c, Q3d, Q3e, Q3f, Q5b
	Raising concerns	Q20a, Q20b, Q25e, Q25f
We are safe and healthy	Health and safety climate	Q3g, Q3h, Q3i, Q5a, Q11a, Q13d, Q14d
	Burnout	Q12a, Q12b, Q12c, Q12d, Q12e, Q12f, Q12g
	Negative experiences	Q11b, Q11c, Q11d, Q13a, Q13b, Q13c, Q14a, Q14b, Q14c
	Other questions [Not scored]	Q17a*, Q17b*, Q22* *Q17a, Q17b and Q22 do not contribute to the calculation of any scores or sub-scores.
We are always learning	Development	Q24a, Q24b, Q24c, Q24d, Q24e
	Appraisals	Q23a*, Q23b, Q23c, Q23d *Q23a is a filter question and therefore influences the sub-score without being a directly scored question.
We work flexibly	Support for work-life balance	Q6b, Q6c, Q6d
	Flexible working	Q4d
We are a team	Team working	Q7a, Q7b, Q7c, Q7d, Q7e, Q7f, Q7g, Q8a
	Line management	Q9a, Q9b, Q9c, Q9d

Themes	Sub-scores	Questions
Staff Engagement	Motivation	Q2a, Q2b, Q2c
	Involvement	Q3c, Q3d, Q3f
	Advocacy	Q25a, Q25c, Q25d
Morale	Thinking about leaving	Q26a, Q26b, Q26c
	Work pressure	Q3g, Q3h, Q3i
	Stressors	Q3a, Q3e, Q5a, Q5b, Q5c, Q7c, Q9a

Questions not linked to the People Promise elements or themes

Q1, Q10a, Q10b, Q10c, Q11e, Q15, Q16c, Q18, Q19a, Q19b, Q19c, Q19d, Q26d, Q31b

Introduction

This section provides a brief introduction to the report, including how questions map to the People Promise elements, themes and sub-scores, as well as features of the charts used throughout.

Organisation details

This slide contains **key information** about the NHS organisations participating in this survey and details for your own organisation, such as response rate.

People Promise elements, themes and sub-scores: Overview

This section provides a high-level **overview** of the results for the seven elements of the People Promise and the two themes, followed by the results for each of the **sub-scores** that feed into these measures.

People Promise elements, themes and sub-scores: Trends

This section provides trend results for the seven elements of the People Promise and the two themes, followed by the trend results for each of the sub-scores that feed into these measures.

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, where a higher score is more positive than a lower score. For example, the Burnout sub-score, a higher score (closer to 10) means a lower proportion of staff are experiencing burnout from their work. These scores are created by scoring questions linked to these areas of experience and grouping these results together. Your organisation results are benchmarked against the benchmarking group average, the best scoring organisation and the worst scoring organisation. These charts are reported as percentages. The meaning of the value is outlined along the y axis. The questions that feed into each sub-score are detailed on slide 5.

Note where there are fewer than 10 responses for a question this data is not shown to protect the confidentiality of staff and reliability of results.

People Promise elements, themes and sub-scores: Questions

This section provides trend results for **questions**. The questions are presented in sections for each of the People Promise elements and themes.
Not all questions reported within the section for a People Promise element or theme feed into the score and sub-scores for that element or theme. The first slide in the section for each People Promise element or theme lists which of the questions that are included in the section feed into the score and sub-scores, and which do not.

Questions not linked to People Promise

Results for the questions that are not related to any People Promise element or theme and do not contribute to the scores and sub-scores are included in this section.

Workforce Equality Standards

This section shows that data required for the indicators used in the **Workforce Race Equality Standard (WRES)** and the **Workforce Disability Equality Standard (WDES).**

About your respondents

This section provides details of the staff responding to the survey, including their **demographic and other classification questions**.

Appendices

Here you will find:

- Response rate.
- Significance testing of the People Promise element and theme results for 2022 vs 2023.
- Guidance on data in the benchmark reports.
- Additional reporting outputs.
- Tips on action planning and interpreting the results.
- Contact information.

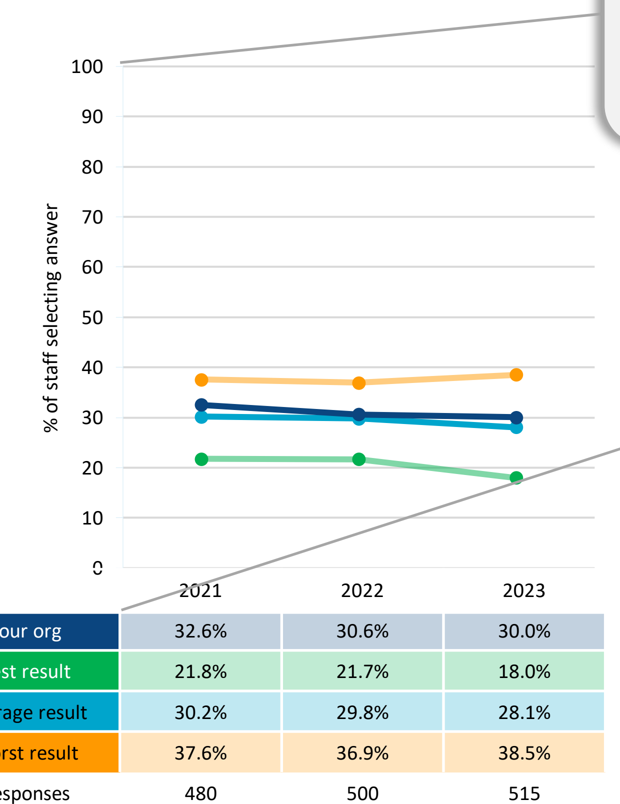
Using the report

Note this is example data

Key features

Question number and text (or summary measure) specified at the top of each slide.

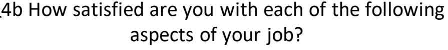
Question-level results are always reported as percentages; the **meaning of the value** is outlined along the axis. Summary measures and sub-scores are always on a 0-10pt scale where 10 is the best score attainable.

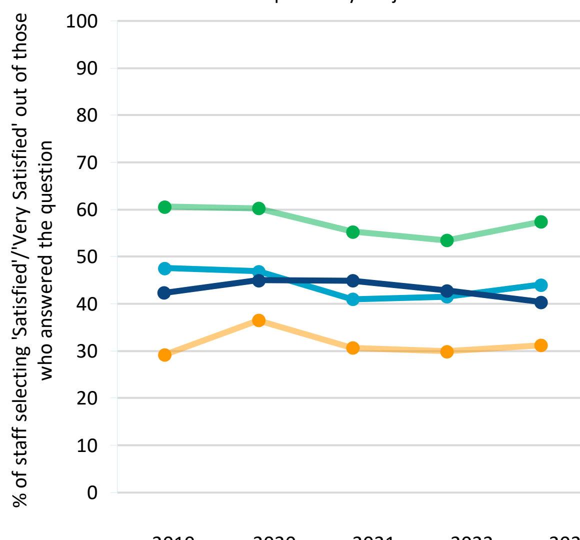


	2021	2022	2023
Your org	32.6%	30.6%	30.0%
Best result	21.8%	21.7%	18.0%
Average result	30.2%	29.8%	28.1%
Worst result	37.6%	36.9%	38.5%
Responses	480	500	515

Colour coding highlights best / worst results, making it easy to spot questions where a lower percentage is a better or worse result.

‘Best result’, ‘Average result’, and ‘Worst result’ refer to the **benchmarking group’s** best, average and worst **results.**





	2019	2020	2021	2022	2023
Your org	42.3%	45.0%	44.9%	42.8%	40.4%
Best result	60.6%	60.3%	55.3%	53.5%	57.4%
Average result	47.5%	46.9%	41.0%	41.5%	44.0%
Worst result	29.2%	36.5%	30.6%	29.9%	31.2%
Responses	835	1255	1491	1325	517

Number of responses for the organisation for the given question.

Tips on how to read, interpret and use the data are included in the Appendices

Note charts will only display data for the years where an organisation has data. For example, an organisation with three years of trend data will see charts such as q4b with data only in the 2021, 2022 and 2023 portions of the chart and table.

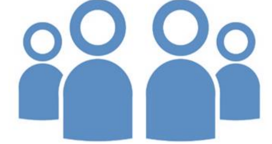
Survey Coordination Centre

Organisation details

Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

The Rotherham NHS Foundation Trust

2023 NHS Staff Survey



Organisation details

Completed questionnaires 3255

2023 response rate 67%

This organisation is benchmarked against:

Acute and Acute & Community Trusts

2023 benchmarking group details

Organisations in group: 122

Median response rate: 45%

No. of completed questionnaires: 477643

Survey details

Survey mode Paper

For more information on benchmarking group definitions please see the Technical document.

People Promise elements, themes and sub-score results

Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Survey Coordination Centre

People Promise elements, themes and sub-scores: Overview

Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

People Promise elements and themes: Overview

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

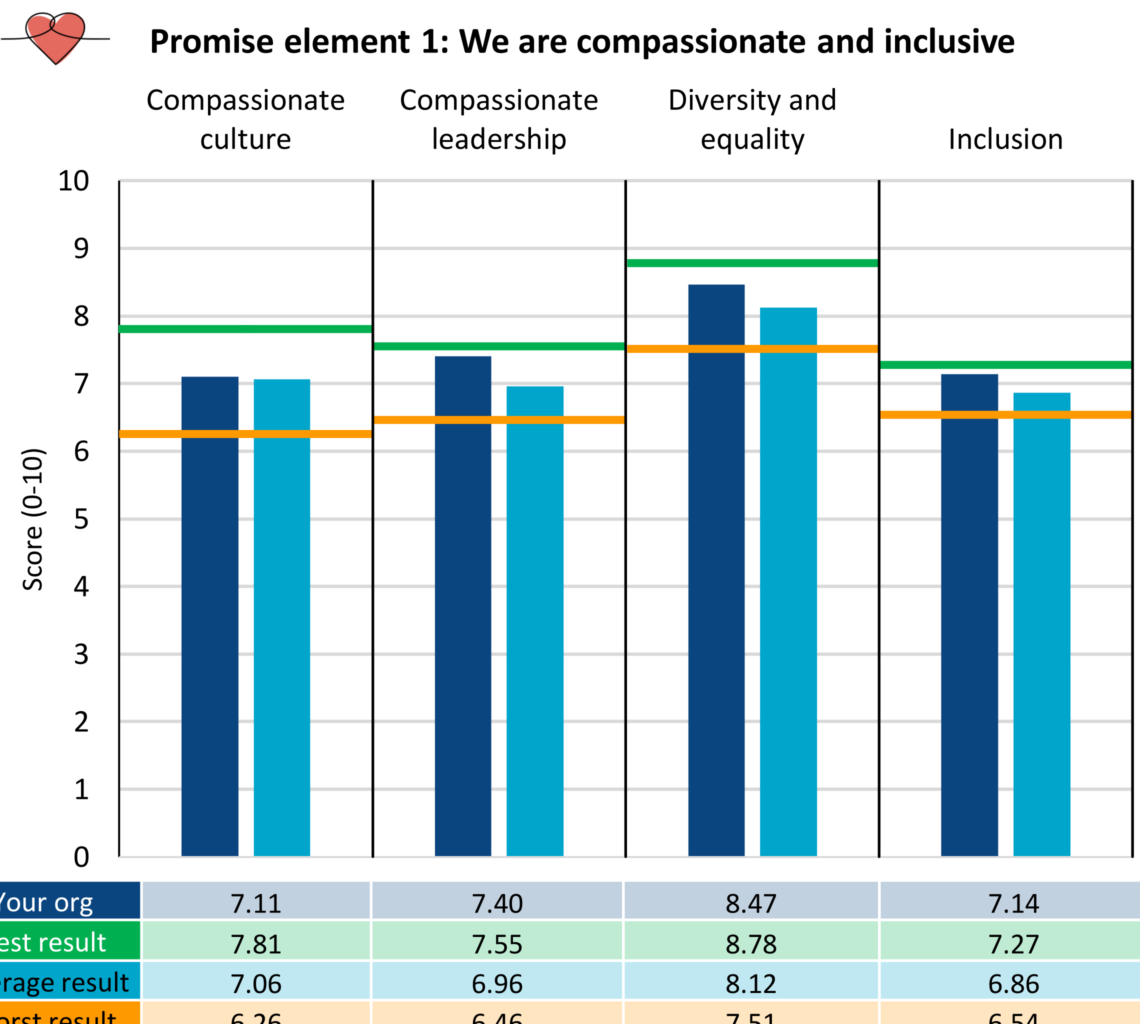
	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.53	6.28	7.01	6.27	5.94	6.57	7.07	6.98	6.20
Best result	7.71	6.37	7.16	6.55	6.07	6.87	7.19	7.32	6.52
Average result	7.24	5.94	6.70	6.06	5.61	6.20	6.75	6.91	5.91
Worst result	6.85	5.50	6.21	5.75	5.05	5.60	6.35	6.34	5.54
Responses	3239	3240	3190	3178	3029	3207	3229	3241	3241

Score (0-10): 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10

People Promise elements, themes and sub-scores: Sub-score overview

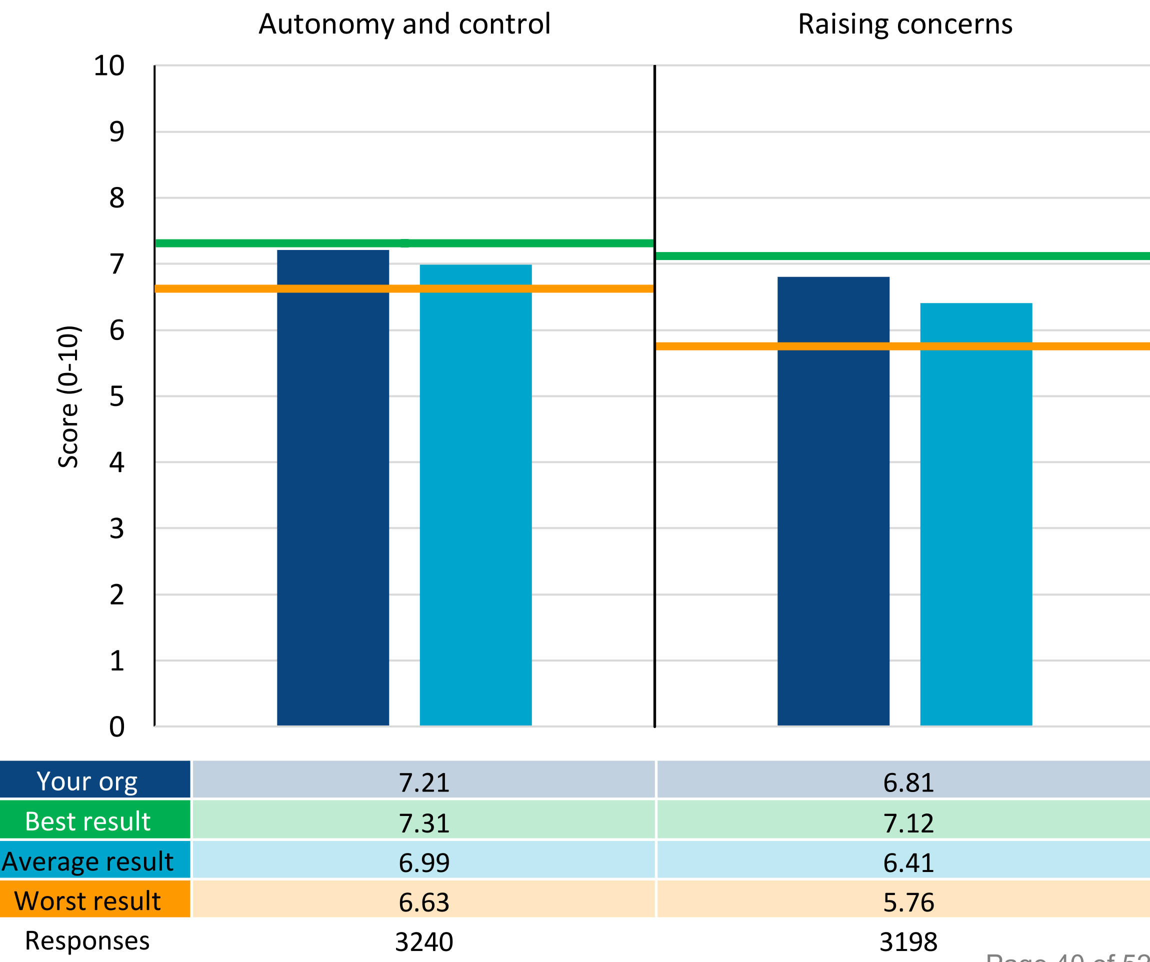
People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 1: We are compassionate and inclusive



	Compassionate culture	Compassionate leadership	Diversity and equality	Inclusion
Your org	7.11	7.40	8.47	7.14
Best result	7.81	7.55	8.78	7.27
Average result	7.06	6.96	8.12	6.86
Worst result	6.26	6.46	7.51	6.54
Responses	3213	3235	3220	3231

Promise element 3: We each have a voice that counts



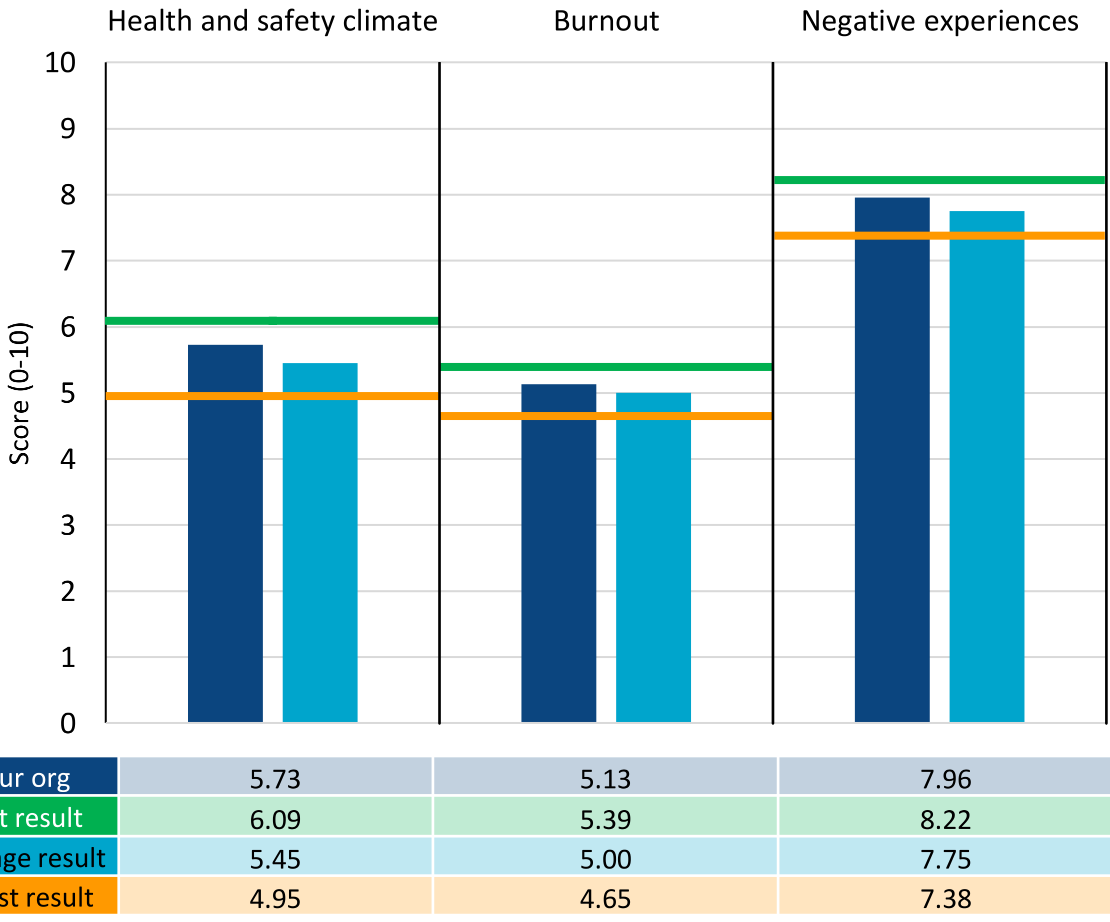
	Autonomy and control	Raising concerns
Your org	7.21	6.81
Best result	7.31	7.12
Average result	6.99	6.41
Worst result	6.63	5.76
Responses	3240	3198

Note. People Promise element 2 ‘We are recognised and rewarded’ does not have any sub-scores. Overall trend score data for this element is reported on slide 21.

People Promise elements, themes and sub-scores: Sub-score overview

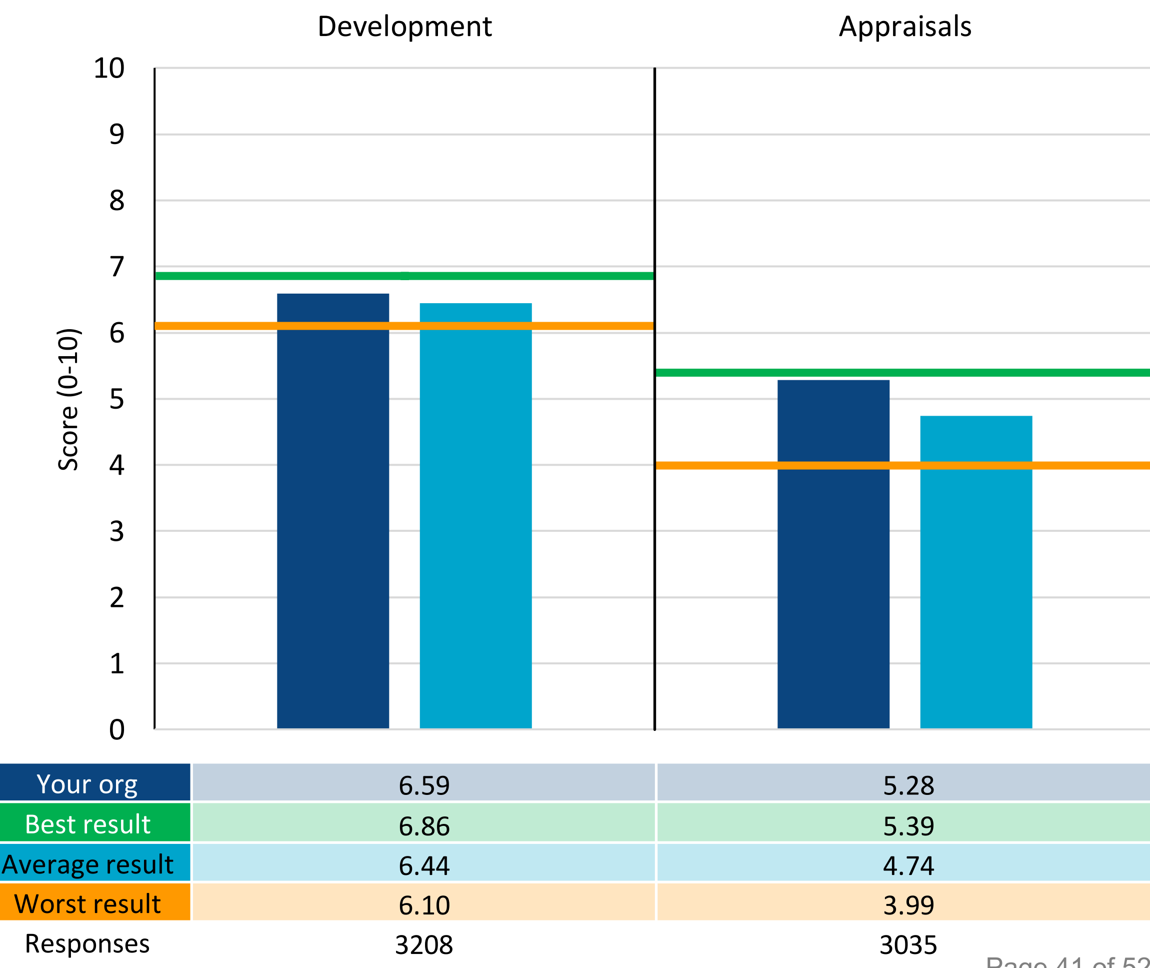
People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 4: We are safe and healthy



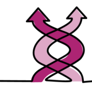
	Health and safety climate	Burnout	Negative experiences
Your org	5.73	5.13	7.96
Best result	6.09	5.39	8.22
Average result	5.45	5.00	7.75
Worst result	4.95	4.65	7.38
Responses	3243	3226	3194

Promise element 5: We are always learning



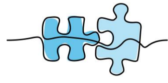
	Development	Appraisals
Your org	6.59	5.28
Best result	6.86	5.39
Average result	6.44	4.74
Worst result	6.10	3.99
Responses	3208	3035

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

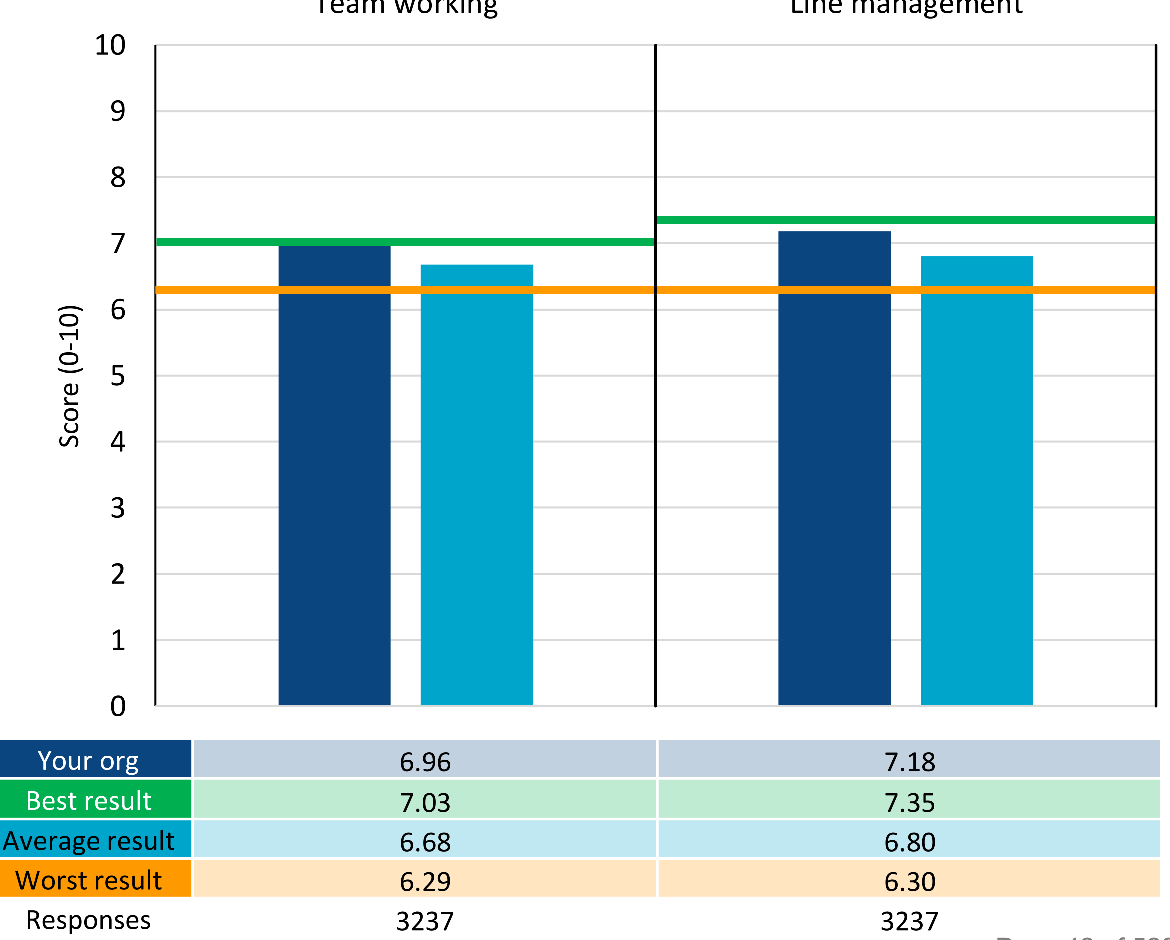


Promise element 6: We work flexibly

	Support for work-life balance	Flexible working
Your org	6.70	6.44
Best result	6.92	6.85
Average result	6.25	6.15
Worst result	5.68	5.50
Responses	3229	3221



Promise element 7: We are a team

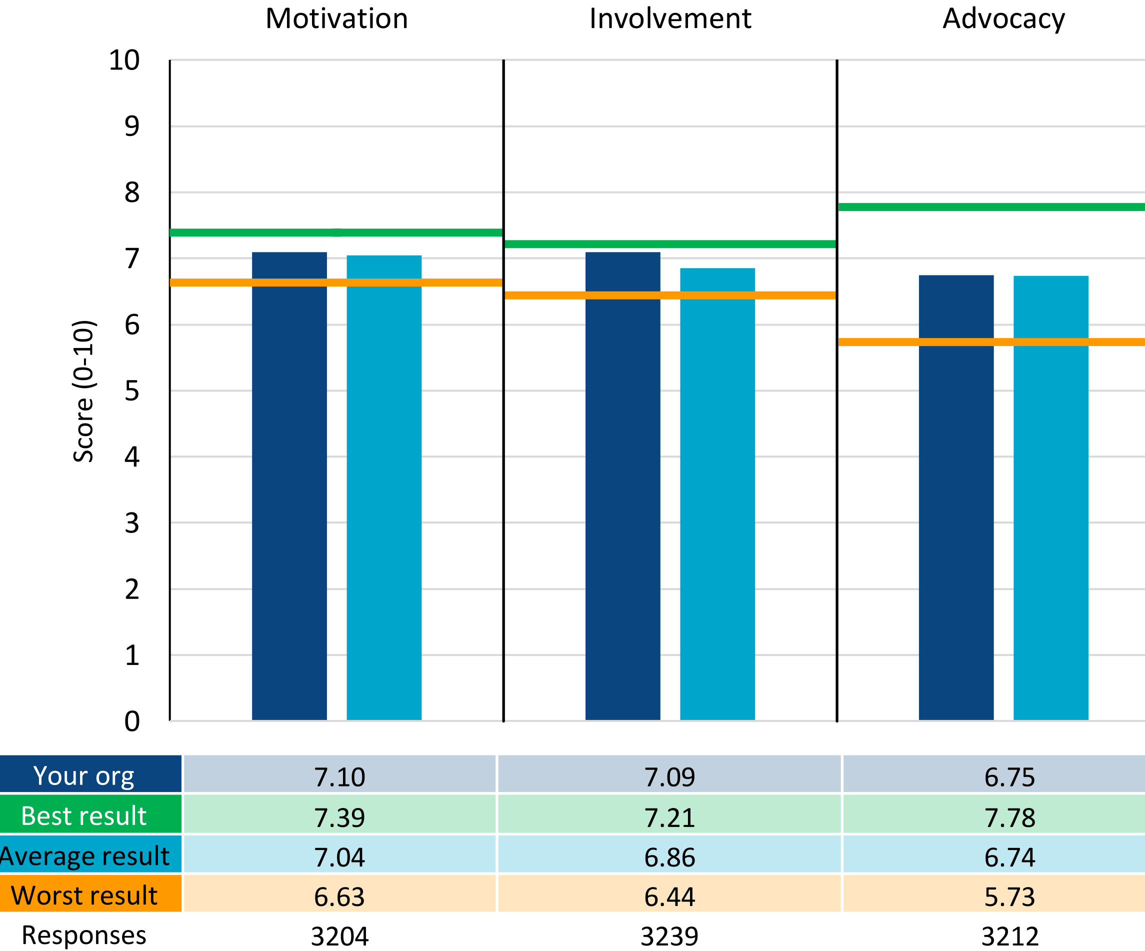


	Team working	Line management
Your org	6.96	7.18
Best result	7.03	7.35
Average result	6.68	6.80
Worst result	6.29	6.30
Responses	3237	3237

People Promise elements, themes and sub-scores: Sub-score overview

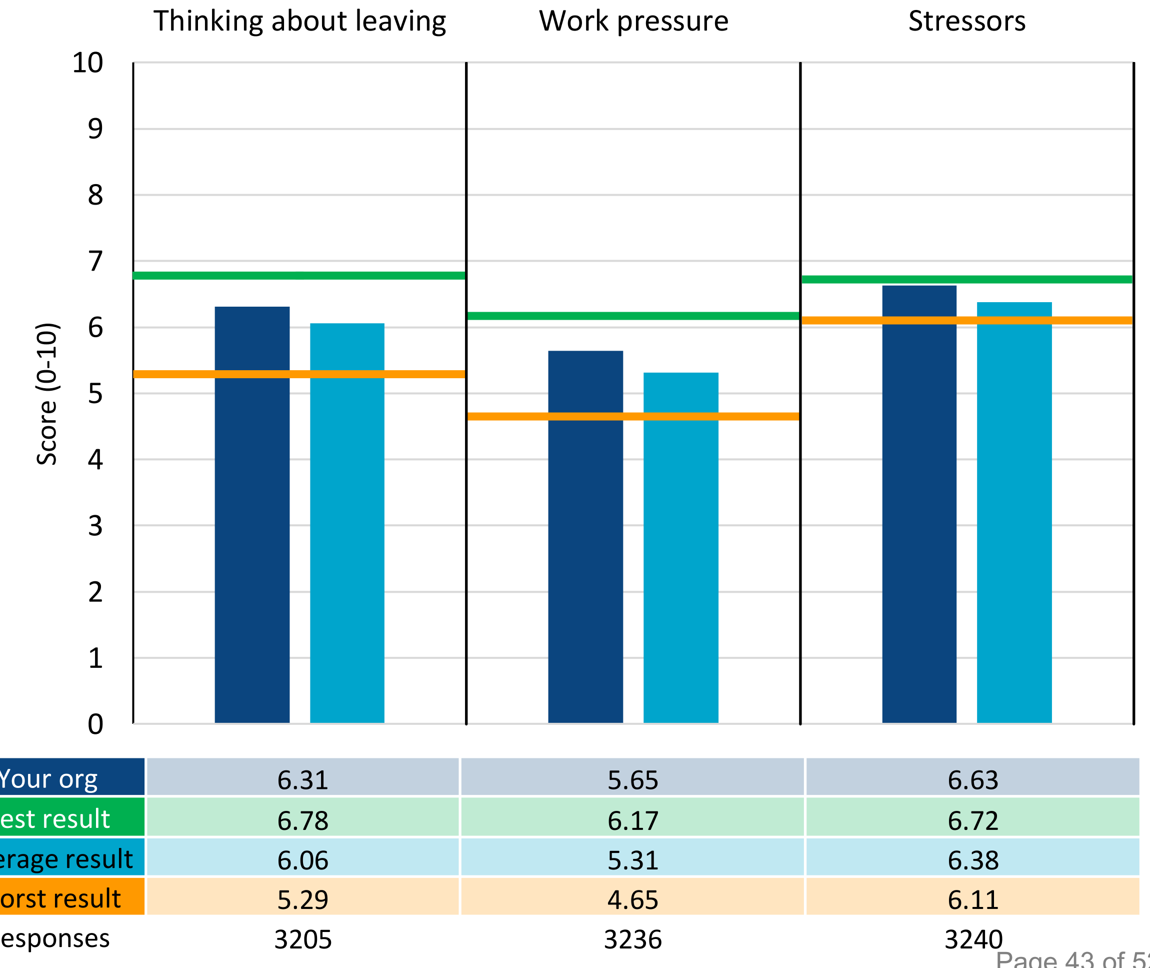
People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Theme: Staff engagement



	Motivation	Involvement	Advocacy
Your org	7.10	7.09	6.75
Best result	7.39	7.21	7.78
Average result	7.04	6.86	6.74
Worst result	6.63	6.44	5.73
Responses	3204	3239	3212

Theme: Morale



	Thinking about leaving	Work pressure	Stressors
Your org	6.31	5.65	6.63
Best result	6.78	6.17	6.72
Average result	6.06	5.31	6.38
Worst result	5.29	4.65	6.11
Responses	3205	3236	3240

Survey Coordination Centre

People Promise elements, themes and sub-scores: Trends

Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 1: We are compassionate and inclusive

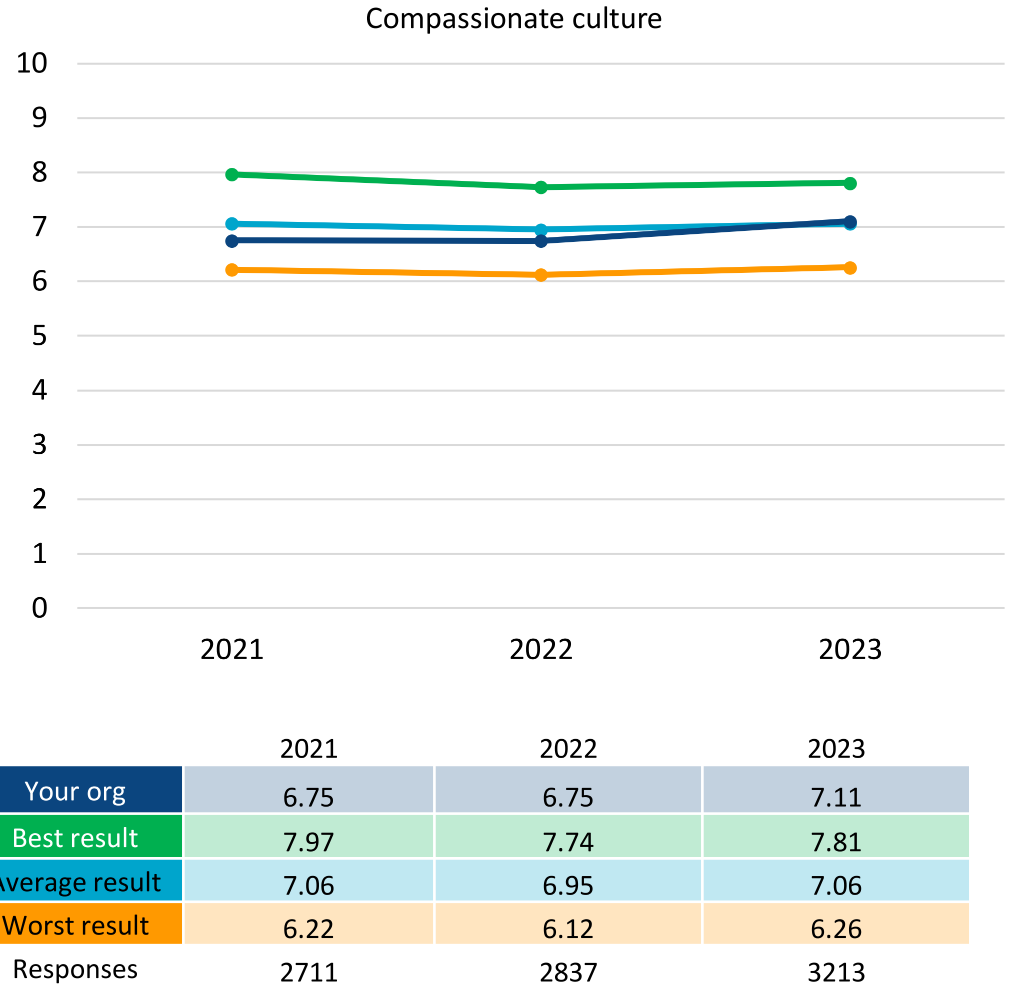
We are compassionate and inclusive

	2021	2022	2023
Your org	7.23	7.36	7.53
Best result	7.78	7.67	7.71
Average result	7.20	7.18	7.24
Worst result	6.75	6.76	6.85
Responses	2735	2862	3239

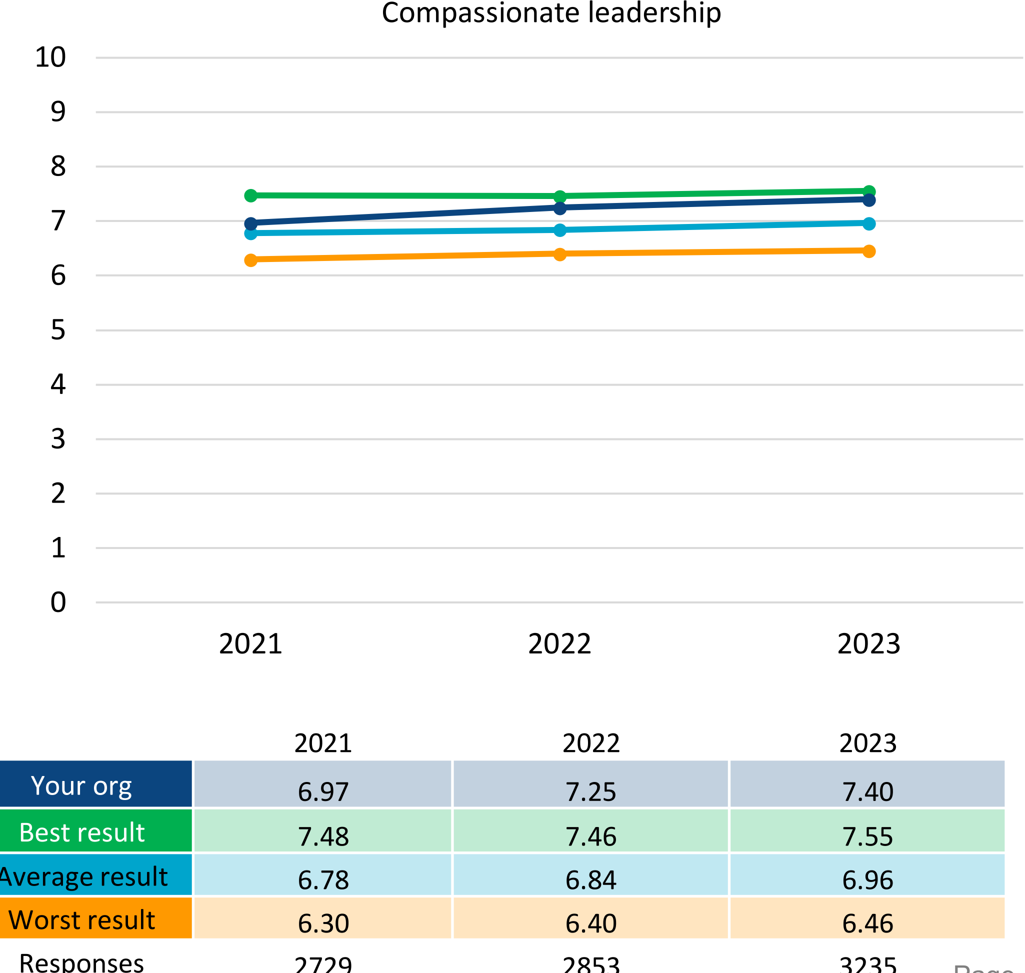
People Promise elements, themes and sub-scores: Sub-score trends

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 1: We are compassionate and inclusive (1)



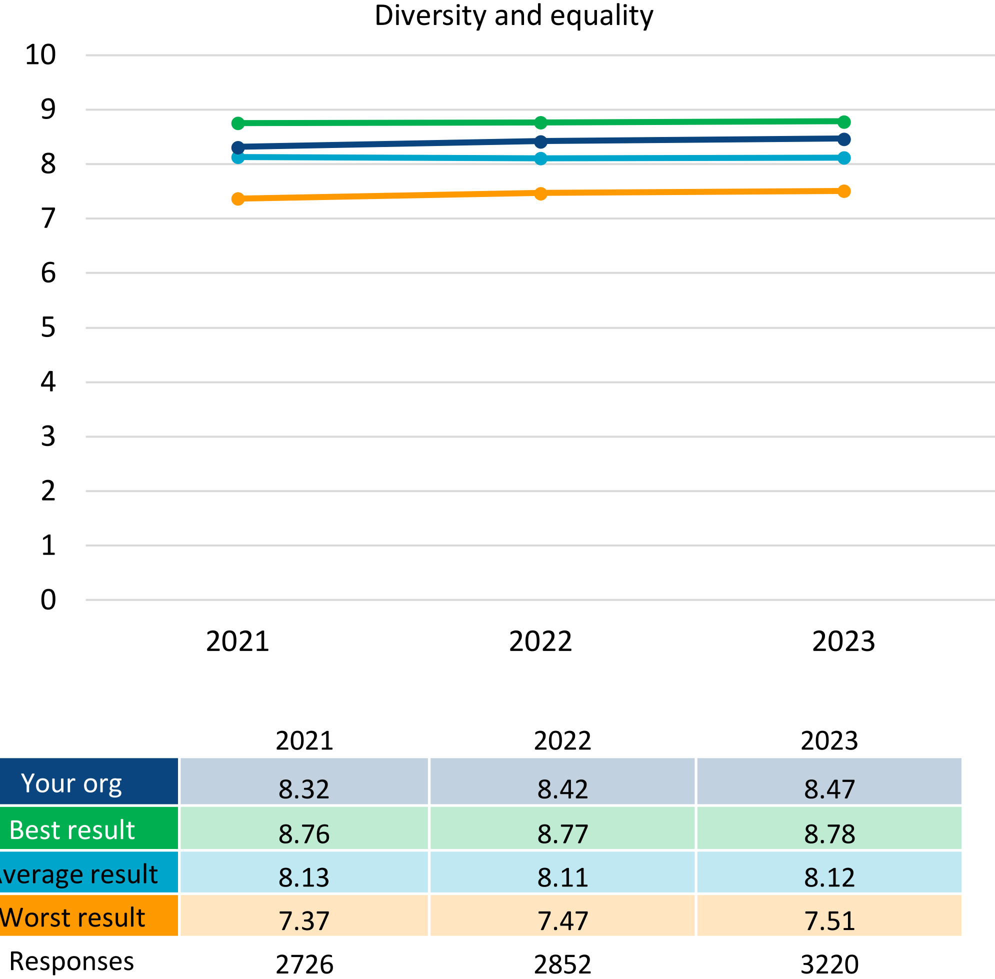
	2021	2022	2023
Your org	6.75	6.75	7.11
Best result	7.97	7.74	7.81
Average result	7.06	6.95	7.06
Worst result	6.22	6.12	6.26
Responses	2711	2837	3213



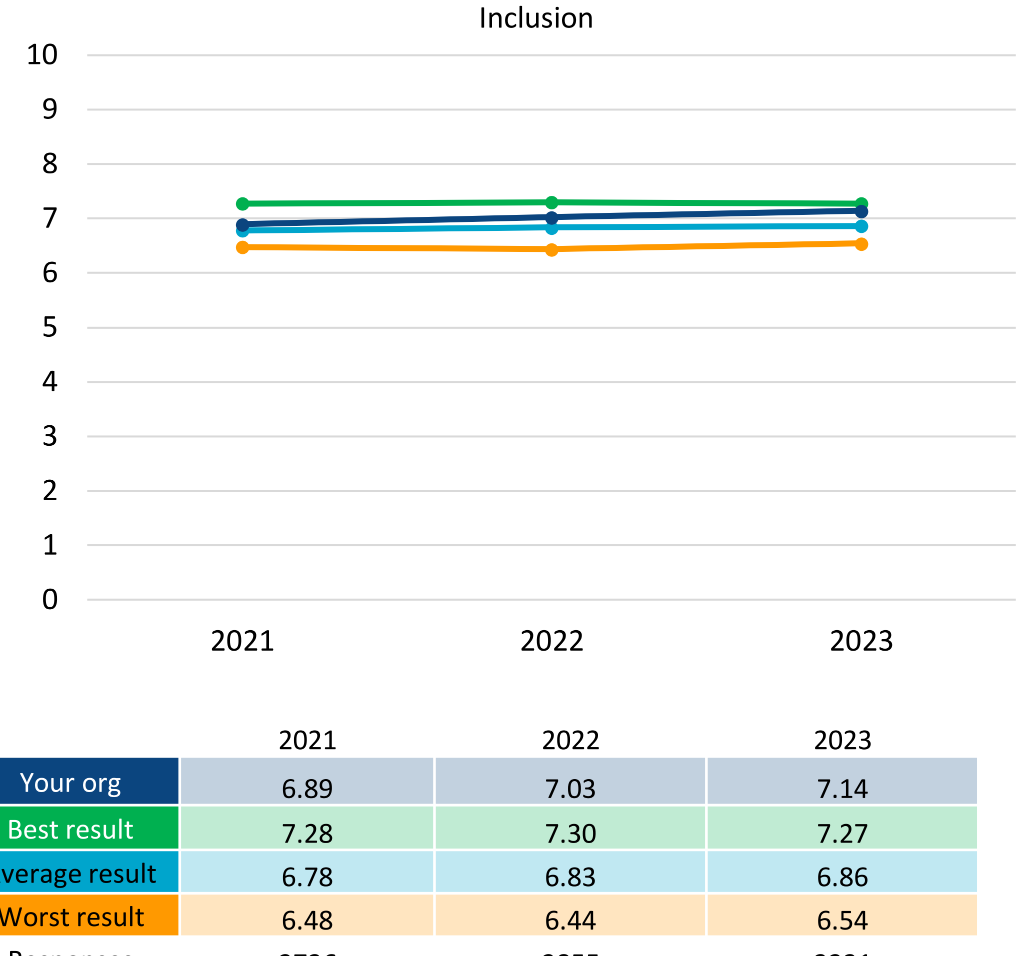
	2021	2022	2023
Your org	6.97	7.25	7.40
Best result	7.48	7.46	7.55
Average result	6.78	6.84	6.96
Worst result	6.30	6.40	6.46
Responses	2729	2853	3235

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 1: We are compassionate and inclusive (2)



	2021	2022	2023
Your org	8.32	8.42	8.47
Best result	8.76	8.77	8.78
Average result	8.13	8.11	8.12
Worst result	7.37	7.47	7.51
Responses	2726	2852	3220



	2021	2022	2023
Your org	6.89	7.03	7.14
Best result	7.28	7.30	7.27
Average result	6.78	6.83	6.86
Worst result	6.48	6.44	6.54
Responses	2736	2855	3231

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 2: We are recognised and rewarded

	2021	2022	2023
Your org	5.93	6.00	6.28
Best result	6.47	6.36	6.37
Average result	5.82	5.73	5.94
Worst result	5.34	5.24	5.50
Responses	2754	2866	3240

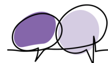
People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 3: We each have a voice that counts

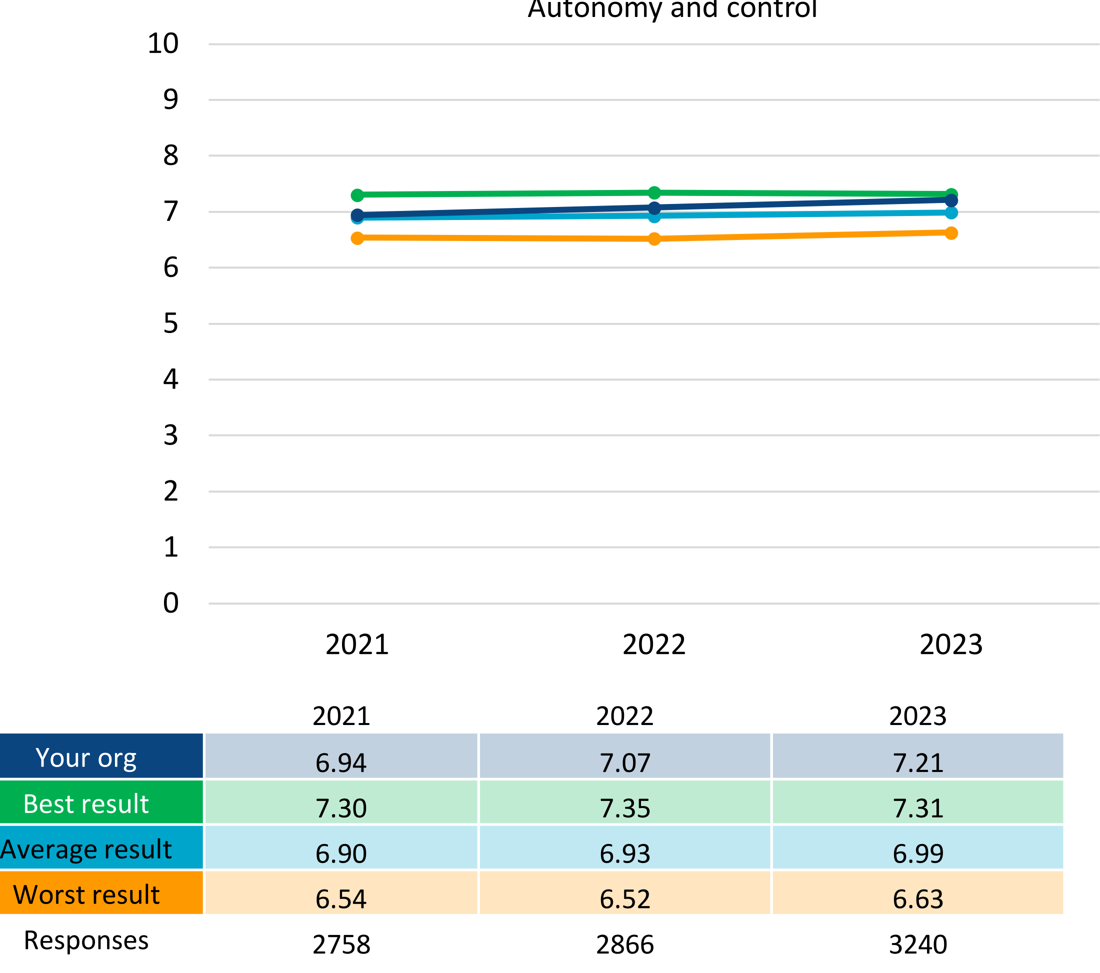
	2021	2022	2023
Your org	6.73	6.84	7.01
Best result	7.31	7.14	7.16
Average result	6.67	6.65	6.70
Worst result	6.16	6.16	6.21
Responses	2675	2813	3190

People Promise elements, themes and sub-scores: Sub-score trends

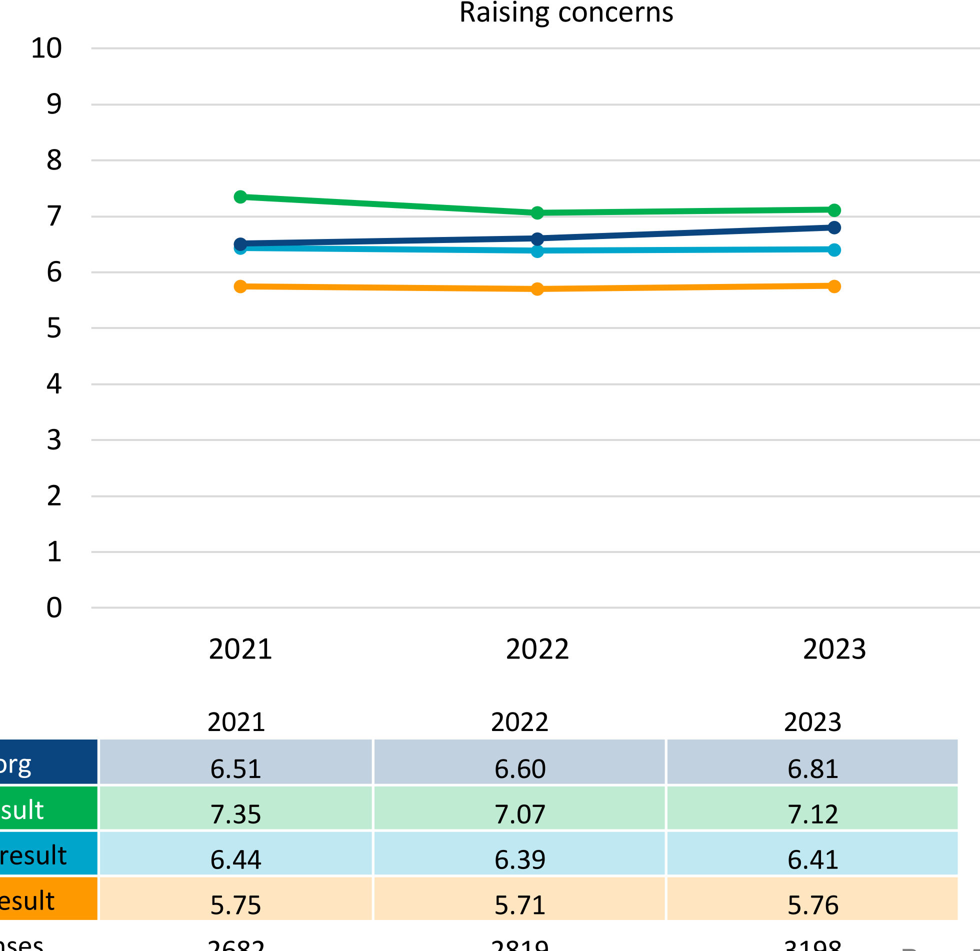
People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.



Promise element 3: We each have a voice that counts



	2021	2022	2023
Your org	6.94	7.07	7.21
Best result	7.30	7.35	7.31
Average result	6.90	6.93	6.99
Worst result	6.54	6.52	6.63
Responses	2758	2866	3240



	2021	2022	2023
Your org	6.51	6.60	6.81
Best result	7.35	7.07	7.12
Average result	6.44	6.39	6.41
Worst result	5.75	5.71	5.76
Responses	2682	2819	3198

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

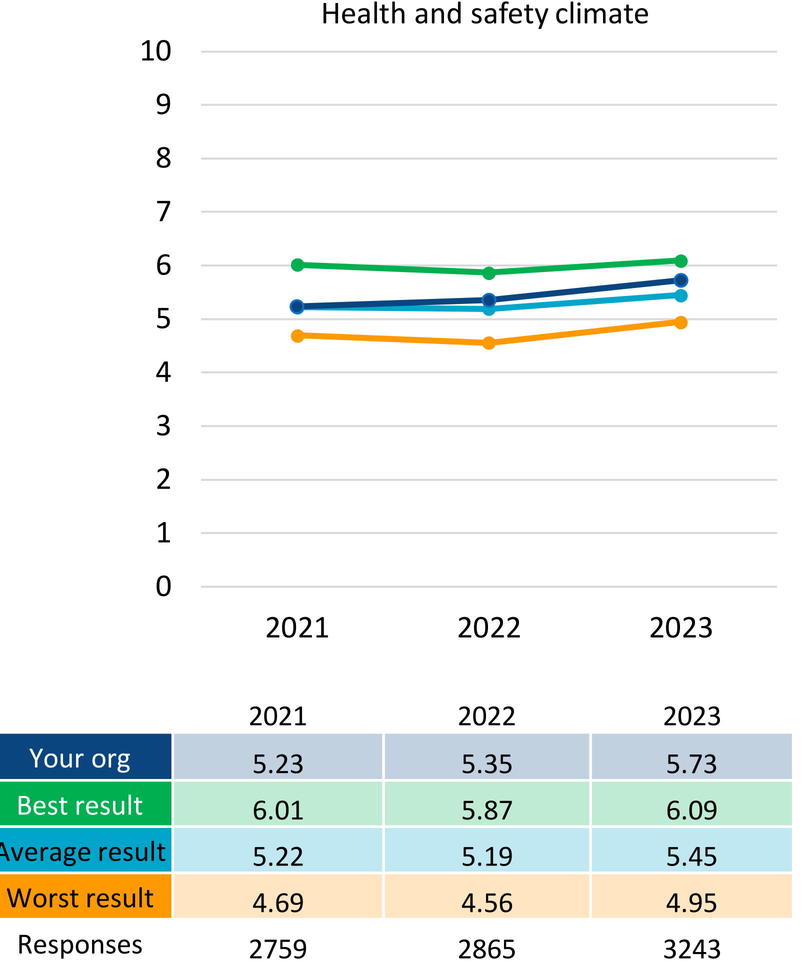
Promise element 4: We are safe and healthy

We are safe and healthy

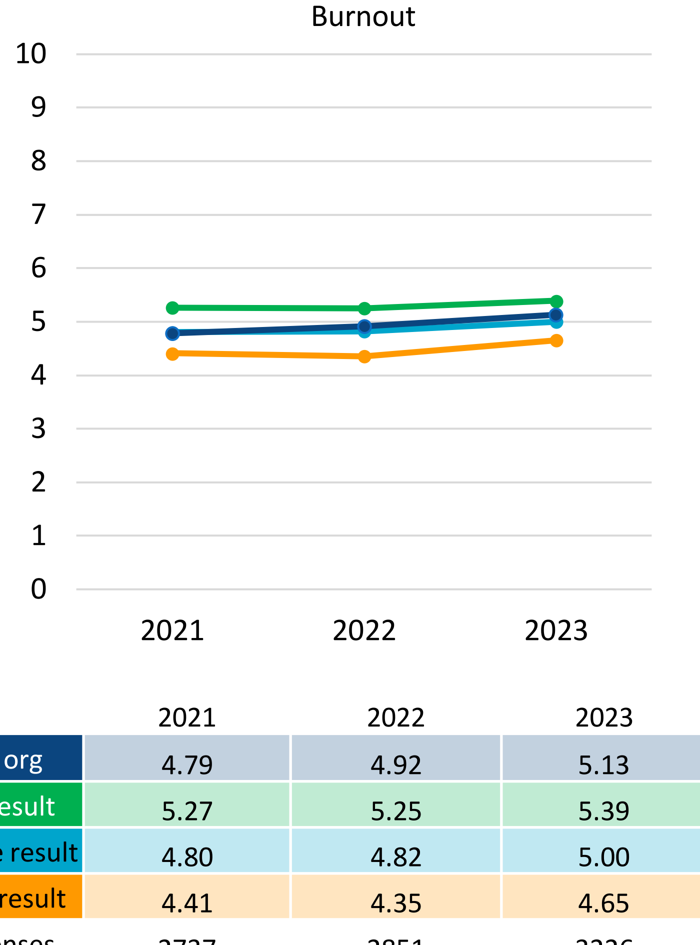
	2021	2022	2023
Your org	5.96	6.06	6.27
Best result	6.47	6.41	6.55
Average result	5.90	5.89	6.06
Worst result	5.50	5.42	5.75
Responses	2686	2809	3178

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

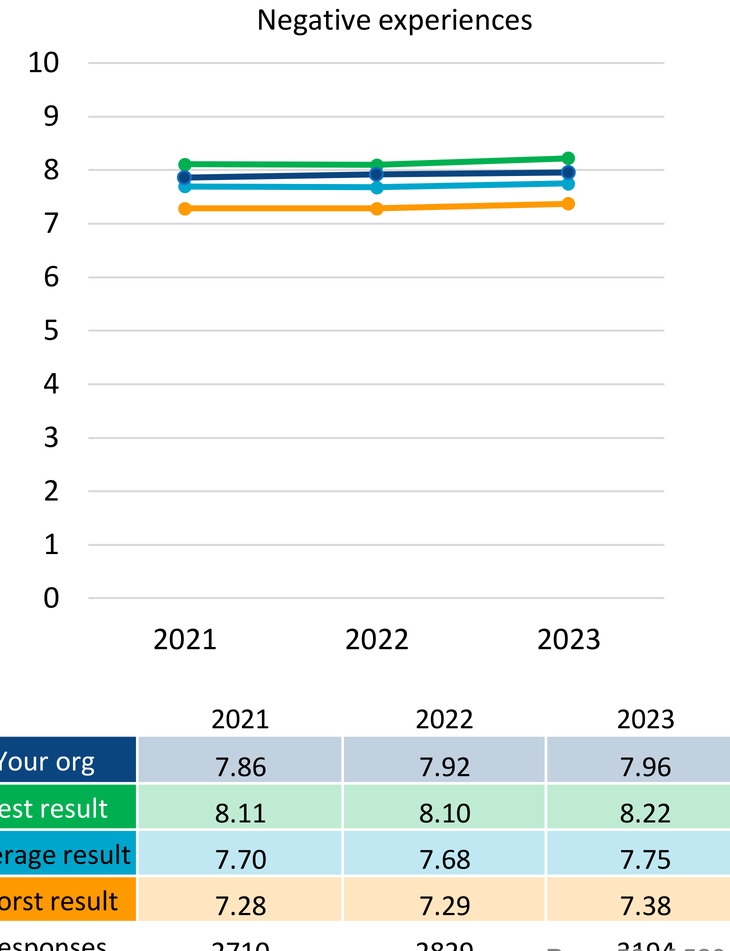
Promise element 4: We are safe and healthy



	2021	2022	2023
Your org	5.23	5.35	5.73
Best result	6.01	5.87	6.09
Average result	5.22	5.19	5.45
Worst result	4.69	4.56	4.95
Responses	2759	2865	3243



	2021	2022	2023
Your org	4.79	4.92	5.13
Best result	5.27	5.25	5.39
Average result	4.80	4.82	5.00
Worst result	4.41	4.35	4.65
Responses	2737	2851	3226



	2021	2022	2023
Your org	7.86	7.92	7.96
Best result	8.11	8.10	8.22
Average result	7.70	7.68	7.75
Worst result	7.28	7.29	7.38
Responses	2710	2829	3194

People Promise elements and themes: Trends

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

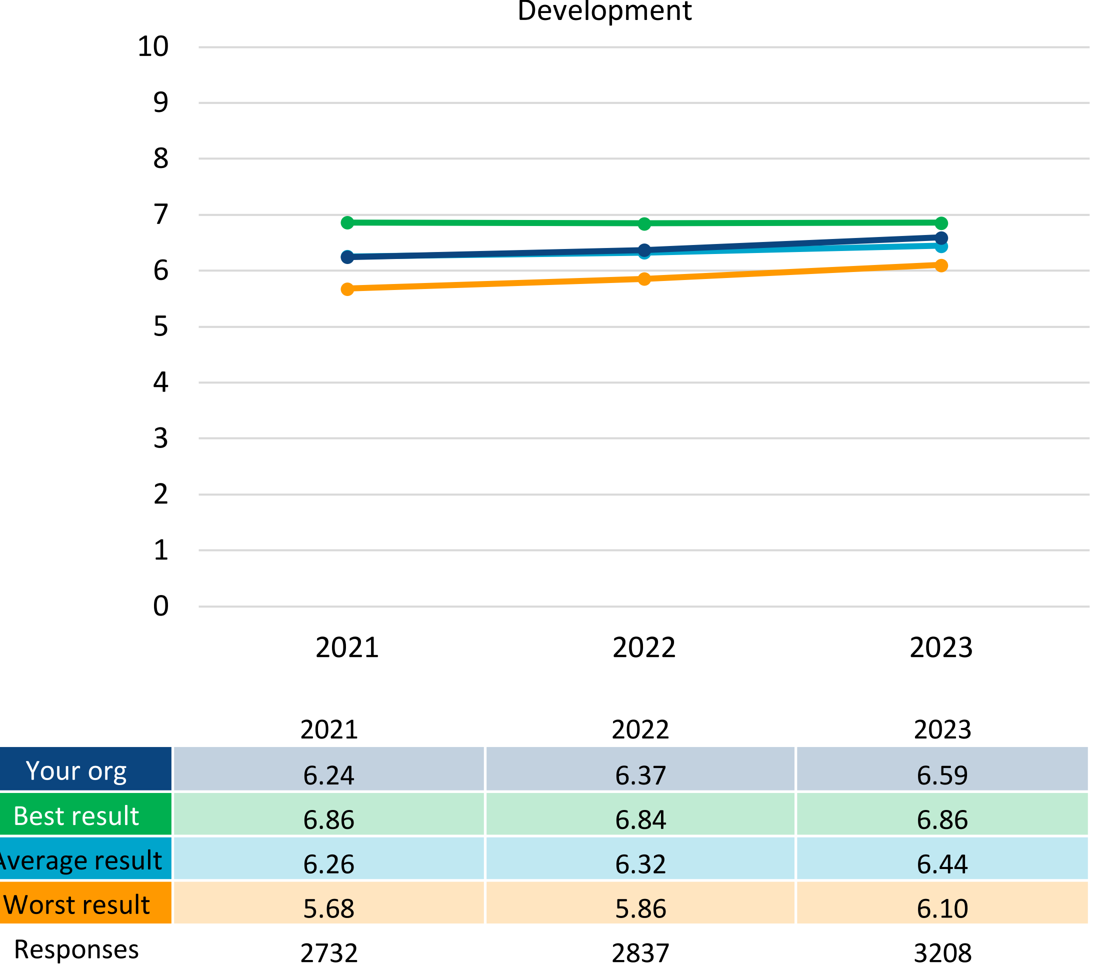
Promise element 5: We are always learning

We are always learning

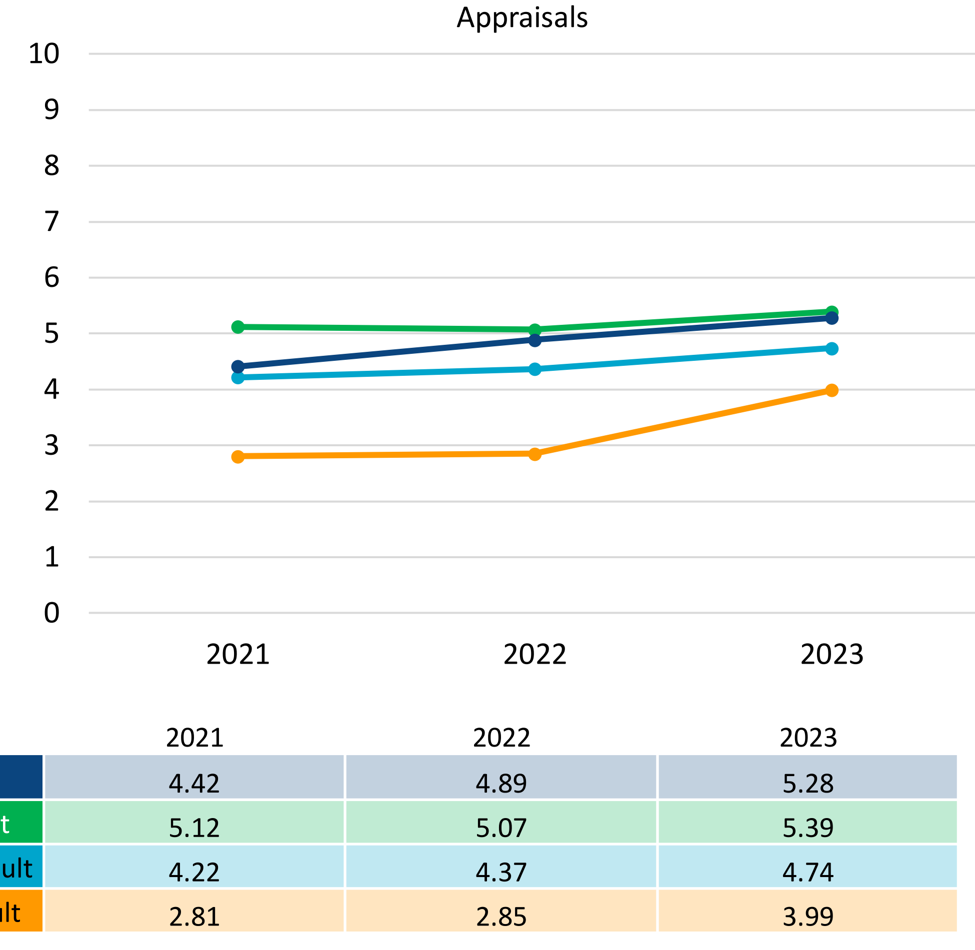
	2021	2022	2023
Your org	5.34	5.64	5.94
Best result	6.00	5.92	6.07
Average result	5.23	5.35	5.61
Worst result	4.30	4.38	5.05
Responses	2597	2729	3029

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 5: We are always learning

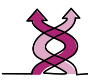


	2021	2022	2023
Your org	6.24	6.37	6.59
Best result	6.86	6.84	6.86
Average result	6.26	6.32	6.44
Worst result	5.68	5.86	6.10
Responses	2732	2837	3208



	2021	2022	2023
Your org	4.42	4.89	5.28
Best result	5.12	5.07	5.39
Average result	4.22	4.37	4.74
Worst result	2.81	2.85	3.99
Responses	2607	2758	3035

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

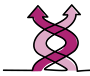


Promise element 6: We work flexibly

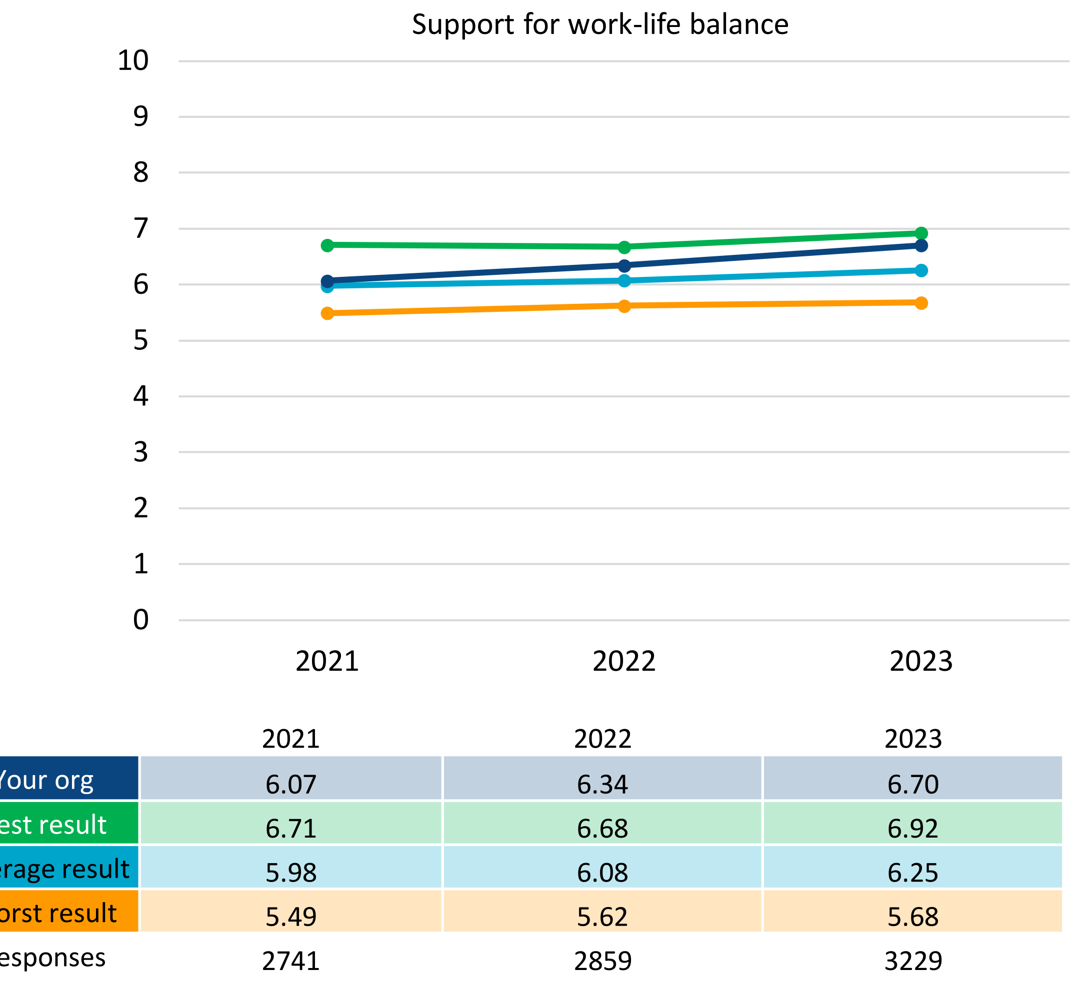
We work flexibly

	2021	2022	2023
Your org	6.03	6.20	6.57
Best result	6.70	6.64	6.87
Average result	5.96	6.01	6.20
Worst result	5.44	5.57	5.60
Responses	2727	2846	3207

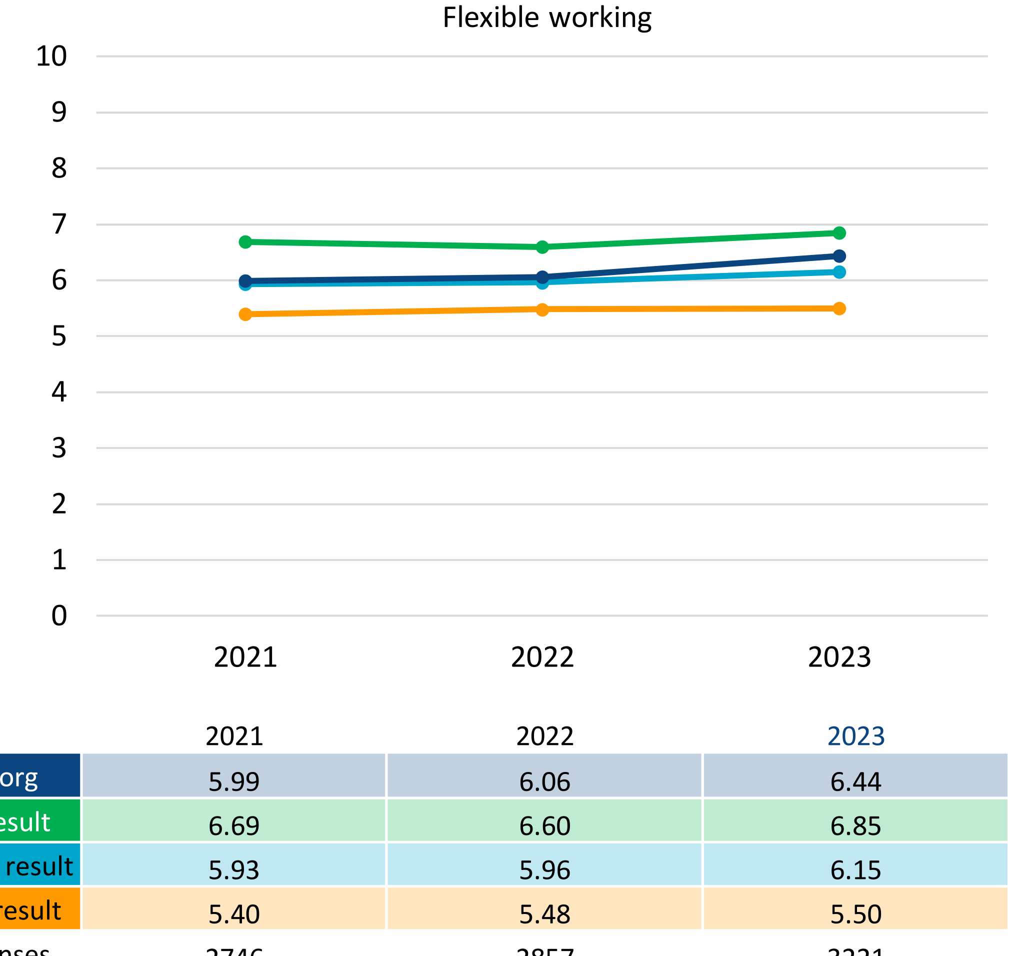
People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.



Promise element 6: We work flexibly

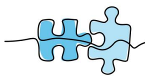


	2021	2022	2023
Your org	6.07	6.34	6.70
Best result	6.71	6.68	6.92
Average result	5.98	6.08	6.25
Worst result	5.49	5.62	5.68
Responses	2741	2859	3229



	2021	2022	2023
Your org	5.99	6.06	6.44
Best result	6.69	6.60	6.85
Average result	5.93	5.96	6.15
Worst result	5.40	5.48	5.50
Responses	2746	2857	3221

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

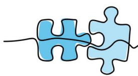


Promise element 7: We are a team

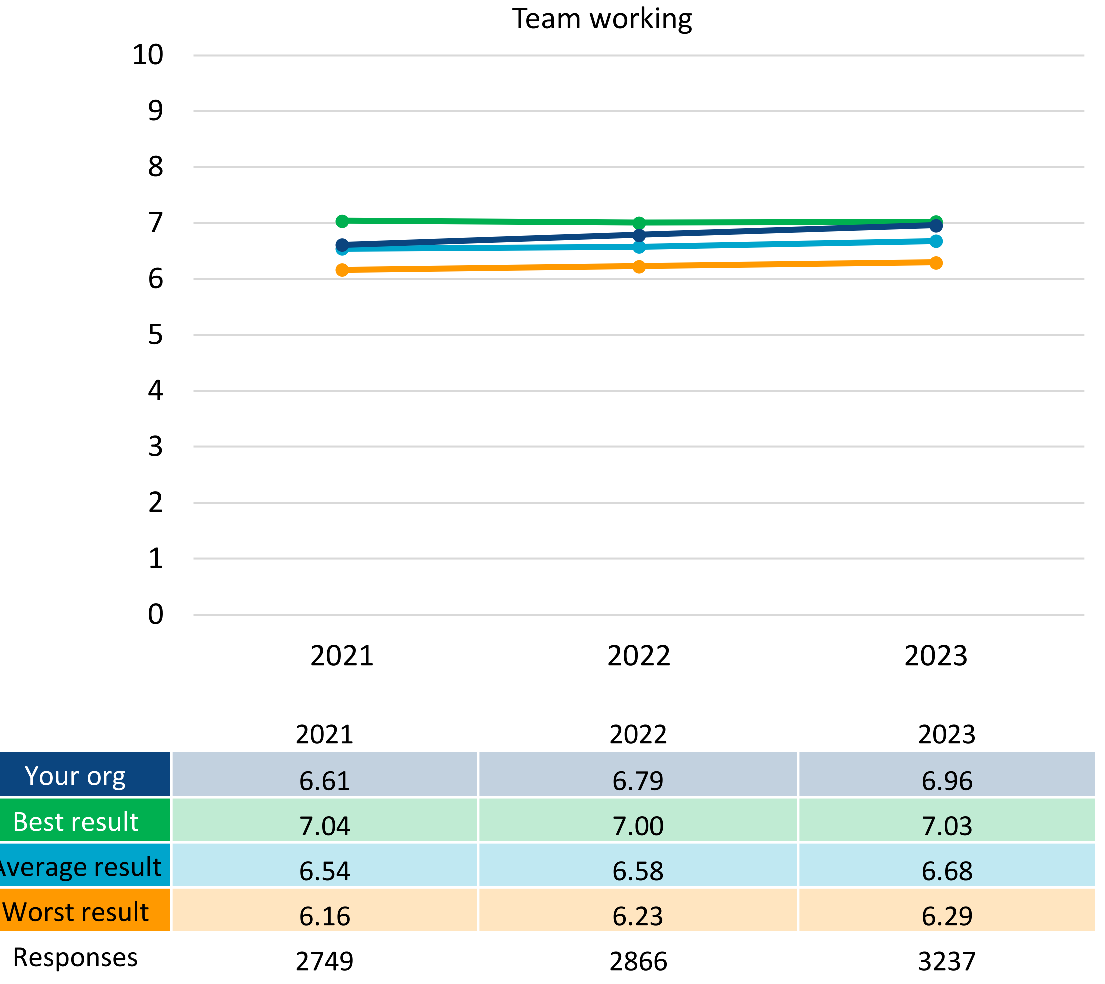
We are a team

	2021	2022	2023
Your org	6.69	6.92	7.07
Best result	7.15	7.15	7.19
Average result	6.58	6.64	6.75
Worst result	6.18	6.25	6.35
Responses	2728	2854	3229

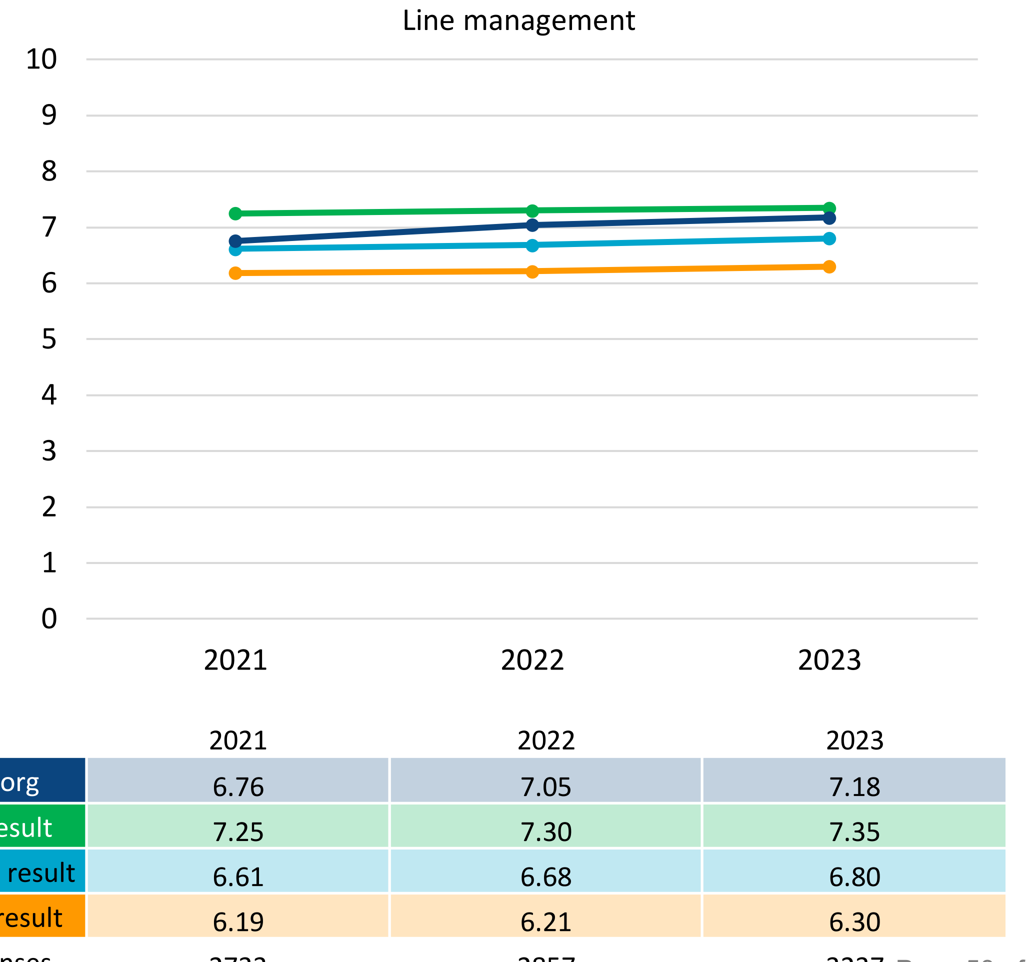
People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.



Promise element 7: We are a team



	2021	2022	2023
Your org	6.61	6.79	6.96
Best result	7.04	7.00	7.03
Average result	6.54	6.58	6.68
Worst result	6.16	6.23	6.29
Responses	2749	2866	3237



	2021	2022	2023
Your org	6.76	7.05	7.18
Best result	7.25	7.30	7.35
Average result	6.61	6.68	6.80
Worst result	6.19	6.21	6.30
Responses	2733	2857	3237

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Theme: Staff Engagement

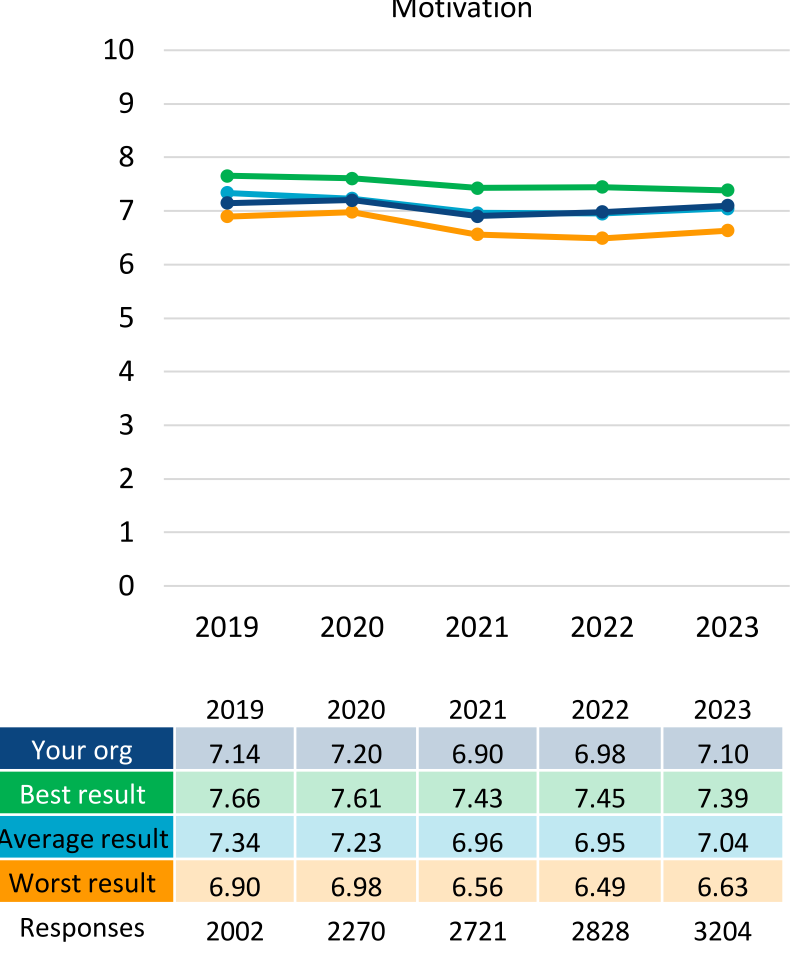
Staff Engagement

	2019	2020	2021	2022	2023
Your org	6.72	6.92	6.66	6.73	6.98
Best result	7.58	7.59	7.44	7.28	7.32
Average result	7.04	7.03	6.84	6.80	6.91
Worst result	6.10	6.45	6.30	6.13	6.34
Responses	2020	2278	2761	2866	3241

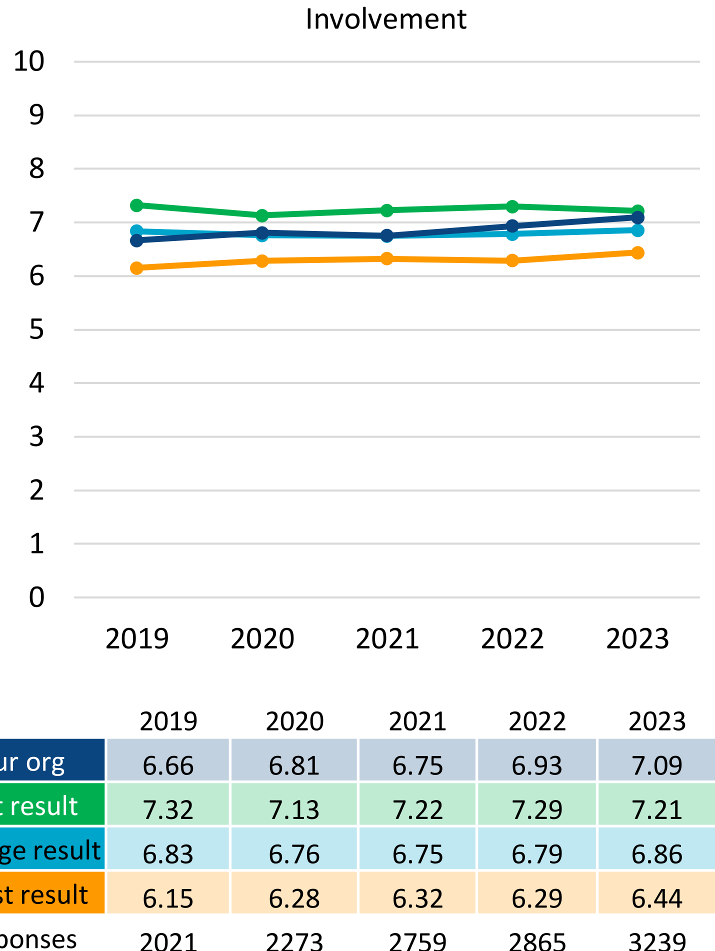
People Promise elements, themes and sub-scores: Sub-score trends

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

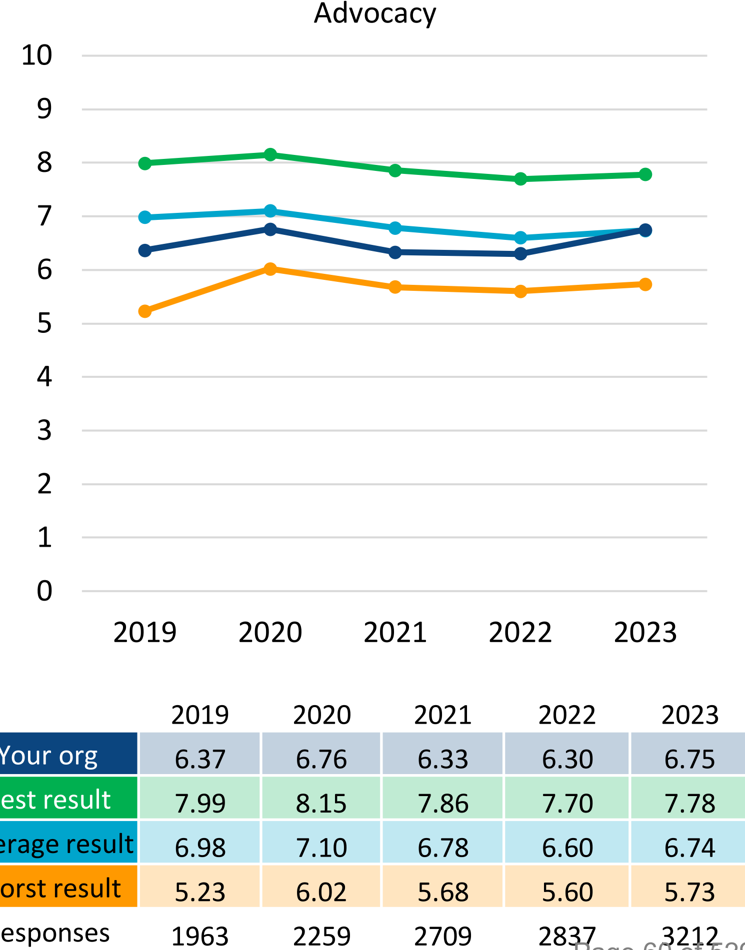
Theme: Staff Engagement



	2019	2020	2021	2022	2023
Your org	7.14	7.20	6.90	6.98	7.10
Best result	7.66	7.61	7.43	7.45	7.39
Average result	7.34	7.23	6.96	6.95	7.04
Worst result	6.90	6.98	6.56	6.49	6.63
Responses	2002	2270	2721	2828	3204



	2019	2020	2021	2022	2023
Your org	6.66	6.81	6.75	6.93	7.09
Best result	7.32	7.13	7.22	7.29	7.21
Average result	6.83	6.76	6.75	6.79	6.86
Worst result	6.15	6.28	6.32	6.29	6.44
Responses	2021	2273	2759	2865	3239



	2019	2020	2021	2022	2023
Your org	6.37	6.76	6.33	6.30	6.75
Best result	7.99	8.15	7.86	7.70	7.78
Average result	6.98	7.10	6.78	6.60	6.74
Worst result	5.23	6.02	5.68	5.60	5.73
Responses	1963	2259	2709	2837	3212

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Theme: Morale

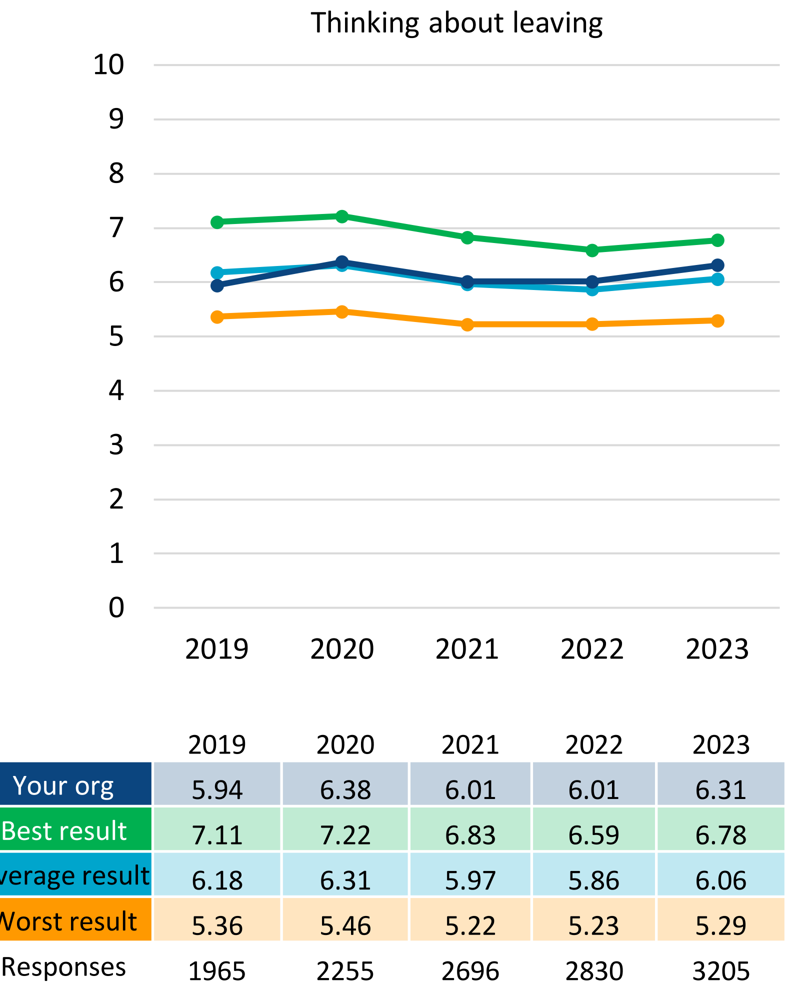
Morale

	2019	2020	2021	2022	2023
Your org	5.70	6.01	5.78	5.87	6.20
Best result	6.66	6.76	6.46	6.31	6.52
Average result	5.95	6.04	5.74	5.69	5.91
Worst result	5.23	5.47	5.26	5.17	5.54
Responses	2008	2272	2753	2866	3241

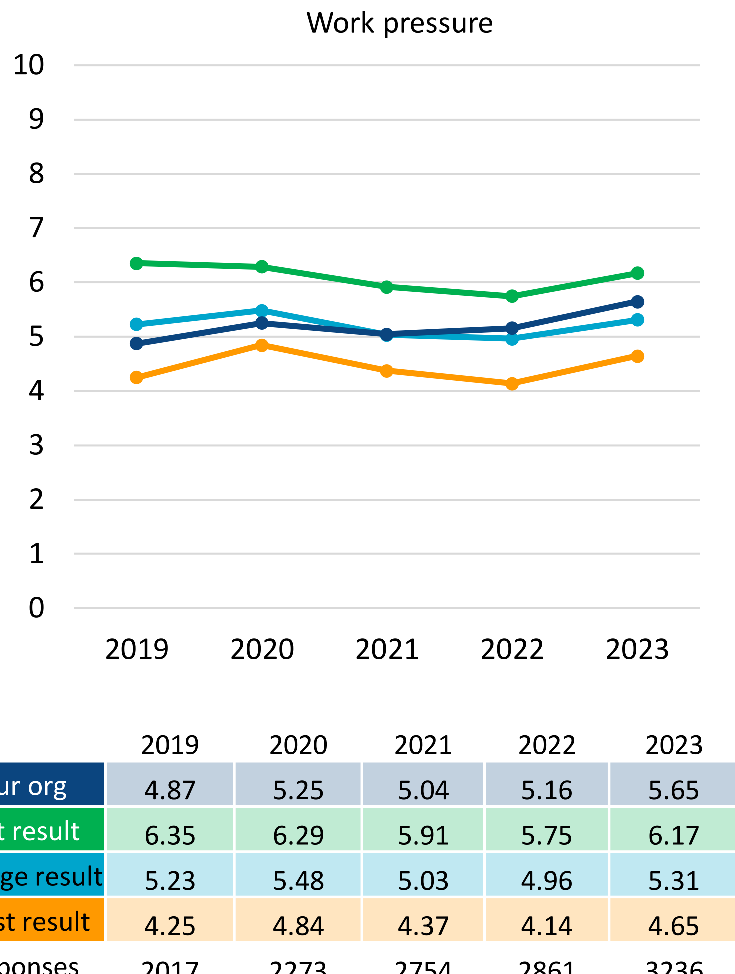
People Promise elements, themes and sub-scores: Sub-score trends

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

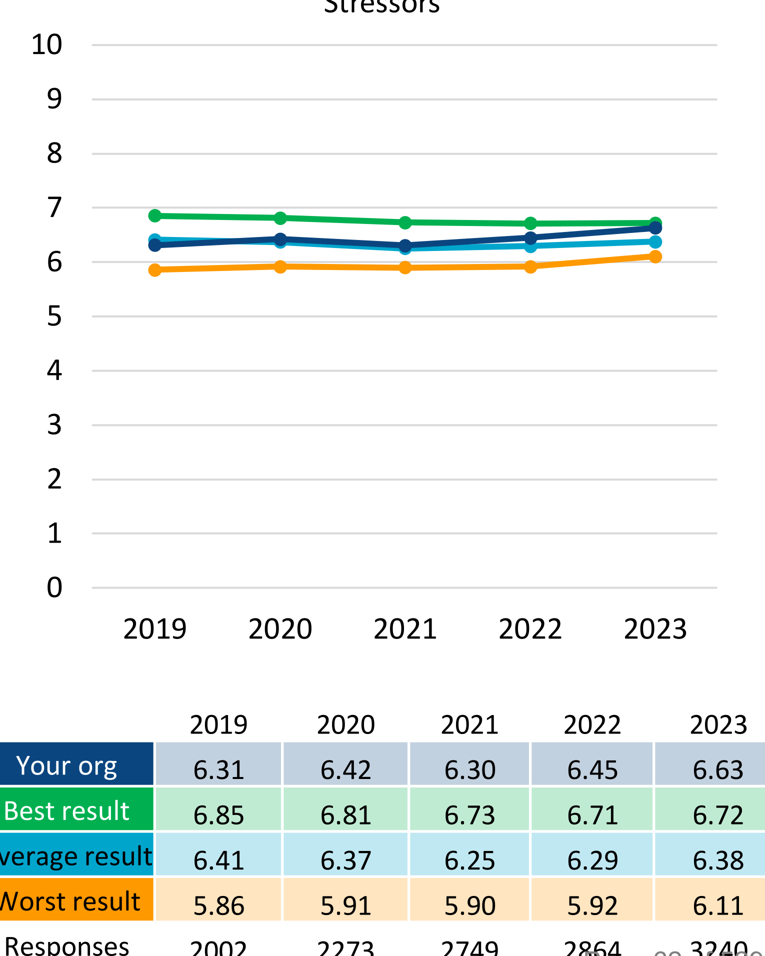
Theme: Morale



	2019	2020	2021	2022	2023
Your org	5.94	6.38	6.01	6.01	6.31
Best result	7.11	7.22	6.83	6.59	6.78
Average result	6.18	6.31	5.97	5.86	6.06
Worst result	5.36	5.46	5.22	5.23	5.29
Responses	1965	2255	2696	2830	3205



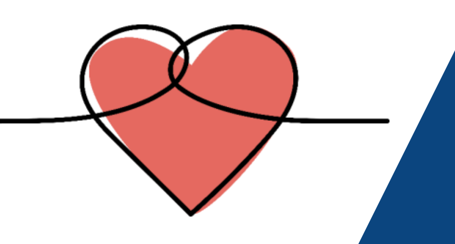
	2019	2020	2021	2022	2023
Your org	4.87	5.25	5.04	5.16	5.65
Best result	6.35	6.29	5.91	5.75	6.17
Average result	5.23	5.48	5.03	4.96	5.31
Worst result	4.25	4.84	4.37	4.14	4.65
Responses	2017	2273	2754	2861	3236



	2019	2020	2021	2022	2023
Your org	6.31	6.42	6.30	6.45	6.63
Best result	6.85	6.81	6.73	6.71	6.72
Average result	6.41	6.37	6.25	6.29	6.38
Worst result	5.86	5.91	5.90	5.92	6.11
Responses	2002	2273	2749	2864	3240

Survey Coordination Centre

People Promise element – We are compassionate and inclusive



Questions included:

Compassionate culture – Q6a, Q25a, Q25b, Q25c, Q25d

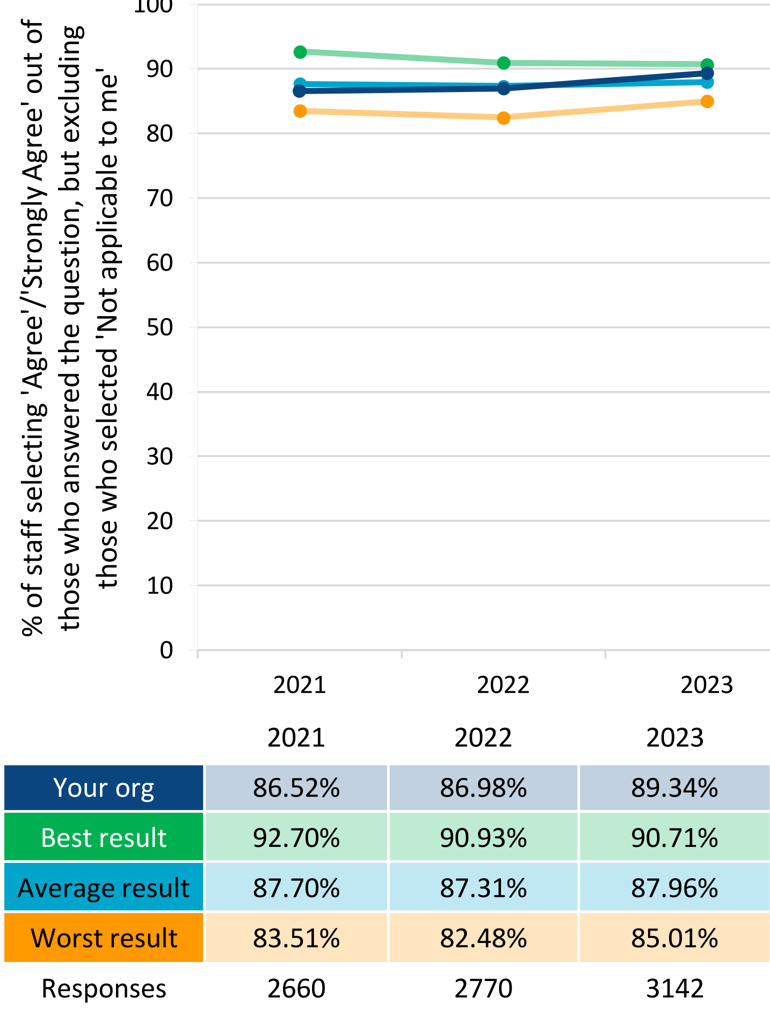
Compassionate leadership – Q9f, Q9g, Q9h, Q9i

Diversity and equality – Q15, Q16a, Q16b, Q21

Inclusion – Q7h, Q7i, Q8b, Q8c

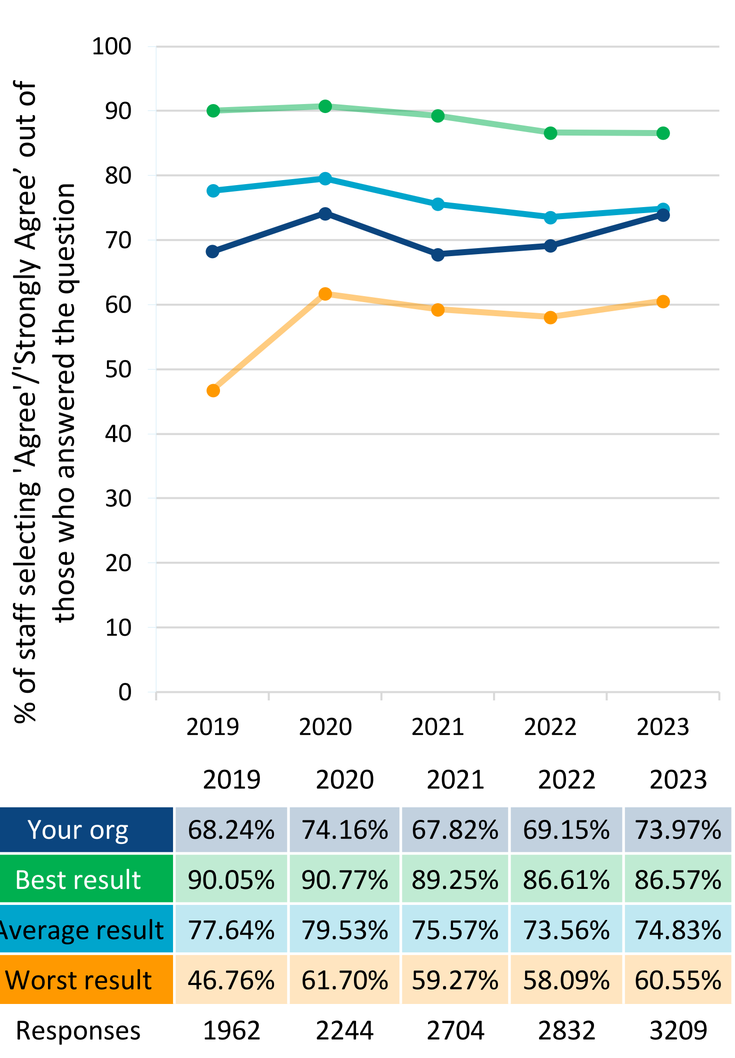
Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Q6a I feel that my role makes a difference to patients / service users.



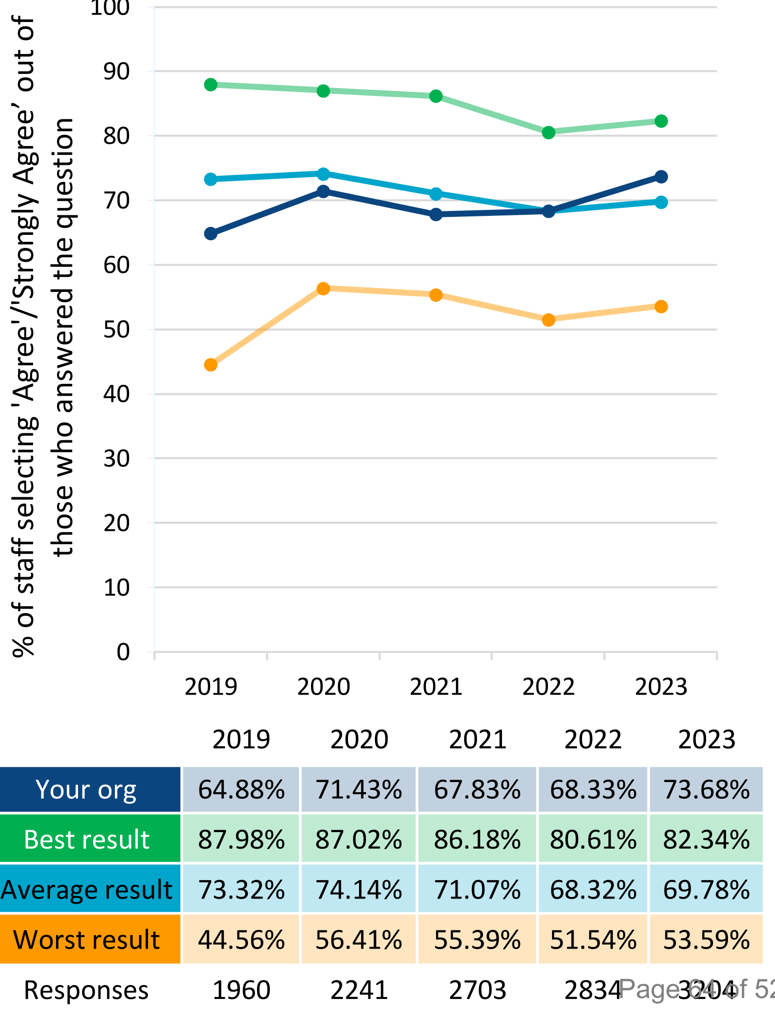
	2021	2022	2023
Your org	86.52%	86.98%	89.34%
Best result	92.70%	90.93%	90.71%
Average result	87.70%	87.31%	87.96%
Worst result	83.51%	82.48%	85.01%
Responses	2660	2770	3142

Q25a Care of patients / service users is my organisation's top priority.

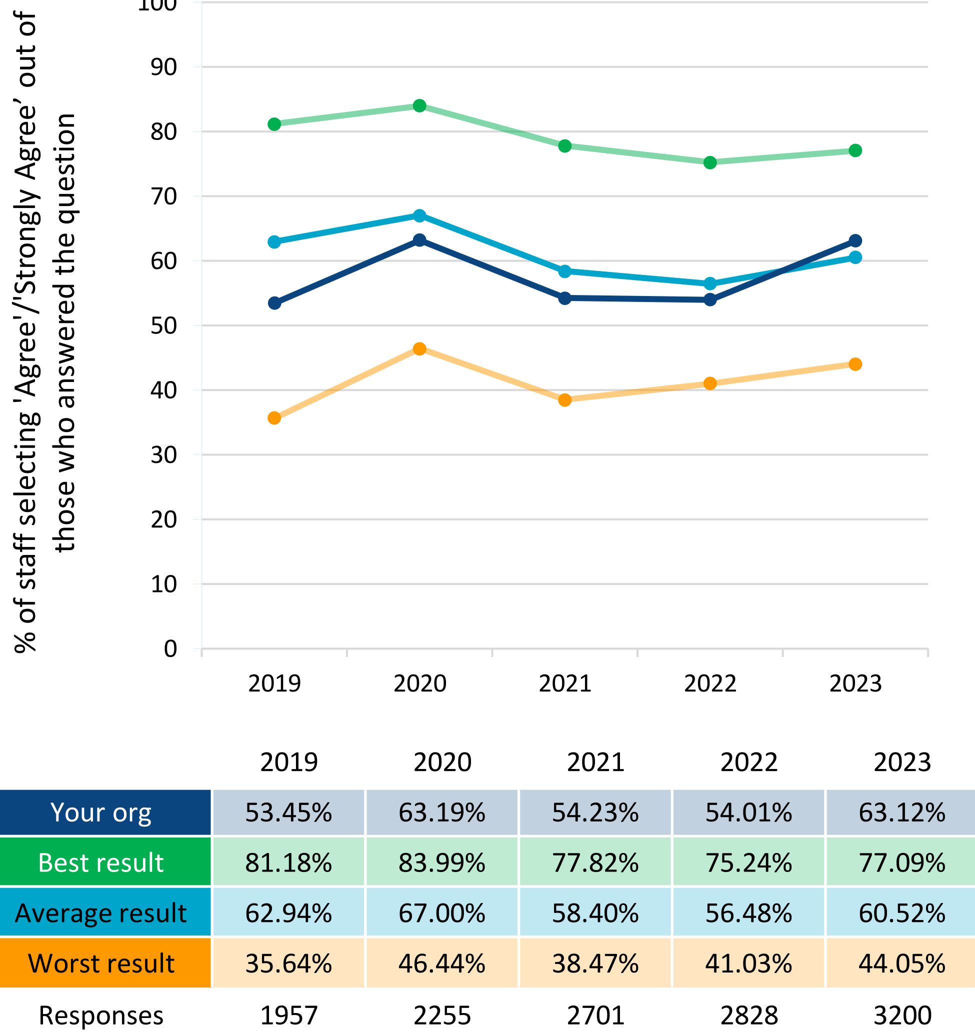


	2019	2020	2021	2022	2023
Your org	68.24%	74.16%	67.82%	69.15%	73.97%
Best result	90.05%	90.77%	89.25%	86.61%	86.57%
Average result	77.64%	79.53%	75.57%	73.56%	74.83%
Worst result	46.76%	61.70%	59.27%	58.09%	60.55%
Responses	1962	2244	2704	2832	3209

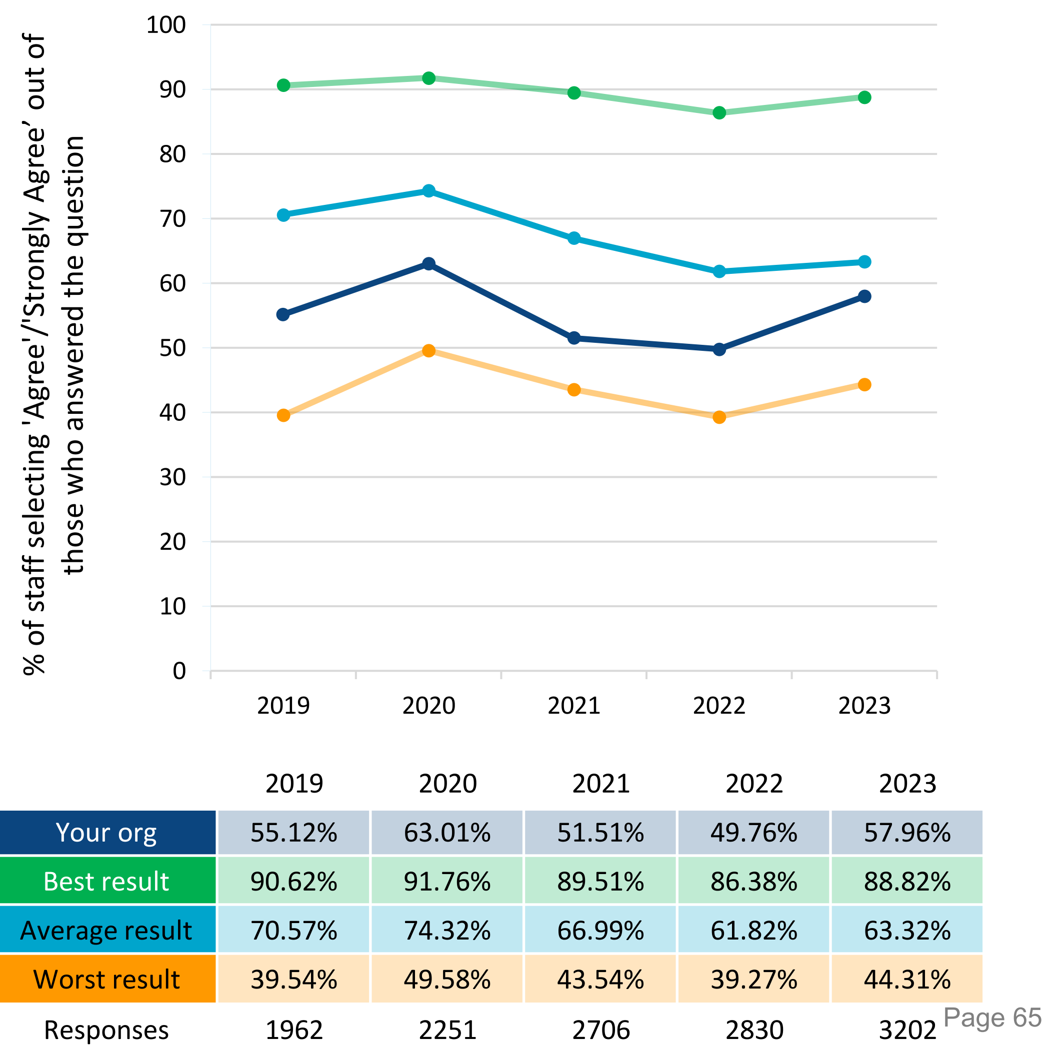
Q25b My organisation acts on concerns raised by patients / service users.



	2019	2020	2021	2022	2023
Your org	64.88%	71.43%	67.83%	68.33%	73.68%
Best result	87.98%	87.02%	86.18%	80.61%	82.34%
Average result	73.32%	74.14%	71.07%	68.32%	69.78%
Worst result	44.56%	56.41%	55.39%	51.54%	53.59%
Responses	1960	2241	2703	2834	3204



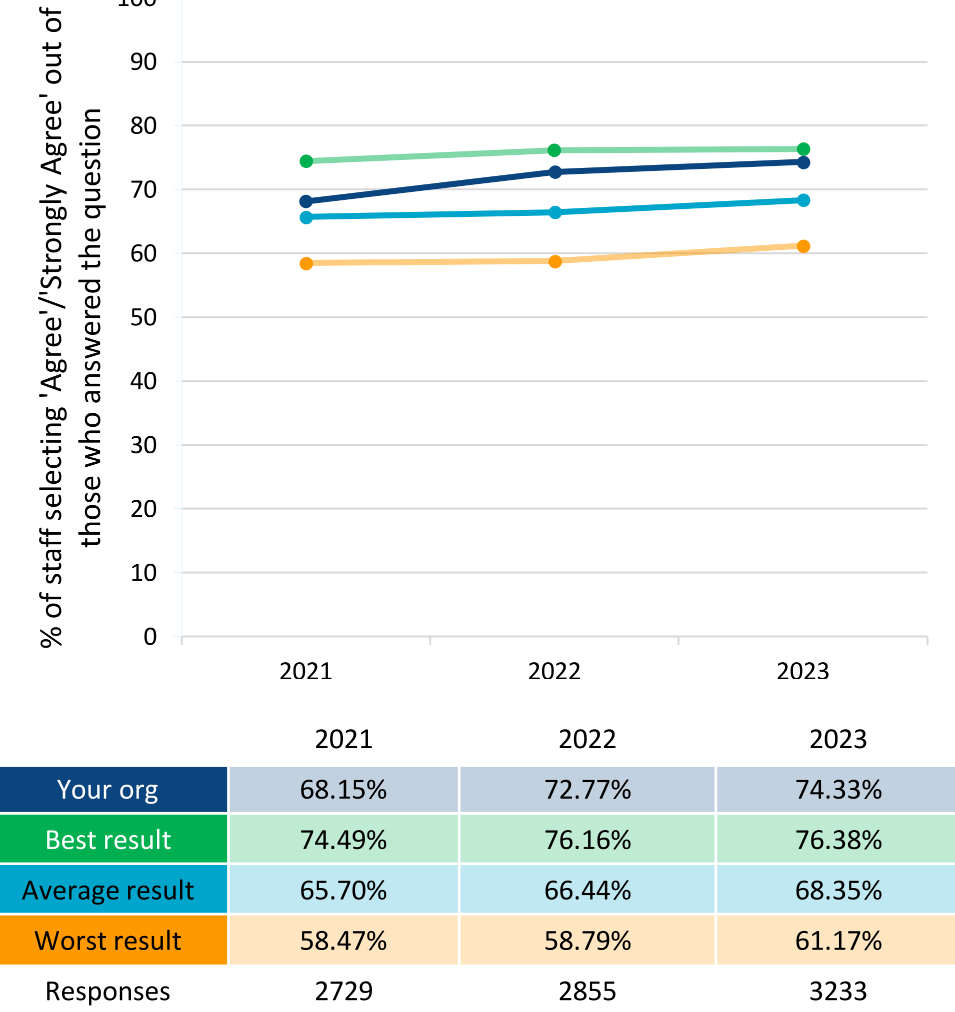
	2019	2020	2021	2022	2023
Your org	53.45%	63.19%	54.23%	54.01%	63.12%
Best result	81.18%	83.99%	77.82%	75.24%	77.09%
Average result	62.94%	67.00%	58.40%	56.48%	60.52%
Worst result	35.64%	46.44%	38.47%	41.03%	44.05%
Responses	1957	2255	2701	2828	3200



	2019	2020	2021	2022	2023
Your org	55.12%	63.01%	51.51%	49.76%	57.96%
Best result	90.62%	91.76%	89.51%	86.38%	88.82%
Average result	70.57%	74.32%	66.99%	61.82%	63.32%
Worst result	39.54%	49.58%	43.54%	39.27%	44.31%
Responses	1962	2251	2706	2830	3202

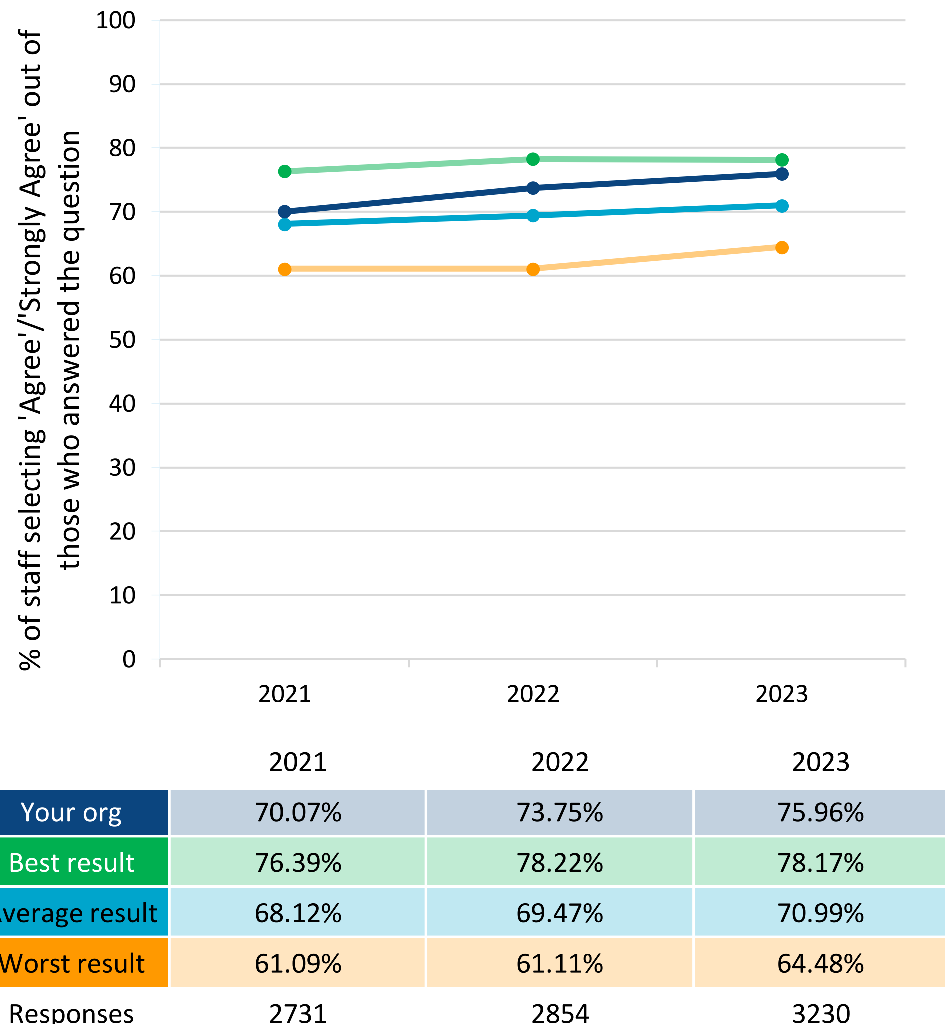
People Promise elements and theme results – We are compassionate and inclusive: Compassionate leadership

Q9f My immediate manager works together with me to come to an understanding of problems.

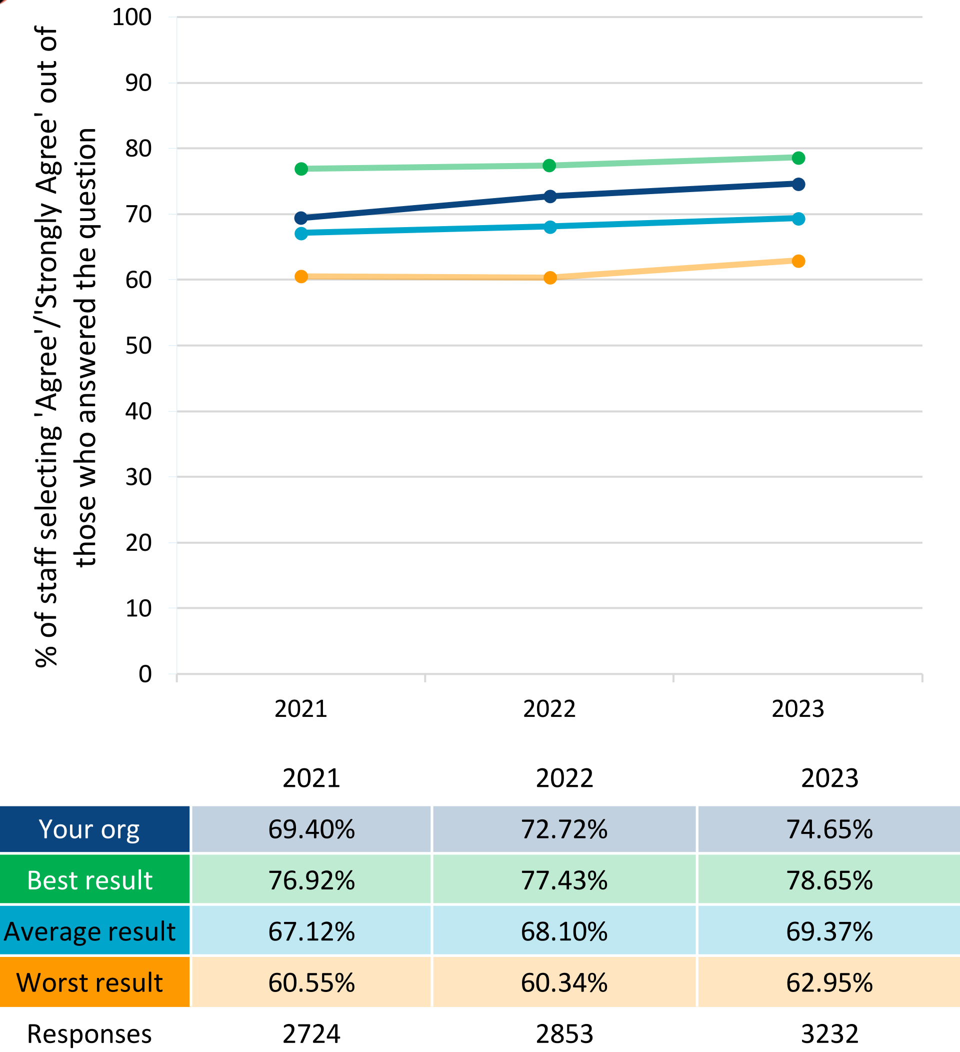


	2021	2022	2023
Your org	68.15%	72.77%	74.33%
Best result	74.49%	76.16%	76.38%
Average result	65.70%	66.44%	68.35%
Worst result	58.47%	58.79%	61.17%
Responses	2729	2855	3233

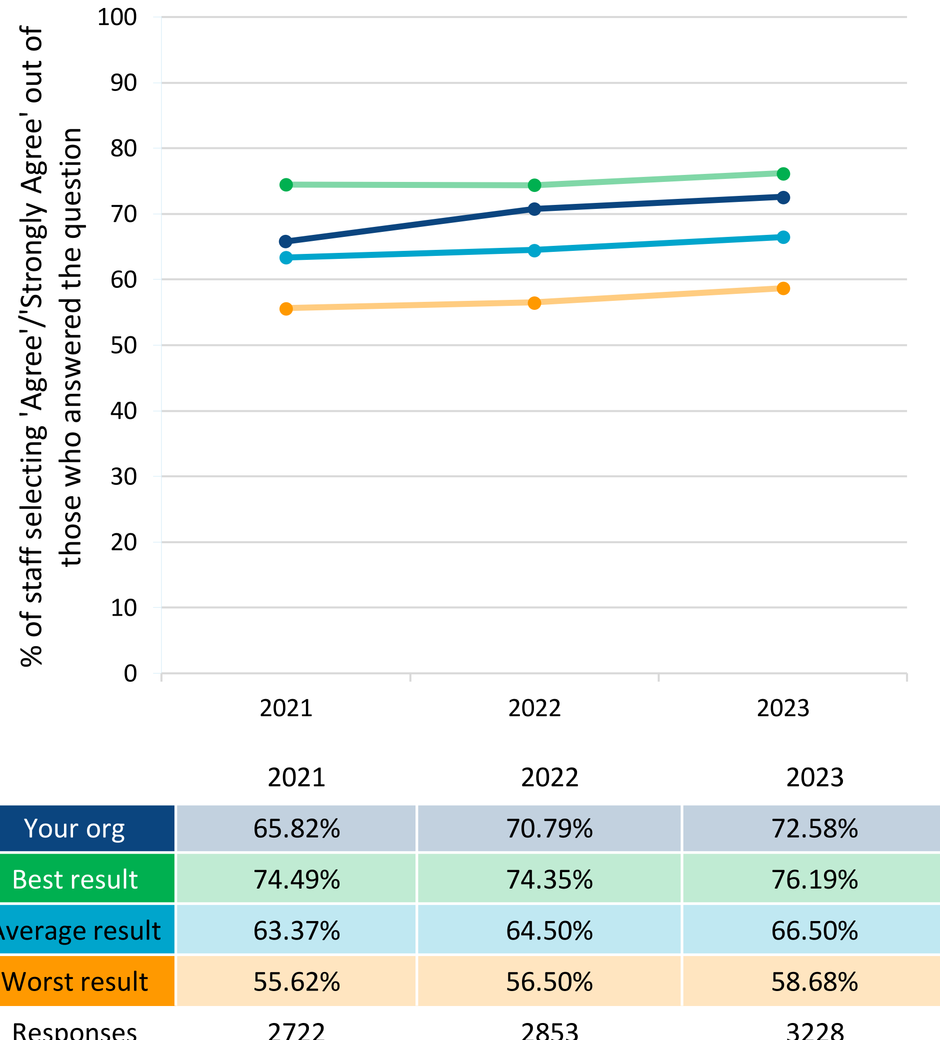
Q9g My immediate manager is interested in listening to me when I describe challenges I face.



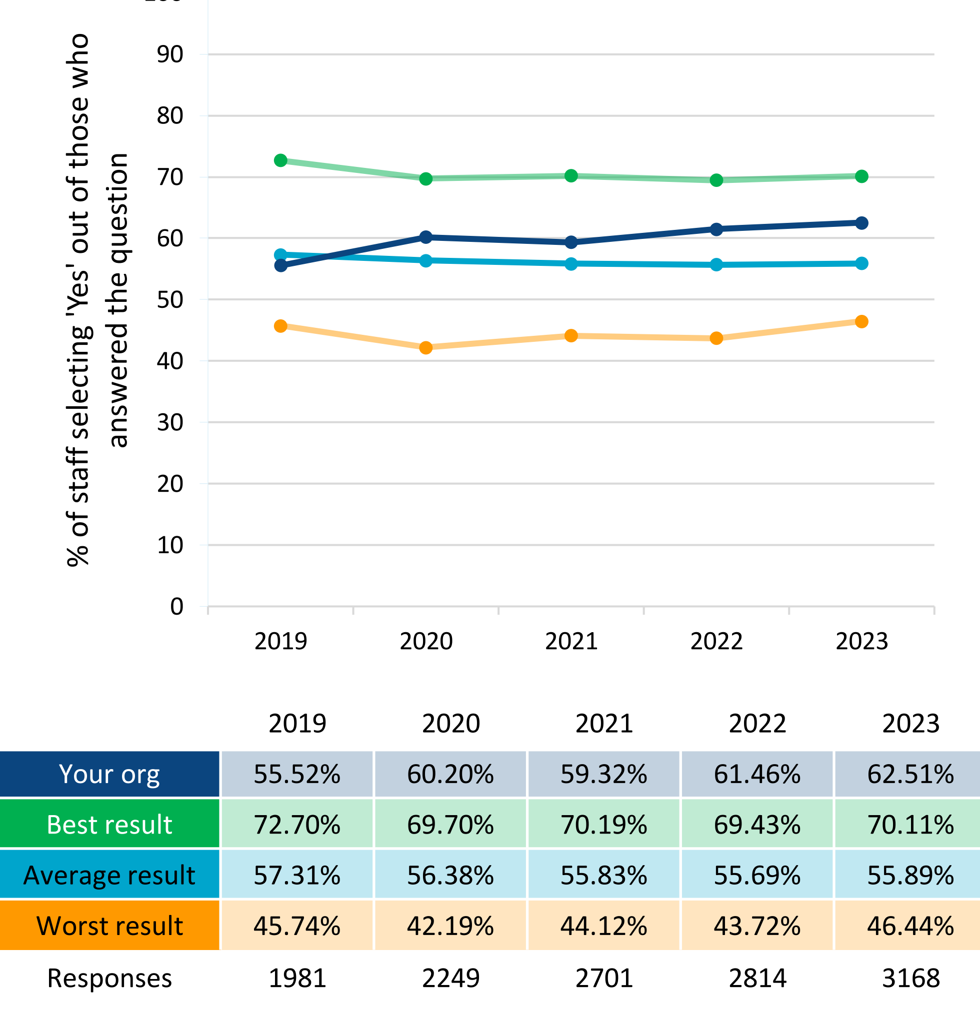
	2021	2022	2023
Your org	70.07%	73.75%	75.96%
Best result	76.39%	78.22%	78.17%
Average result	68.12%	69.47%	70.99%
Worst result	61.09%	61.11%	64.48%
Responses	2731	2854	3230



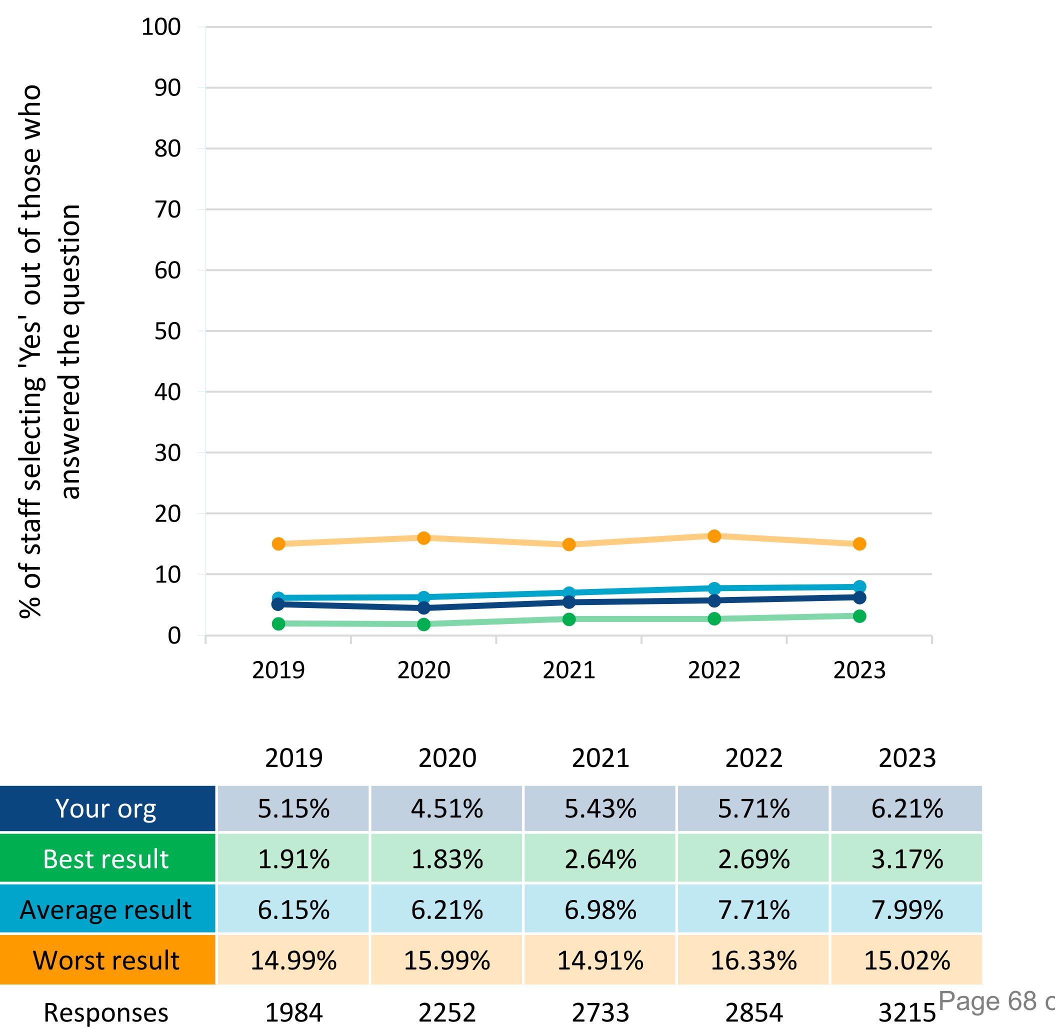
	2021	2022	2023
Your org	69.40%	72.72%	74.65%
Best result	76.92%	77.43%	78.65%
Average result	67.12%	68.10%	69.37%
Worst result	60.55%	60.34%	62.95%
Responses	2724	2853	3232



	2021	2022	2023
Your org	65.82%	70.79%	72.58%
Best result	74.49%	74.35%	76.19%
Average result	63.37%	64.50%	66.50%
Worst result	55.62%	56.50%	58.68%
Responses	2722	2853	3228

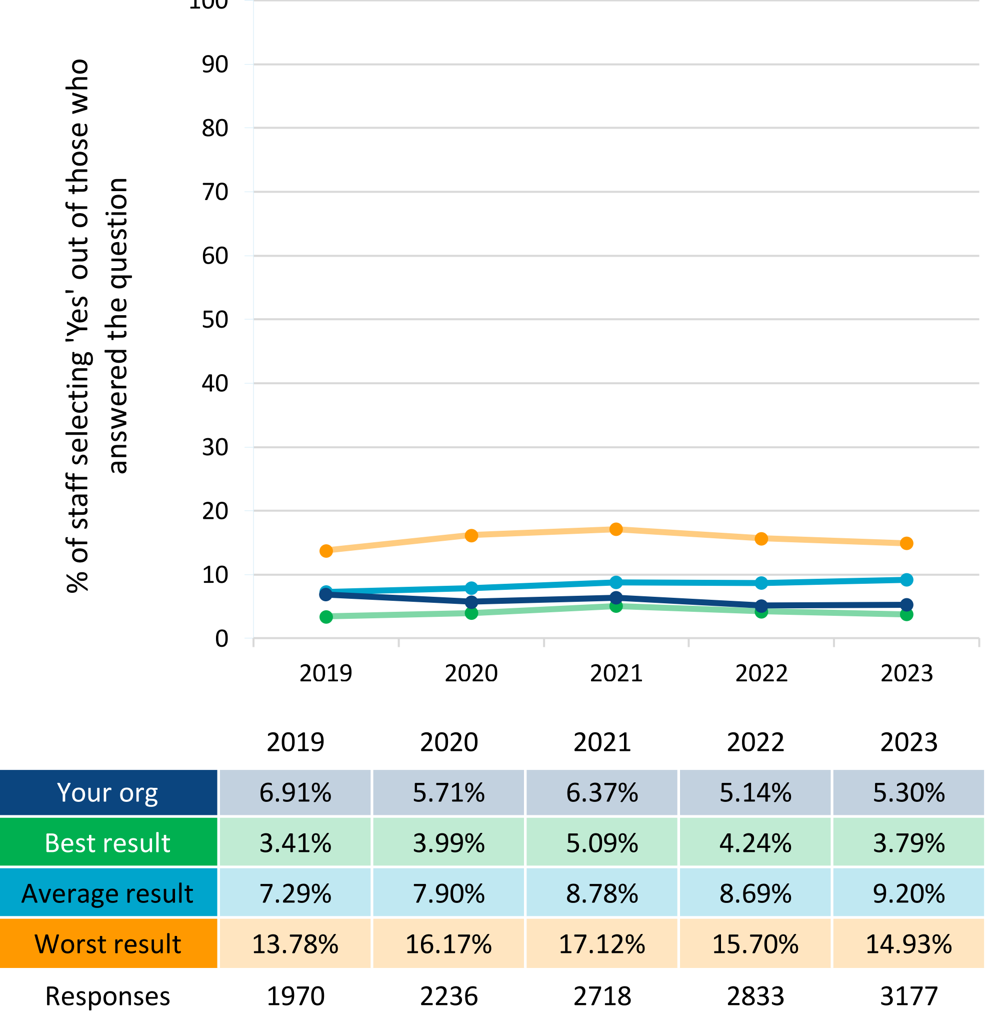


	2019	2020	2021	2022	2023
Your org	55.52%	60.20%	59.32%	61.46%	62.51%
Best result	72.70%	69.70%	70.19%	69.43%	70.11%
Average result	57.31%	56.38%	55.83%	55.69%	55.89%
Worst result	45.74%	42.19%	44.12%	43.72%	46.44%
Responses	1981	2249	2701	2814	3168

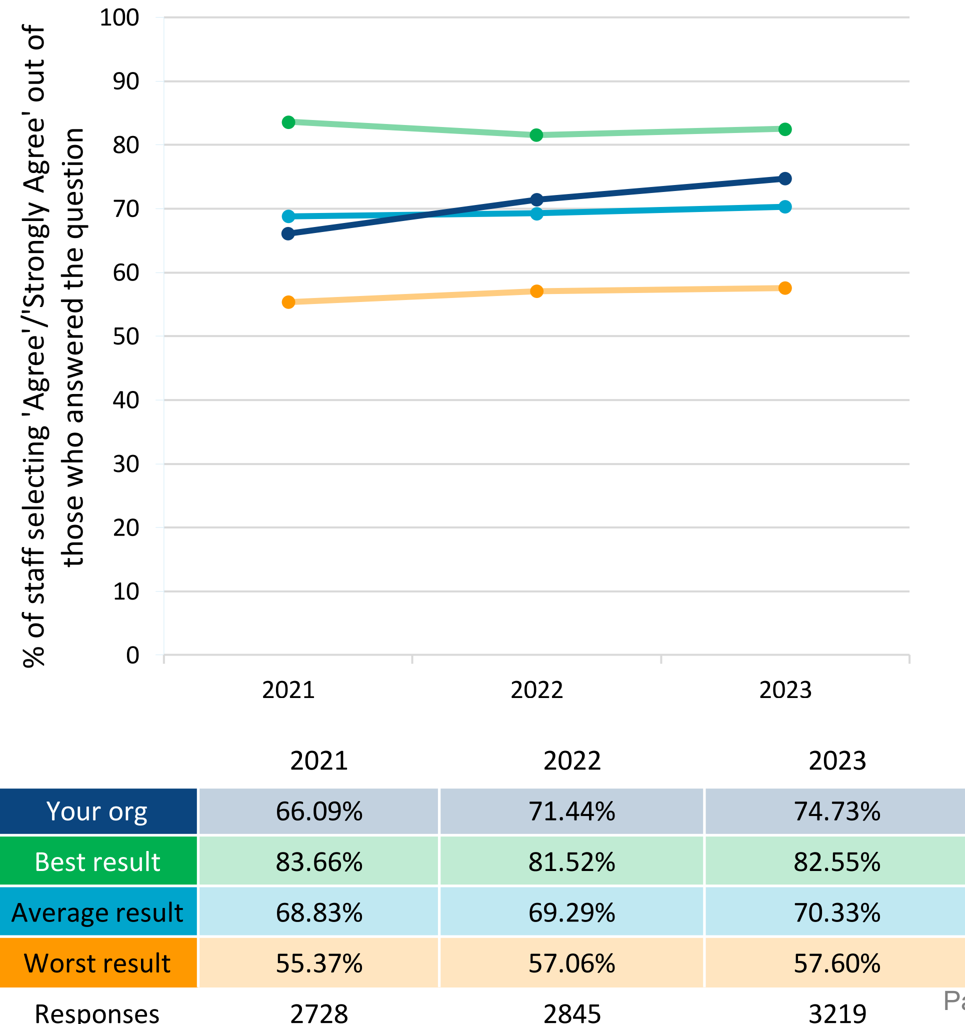


	2019	2020	2021	2022	2023
Your org	5.15%	4.51%	5.43%	5.71%	6.21%
Best result	1.91%	1.83%	2.64%	2.69%	3.17%
Average result	6.15%	6.21%	6.98%	7.71%	7.99%
Worst result	14.99%	15.99%	14.91%	16.33%	15.02%
Responses	1984	2252	2733	2854	3215

People Promise elements and theme results – We are compassionate and inclusive: Diversity and equality

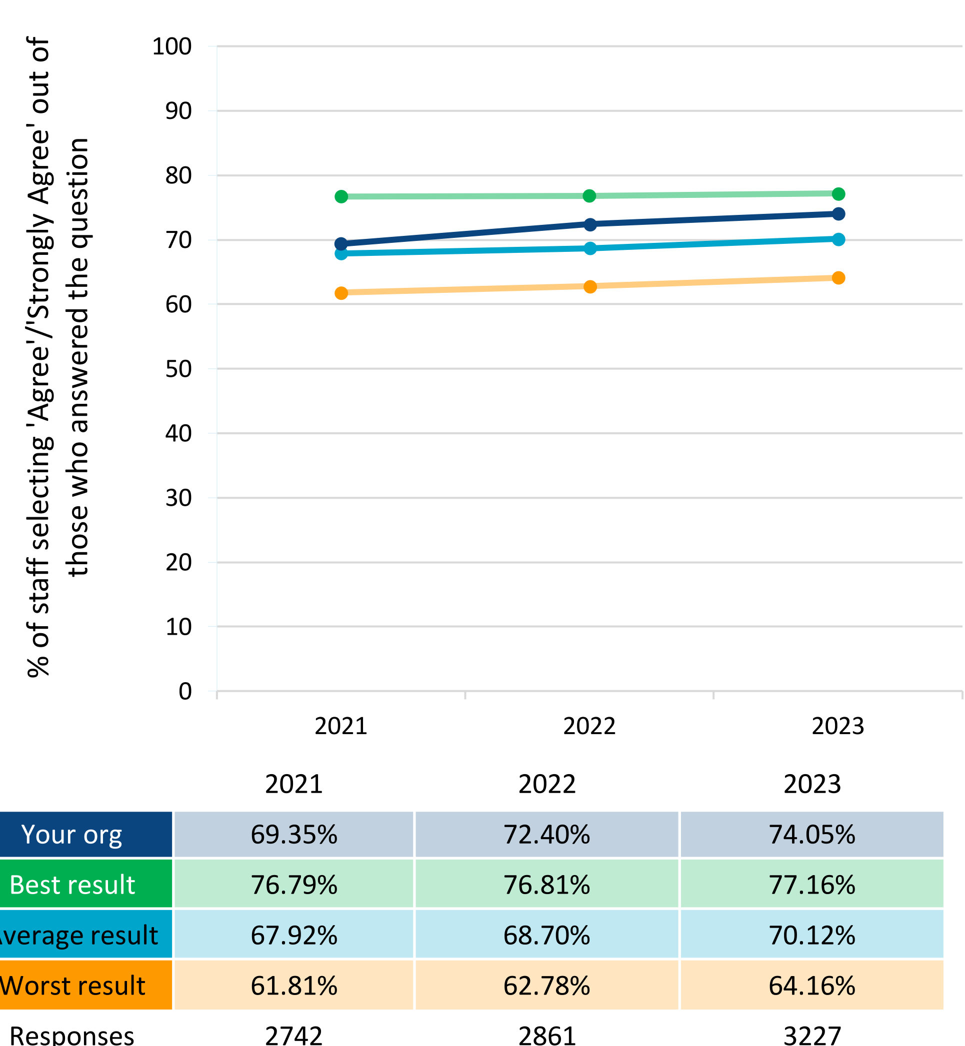


	2019	2020	2021	2022	2023
Your org	6.91%	5.71%	6.37%	5.14%	5.30%
Best result	3.41%	3.99%	5.09%	4.24%	3.79%
Average result	7.29%	7.90%	8.78%	8.69%	9.20%
Worst result	13.78%	16.17%	17.12%	15.70%	14.93%
Responses	1970	2236	2718	2833	3177



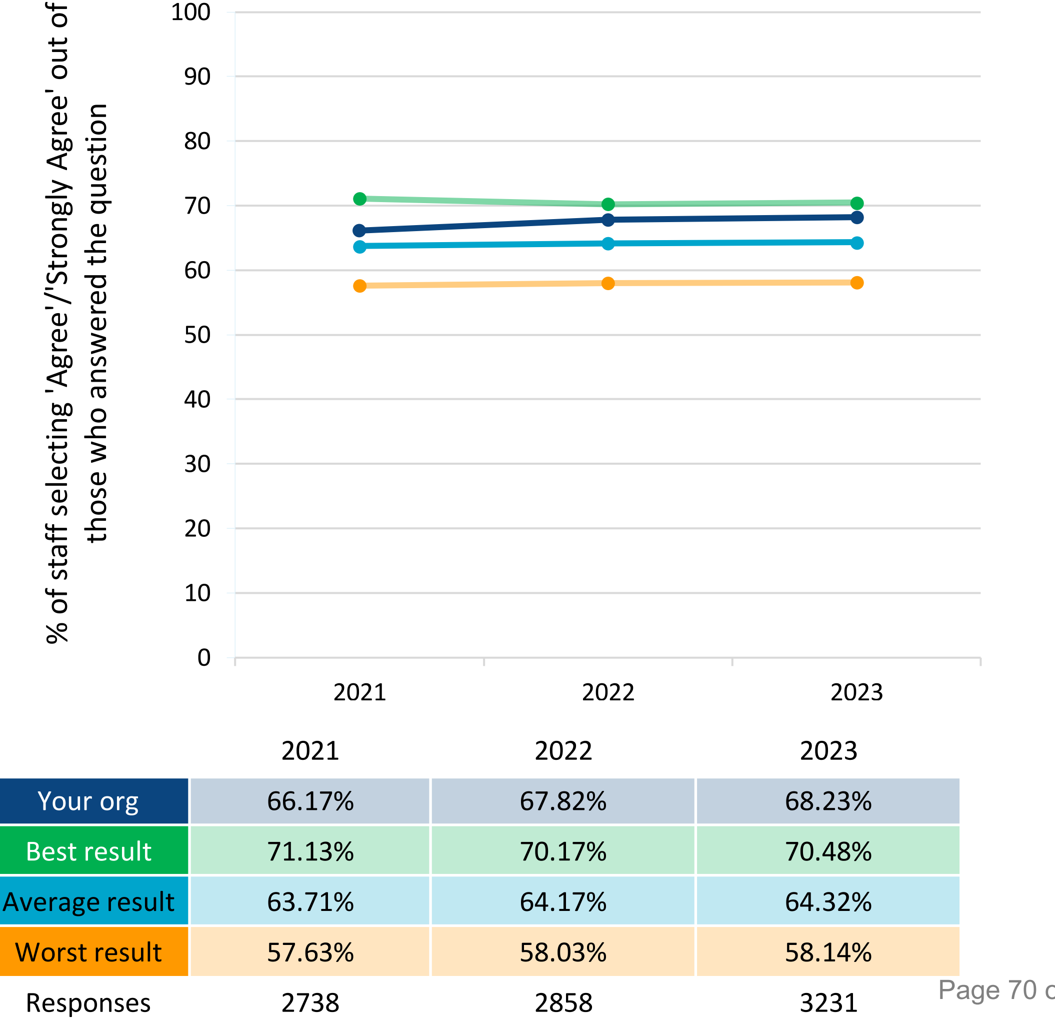
	2021	2022	2023
Your org	66.09%	71.44%	74.73%
Best result	83.66%	81.52%	82.55%
Average result	68.83%	69.29%	70.33%
Worst result	55.37%	57.06%	57.60%
Responses	2728	2845	3219

Q7h I feel valued by my team.



	2021	2022	2023
Your org	69.35%	72.40%	74.05%
Best result	76.79%	76.81%	77.16%
Average result	67.92%	68.70%	70.12%
Worst result	61.81%	62.78%	64.16%
Responses	2742	2861	3227

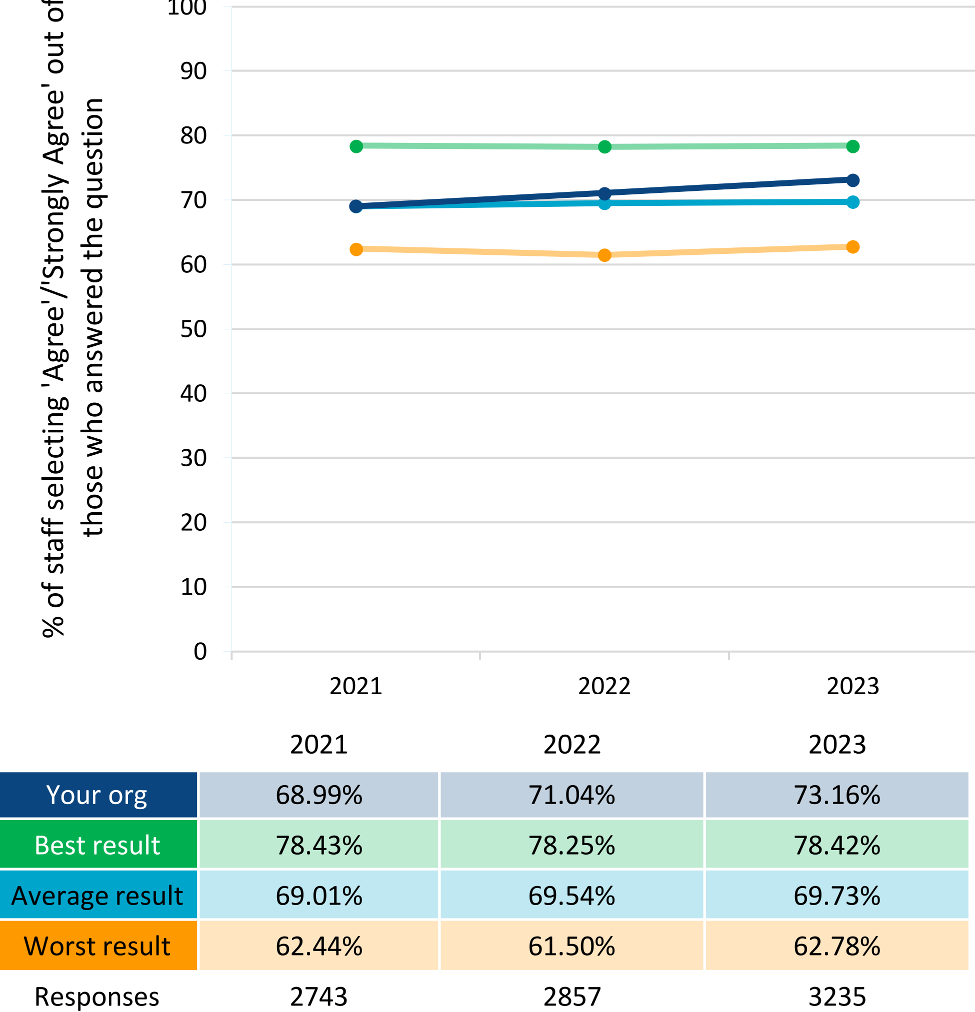
Q7i I feel a strong personal attachment to my team.



	2021	2022	2023
Your org	66.17%	67.82%	68.23%
Best result	71.13%	70.17%	70.48%
Average result	63.71%	64.17%	64.32%
Worst result	57.63%	58.03%	58.14%
Responses	2738	2858	3231

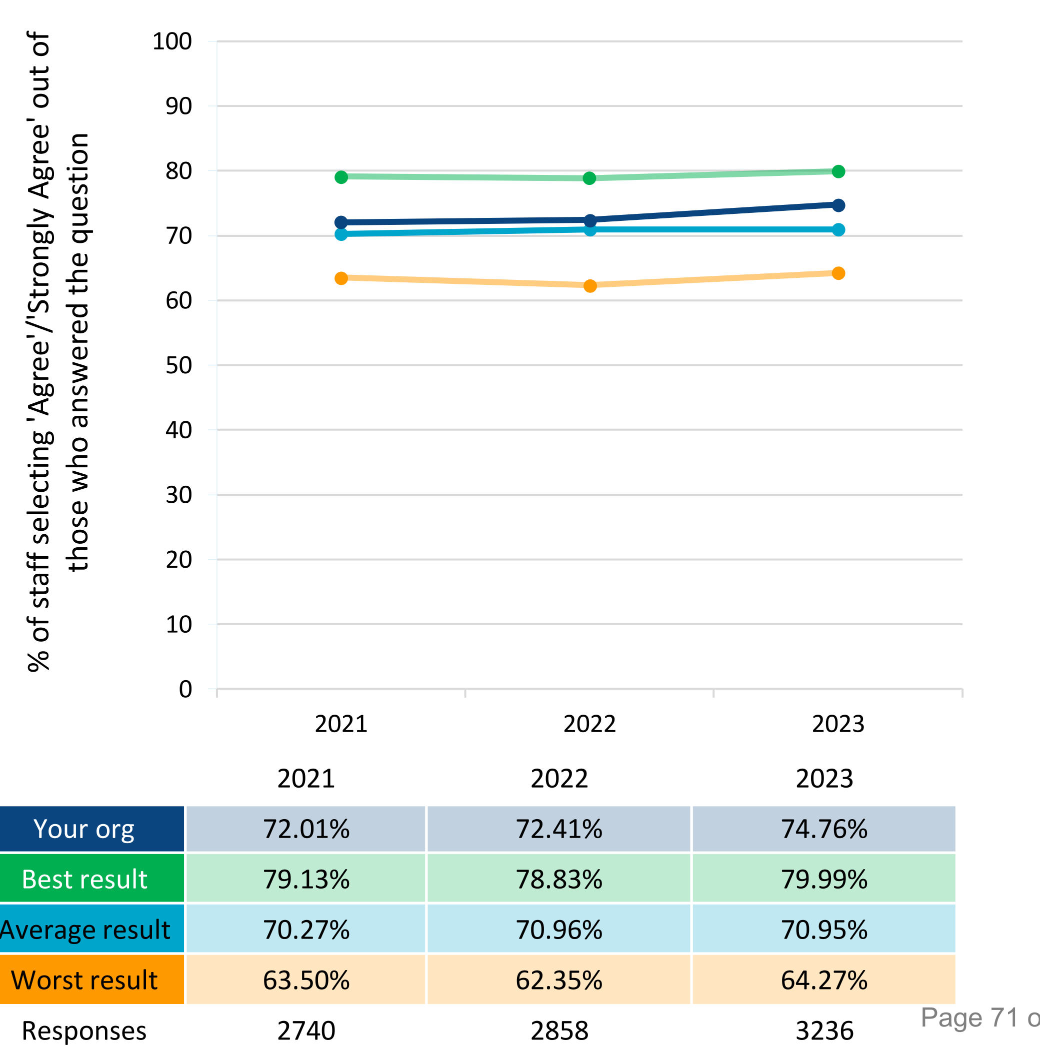
People Promise elements and theme results – We are compassionate and inclusive: Inclusion

Q8b The people I work with are understanding and kind to one another.



	2021	2022	2023
Your org	68.99%	71.04%	73.16%
Best result	78.43%	78.25%	78.42%
Average result	69.01%	69.54%	69.73%
Worst result	62.44%	61.50%	62.78%
Responses	2743	2857	3235

Q8c The people I work with are polite and treat each other with respect.



	2021	2022	2023
Your org	72.01%	72.41%	74.76%
Best result	79.13%	78.83%	79.99%
Average result	70.27%	70.96%	70.95%
Worst result	63.50%	62.35%	64.27%
Responses	2740	2858	3236

Survey Coordination Centre

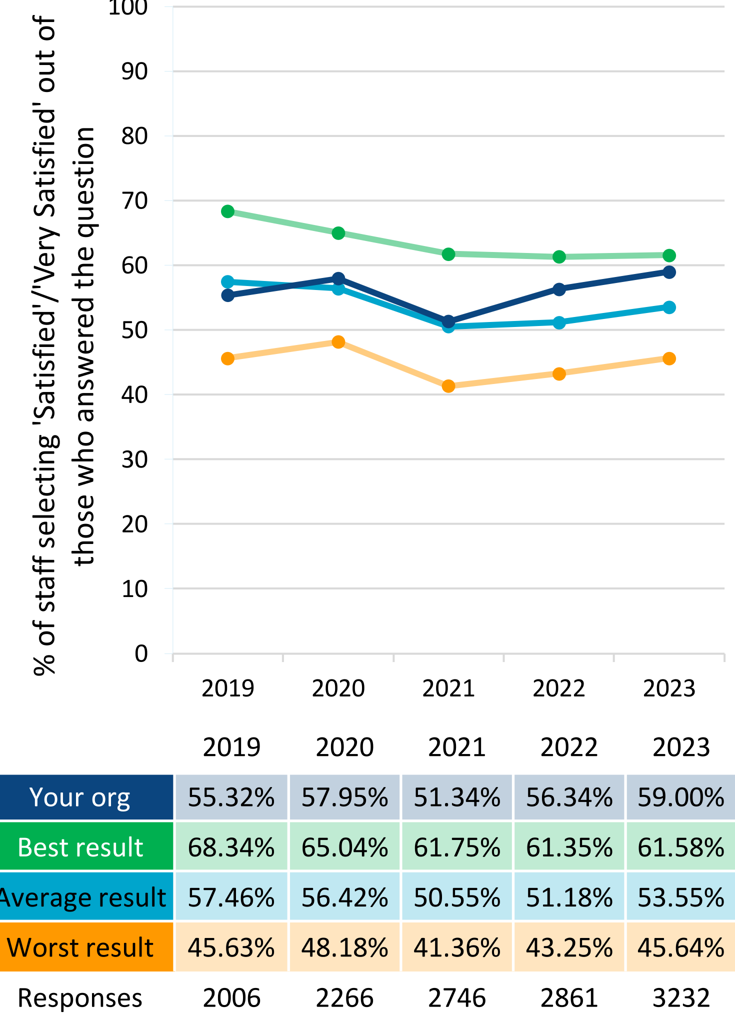
People Promise element – We are recognised and rewarded

Questions included:

Q4a, Q4b, Q4c, Q8d, Q9e

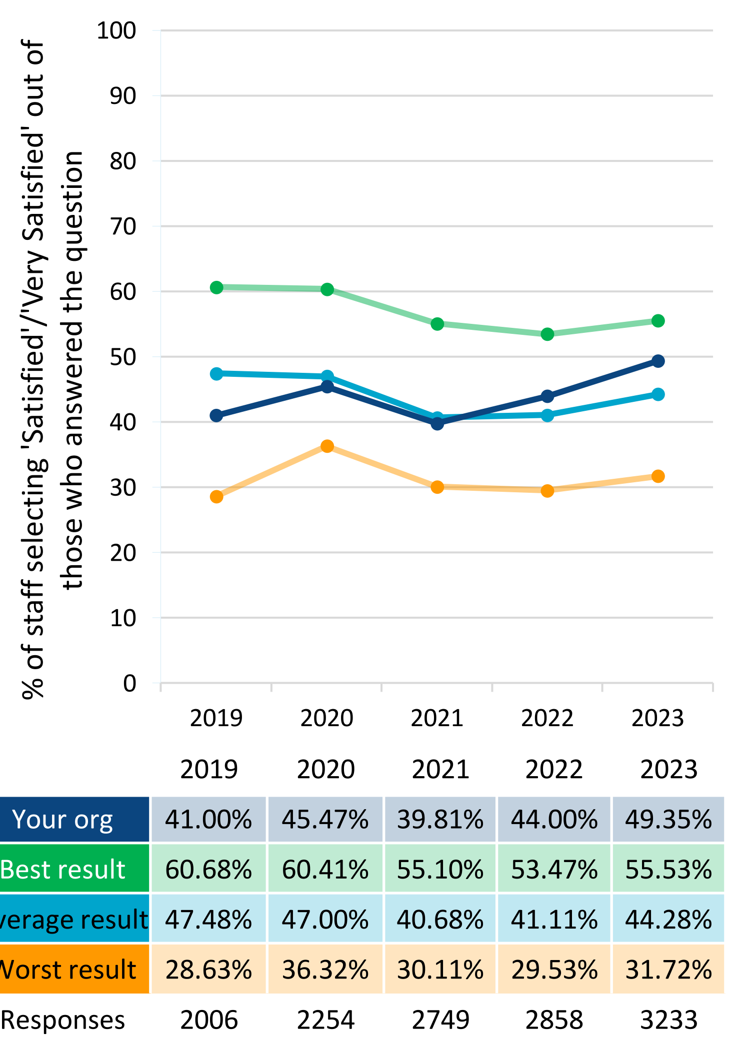
Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Q4a How satisfied are you with each of the following aspects of your job? The recognition I get for good work.



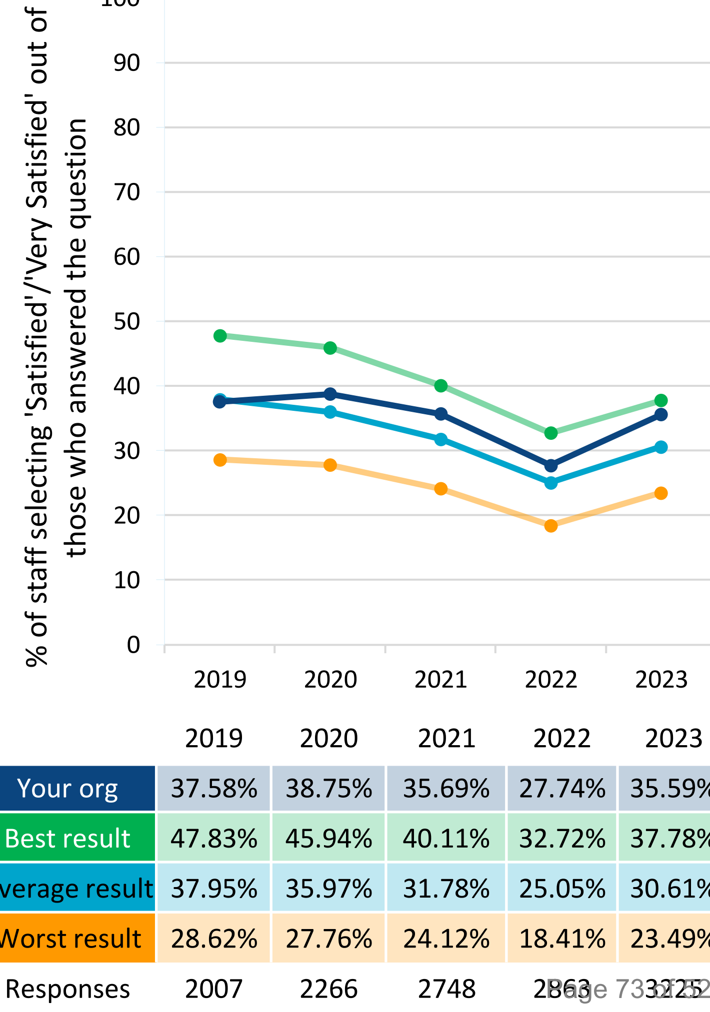
	2019	2020	2021	2022	2023
Your org	55.32%	57.95%	51.34%	56.34%	59.00%
Best result	68.34%	65.04%	61.75%	61.35%	61.58%
Average result	57.46%	56.42%	50.55%	51.18%	53.55%
Worst result	45.63%	48.18%	41.36%	43.25%	45.64%
Responses	2006	2266	2746	2861	3232

Q4b How satisfied are you with each of the following aspects of your job? The extent to which my organisation values my work.

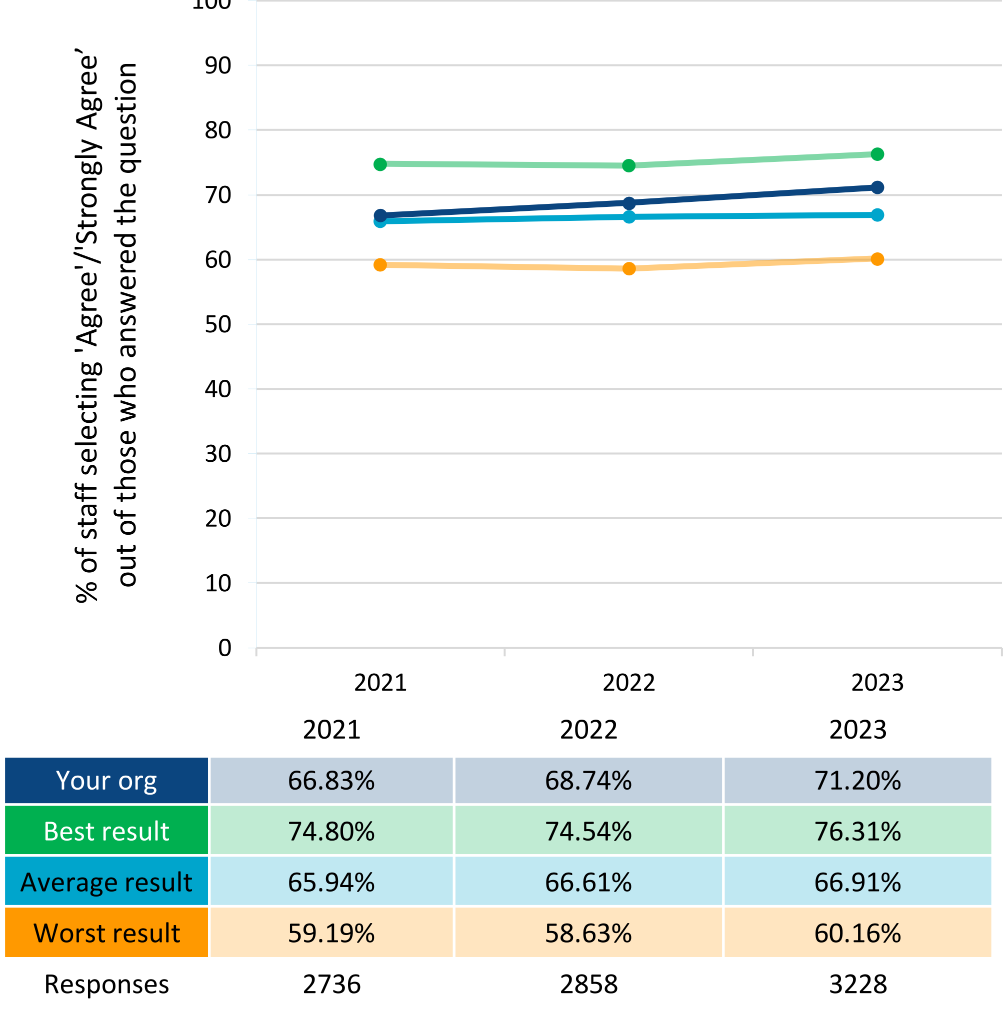


	2019	2020	2021	2022	2023
Your org	41.00%	45.47%	39.81%	44.00%	49.35%
Best result	60.68%	60.41%	55.10%	53.47%	55.53%
Average result	47.48%	47.00%	40.68%	41.11%	44.28%
Worst result	28.63%	36.32%	30.11%	29.53%	31.72%
Responses	2006	2254	2749	2858	3233

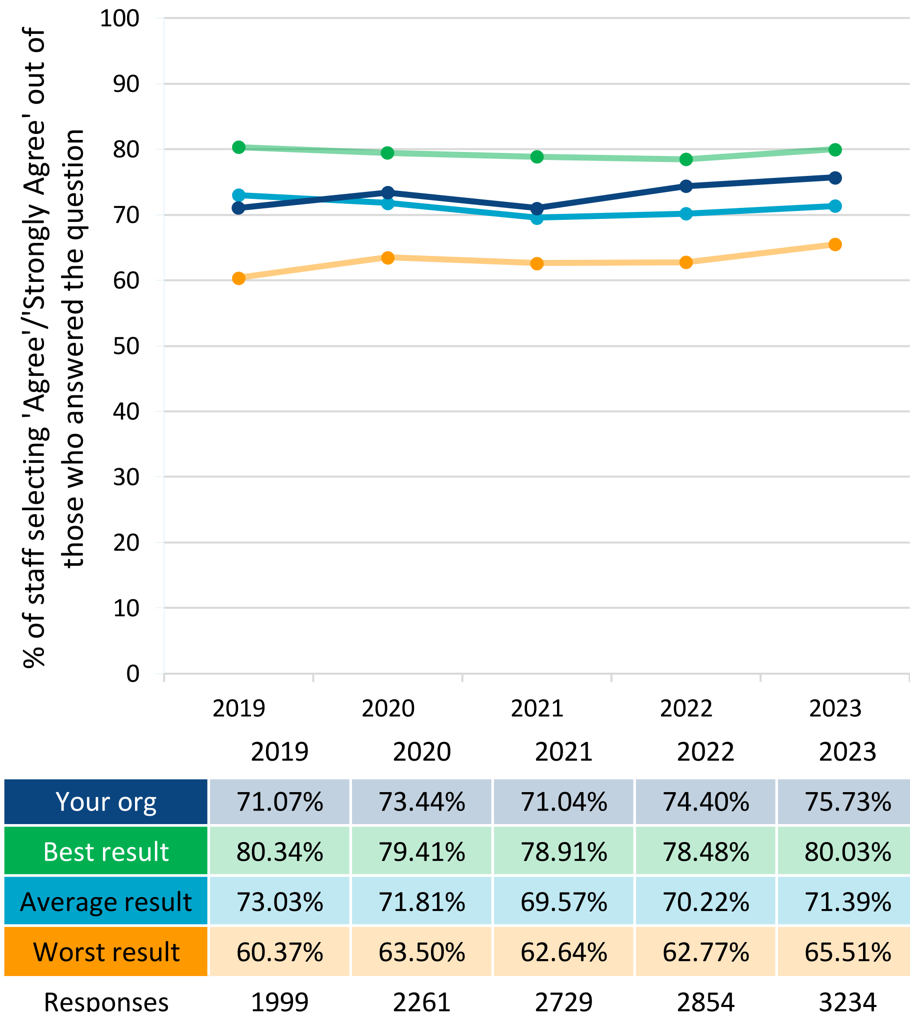
Q4c How satisfied are you with each of the following aspects of your job? My level of pay.



	2019	2020	2021	2022	2023
Your org	37.58%	38.75%	35.69%	27.74%	35.59%
Best result	47.83%	45.94%	40.11%	32.72%	37.78%
Average result	37.95%	35.97%	31.78%	25.05%	30.61%
Worst result	28.62%	27.76%	24.12%	18.41%	23.49%
Responses	2007	2266	2748	2863	3225



	2021	2022	2023
Your org	66.83%	68.74%	71.20%
Best result	74.80%	74.54%	76.31%
Average result	65.94%	66.61%	66.91%
Worst result	59.19%	58.63%	60.16%
Responses	2736	2858	3228



	2019	2020	2021	2022	2023
Your org	71.07%	73.44%	71.04%	74.40%	75.73%
Best result	80.34%	79.41%	78.91%	78.48%	80.03%
Average result	73.03%	71.81%	69.57%	70.22%	71.39%
Worst result	60.37%	63.50%	62.64%	62.77%	65.51%
Responses	1999	2261	2729	2854	3234

Survey Coordination Centre

People Promise element – We each have a voice that counts

Questions included:

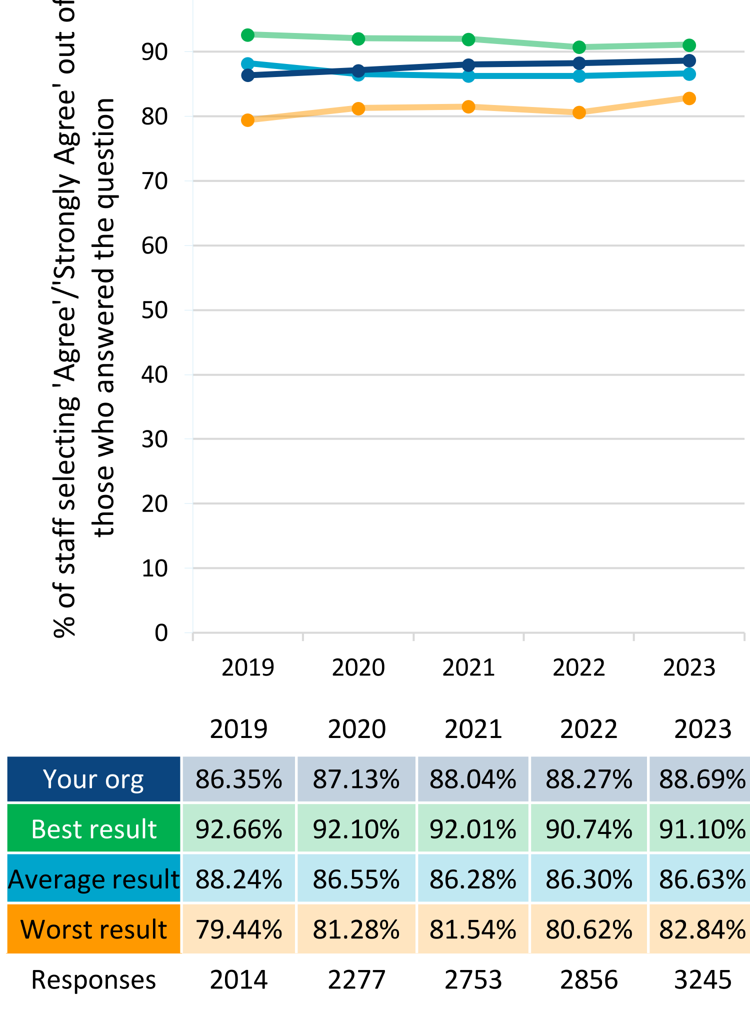
Autonomy and control – Q3a, Q3b, Q3c, Q3d, Q3e, Q3f, Q5b

Raising concerns – Q20a, Q20b, Q25e, Q25f

Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

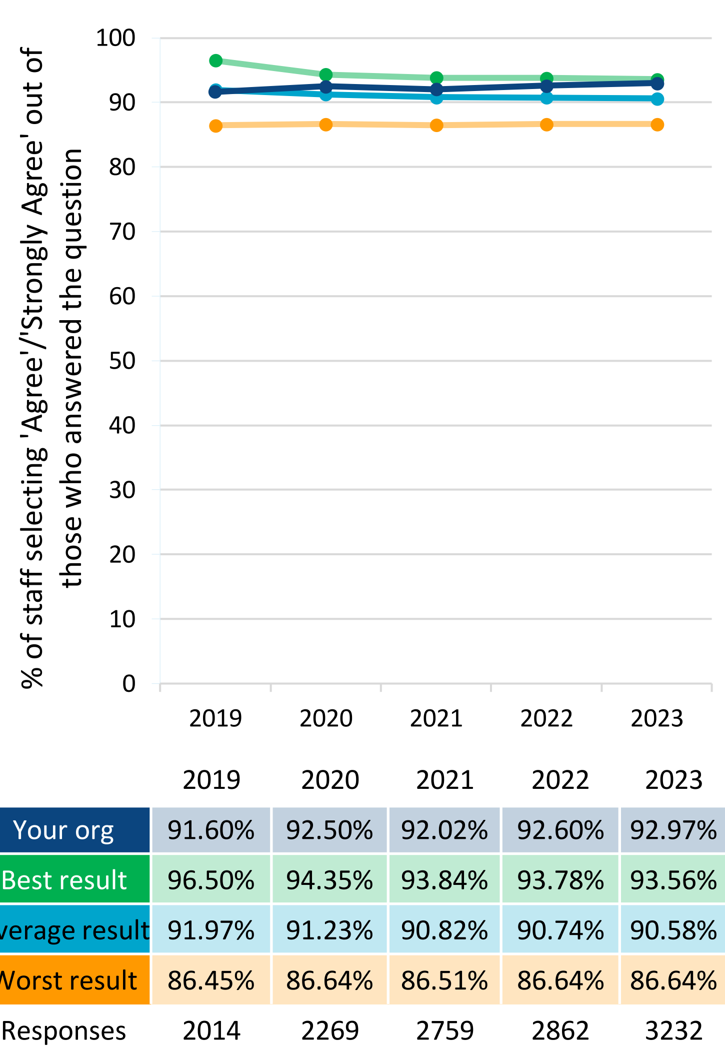
People Promise elements and theme results – We each have a voice that counts: Autonomy and control

Q3a I always know what my work responsibilities are.



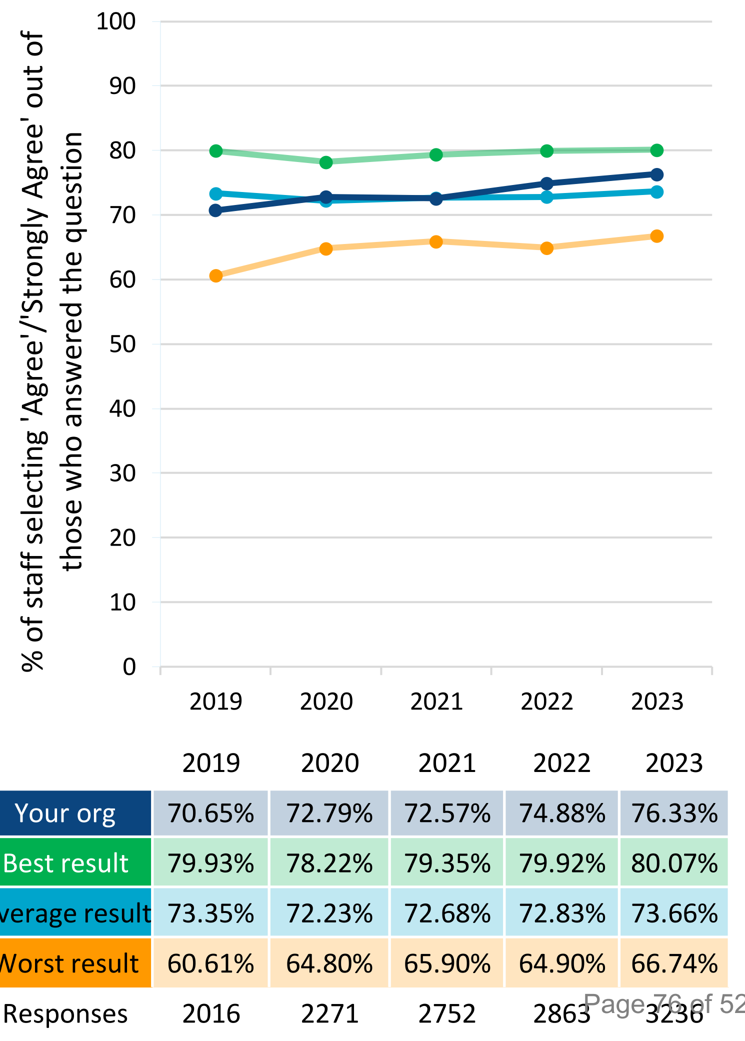
	2019	2020	2021	2022	2023
Your org	86.35%	87.13%	88.04%	88.27%	88.69%
Best result	92.66%	92.10%	92.01%	90.74%	91.10%
Average result	88.24%	86.55%	86.28%	86.30%	86.63%
Worst result	79.44%	81.28%	81.54%	80.62%	82.84%
Responses	2014	2277	2753	2856	3245

Q3b I am trusted to do my job.

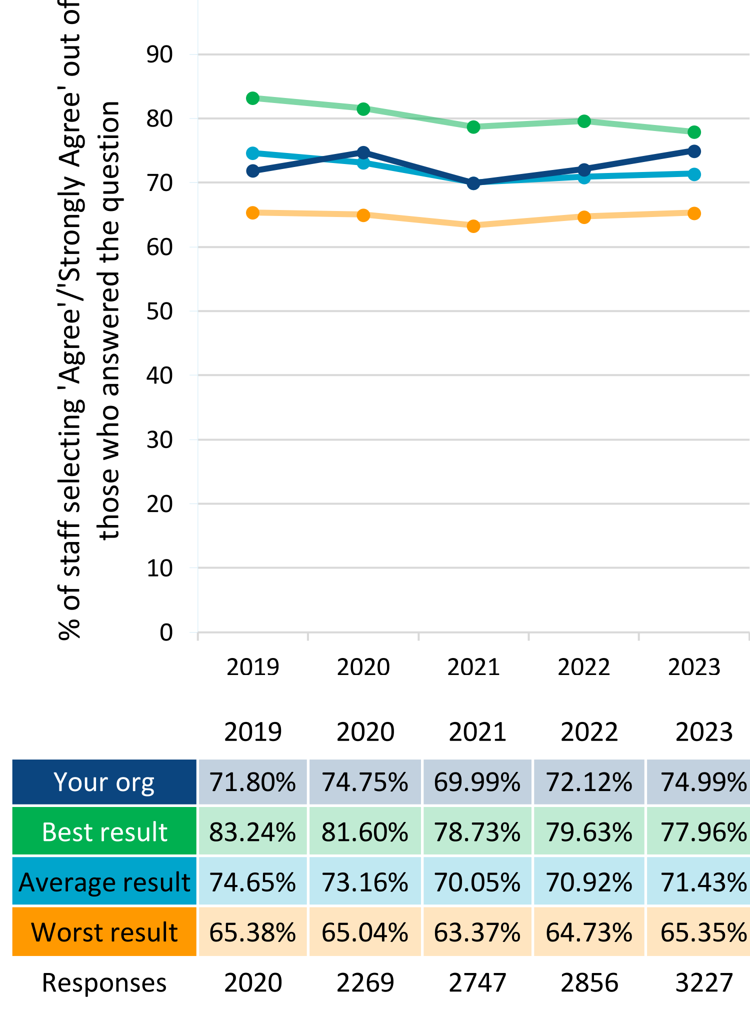


	2019	2020	2021	2022	2023
Your org	91.60%	92.50%	92.02%	92.60%	92.97%
Best result	96.50%	94.35%	93.84%	93.78%	93.56%
Average result	91.97%	91.23%	90.82%	90.74%	90.58%
Worst result	86.45%	86.64%	86.51%	86.64%	86.64%
Responses	2014	2269	2759	2862	3232

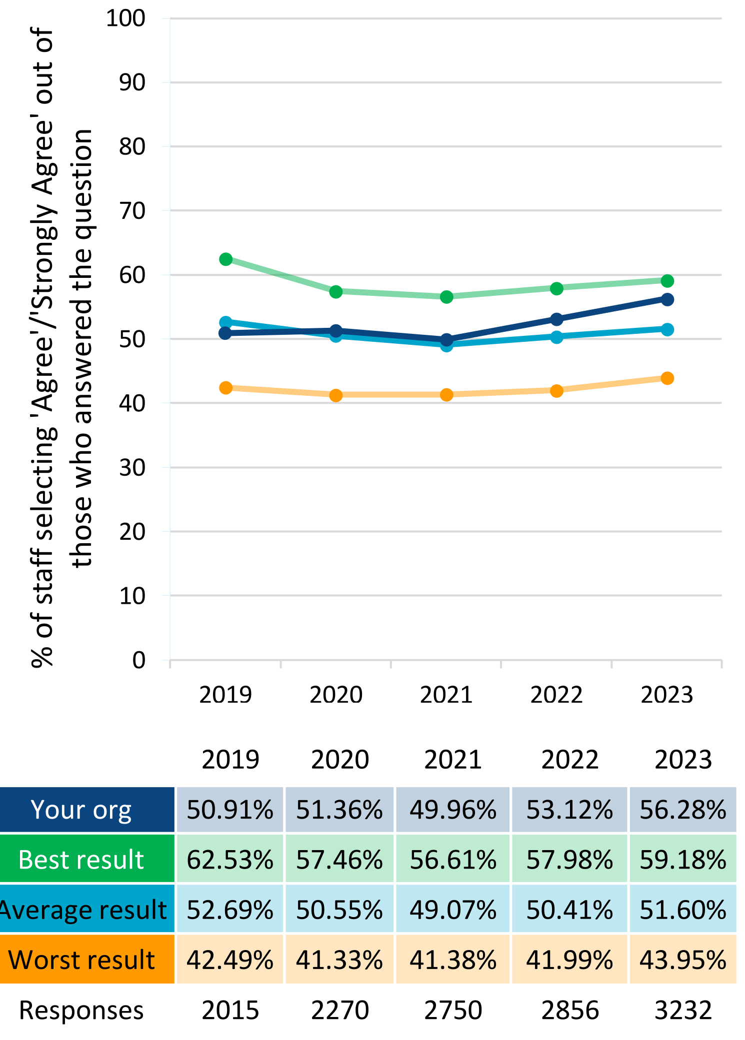
Q3c There are frequent opportunities for me to show initiative in my role.



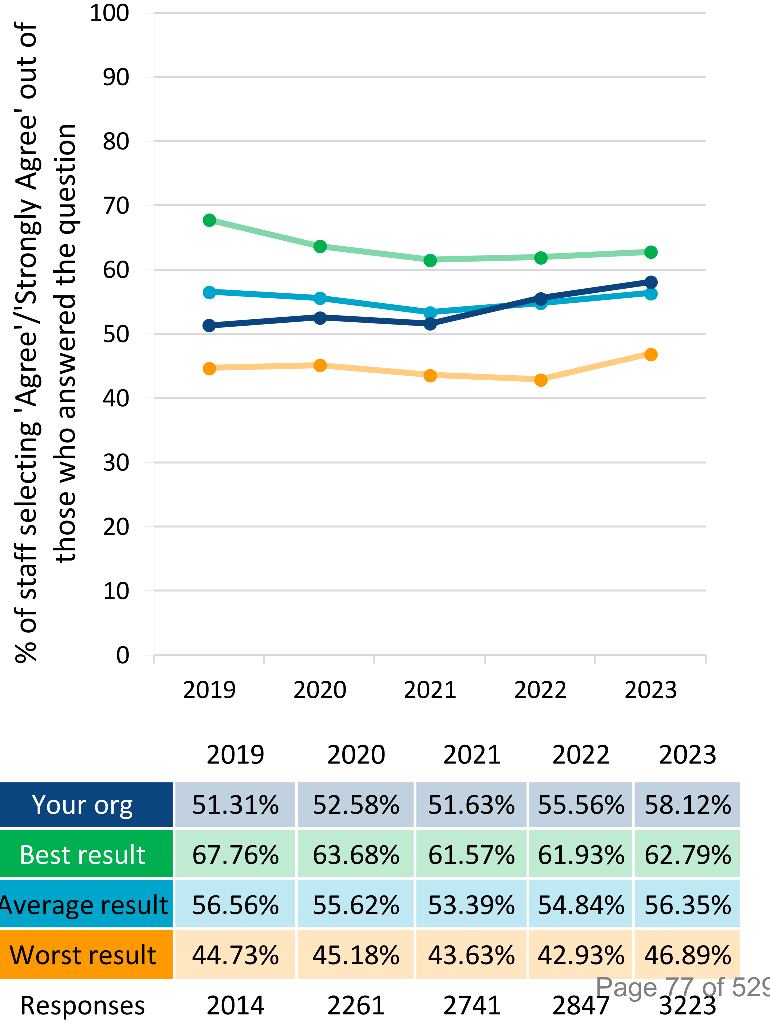
	2019	2020	2021	2022	2023
Your org	70.65%	72.79%	72.57%	74.88%	76.33%
Best result	79.93%	78.22%	79.35%	79.92%	80.07%
Average result	73.35%	72.23%	72.68%	72.83%	73.66%
Worst result	60.61%	64.80%	65.90%	64.90%	66.74%
Responses	2016	2271	2752	2863	3236



	2019	2020	2021	2022	2023
Your org	71.80%	74.75%	69.99%	72.12%	74.99%
Best result	83.24%	81.60%	78.73%	79.63%	77.96%
Average result	74.65%	73.16%	70.05%	70.92%	71.43%
Worst result	65.38%	65.04%	63.37%	64.73%	65.35%
Responses	2020	2269	2747	2856	3227

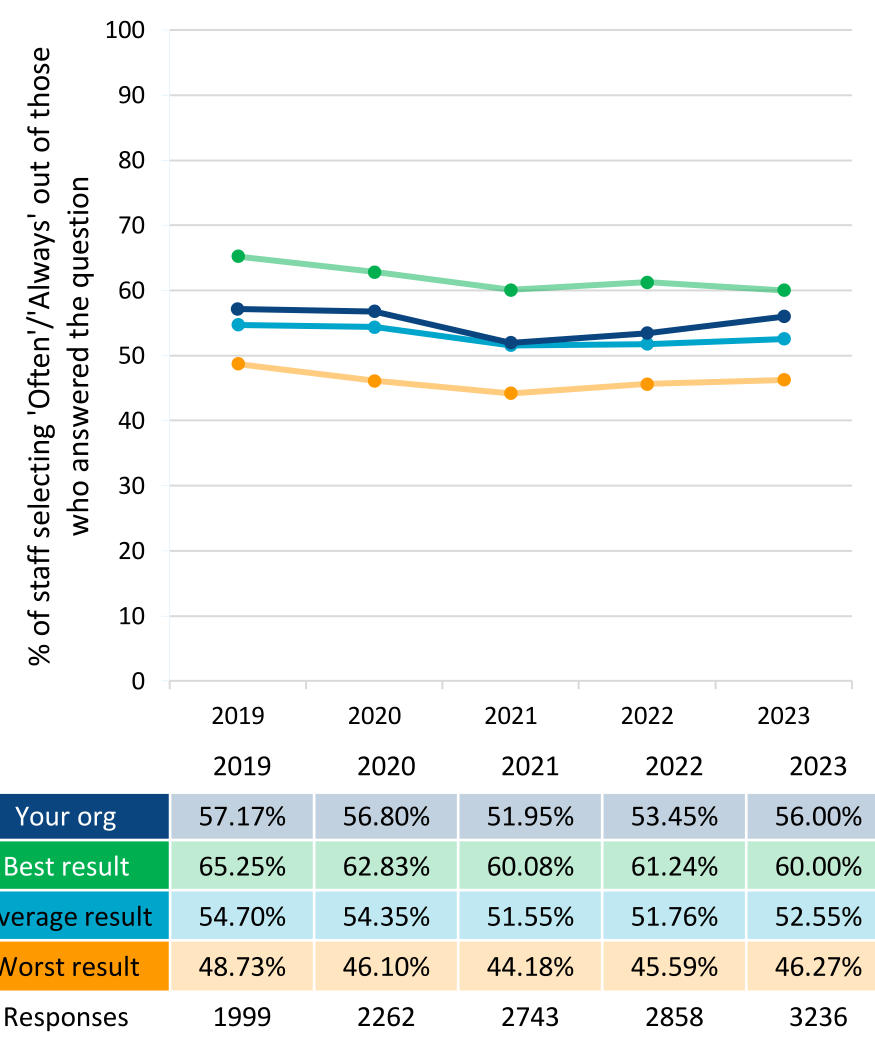


	2019	2020	2021	2022	2023
Your org	50.91%	51.36%	49.96%	53.12%	56.28%
Best result	62.53%	57.46%	56.61%	57.98%	59.18%
Average result	52.69%	50.55%	49.07%	50.41%	51.60%
Worst result	42.49%	41.33%	41.38%	41.99%	43.95%
Responses	2015	2270	2750	2856	3232

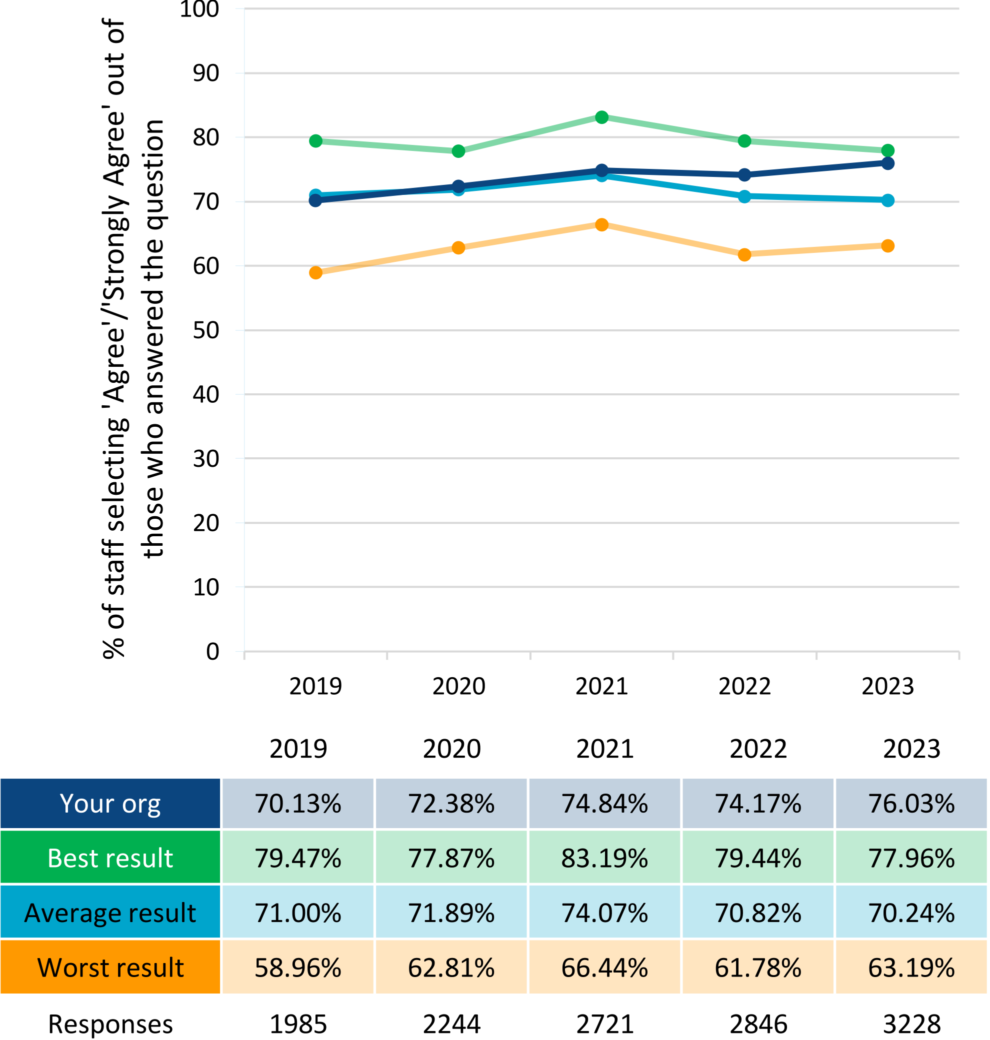


	2019	2020	2021	2022	2023
Your org	51.31%	52.58%	51.63%	55.56%	58.12%
Best result	67.76%	63.68%	61.57%	61.93%	62.79%
Average result	56.56%	55.62%	53.39%	54.84%	56.35%
Worst result	44.73%	45.18%	43.63%	42.93%	46.89%
Responses	2014	2261	2741	2847	3223

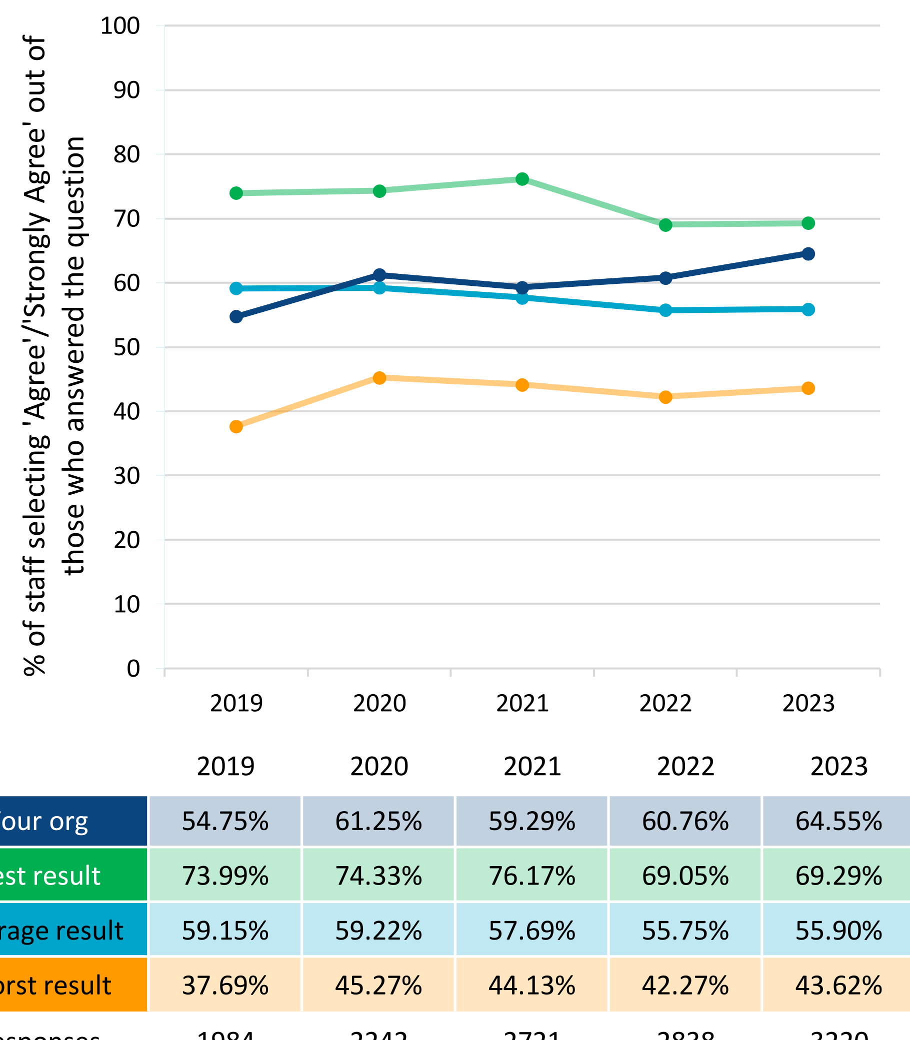
Q5b I have a choice in deciding how to do my work.



	2019	2020	2021	2022	2023
Your org	57.17%	56.80%	51.95%	53.45%	56.00%
Best result	65.25%	62.83%	60.08%	61.24%	60.00%
Average result	54.70%	54.35%	51.55%	51.76%	52.55%
Worst result	48.73%	46.10%	44.18%	45.59%	46.27%
Responses	1999	2262	2743	2858	3236



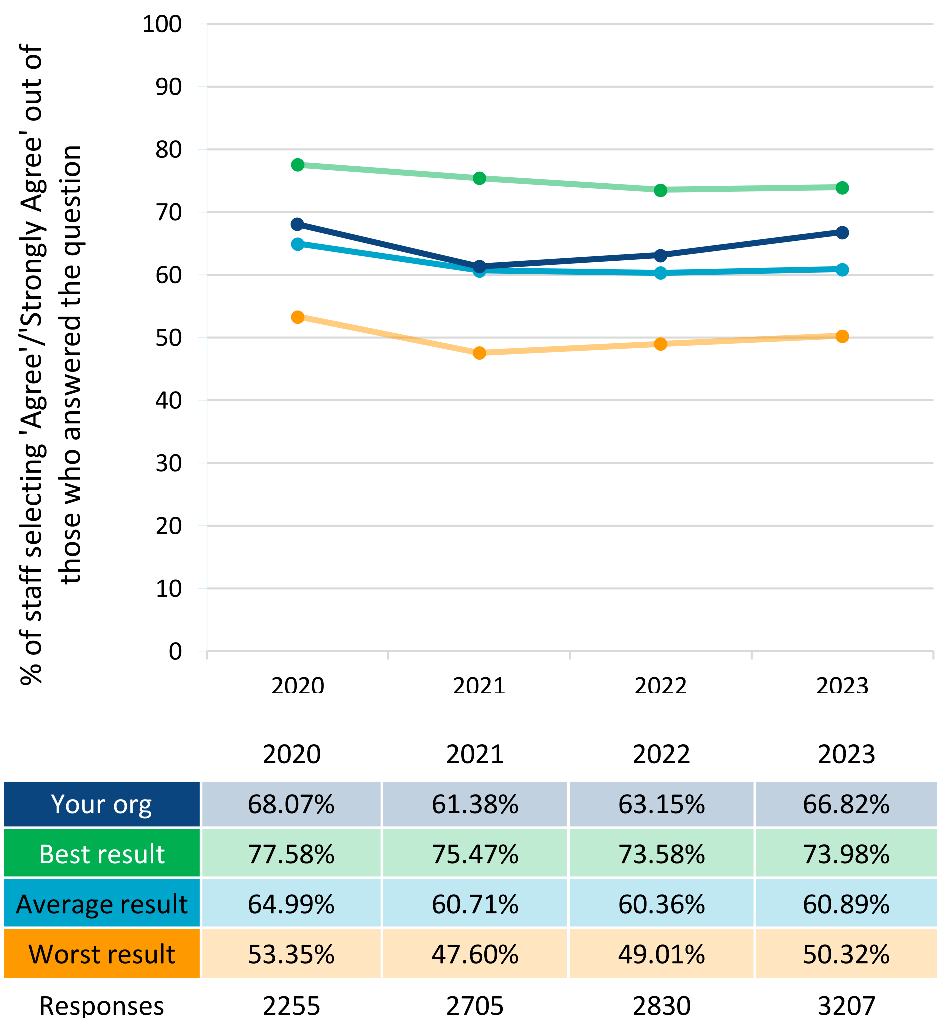
	2019	2020	2021	2022	2023
Your org	70.13%	72.38%	74.84%	74.17%	76.03%
Best result	79.47%	77.87%	83.19%	79.44%	77.96%
Average result	71.00%	71.89%	74.07%	70.82%	70.24%
Worst result	58.96%	62.81%	66.44%	61.78%	63.19%
Responses	1985	2244	2721	2846	3228



	2019	2020	2021	2022	2023
Your org	54.75%	61.25%	59.29%	60.76%	64.55%
Best result	73.99%	74.33%	76.17%	69.05%	69.29%
Average result	59.15%	59.22%	57.69%	55.75%	55.90%
Worst result	37.69%	45.27%	44.13%	42.27%	43.62%
Responses	1984	2242	2721	2838	3220

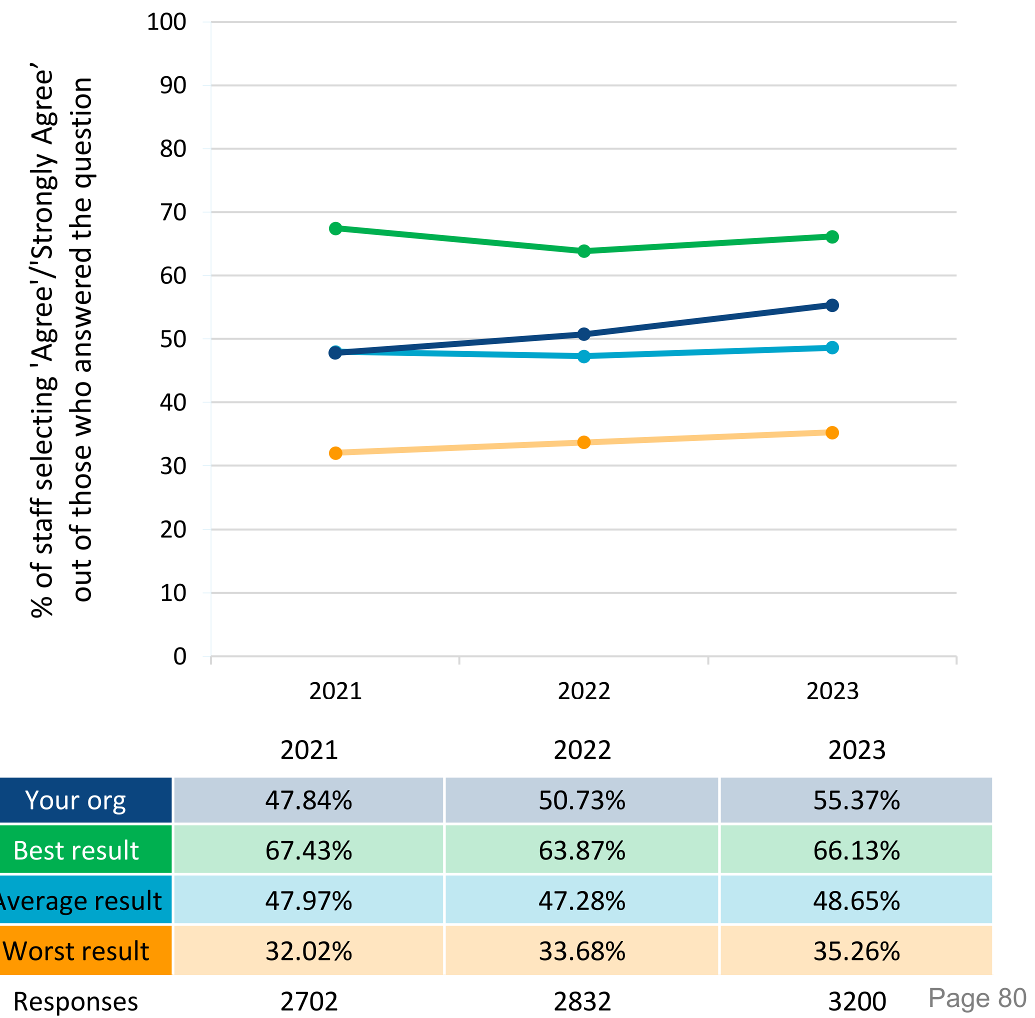
People Promise elements and theme results – We each have a voice that counts: Raising concerns

Q25e I feel safe to speak up about anything that concerns me in this organisation.



	2020	2021	2022	2023
Your org	68.07%	61.38%	63.15%	66.82%
Best result	77.58%	75.47%	73.58%	73.98%
Average result	64.99%	60.71%	60.36%	60.89%
Worst result	53.35%	47.60%	49.01%	50.32%
Responses	2255	2705	2830	3207

Q25f If I spoke up about something that concerned me I am confident my organisation would address my concern.



	2021	2022	2023
Your org	47.84%	50.73%	55.37%
Best result	67.43%	63.87%	66.13%
Average result	47.97%	47.28%	48.65%
Worst result	32.02%	33.68%	35.26%
Responses	2702	2832	3200

Survey Coordination Centre

People Promise element – We are safe and healthy

Questions included:

Health and safety climate: Q3g, Q3h, Q3i, Q5a, Q11a, Q13d, Q14d

Burnout: Q12a, Q12b, Q12c, Q12d, Q12e, Q12f, Q12g

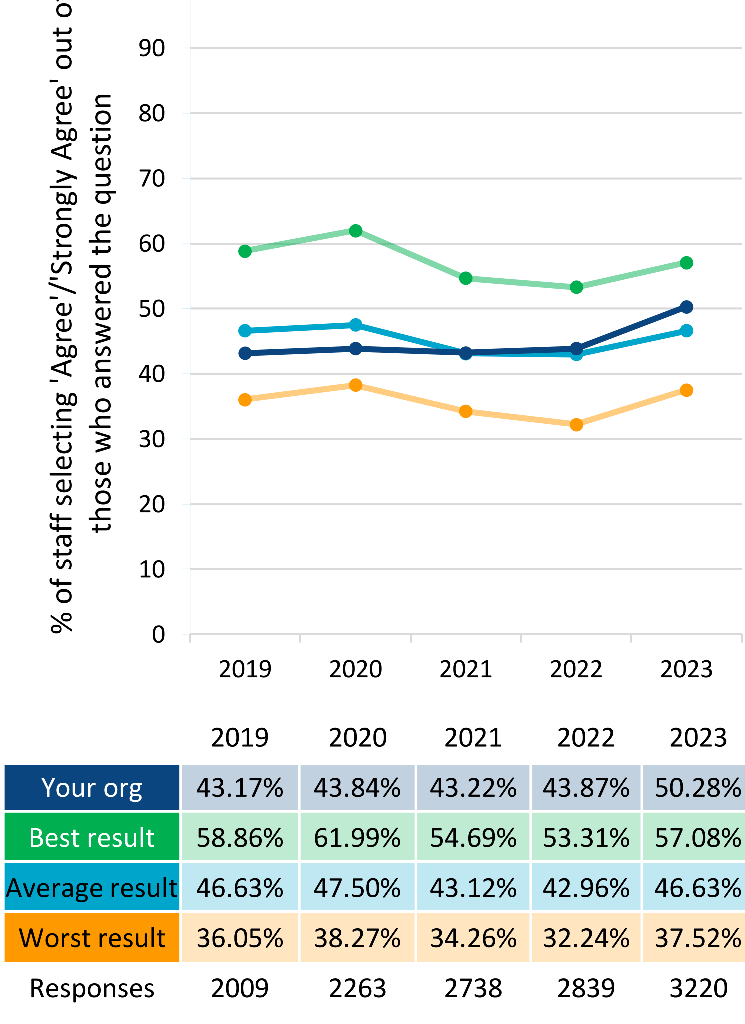
Negative experiences: Q11b, Q11c, Q11d, Q13a, Q13b, Q13c, Q14a, Q14b, Q14c

Other questions:* Q17a, Q17b, Q22

*Q17a, Q17b and Q22 do not contribute to the calculation of any scores or sub-scores.

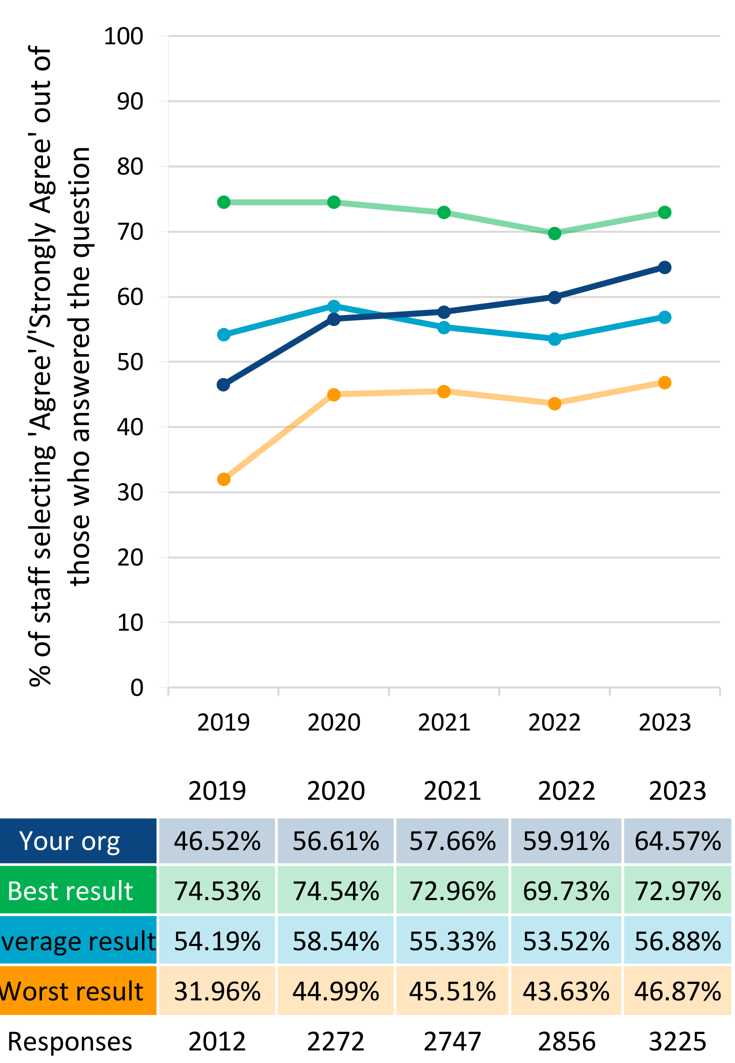
Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Q3g I am able to meet all the conflicting demands on my time at work.



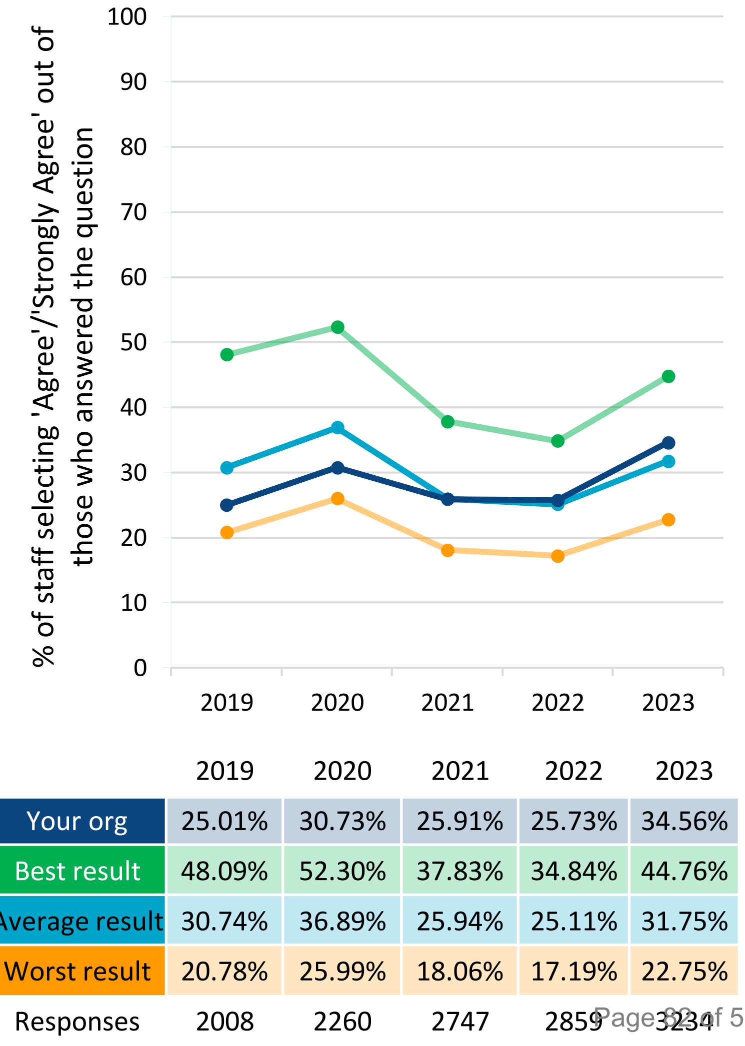
	2019	2020	2021	2022	2023
Your org	43.17%	43.84%	43.22%	43.87%	50.28%
Best result	58.86%	61.99%	54.69%	53.31%	57.08%
Average result	46.63%	47.50%	43.12%	42.96%	46.63%
Worst result	36.05%	38.27%	34.26%	32.24%	37.52%
Responses	2009	2263	2738	2839	3220

Q3h I have adequate materials, supplies and equipment to do my work.

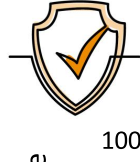


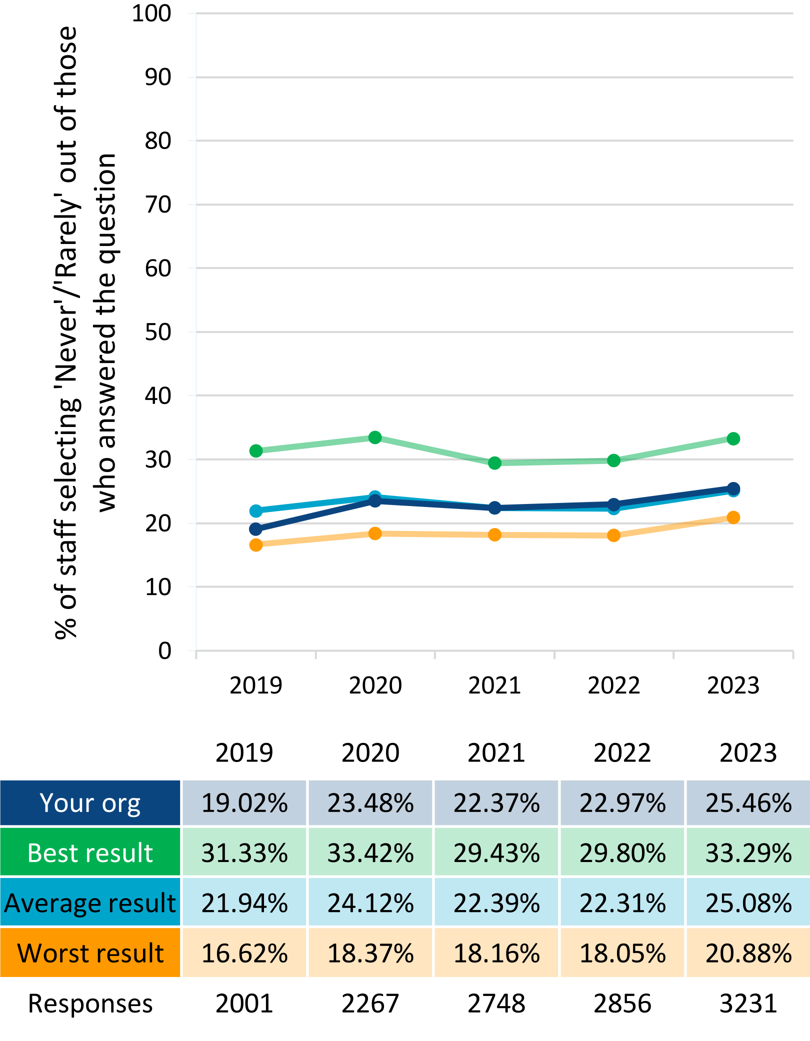
	2019	2020	2021	2022	2023
Your org	46.52%	56.61%	57.66%	59.91%	64.57%
Best result	74.53%	74.54%	72.96%	69.73%	72.97%
Average result	54.19%	58.54%	55.33%	53.52%	56.88%
Worst result	31.96%	44.99%	45.51%	43.63%	46.87%
Responses	2012	2272	2747	2856	3225

Q3i There are enough staff at this organisation for me to do my job properly.

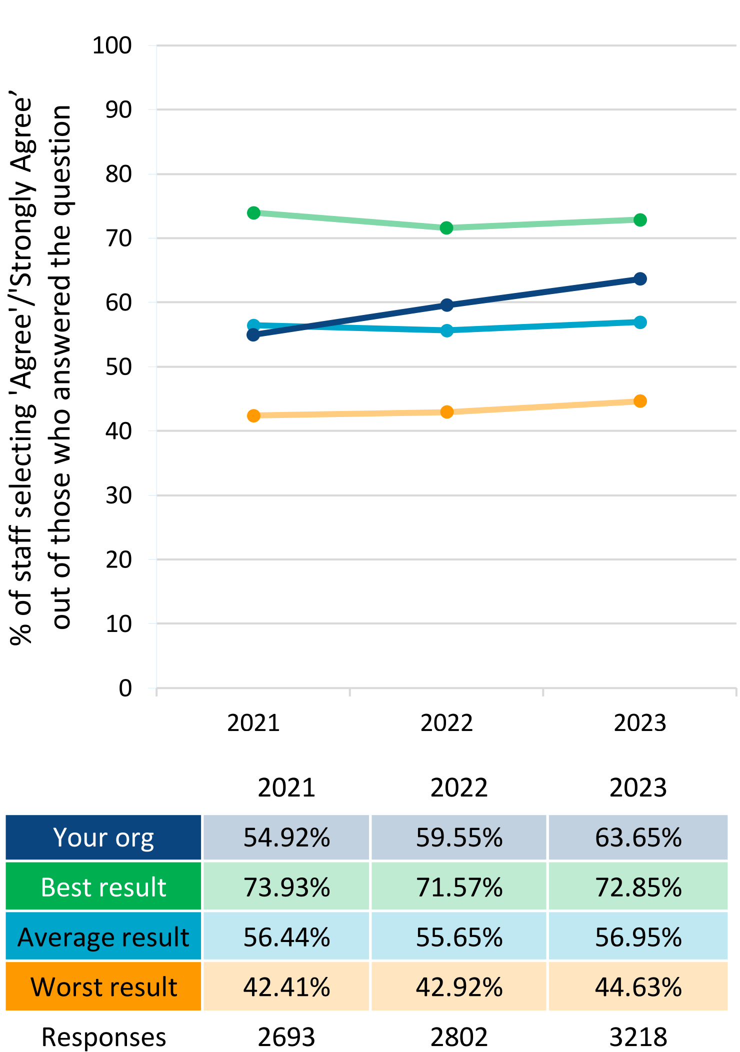


	2019	2020	2021	2022	2023
Your org	25.01%	30.73%	25.91%	25.73%	34.56%
Best result	48.09%	52.30%	37.83%	34.84%	44.76%
Average result	30.74%	36.89%	25.94%	25.11%	31.75%
Worst result	20.78%	25.99%	18.06%	17.19%	22.75%
Responses	2008	2260	2747	2859	3234

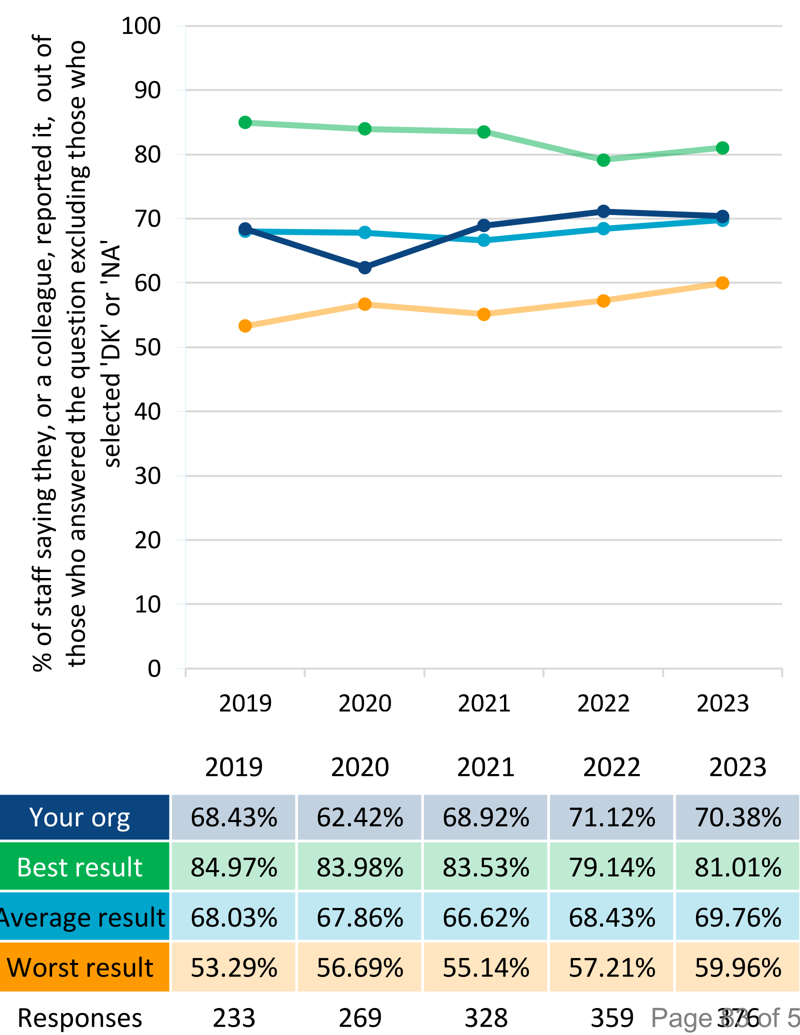




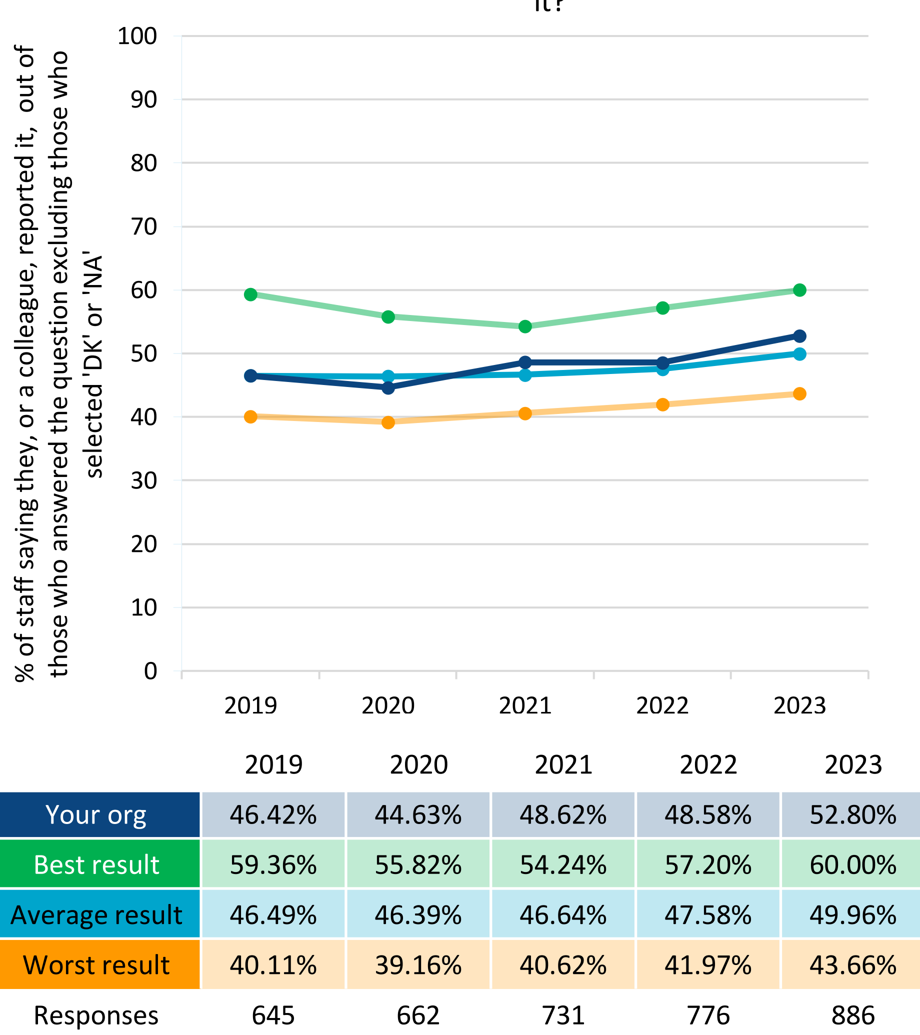
	2019	2020	2021	2022	2023
Your org	19.02%	23.48%	22.37%	22.97%	25.46%
Best result	31.33%	33.42%	29.43%	29.80%	33.29%
Average result	21.94%	24.12%	22.39%	22.31%	25.08%
Worst result	16.62%	18.37%	18.16%	18.05%	20.88%
Responses	2001	2267	2748	2856	3231



	2021	2022	2023
Your org	54.92%	59.55%	63.65%
Best result	73.93%	71.57%	72.85%
Average result	56.44%	55.65%	56.95%
Worst result	42.41%	42.92%	44.63%
Responses	2693	2802	3218

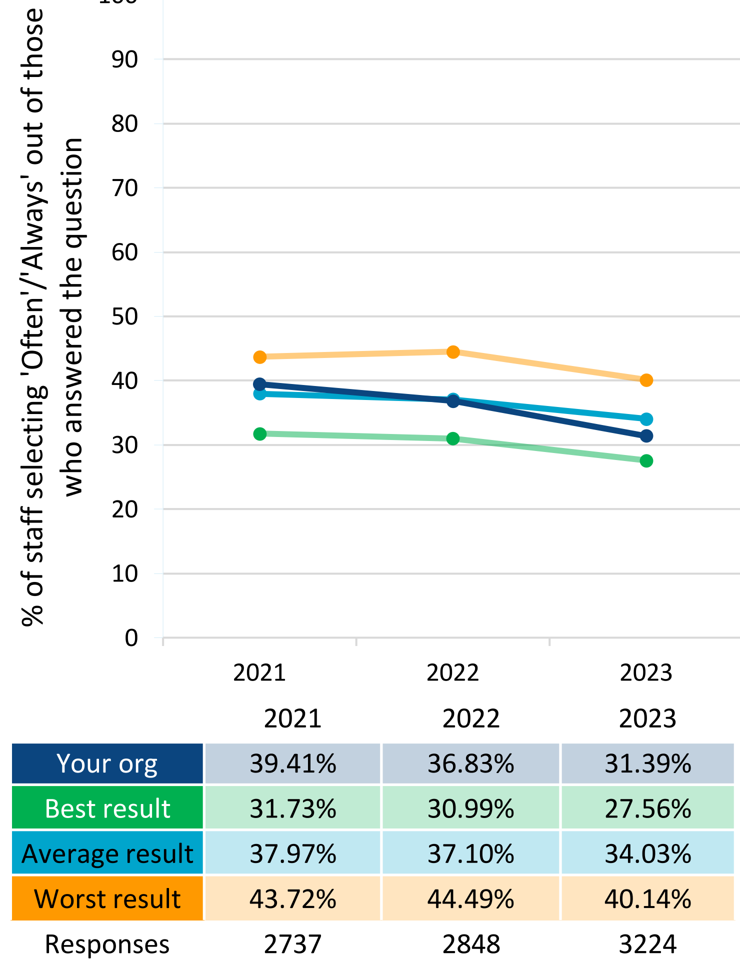


	2019	2020	2021	2022	2023
Your org	68.43%	62.42%	68.92%	71.12%	70.38%
Best result	84.97%	83.98%	83.53%	79.14%	81.01%
Average result	68.03%	67.86%	66.62%	68.43%	69.76%
Worst result	53.29%	56.69%	55.14%	57.21%	59.96%
Responses	233	269	328	359	376



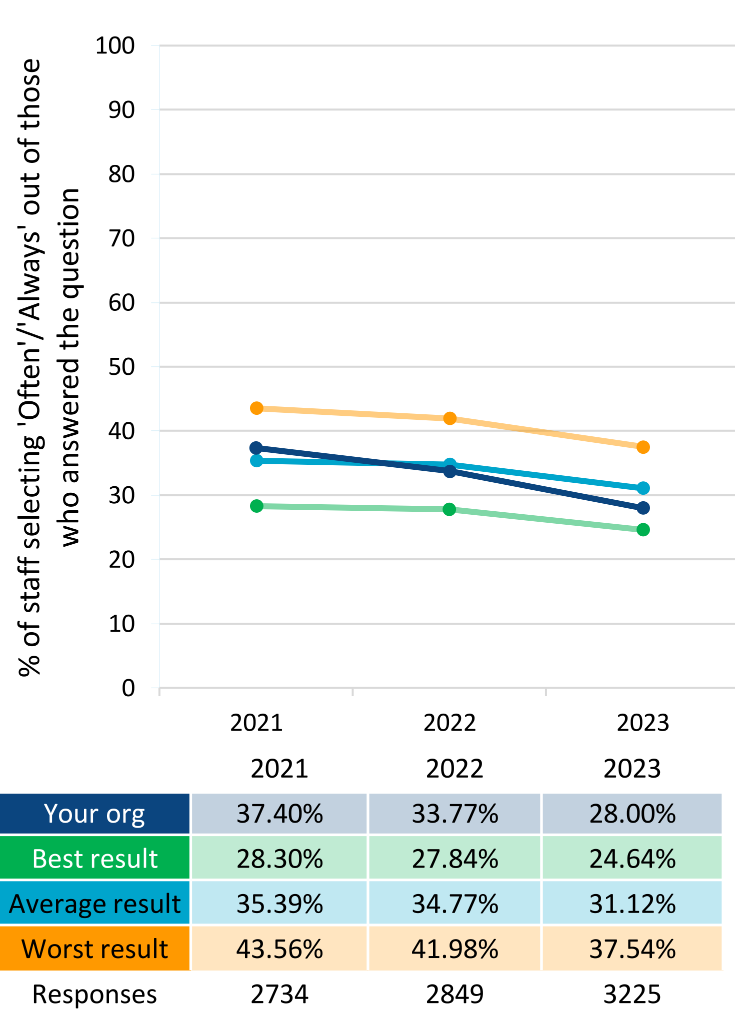
	2019	2020	2021	2022	2023
Your org	46.42%	44.63%	48.62%	48.58%	52.80%
Best result	59.36%	55.82%	54.24%	57.20%	60.00%
Average result	46.49%	46.39%	46.64%	47.58%	49.96%
Worst result	40.11%	39.16%	40.62%	41.97%	43.66%
Responses	645	662	731	776	886

Q12a How often, if at all, do you find your work emotionally exhausting?



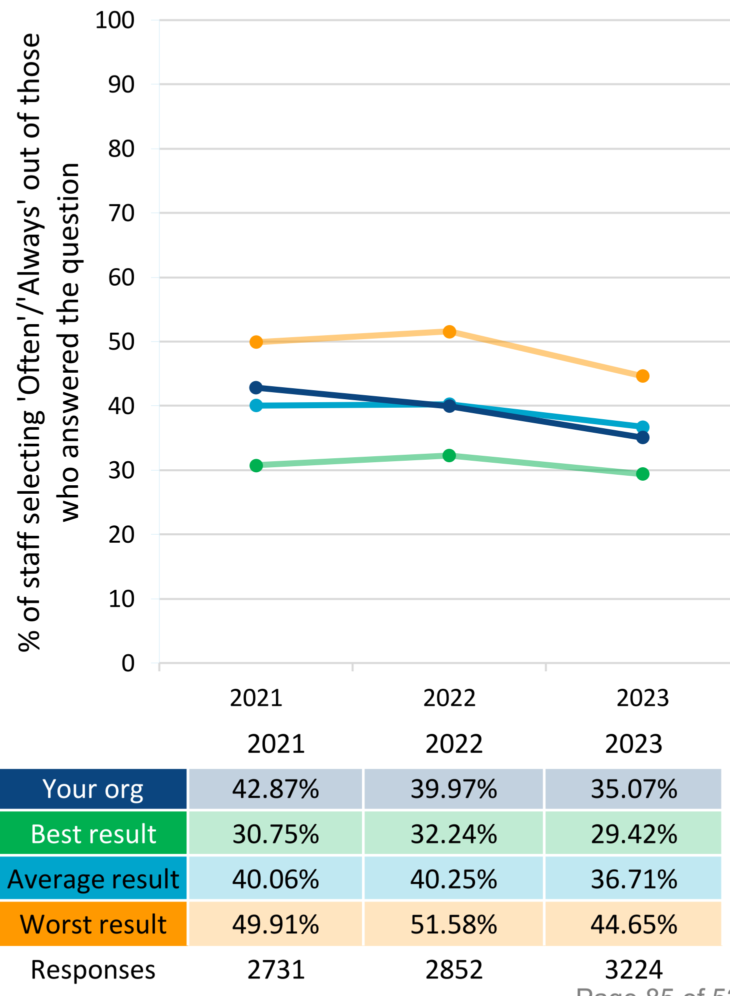
	2021	2022	2023
Your org	39.41%	36.83%	31.39%
Best result	31.73%	30.99%	27.56%
Average result	37.97%	37.10%	34.03%
Worst result	43.72%	44.49%	40.14%
Responses	2737	2848	3224

Q12b How often, if at all, do you feel burnt out because of your work?



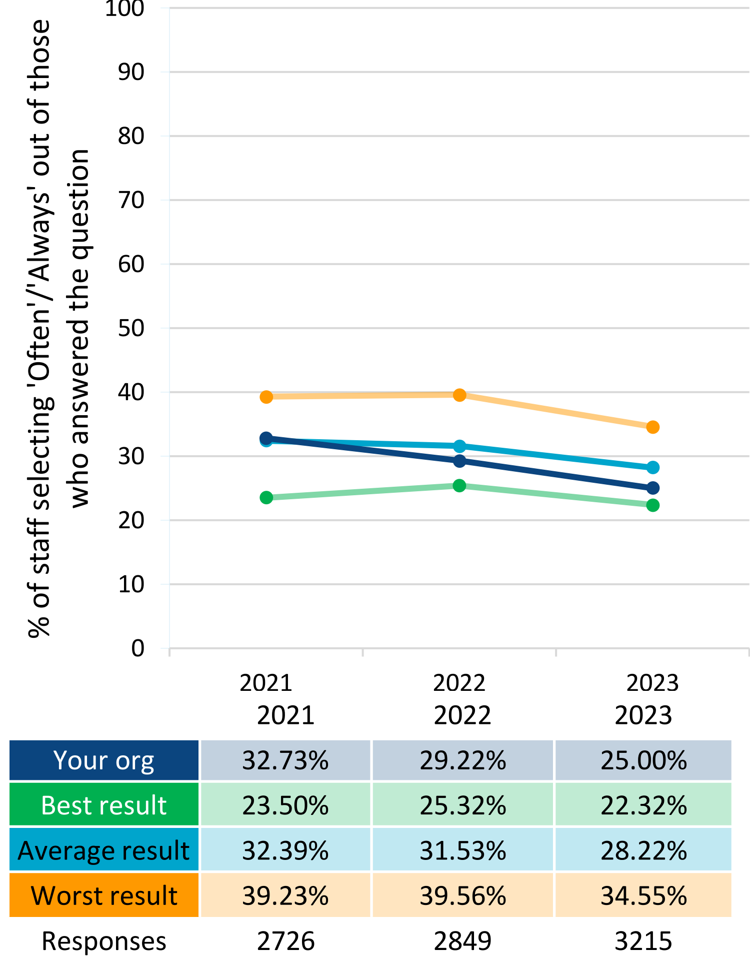
	2021	2022	2023
Your org	37.40%	33.77%	28.00%
Best result	28.30%	27.84%	24.64%
Average result	35.39%	34.77%	31.12%
Worst result	43.56%	41.98%	37.54%
Responses	2734	2849	3225

Q12c How often, if at all, does your work frustrate you?



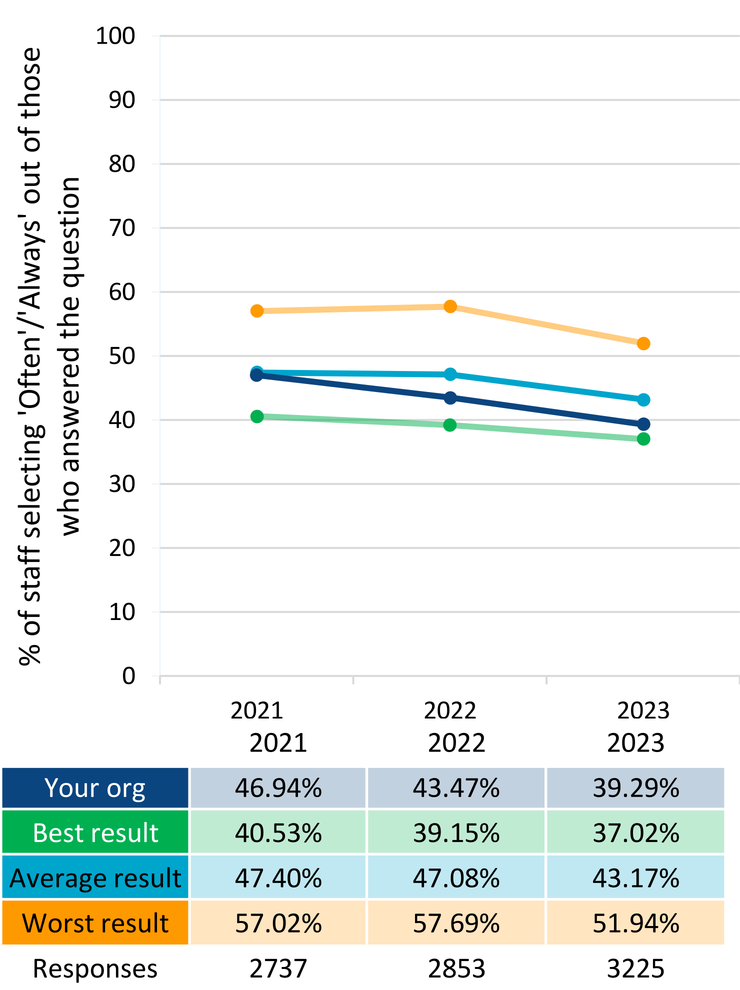
	2021	2022	2023
Your org	42.87%	39.97%	35.07%
Best result	30.75%	32.24%	29.42%
Average result	40.06%	40.25%	36.71%
Worst result	49.91%	51.58%	44.65%
Responses	2731	2852	3224

Q12d How often, if at all, are you exhausted at the thought of another day/shift at work?



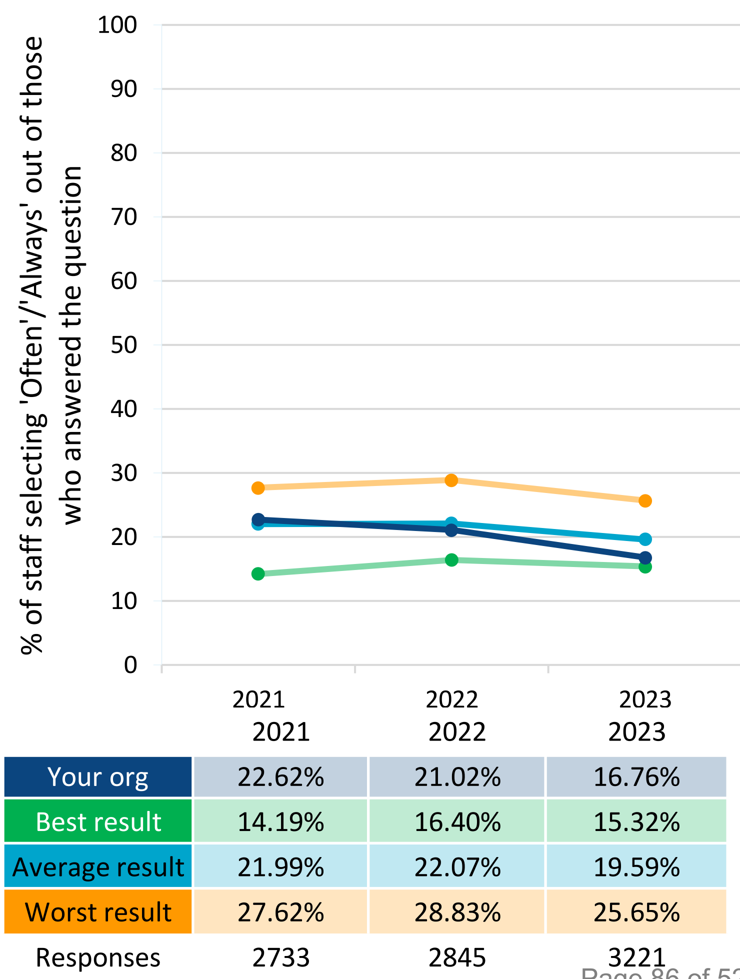
	2021	2022	2023
Your org	32.73%	29.22%	25.00%
Best result	23.50%	25.32%	22.32%
Average result	32.39%	31.53%	28.22%
Worst result	39.23%	39.56%	34.55%
Responses	2726	2849	3215

Q12e How often, if at all, do you feel worn out at the end of your working day/shift?

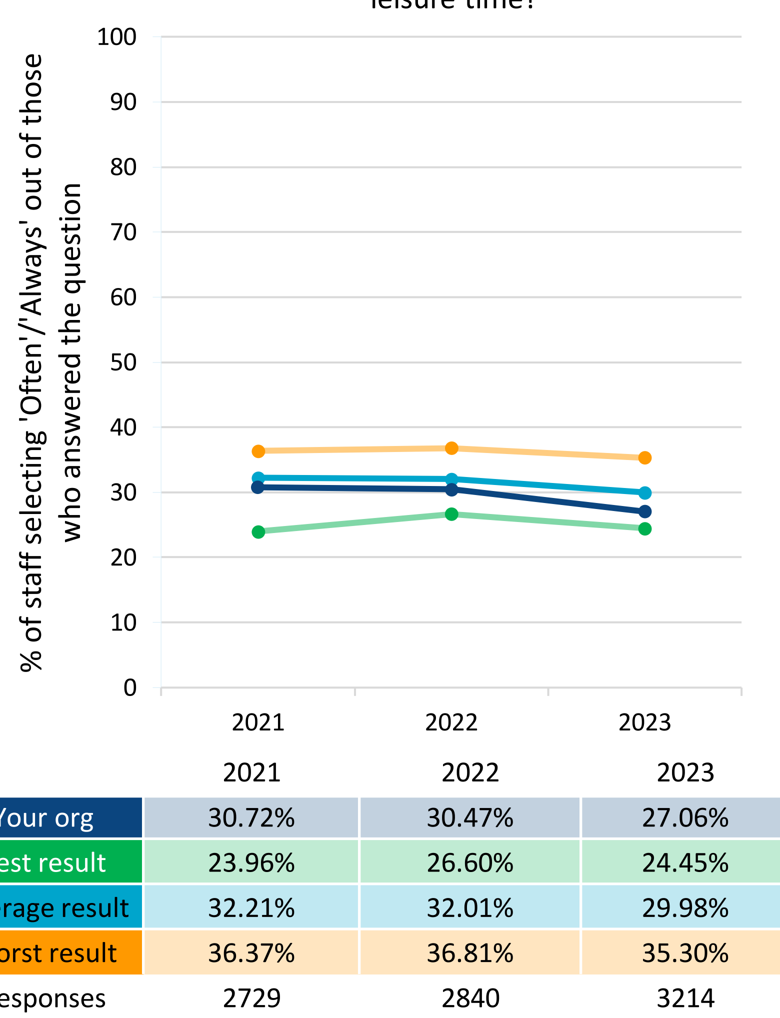


	2021	2022	2023
Your org	46.94%	43.47%	39.29%
Best result	40.53%	39.15%	37.02%
Average result	47.40%	47.08%	43.17%
Worst result	57.02%	57.69%	51.94%
Responses	2737	2853	3225

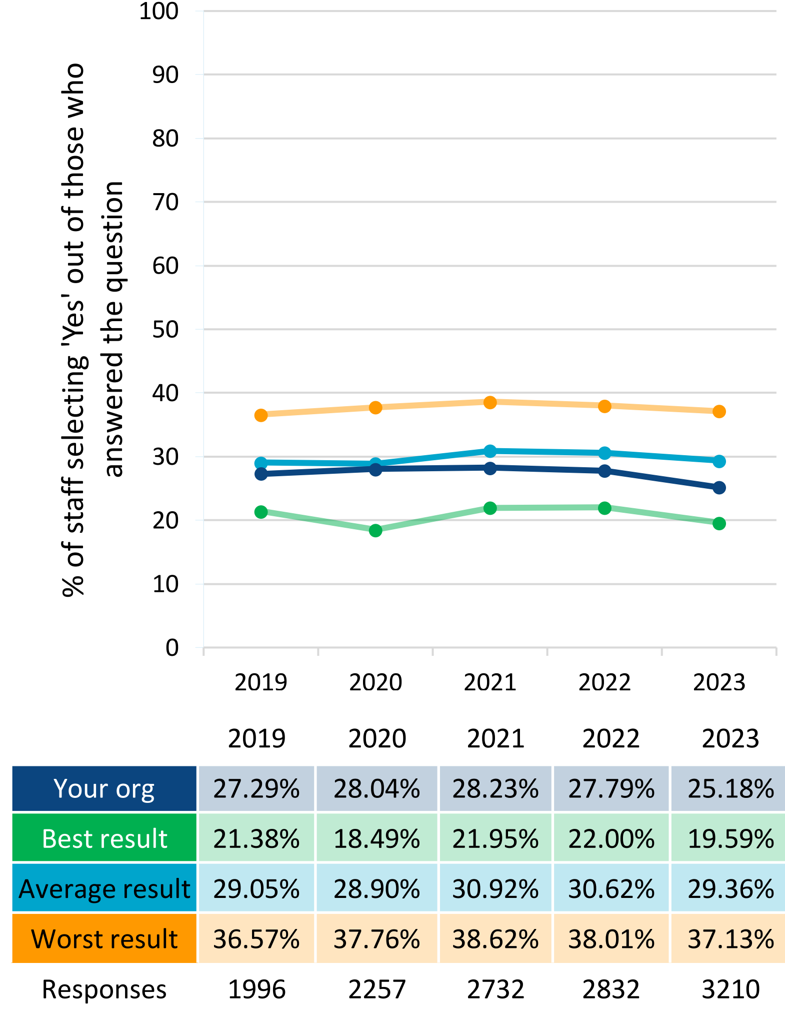
Q12f How often, if at all, do you feel that every working hour is tiring for you?



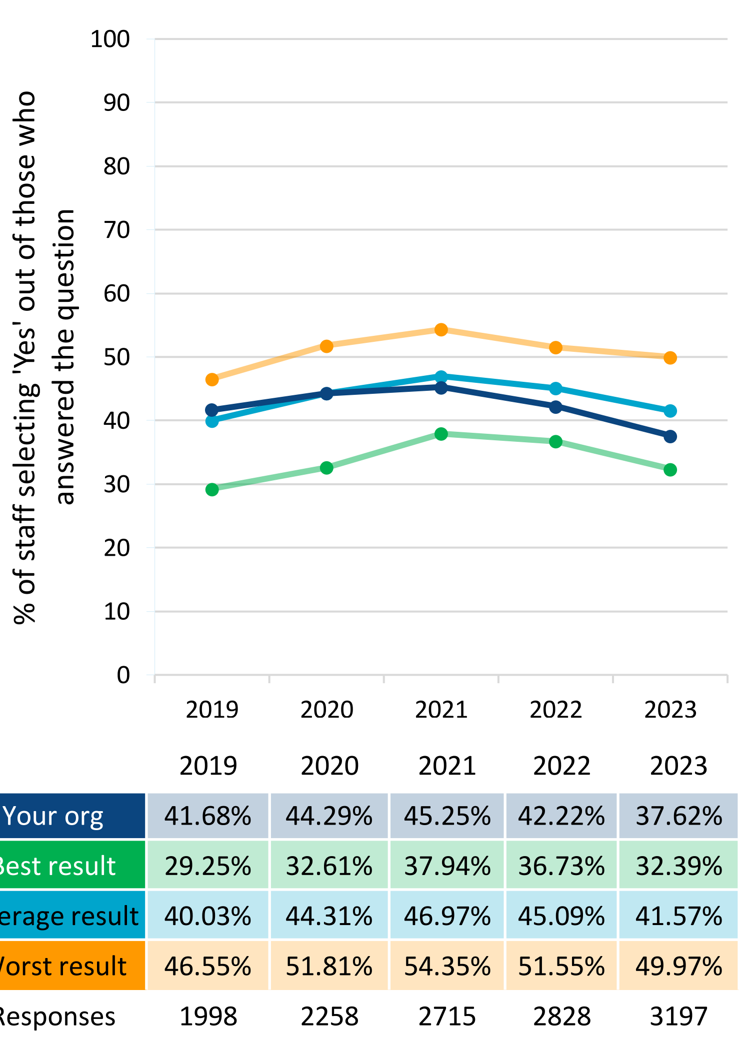
	2021	2022	2023
Your org	22.62%	21.02%	16.76%
Best result	14.19%	16.40%	15.32%
Average result	21.99%	22.07%	19.59%
Worst result	27.62%	28.83%	25.65%
Responses	2733	2845	3221



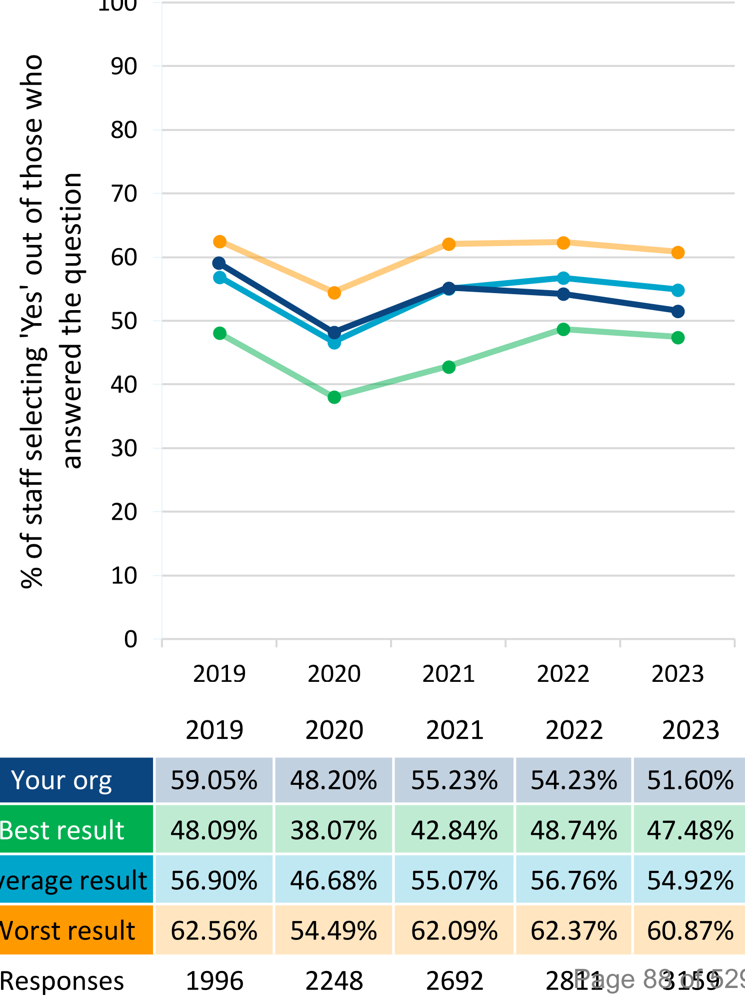
	2021	2022	2023
Your org	30.72%	30.47%	27.06%
Best result	23.96%	26.60%	24.45%
Average result	32.21%	32.01%	29.98%
Worst result	36.37%	36.81%	35.30%
Responses	2729	2840	3214



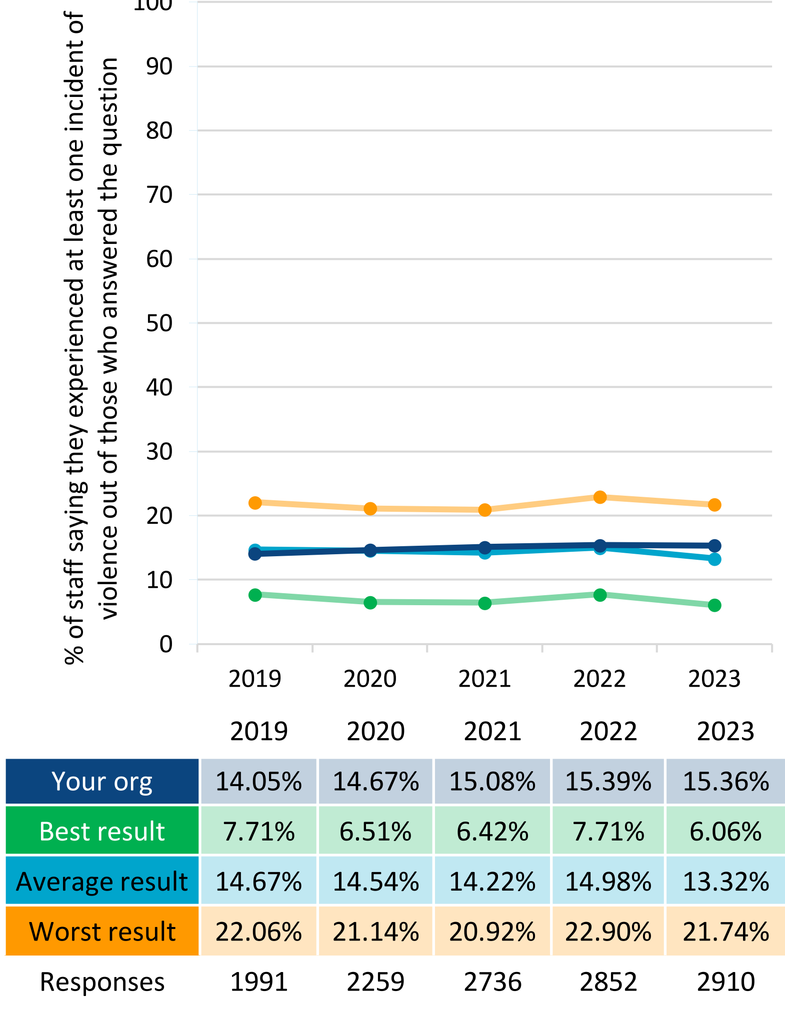
	2019	2020	2021	2022	2023
Your org	27.29%	28.04%	28.23%	27.79%	25.18%
Best result	21.38%	18.49%	21.95%	22.00%	19.59%
Average result	29.05%	28.90%	30.92%	30.62%	29.36%
Worst result	36.57%	37.76%	38.62%	38.01%	37.13%
Responses	1996	2257	2732	2832	3210



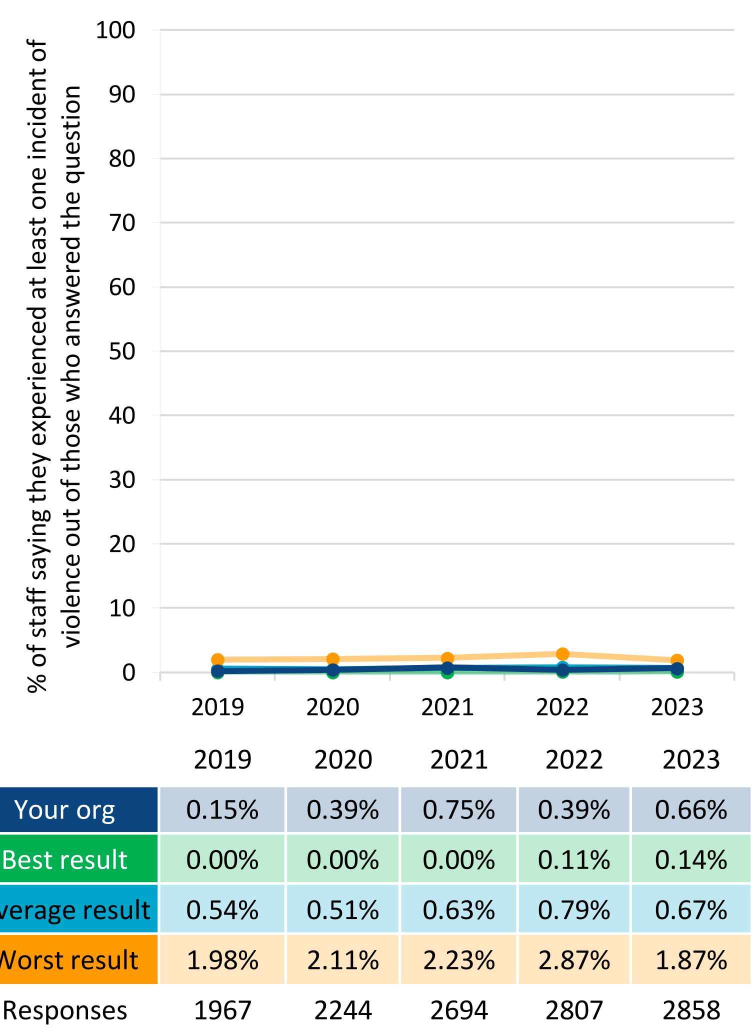
	2019	2020	2021	2022	2023
Your org	41.68%	44.29%	45.25%	42.22%	37.62%
Best result	29.25%	32.61%	37.94%	36.73%	32.39%
Average result	40.03%	44.31%	46.97%	45.09%	41.57%
Worst result	46.55%	51.81%	54.35%	51.55%	49.97%
Responses	1998	2258	2715	2828	3197



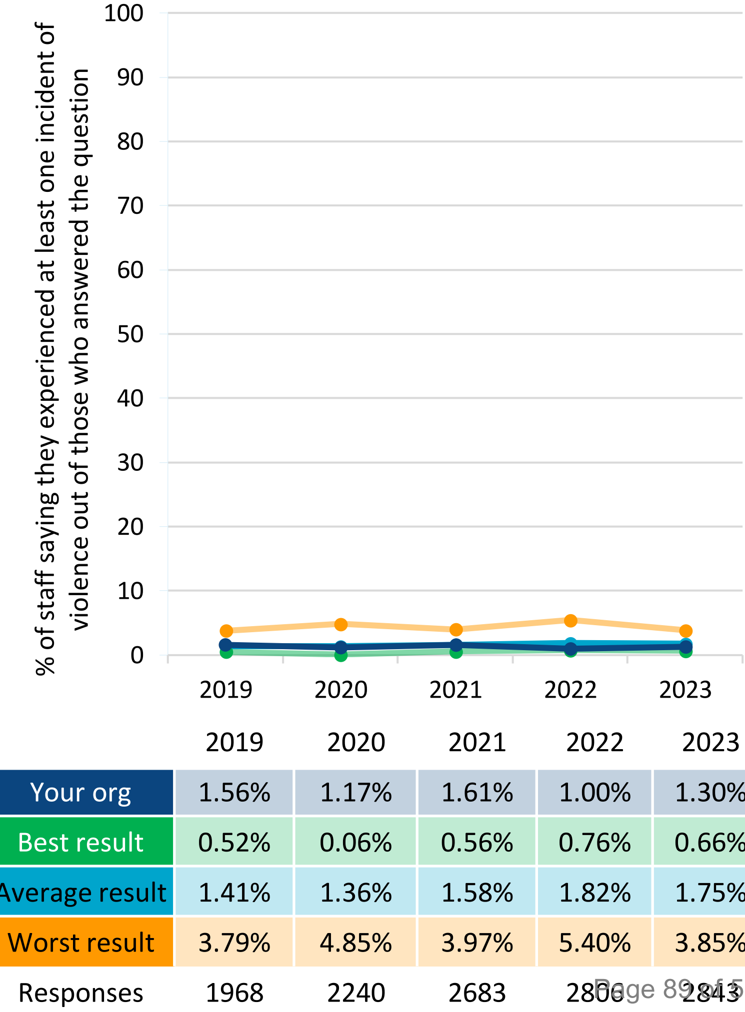
	2019	2020	2021	2022	2023
Your org	59.05%	48.20%	55.23%	54.23%	51.60%
Best result	48.09%	38.07%	42.84%	48.74%	47.48%
Average result	56.90%	46.68%	55.07%	56.76%	54.92%
Worst result	62.56%	54.49%	62.09%	62.37%	60.87%
Responses	1996	2248	2692	2811	3159



	2019	2020	2021	2022	2023
Your org	14.05%	14.67%	15.08%	15.39%	15.36%
Best result	7.71%	6.51%	6.42%	7.71%	6.06%
Average result	14.67%	14.54%	14.22%	14.98%	13.32%
Worst result	22.06%	21.14%	20.92%	22.90%	21.74%
Responses	1991	2259	2736	2852	2910

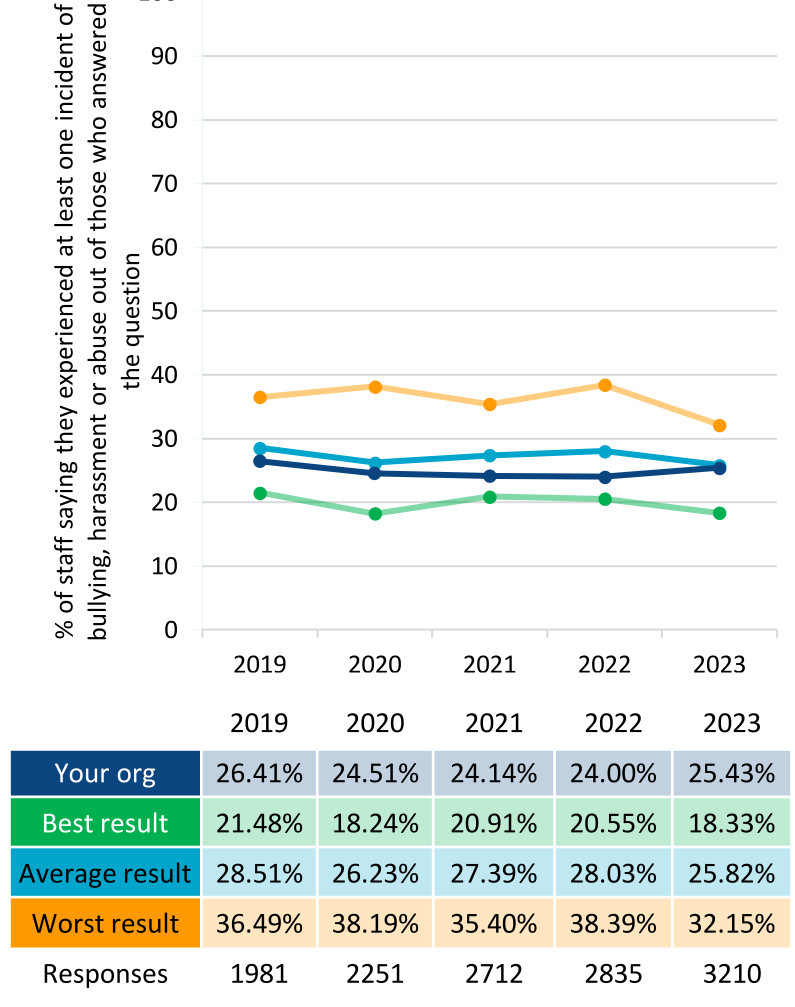


	2019	2020	2021	2022	2023
Your org	0.15%	0.39%	0.75%	0.39%	0.66%
Best result	0.00%	0.00%	0.00%	0.11%	0.14%
Average result	0.54%	0.51%	0.63%	0.79%	0.67%
Worst result	1.98%	2.11%	2.23%	2.87%	1.87%
Responses	1967	2244	2694	2807	2858



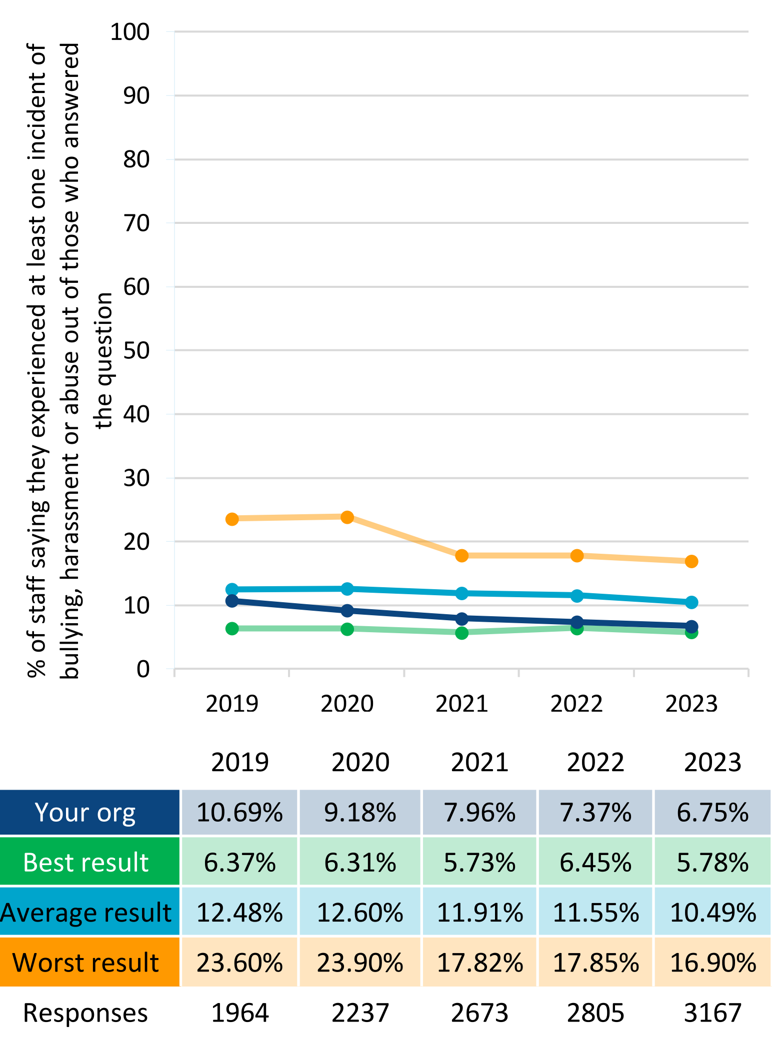
	2019	2020	2021	2022	2023
Your org	1.56%	1.17%	1.61%	1.00%	1.30%
Best result	0.52%	0.06%	0.56%	0.76%	0.66%
Average result	1.41%	1.36%	1.58%	1.82%	1.75%
Worst result	3.79%	4.85%	3.97%	5.40%	3.85%
Responses	1968	2240	2683	2806	2843

Q14a In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? Patients / service users, their relatives or other members of the public.



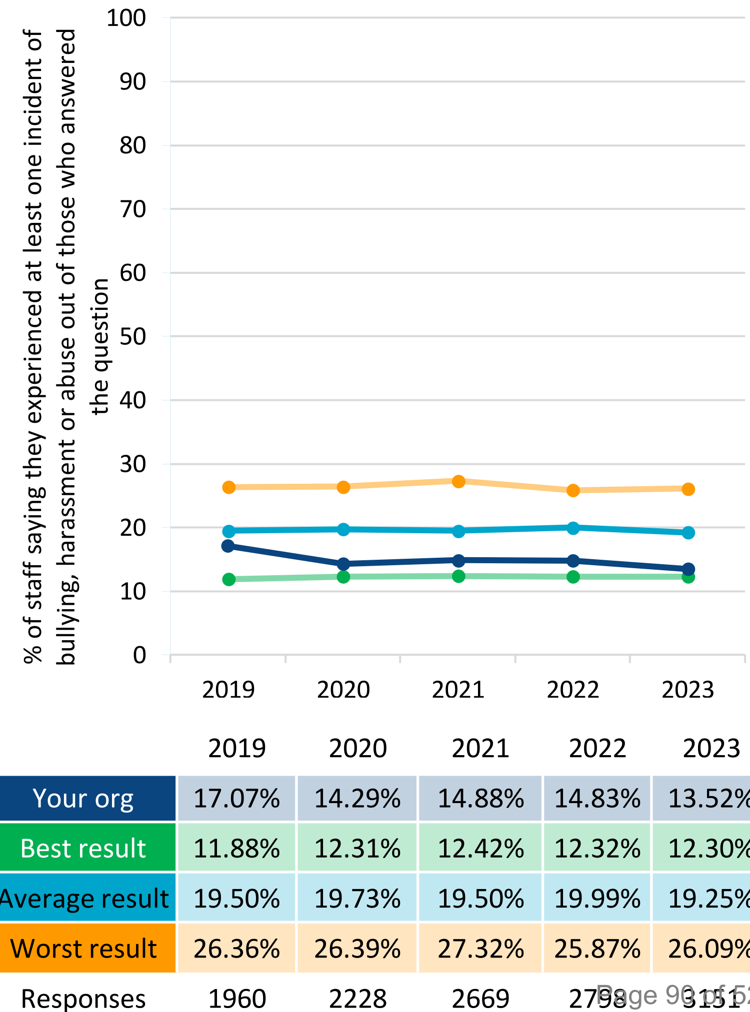
	2019	2020	2021	2022	2023
Your org	26.41%	24.51%	24.14%	24.00%	25.43%
Best result	21.48%	18.24%	20.91%	20.55%	18.33%
Average result	28.51%	26.23%	27.39%	28.03%	25.82%
Worst result	36.49%	38.19%	35.40%	38.39%	32.15%
Responses	1981	2251	2712	2835	3210

Q14b In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? Managers.

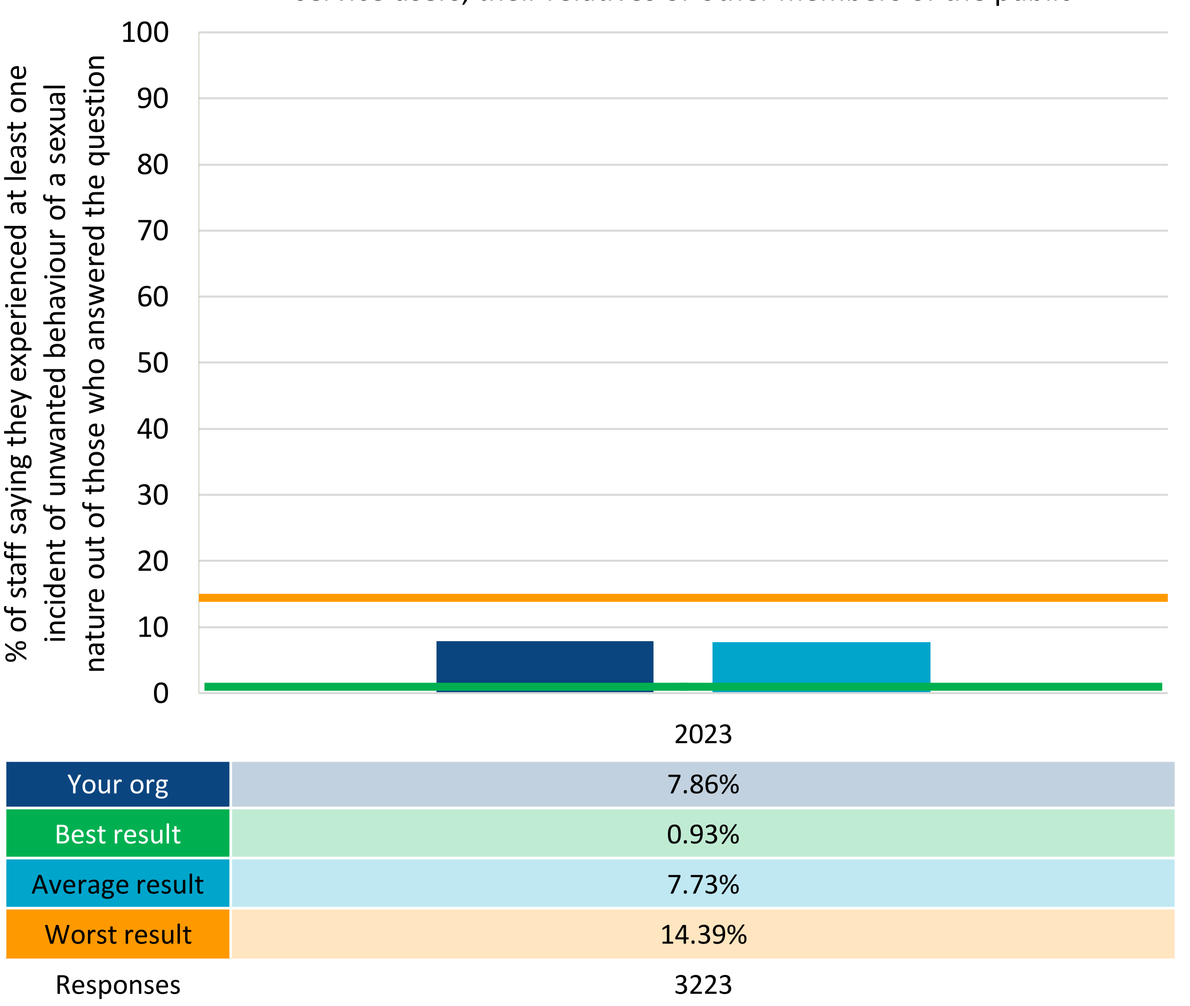


	2019	2020	2021	2022	2023
Your org	10.69%	9.18%	7.96%	7.37%	6.75%
Best result	6.37%	6.31%	5.73%	6.45%	5.78%
Average result	12.48%	12.60%	11.91%	11.55%	10.49%
Worst result	23.60%	23.90%	17.82%	17.85%	16.90%
Responses	1964	2237	2673	2805	3167

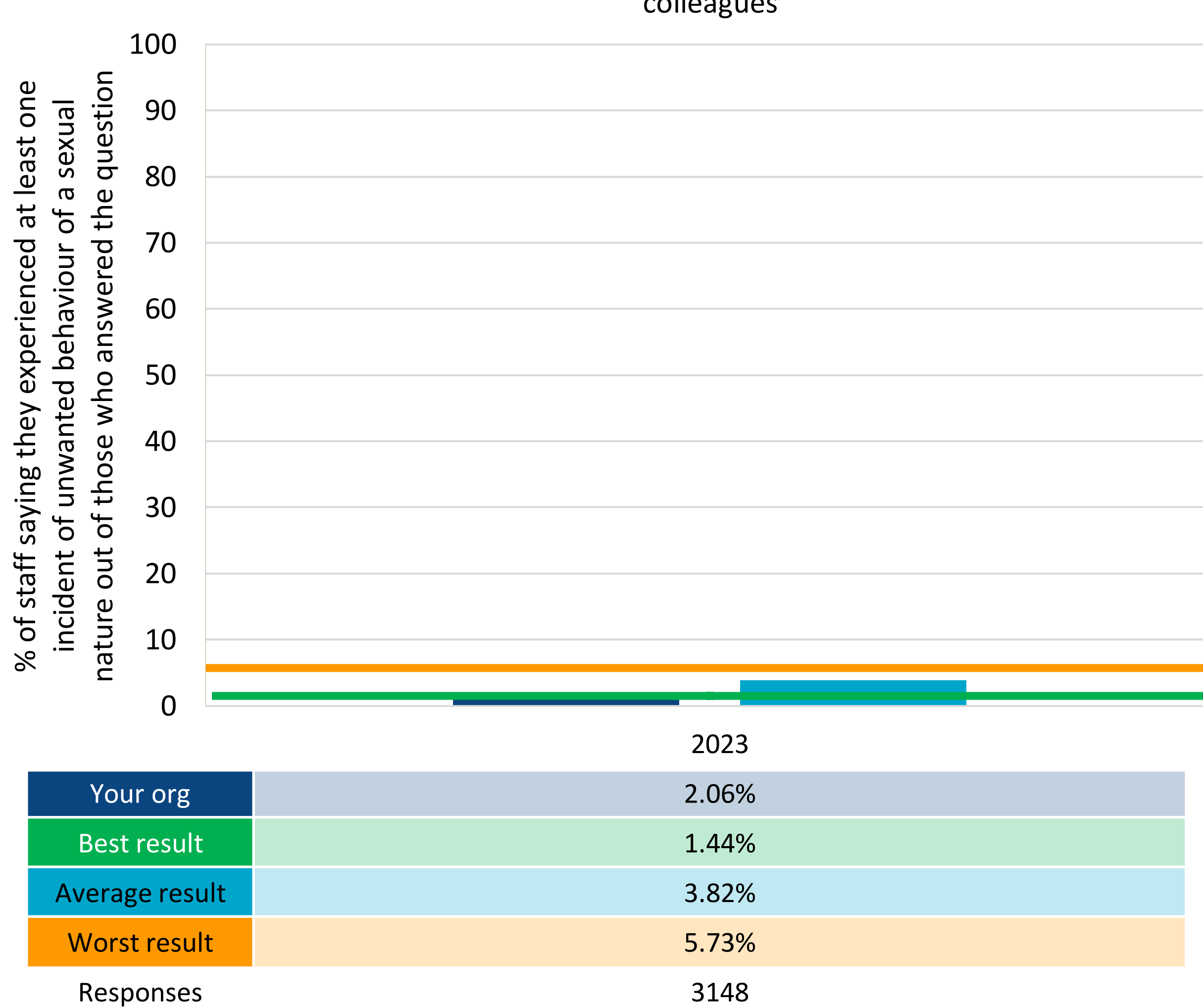
Q14c In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? Other colleagues.



	2019	2020	2021	2022	2023
Your org	17.07%	14.29%	14.88%	14.83%	13.52%
Best result	11.88%	12.31%	12.42%	12.32%	12.30%
Average result	19.50%	19.73%	19.50%	19.99%	19.25%
Worst result	26.36%	26.39%	27.32%	25.87%	26.09%
Responses	1960	2228	2669	2798	3151

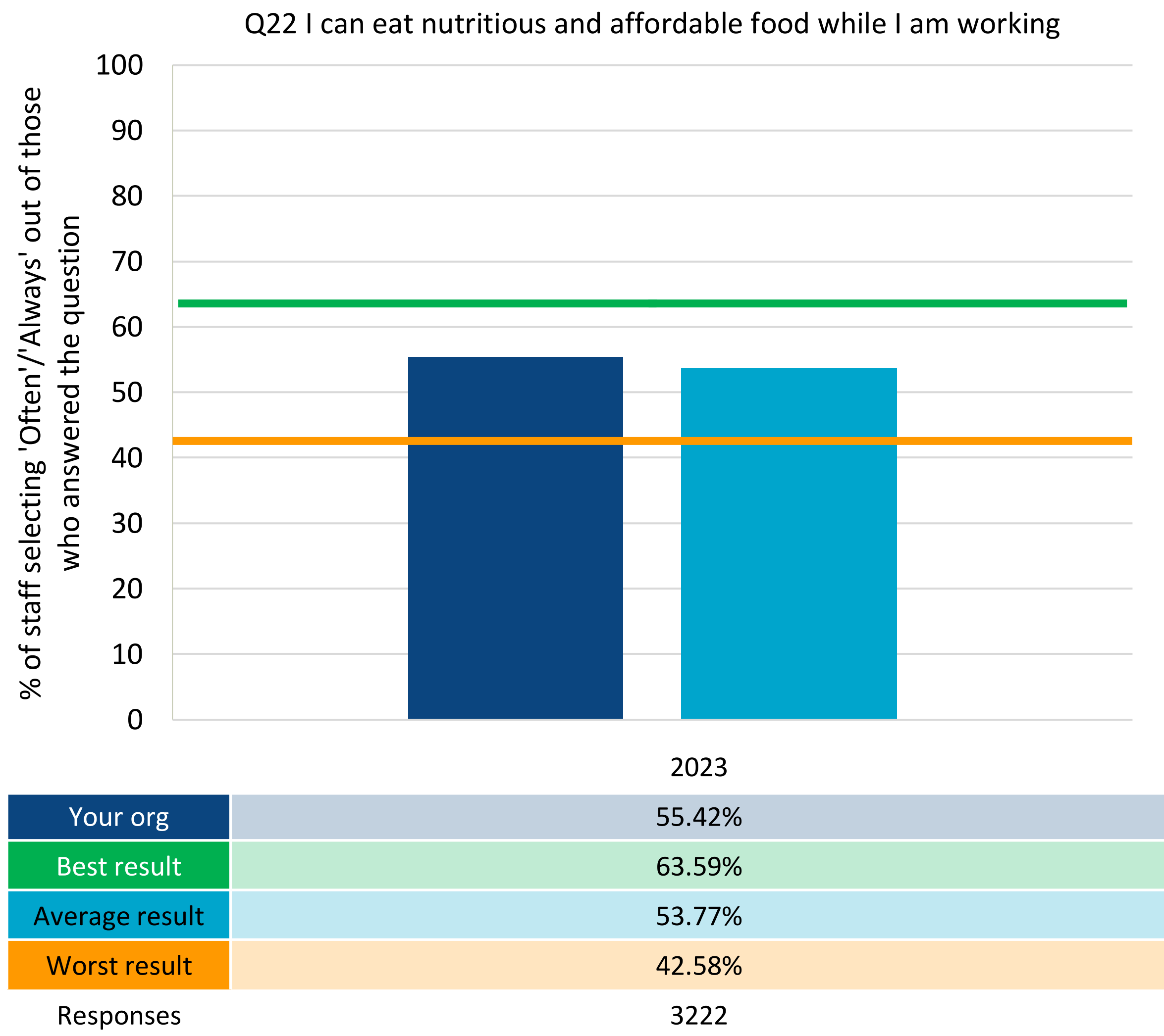


Your org	7.86%
Best result	0.93%
Average result	7.73%
Worst result	14.39%
Responses	3223



Your org	2.06%
Best result	1.44%
Average result	3.82%
Worst result	5.73%
Responses	3148

*These questions do not contribute towards any People Promise element score, theme score or sub-score

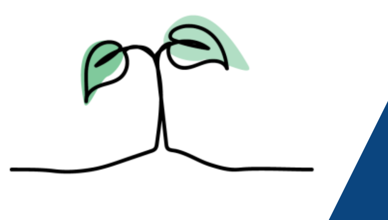


	2023
Your org	55.42%
Best result	63.59%
Average result	53.77%
Worst result	42.58%
Responses	3222

*These questions do not contribute towards any People Promise element score, theme score or sub-score

Survey Coordination Centre

People Promise element – We are always learning



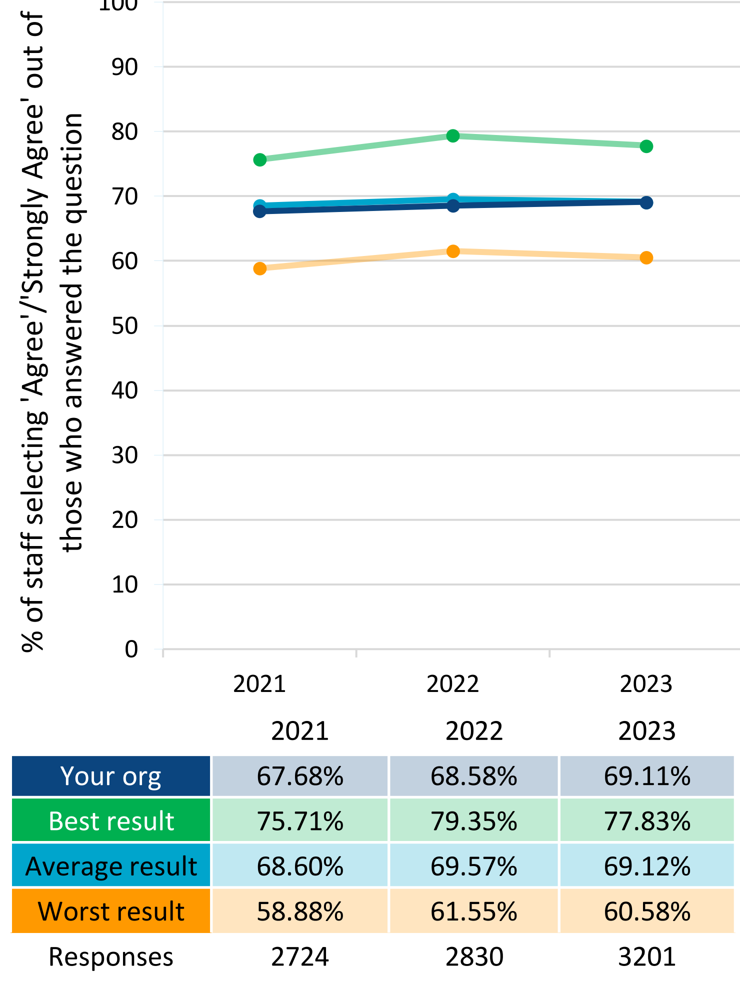
Questions included:

Development – Q24a, Q24b, Q24c, Q24d, Q24e

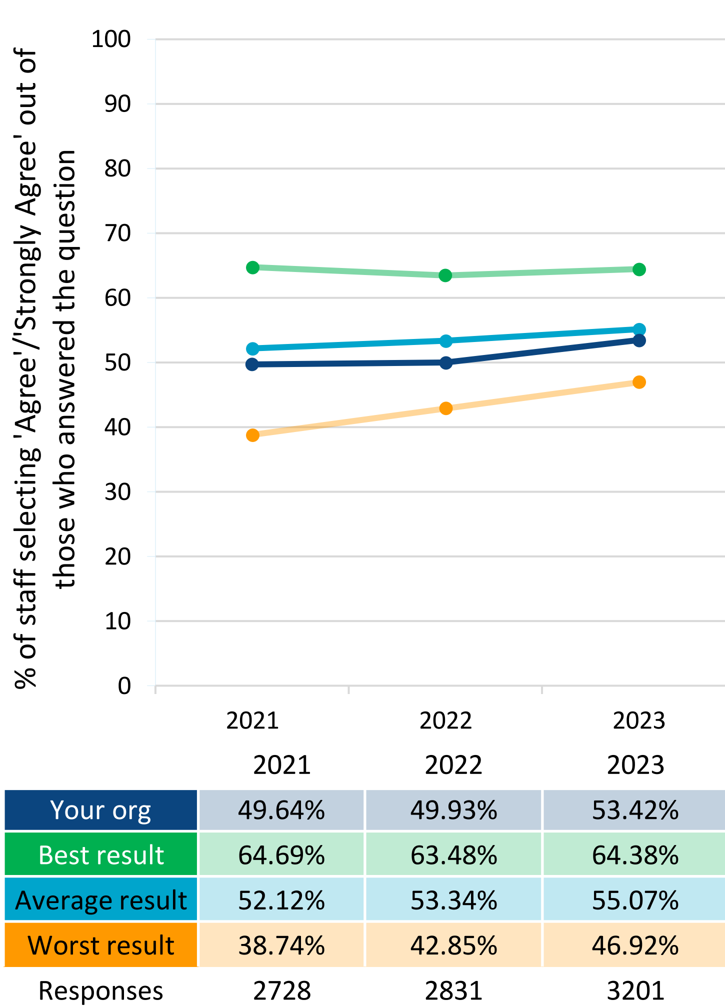
Appraisals – Q23a*, Q23b, Q23c, Q23d

*Q23a is a filter question and therefore influences the sub-score without being a directly scored question.

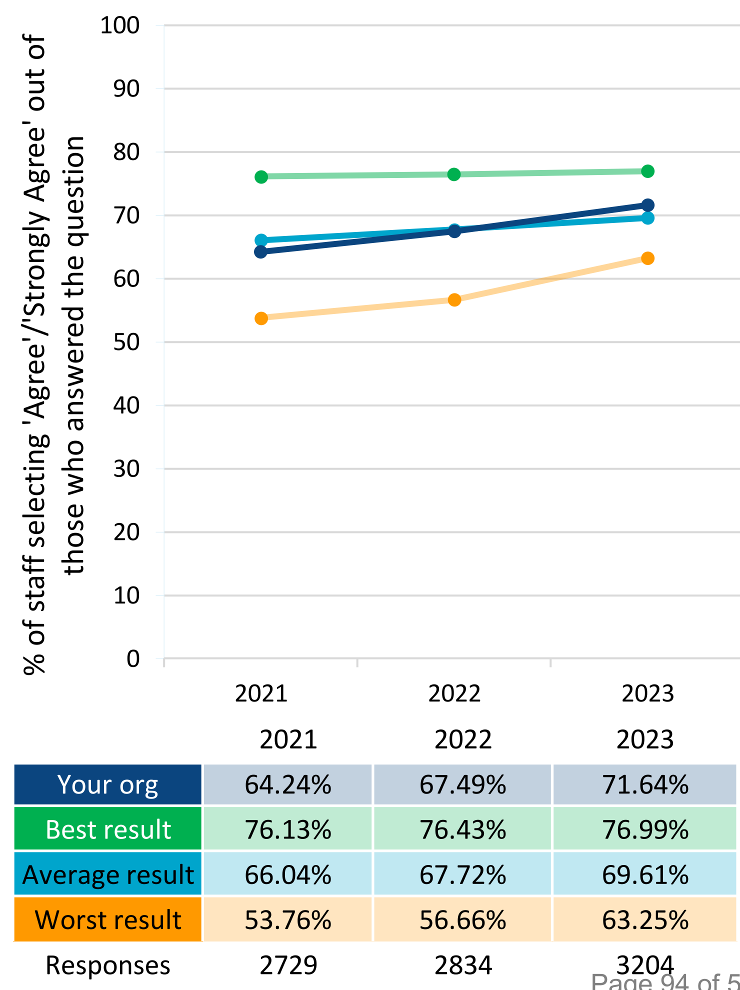
Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.



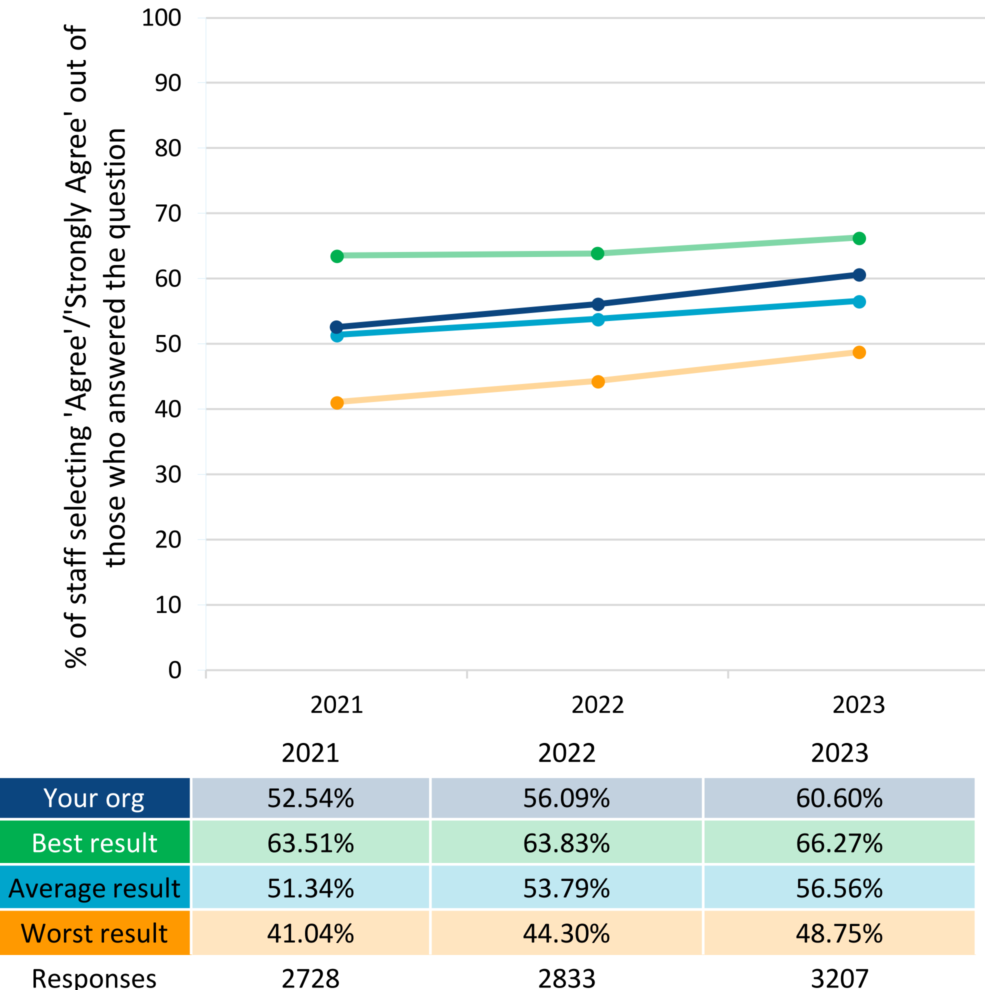
	2021	2022	2023
Your org	67.68%	68.58%	69.11%
Best result	75.71%	79.35%	77.83%
Average result	68.60%	69.57%	69.12%
Worst result	58.88%	61.55%	60.58%
Responses	2724	2830	3201



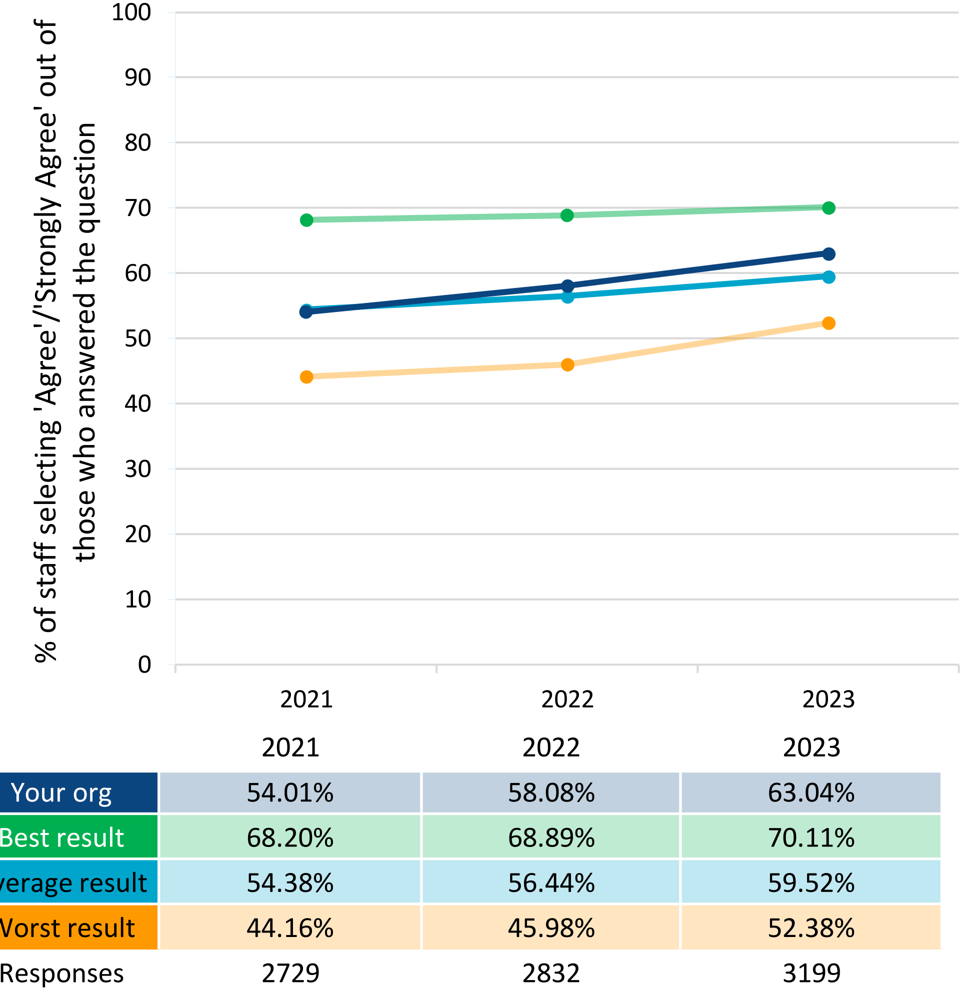
	2021	2022	2023
Your org	49.64%	49.93%	53.42%
Best result	64.69%	63.48%	64.38%
Average result	52.12%	53.34%	55.07%
Worst result	38.74%	42.85%	46.92%
Responses	2728	2831	3201



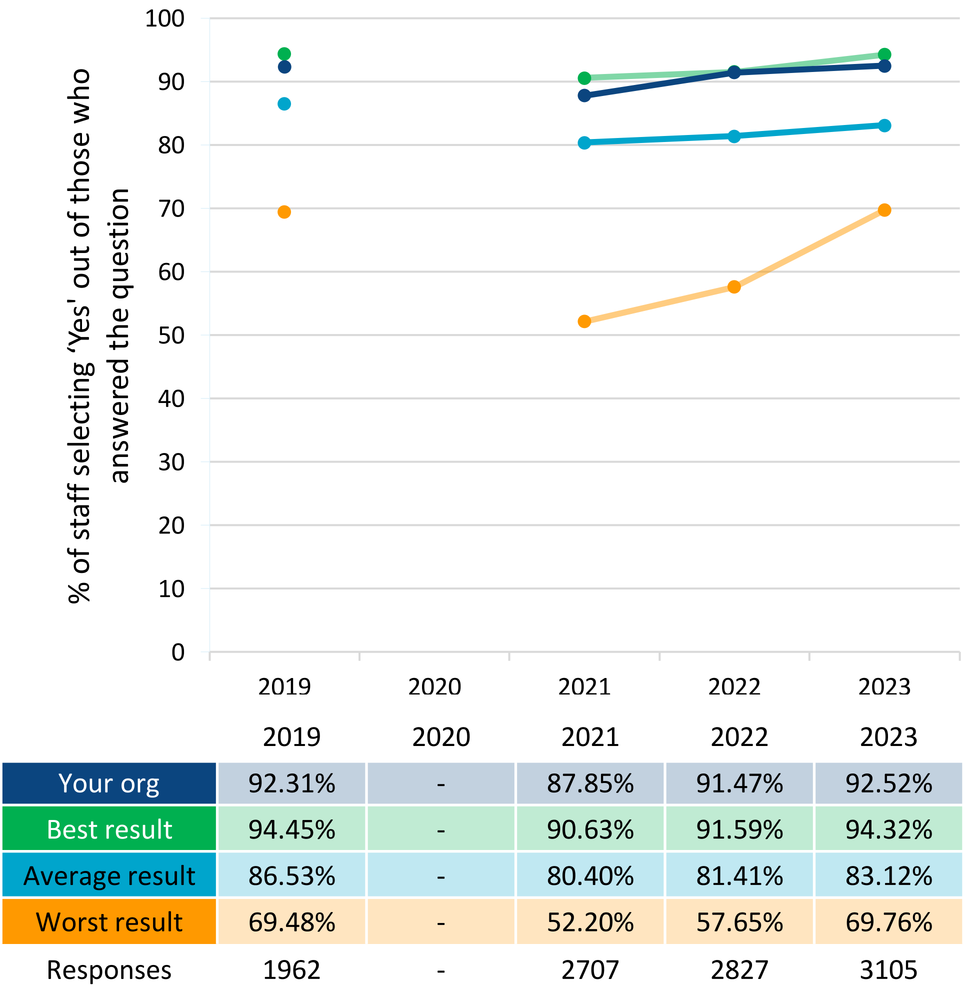
	2021	2022	2023
Your org	64.24%	67.49%	71.64%
Best result	76.13%	76.43%	76.99%
Average result	66.04%	67.72%	69.61%
Worst result	53.76%	56.66%	63.25%
Responses	2729	2834	3204



	2021	2022	2023
Your org	52.54%	56.09%	60.60%
Best result	63.51%	63.83%	66.27%
Average result	51.34%	53.79%	56.56%
Worst result	41.04%	44.30%	48.75%
Responses	2728	2833	3207

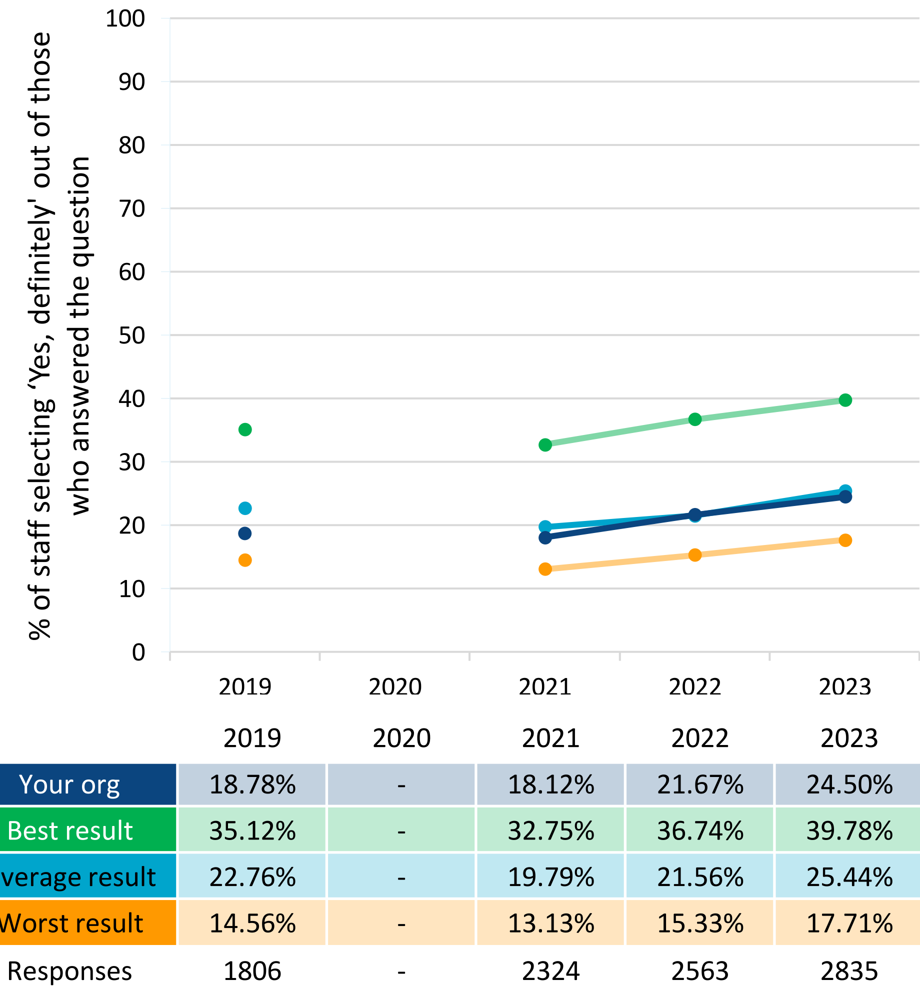


	2021	2022	2023
Your org	54.01%	58.08%	63.04%
Best result	68.20%	68.89%	70.11%
Average result	54.38%	56.44%	59.52%
Worst result	44.16%	45.98%	52.38%
Responses	2729	2832	3199



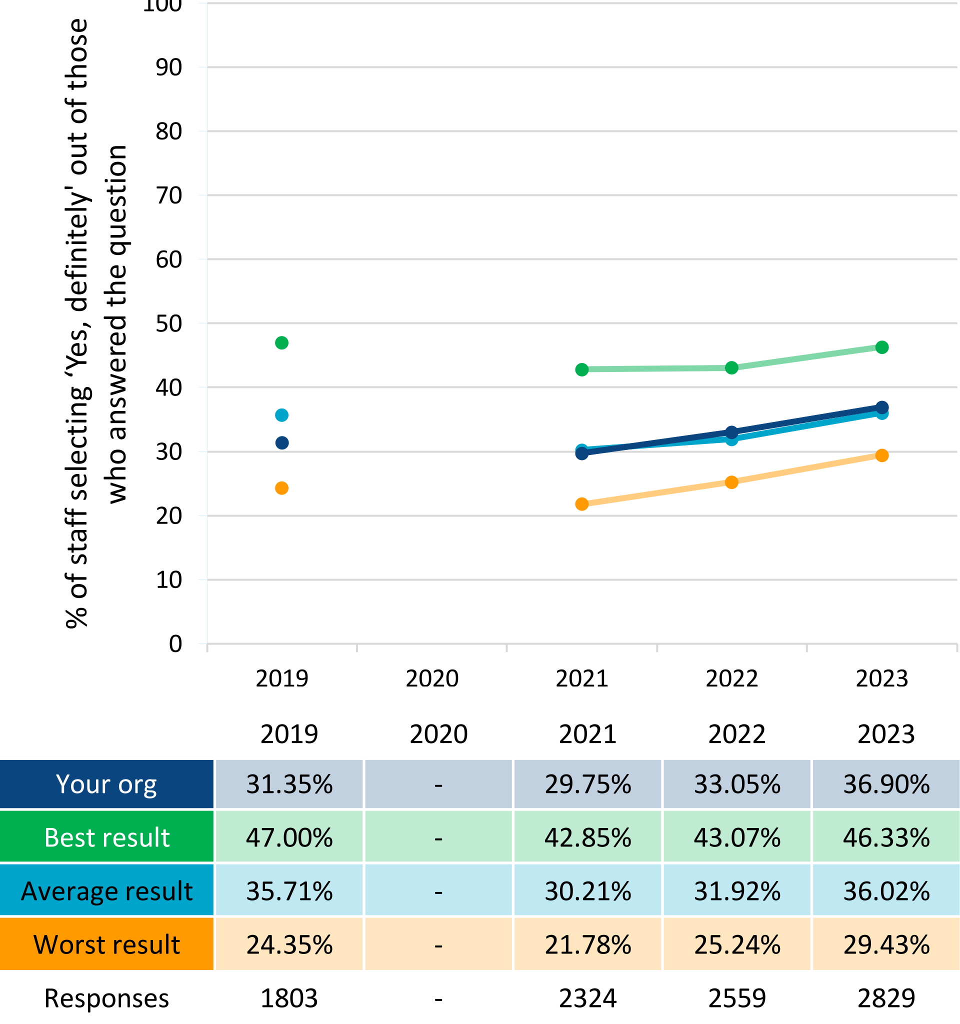
	2019	2020	2021	2022	2023
Your org	92.31%	-	87.85%	91.47%	92.52%
Best result	94.45%	-	90.63%	91.59%	94.32%
Average result	86.53%	-	80.40%	81.41%	83.12%
Worst result	69.48%	-	52.20%	57.65%	69.76%
Responses	1962	-	2707	2827	3105

*Q23a is a filter question and therefore influences the sub-score without being a directly scored question.



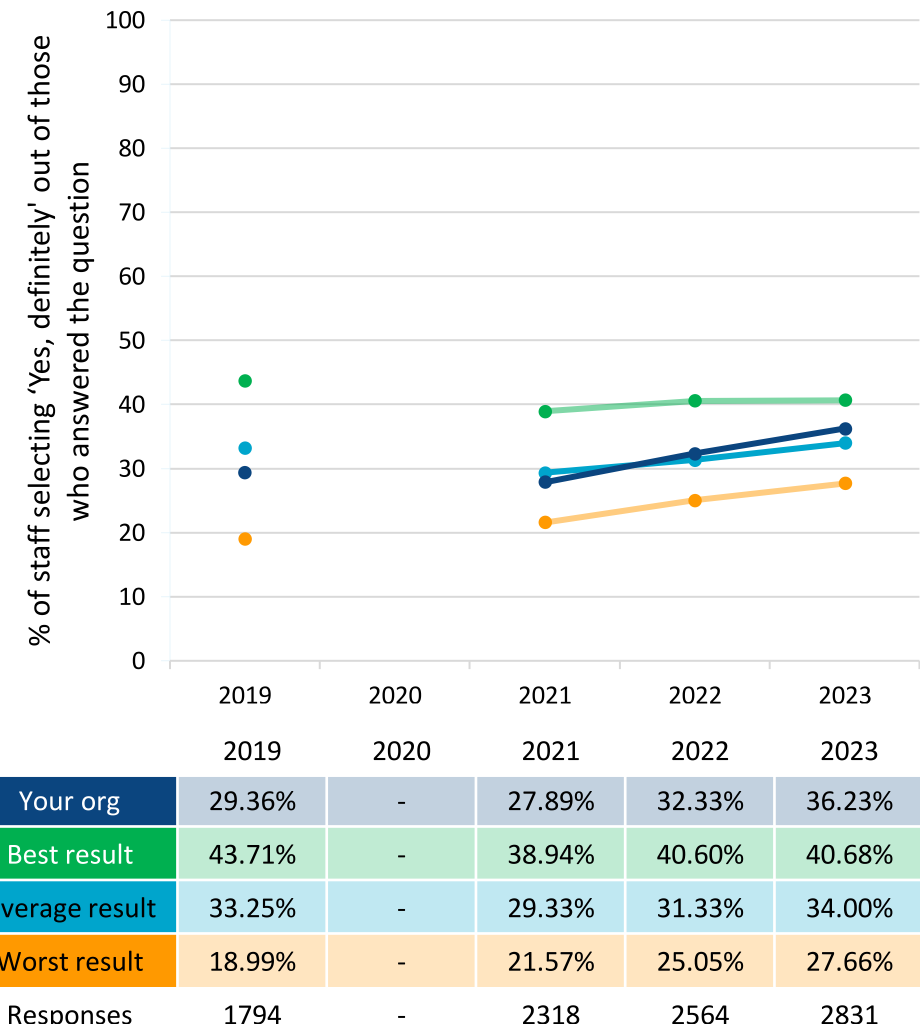
	2019	2020	2021	2022	2023
Your org	18.78%	-	18.12%	21.67%	24.50%
Best result	35.12%	-	32.75%	36.74%	39.78%
Average result	22.76%	-	19.79%	21.56%	25.44%
Worst result	14.56%	-	13.13%	15.33%	17.71%
Responses	1806	-	2324	2563	2835

Q23c It helped me agree clear objectives for my work.



	2019	2020	2021	2022	2023
Your org	31.35%	-	29.75%	33.05%	36.90%
Best result	47.00%	-	42.85%	43.07%	46.33%
Average result	35.71%	-	30.21%	31.92%	36.02%
Worst result	24.35%	-	21.78%	25.24%	29.43%
Responses	1803	-	2324	2559	2829

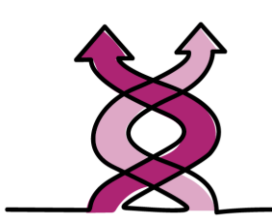
Q23d It left me feeling that my work is valued by my organisation.



	2019	2020	2021	2022	2023
Your org	29.36%	-	27.89%	32.33%	36.23%
Best result	43.71%	-	38.94%	40.60%	40.68%
Average result	33.25%	-	29.33%	31.33%	34.00%
Worst result	18.99%	-	21.57%	25.05%	27.66%
Responses	1794	-	2318	2564	2831

Survey Coordination Centre

People Promise element – We work flexibly

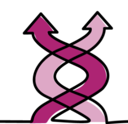


Questions included:

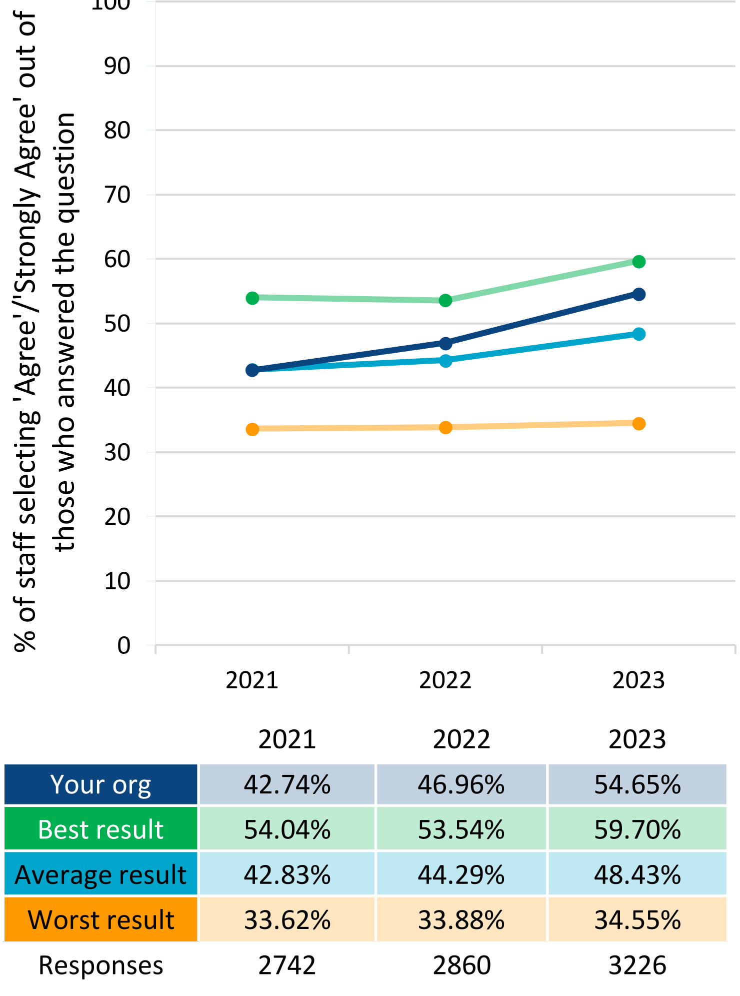
Support for work-life balance – Q6b, Q6c, Q6d

Flexible working – Q4d

Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

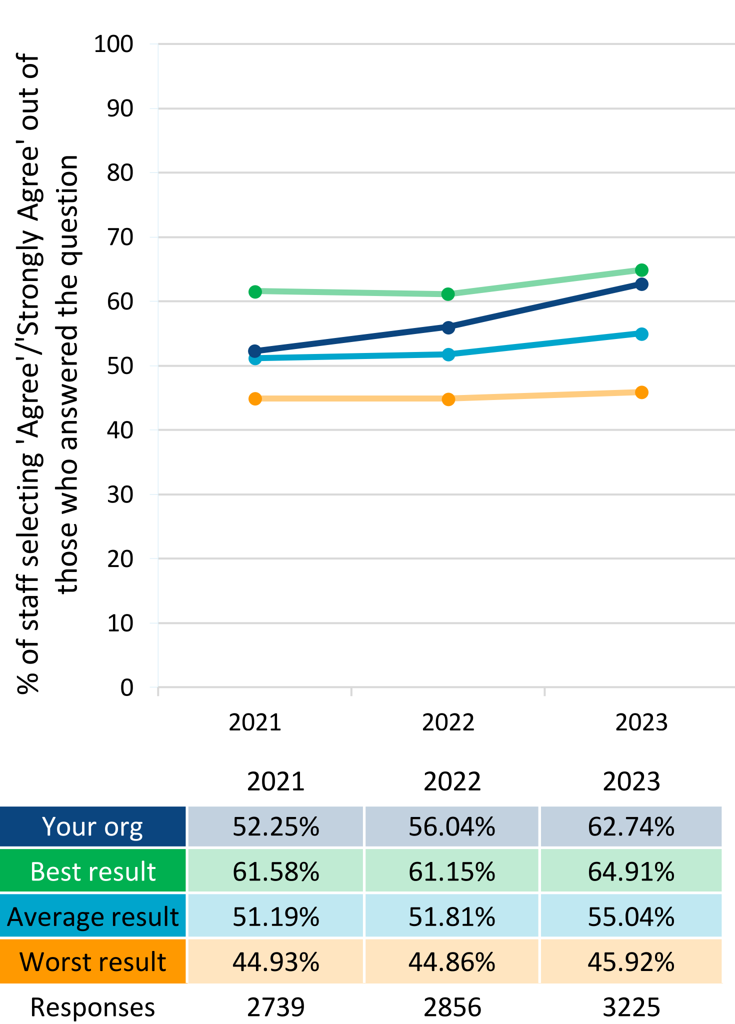


Q6b My organisation is committed to helping me balance my work and home life.



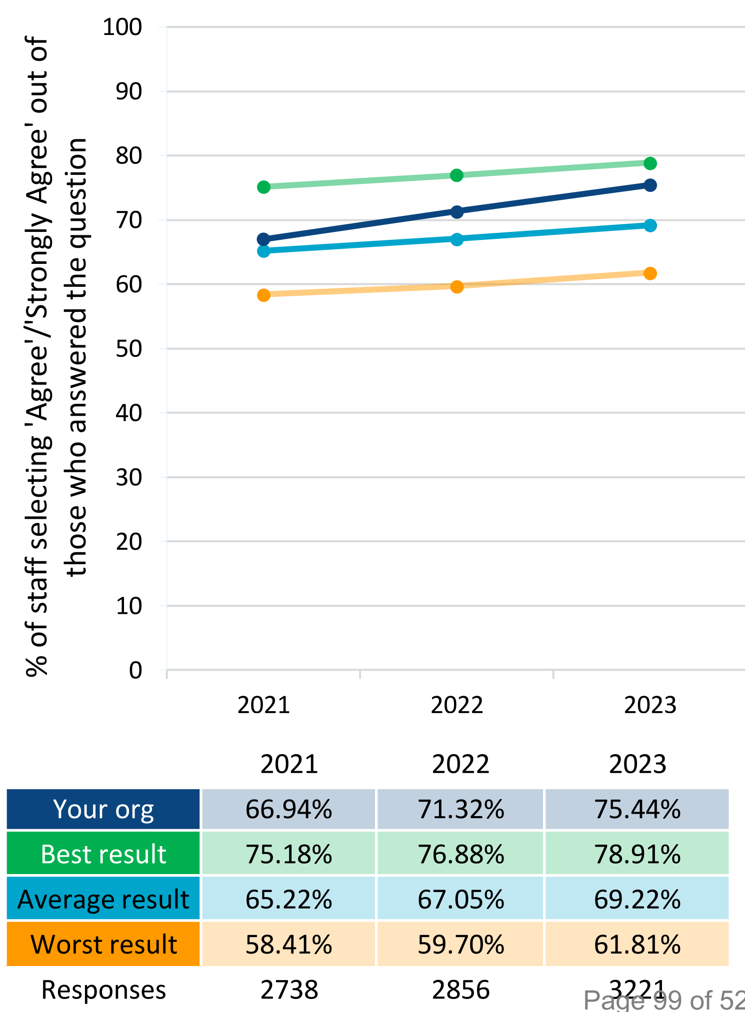
	2021	2022	2023
Your org	42.74%	46.96%	54.65%
Best result	54.04%	53.54%	59.70%
Average result	42.83%	44.29%	48.43%
Worst result	33.62%	33.88%	34.55%
Responses	2742	2860	3226

Q6c I achieve a good balance between my work life and my home life.

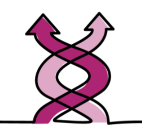


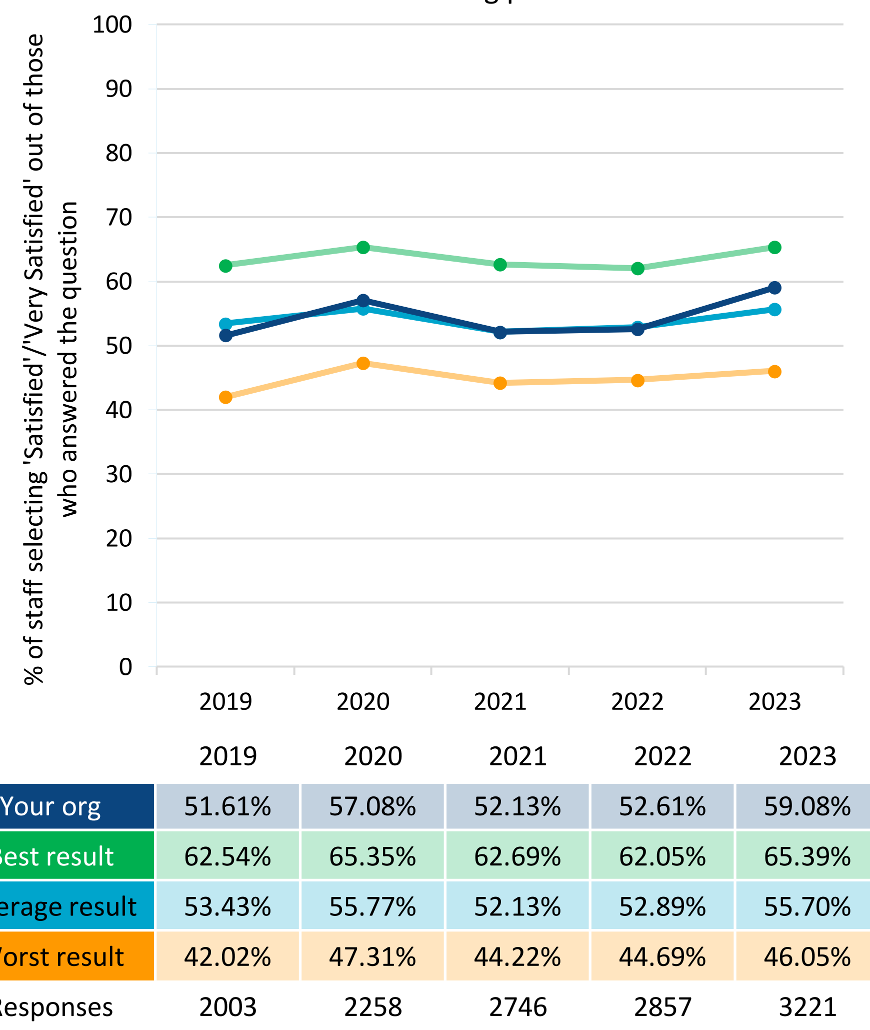
	2021	2022	2023
Your org	52.25%	56.04%	62.74%
Best result	61.58%	61.15%	64.91%
Average result	51.19%	51.81%	55.04%
Worst result	44.93%	44.86%	45.92%
Responses	2739	2856	3225

Q6d I can approach my immediate manager to talk openly about flexible working.



	2021	2022	2023
Your org	66.94%	71.32%	75.44%
Best result	75.18%	76.88%	78.91%
Average result	65.22%	67.05%	69.22%
Worst result	58.41%	59.70%	61.81%
Responses	2738	2856	3221

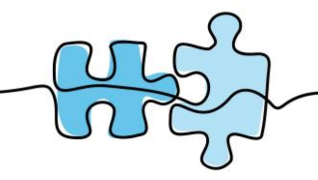




	2019	2020	2021	2022	2023
Your org	51.61%	57.08%	52.13%	52.61%	59.08%
Best result	62.54%	65.35%	62.69%	62.05%	65.39%
Average result	53.43%	55.77%	52.13%	52.89%	55.70%
Worst result	42.02%	47.31%	44.22%	44.69%	46.05%
Responses	2003	2258	2746	2857	3221

Survey Coordination Centre

People Promise element – We are a team

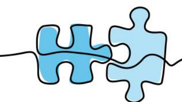


Questions included:

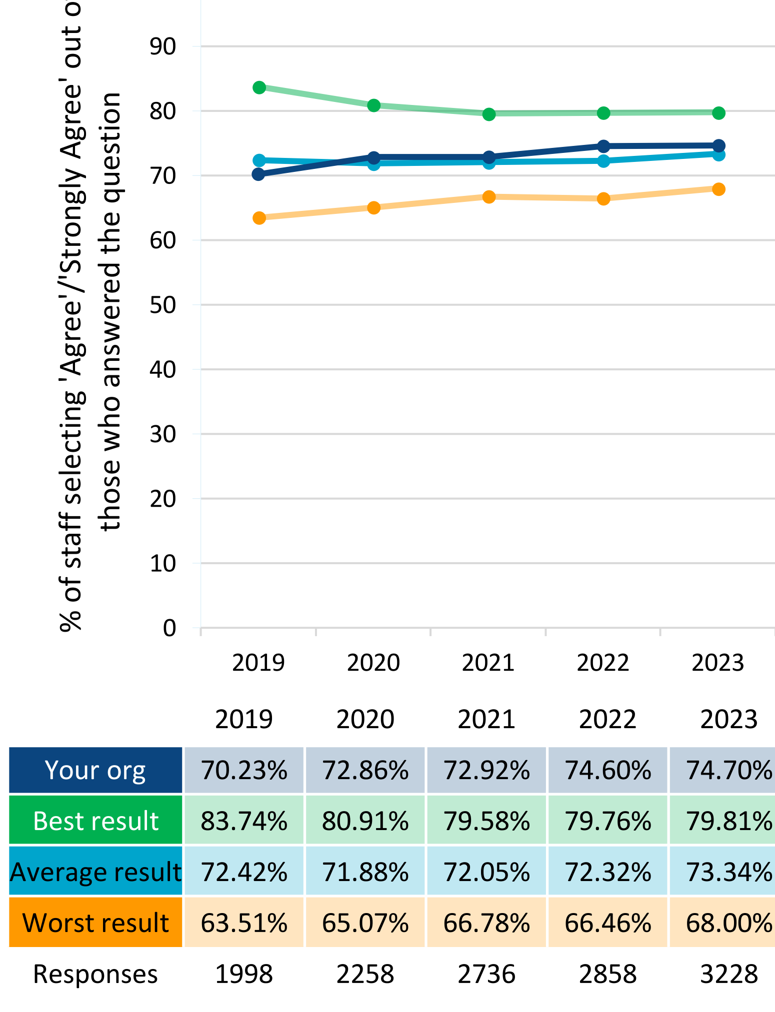
Team working – Q7a, Q7b, Q7c, Q7d, Q7e, Q7f, Q7g, Q8a

Line management – Q9a, Q9b, Q9c, Q9d

Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

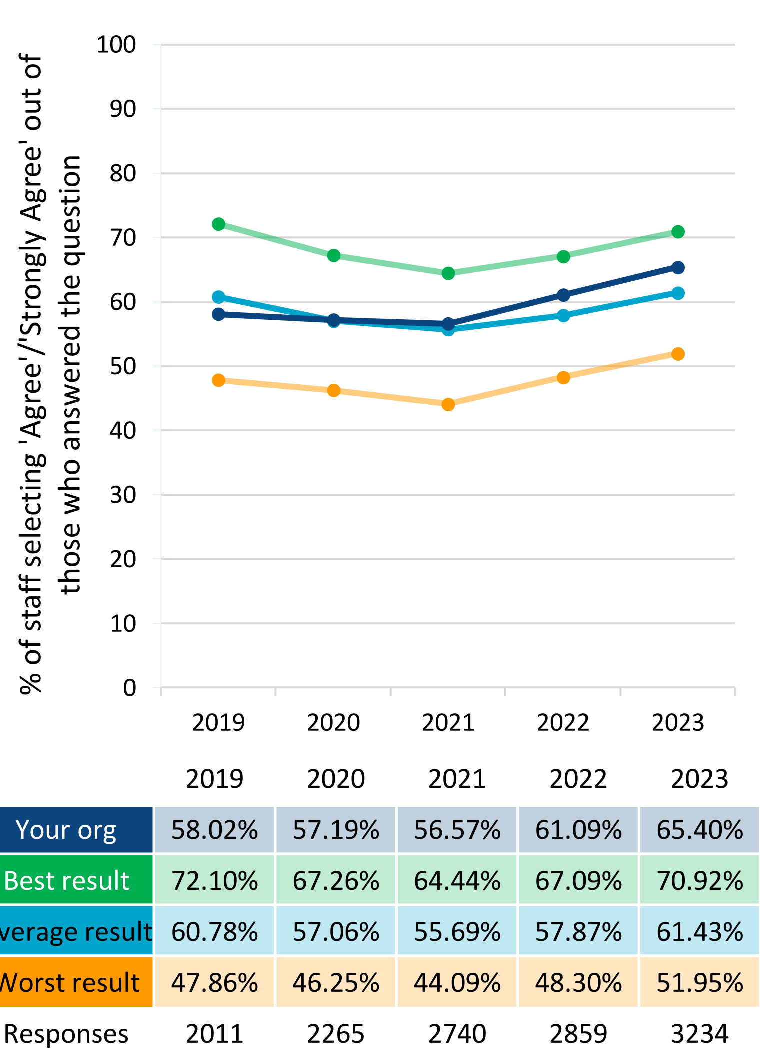


Q7a The team I work in has a set of shared objectives.



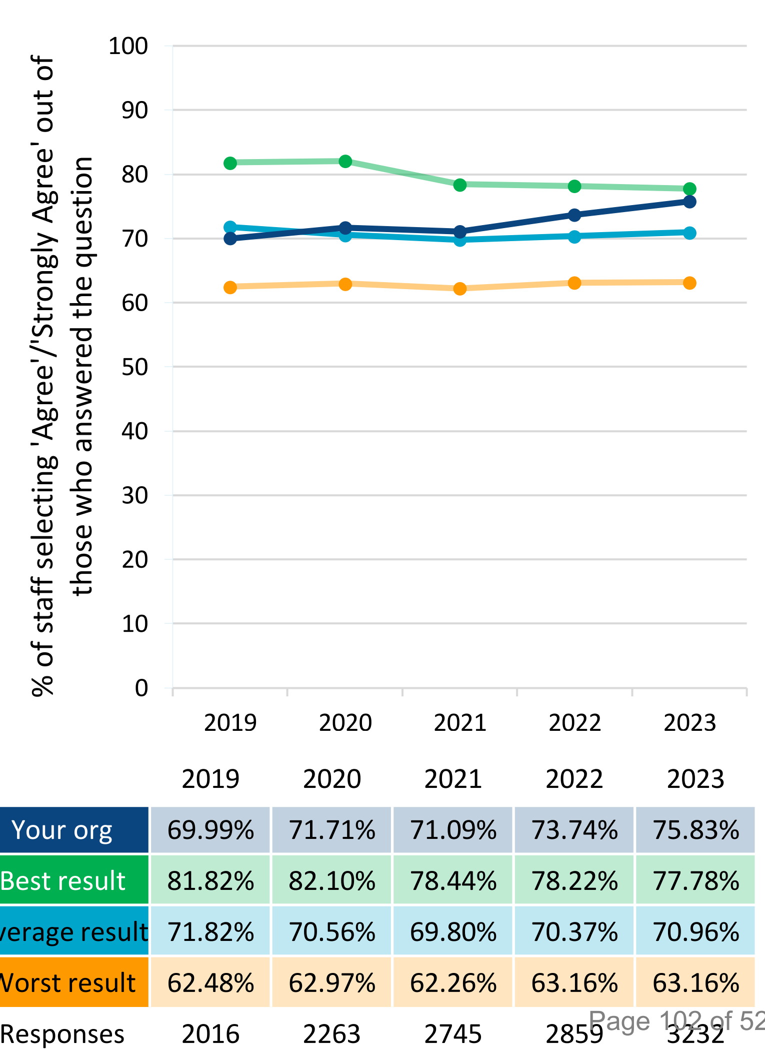
	2019	2020	2021	2022	2023
Your org	70.23%	72.86%	72.92%	74.60%	74.70%
Best result	83.74%	80.91%	79.58%	79.76%	79.81%
Average result	72.42%	71.88%	72.05%	72.32%	73.34%
Worst result	63.51%	65.07%	66.78%	66.46%	68.00%
Responses	1998	2258	2736	2858	3228

Q7b The team I work in often meets to discuss the team's effectiveness.

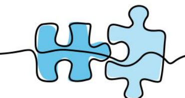


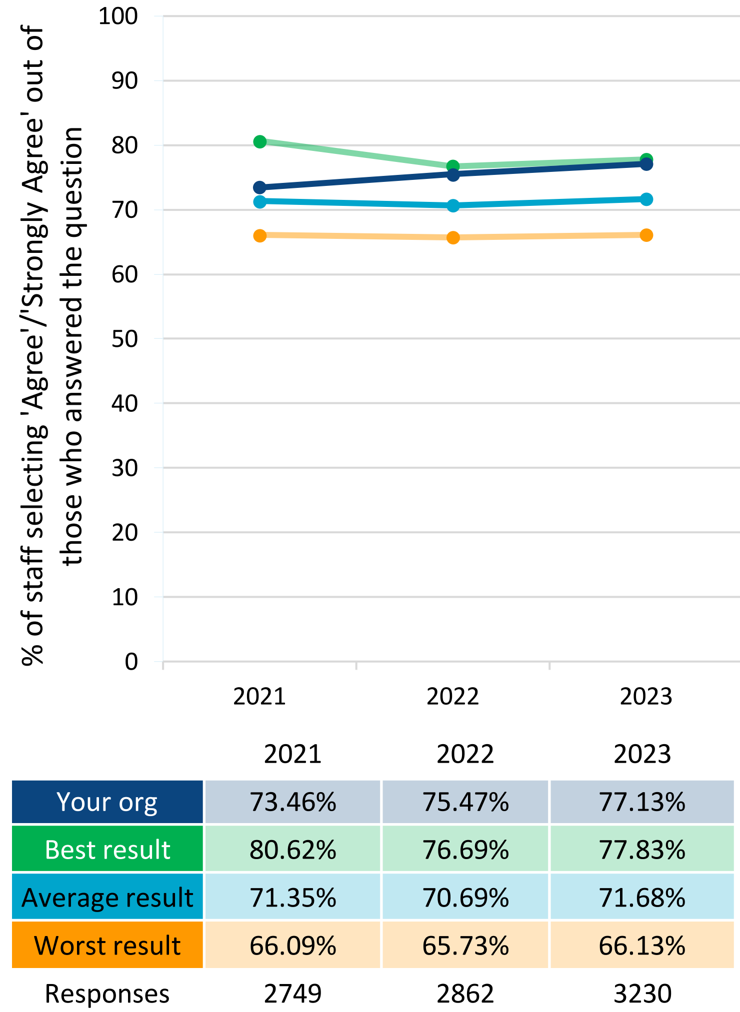
	2019	2020	2021	2022	2023
Your org	58.02%	57.19%	56.57%	61.09%	65.40%
Best result	72.10%	67.26%	64.44%	67.09%	70.92%
Average result	60.78%	57.06%	55.69%	57.87%	61.43%
Worst result	47.86%	46.25%	44.09%	48.30%	51.95%
Responses	2011	2265	2740	2859	3234

Q7c I receive the respect I deserve from my colleagues at work.

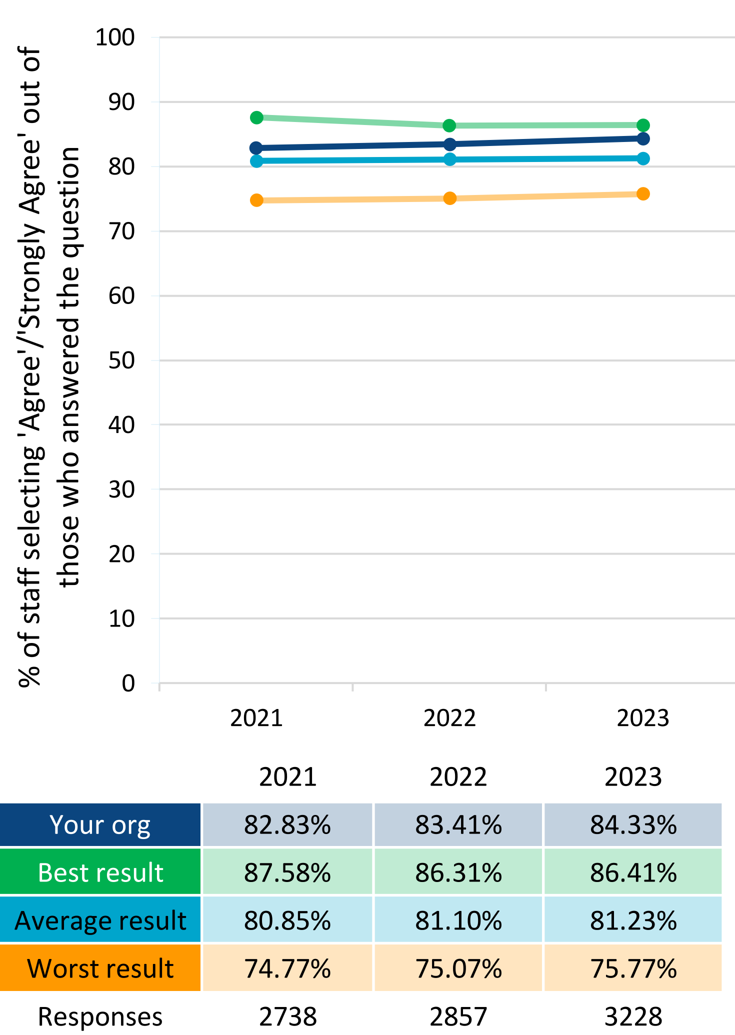


	2019	2020	2021	2022	2023
Your org	69.99%	71.71%	71.09%	73.74%	75.83%
Best result	81.82%	82.10%	78.44%	78.22%	77.78%
Average result	71.82%	70.56%	69.80%	70.37%	70.96%
Worst result	62.48%	62.97%	62.26%	63.16%	63.16%
Responses	2016	2263	2745	2859	3232

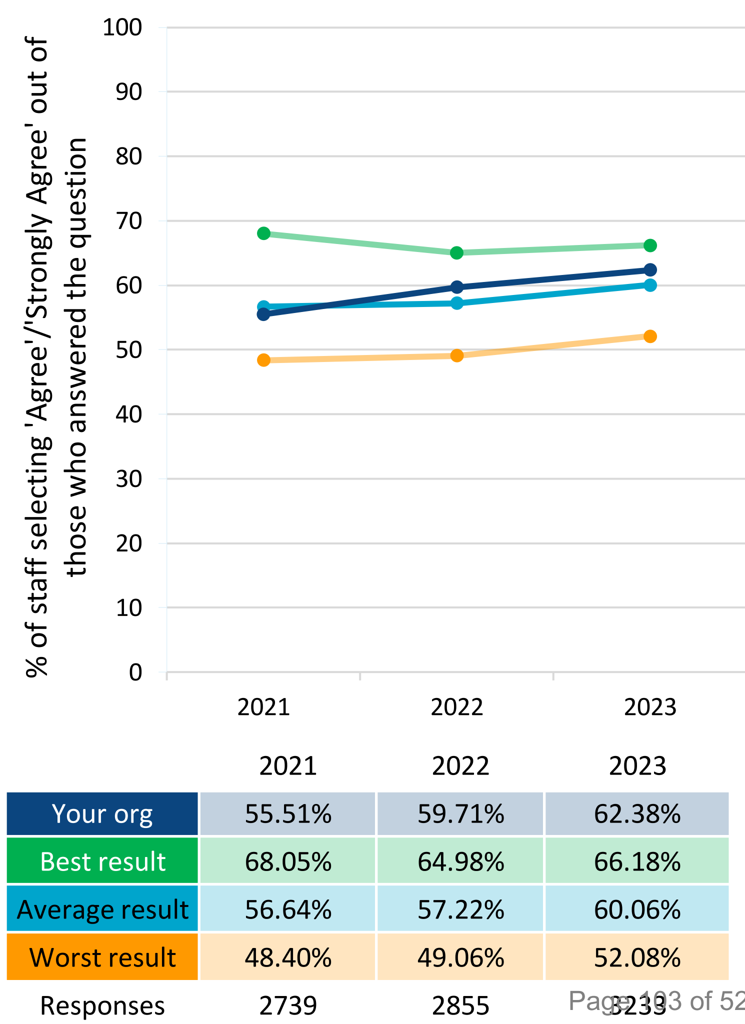




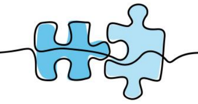
	2021	2022	2023
Your org	73.46%	75.47%	77.13%
Best result	80.62%	76.69%	77.83%
Average result	71.35%	70.69%	71.68%
Worst result	66.09%	65.73%	66.13%
Responses	2749	2862	3230

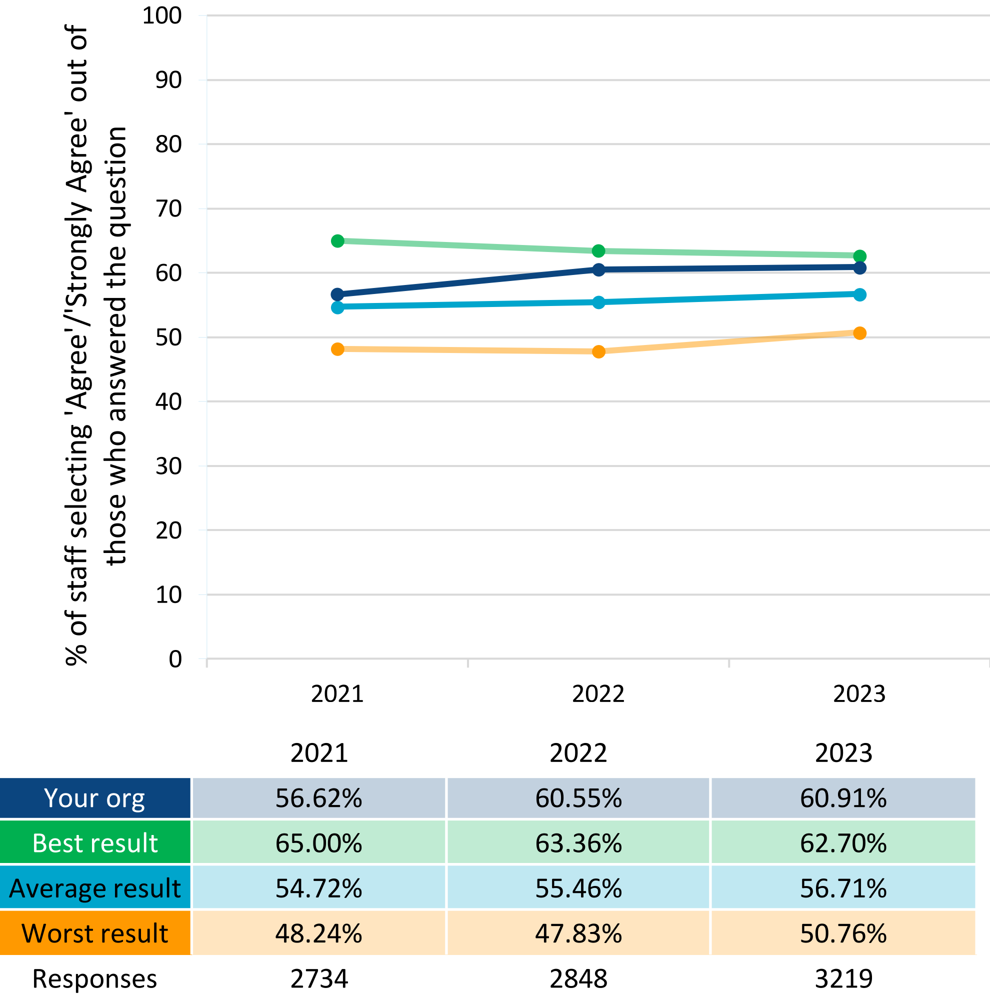


	2021	2022	2023
Your org	82.83%	83.41%	84.33%
Best result	87.58%	86.31%	86.41%
Average result	80.85%	81.10%	81.23%
Worst result	74.77%	75.07%	75.77%
Responses	2738	2857	3228

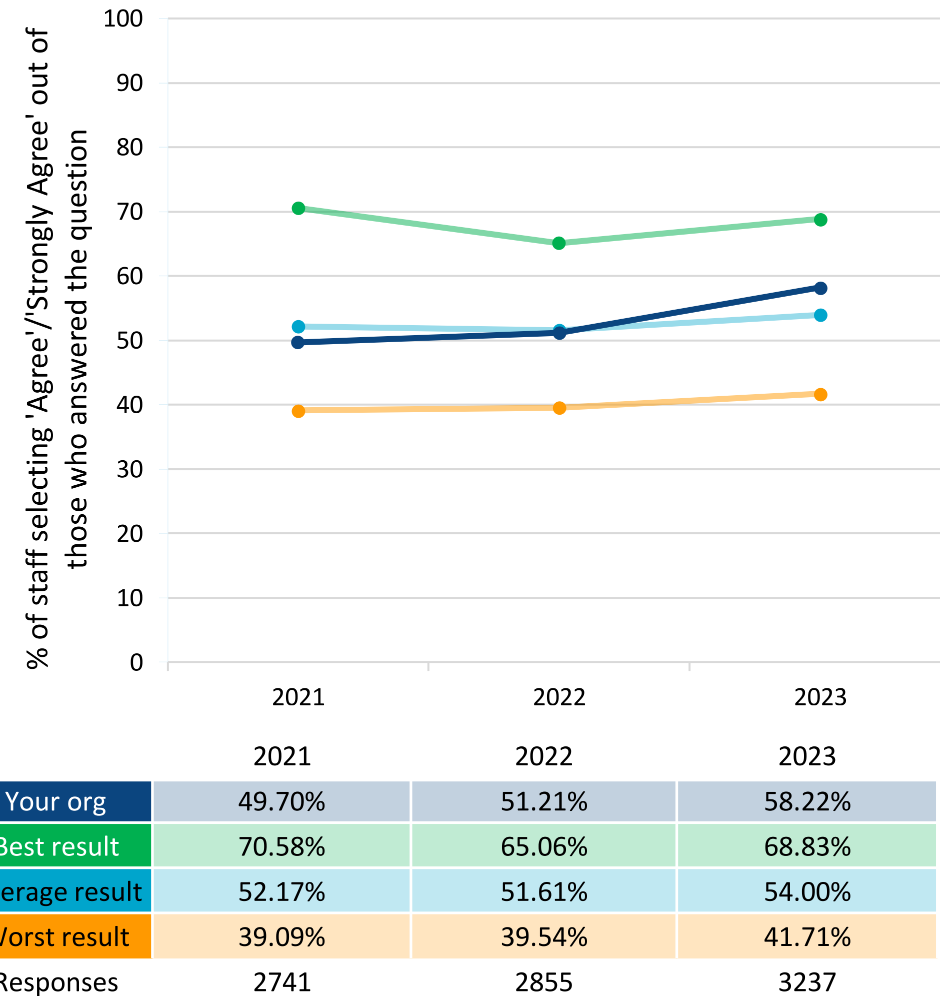


	2021	2022	2023
Your org	55.51%	59.71%	62.38%
Best result	68.05%	64.98%	66.18%
Average result	56.64%	57.22%	60.06%
Worst result	48.40%	49.06%	52.08%
Responses	2739	2855	3233

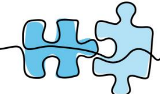




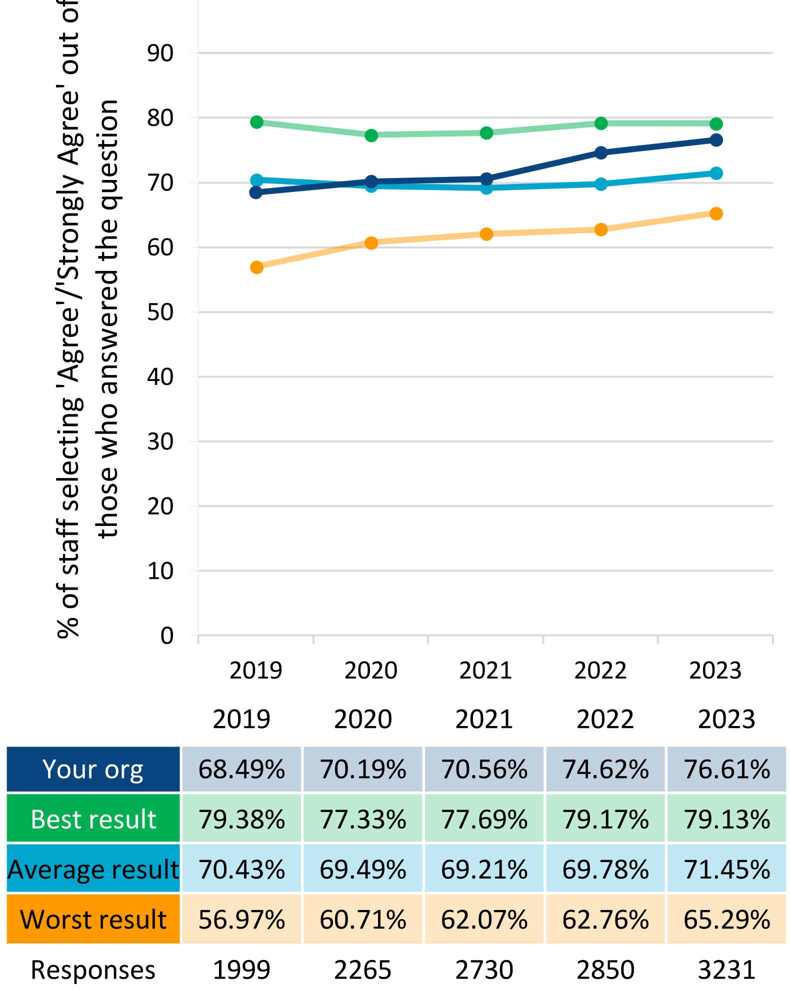
	2021	2022	2023
Your org	56.62%	60.55%	60.91%
Best result	65.00%	63.36%	62.70%
Average result	54.72%	55.46%	56.71%
Worst result	48.24%	47.83%	50.76%
Responses	2734	2848	3219



	2021	2022	2023
Your org	49.70%	51.21%	58.22%
Best result	70.58%	65.06%	68.83%
Average result	52.17%	51.61%	54.00%
Worst result	39.09%	39.54%	41.71%
Responses	2741	2855	3237

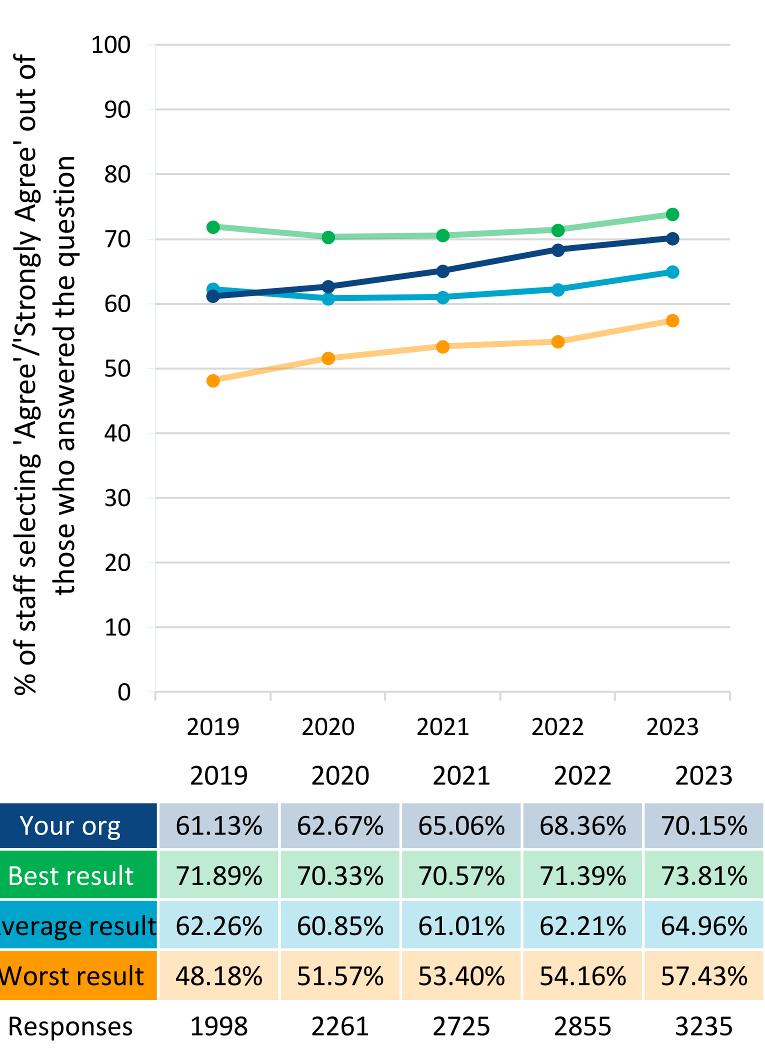


Q9a My immediate manager encourages me at work.



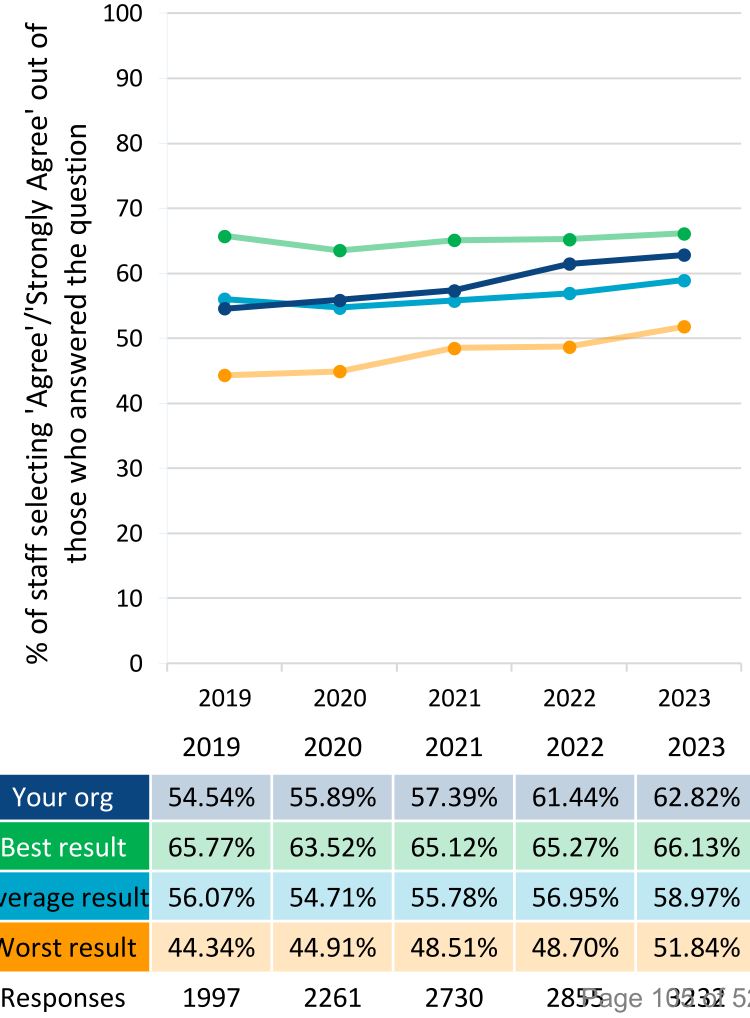
	2019	2020	2021	2022	2023
Your org	68.49%	70.19%	70.56%	74.62%	76.61%
Best result	79.38%	77.33%	77.69%	79.17%	79.13%
Average result	70.43%	69.49%	69.21%	69.78%	71.45%
Worst result	56.97%	60.71%	62.07%	62.76%	65.29%
Responses	1999	2265	2730	2850	3231

Q9b My immediate manager gives me clear feedback on my work.

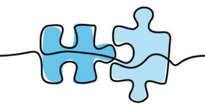


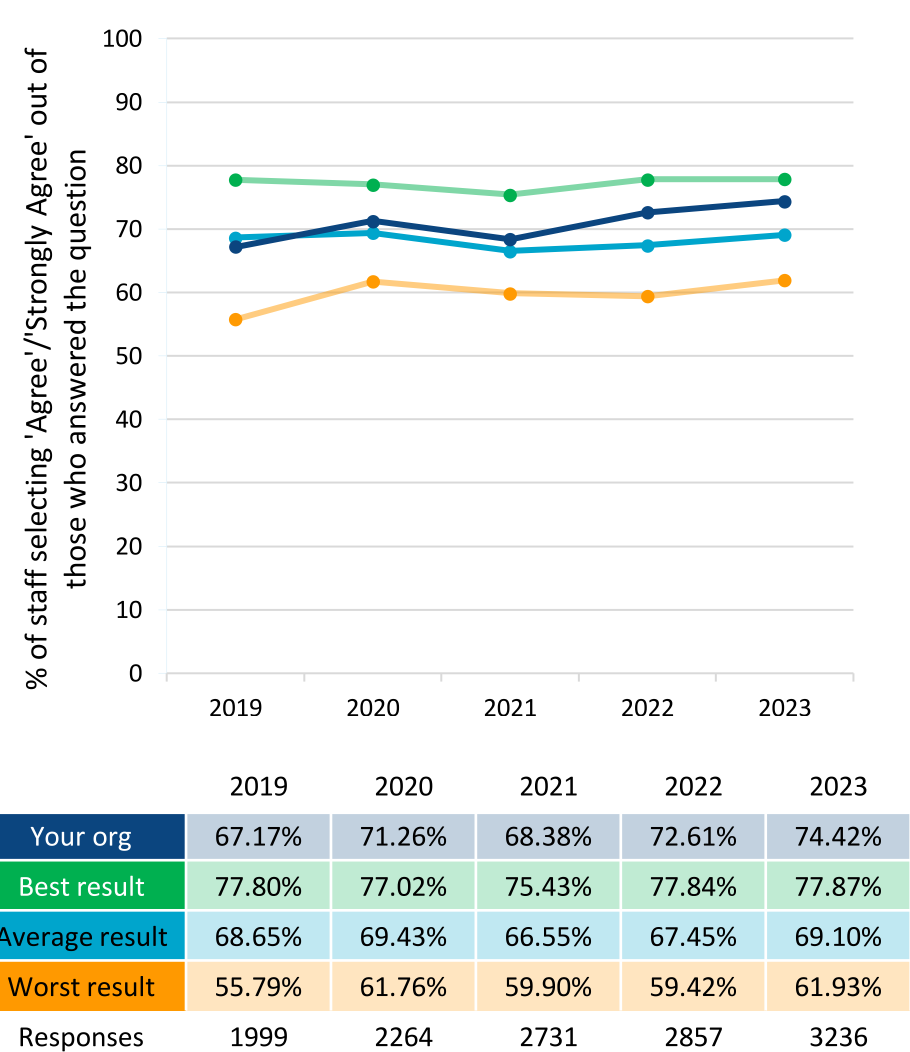
	2019	2020	2021	2022	2023
Your org	61.13%	62.67%	65.06%	68.36%	70.15%
Best result	71.89%	70.33%	70.57%	71.39%	73.81%
Average result	62.26%	60.85%	61.01%	62.21%	64.96%
Worst result	48.18%	51.57%	53.40%	54.16%	57.43%
Responses	1998	2261	2725	2855	3235

Q9c My immediate manager asks for my opinion before making decisions that affect my work.



	2019	2020	2021	2022	2023
Your org	54.54%	55.89%	57.39%	61.44%	62.82%
Best result	65.77%	63.52%	65.12%	65.27%	66.13%
Average result	56.07%	54.71%	55.78%	56.95%	58.97%
Worst result	44.34%	44.91%	48.51%	48.70%	51.84%
Responses	1997	2261	2730	2855	3232





	2019	2020	2021	2022	2023
Your org	67.17%	71.26%	68.38%	72.61%	74.42%
Best result	77.80%	77.02%	75.43%	77.84%	77.87%
Average result	68.65%	69.43%	66.55%	67.45%	69.10%
Worst result	55.79%	61.76%	59.90%	59.42%	61.93%
Responses	1999	2264	2731	2857	3236

Survey Coordination Centre

Theme – Staff engagement

Questions included:

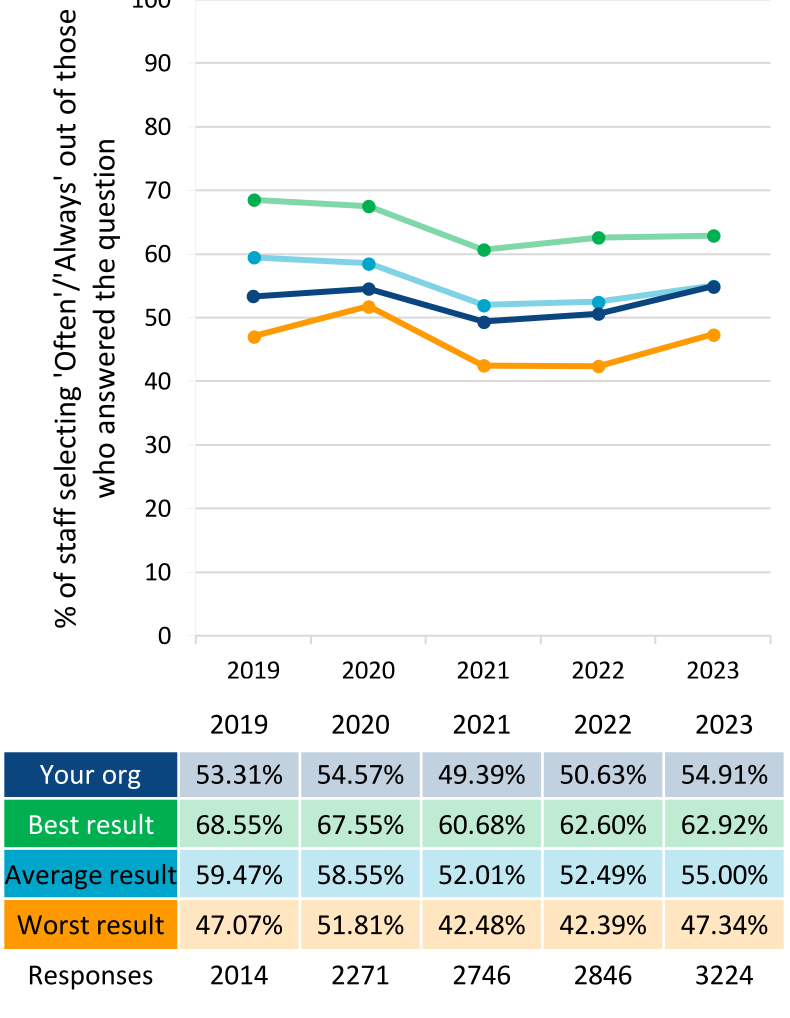
Motivation – Q2a, Q2b, Q2c

Involvement – Q3c, Q3d, Q3f

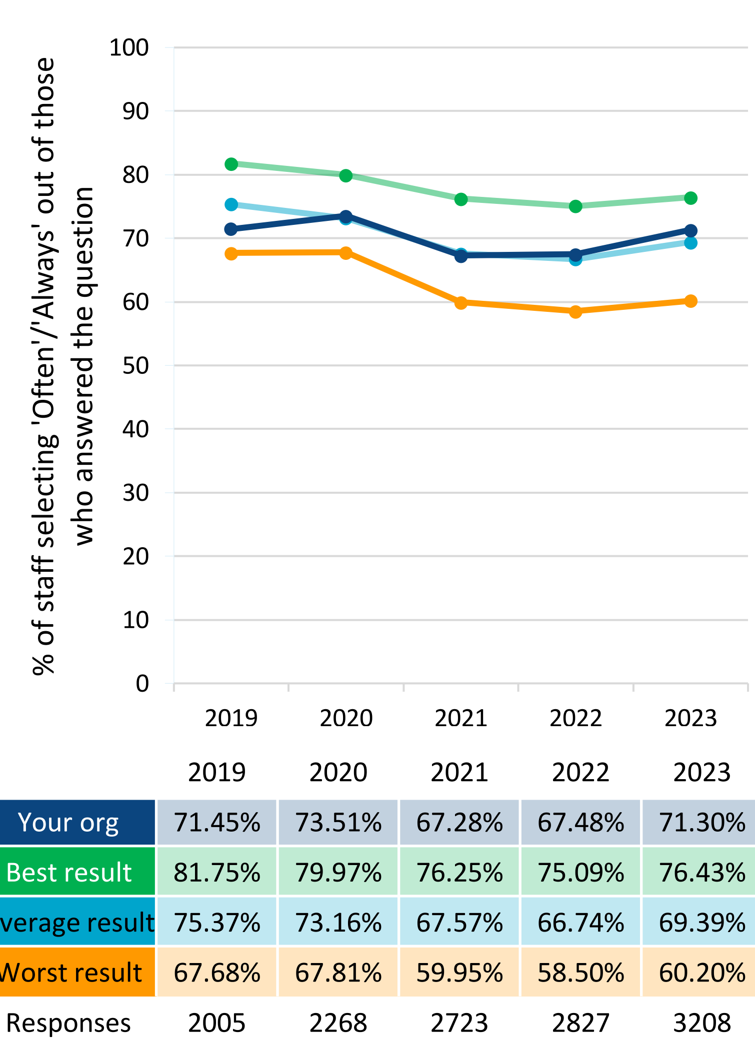
Advocacy – Q25a, Q25c, Q25d

Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

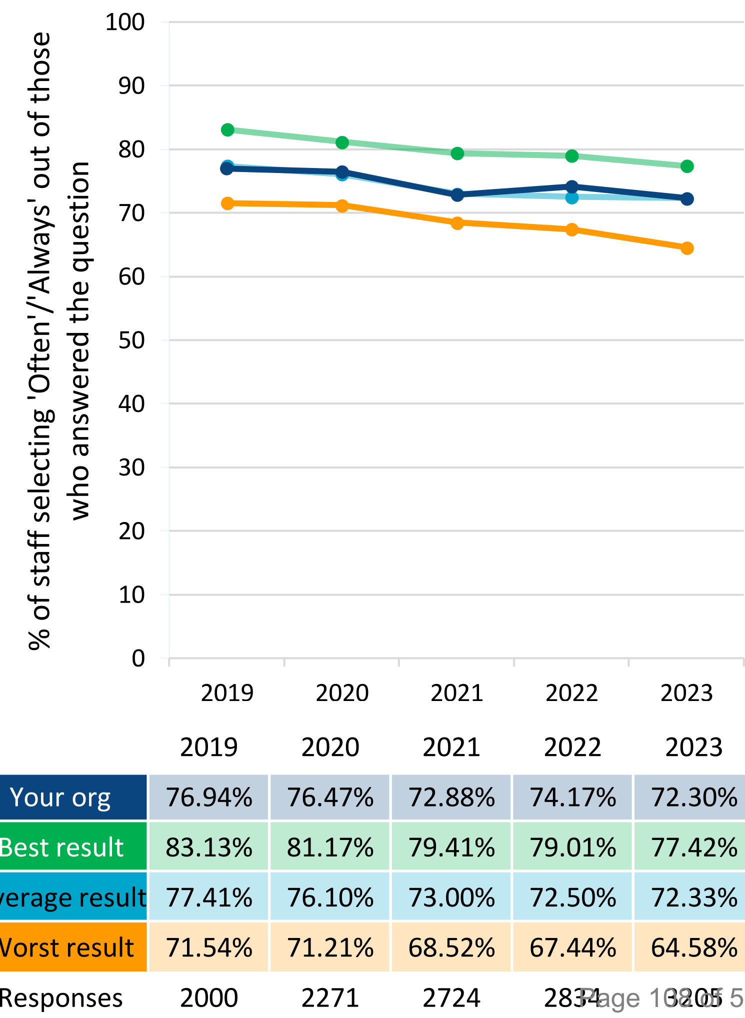
People Promise elements and theme results – Staff engagement: Motivation



	2019	2020	2021	2022	2023
Your org	53.31%	54.57%	49.39%	50.63%	54.91%
Best result	68.55%	67.55%	60.68%	62.60%	62.92%
Average result	59.47%	58.55%	52.01%	52.49%	55.00%
Worst result	47.07%	51.81%	42.48%	42.39%	47.34%
Responses	2014	2271	2746	2846	3224



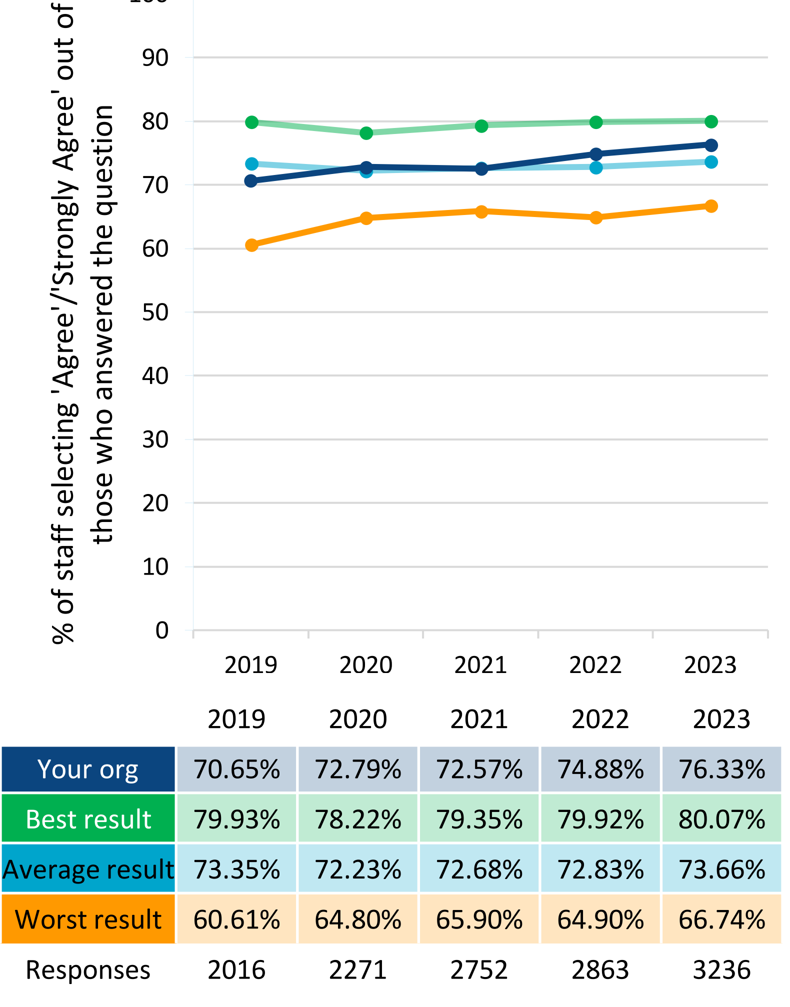
	2019	2020	2021	2022	2023
Your org	71.45%	73.51%	67.28%	67.48%	71.30%
Best result	81.75%	79.97%	76.25%	75.09%	76.43%
Average result	75.37%	73.16%	67.57%	66.74%	69.39%
Worst result	67.68%	67.81%	59.95%	58.50%	60.20%
Responses	2005	2268	2723	2827	3208



	2019	2020	2021	2022	2023
Your org	76.94%	76.47%	72.88%	74.17%	72.30%
Best result	83.13%	81.17%	79.41%	79.01%	77.42%
Average result	77.41%	76.10%	73.00%	72.50%	72.33%
Worst result	71.54%	71.21%	68.52%	67.44%	64.58%
Responses	2000	2271	2724	2834	3205

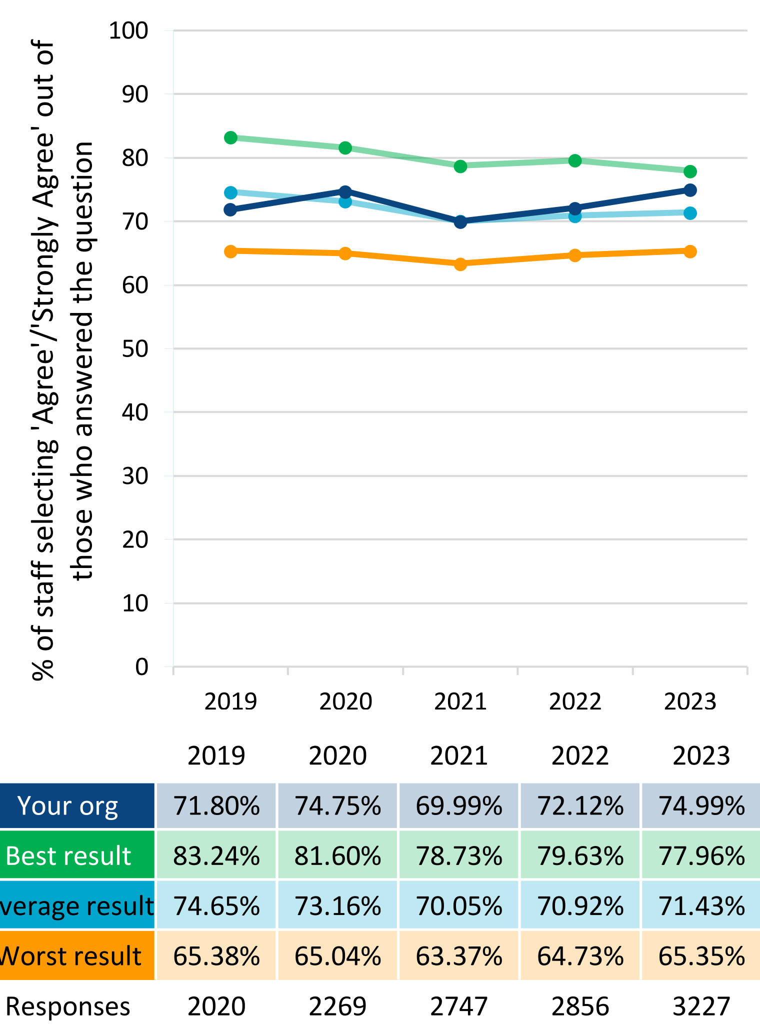
People Promise elements and theme results – Staff engagement: Involvement

Q3c There are frequent opportunities for me to show initiative in my role.



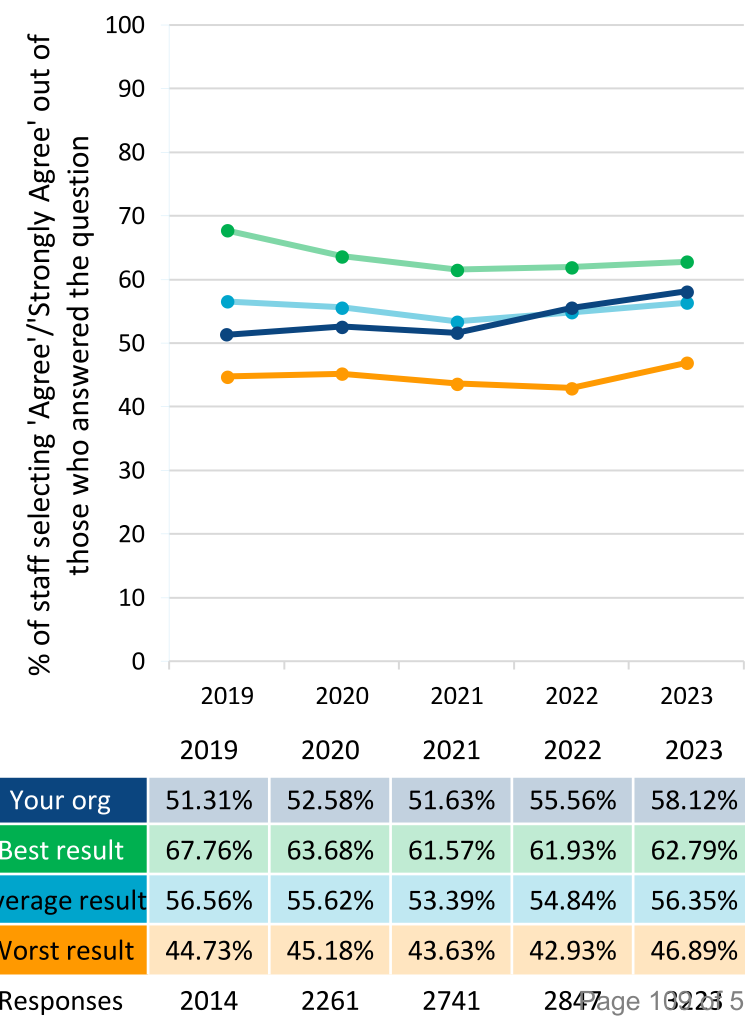
	2019	2020	2021	2022	2023
Your org	70.65%	72.79%	72.57%	74.88%	76.33%
Best result	79.93%	78.22%	79.35%	79.92%	80.07%
Average result	73.35%	72.23%	72.68%	72.83%	73.66%
Worst result	60.61%	64.80%	65.90%	64.90%	66.74%
Responses	2016	2271	2752	2863	3236

Q3d I am able to make suggestions to improve the work of my team / department.

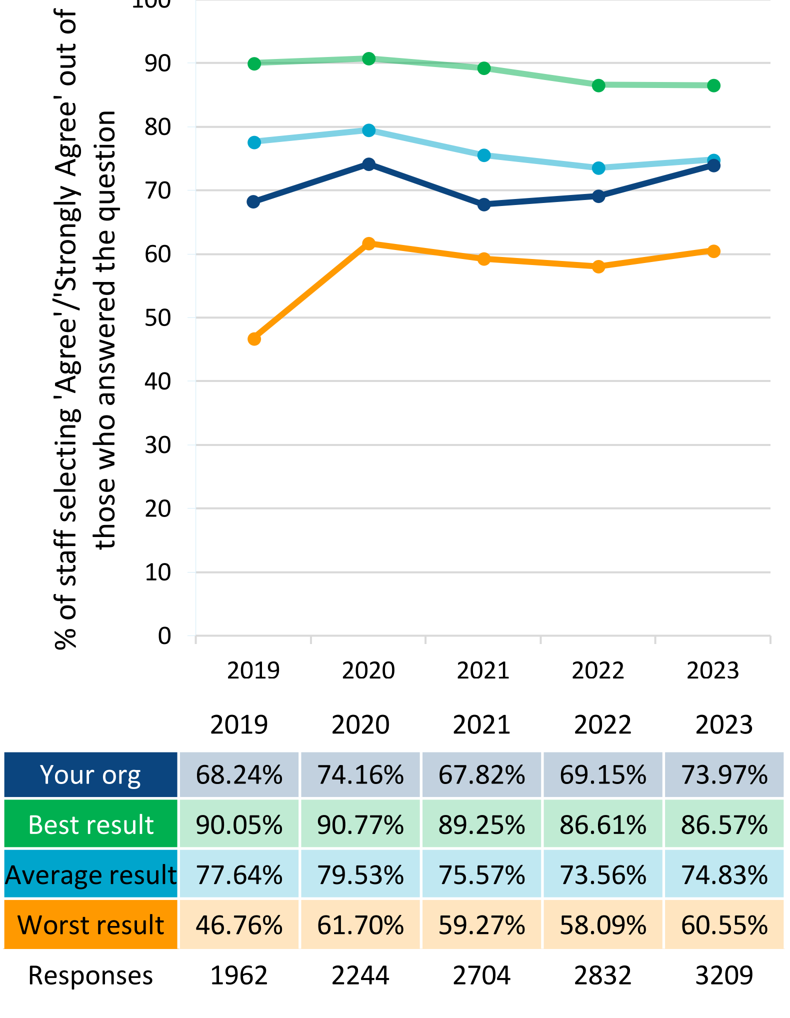


	2019	2020	2021	2022	2023
Your org	71.80%	74.75%	69.99%	72.12%	74.99%
Best result	83.24%	81.60%	78.73%	79.63%	77.96%
Average result	74.65%	73.16%	70.05%	70.92%	71.43%
Worst result	65.38%	65.04%	63.37%	64.73%	65.35%
Responses	2020	2269	2747	2856	3227

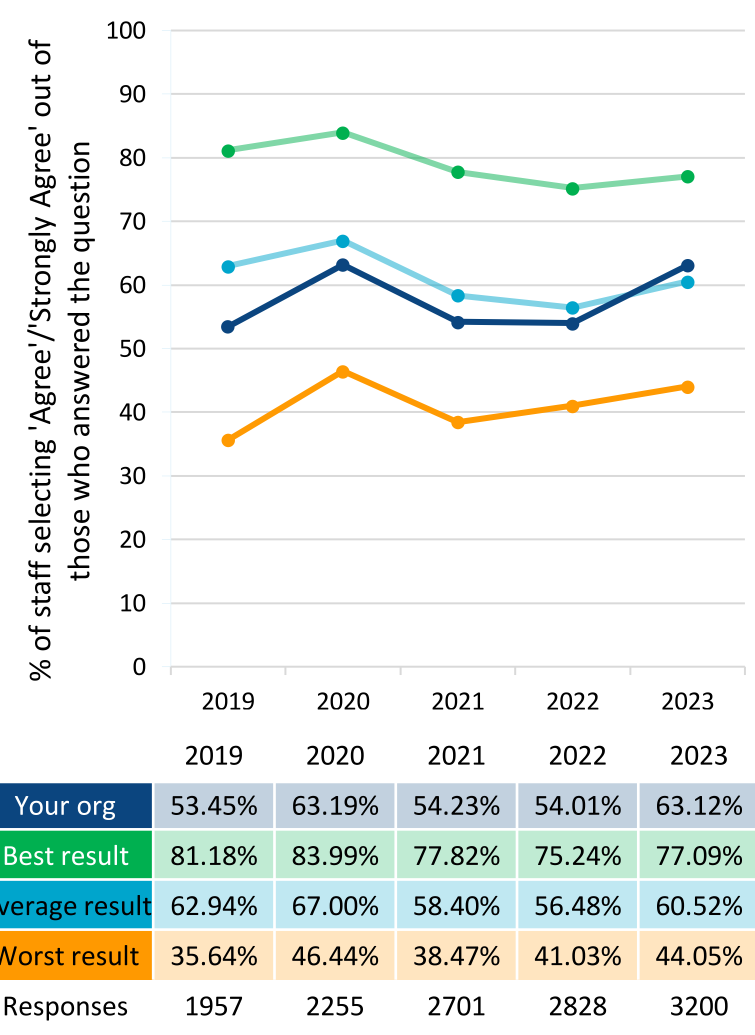
Q3f I am able to make improvements happen in my area of work.



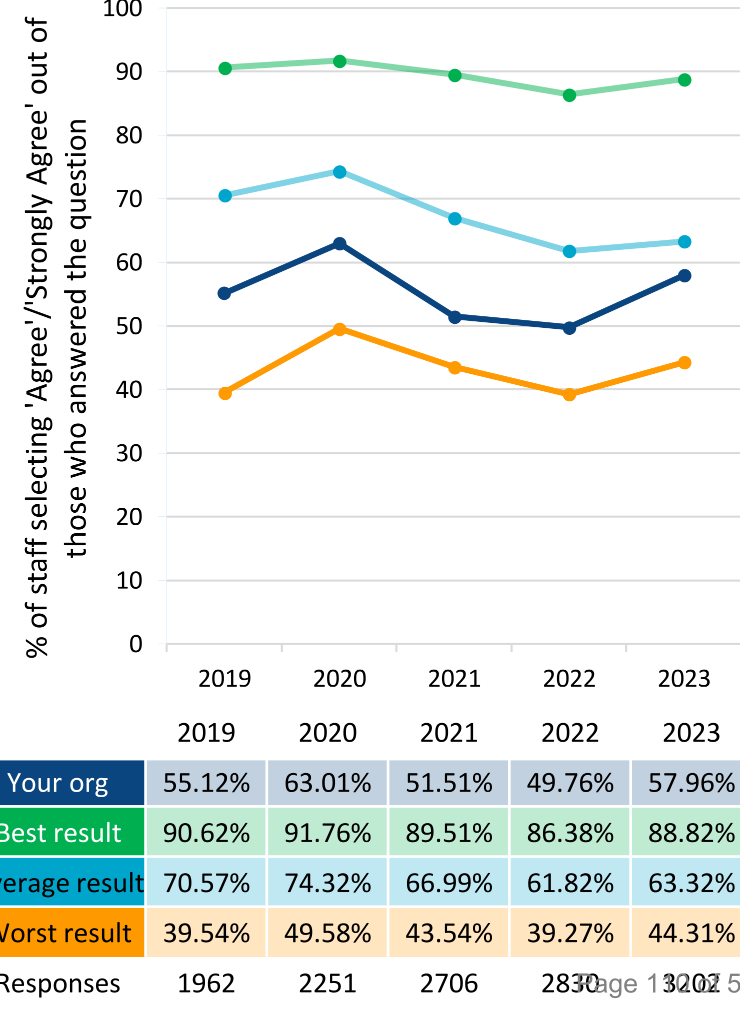
	2019	2020	2021	2022	2023
Your org	51.31%	52.58%	51.63%	55.56%	58.12%
Best result	67.76%	63.68%	61.57%	61.93%	62.79%
Average result	56.56%	55.62%	53.39%	54.84%	56.35%
Worst result	44.73%	45.18%	43.63%	42.93%	46.89%
Responses	2014	2261	2741	2847	3223



	2019	2020	2021	2022	2023
Your org	68.24%	74.16%	67.82%	69.15%	73.97%
Best result	90.05%	90.77%	89.25%	86.61%	86.57%
Average result	77.64%	79.53%	75.57%	73.56%	74.83%
Worst result	46.76%	61.70%	59.27%	58.09%	60.55%
Responses	1962	2244	2704	2832	3209



	2019	2020	2021	2022	2023
Your org	53.45%	63.19%	54.23%	54.01%	63.12%
Best result	81.18%	83.99%	77.82%	75.24%	77.09%
Average result	62.94%	67.00%	58.40%	56.48%	60.52%
Worst result	35.64%	46.44%	38.47%	41.03%	44.05%
Responses	1957	2255	2701	2828	3200



	2019	2020	2021	2022	2023
Your org	55.12%	63.01%	51.51%	49.76%	57.96%
Best result	90.62%	91.76%	89.51%	86.38%	88.82%
Average result	70.57%	74.32%	66.99%	61.82%	63.32%
Worst result	39.54%	49.58%	43.54%	39.27%	44.31%
Responses	1962	2251	2706	2830	3202

Survey Coordination Centre

Theme - Morale

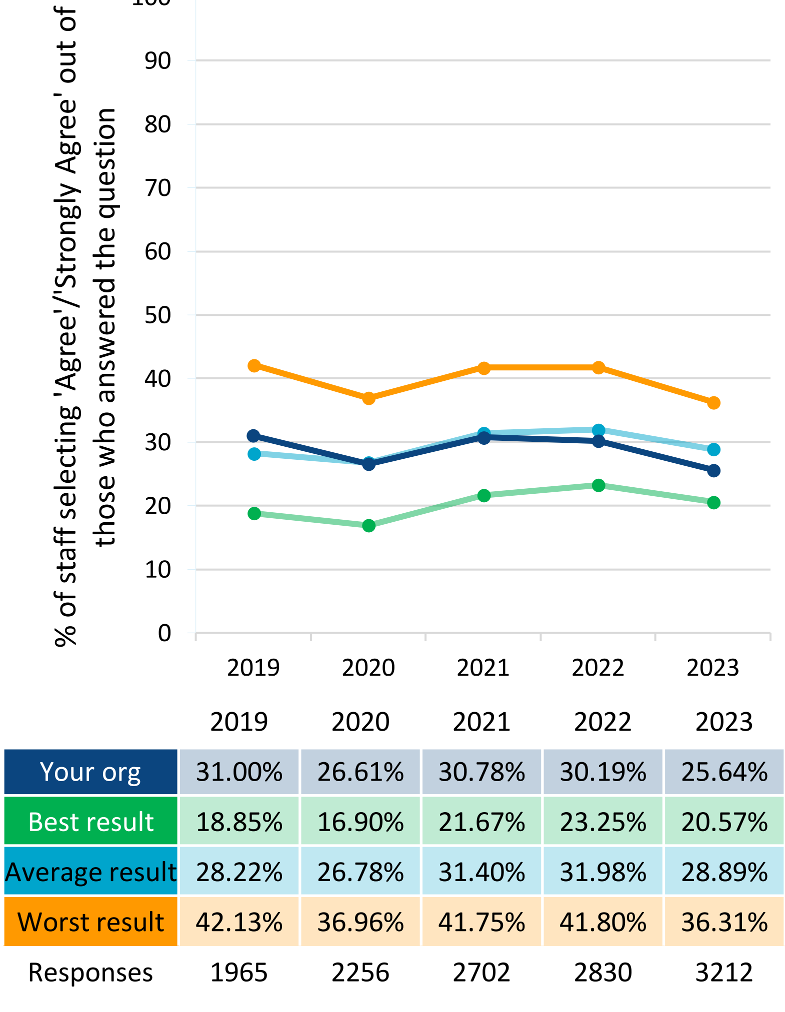
Questions included:

Thinking about leaving – Q26a, Q26b, Q26c

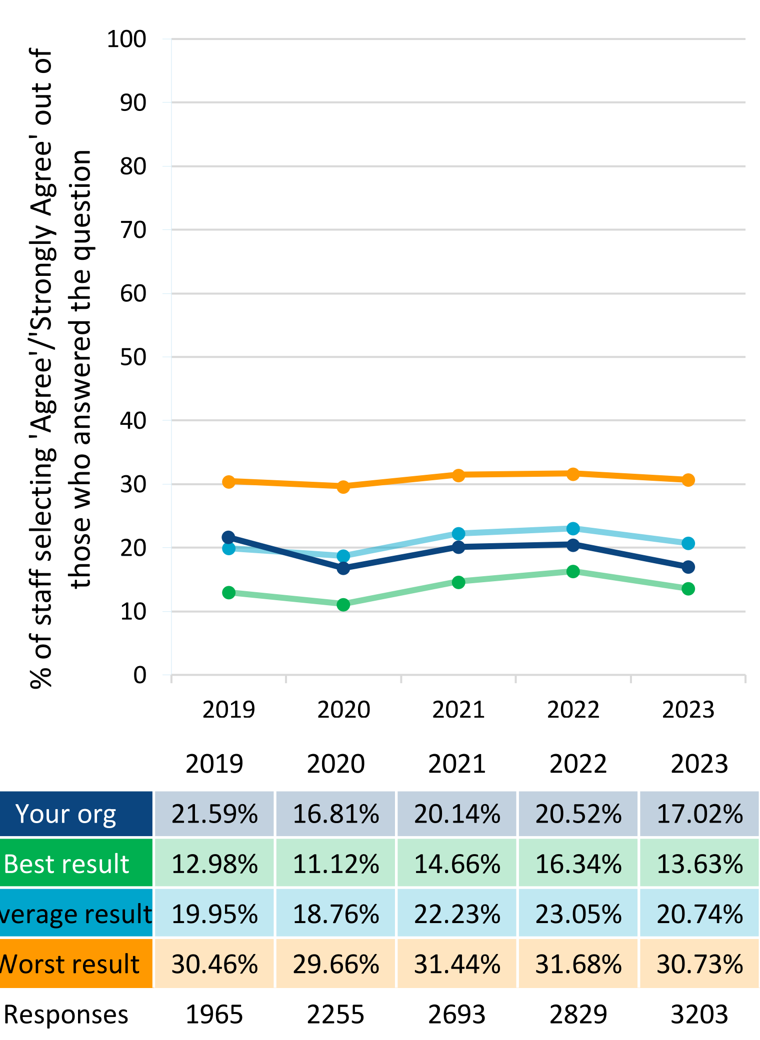
Work pressure – Q3g, Q3h, Q3i

Stressors – Q3a, Q3e, Q5a, Q5b, Q5c, Q7c, Q9a

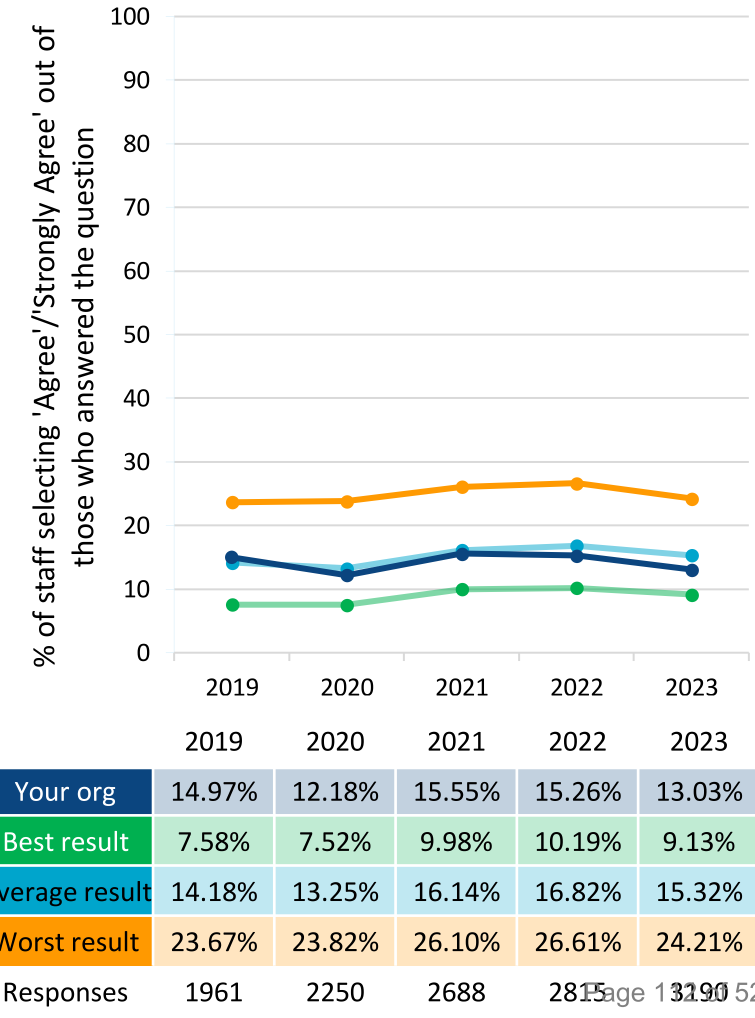
Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.



	2019	2020	2021	2022	2023
Your org	31.00%	26.61%	30.78%	30.19%	25.64%
Best result	18.85%	16.90%	21.67%	23.25%	20.57%
Average result	28.22%	26.78%	31.40%	31.98%	28.89%
Worst result	42.13%	36.96%	41.75%	41.80%	36.31%
Responses	1965	2256	2702	2830	3212

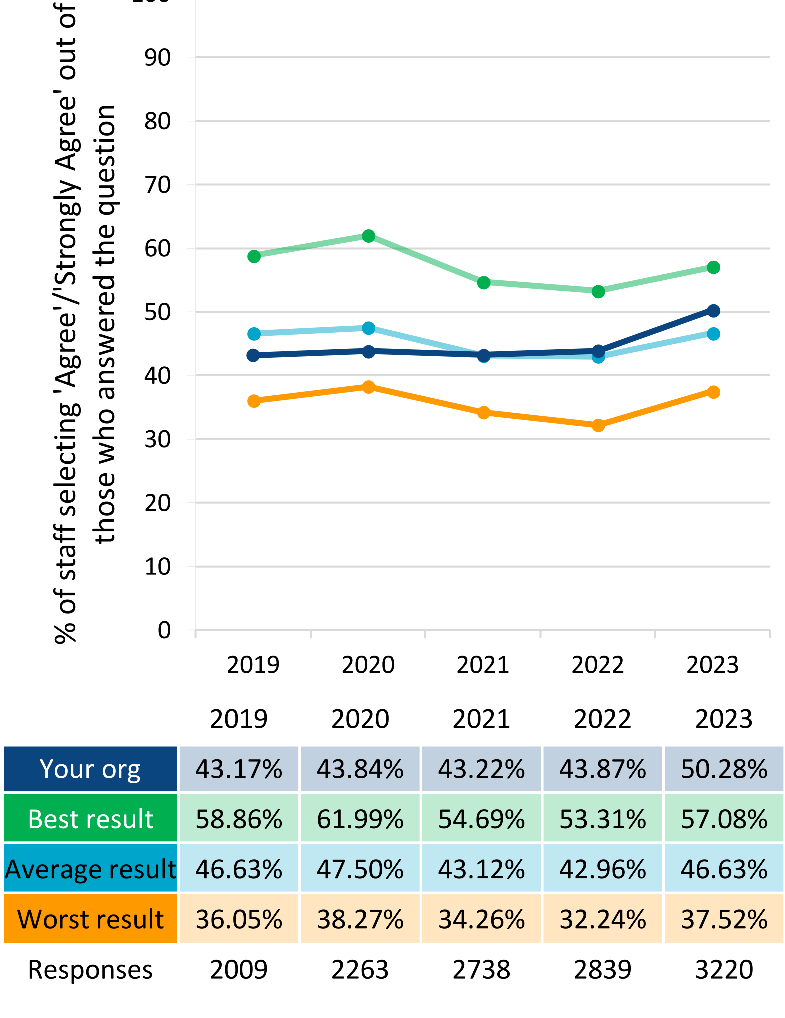


	2019	2020	2021	2022	2023
Your org	21.59%	16.81%	20.14%	20.52%	17.02%
Best result	12.98%	11.12%	14.66%	16.34%	13.63%
Average result	19.95%	18.76%	22.23%	23.05%	20.74%
Worst result	30.46%	29.66%	31.44%	31.68%	30.73%
Responses	1965	2255	2693	2829	3203

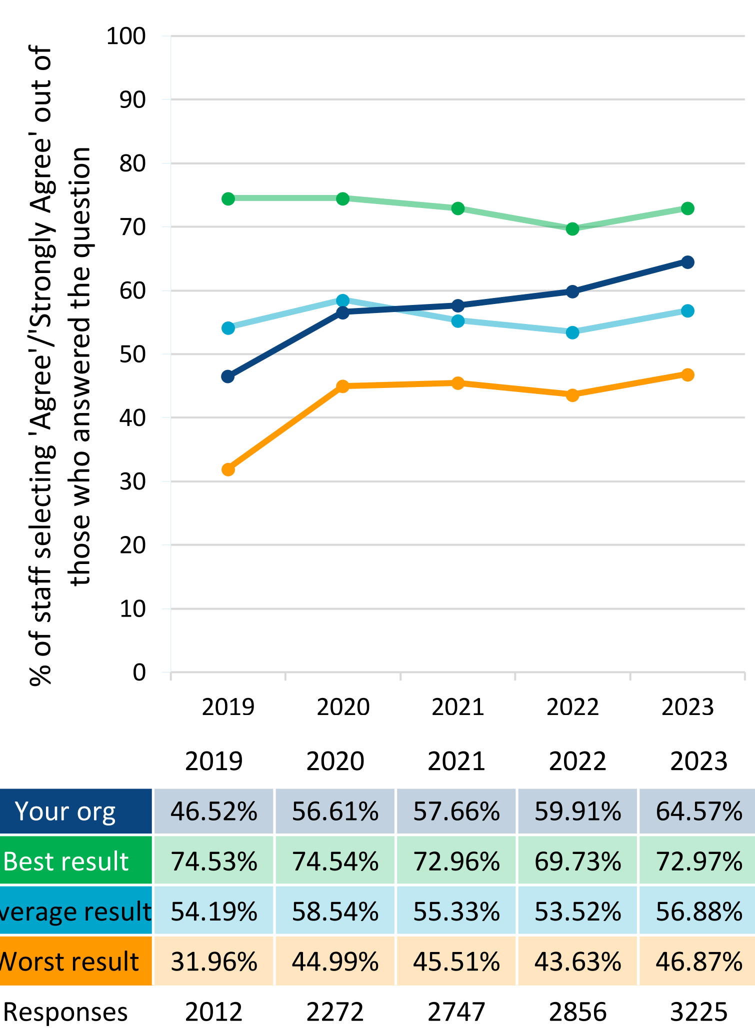


	2019	2020	2021	2022	2023
Your org	14.97%	12.18%	15.55%	15.26%	13.03%
Best result	7.58%	7.52%	9.98%	10.19%	9.13%
Average result	14.18%	13.25%	16.14%	16.82%	15.32%
Worst result	23.67%	23.82%	26.10%	26.61%	24.21%
Responses	1961	2250	2688	2815	3190

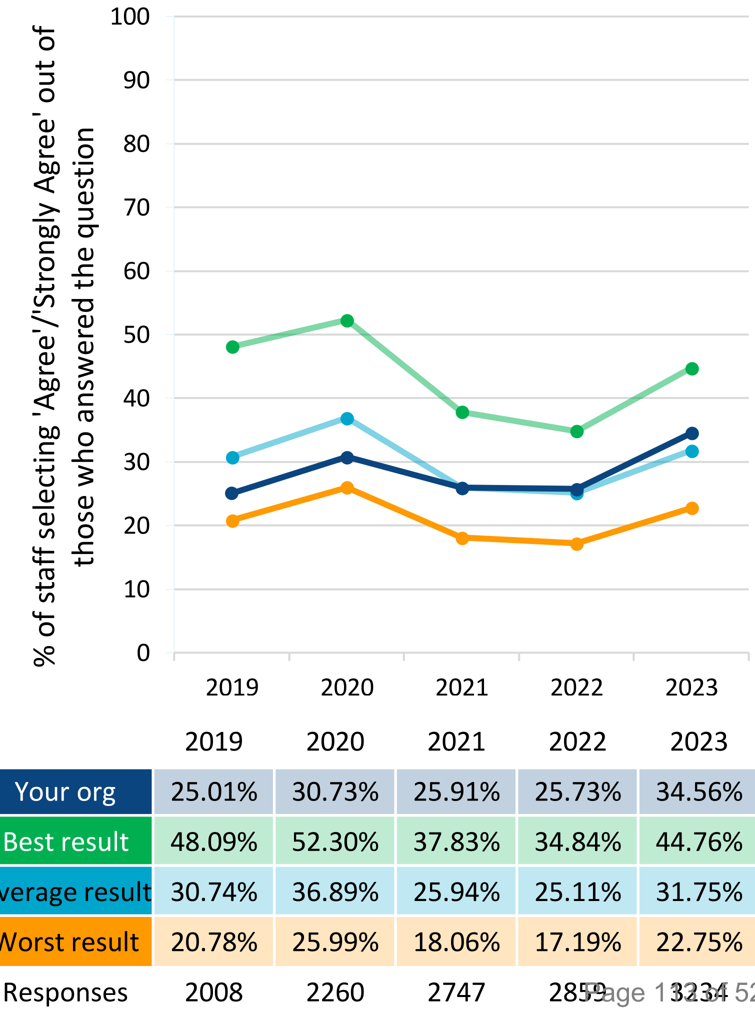
People Promise elements and theme results – Morale: Work pressure



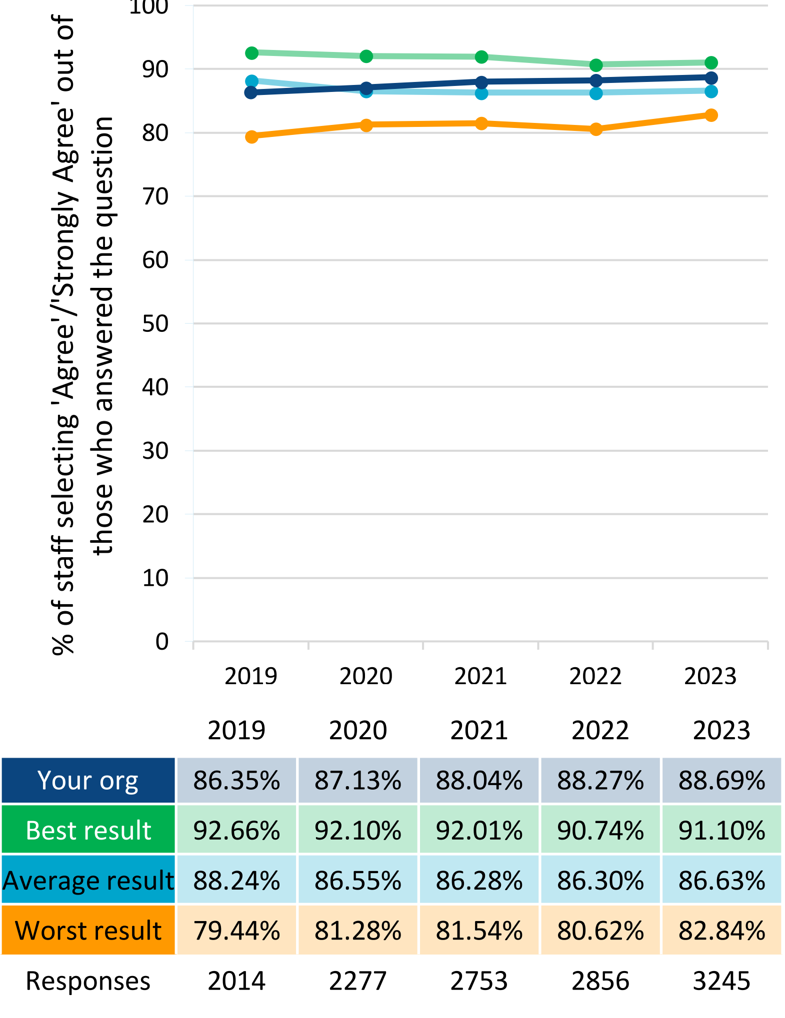
	2019	2020	2021	2022	2023
Your org	43.17%	43.84%	43.22%	43.87%	50.28%
Best result	58.86%	61.99%	54.69%	53.31%	57.08%
Average result	46.63%	47.50%	43.12%	42.96%	46.63%
Worst result	36.05%	38.27%	34.26%	32.24%	37.52%
Responses	2009	2263	2738	2839	3220



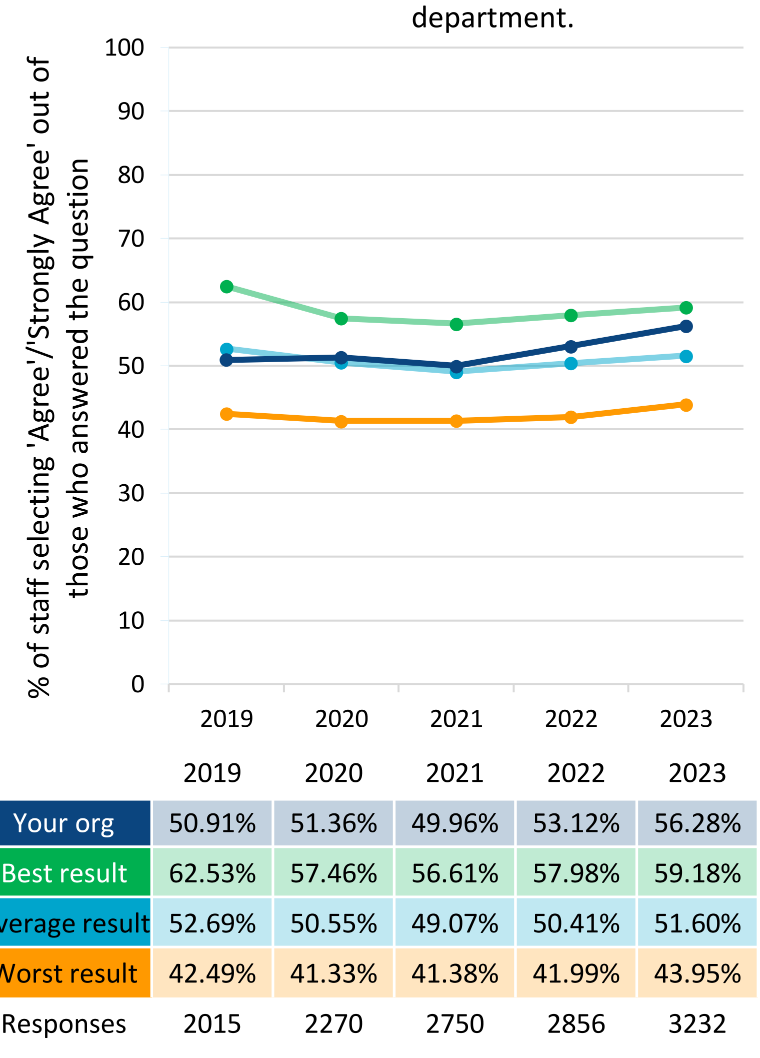
	2019	2020	2021	2022	2023
Your org	46.52%	56.61%	57.66%	59.91%	64.57%
Best result	74.53%	74.54%	72.96%	69.73%	72.97%
Average result	54.19%	58.54%	55.33%	53.52%	56.88%
Worst result	31.96%	44.99%	45.51%	43.63%	46.87%
Responses	2012	2272	2747	2856	3225



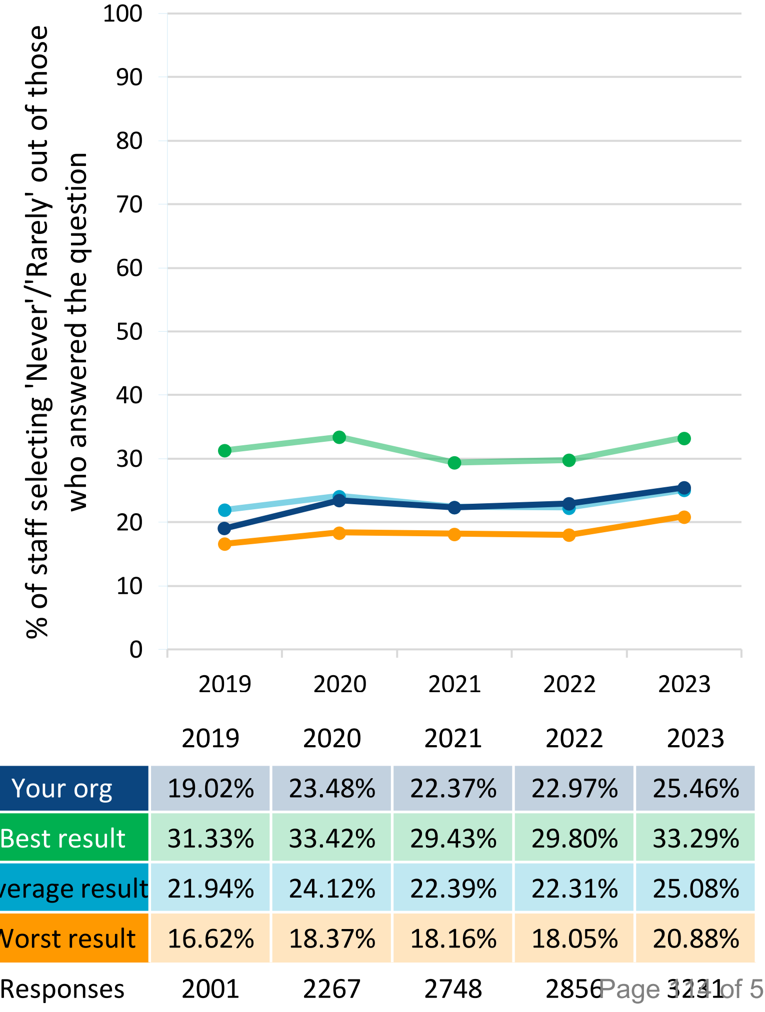
	2019	2020	2021	2022	2023
Your org	25.01%	30.73%	25.91%	25.73%	34.56%
Best result	48.09%	52.30%	37.83%	34.84%	44.76%
Average result	30.74%	36.89%	25.94%	25.11%	31.75%
Worst result	20.78%	25.99%	18.06%	17.19%	22.75%
Responses	2008	2260	2747	2859	3234



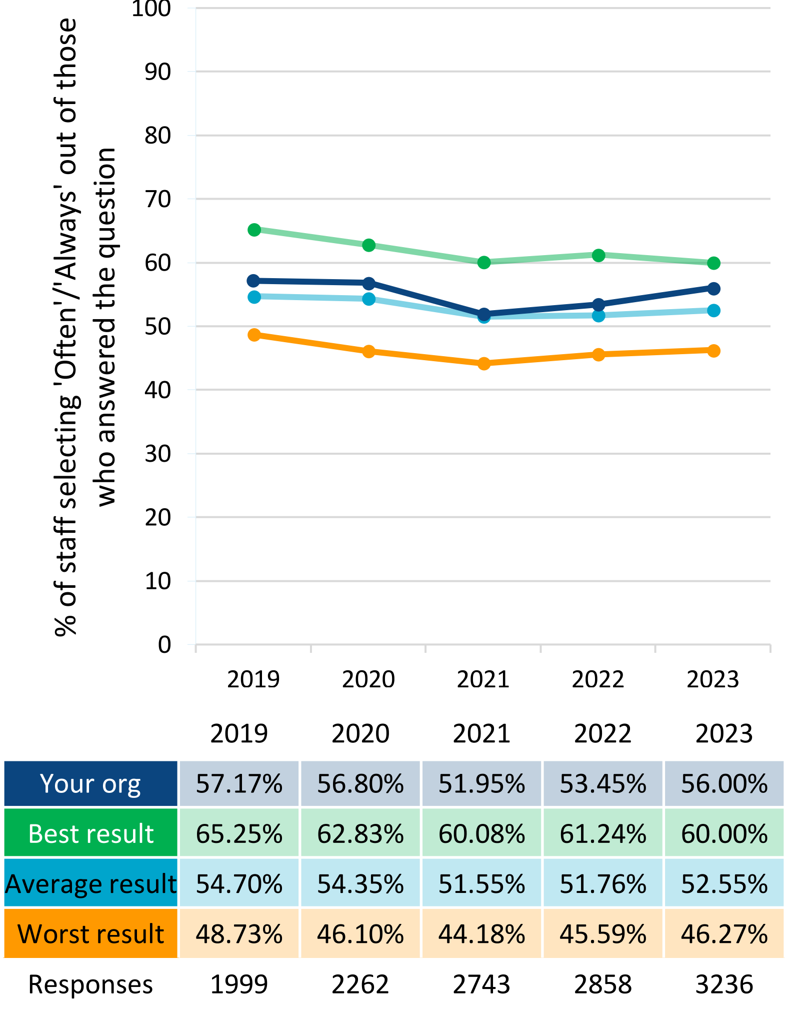
	2019	2020	2021	2022	2023
Your org	86.35%	87.13%	88.04%	88.27%	88.69%
Best result	92.66%	92.10%	92.01%	90.74%	91.10%
Average result	88.24%	86.55%	86.28%	86.30%	86.63%
Worst result	79.44%	81.28%	81.54%	80.62%	82.84%
Responses	2014	2277	2753	2856	3245



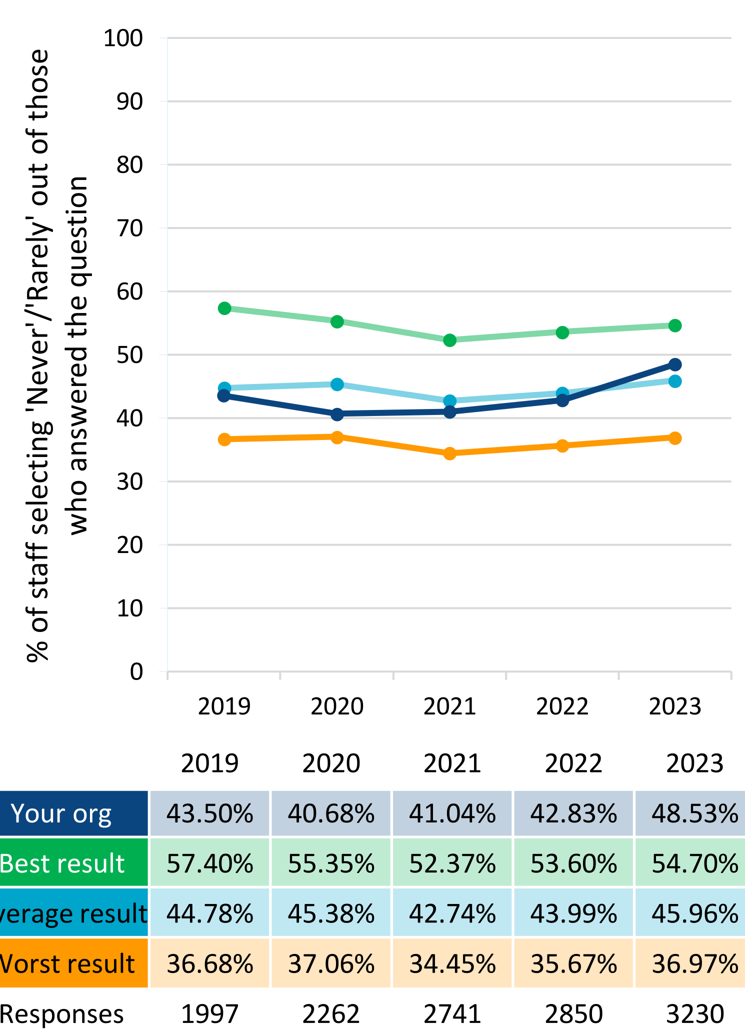
	2019	2020	2021	2022	2023
Your org	50.91%	51.36%	49.96%	53.12%	56.28%
Best result	62.53%	57.46%	56.61%	57.98%	59.18%
Average result	52.69%	50.55%	49.07%	50.41%	51.60%
Worst result	42.49%	41.33%	41.38%	41.99%	43.95%
Responses	2015	2270	2750	2856	3232



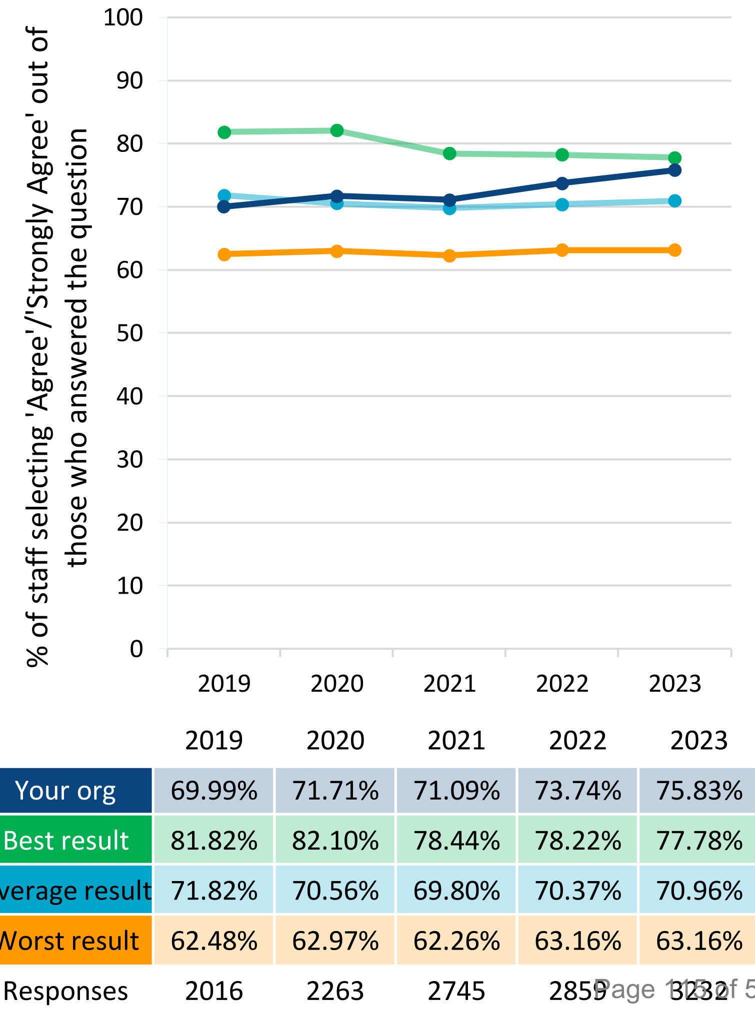
	2019	2020	2021	2022	2023
Your org	19.02%	23.48%	22.37%	22.97%	25.46%
Best result	31.33%	33.42%	29.43%	29.80%	33.29%
Average result	21.94%	24.12%	22.39%	22.31%	25.08%
Worst result	16.62%	18.37%	18.16%	18.05%	20.88%
Responses	2001	2267	2748	2856	3241



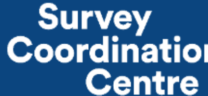
	2019	2020	2021	2022	2023
Your org	57.17%	56.80%	51.95%	53.45%	56.00%
Best result	65.25%	62.83%	60.08%	61.24%	60.00%
Average result	54.70%	54.35%	51.55%	51.76%	52.55%
Worst result	48.73%	46.10%	44.18%	45.59%	46.27%
Responses	1999	2262	2743	2858	3236

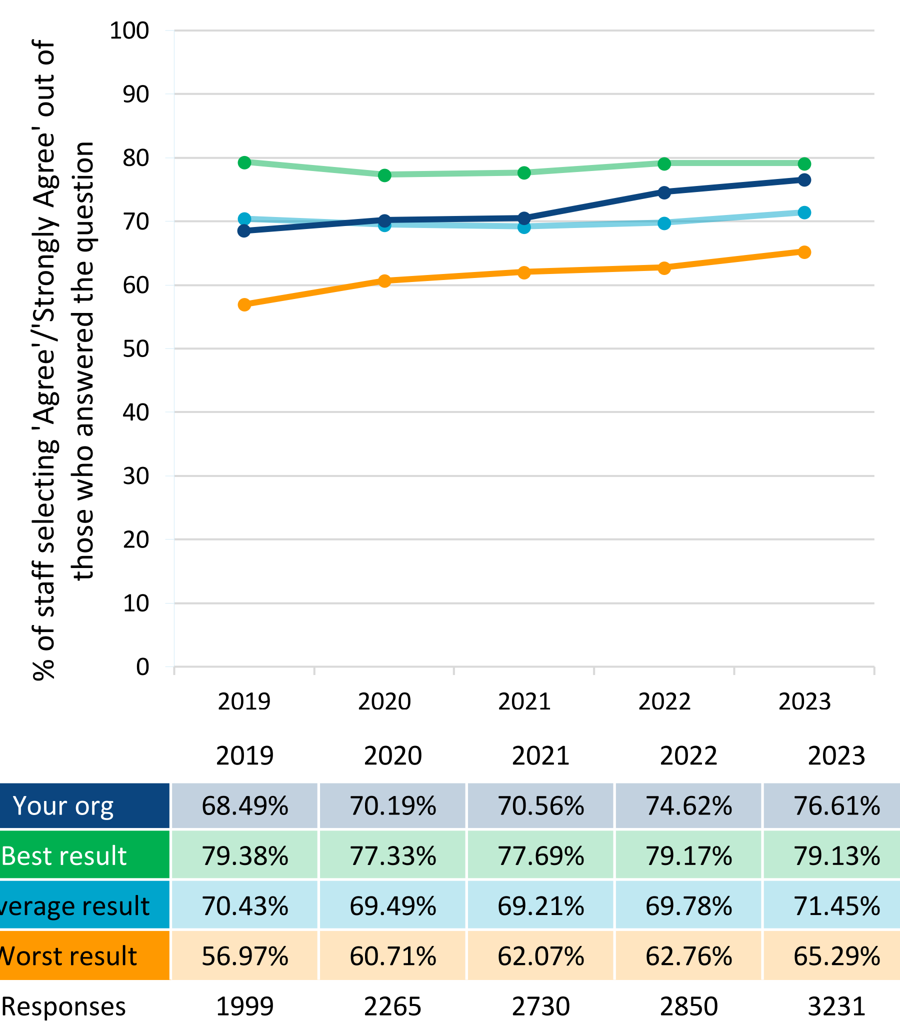


	2019	2020	2021	2022	2023
Your org	43.50%	40.68%	41.04%	42.83%	48.53%
Best result	57.40%	55.35%	52.37%	53.60%	54.70%
Average result	44.78%	45.38%	42.74%	43.99%	45.96%
Worst result	36.68%	37.06%	34.45%	35.67%	36.97%
Responses	1997	2262	2741	2850	3230



	2019	2020	2021	2022	2023
Your org	69.99%	71.71%	71.09%	73.74%	75.83%
Best result	81.82%	82.10%	78.44%	78.22%	77.78%
Average result	71.82%	70.56%	69.80%	70.37%	70.96%
Worst result	62.48%	62.97%	62.26%	63.16%	63.16%
Responses	2016	2263	2745	2859	3232





	2019	2020	2021	2022	2023
Your org	68.49%	70.19%	70.56%	74.62%	76.61%
Best result	79.38%	77.33%	77.69%	79.17%	79.13%
Average result	70.43%	69.49%	69.21%	69.78%	71.45%
Worst result	56.97%	60.71%	62.07%	62.76%	65.29%
Responses	1999	2265	2730	2850	3231

Question not linked to People Promise elements or themes

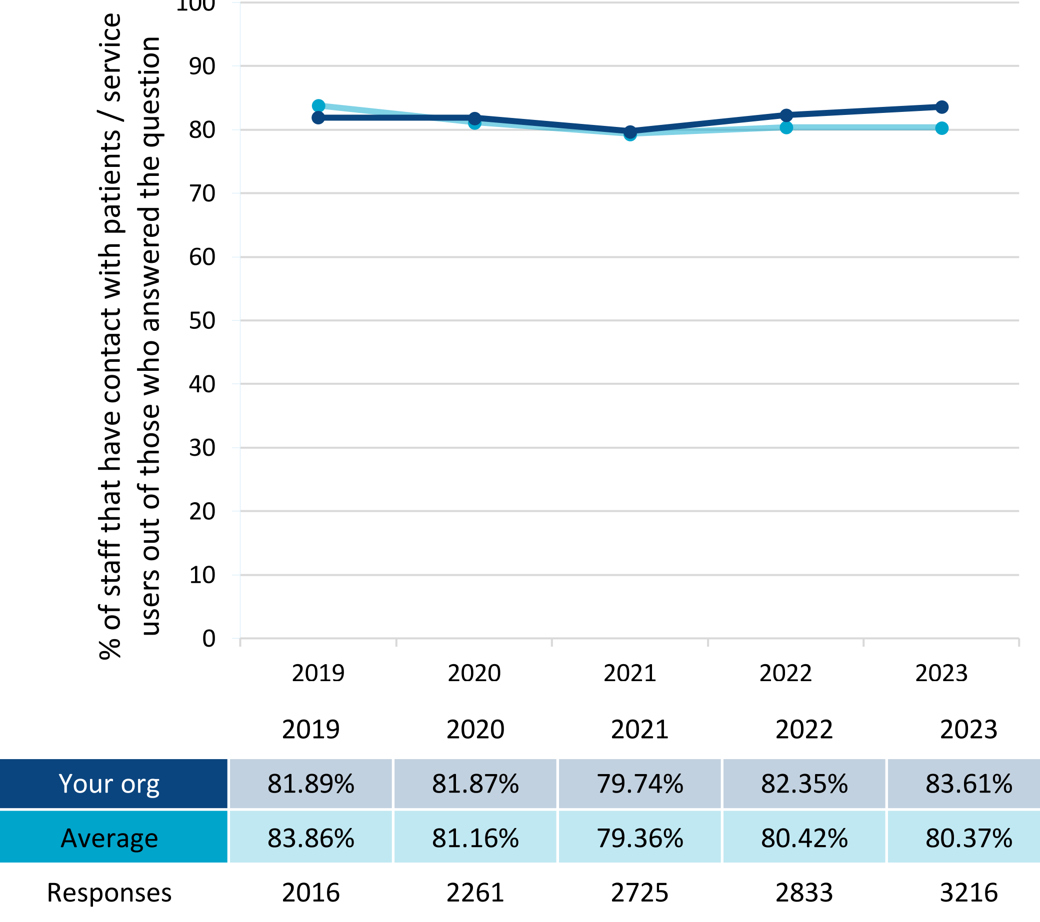
Questions included:*

Q1, Q10a, Q10b, Q10c, Q11e, Q16c, Q18, Q19a, Q19b, Q19c, Q19d, Q31b, Q26d

*The results for Q17a, Q17b and Q22 are reported in the section for People Promise element 4: We are safe and healthy. These questions do not contribute to any score or sub-score calculations.

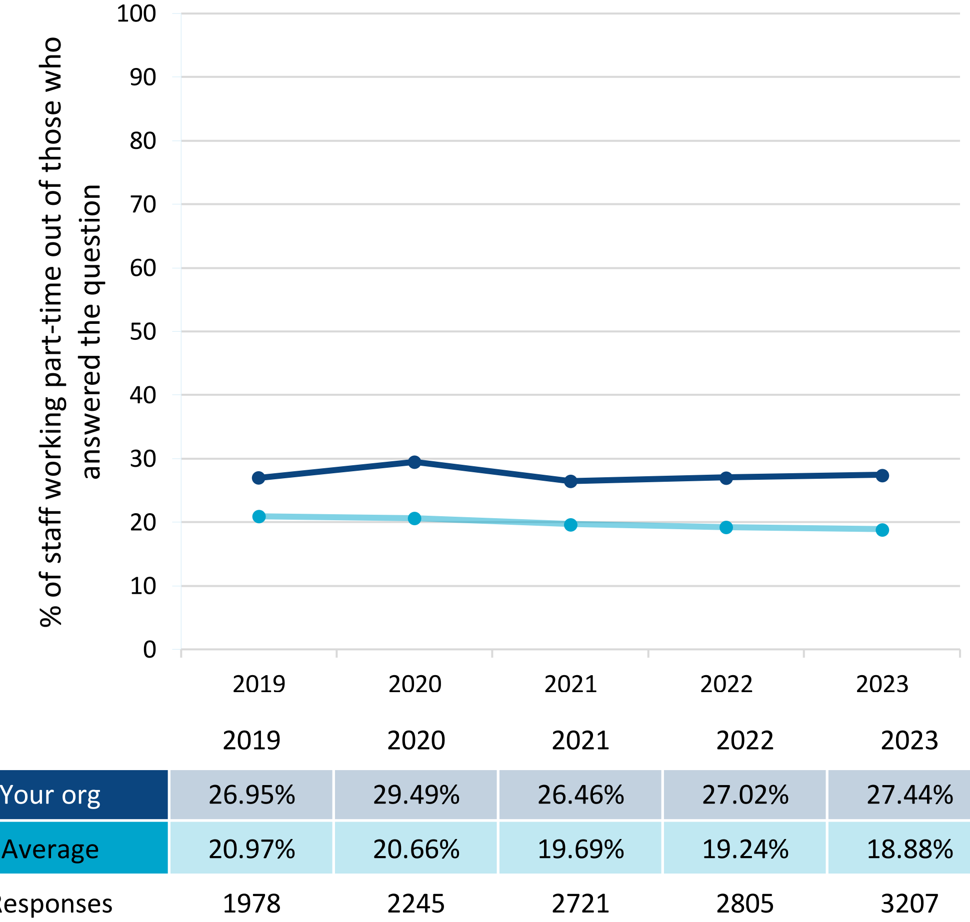
Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Q1 Do you have face-to-face, video or telephone contact with patients / service users as part of your job?



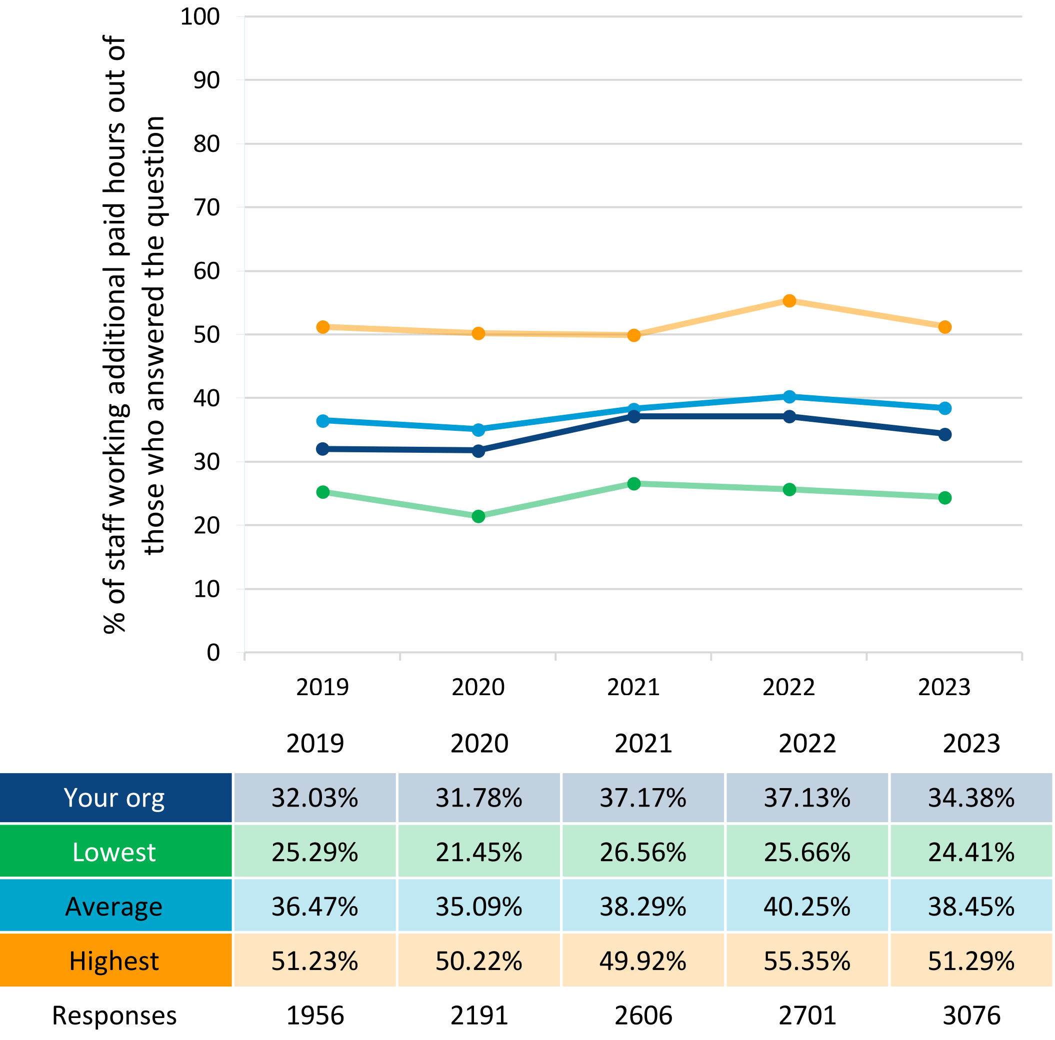
	2019	2020	2021	2022	2023
Your org	81.89%	81.87%	79.74%	82.35%	83.61%
Average	83.86%	81.16%	79.36%	80.42%	80.37%
Responses	2016	2261	2725	2833	3216

Q10a How many hours a week are you contracted to work?

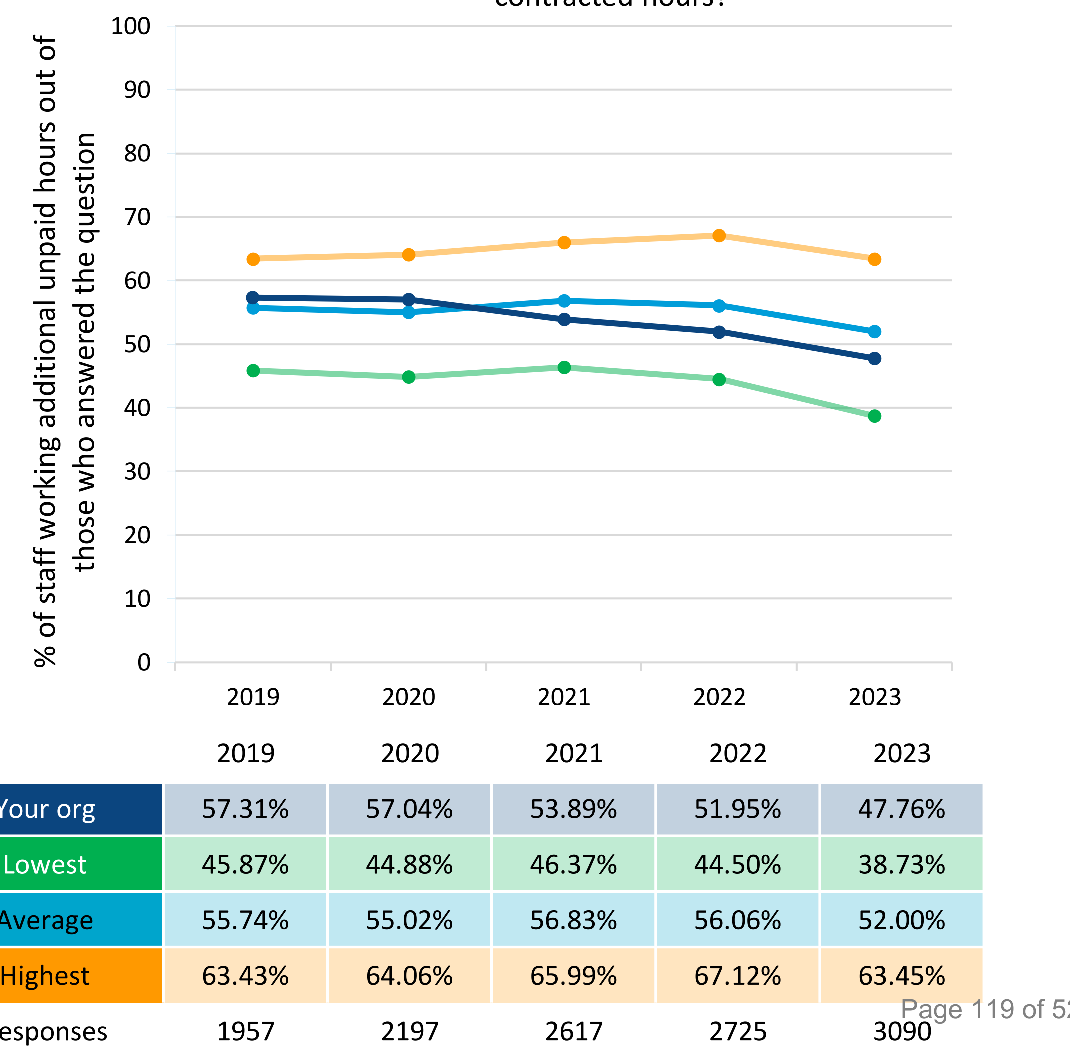


	2019	2020	2021	2022	2023
Your org	26.95%	29.49%	26.46%	27.02%	27.44%
Average	20.97%	20.66%	19.69%	19.24%	18.88%
Responses	1978	2245	2721	2805	3207

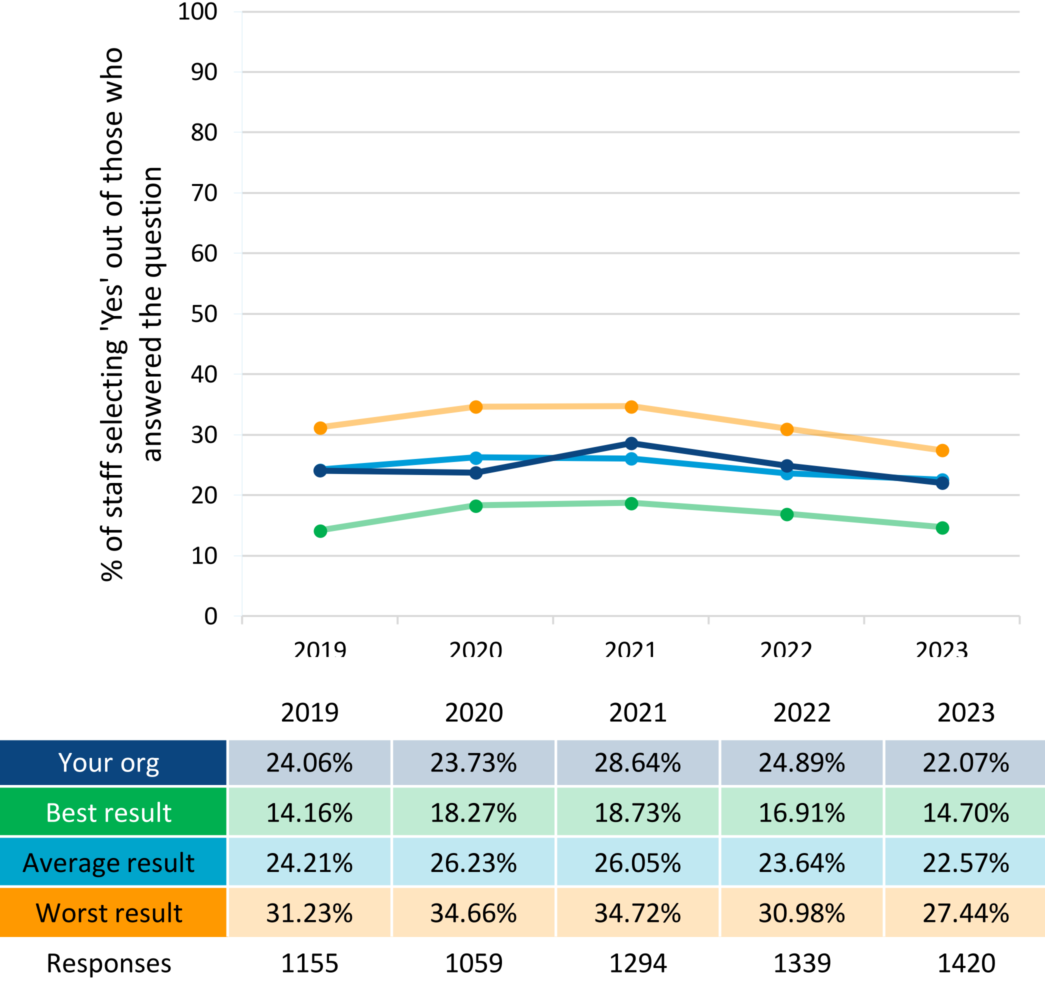
People Promise elements and theme results – Questions not linked to People Promise elements or themes



	2019	2020	2021	2022	2023
Your org	32.03%	31.78%	37.17%	37.13%	34.38%
Lowest	25.29%	21.45%	26.56%	25.66%	24.41%
Average	36.47%	35.09%	38.29%	40.25%	38.45%
Highest	51.23%	50.22%	49.92%	55.35%	51.29%
Responses	1956	2191	2606	2701	3076

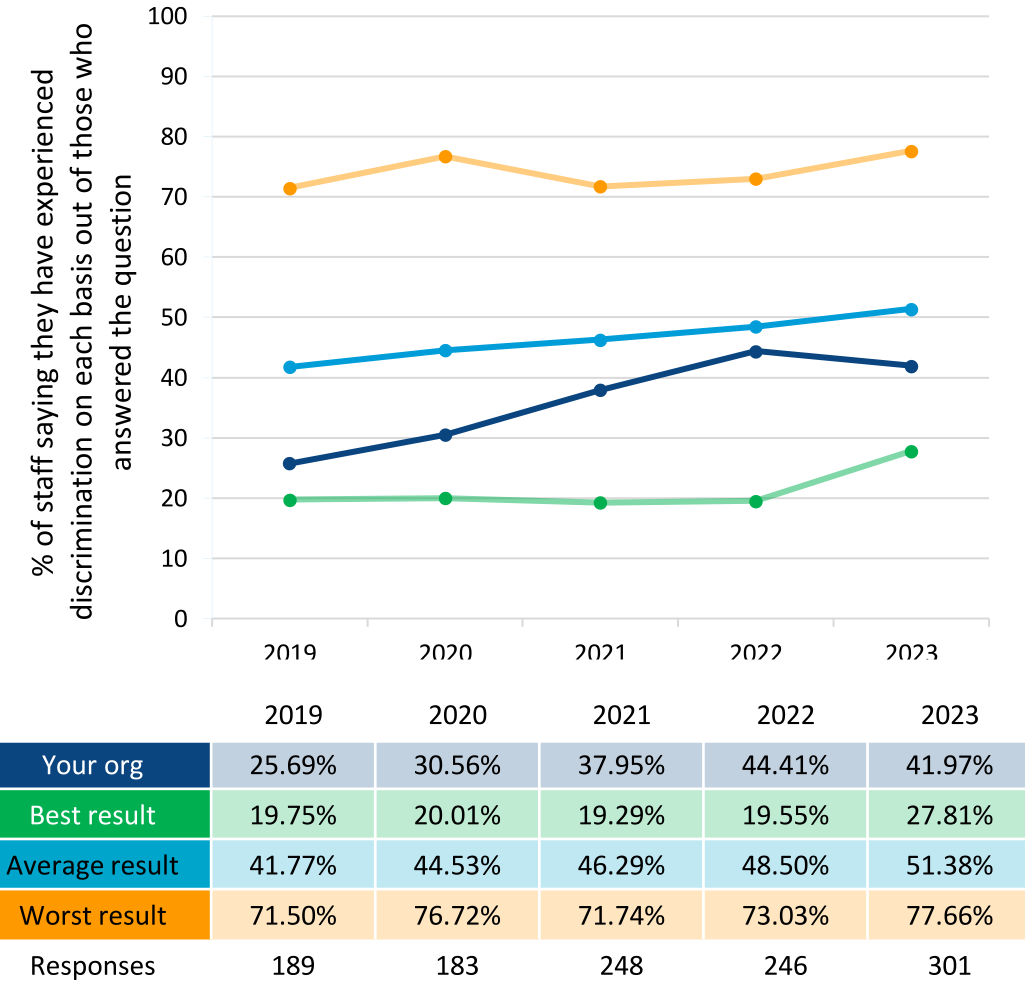


	2019	2020	2021	2022	2023
Your org	57.31%	57.04%	53.89%	51.95%	47.76%
Lowest	45.87%	44.88%	46.37%	44.50%	38.73%
Average	55.74%	55.02%	56.83%	56.06%	52.00%
Highest	63.43%	64.06%	65.99%	67.12%	63.45%
Responses	1957	2197	2617	2725	3090

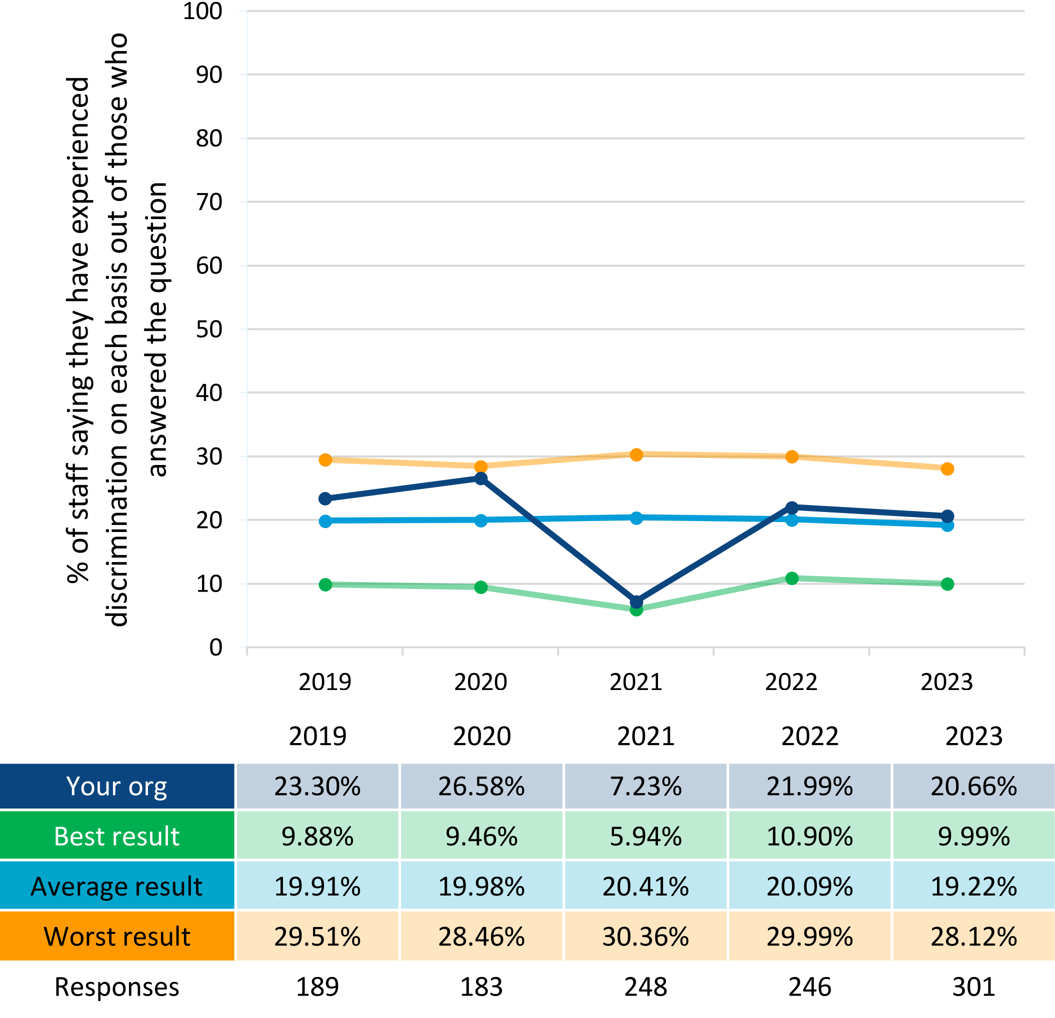


	2019	2020	2021	2022	2023
Your org	24.06%	23.73%	28.64%	24.89%	22.07%
Best result	14.16%	18.27%	18.73%	16.91%	14.70%
Average result	24.21%	26.23%	26.05%	23.64%	22.57%
Worst result	31.23%	34.66%	34.72%	30.98%	27.44%
Responses	1155	1059	1294	1339	1420

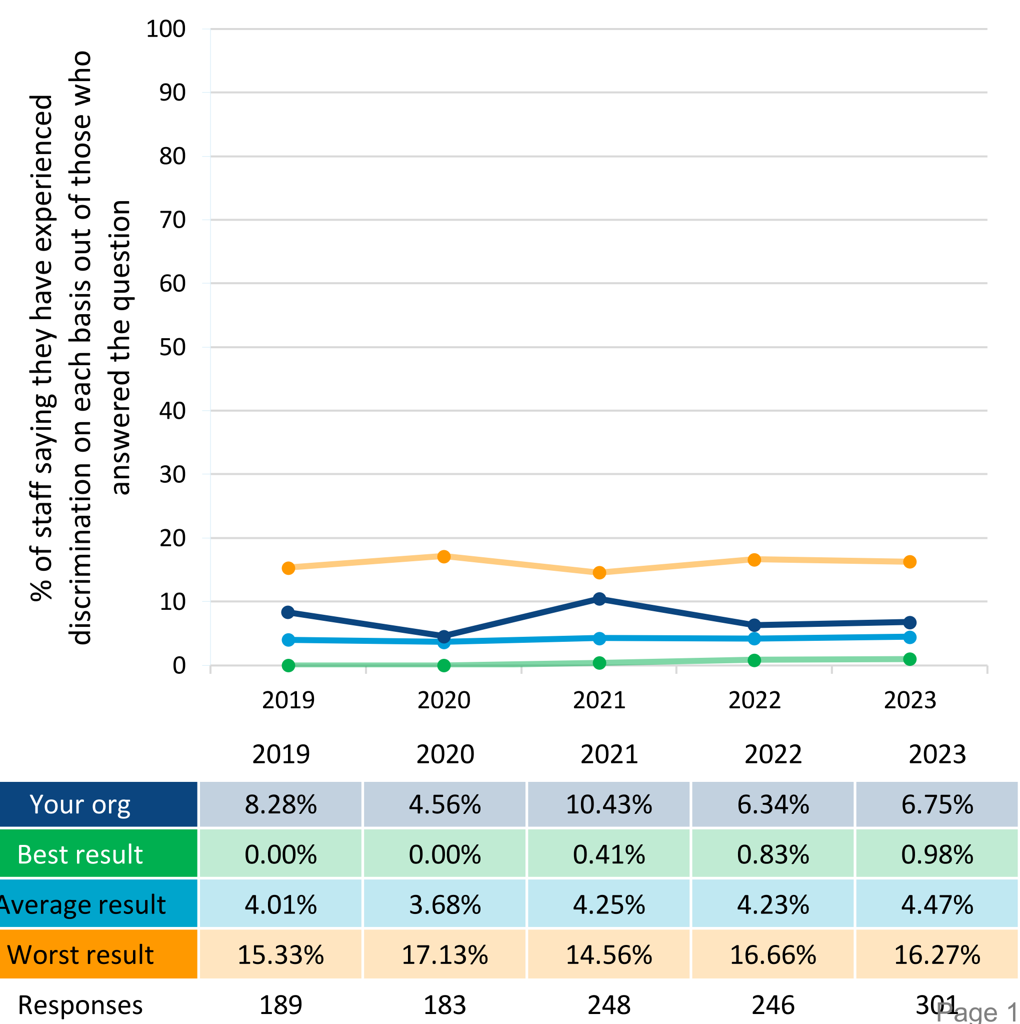
*Q11e is only answered by staff who responded 'Yes' to Q11d.



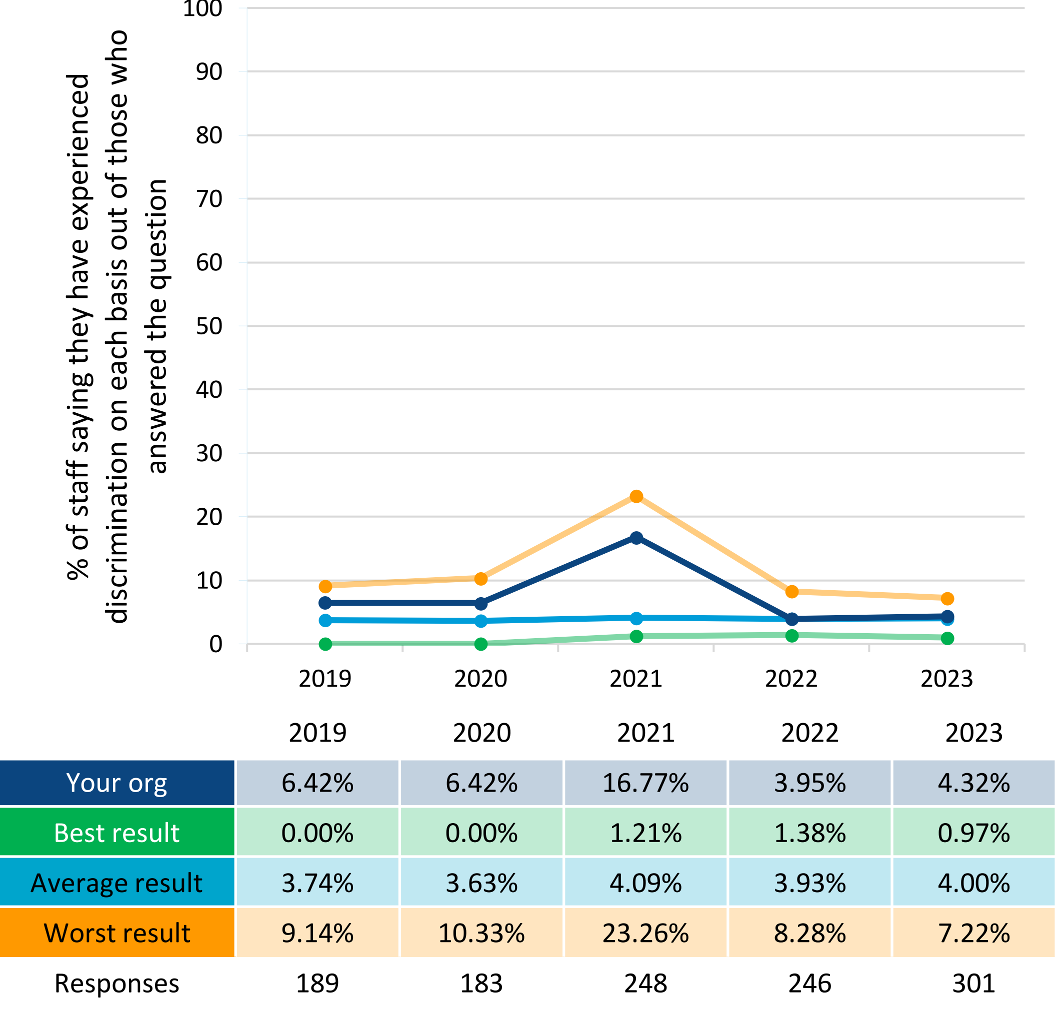
	2019	2020	2021	2022	2023
Your org	25.69%	30.56%	37.95%	44.41%	41.97%
Best result	19.75%	20.01%	19.29%	19.55%	27.81%
Average result	41.77%	44.53%	46.29%	48.50%	51.38%
Worst result	71.50%	76.72%	71.74%	73.03%	77.66%
Responses	189	183	248	246	301



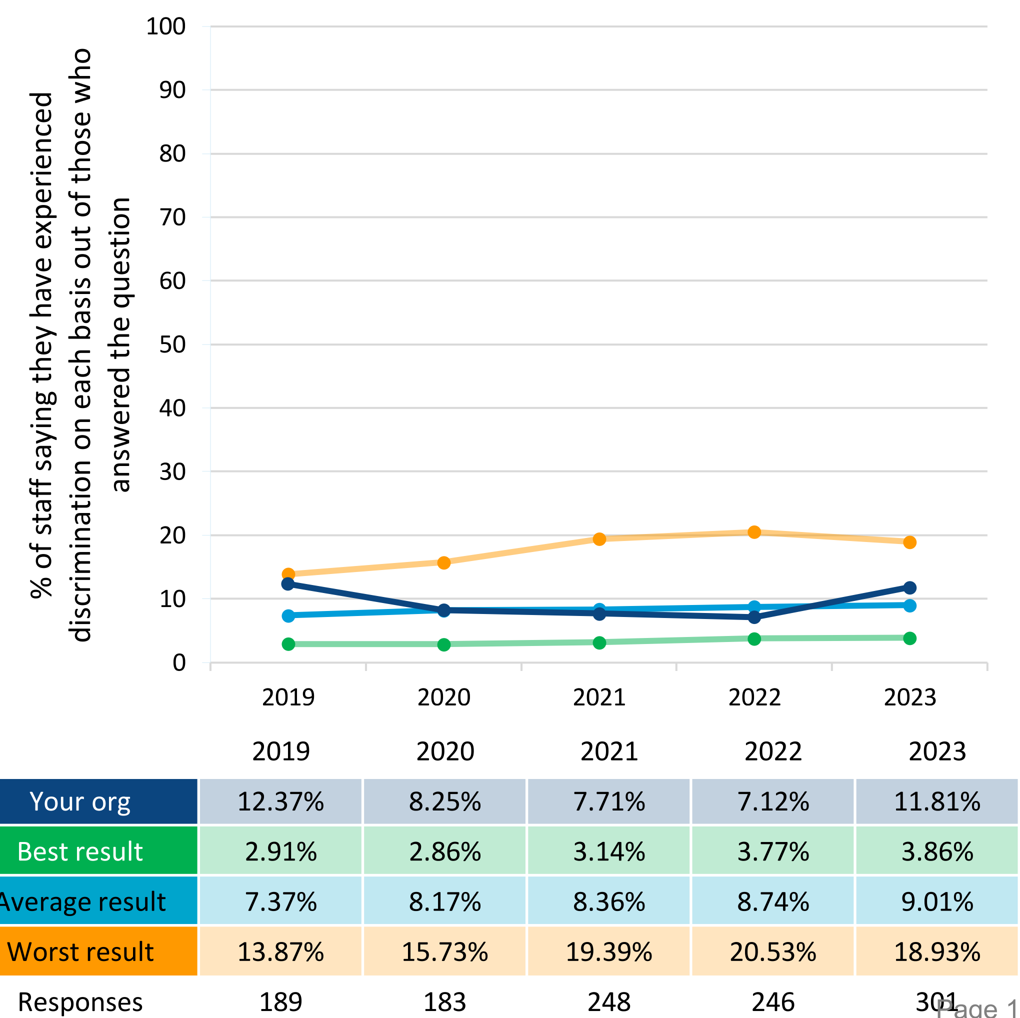
	2019	2020	2021	2022	2023
Your org	23.30%	26.58%	7.23%	21.99%	20.66%
Best result	9.88%	9.46%	5.94%	10.90%	9.99%
Average result	19.91%	19.98%	20.41%	20.09%	19.22%
Worst result	29.51%	28.46%	30.36%	29.99%	28.12%
Responses	189	183	248	246	301



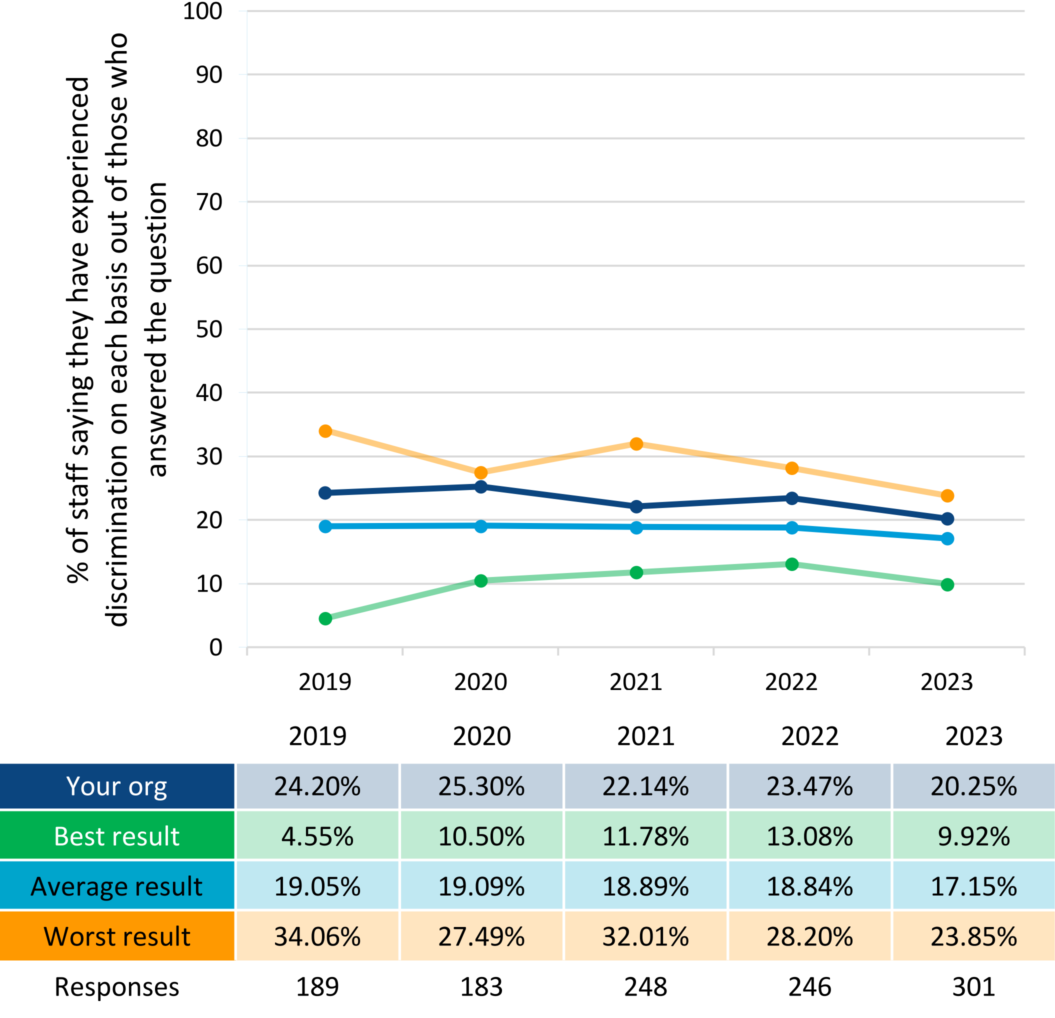
	2019	2020	2021	2022	2023
Your org	8.28%	4.56%	10.43%	6.34%	6.75%
Best result	0.00%	0.00%	0.41%	0.83%	0.98%
Average result	4.01%	3.68%	4.25%	4.23%	4.47%
Worst result	15.33%	17.13%	14.56%	16.66%	16.27%
Responses	189	183	248	246	301



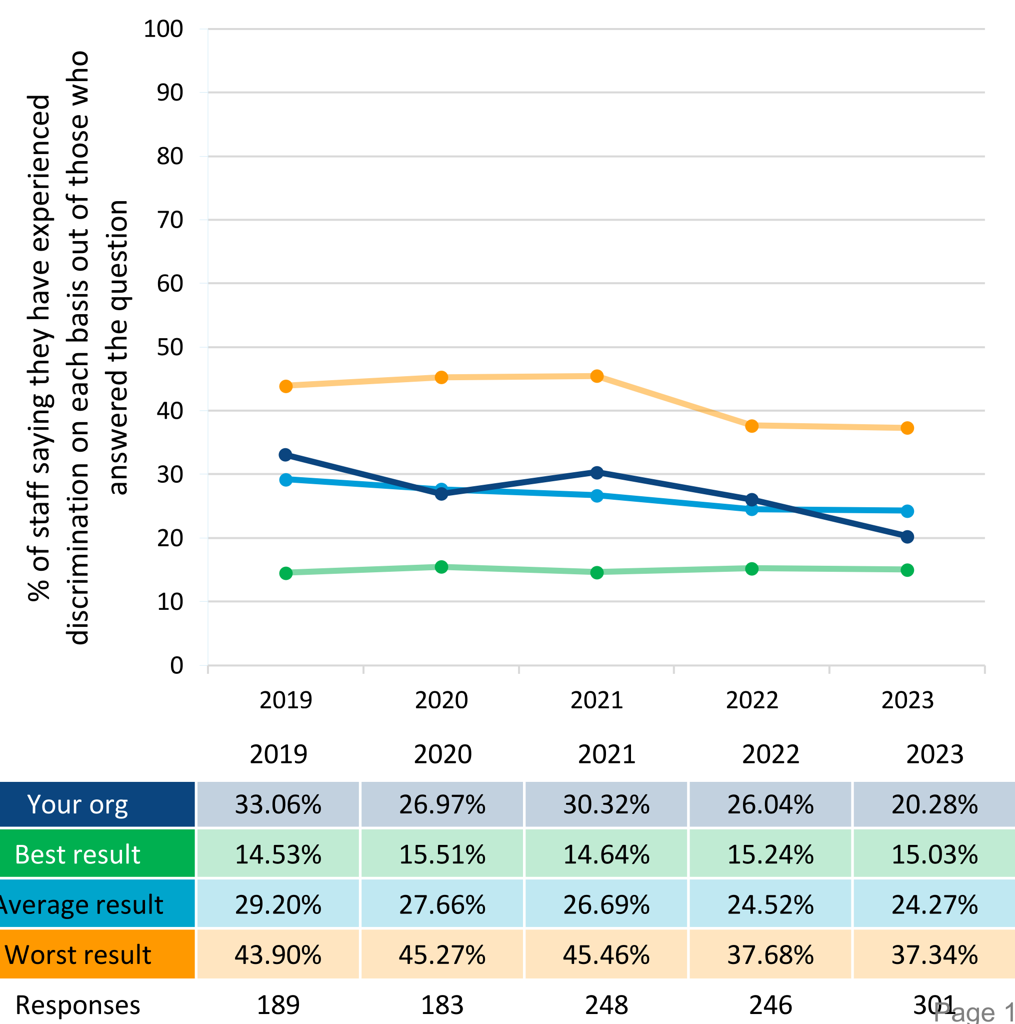
	2019	2020	2021	2022	2023
Your org	6.42%	6.42%	16.77%	3.95%	4.32%
Best result	0.00%	0.00%	1.21%	1.38%	0.97%
Average result	3.74%	3.63%	4.09%	3.93%	4.00%
Worst result	9.14%	10.33%	23.26%	8.28%	7.22%
Responses	189	183	248	246	301



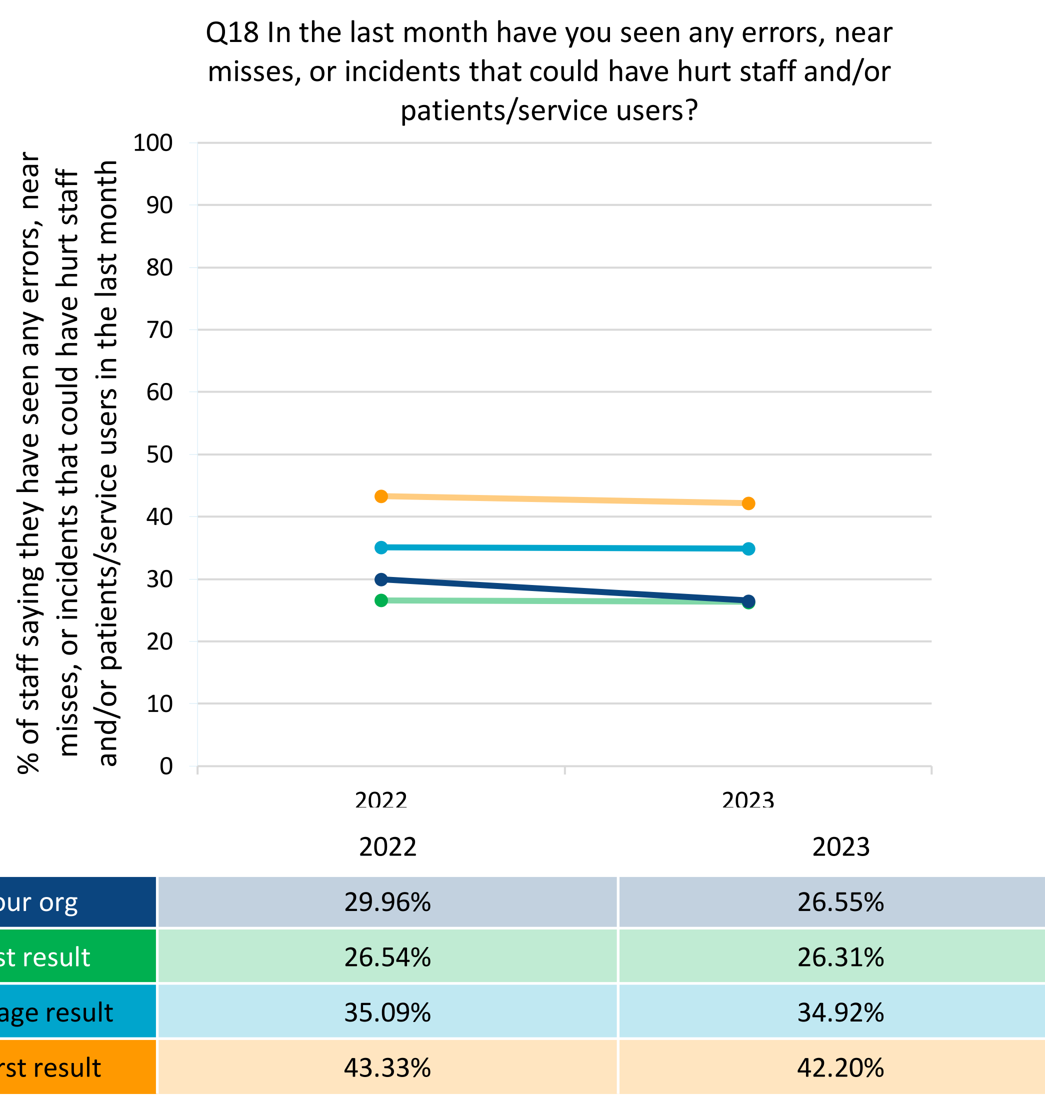
	2019	2020	2021	2022	2023
Your org	12.37%	8.25%	7.71%	7.12%	11.81%
Best result	2.91%	2.86%	3.14%	3.77%	3.86%
Average result	7.37%	8.17%	8.36%	8.74%	9.01%
Worst result	13.87%	15.73%	19.39%	20.53%	18.93%
Responses	189	183	248	246	301



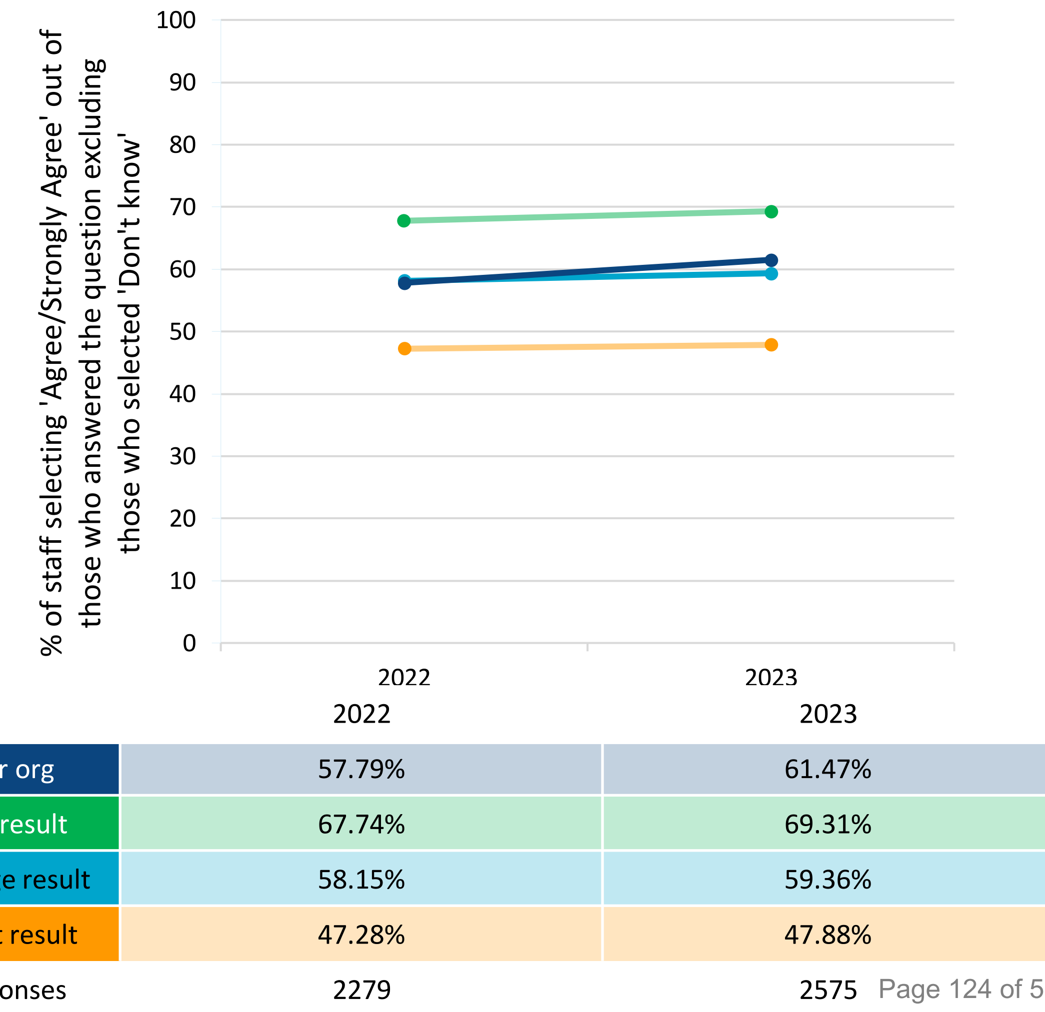
	2019	2020	2021	2022	2023
Your org	24.20%	25.30%	22.14%	23.47%	20.25%
Best result	4.55%	10.50%	11.78%	13.08%	9.92%
Average result	19.05%	19.09%	18.89%	18.84%	17.15%
Worst result	34.06%	27.49%	32.01%	28.20%	23.85%
Responses	189	183	248	246	301



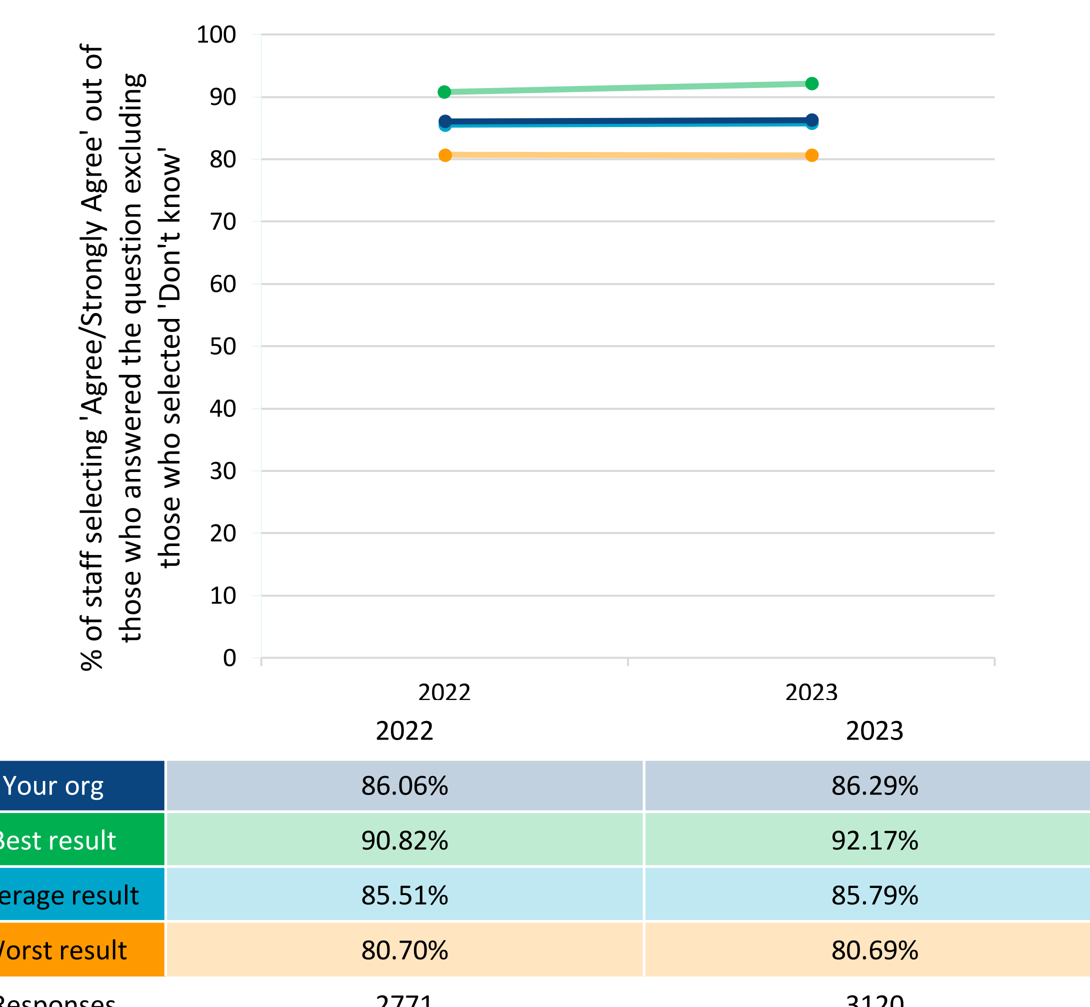
	2019	2020	2021	2022	2023
Your org	33.06%	26.97%	30.32%	26.04%	20.28%
Best result	14.53%	15.51%	14.64%	15.24%	15.03%
Average result	29.20%	27.66%	26.69%	24.52%	24.27%
Worst result	43.90%	45.27%	45.46%	37.68%	37.34%
Responses	189	183	248	246	301



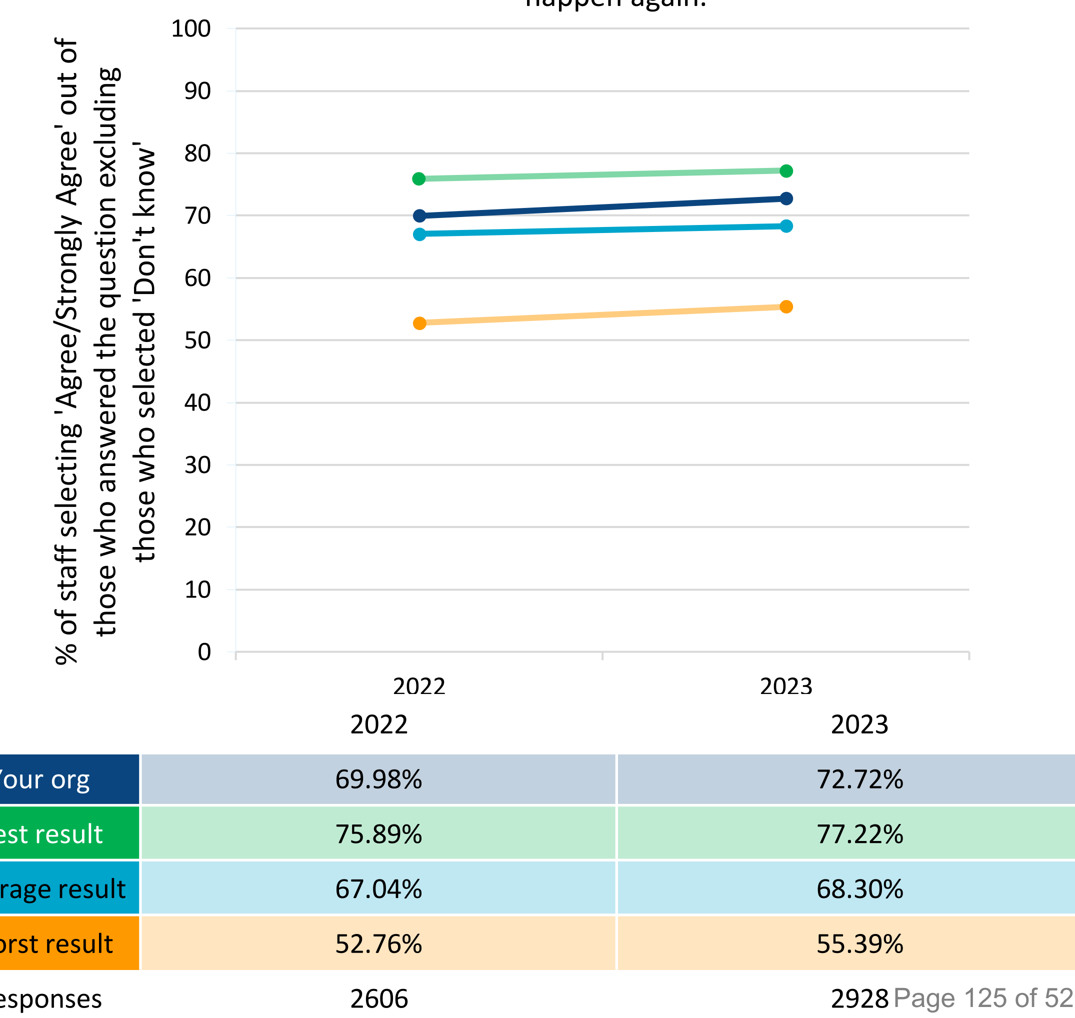
	2022	2023
Your org	29.96%	26.55%
Best result	26.54%	26.31%
Average result	35.09%	34.92%
Worst result	43.33%	42.20%
Responses	2806	3188



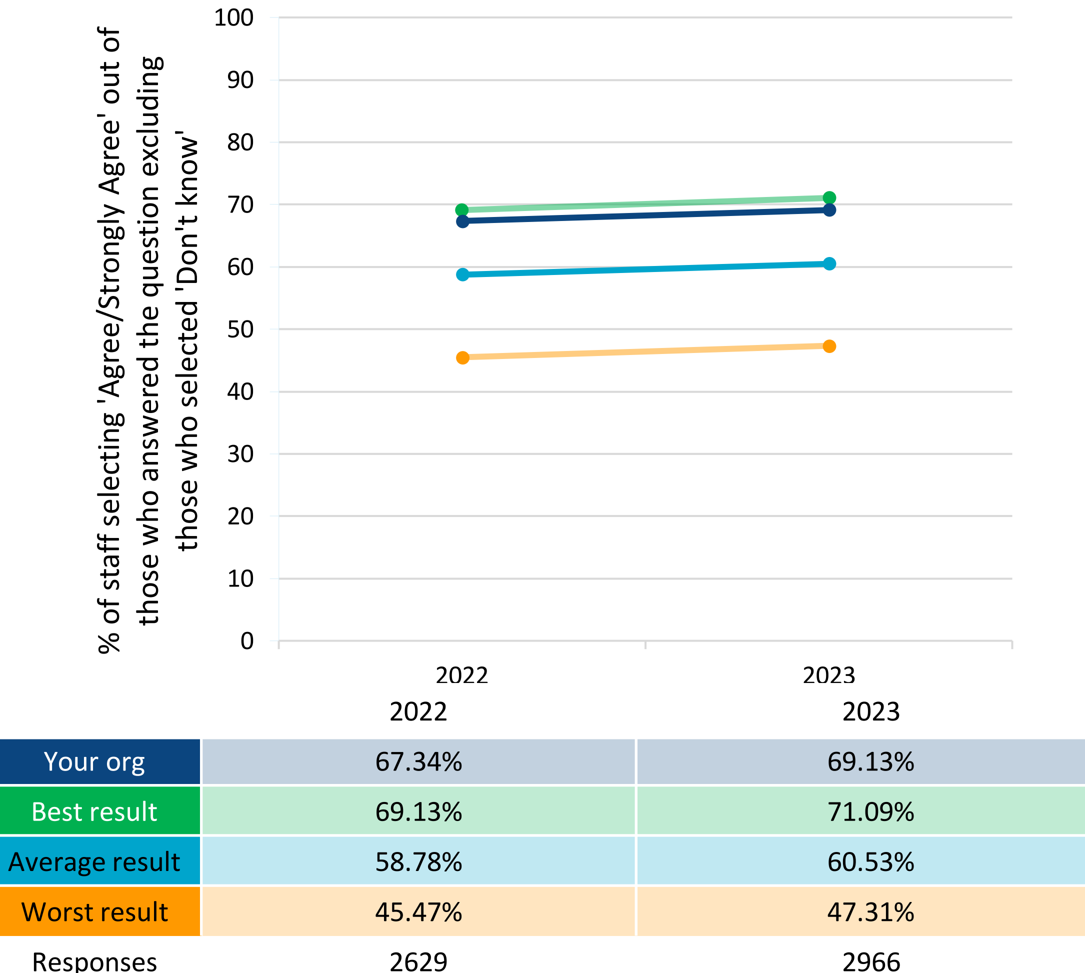
	2022	2023
Your org	57.79%	61.47%
Best result	67.74%	69.31%
Average result	58.15%	59.36%
Worst result	47.28%	47.88%
Responses	2279	2575



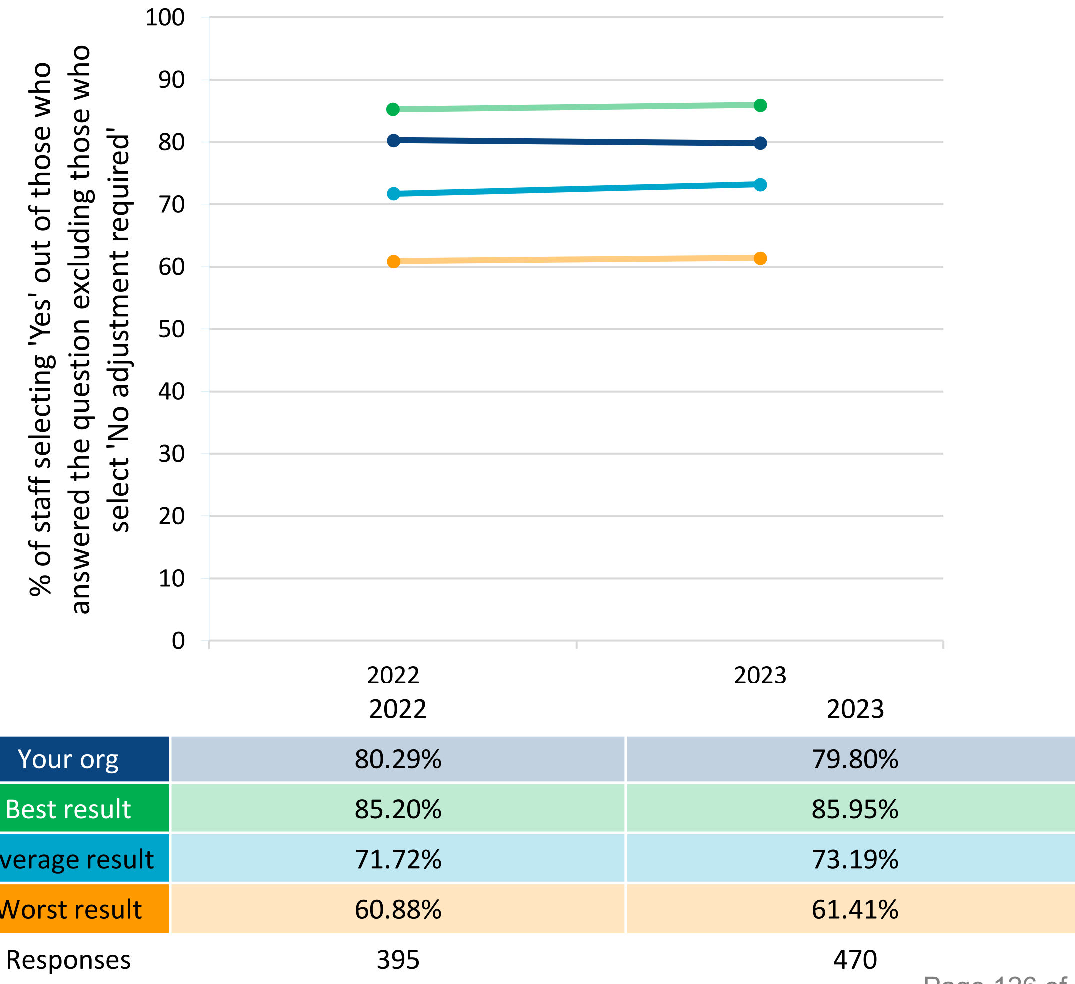
	2022	2023
Your org	86.06%	86.29%
Best result	90.82%	92.17%
Average result	85.51%	85.79%
Worst result	80.70%	80.69%
Responses	2771	3120



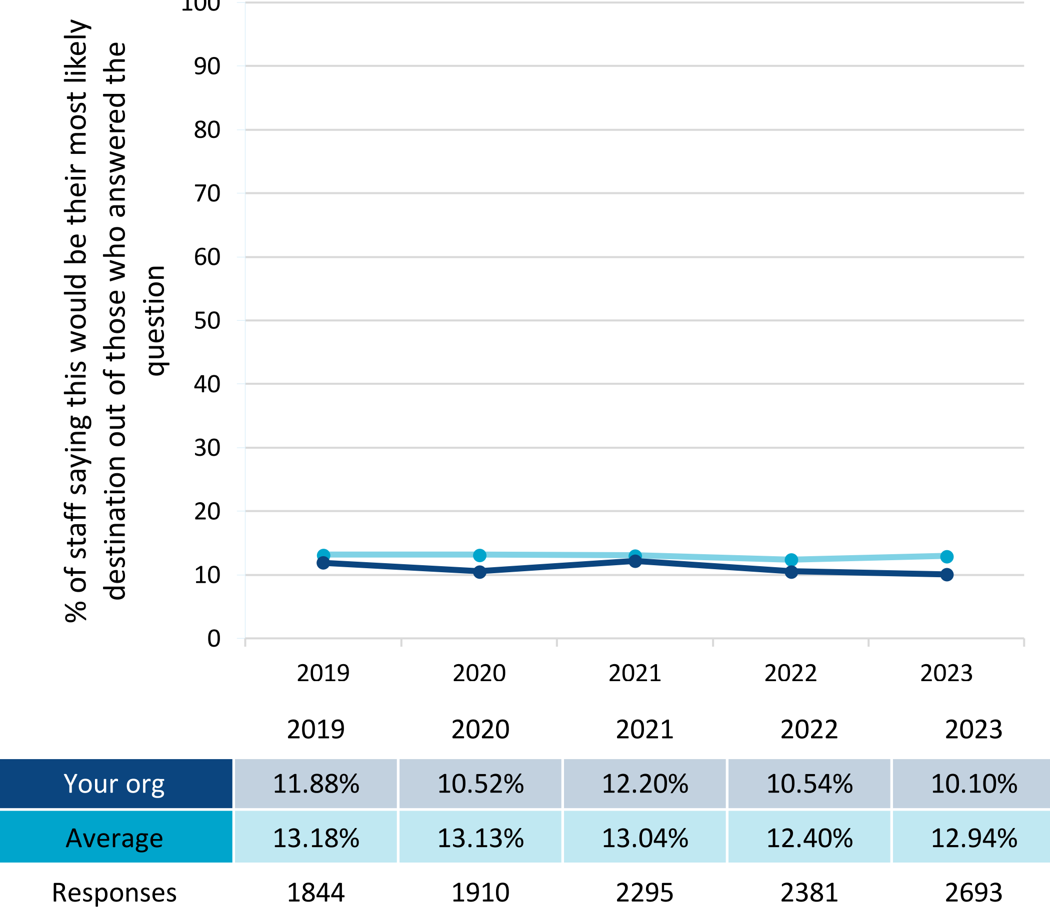
	2022	2023
Your org	69.98%	72.72%
Best result	75.89%	77.22%
Average result	67.04%	68.30%
Worst result	52.76%	55.39%
Responses	2606	2928



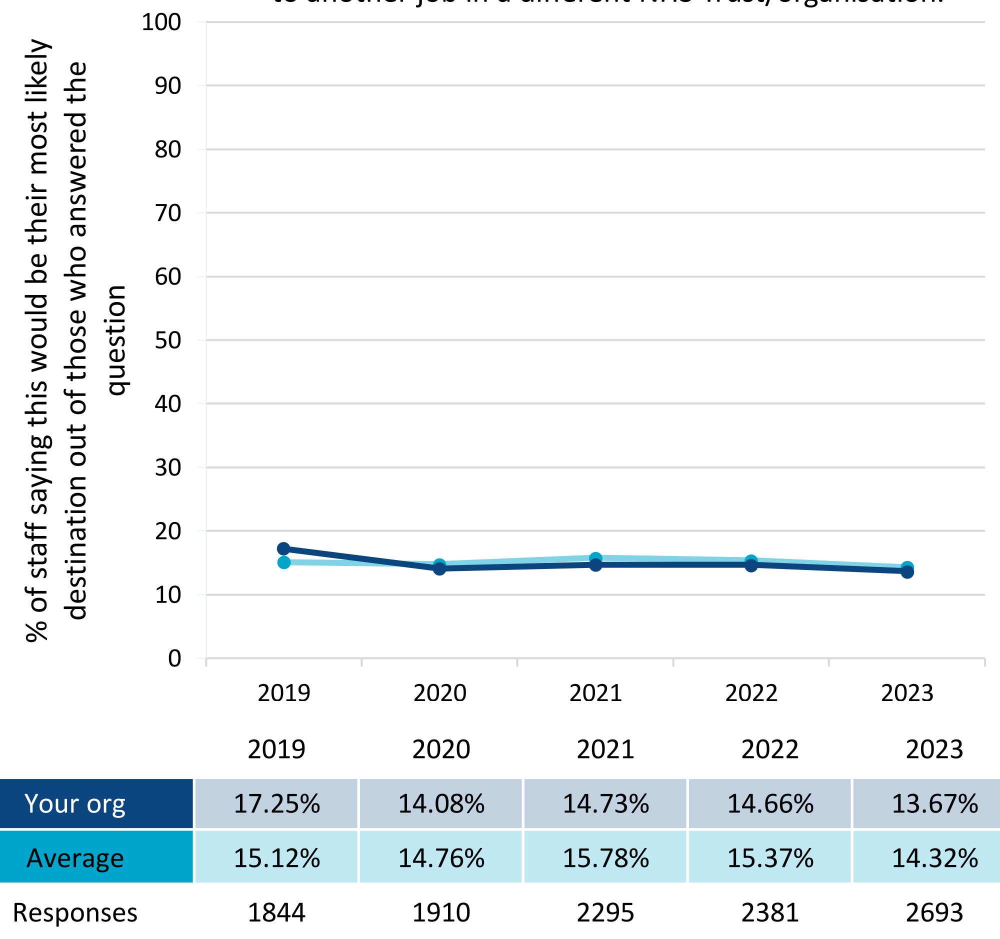
	2022	2023
Your org	67.34%	69.13%
Best result	69.13%	71.09%
Average result	58.78%	60.53%
Worst result	45.47%	47.31%
Responses	2629	2966



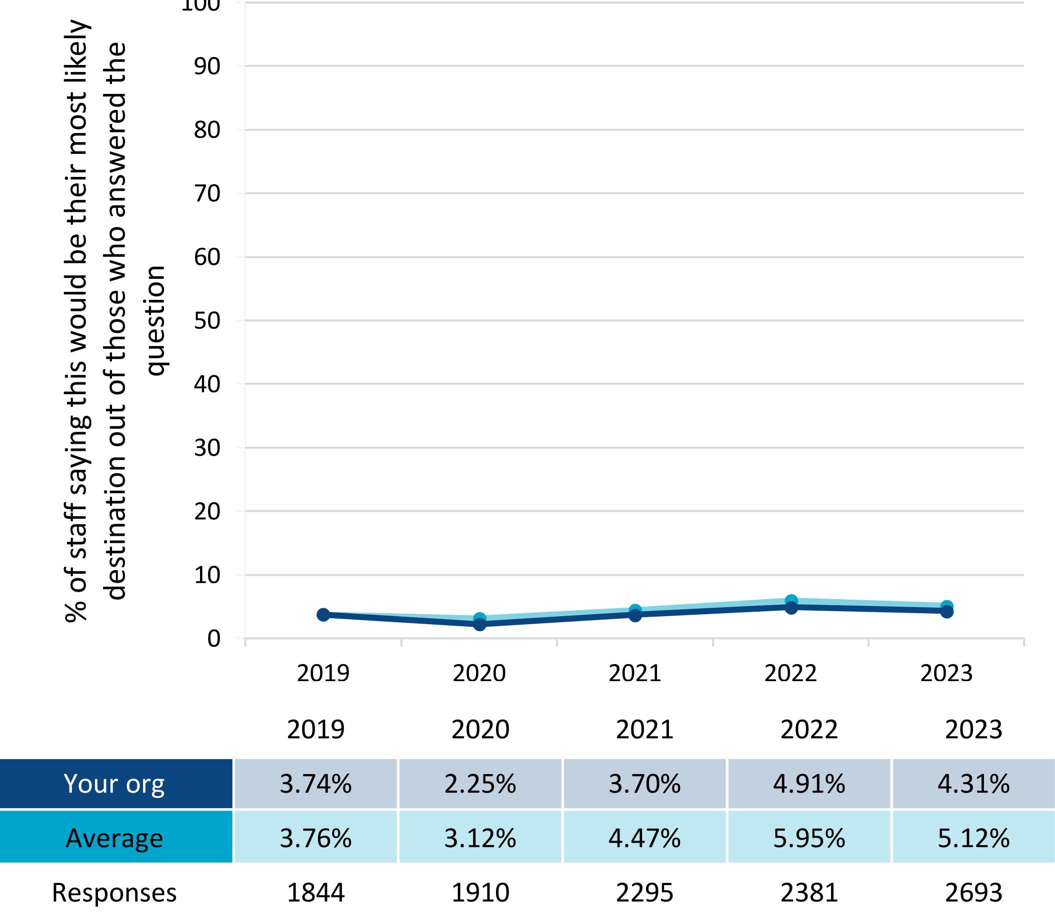
	2022	2023
Your org	80.29%	79.80%
Best result	85.20%	85.95%
Average result	71.72%	73.19%
Worst result	60.88%	61.41%
Responses	395	470



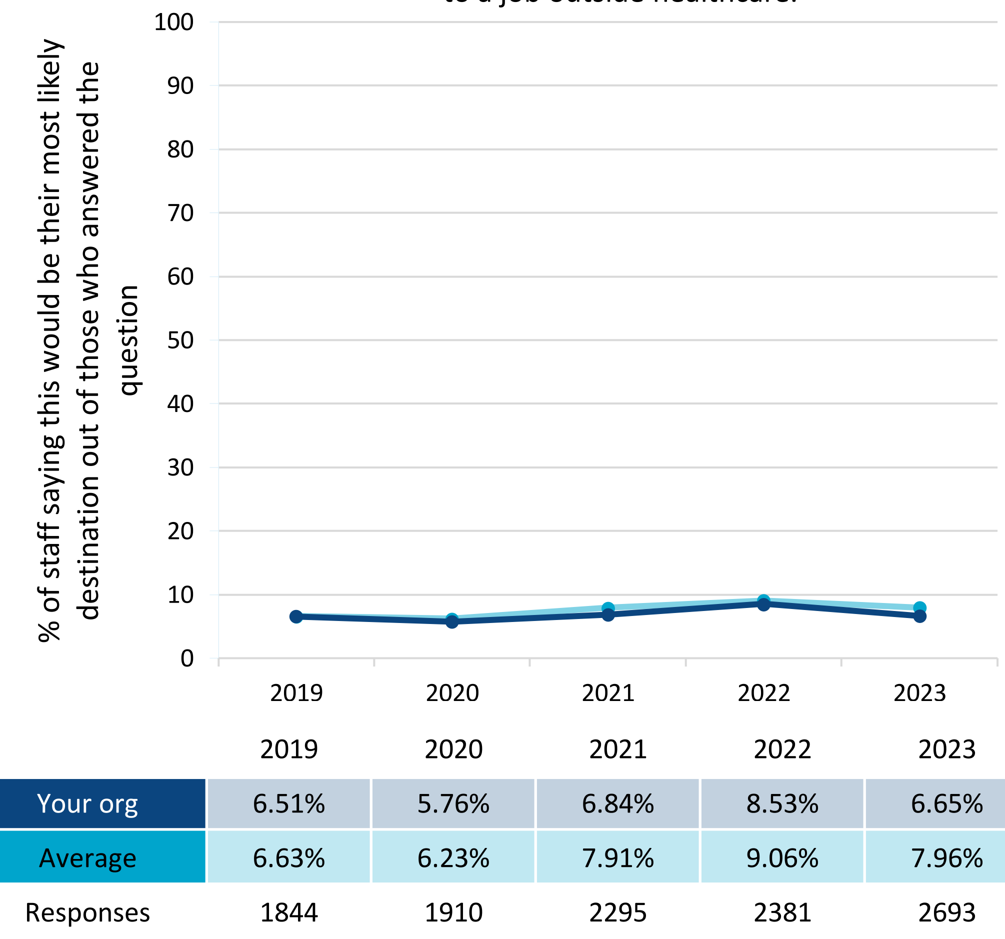
	2019	2020	2021	2022	2023
Your org	11.88%	10.52%	12.20%	10.54%	10.10%
Average	13.18%	13.13%	13.04%	12.40%	12.94%
Responses	1844	1910	2295	2381	2693



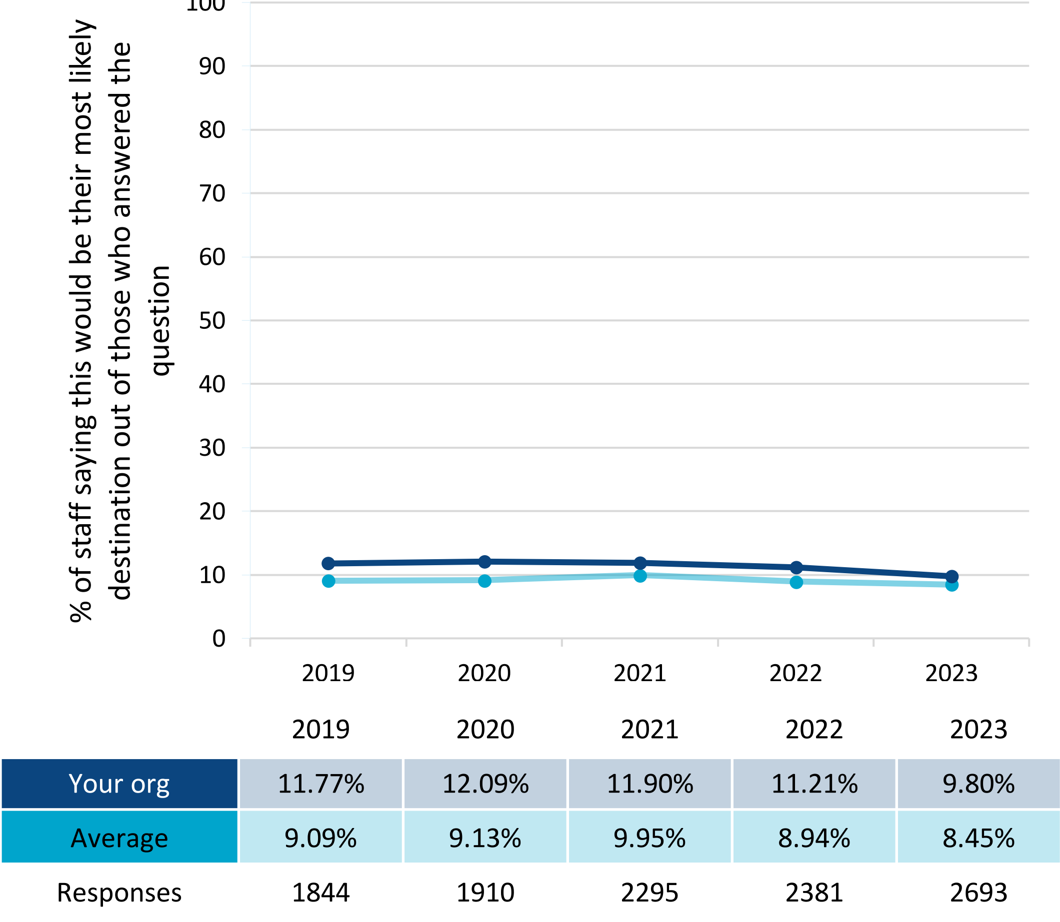
	2019	2020	2021	2022	2023
Your org	17.25%	14.08%	14.73%	14.66%	13.67%
Average	15.12%	14.76%	15.78%	15.37%	14.32%
Responses	1844	1910	2295	2381	2693



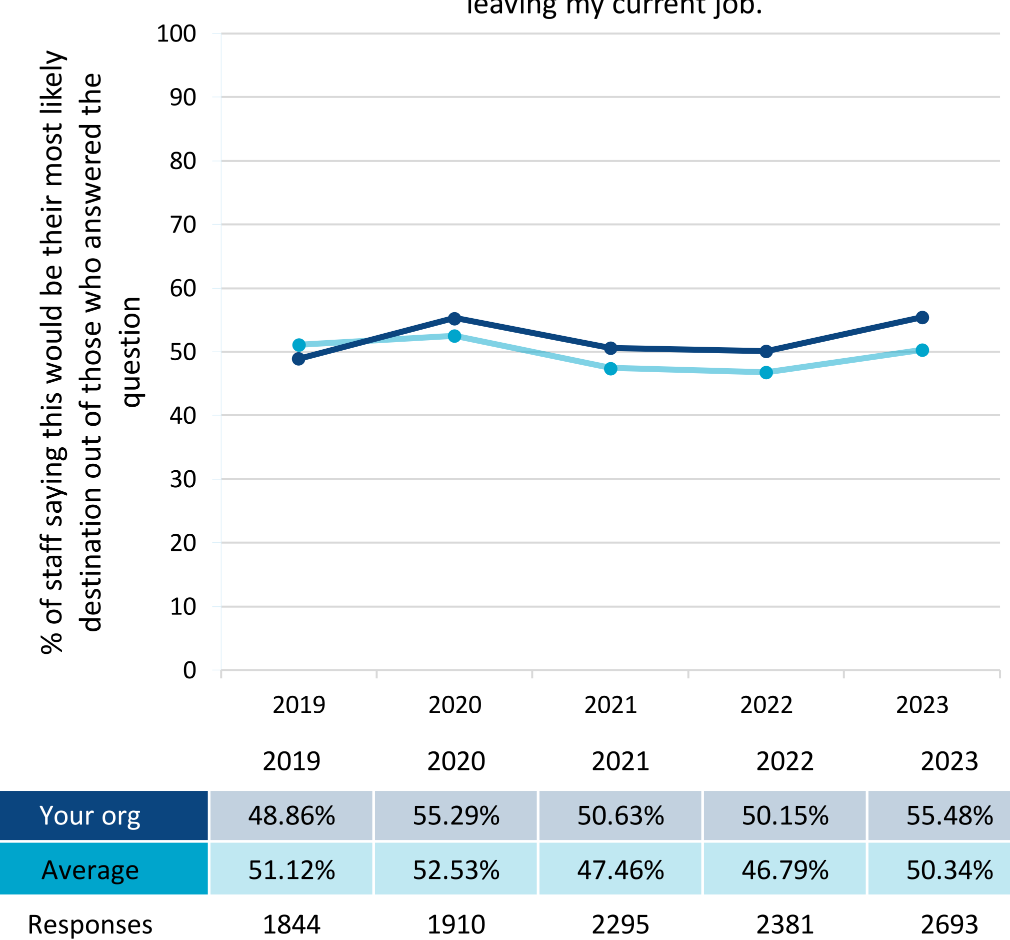
	2019	2020	2021	2022	2023
Your org	3.74%	2.25%	3.70%	4.91%	4.31%
Average	3.76%	3.12%	4.47%	5.95%	5.12%
Responses	1844	1910	2295	2381	2693



	2019	2020	2021	2022	2023
Your org	6.51%	5.76%	6.84%	8.53%	6.65%
Average	6.63%	6.23%	7.91%	9.06%	7.96%
Responses	1844	1910	2295	2381	2693



	2019	2020	2021	2022	2023
Your org	11.77%	12.09%	11.90%	11.21%	9.80%
Average	9.09%	9.13%	9.95%	8.94%	8.45%
Responses	1844	1910	2295	2381	2693



	2019	2020	2021	2022	2023
Your org	48.86%	55.29%	50.63%	50.15%	55.48%
Average	51.12%	52.53%	47.46%	46.79%	50.34%
Responses	1844	1910	2295	2381	2693

Survey Coordination Centre

Workforce Equality Standards

Note where there are fewer than 10 responses for a question, results are suppressed to protect staff confidentiality and reliability of data.

Workforce Race Equality Standards (WRES)

This section contains data for the organisation required for the NHS Staff Survey indicators used in the Workforce Race Equality Standard (WRES). It includes the 2019-2023 organisation and benchmarking group median results for q13a, q13b&c combined, q15, and q16b split by ethnicity (by white staff / staff from all other ethnic groups combined).

Workforce Disability Equality Standards (WDES)

This section contains data for the organisation required for the NHS Staff Survey indicators used in the Workforce Disability Equality Standard (WDES). It includes the 2019-2023 organisation and benchmarking group median results for q4b, q11e, q14a-d, and q15 split by staff with a long lasting health condition or illness compared to staff without a long lasting health condition or illness. It also shows results for q31b (for staff with a long lasting health condition or illness only), and the staff engagement score for staff with a long lasting health condition or illness, compared to staff without a long lasting health condition or illness and the overall engagement score for the organisation.

In 2022, the text for q31b was updated and the word ‘adequate’ was updated to ‘reasonable’.

The WDES breakdowns are based on the responses to q31a Do you have any physical or mental health conditions or illnesses lasting or expected to last for 12 months or more?

Workforce Equality Standards

This section contains data required for the staff survey indicators used in the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES). Data presented in this section are unweighted.

Workforce Race Equality Standards (WRES)

Indicator	Qu No	Workforce Race Equality Standard
		For each of the following indicators, compare the outcomes of the responses for white staff and staff from all other ethnic groups combined
5	Q14a	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
6	Q14b & Q14c	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
7	Q15	Percentage believing that their organisation provides equal opportunities for career progression or promotion
8	Q16b	In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues

Workforce Disability Equality Standards (WDES)

Indicator	Qu No	Workforce Disability Equality Standard
		For each of the following indicators, compare the responses for staff with a LTC* or illness vs staff without a LTC or illness
4a	Q14a	Percentage of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or other members of the public
4b	Q14b	Percentage of staff experiencing harassment, bullying or abuse from managers
4c	Q14c	Percentage of staff experiencing harassment, bullying or abuse from other colleagues
4d	Q14d	Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it
5	Q15	Percentage believing that their organisation provides equal opportunities for career progression or promotion
6	Q11e	Percentage of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties
7	Q4b	Percentage staff saying that they are satisfied with the extent to which their organisation values their work
8	Q31b	Percentage of staff with a long lasting health condition or illness saying their employer has made reasonable adjustment(s) to enable them to carry out their work
9a	theme_engagement	The staff engagement score for staff with LTC or illness vs staff without a LTC or illness

*Staff with a long term condition

Survey Coordination Centre

Workforce Race Equality Standards (WRES)

Vertical scales on the following charts vary from slide to slide and this effects how results are displayed. This allows incremental changes and small differences between results for subgroups to be more easily interpreted.
Data shown in the WRES charts are unweighted.
Averages are calculated as the median for the benchmark group.

Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

	2019	2020	2021	2022	2023
White staff: Your org	25.27%	23.74%	23.37%	23.98%	24.55%
All other ethnic groups*: Your org	26.53%	25.75%	26.39%	28.57%	34.65%
White staff: Average	27.67%	25.36%	26.47%	26.91%	24.72%
All other ethnic groups*: Average	29.51%	28.01%	28.84%	30.82%	28.11%
White staff: Responses	1777	2005	2379	2460	2701
All other ethnic groups*: Responses	147	167	269	322	430

*Staff from all other ethnic groups combined

Workforce Race Equality Standard (WRES)

Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months

Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months out of those who answered the question

	2019	2020	2021	2022	2023
White staff: Your org	21.09%	18.16%	17.39%	16.90%	15.25%
All other ethnic groups*: Your org	29.73%	23.49%	22.73%	23.60%	24.30%
White staff: Average	24.44%	24.37%	23.65%	23.25%	22.37%
All other ethnic groups*: Average	28.39%	29.07%	28.53%	28.81%	26.20%
White staff: Responses	1769	2004	2364	2444	2682
All other ethnic groups*: Responses	148	166	264	322	428

*Staff from all other ethnic groups combined

Workforce Race Equality Standard (WRES)

Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion

70
60
50
40
30
20
10
0

2019 2020 2021 2022 2023

	2019	2020	2021	2022	2023
White staff: Your org	56.54%	61.04%	61.04%	62.82%	64.47%
All other ethnic groups*: Your org	44.67%	51.20%	44.57%	53.75%	49.29%
White staff: Average	60.00%	59.39%	58.64%	58.65%	58.84%
All other ethnic groups*: Average	46.62%	45.24%	44.56%	47.00%	49.64%
White staff: Responses	1774	2002	2369	2442	2668
All other ethnic groups*: Responses	150	166	267	320	424

*Staff from all other ethnic groups combined

	2019	2020	2021	2022	2023
White staff: Your org	5.84%	4.61%	4.91%	3.78%	4.14%
All other ethnic groups*: Your org	18.79%	14.72%	18.96%	14.69%	12.80%
White staff: Average	5.85%	6.09%	6.67%	6.52%	6.73%
All other ethnic groups*: Average	14.14%	16.77%	17.28%	17.33%	16.17%
White staff: Responses	1764	1995	2381	2462	2680
All other ethnic groups*: Responses	149	163	269	320	422

*Staff from all other ethnic groups combined

Survey Coordination Centre

Workforce Disability Equality Standards (WDES)

Vertical scales on the following charts vary from slide to slide and this effects how results are displayed. This allows incremental changes and small differences between results for subgroups to be more easily interpreted.
Data shown in the WDES charts are unweighted.

Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Percentage of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or the public in the last 12 months.

Y-axis: Percentage of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or the public in the last 12 months out of those who answered the question (0–35); X-axis: 2019, 2020, 2021, 2022, 2023

	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	32.71%	31.14%	29.80%	30.66%	29.77%
Staff without a LTC or illness: Your org	23.52%	22.28%	22.00%	22.88%	24.76%
Staff with a LTC or illness: Average	33.17%	30.86%	32.43%	32.98%	30.35%
Staff without a LTC or illness: Average	26.45%	24.53%	25.19%	26.16%	23.76%
Staff with a LTC or illness: Responses	373	440	594	636	766
Staff without a LTC or illness: Responses	1573	1737	2064	2159	2379

Workforce Disability Equality Standards

Percentage of staff experiencing harassment, bullying or abuse from managers in the last 12 months.

Y-axis: Percentage of staff experiencing harassment, bullying or abuse from managers in the last 12 months out of those who answered the question

	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	17.76%	13.18%	10.63%	11.80%	8.55%
Staff without a LTC or illness: Your org	8.51%	7.83%	7.11%	5.83%	6.01%
Staff with a LTC or illness: Average	18.45%	19.35%	18.00%	17.09%	15.87%
Staff without a LTC or illness: Average	10.76%	10.78%	9.77%	9.88%	8.74%
Staff with a LTC or illness: Responses	366	440	583	627	760
Staff without a LTC or illness: Responses	1563	1724	2039	2143	2346

Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months.

	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	23.43%	20.92%	21.12%	21.69%	18.39%
Staff without a LTC or illness: Your org	15.03%	12.90%	12.71%	12.50%	11.99%
Staff with a LTC or illness: Average	27.71%	26.89%	26.60%	26.93%	25.86%
Staff without a LTC or illness: Average	17.51%	17.79%	17.11%	17.67%	16.60%
Staff with a LTC or illness: Responses	367	435	587	627	756
Staff without a LTC or illness: Responses	1557	1721	2030	2136	2335

Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.

Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it out of those who answered the question

	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	49.43%	49.43%	46.61%	47.19%	57.75%
Staff without a LTC or illness: Your org	46.85%	42.67%	49.09%	50.09%	51.22%
Staff with a LTC or illness: Average	46.92%	47.01%	47.03%	48.43%	50.44%
Staff without a LTC or illness: Average	46.07%	45.80%	46.20%	47.30%	49.33%
Staff with a LTC or illness: Responses	174	176	221	231	258
Staff without a LTC or illness: Responses	461	464	493	535	615

Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion.

Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion out of those who answered the question

	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	48.40%	52.16%	51.85%	54.76%	59.37%
Staff without a LTC or illness: Your org	57.38%	62.02%	61.55%	63.82%	63.66%
Staff with a LTC or illness: Average	51.93%	51.61%	51.41%	51.39%	51.54%
Staff without a LTC or illness: Average	58.39%	57.45%	56.84%	57.25%	57.52%
Staff with a LTC or illness: Responses	374	439	596	630	763
Staff without a LTC or illness: Responses	1572	1735	2052	2145	2342

Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.

	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	32.87%	28.71%	37.14%	28.90%	25.82%
Staff without a LTC or illness: Your org	21.07%	21.49%	24.86%	23.04%	20.36%
Staff with a LTC or illness: Average	32.66%	33.00%	32.18%	29.97%	28.55%
Staff without a LTC or illness: Average	21.84%	23.44%	23.74%	20.80%	19.46%
Staff with a LTC or illness: Responses	286	303	377	391	457
Staff without a LTC or illness: Responses	845	726	893	933	938

Percentage of staff satisfied with the extent to which their organisation values their work.

Percentage of staff satisfied with the extent to which their organisation values their work out of those who answered the question

	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	28.07%	36.41%	31.34%	35.68%	43.47%
Staff without a LTC or illness: Your org	44.66%	47.73%	42.65%	46.41%	51.42%
Staff with a LTC or illness: Average	38.11%	37.36%	32.62%	32.46%	35.66%
Staff without a LTC or illness: Average	49.92%	49.27%	43.30%	43.56%	47.19%
Staff with a LTC or illness: Responses	374	434	603	639	773
Staff without a LTC or illness: Responses	1583	1743	2082	2174	2394

Percentage of staff with a long lasting health condition or illness saying their employer has made reasonable adjustment(s) to enable them to carry out their work.

Percentage of staff with a long lasting health condition or illness saying their employer has made reasonable adjustment(s) to enable them to carry out their work out of those who answered the question

	2022	2023
Staff with a LTC or illness: Your org	80.76%	79.79%
Staff with a LTC or illness: Average	71.76%	73.38%
Staff with a LTC or illness: Responses	395	470

Workforce Disability Equality Standards

Staff engagement score (0-10)

	2019	2020	2021	2022	2023
Organisation average	6.72	6.91	6.67	6.73	6.98
Staff with a LTC or illness: Your org	6.41	6.61	6.36	6.33	6.80
Staff without a LTC or illness: Your org	6.80	7.00	6.77	6.86	7.05
Staff with a LTC or illness: Average	6.65	6.65	6.42	6.35	6.46
Staff without a LTC or illness: Average	7.13	7.14	6.97	6.92	7.04
Staff with a LTC or illness: Responses	374	443	603	640	775
Staff without a LTC or illness: Responses	1584	1754	2087	2182	2401

Note. Data shown in this chart are unweighted therefore will not match weighted staff engagement scores in other outputs.

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About your respondents

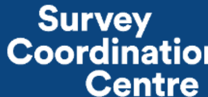
This section shows demographic and other background information for 2023.

Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Background details - Gender

	Female	Male	Non-binary	Prefer to self-describe	Prefer not to say
Your org	81.34%	16.59%	0.13%	0.03%	1.91%
Average	76.60%	19.78%	0.24%	0.18%	3.22%
Responses	3200	3200	3200	3200	3200

Background details – Is your gender identity the same as the sex you were registered at birth?



	Yes	No	Prefer not to say
Your org	97.16%	0.47%	2.37%
Average	96.62%	0.37%	3.08%
Responses	2360	2360	2360

Background details - Age

	16-20	21-30	31-40	41-50	51-65	66+
Your org	0.48%	15.40%	26.45%	23.07%	32.91%	1.69%
Average	0.55%	15.42%	25.91%	24.51%	31.50%	1.70%
Responses	3130	3130	3130	3130	3130	3130

Background details - Ethnicity

	White	Mixed / Multiple ethnic background	Black / African / Caribbean / Black British	Asian / Asian British	Arab	Other
Your org	86.31%	1.36%	8.96%	2.27%	0.66%	0.44%
Average	78.07%	1.97%	14.15%	3.83%	0.44%	0.84%
Responses	3171	3171	3171	3171	3171	3171

Background details – Sexual orientation

	Heterosexual or straight	Gay or lesbian	Bisexual	Other	Prefer not to say
Your org	92.60%	1.79%	1.29%	0.31%	4.01%
Average	89.71%	2.00%	1.84%	0.52%	5.94%
Responses	3189	3189	3189	3189	3189

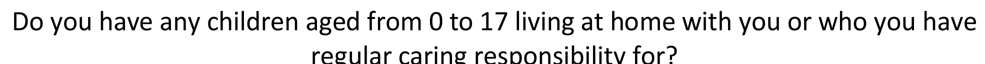
Background details - Religion

	No religion	Christian	Buddhist	Hindu	Jewish	Muslim	Sikh	Any other religion	I would prefer not to say
Your org	43.67%	45.69%	0.47%	1.83%	0.06%	3.50%	0.16%	0.79%	3.82%
Average	38.30%	47.38%	0.65%	2.43%	0.15%	2.93%	0.23%	1.51%	5.80%
Responses	3167	3167	3167	3167	3167	3167	3167	3167	3167

Background details – Long lasting health condition or illness

% of staff selecting 'Yes'

Your org	24.33%
Average	24.33%
Responses	3185



	Do you have any children aged from 0 to 17 living at home with you or who you have regular caring responsibility for?	Do you look after or give any help or support to family members, friends, neighbours or others because of either: long term physical or mental ill health / disability, or problems related to old age.
Your org	44.74%	35.79%
Average	40.90%	31.16%
Responses	3172	3149

Background details – How often do you work at/from home?

	Never	Rarely	Sometimes	Often	Always
Your org	56.68%	16.54%	16.73%	8.83%	1.22%
Average	56.75%	15.34%	15.41%	10.73%	1.52%
Responses	3204	3204	3204	3204	3204

Background details – Length of service

	Less than 1 year	1-2 years	3-5 years	6-10 years	11-15 years	More than 15 years
Your org	9.42%	15.11%	17.30%	17.23%	10.60%	30.34%
Average	10.57%	16.18%	18.32%	18.03%	10.71%	25.95%
Responses	3197	3197	3197	3197	3197	3197

	Yes	No	Prefer not to say
Your org	4.86%	94.56%	0.58%
Average	7.79%	90.98%	1.04%
Responses	2592	2592	2592

Background details – Occupational group

	Registered Nurses and Midwives	Nursing or Healthcare assistants	Medical and Dental	Allied Health Professionals	Scientific and Technical	Social Care	Public Health	Commissioning	Admin and Clerical	Central Functions
Your org	30.05%	9.90%	8.15%	17.46%	5.76%	0.23%	0.71%	0.03%	14.17%	5.40%
Average	30.16%	8.01%	8.16%	13.19%	7.17%	0.15%	0.19%	0.07%	15.88%	5.86%
Responses	3092	3092	3092	3092	3092	3092	3092	3092	3092	3092

Background details – Occupational group

	Maintenance	General Management	Emergency Care Practitioners	Paramedics	Emergency Care Assistants	Ambulance Technicians	Ambulance Control Staff	Patient Transport Service	Other
Your org	3.49%	1.88%	0.06%	0.00%	0.13%	0.00%	0.00%	0.06%	2.52%
Average	3.76%	2.74%	0.02%	0.00%	0.03%	0.00%	0.00%	0.00%	3.63%
Responses	3092	3092	3092	3092	3092	3092	3092	3092	3092

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Appendices

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Appendix A: Response rate

Appendix A: Response rate

Response rate

	2019	2020	2021	2022	2023
Your org	48.02%	52.23%	59.70%	60.88%	67.25%
Highest	75.96%	79.77%	79.95%	68.69%	69.45%
Average	46.93%	45.43%	46.38%	44.46%	45.23%
Lowest	27.20%	28.09%	29.47%	26.17%	23.03%
Responses	2037	2284	2787	2878	3255

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Appendix B: Significance testing 2022 vs 2023

Appendix B: Significance testing – 2022 vs 2023

Statistical significance helps quantify whether a result is likely due to chance or to some factor of interest. The table below presents the results of significance testing conducted on the theme scores calculated in both 2022 and 2023*. For more details please see the technical document.

People Promise elements	2022 score	2022 respondents	2023 score	2023 respondents	Statistically significant change?
We are compassionate and inclusive	7.36	2862	7.53	3239	Significantly higher
We are recognised and rewarded	6.00	2866	6.28	3240	Significantly higher
We each have a voice that counts	6.84	2813	7.01	3190	Significantly higher
We are safe and healthy	6.06	2809	6.27	3178	Significantly higher
We are always learning	5.64	2729	5.94	3029	Significantly higher
We work flexibly	6.20	2846	6.57	3207	Significantly higher
We are a team	6.92	2854	7.07	3229	Significantly higher
Themes					
Staff Engagement	6.73	2866	6.98	3241	Significantly higher
Morale	5.87	2866	6.20	3241	Significantly higher

* Statistical significance is tested using a two-tailed t-test with a 95% level of confidence.

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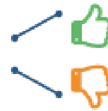
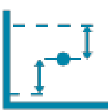
Appendix C: Tips on using your benchmark report

The following pages include tips on how to read, interpret and use the data in this report. The **suggestions are aimed at users who would like some guidance on how to understand the data** in this report. These suggestions are by no means the only way to analyse or use the data, but have been included to aid users.

Key points to note



The seven People Promise elements, the two themes and the sub-scores that feed into them cover key areas of staff experience and present results in these areas in a clear and consistent way. All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, where a higher result is more positive than a lower result. These results are created by scoring questions linked to these areas of experience and grouping these results together. Details of how the results are calculated can be found in the technical document available on the Staff Survey website.



A key feature of the reports is that they **provide organisations with up to five years of trend data**. Trend data provides a much more reliable indication of whether the most recent results represent a change from the norm for an organisation than comparing the most recent results only to those from the previous year. Taking a longer term view will help organisations to identify trends over several years that may have been missed when comparisons are drawn solely between the current and previous year.

People Promise elements, themes and sub-scores are benchmarked so that organisations can make comparisons to their peers on specific areas of staff experience. Question results provide organisations with more granular data that will help them to identify particular areas of concern. The trend data are benchmarked so that organisations can identify how results on each question have changed for themselves and their peers over time by looking at a single chart.

Note. Historical benchmarking data for 2019 has been revised for the Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts, and Community Trusts benchmarking groups. This is due to a revision in the occupation group weighting to correctly reflect historical benchmarking group changes. Historical data is reweighted each year according to the latest results and so historical figures change with each new year of data; however it is advised to keep the above in mind when viewing historical results released in 2023.

Appendix C: 1. Reviewing People Promise and theme results

When analysing People Promise element and theme results, it is easiest to start with the **overview** page to quickly identify areas of interest which can then be compared to the best, average, and worst result in the benchmarking group.

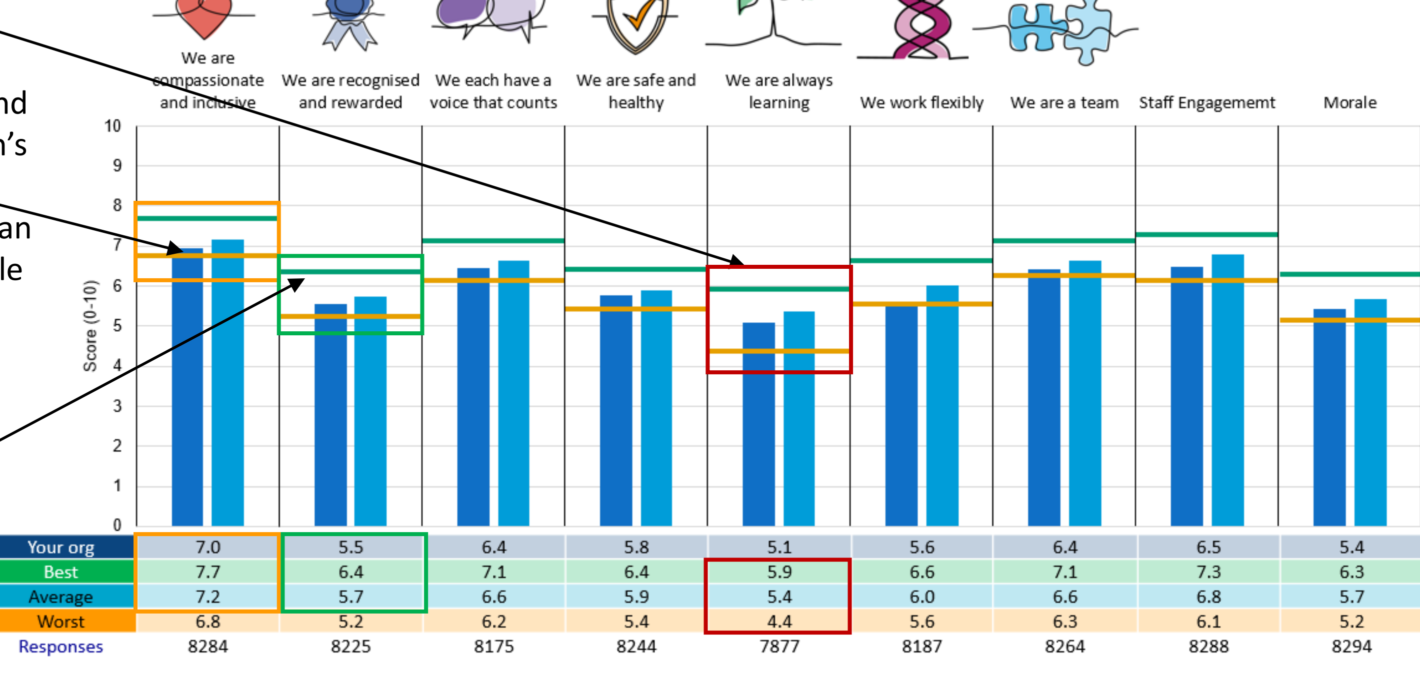
It is important to **consider each result within the range of its benchmarking group 'Best result' and 'Worst result'**, rather than comparing People Promise element and theme results to one another. Comparing organisation results to the benchmarking group average is another important point of reference.

Areas to improve

- By checking where the 'Your org' column/value is lower than the benchmarking group 'Average result' you can quickly identify areas for improvement.
- It is worth looking at the difference between the 'Your org' result and the benchmarking group 'Worst result'. The closer your organisation's result is to the worst result, the more concerning the result.
- Results where your organisation's result is only marginally better than the 'Average result', but still lags behind the 'Best result' by a notable margin, could also be considered as areas for further improvement.

Positive outcomes

- Similarly, using the overview page it is easy to identify People Promise elements and themes which show a positive outcome for your organisation, where 'Your org' results are distinctly higher than the benchmarking group 'Average result'.
- Positive stories to report could be ones where your organisation approaches or matches the benchmarking group's 'Best result'.

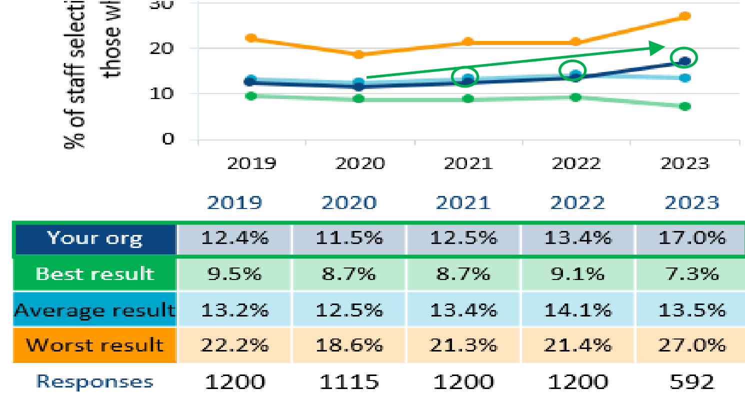


	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagememt	Morale
Your org	7.0	5.5	6.4	5.8	5.1	5.6	6.4	6.5	5.4
Best	7.7	6.4	7.1	6.4	5.9	6.6	7.1	7.3	6.3
Average	7.2	5.7	6.6	5.9	5.4	6.0	6.6	6.8	5.7
Worst	6.8	5.2	6.2	5.4	4.4	5.6	6.3	6.1	5.2
Responses	8284	8225	8175	8244	7877	8187	8264	8288	8294

Only one example is highlighted for each point

Review trend data

Trend data can be used to identify measures which have been consistently improving for your organisation (i.e. showing an upward trend) over the past years and ones which have been declining over time. These charts can **help establish if there is genuine change in the results** (if the results are consistently improving or declining over time), or whether a change between years is just a minor **year-on-year** fluctuation.



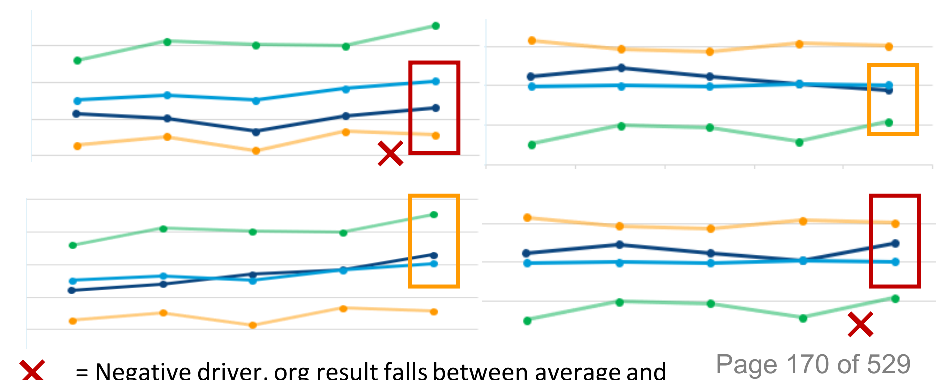
	2019	2020	2021	2022	2023
Your org	12.4%	11.5%	12.5%	13.4%	17.0%
Best result	9.5%	8.7%	8.7%	9.1%	7.3%
Average result	13.2%	12.5%	13.4%	14.1%	13.5%
Worst result	22.2%	18.6%	21.3%	21.4%	27.0%
Responses	1200	1115	1200	1200	592

Benchmarked trend data also allows you to review local changes and benchmark comparisons at the same time, allowing for various types of questions to be considered: e.g. how have the results for my organisation changed over time? Is my organisation improving faster than our peers?

Review the sub-scores and questions feeding into the People Promise elements and themes

In order to understand exactly which factors are driving your organisation's People Promise element and theme results, you should review the sub-scores and questions feeding into these results. The **sub-score results** and the '**Question results**' section contain the sub-scores and questions contributing to each People Promise element and theme, grouped together. By comparing 'Your org' results to the benchmarking group 'Average', 'Best' and 'Worst' results for each question, the **questions which are driving your organisation's People Promise element and theme results can be identified**.

For areas of experience where results need improvement, action plans can be formulated to **focus on the questions where the organisation's results fall between the benchmarking group average and worst results.** Remember to keep an eye out for questions where a lower percentage is a better outcome – such as questions on violence or harassment, bullying and abuse.



✕ = Negative driver, org result falls between average and worst benchmarking group result for question

This benchmark report displays results for all questions in the questionnaire, including benchmarked trend data wherever available. While this a key feature of the report, at first glance the amount of information contained on more than 140 pages might appear daunting. The below suggestions aim to provide some guidance on how to get started with navigating through this set of data.

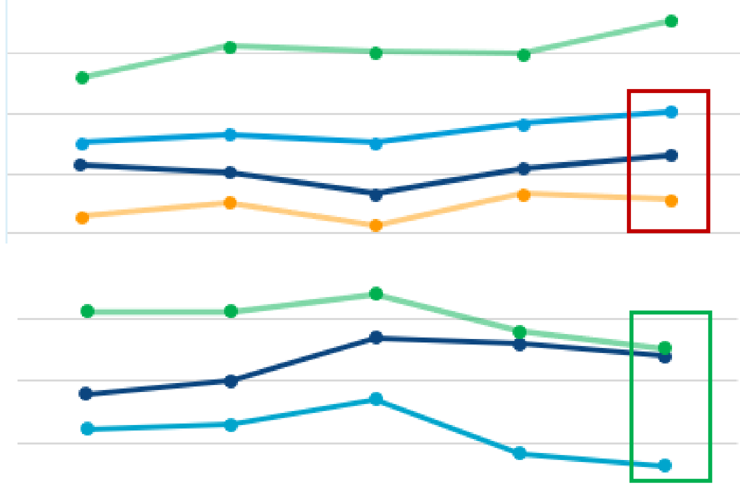
Identifying questions of interest

➢ **Pre-defined questions of interest – key questions for your organisation**

Most organisations will have questions which have traditionally been a focus for them - questions which have been targeted with internal policies or programmes, or whose results are of heightened importance due to organisation values or because they are considered a proxy for key issues. Outcomes for these questions can be assessed on the backdrop of benchmark and historical trend data.

➢ **Identifying questions of interest based on the results in this report**

The methods recommended to review your People Promise and theme results can also be applied to pick out question level results of interest. However, **unlike People Promise elements, themes and sub-scores where a higher result always indicates a better result, it is important to keep an eye out for questions where a lower percentage relates to a better outcome** (see details on the 'Using the report' page in the 'Introduction' section).



➢ **To identify areas of concern:** look for questions where the organisation value falls between the benchmarking group average and the worst result, particularly questions where your organisation result is very close to the worst result. Review changes in the trend data to establish if there has been a decline or stagnation in results across multiple years, but consider the context of how the organisation has performed in comparison to its benchmarking group over this period. A positive trend for a question that is still below the average result can be seen as good progress to build on further in the future.

➢ **When looking for positive outcomes:** search for results where your organisation is closest to the benchmarking group best result (but remember to consider results for previous years), or ones where there is a clear trend of continued improvement over multiple years.

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Appendix D: Additional reporting outputs

Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Appendix D: Additional reporting outputs

Below are links to other key reporting outputs that complement this report. A full list and more detailed explanation of the reporting outputs is included in the Technical Document.

Supporting documents

Basic Guide: Provides a brief overview of the NHS Staff Survey data and details on what is contained in each of the reporting outputs.

Technical Document: Contains technical details about the NHS Staff Survey data, including: data cleaning, weighting, benchmarking, People Promise, historical comparability of organisations and questions in the survey.

Other reporting outputs

Online Dashboards: Interactive dashboards containing results for all trusts nationally, each participating organisation (local), and for each region and ICS. Results are shown with trend data for up to five years where possible and show the full breakdown of response options for each question.

Breakdown reports: Reports containing People Promise and theme results split by breakdown (locality) for The Rotherham NHS Foundation Trust.

National Briefing Document: Report containing the national results for the People Promise elements, themes and sub-scores. Results are shown with trend data for up to five years where possible.

Detailed spreadsheets Contain detailed weighted results for all participating organisations, all trusts nationally, and for each region and ICS.

Board of Directors' Meeting
8 March 2024

Agenda item	P38/24
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	1. NHS England Letter on Segmentation Exit Criteria 2. Chief Executive of NHS South Yorkshire update report

1.0 Operational Matters

1.1 The last two months have continued to be positive from an elective recovery perspective, despite two periods of industrial action which significantly affected activity levels at these times. However, the additional capacity provided by insourcing within theatres and anaesthetics has enabled us to introduce weekend theatre lists within the most pressured specialties, and we have also continued outpatient insourcing within Ophthalmology and Dermatology, to reduce waiting times for patients waiting for their first appointment. The waiting list has remained stable over the last several months as a consequence of this extra activity in some of these high-volume specialties.

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 committed to delivering on the assumption that there will be no further industrial action after the early January period. Obviously there has been a lengthy period of industrial action in February so teams are re-focussing efforts on the longest waiting patients, but it is anticipated that there will be a very small number of patients over 65 weeks at the end of March, who are in one of two specialist treatment groups which the Trust is currently not able to provide (including corneal graft surgery which has been recognised nationally as a challenge to delivery of the initial expectations). The number of patients waiting over 52 weeks for their treatment has also 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 continues to see increased demand on our Urgent and Emergency care pathways, with both attendances and non-elective admissions being higher than the same period last year. The Trust has seen a rise in the number of patients attending with winter viruses, including influenza, which at times has affected bed availability. Work continues to ensure that the Trust and the wider place is improving performance against the four-hour emergency care standard. Ongoing work with the community teams and the Yorkshire Ambulance Service to avoid hospital conveyance continues to take place with medium to longer term improvement plans being worked through.

A focus on recovery and reset has been implemented throughout February and March to support delivery of our year-end target of 76% in March 2024 and no patients waiting over 65 weeks for elective care.

1.4 **Industrial Action (IA):** The British Medical Association (BMA) announced further IA by Junior Doctors, which took place from 24th February to 28th February 2024. As with all previous industrial action, the Trust developed detailed plans to support wards and departments and to maintain patient safety and the flow of patients through the hospital. Once again, this was a really challenging period for the Trust but I would like to thank teams for the hard work and commitment during this time.

2.0 Performance

2.1 The NHS planning guidance for 2024/25 is delayed as reported in my last report. However, as before, the Trust is already aware of the key requirements noted last time and has started to plan for next year.

2.2 I am pleased to report that the Trust has achieved a gold level award from the National Joint Registry (NJR) for Quality Data Provider for 2023. The scheme was devised to offer hospitals public recognition for achieving excellence in supporting the promotion of

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patient safety standards through their compliance with the mandatory NJR data submission quality audit process. The award targets are awarded based on audit compliance, the percentage of cases with no audit status and the percentage of audit cases which have failed to be submitted. Hospitals are also required to have a minimum baseline compliance of 95% to qualify for an award.

2.3 The Trust has received a letter from the Regional Director of NHS England dated 15th February 2024 (see appendix 1) which sets out the requirements that will form the basis for which the Trust will move from its current Segment 3 position to Segment 2 with an assessment to be undertaken at the end of 2023/24. This will feed into the next segmentation review undertaken by the regional team during 2024/25.

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

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

3.2 The Montague Elective Orthopaedic Centre for Excellence (MEOC) has now opened its doors to patients. It offers an exciting opportunity to benefit patient care and is a state of the art facility to support a service under pressure.

3.3 There has been a number of meetings with colleagues from the ICB and the Place to undertake planning for 2024/25 including discussion on the financial challenge and strategy/long term sustainability.

3.4 I also attach (appendix 2) the January 2024 update report from the Chief Executive of NHS South Yorkshire, which highlights the work of the ICB and system partners for November and December 2023.

4.0 People

4.1 As reported last time, the Trust did receive the embargoed initial results from the 2023 National Staff Survey. The results will be published on 7th March 2024 but work has been on-going with internal management teams to review them.

4.2 The following Consultants have commenced in post since my last update:

- Dr H Hashim, Cardiology
- Miss N Ahmed, Orthodontics
- Dr K Flint, Palliative Care
- Mr A Eldahshan, ENT

We also have a number of Consultants who have accepted posts and have start dates confirmed as follows:

- Miss L Thomson, Orthopaedics (April 2024)
- Dr K Khokhar, Rheumatology (September 2024)
- Dr C Anderson, Anaesthetics (September 2024)

4.3 The monthly staff Excellence Awards winners for the months of December 2023 and January 2024 are as follows:

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December 2023
Individual Award: David Smith, ESR & Workforce Information
Team Award: Coronary Care Unit
Public Award: Maternity

January 2024
Individual Award: Mobin Matthew, Sister on A1
Team Award: Cardiology Suite Reception Team

Dr Richard Jenkins
Chief Executive
March 2024

DRAFT

Dr Richard Jenkins

Chief Executive
The Rotherham NHS Foundation Trust

Sent by email: 15 February 2024

Richard Barker
NHS England
7-8 Wellington Place
Leeds
LS1 4AP
richardbarker.neyrd@nhs.net

Dear Richard

Segmentation exit criteria

The latest oversight review confirmed that The Rotherham NHS Foundation Trust remains in segment 3 of the NHS Oversight Framework.

This letter sets out the requirements which will form the basis for a move to Segment 2 and we have updated the exist criteria set out below:

- Develop a financial recovery plan that enables delivery of the Trust's approved financial plan for 2023/24 and contributes to system financial plan delivery.
- Evidence of organisation compliance with financial requirements set out in the 2023/24 system plan closedown letter, including Annex A.
- Improve recurrent efficiency delivery and productivity through engaging with national workstreams, system-wide initiatives and best practice benchmarks.
- Develop a Trust 2024/25 financial plan that to meets Operating Plan guidance and enables the system to submit a breakeven financial plan.
- No other material risks emerge in other delivery domains.

An assessment will be undertaken with regard to the criteria at the end of 2023/24. This assessment will feed into the next segmentation review undertaken by the regional team during 2024/25.

Yours sincerely

Richard Barker CBE
Regional Director
(North East and Yorkshire)

Copied to:

Gavin Boyle, Chief Executive Officer, South Yorkshire ICB
Mark Janvier, Director of Corporate Governance/Board Secretary, South Yorkshire ICB
Leaf Mobbs, Regional Chief Operating Officer, NHS England
Tim Savage, Regional Director of Finance, NHS England

Enclosure 07

Chief Executive Report

Integrated Care Board Meeting

3 January 2024

Author(s)	Gavin Boyle, SY ICB Chief Executive
Sponsor Director	Gavin Boyle, SY ICB Chief Executive
Purpose of Paper	
The purpose of the report is to provide an update from the Chief Executive on key matters to members of the Integrated Care Board.	
Key Issues / Points to Note	
Key issues to note are contained within the attached report from the Chief Executive.	
Is your report for Approval / Consideration / Noting	
To note.	
Recommendations / Action Required by the Board	
The Board is asked to note the content of the report.	
Board Assurance Framework	
The Board Assurance Framework is in development.	
Are there any Resource Implications (including Financial, Staffing etc)?	
No	
Have you carried out an Equality Impact Assessment and is it attached?	
No	
Have *you involved patients, carers and the public in the preparation of the report?*	
No	

Chief Executive Report

Integrated Care Board Meeting

3 January 2024

1. Purpose

This paper provides an update from the Chief Executive of NHS South Yorkshire on the work of the ICB and system partners for November and December 2023.

2. Integrated Care System Update

2.1 Integrated Care Partnership Board meeting.

In November the meeting of the Integrated Care Partnership Board focussed on our work to reduce smoking in South Yorkshire. Partners across the Integrated Care Partnership have written to elected representatives to voice their support for proposed legislation ‘Creating a smoke-free generation’ recently announced by the Prime Minister and subject to a national consultation exercise. The proposed legislation would make it an offence to sell tobacco products to anyone born on or after 1 January 2009, meaning that any child 14 or younger would never be legally sold tobacco. This would have a huge impact on the health and wellbeing of local people. In South Yorkshire:

- There are at least 16,000 hospital admissions due to smoking each year.
- Smoking takes the lives of 5,900 people every year from our communities.
- Smokers are 2.5 times more likely to need social care and on average will need care 10 years earlier than non-smokers.
- There are also estimates that suggest there are around 11,000 people out of work due to smoking.
- More than 50% of those on lower incomes admitted to hospital found to be smokers during screening.

In South Yorkshire we are investing £1.8m in our Quit programme to try and encourage more smokers to stop. This important work has been successful in reducing smoking rates in our region and it has been estimated that 950 lives have been saved so far because of the programme. Whilst we have made progress there is more to do, our estimates are that there are still more than 150,000 smokers in South Yorkshire, our aim is to more than halve this number.

2.2 Financial position

The current financial position of health and care services across England continues to be challenging.

In November NHS England wrote to all Trusts and ICBs requesting that for the remainder of 2023/24 organisations work to improve the financial position whilst maintaining safe patient services, prioritising emergency care and other time critical work such as cancer treatment. There is also additional opportunity for acute hospital trusts to earn income through the Elective Recovery Fund to help maintain progress with reducing waiting times for planned treatments and procedures.

NHS England has made an additional £800m available to ICBs to address additional costs incurred as a result of industrial action. NHS South Yorkshire has received £22.8m of this.

The South Yorkshire ICS deficit at Month 8 is currently £44.7m. Whilst this is an improvement on Month 7, we are still anticipating a year end deficit. The ICB is currently working with NHS providers to minimise this, ensure that financial controls are operating effectively and that agreed plans are being delivered.

We are also working with our place partnerships and cross-South Yorkshire alliances and collaboratives to develop plans for 2024/25 in anticipation of national planning guidance expected before Christmas.

2.3 Industrial action

Industrial action by doctors in training took place between 20-23 December 2023, with further action planned 3-9 January 2024. This is the first strike since joint action by junior doctors and consultants in October 2023.

BMA members who are consultants are currently considering a new pay offer which will potentially see an additional on average 4.95% increase added to the 6% annual rise that has already been given. Speciality and Specialist (SaS) doctors are also considering a revised pay offer.

The NHS in South Yorkshire is working hard to maintain safe urgent and emergency care services as well as elective care and diagnostic appointments during the strikes. As a result of the duration and timing of this latest action the NHS is reminding the public that they should use NHS services wisely but should continue to use 999 and A&E in life threatening situations and 111 online for other health concerns.

NHS South Yorkshire has been continuing to provide support through its Incident Co-ordination Centre, which has operated at all times while action is being taken to meet our Category 1 emergency response duty.

2.4 Covid-19 and vaccinations

We have now vaccinated more than 50% of our eligible population with an autumn booster, which is 277,000 vaccinations since September 2023. This compares well with our regional partners and the national average. The deadline for using the NHS vaccination booking system was 14 December 2023. After this date, patients have

been able to access a small number of specific vaccination clinics. NHS South Yorkshire will be continuing to encourage all those who are eligible to receive their vaccination.

Primary Care Sheffield has been selected to run the Covid-19 Medicines Decision Unit (CMDU) for South Yorkshire. The CMDU is designed to provide access to Covid-19 treatments for patients who are at the highest risk in the community. Patients 16-years-old or under with a paediatrician (including under 18's still under paediatric care) will be treated by Sheffield Children's Hospital via their paediatric specialist.

In addition, more than 47% of our eligible population have now had a flu vaccine, which is 386,000 vaccinations. In South Yorkshire we have the highest school age and over 75 years population uptake in the North East and Yorkshire region.

2.5 Winter planning

Our plans for supporting Winter are now in full implementation, including offering alternatives to emergency departments, improving 'flow' within hospitals and the discharge of patients who are medically fit. The initiatives include:

- Expanded 'virtual' wards in our Places so that patients can receive specialist care in their own homes to avoid or shorten a hospital stay. This also releases capacity for the next patients who need it.
- Increased number of patients who are treated in Same Day Emergency Care (SDEC) units. This reduces the impact on Emergency Departments and reduces the number of patients who are admitted to hospital.
- Closer working between health and social care reducing the number of patients who are medically fit for discharge but are waiting to go home or to their next place of care. Some of our acute providers have also expanded their discharge lounges ahead of winter to facilitate this.
- Improved ambulance handover at Emergency Departments to release crews as rapidly as possible.

The timing of industrial action by junior doctors adds further to the difficulty of managing this traditionally busy period but all system partners are working together to mitigate this risk.

South Yorkshire was not selected to receive a share of £40m of additional national funding announced in December 2023 given comparatively better performance than in other parts of the country.

2.6 Patient choice for planned treatments

A new national initiative aimed at offering patients a potential alternative choice of where to have their treatment was launched last month. The Patient Initiated Digital Mutual Aid System (PIDMAS) has been created to help manage the process of

patients who are eligible to register their interest in being treated regionally or nationally.

The initiative, which is open to 7,000 patients in South Yorkshire in Cohort 1 who have been waiting over 40 weeks, allows individual patients to request to move to an alternative provider if they can provide treatment sooner. However, there may be circumstances in which it is not clinically appropriate for a patient to move to a different hospital or alternative capacity is not available. At the time of writing 250 patients (3.5% of those eligible) had registered to transfer and nearly 30 patients had been identified as potentially being offered alternative care. We are now working with those providers to try to successfully transfer their care.

We are awaiting confirmation that the national plan for further cohorts of patients in a staged process will go ahead as later cohorts have now been delayed. The intention was previously that by March 2024 all patients waiting over 18 weeks (including those aged under 18), will be invited to indicate if they wish the ICB to seek an alternative provider for them.

3. NHS South Yorkshire

3.1 NHS England ICB Running Costs Allowance (RCA)

NHS England will reduce the Running Cost Allowance (RCA) for all ICBs by 30% over the next two years. The ICB has instituted an organisational change programme to reflect this requirement. The formal staff consultation on the new team structures has now completed and the Outcome Report has been shared with all staff. The ICB received national approval to offer voluntary redundancy for some colleagues whose posts are at risk. We will be working with colleagues and trade union representatives as we implement the new arrangements between January and March 2024.

3.2 NHS Research Engagement Network Development programme

As part of the second phase of the NHS Research Engagement Network Development Programme South Yorkshire ICS, in partnership with South Yorkshire Innovation Hub and VCSE Alliance, has secured £93,000 of funding to work with voluntary and community organisations, local National Institute for Health Research partners and health and care staff from across the region to share best practice for designing and delivering inclusive research.

One of our primary aims is to tackle health inequality and as part of this giving equal opportunity to be involved in research trials to help improve future care as well as giving access to novel medicines and treatments is vital.

3.3 NHS Maternity and Neonatal Independent Senior Advocate pilot

South Yorkshire has been chosen as one of 21 ICBs to take part in the NHS Maternity and Neonatal Independent Senior Advocate pilot. Maternity and Neonatal Independent Senior Advocates help to ensure the voices of women and families are listened to, heard and their wishes acted upon by their maternity and neonatal care

providers when they have experienced an adverse outcome during maternity and/or neonatal care. The pilot, which will run until March 2025, follows the immediate and essential actions identified in the Ockenden Review into Maternity Services at Shrewsbury and Telford NHS Trust.

3.4 Chair Appointment, Sheffield Children's Hospital.

Sheffield Children's NHS Foundation Trust has appointed Professor Laura Serrant OBE as its new Trust Chair. Prof. Serrant, who is a nurse by profession with strong links to Sheffield, is currently Regional Head of Nursing for the Northeast and Yorkshire at NHS England and a Professor of Nursing at Manchester Metropolitan University, where she was previously Head of Department. She will take over the Chair from Sarah Jones, who completed her final term at Sheffield Children's on 31 December 2023 after more than seven years in post.

4. NHS South Yorkshire Place Updates

4.1 Sheffield

NHS South Yorkshire leaders recently met with colleagues from Sheffield's voluntary sector to hear about their work and to discuss how the NHS and voluntary organisations can work more closely together to better meet the needs of local communities, improve health and tackle health inequalities. The group visited Sheffield African Caribbean Mental Health Association (SACHMA) in Pitsmoor. SACHMA is an African and Caribbean community led organisation that offers health and social support to all communities in Sheffield They provide specialist services to people in need of assistance with their health and care needs because of their age, youth, disability, financial hardship, or social disadvantage.

Sheffield's Birley Health Centre was named Nursing Team of the Year at the General Practice Awards. The seven-strong team have had a number of achievements this year, including performance for cervical screening, foot checks and baby vaccinations, which contributed to the practice's best year in terms of the Quality of Outcomes Framework (QOF).

4.2 Doncaster

Doncaster and Bassetlaw Teaching Hospitals is expanding its virtual ward service ahead of winter. The service aims to care for 300 patients concurrently, which will alleviate pressures on bed capacity at Doncaster Royal Infirmary and creating much-needed space for those needing urgent and emergency care. The service, which was launched earlier in the year, has cared for nearly 150 patients so far. Patients are, on average, admitted to the Virtual Ward for around eight days, with the longest recorded duration being 14 days.

The Endoscopy Unit at The Montagu Community Diagnostic Centre (CDC) has officially opened. The CDC includes an endoscopy suite with training facilities, and multifunctional clinic rooms, including ultrasound. Additionally, the work initiated during

phase one of the project will continue, with mobile units facilitating CT and MRI scanning. In addition, the £15m Mexborough Elective Orthopaedic Centre (MEOC) is expected to open in the New Year. The project, which is a collaboration between Doncaster and Bassetlaw Teaching Hospitals, Rotherham NHS Foundation Trust, and Barnsley Hospital NHS Foundation Trust. The centre will provide an option for people from across South Yorkshire waiting for orthopaedic surgery in addition to their local hospital.

4.3 Rotherham

A new programme of digital support has launched for communities in Rotherham. Rotherham Metropolitan Borough Council, NHS South Yorkshire, RotherFed, Voluntary Action Rotherham, RNN Colleges, Age UK Rotherham and Barnardo's have partnered together to support digital inclusion in the borough. It is important that we increase the opportunities for local people to access health information to support them in managing their health and care. Giving people the knowledge, skills and confidence will provide them with easier and faster access to advice and support they need.

4.4 Barnsley

One of the largest health and social care careers events took place in Barnsley on 22 November 2023, introducing local students to a range of job opportunities within health and social care. 600 Barnsley secondary school and college students signed up to the 'We Care Into The Future' to find out more about the huge range of jobs and volunteering opportunities available in the health and care sector. The students visited over 40 stands highlighting over 100 different careers. Health and social care staff were on hand to talk about the variety of jobs as well as raise the aspirations of our young people.

5. General Updates

5.1 Dentistry

NHS South Yorkshire brought together more than 80 colleagues from a range of professions, local authority leaders and Healthwatch representatives, to discuss Oral Health and Dentistry in South Yorkshire. The ICB took on the commissioning responsibility for this service from April 2023. Although dentistry performance is comparable to other areas in North East and Yorkshire, we know that access is still a key issue for our communities, particular those from more deprived neighbourhoods.

We also know that we must improve our approach to prevention, for example in South Yorkshire a child is four times more likely to require tooth extraction in secondary care than the England average. We heard some great examples of where prevention is improving outcomes for our children and young people through programmes such as toothbrushing clubs and better information on diet and sugar – for example the "Sheffield is Sweet Enough" campaign.

The dental contract is likely to be nationally reviewed in the coming years. As an ICB we will have a focus on dentistry next year and plan to listen to our communities on their concerns, as well as highlight some of the initiatives taking place.

5.2 HSJ Awards

The ground-breaking South Yorkshire integrated health and care staff wellbeing programme to change the culture around menopause in the workplace was highly commended for the prestigious HSJ Staff Wellbeing Award category. NHS South Yorkshire has worked in partnership with 15 organisations from South Yorkshire's local authorities, hospitals, primary care, social care, and the voluntary sector coming together to share learning and best practice on changing the culture around menopause in the workplace.

All 15 organisations in the integrated care system are now accredited menopause friendly employers, the only example of integrated system achievement in the country. Partners have been working together on initiatives and are showing a real commitment to making menopause something that is discussed in day-to-day conversations.

Teams across South Yorkshire were also Highly Commended for the Integrated Care Initiative of the Year. The teams at NHS South Yorkshire ICB, Doncaster and Bassetlaw Teaching Hospitals Foundation Trust, Primary Care Doncaster and Rotherham, Doncaster and South Humber Foundation Trust and FCMS Doncaster won for the Doncaster Wound Care Alliance

In addition, SHSC were shortlisted for Mental Health Innovation of the Year for "Less Talk, More Action": Listening to, and working with community leaders to reduce Race Inequalities in Mental health.

5.3 Not in a Day's Work - Zero Tolerance to Abuse of NHS Staff

NHS South Yorkshire is supporting primary care staff across the region to put a stop to aggressive and abusive behaviour from patients and members of the public under a new zero tolerance approach and public campaign backed by South Yorkshire Police called #NotInADaysWork.

As reported incidences have increased in recent months, frontline NHS primary care workers such as GP practice, pharmacy, dental and optometrist staff across the region are being offered support and advice from NHS South Yorkshire on reporting such behaviour, and guidance on a process for dealing with it.

Many practices and pharmacies already operate a zero-tolerance approach towards abusive behaviour and will ultimately exercise their right to refuse to see or treat people who are persistently aggressive or abusive. We welcome the public's support for this campaign.

Gavin Boyle
Chief Executive NHS South Yorkshire Integrated Care Board
Date: 3 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: 28 February 2024**	**Chair: Ms Heather Craven**

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
1	Proposed Quality Priorities for 2024/25	The Committee should have discussed the proposed Quality priorities for 2024/2025 and made a recommendation to board around their adoption. These were not ready for discussion. They will be circulated to committee members after ETM on Thursday 14th March for comment and brought to Quality Committee on 27th March for approval. Work plan to be amended to allow for ETM review earlier next year to ensure adequate time for discussion by Committee members.	Board of Directors
2	Divisional Reporting on Quality Compliance: UECC	The Committee were assured by the divisional presentation, the improvements already made and the plans for maintaining the positive actions including the upcoming merger with the Medicine Division.	Board of Directors
3	Quarter 3 Patient Experience Report	The Committee commended the innovative work undertaken to move the subject so far forward in the past year. It noted that the SMART action plan to achieve moderate assurance from 360 would be in place by the end of March but that completing those actions would be done in 2024/2025.	Board of Directors
4	Quality Priority End of Life Care	The Committee noted the progress made and that it was unlikely that it will trigger green level of compliance by the end of March 2024	Board of Directors
5	Holistic Needs Assessment for Cancer Patients Priority	As with the End of Life priority the committee noted the progress made and that it was unlikely that it will trigger green by the end of March 2024	Board of Directors
6	Reducing Health Inequalities Priority	The committee noted the positive report and the status of green compliance status, it also noted from the report and verbal update that this priority was actually exceeding expectations.	Board of Directors

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
7	Maternity & Neonatal Safety	The Committee noted the positive work undertaken as demonstrated by the staff, and culture surveys and feedback from the CQC Maternity survey that the service is achieving results better than most Trusts in 8 areas - slight concern regards middle grade doctors and sign off for entrustability with actions that lie with the college for completion putting increasing pressure on doctors cover. Also agreed that the priorities for maternity should be brought to the attention of Deputy Chief Executive and the Trust group that agrees priorities with the Public Health Consultant.	Board of Directors
8	Safeguarding Report	The Committee noted the progress made on safeguarding, although there is a specific area of concern regarding Medical compliance with MAST, the Medical Director is sighted on this and working on an action plan.	Board of Directors
9	Risk Register	The Committee noted the progress made with the risk management process and engagement of staff, however also agreed that there needed to be focus on progress notes not updated, review date compliance and action plans being SMART. There was also a concern that the wording of certain risks when proposed actions have been progressed, or not, but that has not been reflected in the risk description, or the progress note, and the risk rating has not been changed accordingly. Focus needed on delivery of actions and reduction of risk.	Board of Directors
10	Safeguarding Policy	The policy was approved.	Board of Directors

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: 23rd February 2024**	**Chair: Dr Rumit Shah**

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
1	**Divisional People Performance Presentations:** Surgery Division Senior Leadership Team Community Division Senior Leadership Team	The Committee members received presentations from two Divisions, Surgery and Community and noted the areas of substantial progress, highlighted by the Divisional teams in their presentations. It was noted for Surgery Division the high levels of engagement in the staff survey, however, there was disappointment from the results and the Division's position versus the Trust, and plans were outlined to address the feedback. Surgery was pleased to report above target compliance in regards to Appraisals and MaST compliance, as well as, a significant increase in return to work interviews. The Committee noted Community's diverse and extensive range of services, the continued progression of the virtual ward, as well as, the staff survey engagement and initial feedback.	Board of Directors
2	Terms of Reference	The Committee reviewed the amended Terms of Reference and change in title of the Committee to People and Culture Committee, recommending the same to the Board.	Board of Directors
3	Changes to the National Job Profiles for Agenda for Change Band 2 and 3 Healthcare Support Workers	The Committee concurred with the Trust approach to the changes outlined within the report.	Board of Directors

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
4	Job Planning	Positive progress was noted, in relation to the approval of a new Policy, actions relating to 360 assurance and the improvement in Job Planning positioning. However, the Committee was concerned with the current position as is substantially adrift from target.	Board of Directors
5	Operational Plan Quarterly Report	The Committee noted the key milestones reached for Medical Engagement and Supporting our People, including the joint clinical leads programme with Barnsley, the International Medical Graduates Working Group and the Consultants and SAS Doctors development programme. The Committee questioned the progress on Medical Engagement, linking this to Job Planning and the discourse here.	Board of Directors

Subject:	Finance & Performance Committee CHAIR'S ASSURANCE LOG Quorate: Yes	Ref:	P39/iii

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

Committee / Group: Finance & Performance Committee	Date: 31st January 2024 & 28 February 2024	Chair: Mr Martin Temple

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
1	Operational Plan Priorities Update	The Committee were assured in relation to the 10 priorities already delivered, however noted that there are 6 that are off track. This is due to a delay in completing the actions as a number of related job positions were fixed term; the priorities were displaced by other initiatives to support the 10 completed priorities. This included initiatives in Pharmacy and Haematology joint working. A revised timetable for the 6 outstanding actions is to be developed.	Board of Directors
2	Integrated Performance Report and Operational Update	31/01/24: The Committee were assured that the Trust continued to work through the challenges presented to them and acknowledged that 4 hours target and 65 weeks targets were under pressure although actions were in place. 28/02/24: There was a commitment to hit £4.7m deficit against the £6m deficit plan knowing where we are at month 10, the committee were assured.	Board of Directors

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
3	ICB Finance Update	The committee could not be assured as still have not received planning guidance so do not know what the pressures are going to be next financial year.	Board of Directors
4	Cost Improvement Plan Update	The improved position of £500k was reported and the committee were assured recognising the efforts being made to get to the current position.	Board of Directors

Subject:	AUDIT & RISK COMMITTEE CHAIR'S ASSURANCE LOG Quorate: Yes	Ref:	Board of Directors:

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

Committee / Group: Audit & Risk Committee	**Date: 26 January 2024**	**Chair: Kamran Malik**

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
1	Risk Register including Emerging Risks and Issues Log	Recognition of Medicine as the first Division to be fully compliant in risk management. The Committee welcomed the emerging maturity of the Trust risk management process and the increased level of scrutiny and challenge which aided the "so what" degree of assurance and how this influences decision making at Board of Directors.	Board of Directors
2	360 Assurance Internal Audit Progress Report	It was noted that there was an increased focus on closing audit actions. Audits completed since last Audit and Risk Committee: • PSIRF: evaluation of phases 1 and 2 of implementation Moderate Assurance • Patient experience: focus on "Involving patients in decisions about their treatment" work stream: Split Opinion – Significant Assurance on establishment of themes and Limited Assurance relating to SMART objectives and action planning.	Board of Directors

Ref	Agenda Item	Issue and Lead Officer	Receiving Body, i.e. Board or Committee
3	Annual Report and Accounts Timetable	The Committee were assured that the overall year end process is on target.	Board of Directors
4	Risk Management Committee Terms of Reference	The Risk Management Committee Terms of Reference were approved.	Board of Directors
5	Year End Approvals	The Committee discussed and agreed to recommend approval at the Board of Directors the following: • The Committee endorsed the changes to the 2022/23 Accounting Policies. • Endorsed the Operating Segment for approval by Board of Directors • Endorsed that the 2023/24 accounts are prepared on a Going Concern for ratification by Board of Directors.	Board of Directors

Board of Directors' Meeting
8 March 2024

Agenda item	P40/24
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.
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 continued their industrial action in February. Rotherham Place Board received the monthly Place Performance report and discussed areas of good practice and areas of challenge. It was highlighted that for Diagnostic waits, Rotherham was best performer nationally in December out of the 106 areas. Both the Place Board Terms of Reference and the Place Partnership Agreement which came into effect from 1 July 2022 and are now due for review and are provided for comment. The Health Select Commission met in January. The agenda included reflections and feedback on the Trust workshop which was held on the 8th November.
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	N/A

(what action is required, who is the lead and when should it be completed?)	
Recommendations	It is recommended that the Board note the content of this paper and also provide feedback / comments on the Place Board Terms of Reference and Place Partnership Agreement.
Appendices	Appendix 1 – Place Board Terms of Reference Appendix 2 – Place Partnership Agreement Appendix 3 - Rotherham Place Partnership Update January and February 2024

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 Junior Doctors continued their strike action with a 5 day period of industrial action in February. The impact across the health service is expected to be significant with the main impacts likely to be on elective care. This strike action is the last the BMA is able to undertake as part of their current mandate, but are in the process of balloting members for a new 6 months mandate.

2.2 NHS England announced a number of new Non-Executive Directors to join the Board. This includes Professor Dame Helen Stokes-Lampard, a GP who had served as Chair of the Academy of Medicine Royal Colleges and Professor Sir Robert Lechler Emeritus, Professor at Kings College London. Jane Ellison who serves in Parliament as Minister for Public Health and Mark Bailie, Chief Executive of Compare the Market have also joined the Board.

3.0 South Yorkshire Integrated Care Board (SYICB).

3.1 The SYICB have further developed the existing ICS Outcomes Framework (OF) to include the key measures and metrics that align to the ICB's objectives and priorities. The OF will support the ICB in measuring and evaluating its role in improving patient outcomes, population health and system performance as well as its progress towards the Integrated Care Partnership goals and ambitions.

3.2 The purpose behind the OF is to provide the ICB Board, statutory and strategic boards, partners, staff and the public assurance that the ICB are united with their ICS partners in improving health and reducing inequalities. The ICB board has a key role here in holding NHS South Yorkshire to account and these outcomes metrics will be reported alongside the performance metrics in the IPR.

4.0 Rotherham Place

4.1 Rotherham Place Board met in January and February 2024, 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.

4.2 On 1 July 2022 the NHS South Yorkshire Integrated Care Board (**ICB**) was established pursuant to the Health and Care Act 2022, and the statutory functions, staff, assets and liabilities of NHS Rotherham CCG (and the other three CCGs of South Yorkshire) were transferred to the ICB. The ICB has delegated the exercise of some of its functions to a newly established committee of the ICB Board in the Rotherham Place (the "**ICB Place Committee**") which meets in common with the

existing Rotherham Place Board. As a result of these developments, it was necessary to update the existing terms of reference for the Rotherham Place Board to reflect the establishment of the ICB Place Committee, and to update the existing Rotherham Place Partnership Agreement, originally entered into by Partner organisations in Rotherham in 2018.

4.3 Both the Place Board terms of reference and the Agreement were agreed and came into effect from 1 July 2022 and are now due for updating and reconfirming. The Place Board Terms of reference and the Rotherham Place Partnership Agreement are provided for comment at appendix 1 and 2. Comments will be fed back to Rotherham Place Board. The Trust Board is asked to note that the Terms of Reference has not materially changed from the previous version. The Rotherham Place Partnership Agreement has changed as follows:

- Narrative has been amended throughout the Agreement to reflect that the Place Leadership Team has encompassed the remit of the former Place Delivery Team, which no longer meets.
- In the run up to the formation of the ICB, a Development Plan was included within the Agreement. As this is no longer a requirement it has been removed and the narrative amended accordingly.
- The initial term of the Agreement was up to 31 March 2024, this has been replaced by an extended term up to 31 March 2026. This does not mean that the Agreement cannot be updated earlier should we wish to.

4.4 In January, the Place Board received an update from the Director of Public Health showing that respiratory trends are coming down with peaks of flu and covid being passed. However, a note of caution was added that a second peak was possible following schools returning.

4.5 There had been a significant outbreak of measles in the Midlands, which is of national concern, however Rotherham has had good uptake overall of the Measles, Mumps and Rubella vaccinations with known pockets of low coverage.

4.6 Place Board continue to receive the monthly Place Performance report and discussed areas of good practice and areas of challenge. It was highlighted that for Diagnostic waits, Rotherham was best performer nationally in December out of the 106 areas.

4.7 Place Board also received an update from the Rotherham Place Strategic Estates Group which included the plans for the creation of diagnostic and clinical spaces in the Town Centre. The Trust is currently exploring opportunities with partners as to how the space can be utilised.

4.8 Engagement with people with Long Term Conditions (LTCs) in Maltby and Dinnington - Building on the findings from the Place Development Programme, partners have

been working together to engage local people with LTCs living in two deprived areas of Rotherham (Maltby and Dinnington). The first stage of this project has been a survey distributed via GPs, which received over 1,200 responses, which is approximately 50% of the target population. Early insights from the data collected are already starting to inform work, including a recent workshop on chronic pain. Work will now take place to analyse the results, which will support a wide range of programme areas, including physical activity, mental health, prevention and health inequalities and multi-morbidity. The vision is that the data will be widely shared across Rotherham, to ensure that the insights make the biggest impact on delivery. Over 800 respondents want to be involved in further engagement, so discussions are also taking place around how to maximise this opportunity.

4.9 Further details of initiatives across Rotherham Place are included within the Place Newsletter for January and February 2024 and can be seen at appendix 3.

4.10 The Health Select Commission met in January. The Trust was invited to provide feedback and also receive feedback on the workshop that took place on the 8th November, which was led by the Trust. As referred to previously at Trust Board, the key areas of focus included for the workshop 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.

4.11 Positive feedback on the session was received from the Health Select Commission which was captured in the minutes of the meeting held on the 24th January. The general view was that Councillors felt the session was really constructive and it was helpful to see some of the initiatives to improve the hospital. The Trust are due to attend the Health Select Commission in March to discuss Maternity Services.

4.12 The Trust's Consultant in Public Health, employed jointly by the Trust and the local authority has been in post for eleven months. He is leading a programme of work to manage population health within Rotherham, based on tackling health inequalities and developing preventative interventions. There is a separate presentation at Trust Board that covers the activities he is currently working on.

Michael Wright
Deputy Chief Executive
March 2024

ROTHERHAM PLACE PARTNERSHIP PLACE BOARD AND ICB COMMITTEE Terms of Reference	
Version	**3.1**
Implementation Date	**1 July 2022**
Review Date	**February 2024**
Approved By	**Rotherham Place Board (Partnership and ICB Sessions)**
Approval Date	**16.11.2022 Final version**
Approval of Update	**February 24**

VERSIONS			
Date	**Version**	**Comments**	**Author**
13 June 2022	**1**	Initial draft for feedback	**Hill Dickinson**
23 June 2022	**2**	Amendments following feedback from ICB on ICB committee element	**Hill Dickinson**
24 June 2022	**2.1**	Amendments to Place Board TORs re Participants	**Hill Dickinson**
6 July 2022	**2.2**	Amendments to ICB Committee TORs in Part 3 to reflect final TORs approved by ICB Board on 1/7/22 Amendments to job titles and membership/participation in Part 1 / Part 2	**Hill Dickinson**
15 July 2022	**2.3**	To add the list of participants in Part 3	**LG**
9 November 2022	**2.3**	To add final names to membership and to address RMBC comments	**Hill Dickinson LG**
11 February 2024	**3.0**	Review, dates updated and name of primary care collaborative board updated	**LG**
28 February 2024	**3.1**	Amendment to: • Director of Nursing for Doncaster and Rotherham Places (formerly Chief Nurse) • Removal of Executive GP Lead for Primary Care as the Primary Care Collaborative Board is chaired by the medical director SY ICB, Rotherham Place • Change from joint chair of Health and wellbeing Board to chair and vice chair	**LG**

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1. Structure of these Terms of Reference

These terms of reference are divided into three sections:

Part 1: Background;
Part 2: Terms of reference for the Rotherham Place Board when carrying out Partnership Business (defined below); and
Part 3: Terms of reference for the Rotherham Place Board when carrying out ICB Business (defined below) as a committee of NHS South Yorkshire Integrated Care Board.

PART 1: BACKGROUND

1. The organisations referred to in these terms of reference are Partners in the Rotherham Place Partnership ("**Place Partnership**"). Representatives of the Partners have come together as the Rotherham Place Board ("**Place Board**") to enable the delivery of integrated population health and care services in Rotherham, as set out in more detail below. The Partners have entered into a Place Agreement setting out their commitment to delivery of the Rotherham vision, objectives, and principles (as documented in the Place Agreement).

2. The Place Board in practice carries out two roles:

- Firstly, the Place Board is responsible for aligning decisions on strategic policy matters made by Place Partners that are relevant to the achievement of the Rotherham Place Plan, in accordance with its terms of reference in Part 2. Where applicable, the Place Board may also make recommendations on matters that it has been asked to consider on behalf of a constituent Partner in the Place Partnership. Where the Place Board has been asked to consider matters on behalf of a Partner, the Partner organisation remains responsible for the exercise of its functions and nothing that the Place Board does shall restrict or undermine that responsibility. This work is referred to as "**Partnership Business**".

- Secondly, the Place Board sits as the Rotherham ICB Committee ("**ICB Place Committee**"), which is a committee of the NHS South Yorkshire Integrated Care Board ("**ICB**"). The ICB Place Committee is established as a committee of the ICB Board, in accordance with the ICB's Constitution, Standing Orders and Scheme of Reservation & Delegation. When the Place Board sits as the ICB Place Committee it has delegated authority from the ICB Board to make decisions about the use of ICB resources in Rotherham in line with its remit, and otherwise support the ICB as set out in its terms of reference in Part 3 with the membership as set out in paragraph 7 below. The decisions reached by the ICB Place Committee are decisions of the ICB, in line with the ICB's Scheme of Reservation & Delegation **"ICB Business"**. When sitting as the Rotherham ICB Committee, members must comply with ICB policies and procedures.

3. As far as possible in accordance with their organisation's governance arrangements, the Partners that are statutory bodies will seek to exercise their respective statutory functions within the Place Board governance structure insofar as such functions relate to Partnership Business (in the case of the other statutory Partners) or ICB Business (in the case of the ICB) and are within the scope of these arrangements. This will be enabled:

- For other Partners that are statutory bodies, through those organisations (at their discretion) granting delegated authority for decision making to specific individuals (for example a Place Board member) or to specific committees or other structures established by Partner organisations meeting as part of, or in parallel with, the Place Board.

- For the ICB, through the Place Board sitting as the ICB Place Committee, as outlined above

4. For Partners that are not statutory bodies, it is expected that as far as possible the individuals attending meetings of the Place Board will be authorised to take the decisions under consideration on behalf of their organisation.

5. It is expected that in many cases, ICB Business, or any other reserved statutory decisions taken by individuals on behalf of their statutory organisations, will be able to be conducted at meetings of the

Place Board, as a result of either individual Partner representatives exercising delegated authority or through the ICB Place Committee making the decision as a committee. Other representatives of Partner organisations will be attendees at the Place Board at such times subject to the management of any conflicts of interest.

6. Whether decisions are taken under Part 2 and Part 3, or only Part 2 or Part 3 of these terms of reference, the aim will be to ensure that decisions reflect applicable national and local priority objectives and strategies and are taken in accordance with the collaborative principles for the Place Partnership.

7. Membership and attendance at the Place Board differs according to whether or not the Place Board is undertaking Partnership Business or ICB Business in accordance with the relevant terms of reference. The table below sets out the status of individual representatives in each case for ease of reference:

Nominated Representative (Role/Title)	Organisation	Status for Partnership Business	Status for ICB Business
Executive Place Director / Deputy Chief Executive ICB	NHS South Yorkshire Integrated Care Board	Joint Chair	Chair
Chief Executive	Rotherham Metropolitan Borough Council	Joint Chair	Participant
Director of Public Health	Rotherham Metropolitan Borough Council	Member	Participant
Chief Executive	The Rotherham NHS Foundation Trust (TRFT)	Member	Participant
Deputy Chief Executive	The Rotherham NHS Foundation Trust (TRFT)	Member	Participant
Chief Executive	Voluntary Action Rotherham	Member	Participant
Chief Executive	Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH)	Member	Participant
Medical Director	Connect Healthcare Rotherham CIC	Member	Participant
Chair	Rotherham Health and Wellbeing Board	Participant	Participant
Vice Chair	Rotherham Health and Wellbeing Board	Participant	Participant
Deputy Place Director, Rotherham Place	NHS South Yorkshire Integrated Care Board	Participant	Member
Director of Nursing for Doncaster and Rotherham Places	NHS South Yorkshire Integrated Care Board	Participant	Member
Medical Director, Rotherham Place and Chair of Rotherham Primary Care Collaborative Board	NHS South Yorkshire Integrated Care Board	Participant	Member
Chief Finance Officer, Rotherham Place	NHS South Yorkshire Integrated Care Board	Participant	Member
Independent Non-Executive Member	NHS South Yorkshire Integrated Care Board	Participant	Member

ROTHERHAM PLACE BOARD

PART 2: PLACE BOARD – TERMS OF REFERENCE FOR PARTNERSHIP BUSINESS

1	**Name of committee**	The Rotherham Place Board (the “**Place Board**”).
2	**General**	In these terms of reference the following capitalised terms are given the meaning set out in the NHS South Yorkshire Integrated Care Board (“**ICB**”) Constitution as updated from time to time, unless the context otherwise requires: Constitution ICB Standing Order or Standing Orders
		Other capitalised terms have the meaning set out below: “Chair” means the chair of the Place Board “Executive Place Director” means that individual appointed by the ICB to oversee and help develop the Place Partnership “ICB Business” has the meaning set out in Part 1 “ICB Place Committee” means the committee of the ICB for the Rotherham Place “ICB Policies” means any policy, process or procedure formally adopted by the ICB “Member” refers to a member of the Place Board as listed in paragraph 6 “Participant” refers to a participant of the Place Board as listed in paragraph 7 “Partner” refers to a partner organisation in the Place Partnership which is also a party to the Place Agreement “Partnership Business” has the meaning set out in Part 1 “Place Agreement” means the Place Agreement entered into by the Partners for the transformation and better integration of health and care services for the population of Rotherham “Place Board” means the Place Board as described in the Place Agreement that also sits as the ICB Place Committee as described in the ICB Constitution “Place Partnership” means the partnership of organisations described in the Place Agreement “Terms of Reference for ICB Business” means the terms of reference set out in Part 3 “Working Days” means a weekday that is not a bank holiday in England.

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3	**Reports to**	The Place Board reports to the boards of the Partners in relation to Partnership Business. This is done through each Partner representative sitting on the Place Board reporting back to their respective employing/ host organisation.
4	**Purpose**	In relation to Partnership Business, the Place Board provides the strategic and collective leadership for the Place Partnership to deliver the ambitions of the Place Partnership and the Rotherham Place Plan. The Place Board is the forum where all Partners across health and care in Rotherham come together to formulate, agree and implement strategies for implementing the Rotherham Place Plan. The Place Board works across boundaries to improve patient experience and clinical outcomes, by establishing partnerships and better working relationships between all health and care organisations in the Rotherham health and care community. The Place Board shall operate in accordance with the vision, objectives and principles set out in the Place Agreement for the transformation and better integration of health, care, support and community services for the population of Rotherham.
5	**Remit and responsibilities**	When conducting Partnership Business, the Place Board has responsibility for: • Leading the Rotherham Place Board. • Promoting and encouraging commitment to the Place Plan and "Place Board Principles" set out in the Place Agreement amongst all partner organisations; • Formulating, agreeing and implementing strategies for implementing the Place Plan; • Overseeing the implementation of the Place Agreement and all related contracts in terms of delivering the Rotherham Place Plan in line with the Place Board Principles. • Reviewing performance of the partners against the Rotherham Place Plan and determining strategies to improve performance or rectify poor performance. • Ensuring a proactive approach to establishing the health and social care needs of Rotherham citizens and to react to the changes within the health and social care agenda. • Operating cost of care effectively in the context of the Rotherham health and social care financial circumstances. • Realising cost saving opportunities through system redesign to meet the Rotherham wide efficiency challenge, ensuring impact assessments are completed where appropriate to assess any adverse impact in regard to patient safety and experience. • Providing a forum for parties to resolve disagreement relating to the Rotherham Place Plan. • In undertaking its role, considering recommendations from the Rotherham Place Board Delivery Team in respect of the operation of the Rotherham Place Board and the delivery of the services. • Reporting to the partner organisations and the Health and Wellbeing Board on progress against the Rotherham Place Plan. • Overseeing the development and implementation of the Place Board Development Plan, driving progress in implementation and seeking to overcome any barriers to implementation • Liaising where appropriate with national stakeholders (including NHS England) to communicate the views of the Place Board on matters relating to integrated care in Rotherham. • Operating as the key link between the Place Board and the ICB and work with the ICB to help shape its development, in conjunction with the Place Board's development. This may include nominating Place Board representatives to sit on governance groups at ICB level, as necessary.

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6	**Members**	Members contribute to discussion, participate in aligned decision making and are accountable for decisions made. The Members of the Place Board are: NHS South Yorkshire ICB Rotherham Executive Place Director / Deputy Chief Executive ICB (Joint Chair) Rotherham Metropolitan Borough Council (RMBC) Chief Executive (Joint Chair) Director of Public Health The Rotherham NHS Foundation Trust (TRFT) Chief Executive Deputy Chief Executive Voluntary Action Rotherham (VAR) Chief Executive Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH) Chief Executive Connect Healthcare Rotherham CIC Medical Director Each Partner will ensure that the Member from their organisation: • Is appointed to attend and represent their organisation on the Place Board with such authority as is agreed to be necessary in order for the Place Board to function effectively in discharging its responsibilities as set out in these terms of reference which is, to the extent necessary, recognised in an organisation's respective scheme of delegation (or similar); • Has equivalent delegated authority to the designated officers of all other member organisations comprising the Place Board (as confirmed in writing and agreed between the Partner organisations); and • Understands the dual role of the Place Board as described in Part 1 of these terms of reference, and the limits of their responsibilities and authority in respect of the Place Board when dealing with Partnership Business and ICB Business (to the extent they are a member of both).
7	**Participants**	The following individuals will be invited to attend each meeting of the Place Board as Participants. Participants attend meetings and may be invited by the Chair to participate in discussions from time to time. They do not participate in decision making. The Participants of the Place Board when discussing Partnership Business are: • Chair and Vice Chair, Rotherham Health and Wellbeing Board • Deputy Place Director, Rotherham Place, ICB • Strategic Director, Adult Care, Housing and Public Health, RMBC (as joint Urgent and Community Transformation Group Lead) • Director of Children's Services, RMBC (as Children and Young People's Transformation Group Lead) • Director of Nursing for Doncaster and Rotherham Places • Chief Finance Officer, Rotherham Place, ICB • Medical Director, Rotherham Place, ICB • Independent Non-Executive Member, ICB • Strategy & Delivery Lead, Rotherham Place, ICB • Head of Communications, Rotherham Place, ICB

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		The Chair may invite such other Participants to attend any meeting of the Place Board as the Chair considers appropriate.
8	**Deputies**	With the permission of the Chair, Members of the Place Board may nominate a deputy to attend a meeting that they are unable to attend. The deputy may speak and vote on their behalf. The decision of the Chair regarding authorisation of nominated deputies is final.
9	**Chair**	The meetings will be run alternately by the Joint Chairs of the Place Board (as noted in paragraph 6 above). In the event of both of the Joint Chairs being unable to attend all or part of the meeting, another Member of the Partnership Board shall chair the meeting.
10	**Quoracy**	No Partnership Business shall be transacted unless the following are present as a minimum: a) one Member from each of the ICB and RMBC; and b) two Members from any of the following Partners: TRFT, VAR, RDASH or RPCLG. For the sake of clarity: a) No person can act in more than one capacity when determining the quorum. b) An individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interest, shall no longer count towards the quorum. Members of the Place Board may participate in meetings by telephone, video or by other electronic means where they are available and with the prior agreement of the Chair. Participation by any of these means shall be deemed to constitute presence in person at the meeting. Members are normally expected to attend at least 75% of meetings during the year.
11	**Conduct of meetings**	The Place Board is not a separate legal entity or a committee of any of the Partners when considering Partnership Business, therefore it is unable to take decisions separately from its constituent Members or bind any one of them; nor can one Partner organisation 'overrule' another on any matter. The Place Board will operate as a place for discussion of Partnership Business with the aim of reaching consensus to make recommendations and proposals to the boards of Partner organisations, unless the Members have the requisite delegated authority from their Partner organisations to make the relevant decision.
12	**Frequency of meetings**	The rules set out in the Terms of Reference for ICB Business shall apply, unless the Place Board determines otherwise and amends these terms of reference accordingly.
13	**Urgent decisions**	The rules set out in the Terms of Reference for ICB Business shall apply, unless the Place Board determines otherwise and amends these terms of reference accordingly.
14	**Admission of the press and public**	The Place Board may meet in private to consider Partnership Business. However, if it is also considering ICB Business then press and public will be admitted in accordance with the terms of reference for ICB Business.
15	**Declarations of interest**	The rules set out in the Terms of Reference for ICB Business shall apply, unless the Place Board determines otherwise and amends these terms of reference accordingly.
16	**Support to the Place Board**	The arrangements set out in the Terms of Reference for ICB Business shall apply unless the Place Board determines otherwise and amends these terms of reference accordingly.

17	**Authority**	The arrangements set out in the Terms of Reference for ICB Business shall apply in relation to: • investigations • commissioning of reports and surveys • obtaining legal or other independent professional advice unless the Place Board determines otherwise and amends these terms of reference accordingly. In addition, if the Place Board agrees additional requirements regarding the above, those requirements must be complied with. The Place Board has the sub-committees set out in the Terms of Reference for ICB Business. The Place Board is authorised to create and dissolve permanent workstreams and time limited task and finish groups as are necessary to fulfil its responsibilities. When doing so, the Place Board must set a clear scope and where appropriate deadline for completion for the workstream or group. Such workstreams or groups shall not be able to take decisions on behalf of the Place Board and shall not be formal sub-committees of the Place Board.
18	**Reporting**	The Place Board shall report to the boards/ senior management of Partner organisations in respect of Partnership Business. It does this through Members reporting back to their organisations. The Place Board shall also report to the Health and Wellbeing Board for Rotherham. The Place Board will receive for information updates on the work of any of its task and finish groups or workstreams.
19	**Conduct of the Place Board**	Members of the Place Board will abide by the 'Principles of Public Life' (The Nolan Principles). The Place Board shall undertake an annual self-assessment of its own performance against these terms of reference. This self-assessment shall form the basis of an annual report from the Place Board to the Rotherham Health and Wellbeing Board.
20	**Amendments**	Any amendment to these terms of reference is Partnership Business. Any changes to these terms of reference must be approved by the Place Board.
21	**Review date**	These terms of reference shall be reviewed annually.

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ROTHERHAM PLACE BOARD

PART 3: PLACE BOARD – TERMS OF REFERENCE FOR ICB PLACE COMMITTEE (ICB BUSINESS)

1	**Name of committee**	The Rotherham Place Board (the **Place Board**) is established as and operates as a committee of the NHS South Yorkshire Integrated Care Board ("**ICB**"), in accordance with the ICB's Constitution, Standing Orders and Scheme of Reservation and Delegation when it is considering ICB Business (the "**ICB Place Committee**").
2	**General**	These terms of reference, which must be published on the ICB website, set out the remit, responsibilities, membership and reporting arrangements of the ICB Place Committee and may only be changed with the approval of the ICB Board. The ICB Place Committee has no executive powers, other than those specifically delegated in these terms of reference. In these Terms of Reference the following capitalised terms are given the meaning set out in the NHS South Yorkshire Integrated Care Board Constitution as updated from time to time, unless the context otherwise requires: • Constitution • ICB • Standing Order or Standing Orders Other capitalised terms have the meaning set out below: "**Chair**" means the chair of the ICB Place Committee "**ICB Business**" matters which are delegated to the ICB Place Committee in line with its purpose at paragraph 4 by the ICB for determination by the ICB Place Committee "**ICB Policies**" means any policy, process or procedure formally adopted by the ICB "**Member**" refers to a member of the ICB Place Committee as listed in paragraph 6 "**Participant**" refers to a participant of the ICB Place Committee as listed in paragraph 7 "**Place Agreement**" means the Rotherham Place Agreement entered into by the Partners (including the ICB) for the transformation and better integration of health and care services for the population of Rotherham "**Place Board**" means the place board as described in the Place Agreement that also sits as the ICB Place Committee when conducting ICB Business "**Working Days**" means a weekday that is not a bank holiday in England The ICB is part of the South Yorkshire Integrated Care System, which has four core purposes: • improve outcomes in population health and healthcare • tackle inequalities in outcomes, experience and access • enhance productivity and value for money • help the NHS support broader social and economic development.

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		The ICB will use its resources and powers to achieve demonstrable progress on these aims, collaborating to tackle complex challenges, including: • improving the health of children and young people • supporting people to stay well and independent • acting sooner to help those with preventable conditions • supporting those with long-term conditions or mental health issues • caring for those with multiple needs as populations age • getting the best from collective resources so people get care as quickly as possible.
3	**Reports to**	The ICB Board
4	**Purpose**	The ICB Place Committee will support the ICB in delivering its statutory and/or corporate functions as set out in paragraph 5.
5	**Remit and responsibilities**	The role of the ICB Place Committee will be to actively participate in the Rotherham Place Partnership in accordance with the Place Agreement, and in accordance with the Constitution of the ICB. The ICB Place Committee is responsible for the following: **Regulation and Control** • Establish governance arrangements to support collective accountability between partner organisations for place-based system delivery and performance, underpinned by the statutory and contractual accountabilities of individual organisations. **Strategy and Planning** • Agree a plan to meet the health and healthcare needs of the Rotherham population, having regard to the ICS integrated care strategy and Rotherham health and wellbeing strategies. • Ensure consultation, involvement and engagement on place plans is undertaken where appropriate • Engagement with Health Overview and Scrutiny Committee. • Develop Annual Plan for Delivery of Place Health & Wellbeing Strategy and ICP Strategy • Ensure provision of Health Care Services for Place Population. • Agree Place-based delivery plans. • Allocate resources to deliver the plan in Rotherham, determining what resources should be available to meet population need and setting principles for how they should be allocated across services and providers (both revenue and capital). • Approve the operating structure in Rotherham. • Develop joint working arrangements with partners in place that embed collaboration and integration as the basis for delivery within the ICB plan.

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Arrange for the provision of health services in line with the allocated resources across the ICS through a range of activities including:

convening and supporting providers at Place to lead major service transformation programmes to achieve agreed outcomes.
support the development of primary care networks (PCNs) as the foundations of out-of- hospital care and building blocks of place-based partnerships. Including through investment in PCN management support, data and digital capabilities, workforce development and estates.
working with local authority and voluntary, community and social enterprise (VCSE) sector partners to put in place personalised care for people, including assessment and provision of continuing healthcare and funded nursing care, and agreeing personal health budgets and direct payments for care.

Agree place action on data and digital: working with partners across the NHS and with local authorities to put in place smart digital and data foundations to connect health and care services to put the citizen at the centre of their care.
Agree joint work on estates, procurement, supply chain and commercial strategies to maximise value for money in place and support wider goals of development and sustainability.

Partnership working

Agree joint working arrangements at Place that embed collaboration and integration as the basis for delivery of the Place plan.

Staffing and human resources

Delivery of implementation in Rotherham of people priorities.

Risk management
Make arrangements to implement in place ICB risk management arrangements.
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<tr><td>6</td><td>Members</td><td>
The Members of the ICB Place Committee when undertaking ICB Business are:

Executive Place Director, ICB (Chair)
Director of Nursing for Doncaster and Rotherham Places
Chief Medical Officer, Rotherham Place, ICB
Chief Finance Officer, Rotherham Place, ICB
Independent Non-Executive Member, ICB
Deputy Place Director, ICB

The Chair of the ICB must approve the appointment of any Member of the ICB Place Committee and may remove any Member of the ICB Place Committee, acting always in accordance with the ICB Constitution.
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7	**Participants**	The following individuals will be invited to attend each meeting of the ICB Place Committee as Participants. Participants attend meetings and may be invited by the Chair to participate in discussions from time to time. They do not vote. The Participants of the ICB Place Committee when undertaking ICB Business are: • Rotherham Metropolitan Borough Council (RMBC) - Chief Executive • Rotherham Metropolitan Borough Council (RMBC) - Director of Public Health • The Rotherham NHS Foundation Trust (TRFT) - Chief Executive • Voluntary Action Rotherham (VAR) - Chief Executive • Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH) - Chief Executive • Connect Healthcare Rotherham CIC - Medical Director • Rotherham Primary Care Collaborative Board (RPCB) – Medical Director SY ICB, Rotherham • Rotherham Health and Wellbeing Board (RH&WBB)- Chair • Rotherham Health and Wellbeing Board (RH&WBB)- Vice Chair • The Rotherham NHS Foundation Trust (TRFT) - Deputy Chief Executive ICB officers may request or be requested to attend the meeting when matters concerning their responsibilities are to be discussed or they are presenting a paper. The Chair may invite such other Participants to attend any meeting of the ICB Place Committee as the Chair considers appropriate.
8	**Deputies**	With the permission of the Chair, Members of the ICB Place Committee may nominate a deputy to attend a meeting that they are unable to attend. Members should inform the Chair of their intention to nominate a deputy and should ensure that any such deputy is suitably briefed and qualified to act in that capacity. The deputy may speak on their behalf but may not vote. The decision of the Chair regarding authorisation of nominated deputies is final.
9	**Chair**	The meetings will be run by the Chair of the ICB Place Committee (as noted in paragraph 6 above). If the Chair is absent or is disqualified from participating by a conflict of interest, a member of the ICB shall be chosen by the members present, or by a majority of them, and shall preside. In the event of the Chair being unable to attend all or part of the meeting, another Member of the ICB Place Committee shall chair the meeting.
10	**Quoracy**	No business shall be transacted unless at least 60% of the membership (which equates to 3 individuals) and including the following are present: (1) Executive Place Director and (2) Independent Non-Executive Member For the sake of clarity: a) No person can act in more than one capacity when determining the quorum. b) An individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interest, shall no longer count towards the quorum. Members of the ICB Place Committee may participate in meetings by telephone, video or by other electronic means where they are available and with the prior agreement of the Chair. Participation by any of these means shall be deemed to constitute presence in person at the meeting. Members are normally expected to attend at least 75% of meetings during the year

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11	**Conduct of meetings**	In line with the ICB's Standing Orders, it is expected that decisions will be reached by consensus. Should this not be possible, each member of the ICB Place Committee will have one vote, the process for which is set out below: a. All members of the ICB Place Committee who are present at the meeting will be eligible to cast one vote each. (For the sake of clarity, Members of the ICB Place Committee are set out at paragraph 6; Participants and observers do not have voting rights.) b. Absent Members may not vote by proxy. Absence is defined as not being present at the time of the vote but this does not preclude anyone attending by teleconference or other virtual mechanism from exercising their right to vote if eligible to do so. c. For the sake of clarity, any additional Participants and Observers (as detailed within Section 5.6. of the Constitution) will not have voting rights. A resolution will be passed if more votes are cast for the resolution than against it. d. If an equal number of votes are cast for and against a resolution, then the Chair (or in their absence, the person presiding over the meeting) will have a second and casting vote. e. Should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.
12	**Frequency of meetings**	The ICB Place Committee will meet monthly in common with the Place Board. The Chair may call an additional meeting at any time by giving not less than 14 calendar days' notice in writing to members of the ICB Place Committee. One third of the members of the ICB Place Committee may request the Chair to convene a meeting by notice in writing, specifying the matters which they wish to be considered at the meeting, If the Chair refuses, or fails, to call a meeting within seven calendar days of such a request being presented, the ICB Place Committee Members signing the requisition may call a meeting by giving not less than 14 calendar days' notice in writing to all Members of the ICB Place Committee specifying the matters to be considered at the meeting. In emergency situations the Chair may call a meeting with two days' notice by setting out the reason for the urgency and the decision to be taken.
13	**Urgent decisions**	In the case of urgent decisions and extraordinary circumstances, every attempt will be made for the ICB Place Committee to meet virtually. Where this is not possible the following will apply: a) The powers which are delegated to the ICB Place Committee may allow for an urgent decision be exercised by the Chair subject to every effort having made to consult to consult with as many members as possible in the given circumstances. b) The exercise of such powers shall be reported to the next formal meeting of the ICB Place Committee for formal ratification, where the Chair will explain the reason for the action taken, and the ICB Audit Committee for oversight.

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14	**Admission of the press and public**	In accordance with Public Bodies (Admission to Meetings) Act 1960 all meetings of the ICB at which public functions are exercised will be open to the public. This includes the Place Board where it is discussing ICB Business as the ICB Place Committee. The ICB Place Committee may resolve to exclude the public from a meeting or part of a meeting where it would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time. The chair of the meeting shall give such directions as they think fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the ICB Place Committee's business shall be conducted without interruption and disruption. As permitted by Section 1(8) Public Bodies (Admissions to Meetings) Act 1960 as amended from time to time) the public may be excluded from a meeting to suppress or prevent disorderly conduct or behaviour. Matters to be dealt with by a meeting following the exclusion of representatives of the press, and other members of the public shall be confidential to the members of the ICB Place Committee. A public notice of the time and place of the meeting and how to access the meeting shall be given by posting it electronically at least 7 calendar days before the meeting or, if the meeting is convened at shorter notice, then at the time it is convened. The agenda and papers for meetings will be published electronically in advance of the meeting excluding, if thought fit, any item likely to be addressed in part of a meeting is not likely to be open to the public.
15	**Declarations of interest**	If any Member has an interest, financial or otherwise, in any matter and is present at the meeting at which the matter is under discussion, he/she will declare that interest as early as possible and act in accordance with the ICB's Conflicts of Interests Policy. Subject to any previously agreed arrangements for managing a conflict of interest, the chair of the meeting will determine how a conflict of interest should be managed. The chair of the meeting may require the individual to withdraw from the meeting or part of it. The individual must comply with these arrangements, which must be recorded in the minutes of the meeting.
16	**Support to the ICB Place Committee**	Administrative support will be provided to the ICB Place Committee by officers of the ICB. This will include: • Agreement of the agenda with the Chair, taking minutes of the meetings, keeping an accurate record of attendance, key points of the discussion, matters arising and issues to be carried forward; • Maintaining an on-going list of actions, specifying Members responsible, due dates and keeping track of these actions; • Sending out agendas and supporting papers to Members five working days before the meeting. • Drafting minutes for approval by the Chair within five working days of the meeting and then distribute to all attendees following this approval within 10 working days; and • An annual work plan to be updated and maintained on a quarterly basis.

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17	**Authority**	The ICB Place Committee is authorised to investigate any activity within its terms of reference. It is authorised to seek any information it requires within its remit, from any employee of the ICB and they are directed to co-operate with any such request made by the ICB Place Committee. The ICB Place Committee is authorised to commission any reports or surveys it deems necessary to help it fulfil its obligations. The ICB Place Committee is authorised to obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary. In doing, so, the ICB Place Committee must follow procedures put in place by the ICB for obtaining legal or professional advice. The ICB Place Committee is authorised to create sub-committees or working groups as are necessary to fulfil its responsibilities within its terms of reference. The ICB Place Committee may not delegate powers delegated to it within these terms of reference (unless expressly authorised by the ICB Board) and remains accountable for the work of any such group.
18	**Reporting**	The ICB Place Committee shall submit its minutes to each formal ICB Board meeting. The Chair shall draw to the attention of the ICB Board any significant issues or risks relevant to the ICB. The ICB Place Committee's minutes will be published on the ICB website once ratified. The ICB Place Committee shall submit an annual report to the ICB Audit Committee and the ICB Board. The ICB Place Committee will receive for information the minutes of other meetings which are captured in the ICB Place Committee work plan e.g. sub-committees.
19	**Conduct of the ICB Place Committee**	All Members will have due regard to and operate within the Constitution of the ICB, standing orders, standing financial instructions and other financial procedures. Members of the ICB Place Committee will abide by the 'Principles of Public Life' (The Nolan Principles) and the NHS Code of Conduct. The Place Board (including the ICB Place Committee) shall agree an annual delivery plan with the ICB Board. The ICB Place Committee shall undertake an annual self-assessment of its own performance against the annual work plan, membership and terms of reference. This self-assessment shall form the basis of the annual report from the ICB Place Committee. Any resulting changes to the terms of reference shall be submitted for approval by the ICB Board.
20	**Amendments**	These terms of reference, which must be published on the ICB website, set out the remit, responsibilities, membership and reporting arrangements of the ICB Place Committee and may only be changed with the approval of the ICB Board.
21	**Review date**	These terms of reference shall be reviewed annually.

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ROTHERHAM PLACE PARTNERSHIP AGREEMENT

COMMENCEMENT DATE 01.07.2022

UPDATE 11.02.2024

1. **NHS SOUTH YORKSHIRE INTEGRATED CARE BOARD**
2. **CONNECT HEALTHCARE ROTHERHAM CIC**
3. **ROTHERHAM METROPOLITAN BOROUGH COUNCIL**
4. **ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST**
5. **THE ROTHERHAM NHS FOUNDATION TRUST**
6. **VOLUNTARY ACTION ROTHERHAM LIMITED**

No	Date	Version Number	Author
3-1	300421	1	EV
3-2	290621	2	EV
3-3	140721	3	EV
4	240622	4	EV
5	060722	5	EV
6	041122	6	PH/LG
7	110224	7	LG

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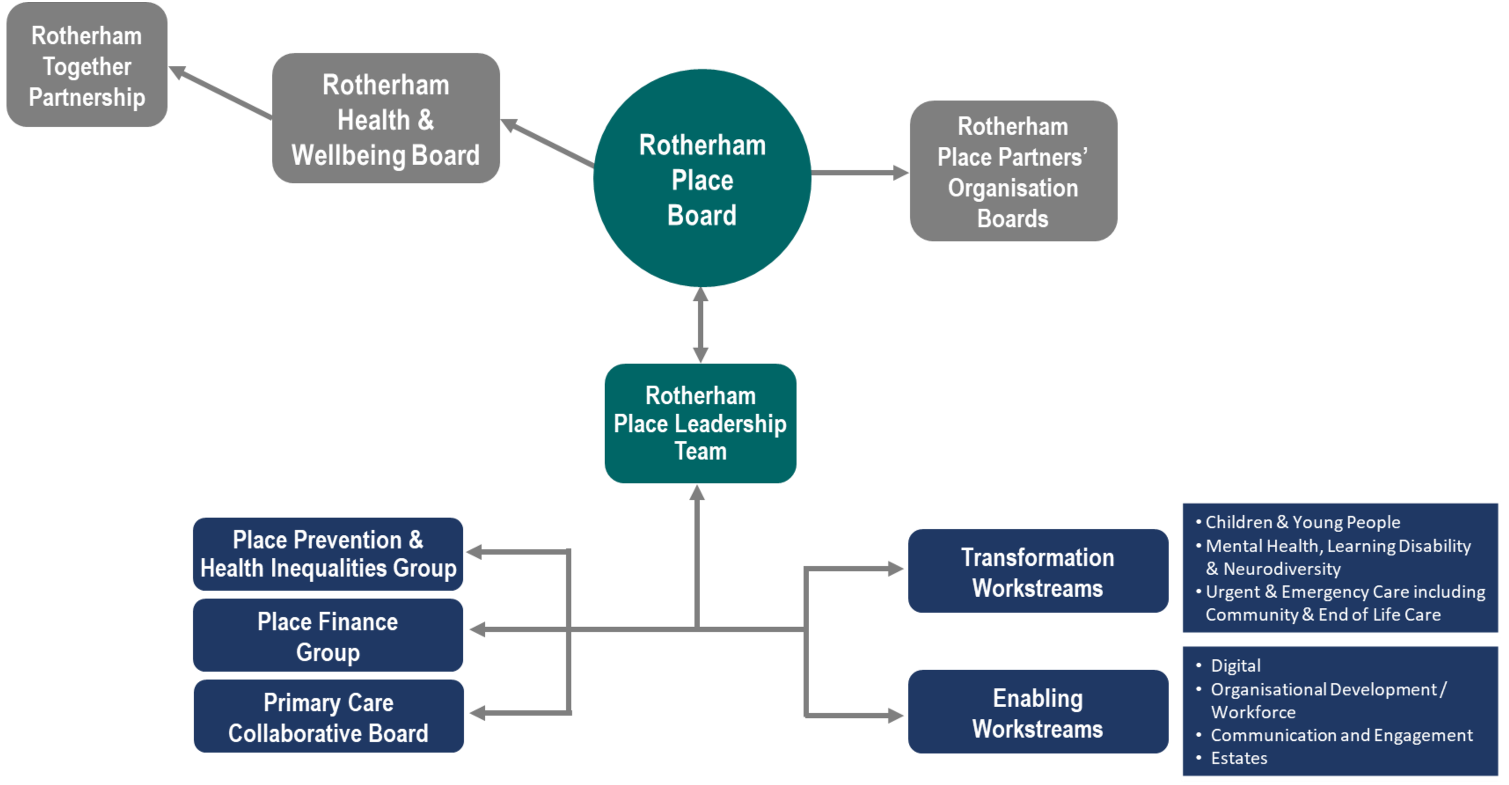
Figure 1: Rotherham Place Partnership governance structure



DATE: 01 07 2022

This Place Agreement (the **Agreement**) is made between:

1. **NHS SOUTH YORKSHIRE INTEGRATED CARE BOARD** of 722 Prince of Wales Road, Sheffield S9 4EU (the "**ICB**");
2. **CONNECT HEALTHCARE ROTHERHAM CIC** (Company number 10648960) whose registered office is Valley Health Centre, Saville Street, Rotherham S65 3HD("**Connect**");
3. **ROTHERHAM METROPOLITAN BOROUGH COUNCIL** of Riverside House, Main Street, Rotherham S60 1AE (the "**Council**");
4. **ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST** of Woodfield House, Tickhill Road Site, Weston Rd, Doncaster DN4 8QN ("**RDASH**");
5. **THE ROTHERHAM NHS FOUNDATION TRUST** of Rotherham Hospital, Moorgate Road, Rotherham S60 2UD ("**TRFT**"); and
6. **VOLUNTARY ACTION ROTHERHAM LIMITED** a registered charity (Registered Charity Number 1075995) and a company limited by guarantee (Registered Company number 02222190) whose registered office is The Spectrum, Coke Hill, Rotherham S60 2HX ("**VAR**"),

together referred to in this Agreement as the "**Partners**".

The ICB and the Council (in its role as commissioner of social care and public health services) are together referred to in this Agreement as the "**Commissioners**".

Connect, TRFT, RDASH, VAR and the Council (in its role as a provider of social care services, whether directly or through contracting arrangements with third party providers) are together referred to in this Agreement as the "**Providers**".

BACKGROUND

a) The Partners have been working collaboratively across Rotherham to integrate services and provide care closer to home for local people for some time, under a collaborative agreement signed in 2018. This updated Agreement sets out the values, principles and shared ambition of the Partners in supporting continued work to further develop place-based health and care provision for the Rotherham population using a population health management approach and building on the progress achieved by the Partners to date.

b) Rotherham's Integrated Health & Social Care Place Plan (the **"Place Plan"**) detailed the Partners' joined up approach to delivering key initiatives that will help achieve the Health and Wellbeing Strategic Aims. The Place Partnership governance framework set out in this Agreement will enable the Providers to collaborate in order to identify opportunities for service improvement or redesign in line with the vision and objectives in the Place Plan.

c) Pursuant to the Health and Care Act 2022, on the Commencement Date the ICB was established as a statutory body and NHS Rotherham Clinical Commissioning Group was dissolved and its functions transferred to the ICB. In line with the principle of subsidiarity,

the ICB has delegated certain of its functions to be exercised on its behalf by the Place Partnership through the governance arrangements set out in this Agreement.

d) The Partners acknowledge that the Council has a dual role within the Rotherham health and care system as both a commissioner of social care and public health services but also as a provider of social care and public health services either through direct delivery or through various contracts. In its role as commissioner of social care and public health services the Council shall work in conjunction with the ICB and in its role as a provider of social care services the Council shall work in conjunction with the other Providers. The Council recognises the need to ensure and will ensure that any potential conflicts of interest arising from its dual role are appropriately identified to the other Partners and managed.

e) This Agreement sets out the key terms that the Partners have agreed, including:

- the vision of the Partners, and key objectives for the development and delivery of integrated services in Rotherham;
- the key principles that the Partners will comply with in working together through the Place Partnership; and
- the governance structures underpinning the Place Partnership.

f) This Agreement is intended to work alongside:

- the Place Plan;
- the Contracts between the ICB and the Providers and between the Council and the Providers for the delivery of the Services; and
- the Section 75 Agreement between the Commissioners under which they commission the services listed in the schedules to that agreement.

IT IS AGREED AS FOLLOWS:

1. DEFINITIONS AND INTERPRETATION

1.1 In this Agreement, capitalised words and expressions shall have the meanings given to them in Schedule 1.

1.2 In this Agreement, unless the context requires otherwise, the following rules of construction shall apply:

1.2.1 a “person” includes a natural person, corporate or unincorporated body (whether or not having separate legal personality);

1.2.2 unless the context otherwise requires, words in the singular shall include the plural and in the plural shall include the singular;

1.2.3 a reference to a "Provider", the "Council", the "ICB" or the "Commissioner" or any Partner includes its personal representatives, successors or permitted assigns;

1.2.4 a reference to a statute or statutory provision is a reference to such statute or provision as amended or re-enacted. A reference to a statute or statutory provision includes any subordinate legislation made under that statute or statutory provision, as amended or re-enacted; and

1.2.5 any phrase introduced by the terms "**including**", "**include**", "**in particular**" or any similar expression shall be construed as illustrative and shall not limit the sense of the words preceding those terms.

2. STATUS AND PURPOSE OF THIS AGREEMENT

2.1 The Partners have agreed to work together to further develop the Place Partnership in order to develop an improved financial, governance and contractual framework for delivering integrated health, support, and community care for the Rotherham population (covered by the ICB and the Council) and to deliver the Place Plan.

2.2 Notwithstanding the good faith consideration that each Partner has afforded the terms set out in this Agreement, the Partners agree that save as provided in Clause 2.3 below this Agreement shall not be legally binding. The Partners each enter into this Agreement intending to honour all of their respective obligations.

2.3 Clauses 9 (*Transparency*), 156 (*Liability*), 18 (*Confidentiality and FOIA*), 19(*Intellectual Property*), 20.4 (*Counterparts*) and 20.5 (*Governing Law and Jurisdiction*) shall come into force from the date of this Agreement and shall give rise to legally binding commitments between the Providers.

2.4 Each of the Providers has one or more individual Contracts (or where appropriate combined Contracts) with the ICB or Council. This Agreement is not intended to conflict with or take precedence over the terms of the Contracts unless expressly agreed by the Partners in writing.

3. APPROVALS

Each of the Partners acknowledges and confirms that as at the date of this Agreement it has obtained all necessary authorisations to enter into this Agreement and that its own organisational leadership body has approved the terms of this Agreement.

4. DURATION AND REVIEW

4.1 This Agreement shall commence on the Commencement Date (1 July 2022) and will continue in full force and effect and will expire on 31 March 2026 (the "Extended **Term**"), unless and until terminated in accordance with the terms of this Agreement.

4.2 Prior to the expiry of the Extended Term of this Agreement will expire automatically without notice unless, no later than six (6) months before the end of the Extended Term,

the Partners agree in writing that the term of the Agreement will be extended for a further term to be agreed between the Partners (the "Further **Extended Term**").

4.3 The Partners will review progress made against the Place Partnership Plan and the terms of this Agreement on a half yearly basis and/or at such intervals thereafter as may be agreed between the Partners, and the Partners may agree to vary the Agreement to reflect developments as appropriate in accordance with Clause 17 (*Variation*).

SECTION A: PLACE PLAN VISION, OBJECTIVES AND PRINCIPLES

5. THE PLACE PLAN VISION AND OBJECTIVES

5.1 The Place Plan agreed by the Partners is intended to deliver sustainable, effective, and efficient health and care support and community services with significant improvements underpinned by collaborative working through the development of the Place Partnership. The Partners have agreed to work together in order to achieve the objectives set out in the Place Plan.

5.2 The Partners' shared vision as set out in the Place Plan is:

"Supporting people and families to live independently in the community, with prevention and self-management at the heart of our delivery"

5.3 The Partners acknowledge that they will have to make decisions together in order for the Place Partnership to work effectively. The Partners agree that they will always look to work together and make decisions on a Best for Rotherham basis in order to achieve the objectives in the Place Plan, save for the Reserved Matters listed at Clause 8.1.

6. THE PRINCIPLES

6.1 These Principles underpin the delivery of the Partners' obligations under this Agreement and set out key factors for a successful relationship between the Partners. The Partners acknowledge and confirm that the successful delivery of the Place Plan will depend on the Providers' ability to effectively co-ordinate and combine their expertise and resources in order to deliver an integrated approach to the provision of the Services in conjunction with the Commissioners.

6.2 The Principles are that the Partners will work together in good faith and, unless the provisions in this Agreement state otherwise, the Partners will:

6.2.1 focus on people and places rather than organisations, pulling pathways together and integrating them around people's homes and localities; adopt a way of working which promotes continuous engagement with and involvement of local people to inform this;

6.2.2 actively encourage prevention, self-management, and early intervention to promote independence and support recovery, and be fair to ensure that all the

people of Rotherham can have timely access to the support they require to retain independence;

6.2.3 design pathways together and collaborate, agreeing how we do pathways once collectively, to make our current and future services work better;

6.2.4 be innovative, using international evidence and proven best practice to shape our pathways to achieve the best outcomes for people in Rotherham in the most cost-effective way;

6.2.5 strive for the best quality services based on the outcomes we want within the resource available;

6.2.6 be financially sustainable and this must be secured through our plans and pathway reform;

6.2.7 align relevant health and social care budgets together so we can buy health, care, and support services once for a place in a joined up way;

6.2.8 work together to reduce health inequalities and tackle the wider determinants of health to ensure that the health of our most vulnerable communities, including those living in poverty and deprivation and those with mental health problems, learning or physical disabilities, is improving the fastest; and

6.2.9 promoting and striving to adhere to the Nolan Principles of public life (selflessness, integrity, objectivity, accountability, openness, honesty and leadership),

(together these are the "**Principles**").

6.3 In addition to the Principles set out above, the Partners will have regard to the values and principles set out in the South Yorkshire Health and Care Compact.

7. PROBLEM RESOLUTION AND ESCALATION

7.1 The Partners agree to adopt a systematic approach to problem resolution which recognises the objectives in the Place Plan and the Principles and which:

7.1.1 seeks solutions without apportioning blame;

7.1.2 is based on mutually beneficial outcomes;

7.1.3 treats each Partner as an equal party in the dispute resolution process; and

7.1.4 contains a mutual acceptance that adversarial attitudes waste time and money.

7.2 If a problem, issue, concern or complaint comes to the attention of a Partner which relates to the Place Plan or the Principles or any matter within the scope of this Agreement and is appropriate for resolution between the Partners such Partner shall notify the other Partners and the Partners each acknowledge and confirm that they shall

then seek to resolve the issue by a process of discussion and/or negotiation within 20 Operational Days of such matter being notified.

7.3 Any Dispute arising between the Partners which is not resolved under Clause 7.2 above will be resolved in accordance with Schedule 3 (*Dispute Resolution Procedure*).

7.4 If any Partner receives any formal enquiry, complaint, claim or threat of action from a third party relating to this Agreement (including, but not limited to, claims made by a supplier or requests for information made under the FOIA relating to this Agreement) the receiving Partner will liaise with the Place Leadership Team as to the contents of any response before a response is issued.

SECTION B: OPERATION OF AND ROLES IN THE PLACE PARTNERSHIP

8. RESERVED MATTERS

8.1 The Partners agree and acknowledge that nothing in this Agreement shall operate as to require them to make any decision or act in anyway which shall place any Partner in breach of:

8.1.1 Law;

8.1.2 any Services Contract or the Section 75 Agreement;

8.1.3 any specific Department of Health and Social Care or NHS England policies;

8.1.4 if applicable its Constitution (including for the ICB and the Council); any terms of its NHS provider licence; its registration with the CQC ; the terms of reference or the Place Board or the ICB Place Committee Terms of Reference; or to breach any legislative requirements including the NHS Act 2006 (as amended); or

8.1.5 any term of a non-NHS party's legal constitution or other legally binding agreement or governance document of which specific written notice has been given to the Partners prior to the date of the Agreement,

and the Place Board will not make a final recommendation which requires any Partner to act as such.

9. TRANSPARENCY

9.1 The Partners will provide to each other all information that is reasonably required in order to achieve the objectives in the Place Plan.

9.2 The Partners have responsibilities to comply with Law (including where applicable Competition Law). The Partners will make sure that they share information, and in particular Competition Sensitive Information, in such a way that is compliant with Competition Law and, accordingly, the Place Board and the Place Team will each ensure that the exchange of Competition Sensitive Information will be restricted to circumstances where:

9.2.1 it is essential;

9.2.2 it is not exchanged more widely than necessary;

9.2.3 it is subject to suitable non-disclosure or confidentiality agreements which include a requirement for the recipient to destroy or return it on request or on termination or expiry of this Agreement; and

9.2.4 it may not be used other than to achieve the aims of this Agreement or the Place Plan in accordance with the Principles.

9.3 Subject to compliance with Clause 9.1 above, the Partners will ensure that they provide the Place Board and Place Leadership Team with all financial cost resourcing, activity or other information as may be reasonably required so that the Place Board and Place Leadership Team can be satisfied that the Place Plan objectives are being satisfied.

9.4 The Commissioners will make sure that the Place Board and Place Leadership Team establish appropriate information barriers between and within the Providers so as to ensure that Competition Sensitive Information and Confidential Information are only available to those Providers who need to see it to achieve the Place Plan and for no other purpose whatsoever so that the Partners do not breach Competition Law.

9.5 It is accepted by the Partners that the involvement of the Providers in the governance arrangements for the Place Partnership is likely to give rise to situations where information will be generated and made available to the Providers, which could potentially give the Providers an unfair advantage in competitions or which may be capable of distorting such competitions (for example, disclosure of pricing information or approach to risk may provide one Provider with a commercial advantage over a separate provider). Any Provider will have the opportunity to demonstrate to the reasonable satisfaction of the ICB and/or the Council (where acting as a commissioner) in relation to any competitive procurements that the information it has acquired as a result of its participation in the Place Partnership, other than as a result of a breach of this Agreement, does not preclude the ICB and the Council (where acting as a commissioner) from running a fair competitive procurement in accordance with their legal obligations.

9.6 Notwithstanding Clause 9.5 above, the Commissioners may take such measures as they consider necessary in relation to such competitive procurements in order to comply with their obligations under Law which may include excluding any potential bidder from the competitive procurement in accordance with the Law governing that competitive procurement.

SECTION C: GOVERNANCE ARRANGEMENTS

10. PLACE PARTNERSHIP GOVERNANCE

10.1 In addition to the Partners' own Boards / Cabinet / Governing Body, which shall remain accountable for the exercise of each of the Partners' respective functions, the Partners must communicate with each other in a clear, direct, and timely manner. The governance structure for the Place Partnership will include:

10.1.1 the Health and Wellbeing Board for Rotherham;

10.1.2 the Place Board;

10.2 the Place Leadership Team. The diagram in Schedule 2 (Governance) sets out the governance structure and the links between the various groups in more detail. In addition to the two groups set out in Clause 10.1, as detailed on the diagram in Schedule 2 the Partners have formed a number of 'Enabling Groups', 'Transformation Groups' and 'Cross Cutting Groups' which report into the Place Leadership Team and focus on the Enabler, Transformation and Cross-Cutting Workstreams respectively.

Rotherham Health and Wellbeing Board

10.3 The Rotherham Health and Wellbeing Board is a committee of the Council, charged with promoting greater health and social care integration in Rotherham. The Health and Wellbeing Board will receive reports from the Place Board as to the development of the ICP arrangements under this Agreement and progress against the Place Plan.

Rotherham Place Board

10.4 The Place Board in practice carries out two roles:

10.4.1 firstly, the Place Board has responsibility for aligning decisions on strategic policy matters made by Partners that are relevant to the Place Partnership. Where applicable, the Place Board may also make recommendations on matters that it has been asked to consider on behalf of a constituent Partner in the Place Partnership. Where the Place Board has been asked to consider matters on behalf of a Partner, the Partner organisation remains responsible for the exercise of its functions and nothing that the Place Board does shall restrict or undermine that responsibility. This work is referred to as "**Partnership Business**"; and

10.4.2 secondly, the Place Board sits as the ICB Place Committee for Rotherham ("**ICB Place Committee**"), which is a formal committee of the ICB. The ICB Place Committee is established as a committee of the ICB Board, in accordance with the ICB's Constitution. The ICB Place Committee has delegated authority from the ICB Board to make decisions about the use of ICB resources in Rotherham in line with its remit, and otherwise support the ICB as set out in its terms of

reference of Schedule 2. The decisions reached by the ICB Place Committee are decisions of the ICB, in line with the ICB's Scheme of Reservation and Delegation. This work is referred to as "**ICB Business**". When sitting as the ICB Place Committee, Partners must comply with ICB policies and procedures.

10.5 As far as possible in accordance with their organisation's governance arrangements, the Partners that are statutory bodies will seek to exercise their respective statutory functions within the Place Board governance structure insofar as such functions relate to ICB Business (in the case of the ICB) or Partnership Business (in the case of the other statutory Partners) and are within the scope of these arrangements. This will be enabled:

10.5.1 for the ICB, through the Place Board sitting as the ICB Place Committee, as outlined above;

10.5.2 for other Partners that are statutory bodies, through those organisations (at their discretion) granting delegated authority for decision making to specific individuals (for example a Place Board member) or to specific committees or other structures established by Partner organisations meeting as part of, or in parallel with, the Place Board; and

10.5.3 for Partners that are not statutory bodies, it is expected that as far as possible the individuals attending meetings of the Place Board will be formally authorised to take the decisions under consideration on behalf of their organisation.

10.6 The terms of reference for Partnership Business in Schedule 3 apply to the Place Board as at the Commencement Date. The terms of reference for ICB Business in Schedule 3 apply to the ICB Place Committee as at the Commencement Date and can be found in the governance handbook issued by the ICB and available on the ICB website. The terms of reference for all governance groups may be updated by agreement of the Partners during the term or as otherwise stated in their terms.

10.7 Whether decisions are Partnership Business or ICB Business or a combination of the two, the aim will be to ensure that decisions reflect applicable national and local strategies and are taken in accordance with the Vision, Objectives and Principles for the Place Partnership.

10.8 The Place Board is the group responsible for:

10.8.1 leading the Place Partnership,

10.8.2 reporting to Partner organisations and the Health and Wellbeing Board for Rotherham on progress against the Place Plan; and

10.8.3 liaising where appropriate with national stakeholders (including NHS England) to communicate the views of the Place Partnership on matters relating to integrated care in Rotherham.

10.9 The Place Board will act in accordance with the terms of reference set out in Schedule 2 (*Governance*) as applicable.

10.10 The joint commissioning governance arrangements between the ICB and the Council in respect of the Better Care Fund as at the Commencement Date will continue to operate separately from the Place Board. Where agreed by the ICB and the Council the Place Board may meet in common with the BCF joint commissioning governance arrangements between the ICB and the Council.

10.11 The Place Board may refer opportunities to develop specific service improvements / redesign (provided they align sufficiently with the Principles and Objectives) to collaboratives of some or all of the Providers (dependent on the opportunity). Where the Place Board refers such opportunities, the Providers may choose to collaborate through existing governance groups (e.g. the Place Leadership Team), or set up specific task and finish groups, in either case aligning with the work of the Place Leadership Team and reporting into the Place Board. The scope and detail of delivery by the Providers of any such opportunities will be agreed by the relevant Partners through the Place Board and appended to this Agreement.

Rotherham Place Leadership Team

10.12 The Place Leadership Team is the oversight group for the delivery of the Rotherham Place Plan, and in driving forward the Partners' ambition for further delegation at place. It is the forum where all Partners come together to strengthen relationships and provide leadership and ambition for transformation of the Place Partnership. It will support oversight of agendas and papers for the Place Board (Partnership Business) and the ICB Place Committee (as appropriate) and agree any partnership issues for escalation to the Place Board. The terms of reference for the Place Leadership Team are set out in [Schedule 2].

10.13 The Place Leadership Team is the group responsible for managing the collaborative operation of the Partners and the delivery of the Place Plan.

10.14 The Partners will communicate with each other clearly, directly and in a timely manner to ensure that the Partners (and their representatives) present at the Place Board and Place Leadership Team are able to represent their nominating organisations to enable effective and timely decisions to be made for each respective Partner under this Agreement.

10.15 Each Partner must ensure that its appointed members of the Place Board and Place Leadership Team (or their appointed deputies/alternatives) attend all meetings of the relevant group and participate fully and exercise their rights on a Best for Rotherham

basis and in accordance with Clause 5 (*Place Plan Objectives*) and Clause 6 (*Principles*).

11. CONFLICTS OF INTEREST

11.1 Subject to compliance with Law (including without limitation Competition Law) and contractual obligations of confidentiality the Partners agree to share all information relevant to the achievement of the Place Plan objectives in an honest, open and timely manner.

11.2 The Partners will:

11.2.1 disclose to each other the full particulars of any real or apparent conflict of interest which arises or may arise in connection with this Agreement or operation of the Place Board and Place Leadership Team, immediately upon becoming aware of the conflict of interest whether that conflict concerns the Partner or any person employed or retained by them for or in connection with the performance of the Services;

11.2.2 not allow themselves to be placed in a position of conflict of interest in regard to any of their rights or obligations under this Agreement (without the prior consent of the other Partners) before they participate in any decision in respect of that matter; and

11.2.3 use best endeavours to ensure that their Place Board and, Place Leadership Team representatives comply with the requirements of this Clause 11 when acting in connection with this Agreement.

SECTION D: FINANCIAL PLANNING

12. PAYMENTS

12.1 The Partners who provide services will continue to be paid in accordance with the mechanism set out in their respective Contracts in respect of Services they deliver.

12.2 The Partners have not agreed as at the Commencement Date to share risk or reward. However, the Partners will continue to work together during the term of the Rotherham Place Plan 2023-25 to develop system financial principles including the potential development of risk/reward sharing mechanisms with the aim of achieving the Objectives of the Plan. Any future introduction of such a mechanism would require additional legally binding provisions to be agreed between the Partners and incorporated into this Agreement in accordance with Clause 17.

SECTION F: GENERAL PROVISIONS

13. EXCLUSION AND TERMINATION

13.1 A Partner may be excluded from this Agreement on notice from the other Partners (acting in consensus) in the event of:

13.1.1 the termination of their Contract; or

13.1.2 an event of Insolvency affecting them.

13.2 A Partner may withdraw from this Agreement by giving not less than 3 months' written notice to each of the other Partners' representatives on the Place Partnership Board.

13.3 A Partner may be excluded from this Agreement on written notice from all of the remaining Partners in the event of a material or persistent breach of the terms of this Agreement by the relevant Partner which has not been rectified within 30 days of notification issued by the remaining Partners (acting in consensus) or which is not reasonably capable of remedy. In such circumstances this Agreement shall be partially terminated in respect of the excluded Partner.

13.4 The Place Board may resolve to terminate this Agreement in whole where:

13.4.1 a Dispute cannot be resolved pursuant to the Dispute Resolution Procedure; or

13.4.2 where the Partners agree for this Agreement to be replaced by a formal legally binding agreement between them.

14.5 Where a Partner is excluded from this Agreement, or withdraws from it, the Partners recognise that the associated Contract may be terminated and/or varied to reflect how the impacted Services are to be delivered. In addition to any specific obligations under the relevant Contract and to ensure a smooth transfer of Services the Partners agree to work together in good faith to agree the necessary changes so that the Services continue to be provided for the benefit of the Population. The excluded Partner shall procure that all data and other material belonging to any other Partner shall be delivered back to the relevant Partner or deleted or destroyed (as instructed by the relevant Partner) as soon as reasonably practicable.

14.6 For the avoidance of doubt, individuals sitting as members of the Place Board may be removed and/ or may be prevented from participating in meetings in accordance with the relevant Terms of Reference set out in Schedule 2.

14. INTRODUCING NEW PARTNERS

Additional parties may become parties to this Agreement on such terms as the Partners will jointly agree in writing, acting at all times on a Best for Rotherham basis. Any new Partner will be required to agree in writing to the terms of this Agreement (including the legally binding elements) before admission.

15. LIABILITY

The Partners' respective responsibilities and liabilities in the event that things go wrong with the Services will be allocated under their respective Contracts and not this Agreement.

16. VARIATION

Any amendment to this Agreement will not be binding unless set out in writing and signed by or on behalf of each of the Partners, provided always that the ICB will be able to amend the Terms of Reference for the ICB Place Committee and ICB Business set out in Schedule 2 without the need for approval from the other Partners.

17. CONFIDENTIALITY AND FOIA

17.1 Each Partner shall keep in strict confidence all Confidential Information it receives from another Partner except to the extent that such Confidential Information is required by Law to be disclosed or is already in the public domain or comes into the public domain otherwise than through an unauthorised disclosure by a Partner. Each Partner shall use Confidential Information received from another Partner solely for the purpose of delivering the Services and complying with its obligations under this Agreement and for no other purpose.

17.2 To the extent that any Confidential Information is covered or protected by legal privilege, then disclosing such Confidential Information to any Partner or otherwise permitting disclosure of such Confidential Information does not constitute a waiver of privilege or of any other rights which a Partner may have in respect of such Confidential Information.

17.3 The Partners agree to procure, as far as is reasonably practicable, that the terms of this Clause 18 (*Confidentiality and FOIA*) are observed by any of their respective successors, assigns, or transferees of respective businesses or interests or any part thereof as if they had been party to this Agreement.

17.4 Nothing in this Clause 18 (*Confidentiality and FOIA*) will affect any of the Partners' regulatory or statutory obligations, including but not limited to competition law of any applicable jurisdiction.

17.5 The Partners acknowledge that some of them are subject to the requirements of FOIA and will facilitate each other's compliance with their information disclosure requirements, including the submission of requests for information and handling any such requests in a prompt manner and so as to ensure that any Partner which is subject to FOIA is able to comply with their statutory obligations.

18. INTELLECTUAL PROPERTY

18.1 In order to develop and deliver the arrangements under this Agreement in accordance with the Principles each Partner grants each of the other Partners a fully paid up, non-exclusive licence to use its existing Intellectual Property insofar as is reasonably

required for the sole purpose of the fulfilment of that Partner's obligations under this Agreement.

18.2 If any Partner creates any new Intellectual Property through the development and delivery of the arrangements under this Agreement, the Partner which creates the new Intellectual Property will grant to the other Partners a fully paid up, non-exclusive licence to use the new Intellectual Property for the sole purpose of the fulfilment of that Partner's obligations for the Services and the development and delivery of the arrangements under this Agreement.

19. GENERAL

19.1 Any notice or other communication given to a Partner under or in connection with this Agreement shall be in writing, addressed to that Partner at its principal place of business or such other address as that Partner may have specified to the other Partner in writing in accordance with this Clause, and shall be delivered personally, or sent by pre-paid first class post, recorded delivery or commercial courier.

19.2 A notice or other communication shall be deemed to have been received: if delivered personally, when left at the address referred to in Clause 19.1; if sent by pre-paid first class post or recorded delivery, at 9.00 am on the second Operational Day after posting; or if delivered by commercial courier, on the date and at the time that the courier's delivery receipt is signed.

19.3 Nothing in this Agreement is intended to, or shall be deemed to, establish any partnership between any of the Partners, constitute any Partner the agent of another Partner, nor authorise any Partner to make or enter into any commitments for or on behalf of any other Partner except as expressly provided in this Agreement.

19.4 This Agreement may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this Agreement, but all the counterparts shall together constitute the same agreement. The expression "counterpart" shall include any executed copy of this Agreement scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e-mail attachment. No counterpart shall be effective until each Partner has executed at least one counterpart.

19.5 This Agreement, and any Dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims), shall be governed by, and construed in accordance with, English law, and where applicable, the Partners irrevocably submit to the exclusive jurisdiction of the courts of England and Wales.

19.6 A person who is not a Partner to this Agreement shall not have any rights under or in connection with it.

This Agreement for a Rotherham Place Partnership has been entered into on the date stated at the beginning of it.

Signed by GAVIN BOYLE for and on behalf of **NHS SOUTH YORKSHIRE INTEGRATED CARE BOARD**	.... CHIEF OFFICER
Signed by DR ANAND BARMADE for and on behalf of **CONNECT HEALTHCARE ROTHERHAM CIC**	.... CHAIR
Signed by TOBY LEWIS for and on behalf of **ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST**	.... CHIEF EXECUTIVE
Signed by RICHARD JENKINS for and on behalf of **THE ROTHERHAM NHS FOUNDATION TRUST**	.... CHIEF EXECUTIVE
Signed by SHARON KEMP for and on behalf of **ROTHERHAM METROPOLITAN BOROUGH COUNCIL**	.... CHIEF EXECUTIVE
Signed by SHAFIQ HUSSAIN for and on behalf of **VOLUNTARY ACTION ROTHERHAM LIMITED**	.... CHIEF EXECUTIVE

SCHEDULE 1

Definitions and Interpretation

1 The following words and phrases have the following meanings:

Agreement or Place Agreement	this agreement incorporating the Schedules
Best for Rotherham	best for the achievement of the Place Plan for the Rotherham population on the basis of the Principles
Commencement Date	1 July 2022
Commercially Sensitive Information	Confidential Information which is of a commercially sensitive nature relating to a Partner, its intellectual property rights or its business or which a Partner has indicated would cause that Partner significant commercial disadvantage or material financial loss
Competition Law	the Competition Act 1998 and the Enterprise Act 2002, as amended by the Enterprise and Regulatory Reform Act 2013 and as applied to the healthcare sector in accordance with the Health and Care Act 2022
Competition Sensitive Information	Confidential Information which is owned, produced and marked as Competition Sensitive Information including information on costs by one of the Partners and which that Partner properly considers is of such a nature that it cannot be exchanged with the other Partners without a breach or potential breach of Competition Law. Competition Sensitive Information may include, by way of illustration, trade secrets, confidential financial information and confidential commercial information, including without limitation, information relating to the terms of actual or proposed contracts or sub-contract arrangements (including bids received under competitive tendering), future pricing, business strategy and costs data, as may be utilised, produced or recorded by any Partner, the publication of which an organisation in the same business would reasonably be able to expect to protect by virtue of business confidentiality provisions
Confidential Information	the provisions of this Agreement and all information which is secret or otherwise not publicly available (in both cases in its entirety or in part) including commercial, financial, marketing or technical information, know-how, trade secrets or business methods, in all cases whether disclosed orally or in writing before or after the date of this Agreement, including Commercially Sensitive Information and Competition Sensitive Information
Contract	a contract entered into by one of the ICB or the Council and a Provider for the provision of the Services linked to the agreed Transformation

	Workstreams and references to a Contract include all or any one of those contracts as the context requires
Dispute	any dispute arising between two or more of the Partners in connection with this Agreement or their respective rights and obligations under it
Dispute Resolution Procedure	the procedure set out in Schedule 3 for the resolution of disputes which are not capable of resolution under Clause 7 (*Problem Resolution and Escalation*)
Enablers	the enabling workstreams as set out in the Place Plan
Further Extended Term	has the meaning set out in Clause 4.2
FOIA	the Freedom of Information Act 2000 and any subordinate legislation (as defined in section 84 of the Freedom of Information Act 2000) from time to time together with any guidance and/or codes of practice issued by the Information Commissioner or relevant Government department in relation to such Act
Good Practice	Good Clinical Practice and/or Good Health and/or Social Care Practice (each as defined in the Contracts), as appropriate
Insolvency	(as may be applicable to each Partner) a Partner taking any step or action in connection with its entering administration, provisional liquidation or any composition or arrangement with its creditors (other than in relation to a solvent restructuring), being wound up (whether voluntarily or by order of the court, unless for the purpose of a solvent restructuring), having a receiver appointed to any of its assets or ceasing to carry on business
Intellectual Property	patents, rights to inventions, copyright and related rights, trade marks, business names and domain names, goodwill, rights in designs, rights in computer software, database rights, rights to use, and protect the confidentiality of, Confidential Information and all other intellectual property rights, in each case whether registered or unregistered and including all applications and rights to apply for and be granted, renewals or extensions of, and rights to claim priority from, such rights and all similar or equivalent rights or forms of protection which subsist or will subsist now or in the future in any part of the world
Law	a) any applicable statute or proclamation or any delegated or subordinate legislation or regulation; b) any applicable judgment of a relevant court of law which is a binding precedent in England and Wales;

	c) Guidance (as defined in the NHS Standard Contract); d) National Standards (as defined in the NHS Standard Contract); and e) any applicable code.
Leadership Team	the Rotherham Place Leadership Team as described in clause 10.12
NHS Standard Contract	the NHS Standard Contract for NHS healthcare services as published by NHS England from time to time
Operational Days	a day other than a Saturday, Sunday or bank holiday in England
Place Board	the Rotherham Place Board
Place Plan	the Rotherham Integrated Health & Social Care Place Plan set out in Schedule 4 of this Agreement
Population	the geographical population group of Rotherham as covered by the ICB and Council
Principles	means the principles set out in Clause 6.2
Reserved Matters	the matters set out in Clause **Error! Reference source not found.**
Section 75 Agreement	the agreement entered into by the ICB and the Council under section 75 of the National Health Service Act 2006 to commission the services listed in the Schedules to that agreement
Service Users	people within the Rotherham population served by the Commissioners and who are in receipt of the Services
Services	the services provided, or to be provided, by each Provider to Service Users pursuant to its respective Contract as set out in the Place Plan
Transformation Workstreams	the workstreams set out in the Place Plan.

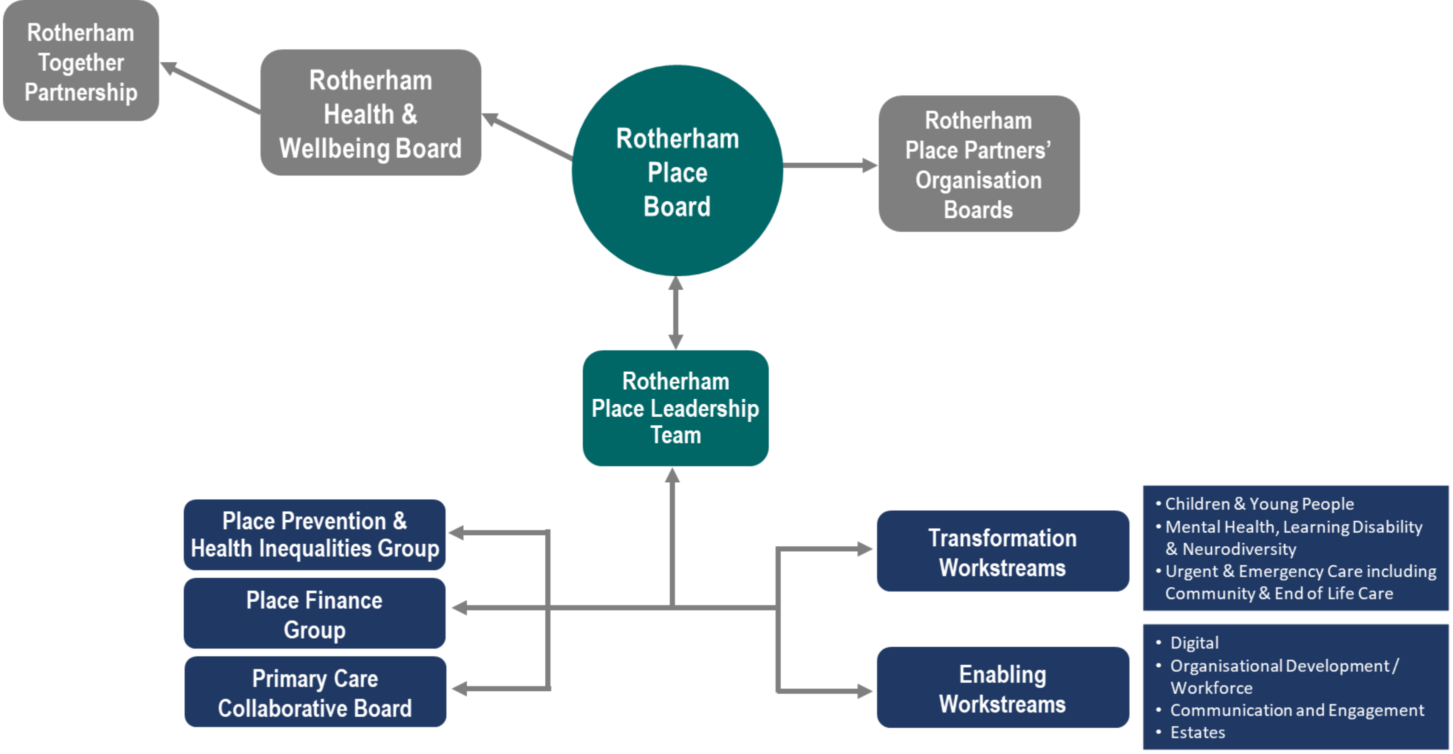
SCHEDULE 2

Governance

1.1 This Schedule 2 sets out the governance arrangements for the Place Partnership under this Agreement.

1.2 The diagram below summarises the governance structure which the Partners have agreed to operate to provide oversight of the development and implementation of the Place Partnership approach and the arrangements under this Agreement.

1.3 This Schedule also contains the terms of reference for the Place Board and the Place Leadership Team.



Rotherham Place Board Terms of Reference (incorporating the Rotherham ICB Place Committee) [TO BE INSERTED]

Rotherham Place Leadership Team Terms of Reference [TO BE INSERTED]

SCHEDULE 3

Dispute Resolution Procedure

1 Avoiding and Solving Disputes

1.1 The Partners commit to working cooperatively to identify and resolve issues to the Partners' mutual satisfaction so as to avoid all forms of dispute or conflict in performing their obligations under this Agreement. Accordingly the Partners will look to collaborate and resolve differences under Clause 7 (*Problem Resolution and Escalation)* of this Agreement prior to commencing this procedure.

1.2 The Partners believe that by focusing on the delivery of the Place Plan and Principles they are reinforcing their commitment to avoiding disputes and conflicts arising out of or in connection with the ICP.

1.3 The Partners shall promptly notify each other of any dispute or claim or any potential dispute or claim in relation to this Agreement or the operation of the Place Partnership (each a "**Dispute**") when it arises.

1.4 In the first instance the Place Leadership Team shall seek to resolve any Dispute to the mutual satisfaction of the Partners. If the Dispute cannot be resolved by the Place Leadership Team within 10 Operational Days of the Dispute being referred to it, the Dispute shall be referred to the Place Board for resolution.

1.5 The Place Board shall deal proactively with any Dispute on a Best for Rotherham basis in accordance with this Agreement so as to seek to reach a unanimous decision. If the Place Board reaches a consensus that resolves, or otherwise concludes a Dispute, it will advise the Partners of its decision by written notice.

1.6 The Partners agree that the Place Board, on a Best for Rotherham basis, may determine whatever action it believes is necessary including the following:

(a) if the Place Board cannot resolve a Dispute within 20 Operational Days of referral, it may by consensus select an independent facilitator to assist with resolving the Dispute; and

(b) the independent facilitator shall:

(i) be provided with any information he or she requests about the Dispute;

(ii) assist the Place Board to work towards a consensus decision in respect of the Dispute;

(iii) regulate his or her own procedure and, subject to the terms of this Agreement, the procedure of the Place Board at such discussions;

(iv) determine the number of facilitated discussions, provided that there will be not less than three (3) and not more than six (6) facilitated discussions, which must take place within twenty (20) Operational Days of the independent facilitator being appointed; and

(v) have its costs and disbursements met by the Partners in Dispute equally.

1.7 If the independent facilitator cannot resolve the Dispute within 30 Operational Days of referral of the Dispute by the Place Board, the Dispute must be considered afresh in accordance with this Schedule 3 and only after such further consideration again fails to resolve the Dispute, the Place Board may decide to:

(i) terminate this Agreement in accordance with Clause 15.4.1; or

(ii) agree that the Dispute need not be resolved.

SCHEDULE 4

Rotherham Place Plan

11.02.2024 LG V7

Rotherham Place Partnership Update: January and February 2024

Children and Young People

In December, the government published their response to the safeguarding review of children and young adults with disabilities and complex needs in residential settings. Our safeguarding team, Named Nurse for Looked After Children and Care Leavers and Head of AACC have continued to work alongside Rotherham Council's social workers, commissioners, and virtual school to ensure we are assured of the safety and progress of our children and young adults with disabilities and complex needs in residential settings. This now includes multi-agency visits to settings as part of our quality assurance process. https://www.gov.uk/government/publications/safeguarding-children-with-disabilities-in-residential-settings-government-response

Coram Voice is a leading children's rights organisation, championing the rights of children in care and care leavers, ensuring young voices are heard in decisions that matter. Rotherham children and young people in care took part in an artwork competition. Our amazing children and young people have managed to achieve 7 invitations for the awards ceremony in London, with 4 nominees for awards and 1 winner (of the art award) already!

Place Board received the monthly Place Performance report and discussed areas of good practice and areas of challenge. It was highlighted that for **Diagnostic waits,** Rotherham was **best performer nationally** in December out of the 106 areas.

Chief Finance officers across the Rotherham place have been meeting regularly for several years and provide regular updates to Place Board. In February, they provided an update on the **financial performance of Rotherham Place partners** as at month 9 (1 April – 31 Dec '23) for:

- SYICB - Rotherham Place
- The Rotherham NHS Foundation Trust
- Rotherham Doncaster and South Humber NHS Foundation Trust
- Rotherham Metropolitan Borough Council

In addition, the report covers the efficiency challenge and risks.

Place Board received an update from the **Rotherham Place Strategic Estates Group**, key partner areas were summarised as:

- Creation of diagnostic and clinical spaces in the Town Centre
- Shared use of RMBC office accommodation and wider asset base
- Asset availability in Wickersley for new surgery, Olive Lane, due for completion by end of 2024
- Land availability for Ambulance Service to deliver transformation plan (new hub & spoke model stations)
- Sharing of knowledge and joined up working on Energy, Climate and Sustainability initiatives. Exploring funding opportunities and ideas
- Sharing of property reviews and early knowledge of surplus properties / opportunities
- Sharing of Estates Strategies to ensure consistent themes and joined up thinking in relation to all property related matters

Place board in January received an update on some of the work taking place within our **Learning Disability and Autism priority.**

Rotherham has drafted 2 strategies, both are built on co-production and engagement, and both align with the South Yorkshire Integrated Care Partnership priorities:

1. People with a learning disability
2. All age autism

Shared Priorities:

a) Improving preparing for adulthood / transitions – this will include transition issues for autistic young people with eating disorders.
b) Independence and choice.
c) Increasing education and employment opportunities.
d) Improving access to better health.
e) Improving housing options - Rotherham's Flexible Purchasing System for Supported Living has been launched.

Some of the challenges and risks members were asked to note included:

- To address the increased number of admissions of autistic people into mental health hospital beds a pathways review is taking place to ensure resources and pathways are best aligned to avoid inappropriate admissions.
- Both finance and staffing are challenges and there are active conversations to deploy skill mixing to close staffing gaps.
- Work has been done with schools to ensure that, regardless of the time taken for assessment, people are supported throughout the process, this is being monitored closely.
- To address the challenge in discharging patients with LD/ND issues to safe spaces a procurement is taking place for future provision.
- Work on internships and the links built with the ICB and RMBC HR teams should see an increase of people going into employment and sharing of their experiences.

Members were asked to raise awareness with staff that small changes can make a big impact for people and by improving communication to promote the service and what's available will help.

Anonymised examples of Case Studies from the Voluntary Action Rotherham PCN

Issue/Background: Tom was referred to social prescribing for the first time while he was a carer for his wife who had Dementia for several years, she was towards the end stages of the illness, but he decided he wanted to manage on his own for as long as possible. Sadly, she passed away leaving Tom feeling expectedly down and lost. He was referred again for support and Tom told us how he had found himself feeling isolated. He told of how he was going out a few times a week to do shopping and other necessities, and enjoyed his gardening, however, what he was not doing was interacting and engaging with other people. While he had family who saw him when they could, that didn't give him enough contact with other people.
Intervention: While Tom was very independent and unsure whether we could make a difference, he agreed to meet me and to try the Social Prescribing hub coffee morning.
Outcome: Within a few weeks a difference was seen in his confidence. Tom now continually attends every week, looks much brighter and always with a smile on his face. Tom has met many friends who also regularly attend the café and now has a sense of community again. He has involved himself in the weekly quiz and is known throughout the group as the currently undefeated quiz champion.

Issue/Background: I met Alice at a local community group; she had seen me there several times before she felt comfortable enough to approach me to ask for support. At her assessment we spoke about how I could support her. She requested support with housing and medical priority, however, was initially reluctant to openly discuss other issues affecting her. While supporting Alice and building up a relationship with her she eventually felt able to discuss other issues significantly impacting her wellbeing. She mentioned she was in some debt and had been contacted by debt collectors. She didn't feel she was able to cope mentally with the added pressure, she was unaware of how to manage this and hadn't made any contact with the companies requesting payments.
Intervention: I supported her speaking to the housing team to discuss options to be rehoused with the local authority. After gathering the information from the various companies whose letters Alice had been sent, I contacted them to establish the circumstances and advise on her financial situation. I arranged a pause on her payments while the investigations took place. She was anxious about an upcoming interview with one of the debtors and felt unable to attend this alone, I reassured her that I will be supporting her at the interview.
Outcome: This was a huge relief for Alice as she felt a burden had been lifted having a positive impact on her mental health. She was now clear on the next steps and what her options are, she felt more capable of dealing with this. She now feels more confident in where and how to access support and has also encouraged two other patients to refer for support.

Engagement with people with Long Term Conditions (LTCs) in Maltby and Dinnington - Building on the findings from the Place Development Programme, partners have been working together to engage local people with LTCs living in two deprived areas of Rotherham (Maltby and Dinnington). The first stage of this project has been a survey distributed via GPs, which received over 1,200 responses, which is approximately 50% of the target population. Early insights from the data collected are already starting to inform work, including a recent workshop on chronic pain. Work will now take place to analyse the results, which will support a wide range of programme areas, including physical activity, mental health, prevention and health inequalities and multi-morbidity. The vision is that the data will be widely shared across Rotherham, to ensure that the insights make the biggest impact on delivery. Over 800 respondents want to be involved in further engagement, so discussions are also taking place around how to maximise this opportunity.

Expansion of the Health Inequalities Tool - To support the delivery of the Prevention and Health Inequalities Strategy, a health inequalities tool and outcomes framework has been developed using PowerBI. Work has recently taken place to expand the tool, to incorporate sections on the five clinical areas in the Core20Plus5 for adults and a profile on Rotherham's ethnic minority communities. The purpose of this tool will be to shape and inform delivery of the strategy, pointing to key issues to be picked up by workstream leads. The plan is to share the findings of the tool with groups leading on each of the clinical areas and to continue to develop the tool drawing on data from different partners.

Information for patients and clinicians about some of our key services has been shared widely, all can be contact via 01709 426600:

Rotherham Metropolitan Borough Council
NHS The Rotherham NHS Foundation Trust
Care homes
GPs
Healthcare Professionals
Social Care
Yorkshire Ambulance Service
Public 260,000 Rotherham Citizens
Carers
NHS 111
Who can contact us?
Rotherham Transfer of Care Hub
REFERRAL CONTACTS
Care Coordination Centre: 01709 42 6600
What do we offer?
Admissions Avoidance
Urgent Community Response
Home First Reablement
Virtual Wards
Social Care
Advanced Clinical Practitioners
Therapies
Voluntary Sector and Social Prescribing

Transfer of Care Hub - are the local health and social care system co-ordination centres which link all relevant services across sectors to aid discharge and recovery and admission avoidance.

It is a place-based approach where all relevant services are linked to coordinate care and support for people who need it. This may be to prevent avoidable hospital admissions or during and following discharge.

In Rotherham, the Transfer of Care Hub incorporates the Care Coordination Centre, Urgent Community Hub (including Urgent Community Response, adult social care and reablement) and Integrated Discharge Team, along with voluntary and community sector partners, into one location, based at Woodside.

Virtual Ward – helps to deliver care to patients who are unwell but do not need to be in an acute setting, they adopt a positive, patient-centred approach.

A 'hospital at home' service, bringing acute care to patients' home settings and providing support to people with complex medical needs. Preventing unnecessary hospital admissions and facilitating early discharge for patients on a respiratory or frailty pathway. The team is led by senior clinicians and includes consultants, nurse consultants, advanced clinical practitioners, nurses, therapists, support workers, and reablement, who deliver care in patients' own environments.

Urgent Community Response service - provides urgent assessment, treatment, and support to residents if they are at risk of being admitted to hospital within the next two to twenty-four hours.

The UCR is a collective of several teams, all working together to provide optimal care for our community:

- **Rotherham Care Coordination Centre**: Single point of contact, staffed by a team of dedicated call handlers, ready to field requests for clinical interventions, triage queries, and facilitate access to community nursing services
- **Rotherham Unplanned Community Nursing Team**: Delivers same-day home-based nursing care for adults aged 18 years and over, 24/7. To support patients in their home, to maximise independence, and improve health outcomes
- **Integrated Rapid Response:** Provides urgent care in a patients home within two hours to avoid hospital admissions and enable independent living for longer
- **Virtual Ward:** Helps to deliver care to patients who are unwell but do not need to be in an acute setting, they adopt a positive, patient-centred approach (more above)
- **Rotherham Out of Hours Team:** Ensuring patients have access to clinical interventions outside regular working hours, from 8pm to 8am

The service is available 24 hours, 365 days per year, to help people at home and prevent unnecessary hospital visits or admissions, except in life-threatening circumstances.

Public Board of Directors Meeting
March 2024

Agenda item	P41/24
Report	**Needs of Rotherham Community and the Consultant in Public Health Work Programme**
Executive Lead	Michael Wright, Deputy Chief Executive
Link with the BAF	
How does this paper support Trust Values	Delivering high-quality, equitable care, tailored to population needs; collaborating with local organisations to build strong, resilient partnerships that deliver excellent care.
Purpose	**For decision** ☐ **For assurance** ☐ **For information** ☒
Executive Summary	• The needs of the Rotherham community are broadly articulated in the Health and Well Being Strategy. In summary, the population is generally in poorer health, have more long-term conditions and are more deprived than average. Our population is ageing, is more likely to live in poverty and are more likely to struggle with behavioural impacts of health through smoking, drinking and maintaining a healthy weight. • Trust Board has requested a discussion about the work of the role and the wider public health opportunities across the Trust and local system • The Consultant in Public Health role was newly established in Spring 2023, and aims to work across the Trust and wider system to tackle health inequalities and to promote preventative and sustainable approaches to the population health challenges in Rotherham. • The high-level work programme is appended, but immediate priorities being tackled include: • 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, looking at their experiences of health and healthcare, with a longer term view to develop targeted, evidence based and effective interventions, and to roll out the model to other geographical and demographic groups. • Undertaking an evaluation of the equalities impacts of the Mexborough Elective Orthopaedic Centre, working alongside colleagues from Barnsley and Doncaster in order to identify existing inequalities and to capture and mitigate any newly-introduced variation. • Developing an understanding of the wider impacts of outreach interventions in the alcohol liaison team, exploring how individuals and the wider system can benefit from supporting high-need, high-resource patients. • Building a programme of health coaching training for staff across the trust and wider system, building on the Making Every Contact Count programme and working with local authority and ICB colleagues in order

	to support patients to make and sustain changes to their health behaviours. • Developing approaches to highlight and tackle inequalities in patient access, experience and outcome. • Continuing to build upon the successes of the QUIT smoking cessation programme and exploring ways to sustain quit attempts post-discharge.
Due Diligence	This brief presentation has been prepared by the Consultant in Public Health at the request of the Quality Committee
Board powers to make this decision	For discussion and assurance
Who, What and When	*Andrew Turvey, Consultant in Public Health*
Recommendations	**That Board be assured that the public health programme is aligned to the values and aspirations of the Trust and that it is adaptable to meet new and emerging health needs of our community.**
Appendices	**Population Need and Healthcare Public Health in Rotherham (Powerpoint)**

Population Need and Healthcare Public Health in Rotherham

Andrew Turvey,

Consultant in Public Health

Trust Board, March 2024

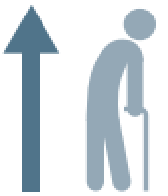
Population Needs – From JSNA

Joint Strategic Needs Assessment – what the data tells us

Table 1: **Rotherham – at a glance**[2]

The **health** of people in Rotherham is generally poorer than the England average

Life expectancy for men and women is lower than the England average and is nearly **9.9 years** lower for men and **9.5** years lower for women in the most deprived areas of Rotherham compared to the most affluent areas (2018 -2020)

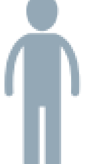


The number of **older people** is increasing, especially in the oldest age groups, and people will live longer with poorer health

Our **Black and Minority Ethnic** communities are growing and changing, most evident amongst children and young people and a growing Roma community

Deprivation in Rotherham is amongst the highest **20%** in England, with almost **40%** of Rotherham residents living in the **10%** most deprived areas in England

Rotherham's older population (over 60) has increased from 61,500 in 2011 to 68,600 in the 2021 Census, an 11.5 % rise (51,700 in 2001). Rotherham's population is ageing broadly in line with national trends and the percentage aged over 85 increased from 2.1 % in 2011 to 2.3 % in 2021



34.64% of children in Rotherham are estimated to live in **poverty**

12,800 people in Rotherham are **economically inactive** (neither working nor seeking work) due to long-term sickness

[2] Data sources range between 2015-2021. All data are the latest available on the PHOF and the Rotherham Joint Strategic Needs Assessment as of July 2022.

9.4% of working age people in Rotherham are claiming long term sickness or disability-related benefits

People in Rotherham are **24%** more likely to have a long term health problem or disability than the English average

8,893 people in Rotherham are entitled to Carers Allowance with 6,520 receiving the payment due to their role as a carer

Household incomes in Rotherham are lower than the Yorkshire and Humber and UK average for both men and women. Rotherham women earn only **80%** of the average salary for for women in England and earn only **76%** of the average salary for Rotherham men

In 2020, 20,889 households in Rotherham (17.9%) were in **fuel poverty** with localised rates up to 39.5%. This compares with 10,814 households (9.5%) in 2018

17.9% of **mothers were smokers during pregnancy** in 2018/19. Smoking in pregnancy contributes to increased risk of stillbirth, low birthweight and neonatal deaths. Smoking at the time of delivery rates in Rotherham (which are used to approximate rates of smoking during pregnancy) fell substantially from 16.2% in 2019/20 to **14.0% in 2020/2021**, although the absence of carbon monoxide monitoring meant that it has not been possible to verify smoking status throughout the pandemic

23.6% of children leaving primary school are obese, above the national average of 20.2%. 73% of the adult population, around **27%** of children at reception age and **38%** of children at year 6 were classed as **overweight or obese**

1,990 hospital admissions in Rotherham during 2018/19 could be attributed to alcohol and 1,687 years of life were lost due to alcohol related conditions in 2018

Just over **30%** of the Rotherham population (31.1 %, 2015-18) are estimated to drink at a level that puts their health at risk (over 14 units per week).

Smoking is the leading cause of preventable illness and premature death in England and Rotherham. Despite significant reductions over the past 10 years, 17.8 % of Rotherham adults smoked in 2019 - significantly more than the all-England rate of 13.9 %. As smoking prevalence has declined, it has become increasingly concentrated among more disadvantaged communities.

Between 2015-2018 the number of smoking related deaths in Rotherham was **34%** higher than the England average.

Table 2: **The National Picture**

Loneliness was a public health concern both nationally and locally prior to the pandemic with all ages experiencing loneliness. The pandemic has heightened this as an issue and referrals for befriending support in Rotherham have reinforced that this is an issue across the life course.

Almost 1 in 5 people of **pension age** in England were living in **relative poverty** in 2019/20, following a sharp increase (of 200,000 people) over the previous year. This extends a worrying trend which first emerged in the middle of the last decade and means more than 2 million people of state pension age in the UK were living in poverty in 2019/20.

Almost 1 in 5 homes in England headed by someone aged 60 or older is in a condition that endangers the health of the people who live there. Almost 9,000 people died in England and Wales last year because their homes were too cold.

Factors causing morbidity in the Rotherham population

Blue: non-communicable disease
Red: Communicable disease
Green: Injury

Large prevention opportunity

Global Burden of Disease, 2019

Percentage of Rotherham population (blue) with a condition compared to England (black)

Condition	%
Hypertension	13.3%
Depression	10.6%
Asthma	8.4%
Osteoarthritis	8.1%
Diabetes	7.2%
Coronary Heart Disease (CHD)	5.1%
Cancer	3.8%
Atrial Fibrillation	3.1%
COPD	2.9%
Osteoporosis	2.6%
Cerebrovascular Disease (CVD)	2.5%
Chronic Pain	2.1%
Peripheral Vascular Disease (PV..	1.7%
Heart Failure	1.6%
Chronic Kidney Disease (CKD)	1.5%
Dementia	1.2%
Epilepsy	1.2%
Physical Disability	1.1%
Serious Mental Illness (SMI)	1.1%
Rheumatoid Arthritis	0.9%
Alcohol Dependence	0.9%
Intermediate Frailty Risk (HFRS)	0.9%
Learning Disability	0.9%
Inflammatory Bowel Disease (IB..	0.8%
High Frailty Risk (HFRS)	0.8%
Chronic Liver Disease	0.7%
Autism	0.6%
Severe COPD	0.5%
Severe Heart Failure	0.4%

Use of services across the system by segmented group of need

A&E Attendance

Non Elective Admissions

Elective Admissions

Outpatient - First Attendance

Outpatient - Follow Up Attendance

Source: PaPi dashboard NHSE (Feb 24)

The role of TRFT Consultant in Public Health

Aims

- Grow system PHM maturity
- Tackle health inequalities
- Embed prevention
- Develop sustainable approaches

Main levers

- TRFT
  - QUIT programme
  - Healthy hospitals
  - Health Inequalities group
  - Membership of committees/ groups
- System
  - PHM Ops group
  - Member of RMBC PH senior management team
  - Plugged in to ICB and wider commissioning landscape

Health Inequalities Plan on a Page 2024

Understand our population and **patients' needs** better

- Carry out deep dives on our patient demography
- Undertake detailed analysis of patient behaviours (e.g. DNAs, 'frequent flyers')
- Identify areas of inequality of access and relevant drivers (e.g. Insulin pumps)
- Develop a universal health inequalities dashboard and other HI tools

Ensure **equity of access** to our services

- Reduce barriers to outpatient access, informed by 'Did Not Attend' analysis
- Work with Place colleagues to fill gaps in primary care provision
- Undertake targeted equity impact assessments (e.g. MEOC)
- Consider evidence base for developing an equitable elective recovery model

Provide **tailored, patient-centred care**, adapted to individual patient needs

- Include lifestyle / teachable moment support page in bedside information folders
- Continue to develop Learning Disability and Autism staff resources
- Grow the newly recruited Armed Forces Welfare support worker role

Build **prevention** into our pathways

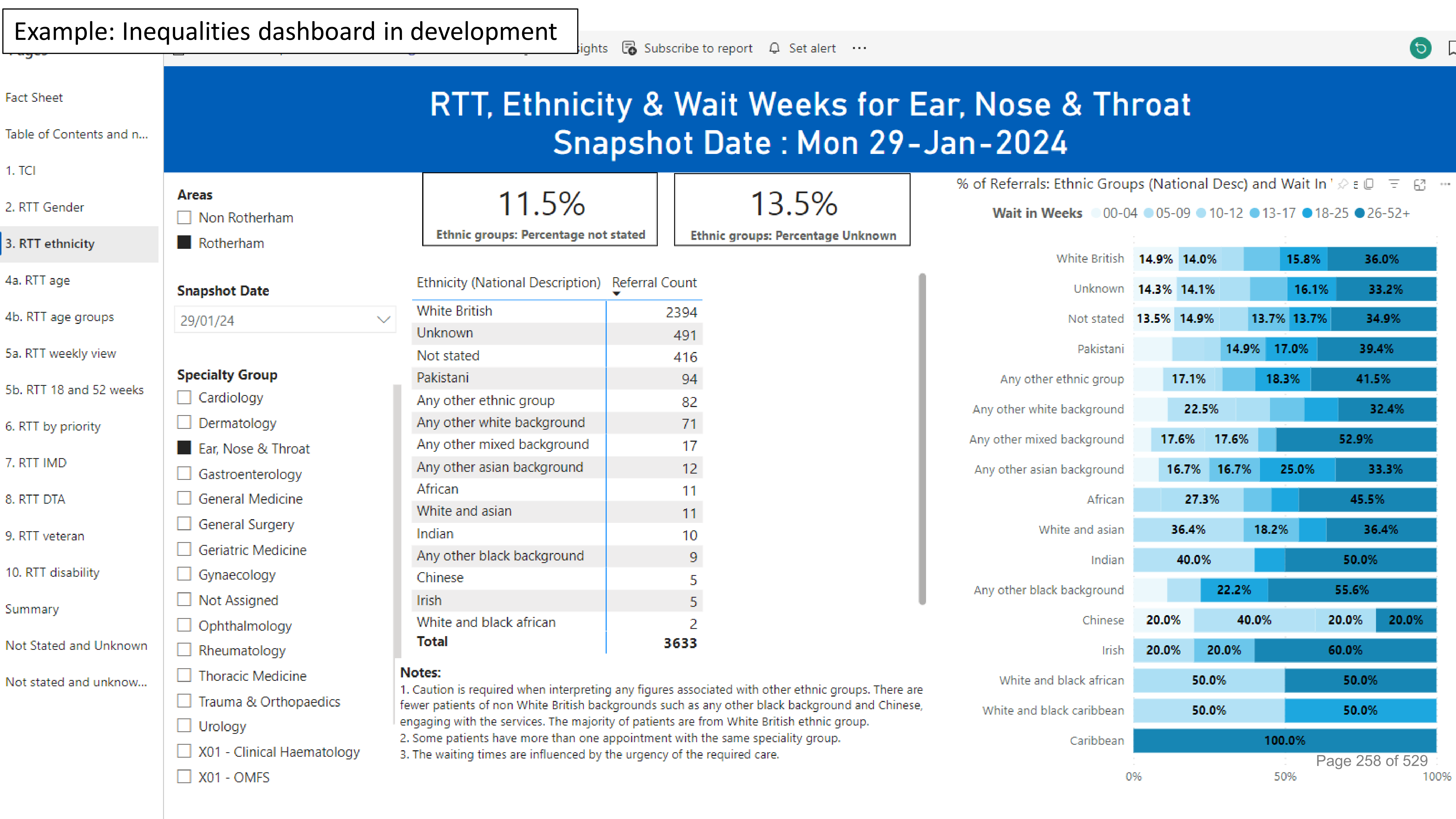
- Develop an enhanced 'Making Every Contact Count' training offer
- Continue development of appropriate, targeted waiting well support
- Build in exercise to our clinical pathways (eg Active Together)
- Evaluate impact of embedded social prescriber role within UECC

Support **our staff** to live **healthy lives**

- Provide routes to financial assistance and advice to colleagues
- Offer full health and wellbeing programme to staff
- Expand QUIT programme to staff to reduce smoking levels

Act as a leader across Rotherham at **improving the lives** of our communities

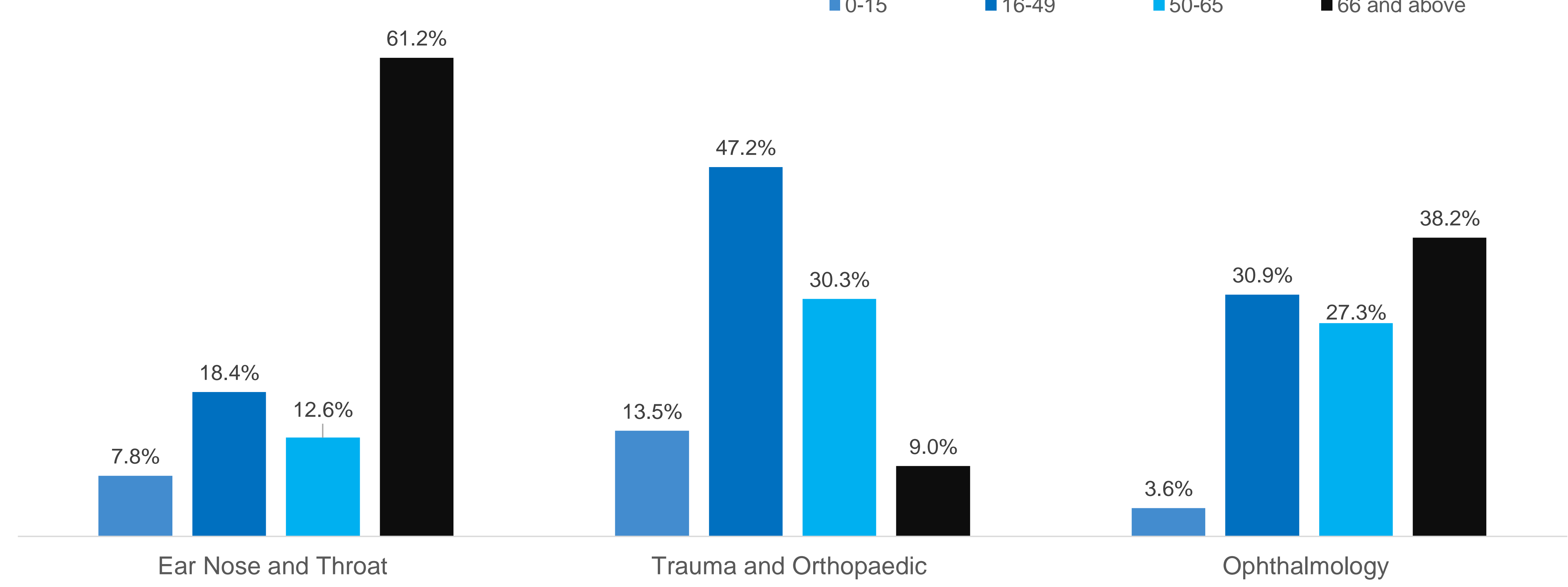
- Explore procurement options to reduce carbon emissions and other environmental impacts
- Support Rotherham recruitment events to source local talent
- Increase use of and support local suppliers where possible
- Collaborate with groups at Place and System to join up on population health initiatives



Example: Inequalities dashboard in development
Subscribe to report
Set alert
Fact Sheet
Table of Contents and n...
1. TCI
2. RTT Gender
3. RTT ethnicity
4a. RTT age
4b. RTT age groups
5a. RTT weekly view
5b. RTT 18 and 52 weeks
6. RTT by priority
7. RTT IMD
8. RTT DTA
9. RTT veteran
10. RTT disability
Summary
Not Stated and Unknown
Not stated and unknow...
RTT, Ethnicity & Wait Weeks for Ear, Nose & Throat
Snapshot Date : Mon 29-Jan-2024
Areas
Non Rotherham
Rotherham
Snapshot Date
29/01/24
Specialty Group
Cardiology
Dermatology
Ear, Nose & Throat
Gastroenterology
General Medicine
General Surgery
Geriatric Medicine
Gynaecology
Not Assigned
Ophthalmology
Rheumatology
Thoracic Medicine
Trauma & Orthopaedics
Urology
X01 - Clinical Haematology
X01 - OMFS
11.5%
Ethnic groups: Percentage not stated
13.5%
Ethnic groups: Percentage Unknown
Ethnicity (National Description) | Referral Count
White British 2394
Unknown 491
Not stated 416
Pakistani 94
Any other ethnic group 82
Any other white background 71
Any other mixed background 17
Any other asian background 12
African 11
White and asian 11
Indian 10
Any other black background 9
Chinese 5
Irish 5
White and black african 2
Total 3633
Notes:
1. Caution is required when interpreting any figures associated with other ethnic groups. There are fewer patients of non White British backgrounds such as any other black background and Chinese, engaging with the services. The majority of patients are from White British ethnic group.
2. Some patients have more than one appointment with the same speciality group.
3. The waiting times are influenced by the urgency of the required care.
% of Referrals: Ethnic Groups (National Desc) and Wait In
Wait in Weeks 00-04 05-09 10-12 13-17 18-25 26-52+
White British 14.9% 14.0% 15.8% 36.0%
Unknown 14.3% 14.1% 16.1% 33.2%
Not stated 13.5% 14.9% 13.7% 13.7% 34.9%
Pakistani 14.9% 17.0% 39.4%
Any other ethnic group 17.1% 18.3% 41.5%
Any other white background 22.5% 32.4%
Any other mixed background 17.6% 17.6% 52.9%
Any other asian background 16.7% 16.7% 25.0% 33.3%
African 27.3% 45.5%
White and asian 36.4% 18.2% 36.4%
Indian 40.0% 50.0%
Any other black background 22.2% 55.6%
Chinese 20.0% 40.0% 20.0% 20.0%
Irish 20.0% 20.0% 60.0%
White and black african 50.0% 50.0%
White and black caribbean 50.0% 50.0%
Caribbean 100.0%
0% 50% 100%
Page 258 of 529

Example: Inequalities analysis for DNA rates

3 Services with the Highest DNA rate (%) by Age Group: Maltby East



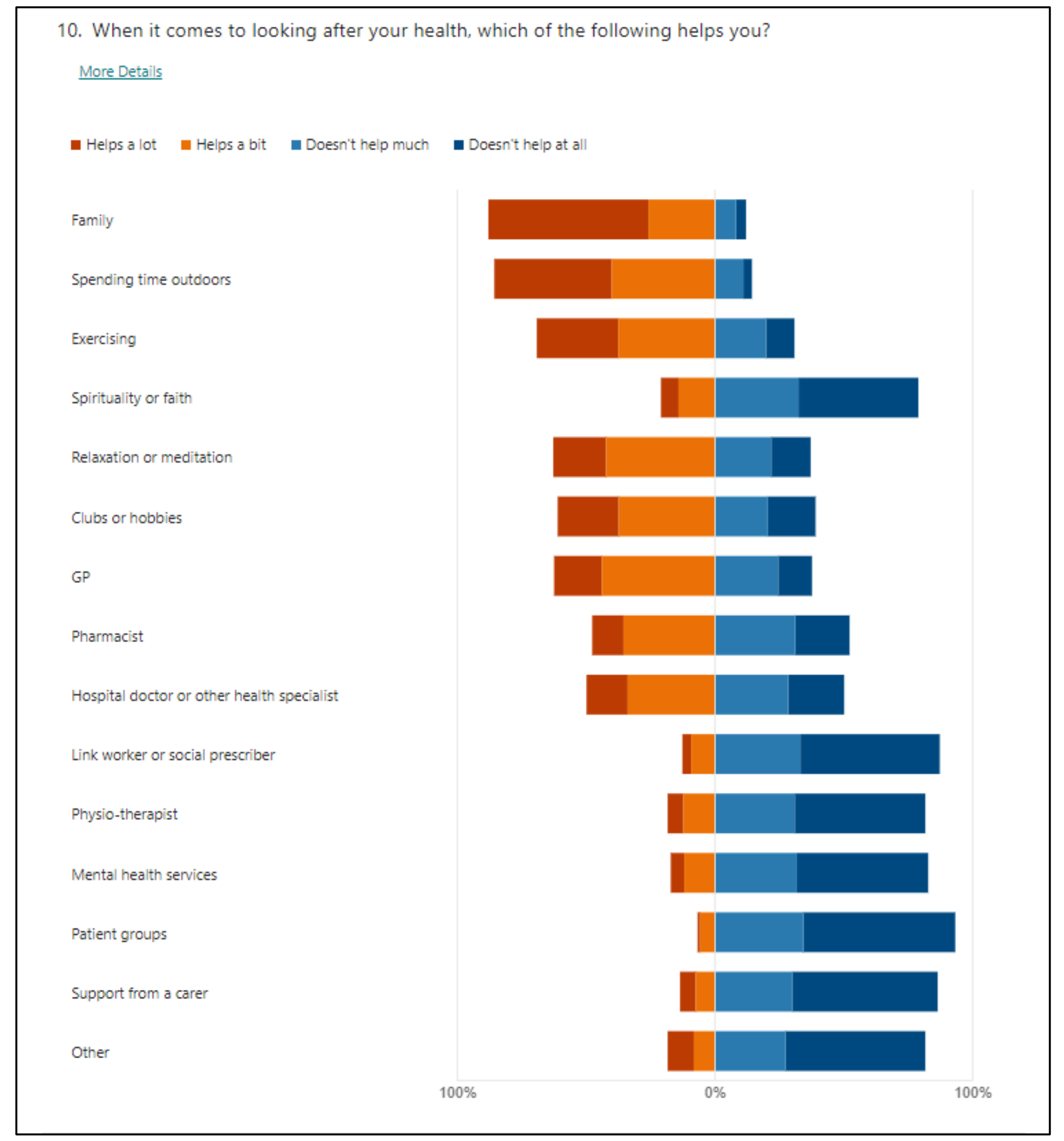
Issues: travel distance and bus routes, low levels of car ownership, health literacy, financial barriers, etc
->Linking in with contact centre work ; -> developing segmentation insight

Wider PHM system work

- ICB priority areas:
  - Respiratory
  - Diabetes
  - Frailty
  - Ambulatory care
  - (+Timely presentation of cancer)

- PHM and prevention:
  - Maltby & Dinnington LTC work
  - Prevention pathway
  - Chronic pain pathway

Example: Maltby & Dinnington PHM work



12. How easy is it for you to access the health services you need?

More Details Insights

Very easy	135
Easy	424
Difficult	483
Very difficult	156

13. What is the main reason for this answer?

More Details Insights

980
Responses

Latest Responses

"Appointments are hard to get hold of and waiting lists are ridiculous "

"No GP appointments and if there is one they don't help. Just tell you to exer...

"Can never get through to anyone"

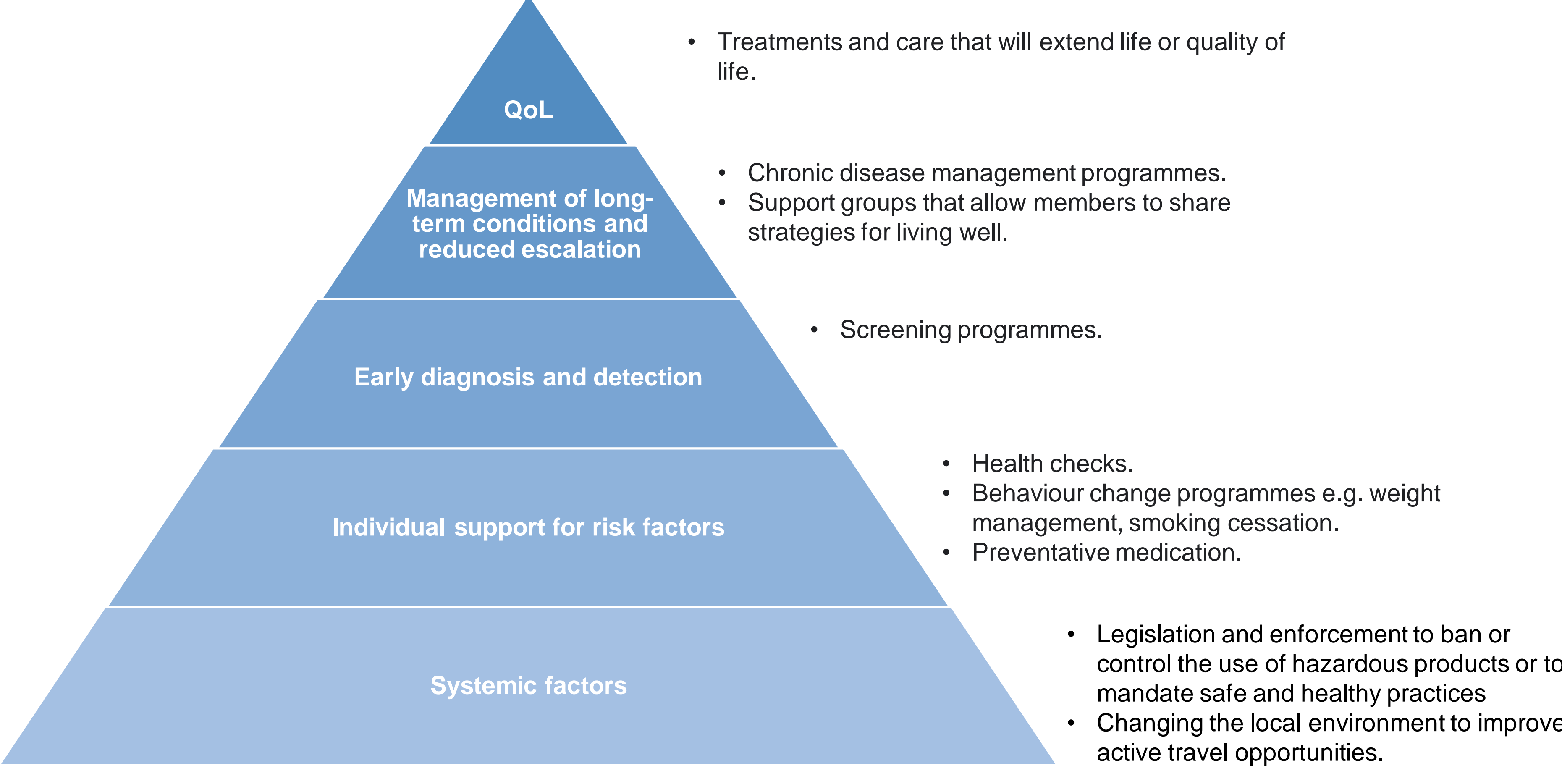
Update

...

291 respondents (**31**%) answered **appointment** for this question.

appointment is difficult
Trying to get an appointment
appointment time
appointment with the doctor
n't get appointments
phone to get a appointment
needed
doctor appointments
appointment
appointments at GP
telephone appointment
gp appointment
GP surgery
getting appointments
appointment when working
hard to get an appointment
Difficult to get an appointment
No appointments
appointment on the day
able to get an appointment

Example: Developing Prevention Pathway



Approach to develop Rotherham prevention pathway is progressing through Prevention & HI Delivery Group

Comments, questions and feedback?

Board of Directors' Meeting
8 March 2024

Agenda item	P42/24
Report	**Committee in Common**
Executive Lead	Dr Richard Jenkins, Chief Executive Angela Wendzicha, Director of Corporate Affairs
Link with the BAF	This paper links with BAF Risk OP3: 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.
How does this paper support Trust Values	This paper supports the Trust value Ambition
Purpose	**For decision** ☒ **For assurance** ☐ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	The Working Together Partnership members (early iteration of the Acute Federation) agreed to put in place a Committees in Common governance structure to enable decision making within the Partnership. The Committee in Common structure comprised common Terms of Reference in addition to a joint Working Agreement. There has been inconsistency across the system with regard to implementation of the formal structure. The Acute Federation recommended a review of the Committee in Common structure which took place during the autumn by the Company Secretary Professional Group resulting in the Acute Federation Board seeking each partner Trust to reaffirm commitment to the Committee in Common model.
Due Diligence	This paper has been discussed at the Executive Team Meeting who recommend approval to Board.
Board powers to make this decision	Paragraph 4.3 of the current Constitution
Who, What and When	Following the discussion, the decision of the Board will be reported back to the Acute Federation Board.

Recommendations	It is recommended that the Board: a) Reconfirm and support the proposal that meetings of the Acute Federation Board should operate under Committee in Common arrangements by each partner Trust formally re-establishing its Committee in Common.
Appendices	Terms of Reference and Joint Working Agreement

1. Introduction

1.1 In 2017, the then Working Together Partnership members agreed to put in place a Committees in Common governance structure to enable them to make decisions and implement change. At the time, Capsticks Solicitors drafted the Joint Working Agreement in addition to the Terms of Reference for a Committee of the Board to meet in common with Committees of other Trust within the system. The aforementioned were approved by the Trust Board in 2017 however the amendments to the governance structure were not completed. However, the Committees in Common did meet with the first being held on 4th December 2017.

1.2 In June 2023, the Acute Federation Board supported a recommendation for a review of the decision-making arrangements to be undertaken by the Company Secretaries Professional Partnership Group (PPG). This was as a result of the Acute Federation Board noting that whilst some Acute Federation organisations were reporting their Acute Federation Committee in Common as part of the Board Committee structure, this was inconsistent across all Trusts.

2. Committees in Common Model

2.1 Under the Committee in Common model governance structure, each Trust agreed to establish a Committee of the Board and adopt terms of reference in substantially the same form with membership of each Committee in Common reflecting the respective Trust's own members.

2.2 Within this model each Committee has functions delegated to it from its own respective Trust in accordance with its own individual Terms of Reference. Each Committee is responsible and accountable to its own Board of Directors and therefore each Trust remains as a separate and sovereign legal entity.

3. Committees in Common Documentation

3.1 Capsticks Solicitors were engaged in 2016/17 in drafting the Joint Working Agreement and the Model Terms of Reference. Since then, amendments have recently been made to reflect the end of the Working Together Vanguard Programme and migration to the Acute Federation in early 2018.

3.2 The Acute Federation Board have requested that the attached updated documents (model Terms of Reference, and Joint Working Agreement) be presented through individual governance processes and Board to reconfirm support.

4. Recommendations

The Board is asked to:

a) Reconfirm and support the proposal that meetings of the Acute Federation Board should operate under Committee in Common arrangements by each partner Trust formally re-establishing its Committee in Common and
b) Approve the Terms of Reference and Joint Working Agreement.

TERMS OF REFERENCE

FOR THE ROTHERHAM NHS FOUNDATION TRUST COMMITTEE OF THE BOARD OF DIRECTORS TO MEET IN COMMON WITH COMMITTEES OF OTHER TRUSTS

1. INTRODUCTION

1.1 The Rotherham NHS Foundation Trust (TRFT) has put in place a governance structure which will enable it to work together with the other Trusts to implement change.

1.2 Each Trust has agreed to establish a committee which shall work in common with the other Acute Federation Partnership Committees in Common (CiC), but which will each take its decisions independently on behalf of its own Trust.

1.3 Each Trust has decided to adopt Terms of Reference in substantially the same form to the other Trusts, except that the membership of each CiC will be different.

1.4 Each Trust has entered into the Joint Working Agreement on [**date to be inserted**] and agrees to operate its CiC in accordance with the Joint Working Agreement.

1.5 Board of Directors has agreed to establish and constitute a committee with these Terms of Reference, to be known as the The Rotherham NHS Foundation Trusts' Committee in Common (CiC). These Terms of Reference set out the membership, remit, responsibilities and reporting arrangements of the TRFTs' CiC.

1.6 TRFT CiC shall work co-operatively with the other CiCs and in accordance with the terms of the Joint Working Agreement.

2 DUTIES / RESPONSIBILITIES

2.1 The duties and responsibilities of TRFTs' CiC are to work with the other CiC to:

- provide strategic leadership, oversight and delivery of new models of care through the development of the Acute Federation and its workstreams;
- set the strategic goals for the Acute Federation, defining its ongoing role and scope ensuring recommendations are provided to Trusts' Boards for any changes which have a material impact on the Trusts;

- consider different employment models for service line specialities including contractual outcomes and governance arrangements;
- review the key deliverables and hold the Trusts to account for progress against agreed decisions;
- ensure the System Delivery Group (SDG) and professional partnership groups (PPGs) have clarity of responsibility and accountability and drive progress;
- establish monitoring arrangements to identify the impact on services and review associated risks to ensure identification, appropriate management and mitigation;
- receive and seek advice from the professional partnership groups (PPGs);
- receive and seek advice from the South Yorkshire Integrated Care Board;
- ensure compliance and due process with regulating authorities regarding service changes;
- oversee the creation of joint ventures or new corporate vehicles where appropriate;
- review and approve the Terms of Reference for the Acute Federation Board;
- improve the quality of care, safety and the patient experience delivered by the Trusts;
- deliver equality of access to the Trusts' service users; and
- ensure the Trusts deliver services which are clinically and financially sustainable.

3 FUNCTIONS OF THE COMMITTEE

3.1 Paragraph 15(2) and (3) of Schedule 7 of the National Health Service Act 2006 allows for any of the functions of a Foundation Trust to be delegated to a committee of directors of the Foundation Trust. This power is enshrined in paragraph 4.3 of TRFTs' Constitution.

3.2 TRFTs' CiC shall have the following function: decision making in accordance with Annex 1 to these Terms of Reference.

4 FUNCTIONS RESERVED TO THE BOARD OF THE FOUNDATION TRUST

Any functions not delegated to TRFTs' CiC in paragraph 3 of these Terms of Reference shall be retained by TRFTs' Trust Board of Directors. For the avoidance of doubt, nothing in this paragraph shall fetter the ability of TRFT to delegate functions to another committee or person.

5 REPORTING REQUIREMENTS

5.1 On receipt of the papers detailed in paragraph 9.1.2, TRFTs' CiC Members and the Executive Team members shall consider if it is necessary (and feasible) to forward any of the agenda items or papers to TRFTs' Board of Directors for inclusion on the agenda of TRFTs' next Board meeting in order that the Board of Directors may consider any additional delegations necessary in accordance with Annex 1.

5.2 TRFT CiC shall send the minutes of its meetings to TRFTs' Trust Board of Directors, on a monthly basis, for inclusion on the agenda of the Board meeting.

5.3 TRFT CiC shall provide such reports and communications briefings as requested by TRFTs' Trust Board of Directors for inclusion on the agenda of its Board meeting.

6. MEMBERSHIP

Members

DESIGNATION	CHAIR/DEPUTY
Chair	Chair
Chief Executive	

Serviced by:

Acute Federation Programme Office

6.1 Each TRFT CiC Member shall nominate a deputy to attend the TRFT CiC meetings on their behalf when necessary ("Nominated Deputy").

6.2 The Nominated Deputy for the Chair shall be a Non-Executive Director of TRFT and the Nominated Deputy for the Chief Executive shall be an Executive Director of TRFT.

6.3 In the absence of the TRFTs' CiC Chair Member and/or TRFTs' CiC Chief Executive Member, his or her Nominated Deputy shall be entitled to:

- attend TRFTs' CiC's meetings;
- be counted towards the quorum of a meeting of TRFT's CiC's; and
- exercise Member voting rights,

and when a Nominated Deputy is attending a TRFTs' CiC meeting, for the purposes of these Terms of Reference, the Nominated Deputy shall be included in the references to "Members".

Non-voting Attendees

6.4 The members of the other CiCs shall have the right to attend the meetings of TRFTs' CiC.

6.5 A nominated Trust Corporate Secretary shall have the right to attend the meeting of s' CiC to support the provision of governance advice and ensure that the working arrangements comply with the accountability and reporting arrangements of the CiCs.

6.6 The Acute Federation Partnership Managing Director shall have the right to attend the meetings of TRFTs' CiC.

6.7 Without prejudice to paragraphs 6.4 to 6.6 inclusive, the Meeting Lead (as defined in section 14) may at his or her discretion invite and permit other persons relevant to any agenda item to attend any of the CiCs' meetings, but for the avoidance of doubt, any such persons in attendance at any meeting of the CiCs shall not count towards the quorum or have the right to vote at such meetings.

6.8 The attendees detailed in paragraphs 6.4 to 6.7 inclusive above, may take contributions, through the Meeting Lead, but shall not have any voting rights nor shall they be counted towards the quorum of the meetings of TRFTs' CiC.

Conflicts of Interest

6.9 Members of TRFTs' CiC shall comply with the provisions on conflicts of interest contained in TRFTs' Constitution / Standing Orders. For the avoidance of doubt, reference to conflicts of interest in TRFTs' Constitution / Standing Orders also apply to conflicts which may arise in their position as a member of TRFTs' CiC.

6.10 All members of TRFTs' CiC shall declare any new interest at the beginning of any TRFTs' CiC meeting and at any point during the meeting if relevant.

7. QUORUM AND VOTING

7.1 Members of TRFTs' CiC have a responsibility for the operation of TRFTs' CiC. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

7.2 Each member of TRFTs' CiC shall have one vote. TRFTs' CiC shall reach decisions by consensus of the members present.

7.3 The quorum shall be two (2) members; one (1) Executive Director and one (1) Non-Executive Director.

7.4 If any member is disqualified from voting due to a conflict of interest, they shall not count towards the quorum for the purposes of that agenda item.

7.5 At the discretion of the Chair, business may be transacted through a teleconference or videoconference provided that all Board members present are able to hear all other parties and where an Agenda has been issued in advance. Participation in a meeting via electronic means shall constitute presence in person at the meeting.

8. MEETING FREQUENCY AND PROCEDURES

8.1 TRFTs' CiC meeting to take place on a regular basis.

8.2 Any Trust CiC Chair may request an extraordinary meeting of the CiC (working in common) on the basis of urgency etc, by informing the Meeting Lead and Managing Director. In the event it is identified that an extraordinary meeting is required the Acute Federation Programme Office shall give five (5) working days' notice to the Trusts.

8.3 Meetings of TRFTs' CiC shall be held in private.

8.4 Matters to be dealt with at the meetings of TRFTs' CiC shall be confidential to TRFTs' CiC members and their nominated deputies, others in attendance at the meeting and the members of TRFT Board.

8.5 TRFT shall ensure that, except for urgent or unavoidable reasons, TRFTs' CiC members (or their nominated deputy) shall attend TRFTs' CiC meetings and fully participate in all TRFT CiC meetings.

9. ADMINISTRATIVE

9.1 Administrative support for TRFTs' CiC will be provided by the Acute Federation Programme Management Office (or such other person as the Trusts may agree). The Acute Federation Programme Management Office will:

9.1.1 draw up an annual schedule of CiC meeting dates and circulate it to the CiCs.

9.1.2 circulate the agenda and papers three (3) working days prior to CiC meetings; and

9.1.3 take minutes of each TRFTs' CiC meeting and, following approval by the Meeting Lead, circulate them to the Trusts and action notes to all members within ten (10) working dates of the relevant TRFT CiC meeting.

9.2 The agenda for TRFTs' CiC meetings shall be determined by the Acute Federation Programme Management Office and agreed by the Meeting Lead prior to circulation.

9.3 The Meeting Lead shall be responsible for approval of the first draft set of minutes for circulation to Members and shall work with the Acute Federation Programme Management Office to agree such within five (5) working days of receipt.

10. DATE TERMS OF REFERENCE WERE APPROVED

[insert date]

11. REVIEW DATE

Annually

12. PROCESS FOR REVIEWING EFFECTIVENESS

Review of progress against duties/responsibilities set out above and Annual Report to be submitted to TRFTs' Board of Directors.

13. REPORTING STRUCTURE

No other groups report to this Committee.

14. GLOSSARY

In this Terms of Reference, the following words bear the following meanings:

Acute Federation	The federation formed by the Trusts to provide strategic leadership and oversight of the delivery of the Partnership;
Acute Federation Board	The South Yorkshire and Bassetlaw Acute Federation Board is constituted as the principal body of the South Yorkshire and Bassetlaw Acute Federation of Providers.
Acute Federation Programme Management Office	Administrative infrastructure supporting the Acute Federation Partnership;
CiCs	The committees established by each of the Trusts to work alongside the committees established by the other Trusts and "CiC" shall be interpreted accordingly;
"Joint Working Agreement" or "JWA"	The agreement signed by each of the Trusts in relation to their joint working and the operation of TRFTs' CiC together with the CiCs;
Meeting Lead	The CiC Member nominated (from time to time) to preside over and run the CiC meetings when they meet in common;
Member	A person nominated as a member of a CiC in accordance with their Trust's Terms of Reference, and Members shall be interpreted accordingly;

TRFT	The Rotherham NHS Foundation Trust
TRFT (CiC)	The committee established by The Rotherham NHS Foundation Trust, pursuant to these Terms of Reference, to work alongside the other CiCs in accordance with these Terms of Reference;
TRFT CiC Chair	The Rotherham NHS Foundation Trust CiC Member nominated to chair TRFT CiC meetings;
Trusts	Barnsley Hospital NHS Foundation Trust Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust Sheffield Children's NHS Foundation Trust Sheffield Teaching Hospitals NHS Foundation Trust The Rotherham NHS Foundation Trust "**Trust**" shall be interpreted accordingly;
Working Day	A day other than a Saturday, Sunday or public holiday in England;

Annex 1

Decisions of The Rotherham NHS Foundation Trust CIC

The Board of each Trust within the Acute Federation partnership remains a sovereign entity and will be sighted on any proposals for service change and all proposals with strategic impact.

Subject to TRFTs' CIC Scheme of Delegation, the matters or type of matters, that are fully delegated to TRFT CIC to decide are set out in the table below.

If it is intended that the CICs are to discuss a proposal or matter which is outside the decisions delegated to TRFTs' CIC, where at all practical, each proposal will be discussed by the Board of each Trust prior to TRFTs' CIC meeting with a view to TRFT CIC requesting individual delegated authority to take action and make decisions (within a set of parameters agreed by TRFTs' Board of Directors). Any proposals discussed at TRFTs' CIC meeting outside of these parameters would come back before TRFT Board of Directors.

References in the table below to the **"Services"** refer to the services that form part of the joint working between the Trusts and may include both back office and clinical services.

	Decisions delegated to TRFTs' CIC
1.	Providing overall strategic oversight and direction to the development of the Acute Federation programme ensuring alignment of all Trusts to the vision and strategy.
2.	Promoting and encouraging commitment to the key principles.
3.	Seeking to determine or resolve any matters referred to it by the Acute Federation Programme Office or any individual Trust.
4.	Reviewing the key deliverables and ensuring adherence with the required timescales including; determining responsibilities within workstreams; receiving assurance that workstreams have been subject to robust quality impact assessments; reviewing the risks associated in terms of the impact to the Acute Federation Programme and recommending remedial and mitigating actions across the system.
5.	Formulating, agreeing and implementing strategies for delivery of the Acute Federation Programme.
6.	In relation to the Services preparing business cases;
7.	Provision of staffing and support and sharing of staffing information in relation to the Services.

8.	Decisions to support service reconfiguration (pre-consultation, consultation and implementation), including but not limited to: a. Provision of financial information; b. Communications with staff and the public and other wider engagement with stakeholders; c. Support in relation to capital and financial cases to be prepared and submitted to national bodies; including NHS England; d. Provision of clinical data, including in relation to patient outcomes, patient access and patient flows; e. Support in relation to any competition assessment; f. Provision of staffing support; and g. Provision of other support.
9.	Decisions relating to information flows and clinical pathways outside of the reconfiguration, including but not limited to: a. Redesign of clinical rotas; b. Provision of clinical data, including in relation to patient outcomes, patient access and patient flows; and c. Developing and improving information recording and information flows (clinical or otherwise).
10.	Planning, preparing and setting up joint venture arrangements for the Services including but not limited to: a. Preparing joint venture documentation and ancillary agreements for final signature; b. Evaluating and taking preparatory steps in relation to shared staffing models between the Trusts; c. Carrying out an analysis of the implications of TUPE on the joint arrangements; d. Engaging staff and providing such information as is necessary to meet each employer's statutory requirements; e. Undergoing soft market testing and managing procurement exercises; f. Aligning the terms of and/or terminating relevant third party supply contracts which are material to the delivery of the Services; and g. Amendments to joint venture agreements for the Services.
11.	Services investment and disinvestment as agreed within Trust Board parameters and delegated authority.
12.	Reviewing and agreeing the Terms of Reference and Joint Working Agreement of the CiC on an annual basis for recommendation to TRFTs' Board of Directors for approval.
13.	Reviewing and approving the Terms of Reference for the Acute Federation Board.

DATED: [Date to be added]

(1) BARNSLEY HOSPITAL NHS FOUNDATION TRUST

(2) DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST

(3) THE ROTHERHAM NHS FOUNDATION TRUST

(4) SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST

(5) SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST

JOINT WORKING AGREEMENT

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1. Introduction

1.1 In this joint working agreement, the following words bear the following meanings:

Confidential Information	all information which is secret or otherwise not publicly available (in both cases in its entirety or in part) including commercial, financial, marketing or technical information, know-how, trade secrets or business methods, in all cases whether disclosed orally or in writing before or after the date of this JWA;
Competition Sensitive Information	means Confidential Information which is owned, produced and marked as Competition Sensitive Information including information on costs by one of the Trusts and which that Trust properly considers is of such a nature that it cannot be exchanged with the other Trusts without a breach or potential breach of competition law;
Dispute	any dispute arising between two or more of the Trusts in connection with this Joint Working Agreement or their respective rights and obligations under it;
Meeting Lead	the Acute Federation CiC Member nominated (from time to time) in accordance with paragraph 6.4 of the Terms of Reference, to preside over and run the Acute Federation CiC meetings when they meet in common;
Member	a person nominated as a member of an Acute Federation CiC in accordance with their Trust's Terms of Reference and "**Members**" shall be interpreted accordingly;
"Joint Working Agreement" or "JWA"	this agreement signed by each of the Trusts in relation to their joint working and the operation of the Acute Federation CiCs;
Terms of Reference	the terms of reference adopted by each Trust (in substantially the same form) more particularly set out in the Appendices to this Joint Working Agreement;

Trusts	Barnsley Hospital NHS Foundation Trust, Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust, The Rotherham NHS Foundation Trust, Sheffield Children's NHS Foundation Trust, Sheffield Teaching Hospitals NHS Foundation Trust and "**Trust**" shall be interpreted accordingly;
Acute Federation **CiCs**	the committees established by each of the Trusts to work alongside the committees established by the other Trusts and "**Acute Federation CiC**" shall be interpreted accordingly.
Acute Federation Board	The South Yorkshire and Bassetlaw Acute Federation Board is constituted as the principal body of the South Yorkshire and Bassetlaw Acute Federation of Providers.

1.2 Each Trust is putting in place a governance structure which will enable it to work together with the other Trusts to implement change.

1.3 Each Trust has agreed to establish a committee which shall work in common with the other Acute Federation CiCs, but which will each take its decisions independently on behalf of its own Trust.

1.4 Each Trust has decided to adopt terms of reference in substantially the same form to the other Trusts, except that the membership of each Acute Federation CiC will be different.

2. Background

2.1 Since 2013, the Trusts have been working together as an innovative partnership (the **Working Together Partnership**) and the Working Together Partnership became an Acute Care Collaboration Vanguard in 2015, and then South Yorkshire and Bassetlaw (SYB) Acute Federation in 2018.

2.2 The Acute Federation's stated strategic aims are:

2.2.1 Working together to drive the quality of care to be amongst the best in the country;

2.2.2 Taking a proactive approach to reduce health inequalities for the populations we serve;

2.2.3 Collaboratively developing our colleagues and teams so that we have happy staff;

2.2.4 Being a great partner to the rest of the health and care system in SYB;

2.2.5 Supporting each other to achieve all the NHS waiting time standards for local people; and

2.2.6 Seeking innovative ways to more effectively use the NHS pound so there is enough resource for the whole system.

2.3 In July 2016 the Boards of the Trusts, as part of the Working Together Partnership, confirmed the creation of the Acute Federation. It was agreed that further phases for changes to the governance structure would develop to enhance the delivery of the new models of care as the service change options became clearer.

2.4 In light of the above, the Trusts have identified that a preferred model for their closer collaboration and joint working is to establish a governance structure that, so far as possible within the existing legislation, enables "group" and common decision making structures; the Acute Federation CiCs.

2.5 The Trusts will remain as five separate legal entities with their own accountabilities and responsibilities. For avoidance of doubt there is no intention that the governance structure outlined in this Joint Working Agreement will lead to a statutory merger or acquisition under section 56 or section 56A of the National Health Service Act 2006 (as amended).

3. Principles of working

3.1 The Trusts have agreed to adopt this Joint Working Agreement dated [Date to be added] and agree to operate the Acute Federation CiCs in line with the terms of this JWA, including the following principles (the "**Principles of Working**"):

3.1.1 through collaboration with each other aspiring, for the benefit of our patients, to be one of the most innovative, safe, caring, responsive, effective, well led and efficient health and care systems;

3.1.2 making the starting point for everything the Trusts do "can this be done better, safer, more economically for our patients if we work with our partners in a different way?";

3.1.3 move at pace in examining all activities on a "bottom up" basis, across the Trusts, engaging clinical and non-clinical teams to adopt innovative approaches and best practice;

3.1.4 challenge themselves and embrace change where it benefits its patients or the health care system as a whole. Status quo is not an option if we are to do the right thing for patients on a sustainable basis;

3.1.5 establish a governance model which facilitates this approach. Structure will not be a barrier to innovative change while recognising the statutory responsibilities of all five individual Trust Board of Directors;

3.1.6 models of cost/benefit equalisation will be a key ingredient of the partnership activity to ensure financial loss or gain for any individual Trust is not a barrier to beneficial system change/progress;

3.1.7 seek support from commissioners to ensure changes are achieved at pace in order to gain maximum benefits for patients and system stability;

3.1.8 collaborate and co-operate. Establish and adhere to the governance structure set out in the Terms of Reference to ensure that activities are delivered and actions taken as required;

3.1.9 be accountable. Take on, manage and account to each other for performance of the respective roles and responsibilities set out in the Terms of Reference;

3.1.10 be open. Communicate openly about major concerns, issues or opportunities relating to the joint working subject always to appropriate treatment of commercially sensitive information and competition law compliance;

3.1.11 adhere to statutory requirements and best practice. Comply with applicable laws and standards including EU procurement rules, competition law, data protection and freedom of information legislation;

3.1.12 act in a timely manner. Recognise the time-critical nature of the joint working and respond accordingly to requests for support;

3.1.13 manage stakeholders effectively; and

3.1.14 deploy appropriate resources. Ensure sufficient and appropriately qualified resources are available and authorised to fulfil the requirements and responsibilities set out in this Joint Working Agreement and the Terms of Reference.

4. Process of working together

4.1 The Acute Federation CiCs shall meet together in accordance with and discuss the matters delegated to them in accordance with their Terms of References (attached here as Appendices 1-6).

4.2 The Acute Federation CiCs shall work collaboratively with each other in relation to the committees in common model.

4.3 Each Acute Federation CiC is a separate committee, with functions delegated to it from its respective Trust in accordance with its Terms of References, and is responsible and accountable to its Trust. Acknowledging this and without fettering the decision-making power of any Acute Federation CiC or its duty to act in the best interests of its Trust, each Acute Federation CiC shall seek to reach agreement with the other Acute Federation CiCs and take decisions in consensus, in light of its aims and Principles of Working set out in clauses 2 and 3 above.

4.4 When the Acute Federation CiCs meet in common, the Meeting Lead shall preside over and run the meeting on a rotational basis for a period of two years, rotating at the January meeting each year.

5. Future Involvement and Addition of Parties

5.1 Subject to complying with all applicable law, and the Trusts' unanimous agreement, third parties may become parties to this Joint Working Agreement on such terms as the Trusts shall unanimously agree.

5.2 Any Trust may propose to the other Trusts that a third party be added as a Party to this Joint Working Agreement.

6. Exit Plan

6.1 Within three (3) months of the date of this JWA the Trusts shall develop and agree an exit plan which shall deal with, for example, the impact on resourcing or financial consequences of:

6.1.1 termination of this JWA;

6.1.2 a Trust exercising its rights under clause 7.1 below; or

6.1.3 the Meeting Lead and the Acute Federation CiC Chairs varying the JWA under clause 10.6.2.

6.2 Once agreed by all of the Trusts, the exit plan shall be inserted into this JWA at Appendix 6 and the Trusts shall review and, as appropriate, update the exit plan on each anniversary of the date of this JWA.

7. Termination

7.1 If any Trust wishes to revoke the delegation of functions to the relevant committee and exit this JWA ("**Exiting Trust**"), then the Exiting Trust shall, prior to such revocation and exit:

7.1.1 send a written notice from the Chair of the Exiting Trust to the other Trusts' Chairs and the Acute Federation Managing Director of their intention to do so; and

7.1.2 if required by any of the other Trusts (by sending a written notice within ten (10) business days of receipt of such notice) meet with the other Trusts' Chairs within ten (10) business days of the notice given under clause 7.1.1 to discuss the consequences of such revocation and exit.

7.2 If:

7.2.1 no other Trust sends a notice to the Exiting Trust within the time limit referred to in clause 7.1.2; or

7.2.2 following the meeting held under clause 7.1.2 the Exiting Trust still intends to exiting the JWA,

then the Exiting Trust may (subject to the terms of the exit plan at Appendix 6) exit this JWA.

7.3 If following the steps and meeting (if any) pursuant to clause 7.1.2 above the Exiting Trust revokes its delegation to its Acute Federation CiC and exits this JWA then the remaining Trusts shall meet and consider whether to:

7.3.1 Revoke their delegations and terminate this JWA; or

7.3.2 Amend and replace this JWA with a revised joint working agreement to be executed by the remaining Trusts and to make such revisions as may be appropriate in the circumstance.

8. Information Sharing and Competition Law

8.1 Subject to compliance with all applicable law (including without limitation competition law and obligations of confidentiality (contractual or otherwise)) the Trusts agree to share all information relevant to the provision of the JWA in an honest, open and timely manner.

8.2 The Trusts will ensure they share information, and in particular Competition Sensitive Information, in such a way that is compliant with competition law.

9. Conflicts of Interest

Members of each of the Acute Federation CiCs shall ensure that Members of the other Acute Federation CiCs are aware of any conflict of interest applicable to them, which has any relevance to the work of the Acute Federation CiCs.

10. Dispute Resolution

10.1 The Trusts agree to adopt a systematic approach to problem resolution which recognises the Principles of Working set out in clause 3 above.

10.2 If a problem, issue, concern or complaint comes to the attention of a Trust in relation to any matter in this JWA, that Trust shall notify the other Trusts in writing and the Trusts each acknowledge and confirm that they shall then seek to resolve the issue by a process of discussion.

10.3 If any Trust considers an issue identified in accordance with clause 10.2 to amount to a Dispute requiring resolution and such issue has not been resolved under clause 10.2 within a reasonable period of time, the matter shall be escalated to the Meeting Lead who shall decide in conjunction with the Acute Federation CiC Chairs the appropriate course of action to take.

10.4 If the Meeting Lead and the Acute Federation CiC Chairs reach a decision that resolves, or otherwise concludes a Dispute, the Meeting Lead will advise the Trusts of

the decision by written notice. Any decision of the Meeting Lead and the Acute Federation CiC Chairs will be final and binding on the Trusts once it has been ratified by the Trusts' Boards (if applicable).

10.5 If the matter referred to in clause 10.3 above cannot be resolved by the Meeting Lead and the Acute Federation CiC Chairs, within fifteen (15) Working Days, the Trusts agree that the Meeting Lead and the Acute Federation CiC Chairs, may determine whatever action they believes is necessary including the following:

10.5.1 If the Meeting Lead and the Acute Federation CiC Chairs cannot resolve a Dispute, the Meeting Lead may select an independent facilitator to assist with resolving the Dispute; and

10.5.1.1 the independent facilitator shall:

a) be provided with any information he or she requests about the Dispute;

b) assist the Meeting Lead and Acute Federation CiC Chairs to work towards a consensus decision in respect of the Dispute;

c) regulate his or her own procedure and, subject to the terms of this JWA, the procedure of the Meeting Lead and Acute Federation CiC Chairs at such discussions;

d) determine the number of facilitated discussions, provided that there will be not less than three and not more than five facilitated discussions, which must take place within 20 Working Days of the independent facilitator being appointed; and

e) have its costs and disbursements met by the Trusts equally.

10.6 If the independent facilitator cannot resolve the Dispute, the Dispute must be considered afresh in accordance with this clause 10 and only after such further consideration again fails to resolve the Dispute, the Meeting Lead and Acute Federation CiC Chairs may decide to recommend their Trust's Board of Directors to:

10.6.1 terminate the JWA;

10.6.2 vary the JWA (which may include a re-drawing the member Trusts); or

10.6.3 agree that the Dispute need not be resolved.

11. Variation

No variation of this JWA shall be effective unless it is in writing and signed by the Trusts (or their authorised representatives).

Counterparts

11.1 This JWA may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this JWA, but all the counterparts shall together constitute the same agreement.

11.2 The expression “counterpart” shall include any executed copy of this JWA transmitted by fax or scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e-mail attachment.

11.3 No counterpart shall be effective until each Trust has executed at least one counterpart.

12. Governing law and jurisdiction

This JWA shall be governed by and construed in accordance with English law.

THIS JOINT WORKING AGREEMENT is executed on the date stated above by

…………………………………………………………

For and on behalf of Barnsley Hospital NHS Foundation Trust

…………………………………………………………

For and on behalf of Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

…………………………………………………………

For and on behalf of The Rotherham NHS Foundation Trust

…………………………………………………………

For and on behalf of Sheffield Children's NHS Foundation Trust

…………………………………………………………

For and on behalf of Sheffield Teaching Hospitals NHS Foundation Trust

APPENDIX 1

[Insert Terms of Reference for the Barnsley Hospital NHS Foundation Trust CiC]

APPENDIX 2

[Insert Terms of Reference for the Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust CiC]

APPENDIX 3

[Insert Terms of Reference for The Rotherham NHS Foundation Trust CiC]

APPENDIX 4

[Insert Terms of Reference for the Sheffield Children's NHS Foundation Trust CiC]

APPENDIX 5

[Insert Terms of Reference for the Sheffield Teaching Hospitals NHS Foundation Trust CiC]

Appendix 6

Exit Plan

1. In the event of termination of this Joint Working Agreement (JWA) by all parties, the Trusts agree that:
    a. each Trust will be responsible for its own costs and expenses incurred as a consequence of the termination of this JWA up to the date of termination *unless* it is agreed between the Trusts that the costs and expenses are to be borne equally between the Trusts;
    b. upon reasonable written notice, each Trust will be liable for one fifth of any professional adviser's fees incurred by and on behalf of the Acute Federation in relation to the termination of this JWA (if any) up to and including the date of termination of this JWA;
    c. each Trust will revoke its delegation to its Working Together Partnership Acute Federation Committee in Common (CiC) on termination of this JWA;
    d. termination of this JWA shall not affect any rights, obligation or liabilities that the Trusts have accrued under this JWA prior to this termination of this JWA;
    e. there are no joint assets and resources but should these be identified in the future, Trusts will need to confirm agreement at termination of this JWA how any joint assets or resources will need to be dealt with on termination of the JWA.
2. In the event of an ~~exiting~~ existing Trust exiting this JWA in accordance with clause 7, the Trusts agree that:
    a. a minimum of six months' notice will be given by the exiting Trust and they shall pay to the other Trusts all reasonable costs and expenses incurred by the other Trusts as a consequence of the exiting Trust's exiting from the Acute Federation and this JWA up to and including the exiting Trust's date of exit from this JWA. Notwithstanding this, the exiting Trust's total aggregate liability, in respect of such reasonable costs and expenses, shall be capped at the value of their annual contribution of resources that are agreed to remain for the financial year or term of any agreement being overseen by the Committee in Common;
    b. upon reasonable written notice from the other Trusts, the exiting Trust shall be liable to pay one fifth of any professional adviser's fees incurred by and on behalf of the Acute Federation as a consequence of the exiting Trust's exit from the Acute Federation and this JWA up to and including the date of exit of the exiting Trust from this JWA;
    c. the exiting Trust will revoke its delegation to its Acute Federation on its exit from this JWA;
    d. the remaining Trusts shall use reasonable endeavours to procure that the JWA is amended or replaced as appropriate in accordance with clause 7.3.2.
    e. subject to any variation to or replacement of this JWA in accordance with paragraph d above and clause 7.3.2 this JWA shall remain in full force and effect following the exit of the exiting Trust from the JWA.

Board of Directors Meeting
8th March 2024

Agenda item	P43/24
Report	**Integrated Performance Report – January 2024**
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 January 2024 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 and our safer staffing levels are provided separately 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. Work continues on the development of a new IPR in time for 2024/25 reporting from May 2024. Board and Executive Team workshops have been held over the last few months to review initial proposals with further discussions to be held in the coming weeks.
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 – January 2024

Board of Directors

Integrated Performance Report - January 2024

Provided by

Business Intelligence Analytics, Health Informatics

Integrated Performance Report

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			

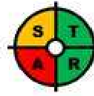
CQC DOMAINS

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 23/24	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	Jan 2024	L	**27,200**		32,774	30,883	30,647	29,954	29,954	26,641		
Referral to Treatment (RTT) Performance	Jan 2024	N	**92%**		61.0%	61.6%	60.4%	60.1%	62.1%	66%		
Number of RTT patients waiting 52+ Weeks	Jan 2024	L	**250**		734	742	713	697	697	289		
Number of RTT patients waiting 78+ Weeks	Jan 2024	L	**0**		1	1	3	6	6	2		
Number of RTT patients waiting 65+ Weeks	Jan 2024	L	**106**		77	76	90	95	95	0		
Overdue Follow-Ups	Jan 2024	L	**-**		15,502	14,514	13,881	13,063	13,063	14,878		
First to follow-up ratio	Jan 2024	B	**2.4**		2.23	2.16	2.32	2.28	2.46	2.57		
Day case rate (%)	Jan 2024	B	**85%**		85.9%	85.6%	84.4%	88.2%	85%	87%		
Day case rate (%) - Model Hospital	Oct 2023	B	**85%**		85.1%	85.1%	83.9%	84.9%	--	78%		
Diagnostic Waiting Times (DM01)	Jan 2024	N	**1%**		3.6%	2.3%	2.8%	2.0%	4.5%	16%		
Diagnostic Activity Levels - for Key Modalities (from Apr 2023)	Jan 2024	L	**8437**		8,264	9,020	7,826	9,049	9,049	8949		
Capped Theatre Utilisation *(internal data)*	Jan 2024	L	**85%**		80.5%	79.3%	77.5%	76.4%	76.4%			
Emergency Performance												
Number of Ambulance Handovers > 60 mins	Jan 2024	N	**0**		106	22	144	348	1,040	145		
Ambulance Handover Times % > 60 mins	Jan 2024	N	**0%**		4.8%	1.0%	6.4%	15.9%	5.1%	9%		
Number of Ambulance Handovers 30+ mins	Jan 2024		**-**		299	200	424	692	2,843	302		
Ambulance Handover Times % 30+ mins	Jan 2024	L	**10%**		13.6%	9.4%	18.7%	31.6%	13.9%	18%		
Average Time to Initial Assesment in ED (mins)	Jan 2024	N	**15**		26	24	26	32	27	36		
4hr Performance in Dept - against internal target	Jan 2024	N	**76%**		58%	63%	58.7%	55.4%	59.0%			
4hr Performance in Dept - against external target	Jan 2024	N	**65%**		58%	63%	58.7%	55.4%	59.0%			
Proportion of patients spending more than 12 hours in A&E from time of arrival	Jan 2024	L	**2%**		5.5%	3.2%	5.1%	8.7%	5.1%	10%		
Number of 12 hour trolley waits	Jan 2024	N	**0**		1	0	7	30	38	55		
Proportion of same day emergency care	Jan 2024	L	**33%**		40.9%	42.1%	38.5%	34.1%	41.4%	41%		
Cancer Care												
31 Day Treatment General Standard *(new standard from Oct 23)*	Dec 2023	N	**96%**		97.1%	96.3%	99.0%	95.7%	96.7%	93%		
62 Day Treatment General Standard *(new standard from Oct 23)*	Dec 2023	N	**85%**		75.6%	76.1%	78.7%	74.5%	76.7%	72%		
The number of cancer patients waiting 63 days or more after a GP 2ww referral	Jan 2024	L	**64**		44	58	54	59	59	-		
28 day faster diagnosis standard	Dec 2023	N	**75%**		73.6%	73.5%	73.8%	78.4%	70.0%	66%		
Inpatient Care												
Mean Length of Stay - Elective (excluding Day Cases)	Jan 2024				2.70	2.22	2.95	2.31	2.72	2.55		
Mean Length of Stay - Non-Elective	Jan 2024				5.40	5.14	5.01	5.35	5.29	5.99		
Length of Stay > 7 days (Snapshot Numbers)	Jan 2024	L	**142**		157	161	174	201	201	196		
Length of Stay > 21 days (Snapshot Numbers)	Jan 2024	L	**70**		38	35	46	56	56	64		
Right to Reside - % not recorded *(internal data)*	Jan 2024	B	**0%**		10.3%	8.2%	9.9%	14.2%	14.2%	6%		
% of patients where date of discharge is same as Discharge Ready Date	Dec 2023				87%	85%	84%	82%	--	0%		
Discharges before 5pm (inc transfers to Community Ready Unit)	Jan 2024	L	**70%**		58.9%	62.2%	62.1%	63.9%	61.6%	59%		
Outpatient Care												
Did Not Attend rate (outpatients)	Jan 2024	B	**6.2%**		8.4%	8.3%	9.2%	8.3%	9.0%	9%		
% of all outpatient activity delivered remotely (via telephone or video)	Jan 2024	N	**25%**		12.7%	12.2%	13.7%	11.8%	12.4%	13%		
Proportion of all outpatient appointments with patients discharged to PIFU	Jan 2024	N	**5%**		2.3%	2.3%	2.8%	3.0%	2.3%			
LUNA Data Quality Score	Jan 2024	N	**99%**		99.2%	99.2%	99.2%	99.0%	--			
% of RTT PTL reported as validated	Jan 2024	N	**90%**		94.0%	91.8%	84.20%	91.67%	91.67%			
Community Care												
MusculoSkeletal Physio <4 weeks	Jan 2024	L	**80%**		35.7%	26.2%	26.2%	19.5%	26.3%	15%		
A&E attendances from care homes	Jan 2024	L	**144**		145	116	162	148	148	125		
Admissions from care homes	Jan 2024	L	**74**		112	98	114	117	117	88		
Urgent 2 hour Community Response	Oct 2023	L	**70%**		74%	75%	76%	73%	78%	77%		
Numbers of pts on virtual ward	Jan 2024	L	**80**		36	76	53	67	67	0		
Number of patients in month accepted onto virtual ward (Total)	Jan 2024				145	162	327	279	279	0		

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)	Oct 2023	B	**As Expected**		101.2	102.1	100.8	100.7	--	106.8		
Mortality index - HSMR (Rolling 12 months)	Nov 2023	B	**As Expected**		90.9	90.6	90.1	89.8	--	99.8		
Number of deaths (crude mortality)	Jan 2024		-		80	82	99	104	782	99		
Infection, Prevention and Control												
C. difficile Infections	Jan 2024	L	**2**		5	7	4	0	34	5		
C. difficile Infections (rate)	Jan 2024		-		28.0	30.0	29.9	26.5	26.5	24.7		
E.coli blood bactertaemica, hospital acquired	Jan 2024	L	**4**		3	6	3	2	37	3		
P. Aeruginosa (Number)	Jan 2024	L	**1**		2	0	2	0	4	0		
Klebsiella (Number)	Jan 2024	L	**1**		0	3	0	0	14	0		
Patient Safety												
Serious Incidents - one month behind (PSII process from 20th Nov 24)	Dec 2023	L	**0**		3	5	3	4	29	3		
Number of Patient Incidents (including no-harm)	Jan 2024		-		918	933	897	1,092	9,505	-		
Number of Patient Falls (moderate and above)	Jan 2024		-		2	1	1	4	15	1		
Number of Pressure Ulcers (G3 and above) - one month behind	Dec 2023		-		1	1	0	2	6	1		
Medication Incidents	Jan 2024		-		109	100	84	99	979	124		
Readmission Rates (one month behind) - NE - excluding D/Cs	Dec 2023		-		9.2%	9.2%	9.3%	8.7%	9.9%	9.6%		
Venous Thromboembolism (VTE) Risk Assessment	Jan 2024	N	**95.0%**		95.8%	97.0%	96.7%	96.8%	95.7%	96.7%		
Hip Fracture Best Practice Tariff Compliance	Dec 2023	L	**65.0%**		74.0%	66.0%	76.0%	62.0%	62.0%	62.1%		
Patient Experience												
Number of complaints per 10,000 patient contacts	Jan 2024	L	**8**		12.92	10.80	7.11	9.01	9.70	9.60		
F&F Postive Score - Inpatients & Day Cases	Jan 2024	N	**95.0%**		95.9%	96.7%	97.8%	97.7%	97.2%	97.8%		
F&F Postive Score - Outpatients	Jan 2024	N	**95.0%**		99.0%	97.0%	95.8%	95.1%	97.3%	98.4%		
F&F Postive Score - Maternity	Jan 2024	N	**95.0%**		96.3%	100.0%	100.0%	95.2%	98.5%	93.6%		
Care Hours per Patient Day	Jan 2024	L	**7.3**		6.80	6.90	6.90	7.10	7.10	6.4		
Maternity												
Bookings by 12 Week 6 Days	Jan 2024	N	**90.0%**		93.4%	93.4%	93.1%	91.9%	92.8%	88.8%		
Babies with a first feed of breast milk (percent)	Jan 2024	N	**70.0%**		57.7%	65.8%	55.1%	53.7%	59.4%	57.0%		
Stillbirth Rate per 1000 live births (Rolling 12 months)	Jan 2024	L	**4.66**		2.77	2.74	2.72	2.34	2.34	3.12		
1:1 care in labour - One month behind	Dec 2023	L	**75.0%**		98.6%	100.0%	100.0%	100.0%	99.7%	78.4%		
Serious Incidents (Maternity) - One month behind	Dec 2023	L	**0**		0	0	0	0	0	0		
Moderate and above Incidents (Harm Free) - One month behind	Dec 2023		-		0	0	0	0	0	0		
Consultants on labour (Hours on Ward)	Jan 2024		-		62.50	62.50	62.50	62.50	62.50	--		

Trust Integrated Performance Dashboard - Workforce

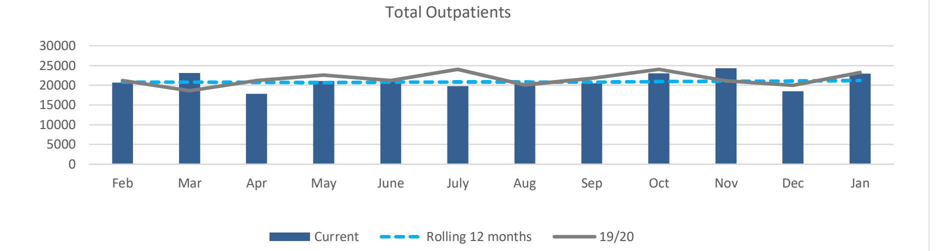
	Reporting Period	Type of Standard	Target	Benchmark	Previous Month (3)	Previous Month (2)	Previous Month (1)	Current Month	YTD	Same Month Prev. Yr	Trend	Data Quality
Workforce												
Number of WTE vacancies - Total	Jan 2024	L	**285**		230	273	251	225	225	462		
Number of WTE vacancies - Nursing and Midwifery	Jan 2024	L	**98**		58	84	71	65	65	85		
Vacancy Rate - TOTAL	Jan 2024	L	**6.4%**		5.7%	6.7%	6.2%	5.6%	5.6%	10.14%		
Vacancy Rate - Nursing	Jan 2024	L	**7.3%**		4.3%	6.0%	5.1%	4.7%	4.7%	6.32%		
Time to Recruit	Jan 2024	L	**34**		36	36	37	34	34	36		
Sickness Rates (%) - inc COVID related	Jan 2024	L	**4.5%**		6.4%	6.3%	6.2%	6.7%	5.8%	6.60%		
Short-term Sickness Rate (%)	Jan 2024				2.2%	2.1%	2.3%	2.8%	-	-		
Long-term Sickness Rate (%)	Jan 2024				4.1%	4.2%	3.9%	3.9%	-	-		
Turnover (12 month rolling)	Jan 2024		**11%**		9.8%	9.5%	9.6%	9.3%	9.3%	-		
Appraisals complete (% 12 month rolling)	Jan 2024	L	**90%**		87%	87%	86%	84%	84%	84.00%		
Appraisals Season Rates (%)	Jan 2024	L	**90%**		86%	87%	85%	84%	84%	84.00%		
MAST (% of staff up to date)	Jan 2024	L	**85%**		91%	91%	91%	91%	91%	92.00%		
% of jobs advertised as flexible	Jan 2024		**-**		70.2%	37.0%	41.1%	32.4%	60.1%	70.2%		

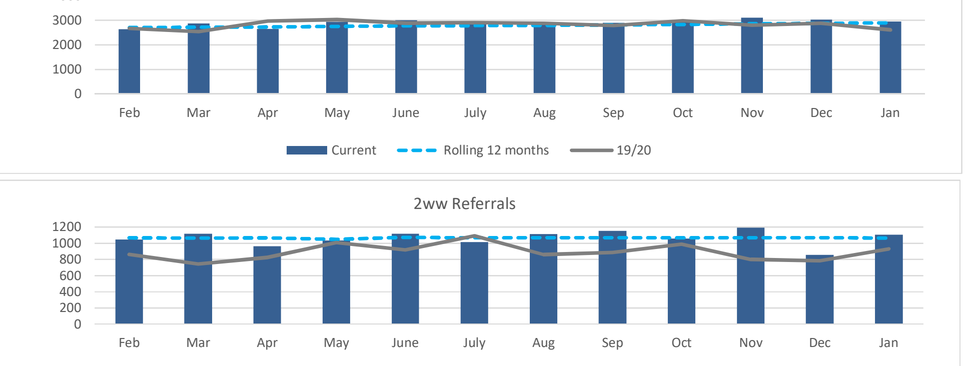
Trust Integrated Performance Dashboard - Finance

Apr 23 - Dec-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)	(375)	(765)	(390)	(5,974)	(8,218)	(2,244)	(4,054)	(4,702)
I&E Performance (Control Total)	(313)	(703)	(390)	(5,350)	(6,930)	(1,579)	(3,389)	(4,036)
Efficiency Programme (CIP) - Risk Adjusted	1,267	1,056	(212)	9,641	6,725	(2,917)	(2,077)	(2,231)
Capital Expenditure	901	1,851	(950)	8,879	6,716	2,163	0	0
Cash Balance	(1,165)	(1,812)	(646)	15,170	13,243	(1,927)	(4,248)	(248)

Trust Integrated Performance Dashboard - Activity





Trust Integrated Performance Dashboard - Activity

ACTIVITY

OUTPATIENTS			
	212	209	
	Activity 19/20	Activity 23/24	As % of 2019/20 WDA
January	21,715	23,179	**107%**
YTD monthly average	20,663	21,001	**103%**

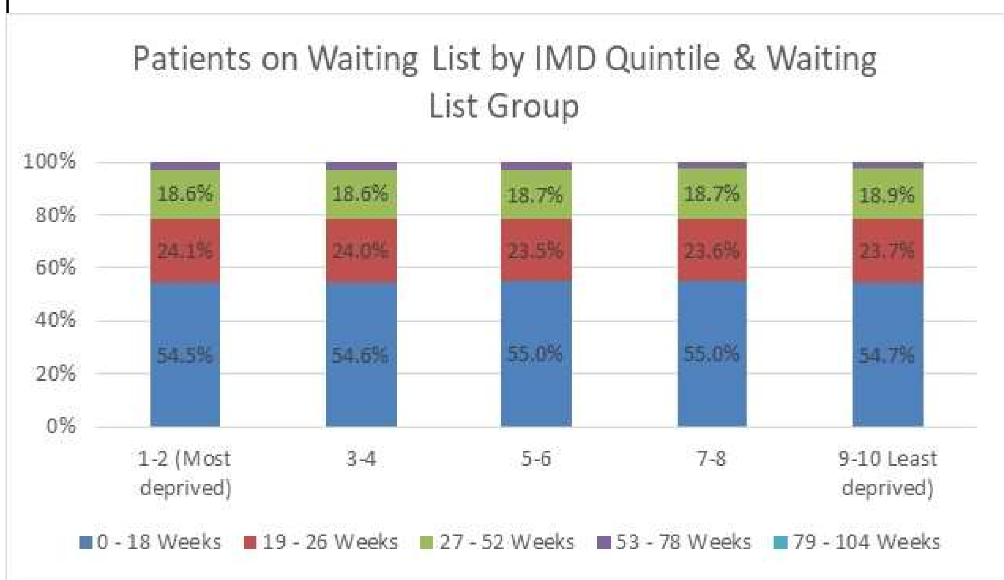
DAYCASES			
	Activity 19/20	Activity 23/24	As % of 2019/20 WDA
January	2,292	2,241	**98%**
YTD monthly average	2,207	1,997	**92%**

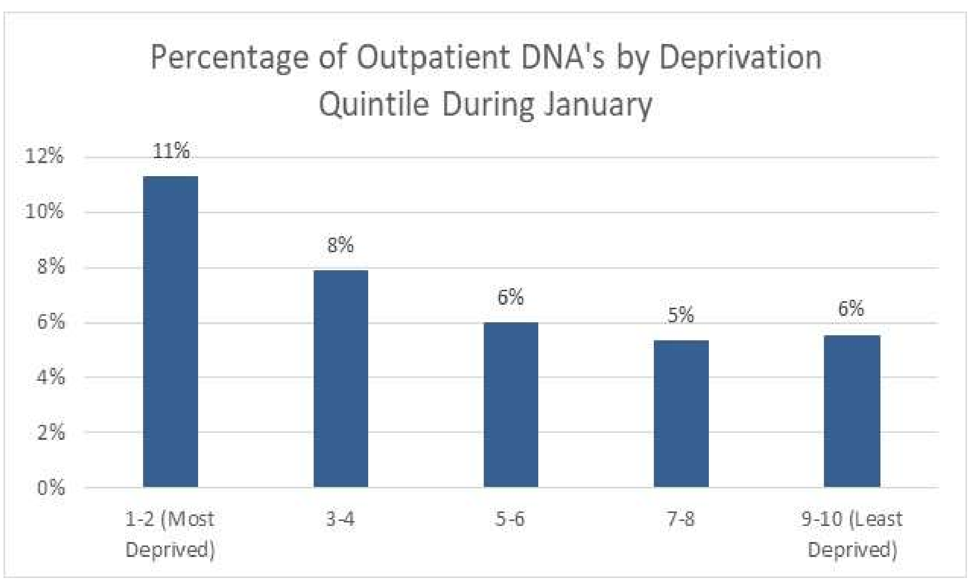
ELECTIVE ACTIVITY			
	Activity 19/20	Activity 23/24	As % of 2019/20 WDA
January	315	278	**88%**
YTD monthly average	409	335	**83%**

Trust Integrated Performance Dashboard - Health Inequalities

RTT Snapshot 28/01/24

IMD Quintile	Patients on Waiting List	Median Wait (Wks)	% of All RTT Patients	% of Rotherham Poulation	% Proportion Difference to Rotherham Population
1-2	10,577	14	38.1%	36.0%	2.1%
3-4	6,526	14	23.5%	23.2%	0.3%
5-6	4,207	14	15.2%	15.2%	-0.1%
7-8	4,951	13	17.8%	19.5%	-1.7%
9-10	1,508	14	5.4%	6.0%	-0.6%
Total	**27,751**	**14**	**100.0%**	**100.0%**	**0.0%**





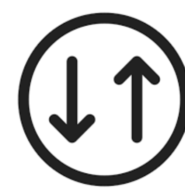
Safer Staffing

Trust Wide Scorecard Rolling 12 Months & Year End position 21/22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
Daily staffing -actual trained staff v planned (Days)	82.9%	84.1%	84.8%	88.0%	91.0%	90.0%	89.0%	86.0%	86.0%	87.0%	90.0%	92.0%	91.0%
Daily staffing -actual trained staff v planned (Nights)	85.0%	88.3%	90.9%	94.0%	98.0%	95.0%	92.0%	90.0%	88.0%	90.0%	92.0%	92.0%	92.0%
Daily staffing - actual HCA v planned (Days)	84.3%	81.8%	80.0%	85.0%	90.0%	89.0%	90.0%	90.0%	89.0%	91.0%	91.0%	91.0%	92.0%
Daily staffing - actual HCA v planned (Nights)	94.8%	92.0%	90.0%	94.0%	97.0%	102.0%	102.0%	100.0%	93.0%	102.0%	103.0%	101.0%	94.0%
Care Hours per Patient per Day (CHPPD)	6.4	6.4	6.5	7.1	8.0	7.4	7.3	7.0	7.0	6.8	6.9	6.9	7.1

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

Statistical Process Control Charts
Fact Sheet

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



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

SPC Rules

A single point outside the control limits

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

Consecutive points above or below the mean line

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

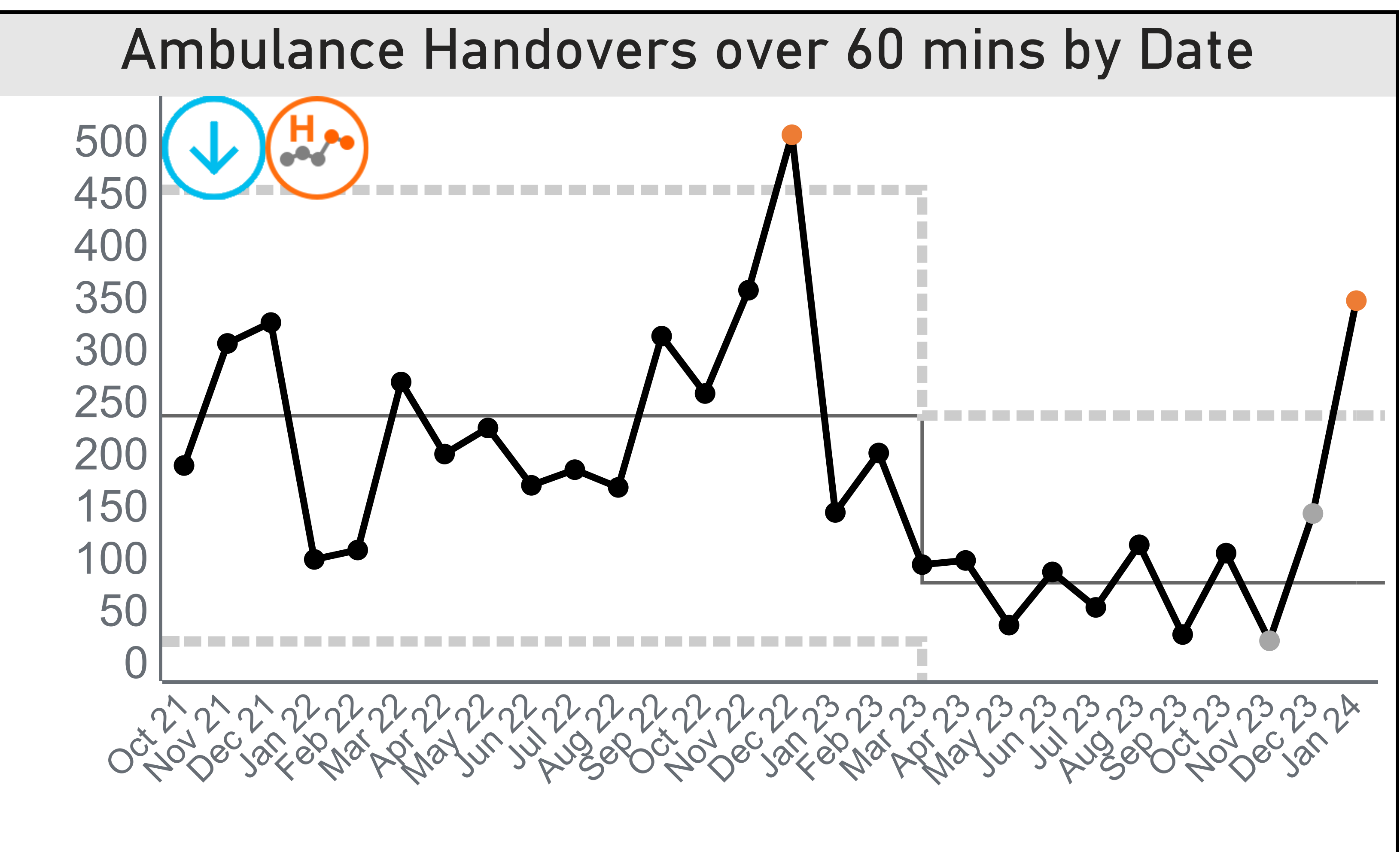
Consecutive points increasing or decreasing

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

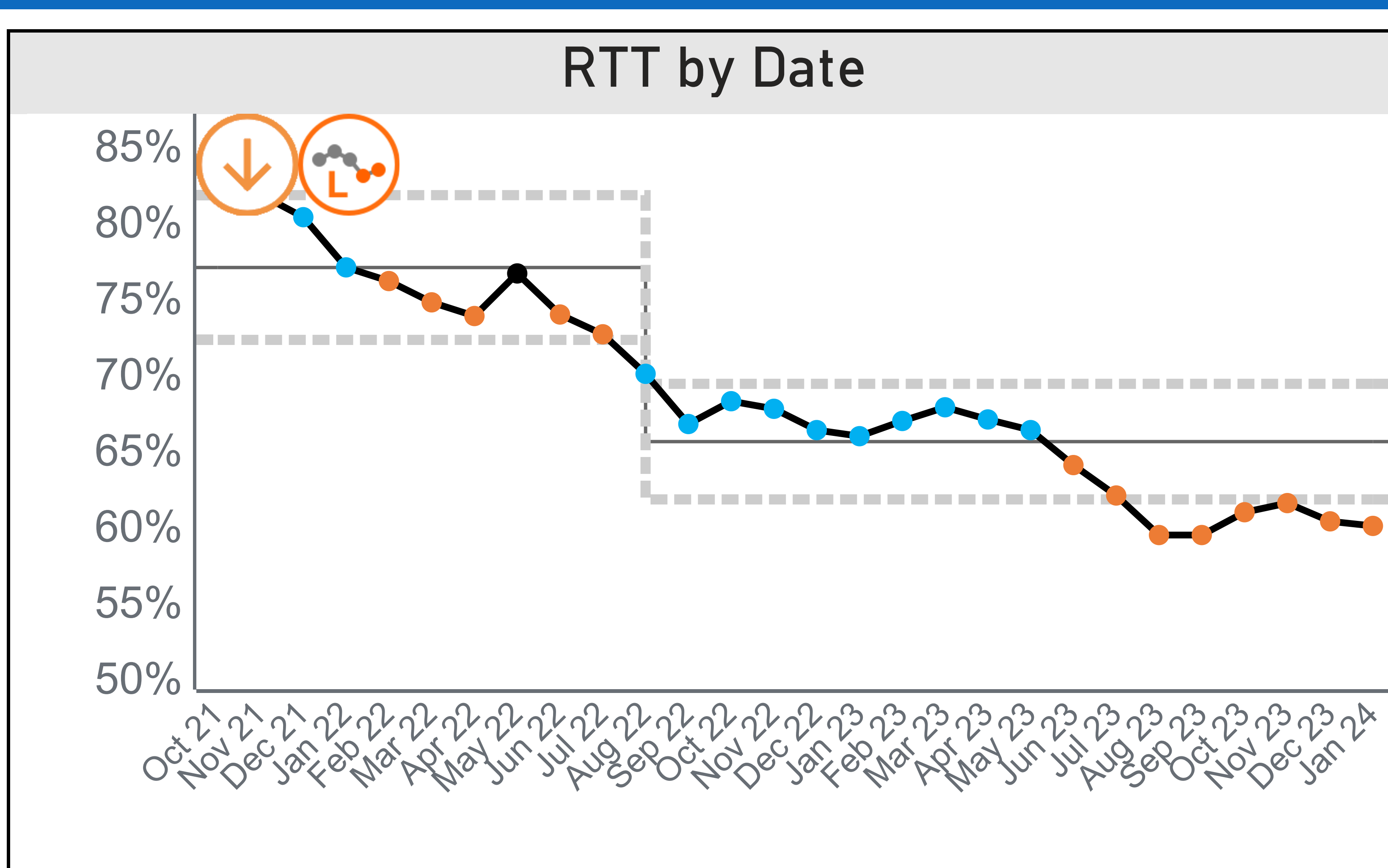
Two out of three points close to the process limits

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

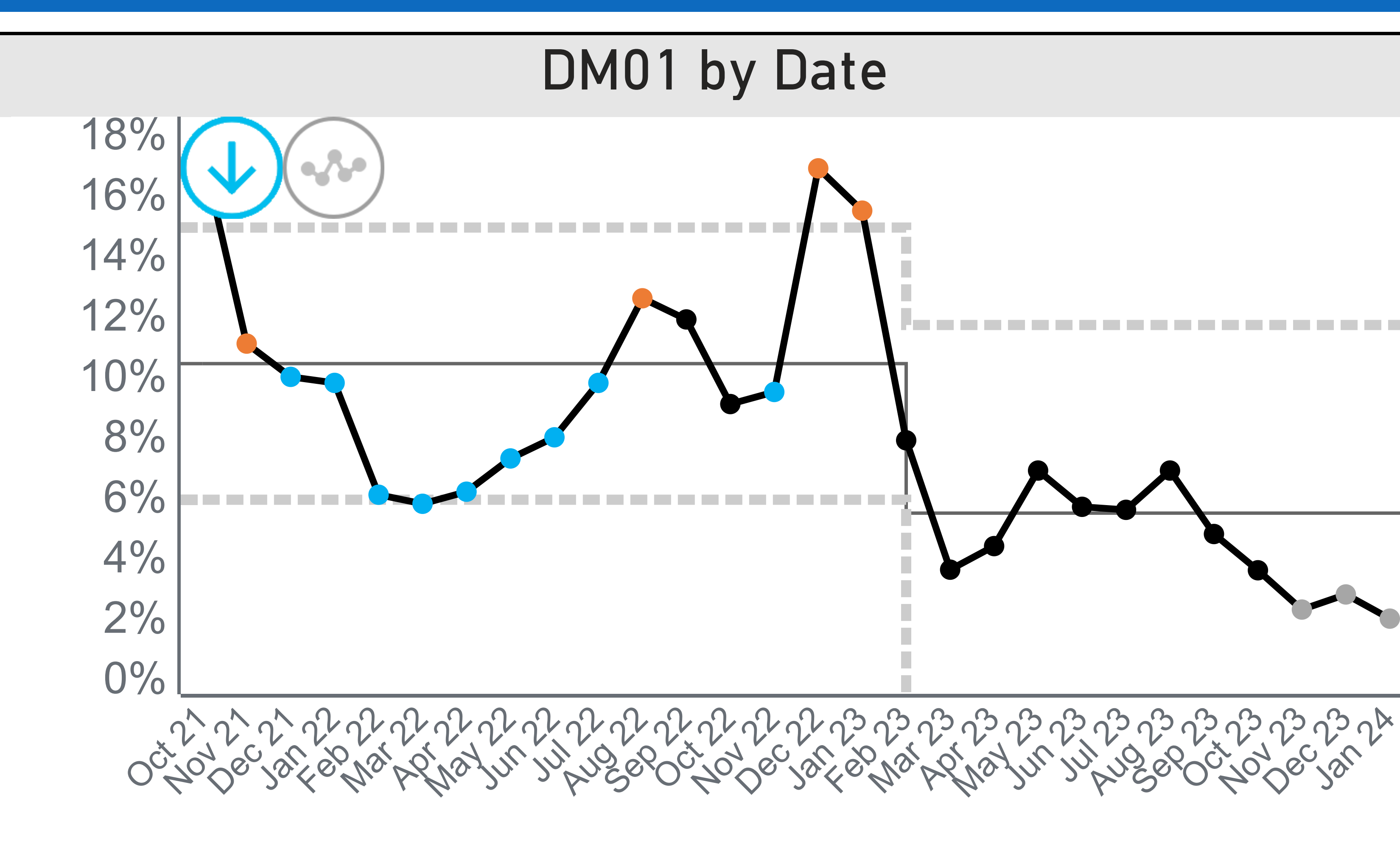
Statistical Process Control Charts
Operational Performance Page 1



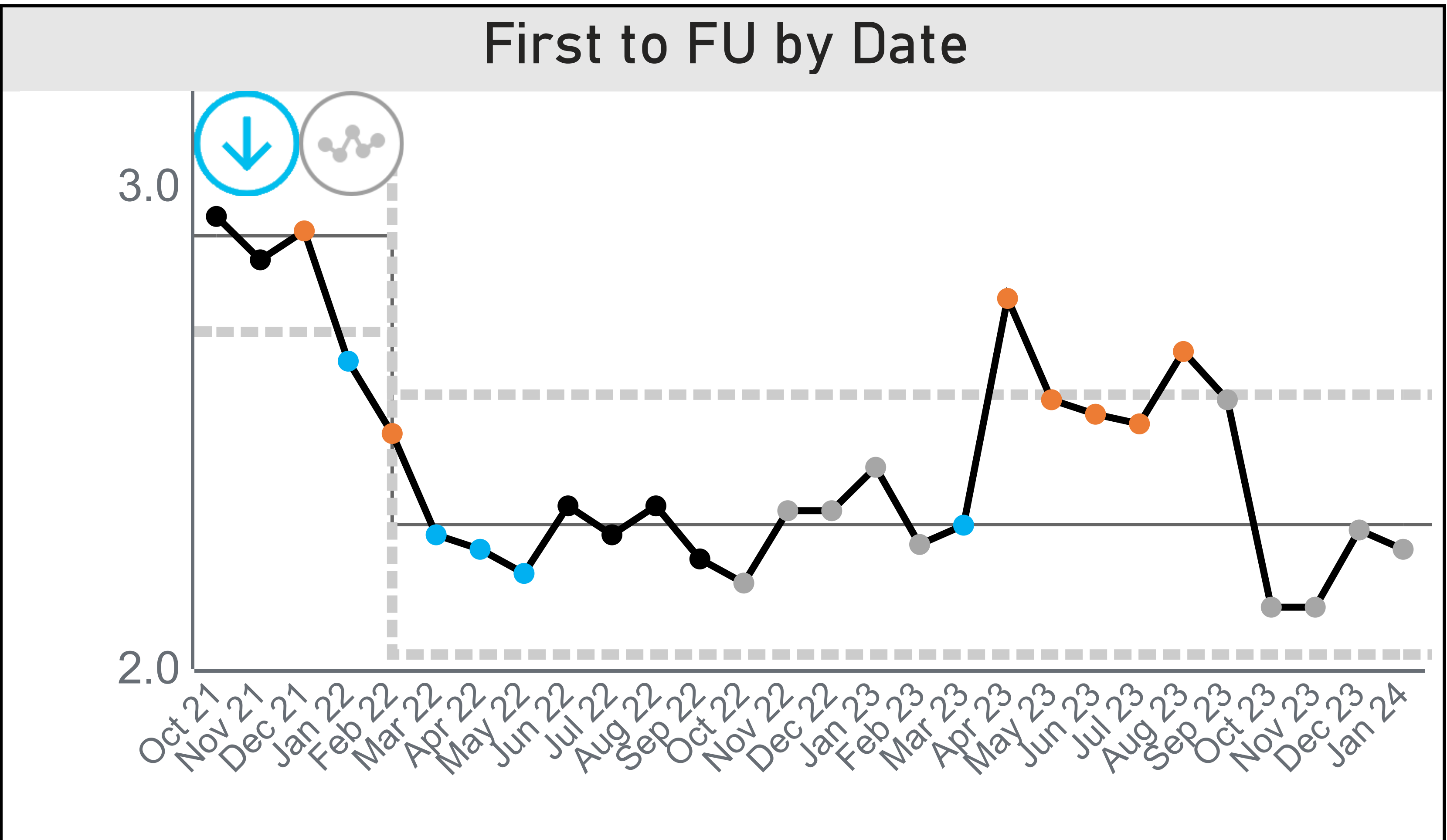
Improvement noted from Mar 23 of an average of 250 Handovers to 75 Handovers. Special cause noted in January with the increase to 348.



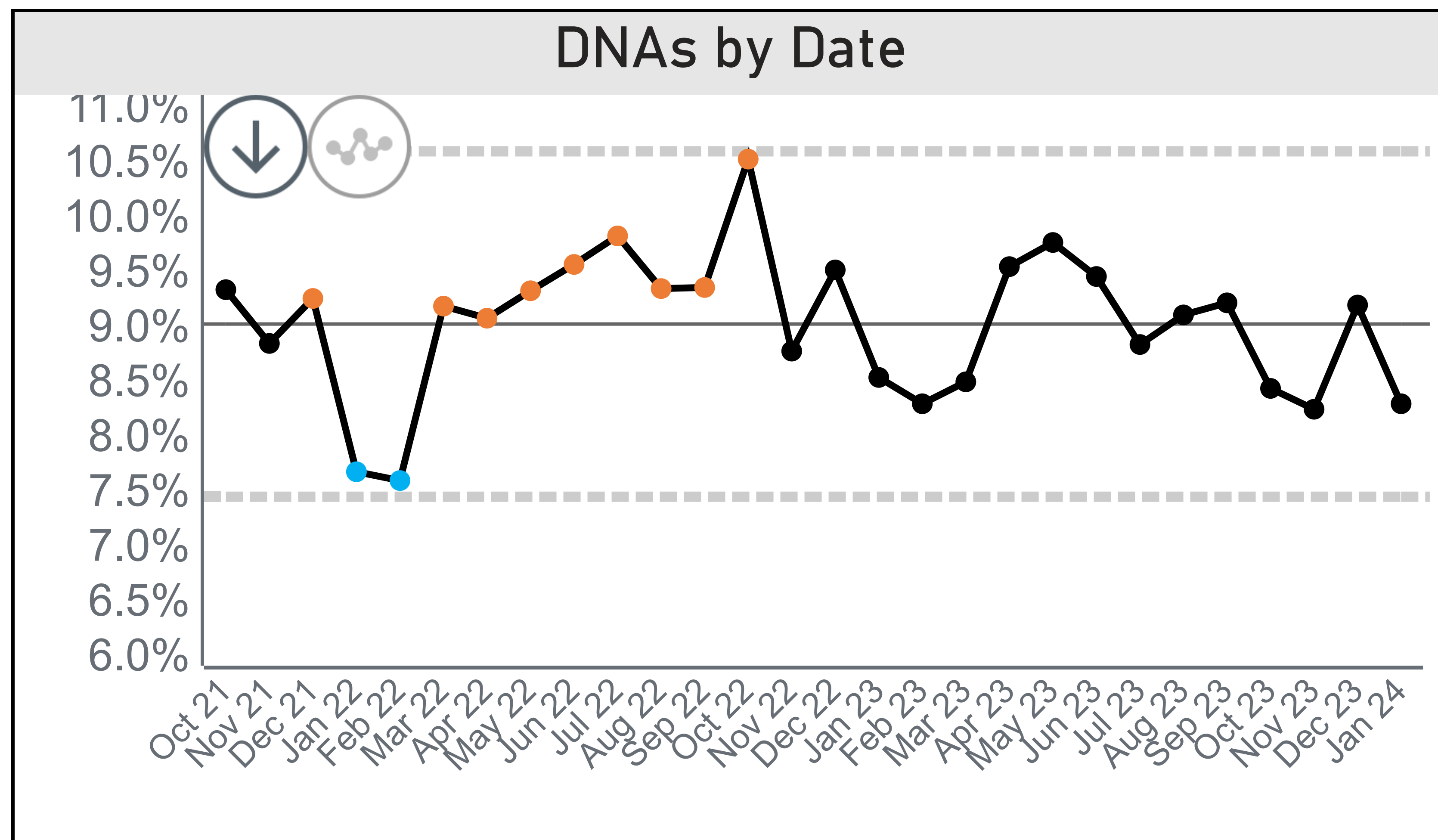
Continuous deterioration from 80% in Oct 21 to 60% in Jan 24, stabilising slightly from Aug 22 - Mar 23.



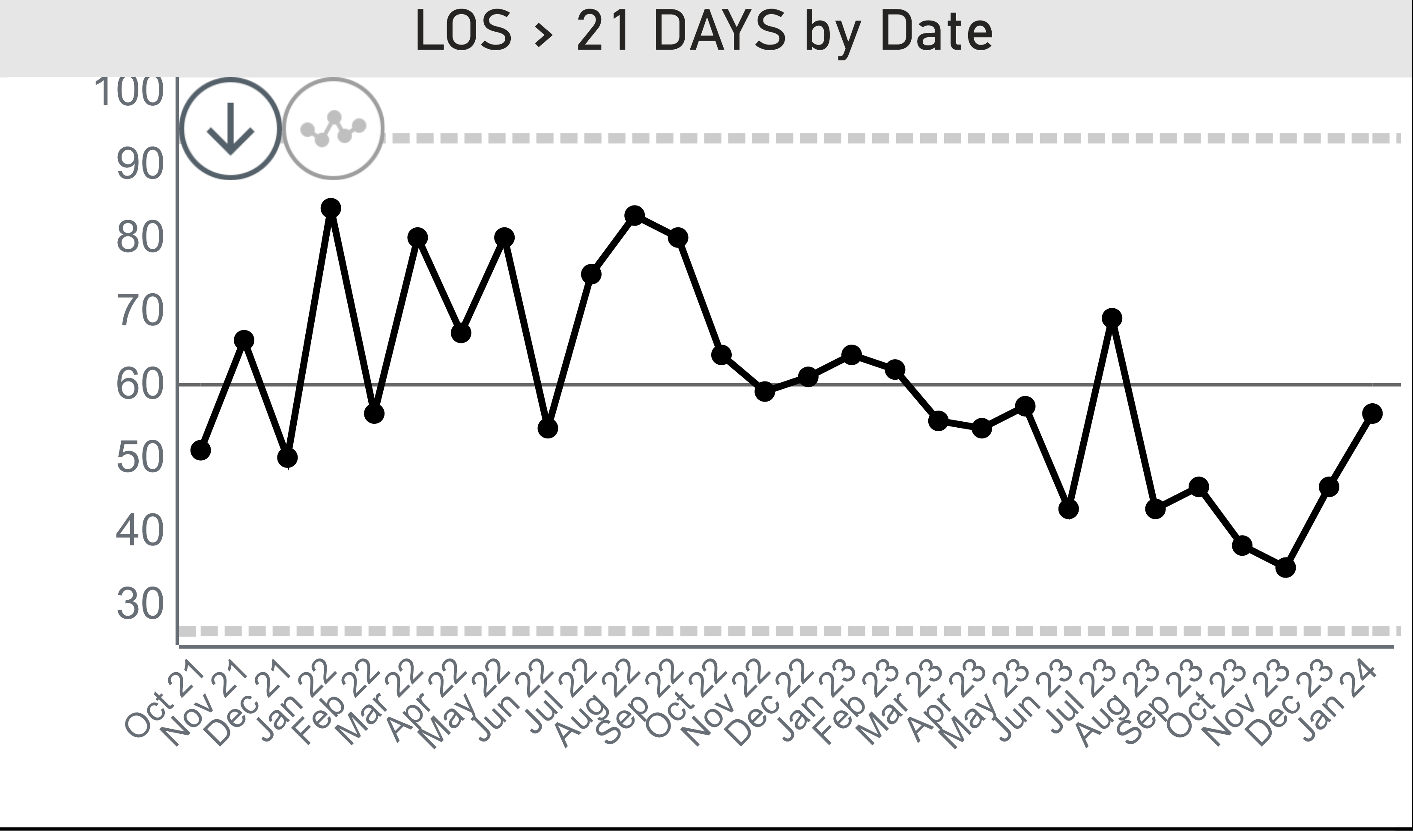
Significant improvement seen from an average of 10% to 6%.



Common cause variation seen at an average of 2.2.

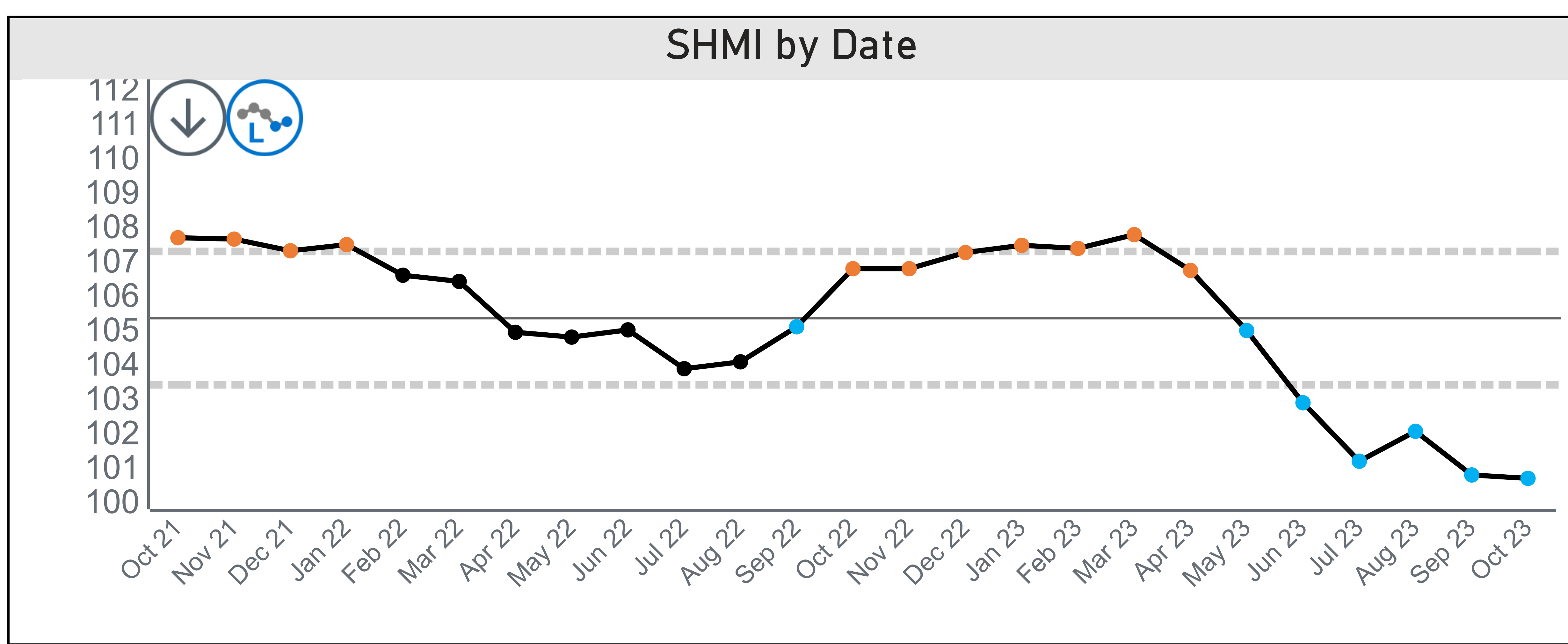


An average of 9% throughout the last 3 years. No significant variations noted.

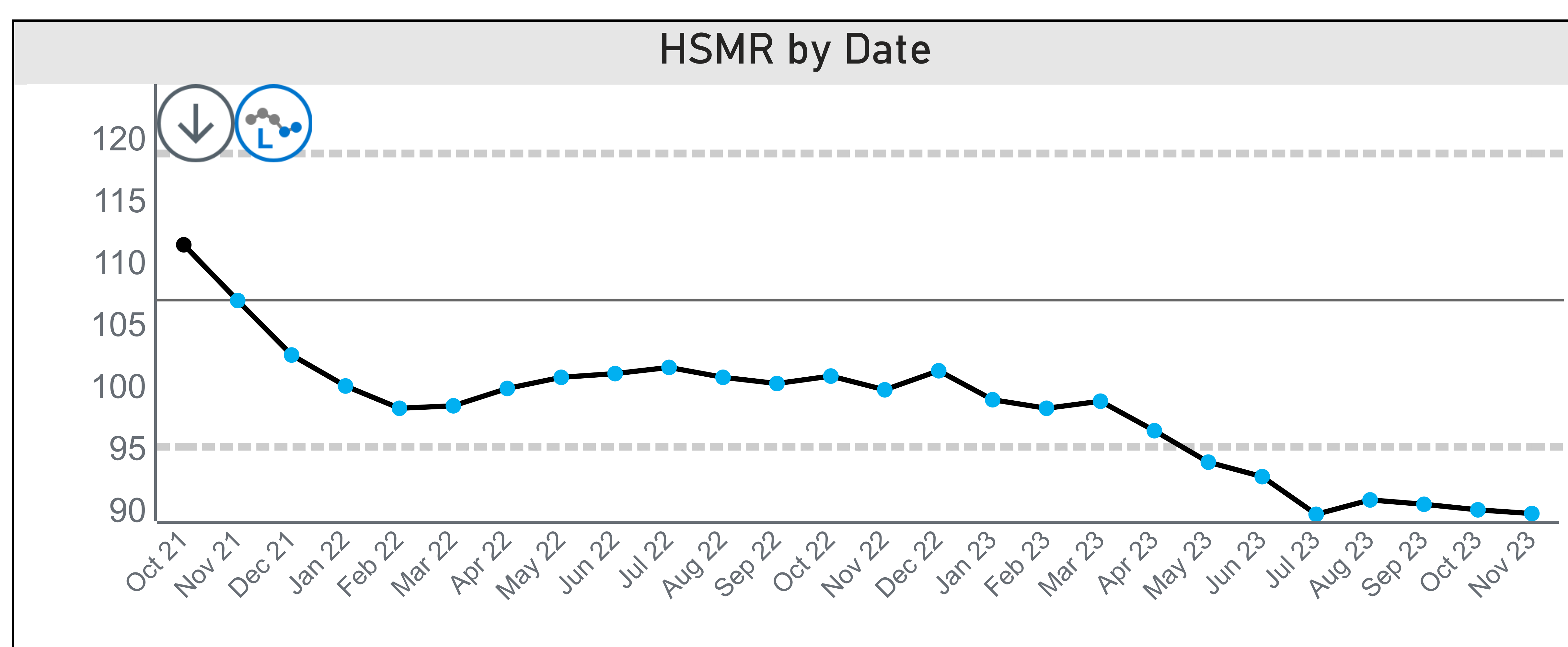


An average of 60 patients throughout the last 3 years. No significant variations noted.

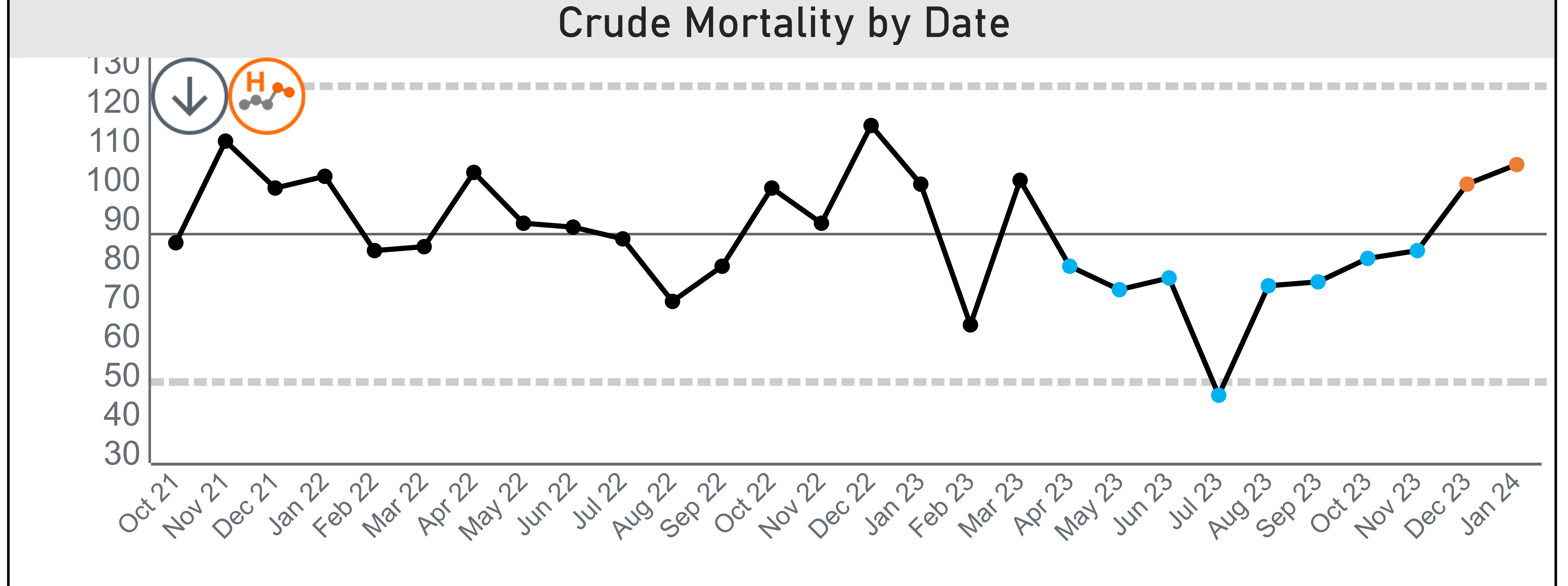
Statistical Process Control Charts
Quality Performance Page 1



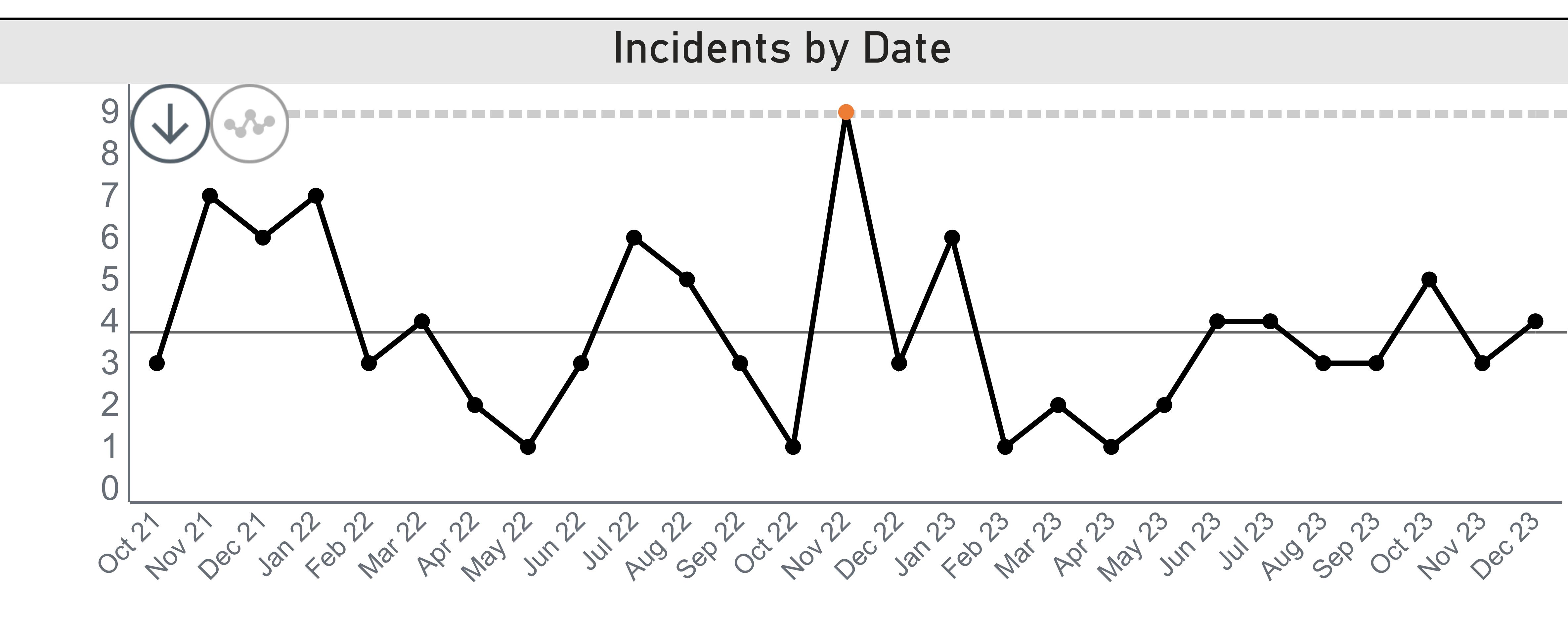
Significant improvement seen. Averaging at 105 over the last 3 years reducing to around 103 from June 23



Significant improvement seen from Oct 21 to Nov 23.

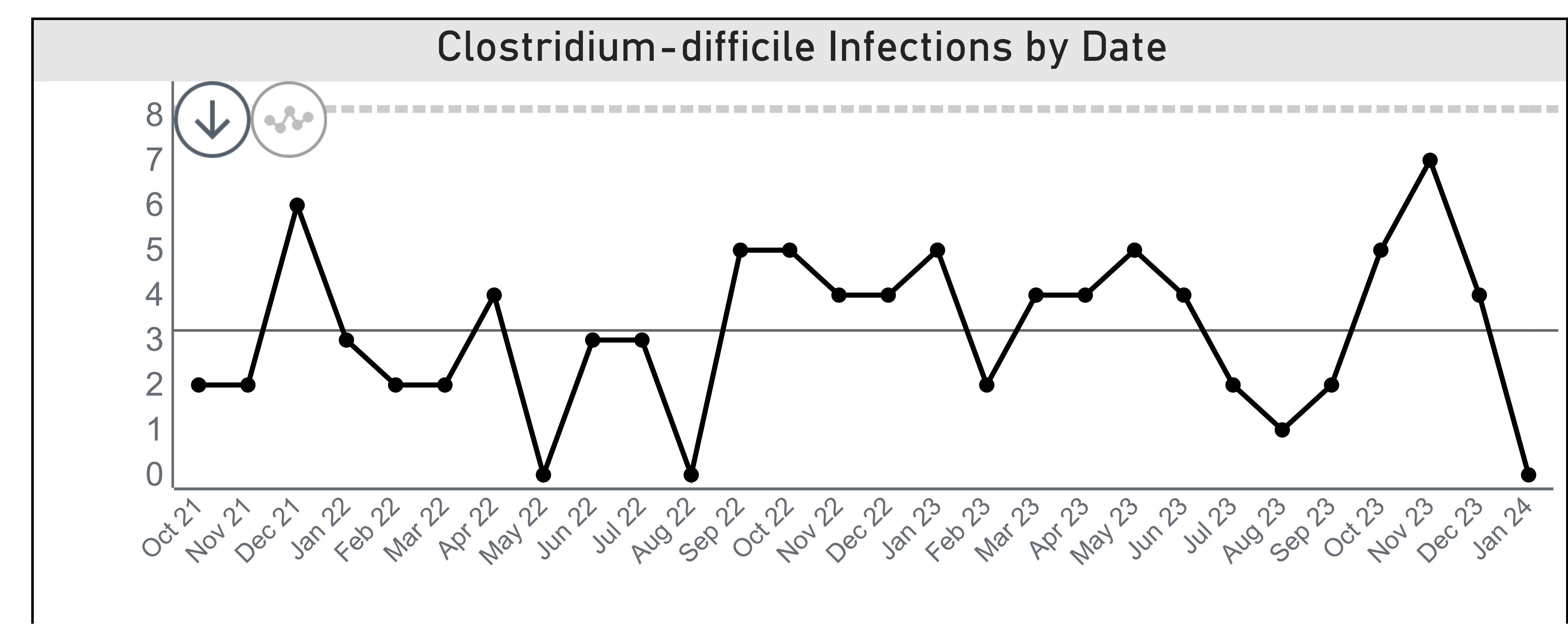


Averaging at 88 cases per month, no significant change.

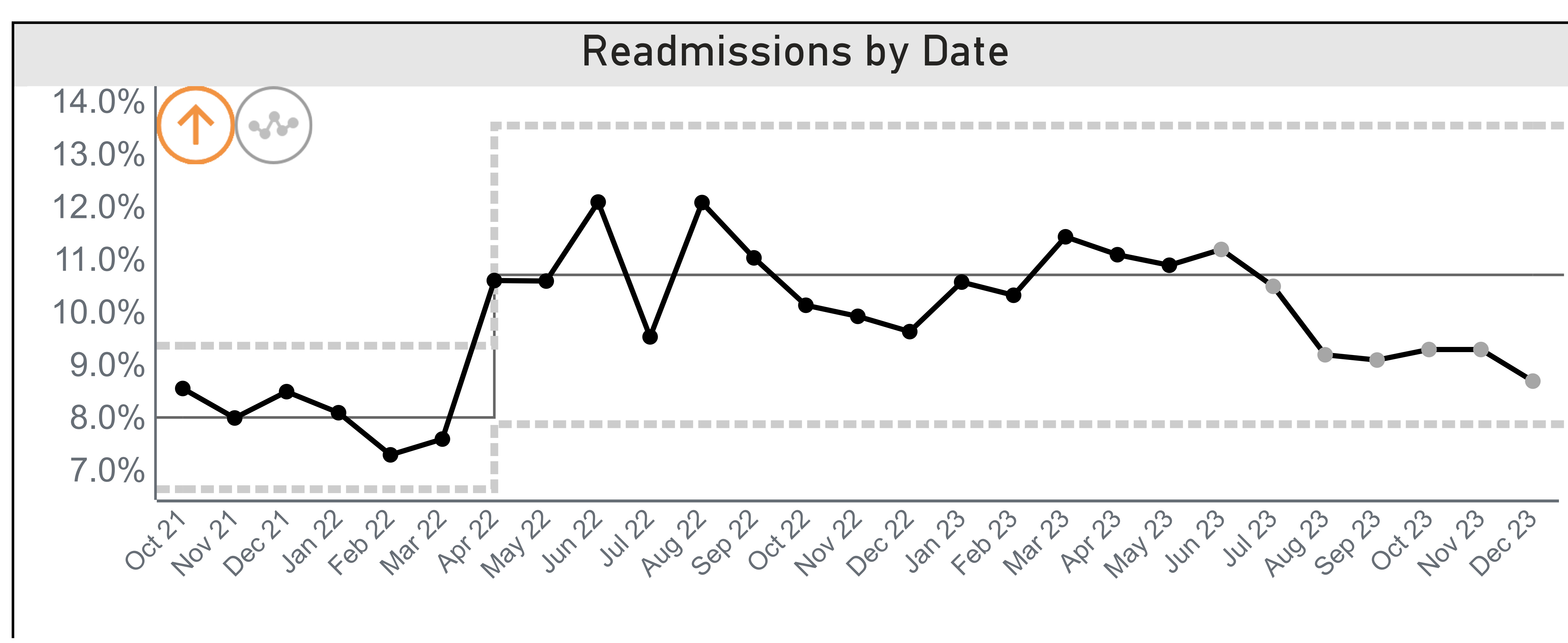


Averaging at 4 incidents a month, no significant change.

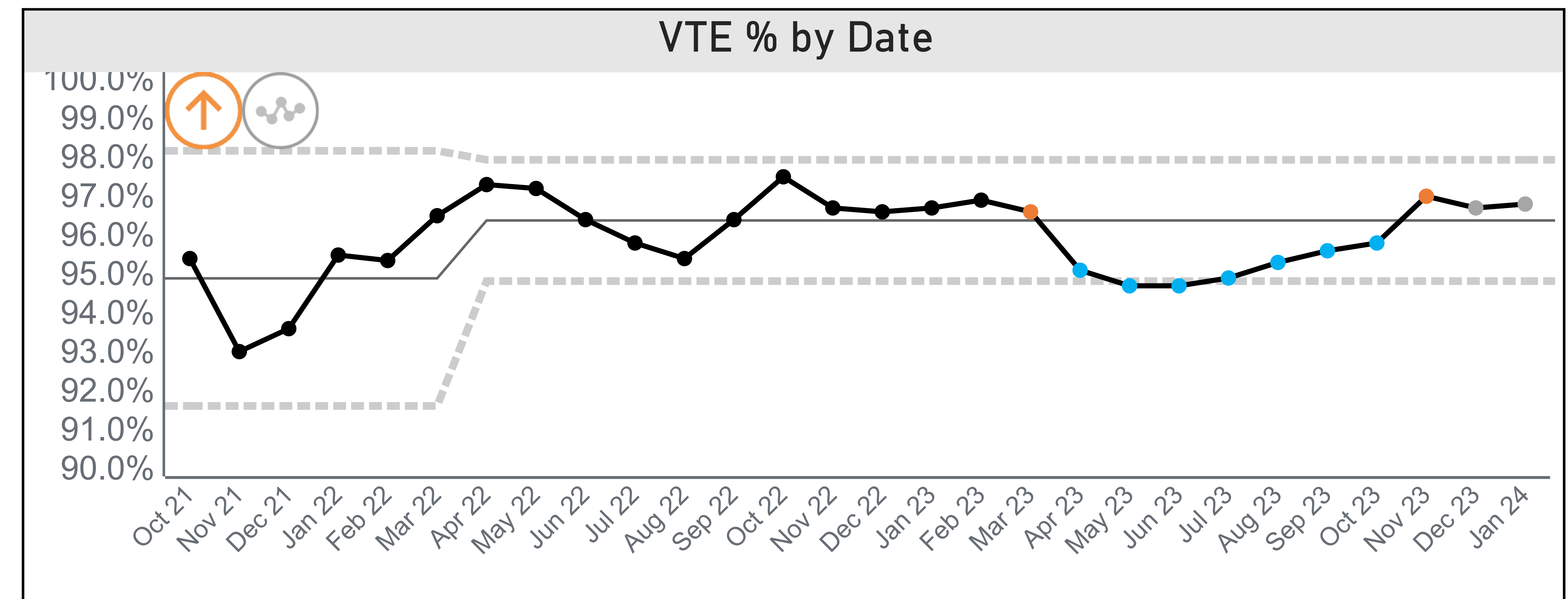
Statistical Process Control Charts
Quality Performance Page 2



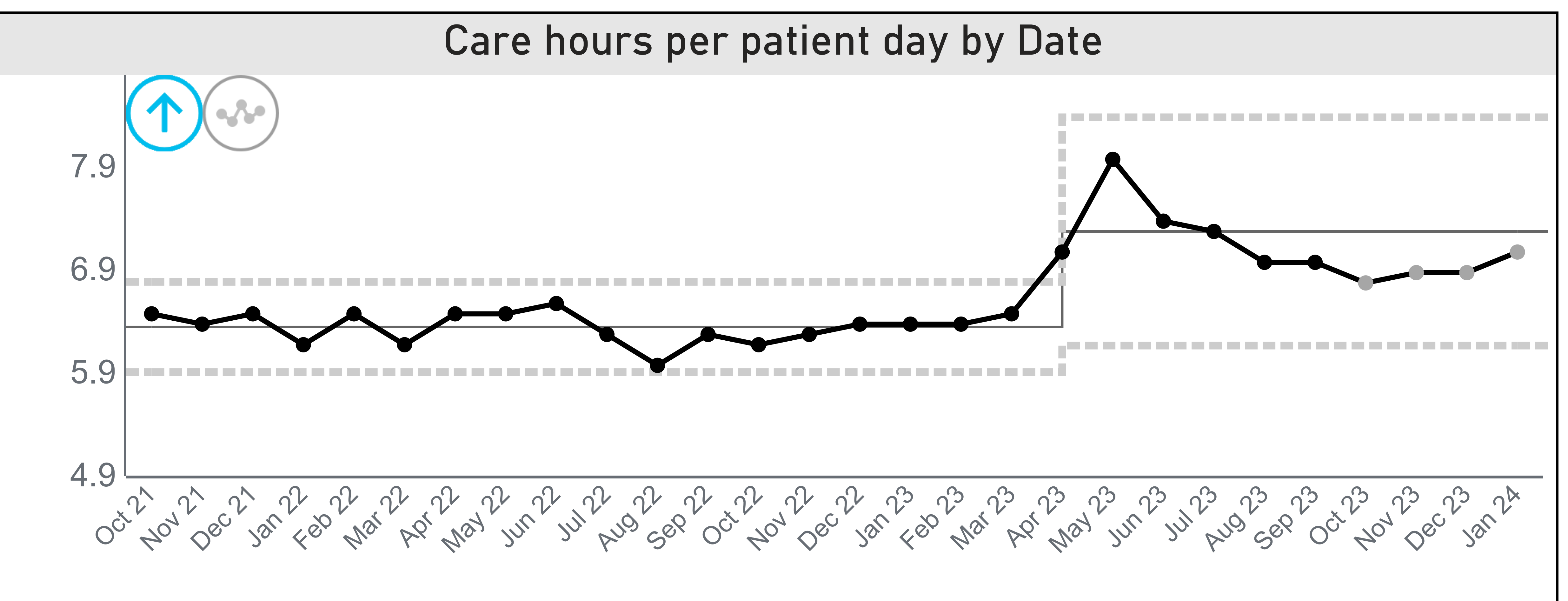
No significant change - averaging at 3 cases per month.



There was a measurement change in April 22 as per guidance. Improvement seen within the measurement change from Aug 23.

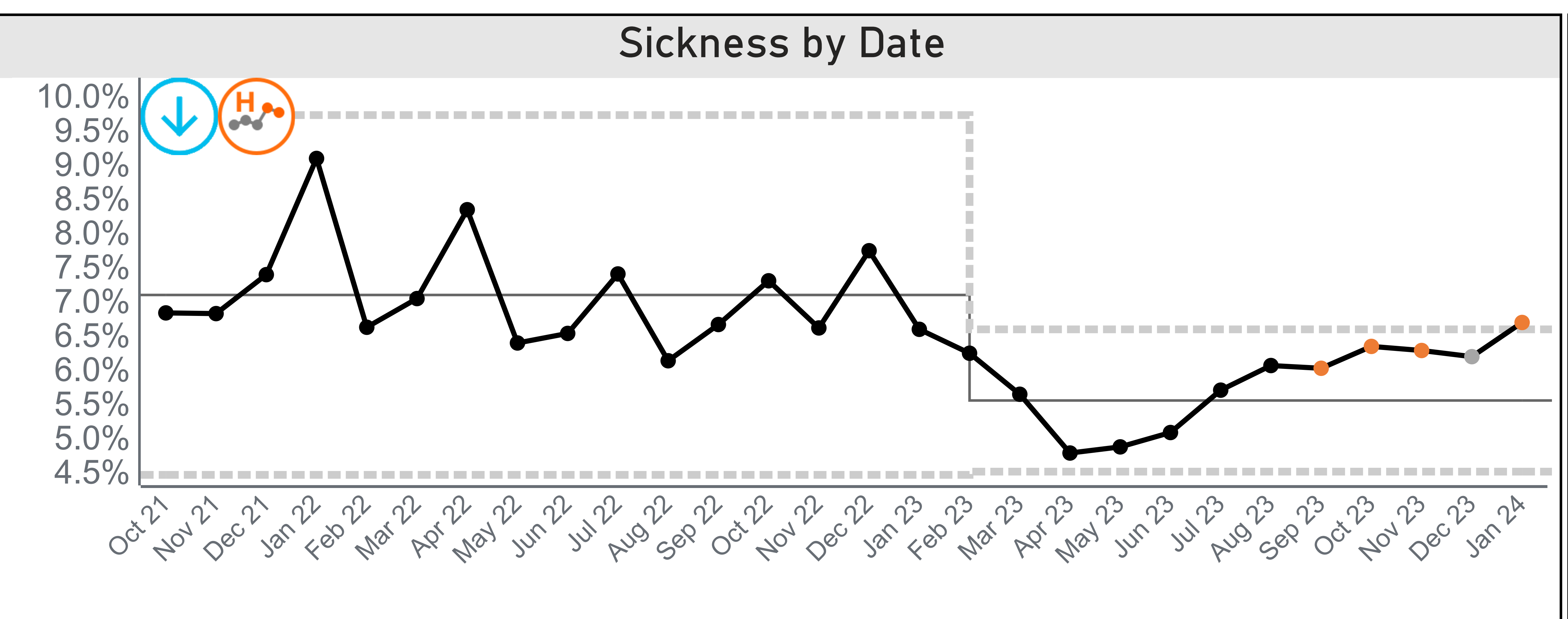


A slight improvement noted from an Average of 95% around Oct 21 - Mar 22, improving to 96.5% between Apr 22 - Jan 24.

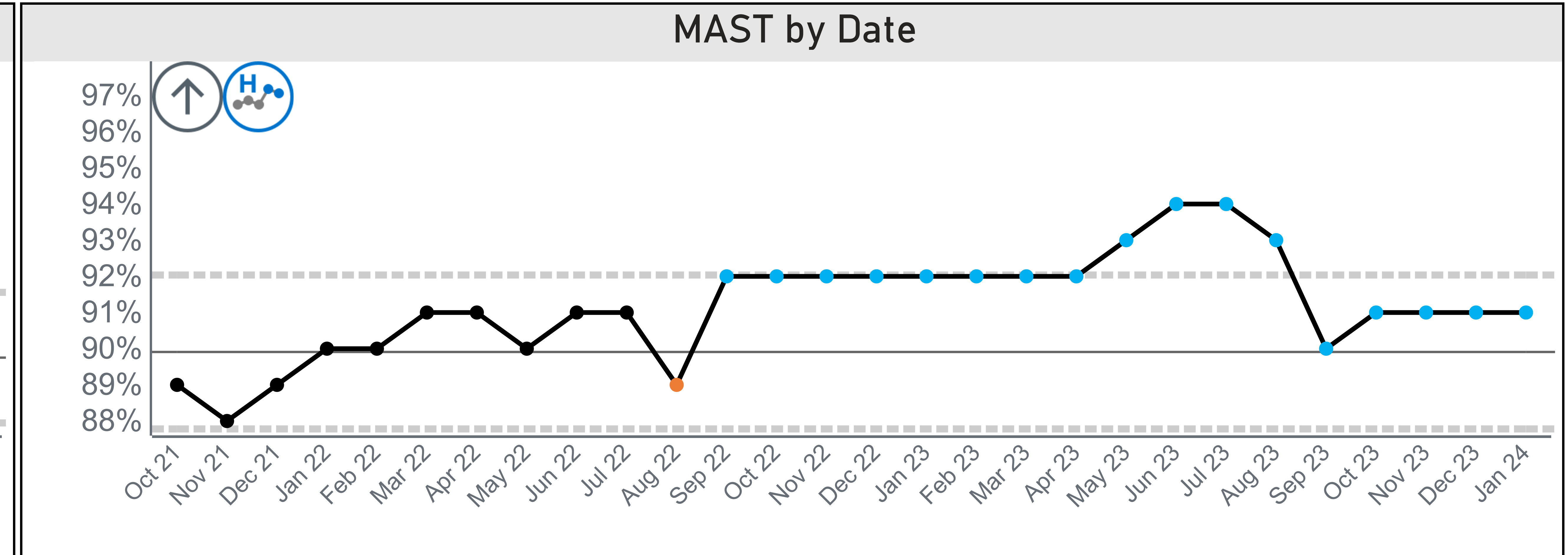


A significant improvement from an average of 6 within Oct 21 - Mar 23 to 7.1 from Apr 23.

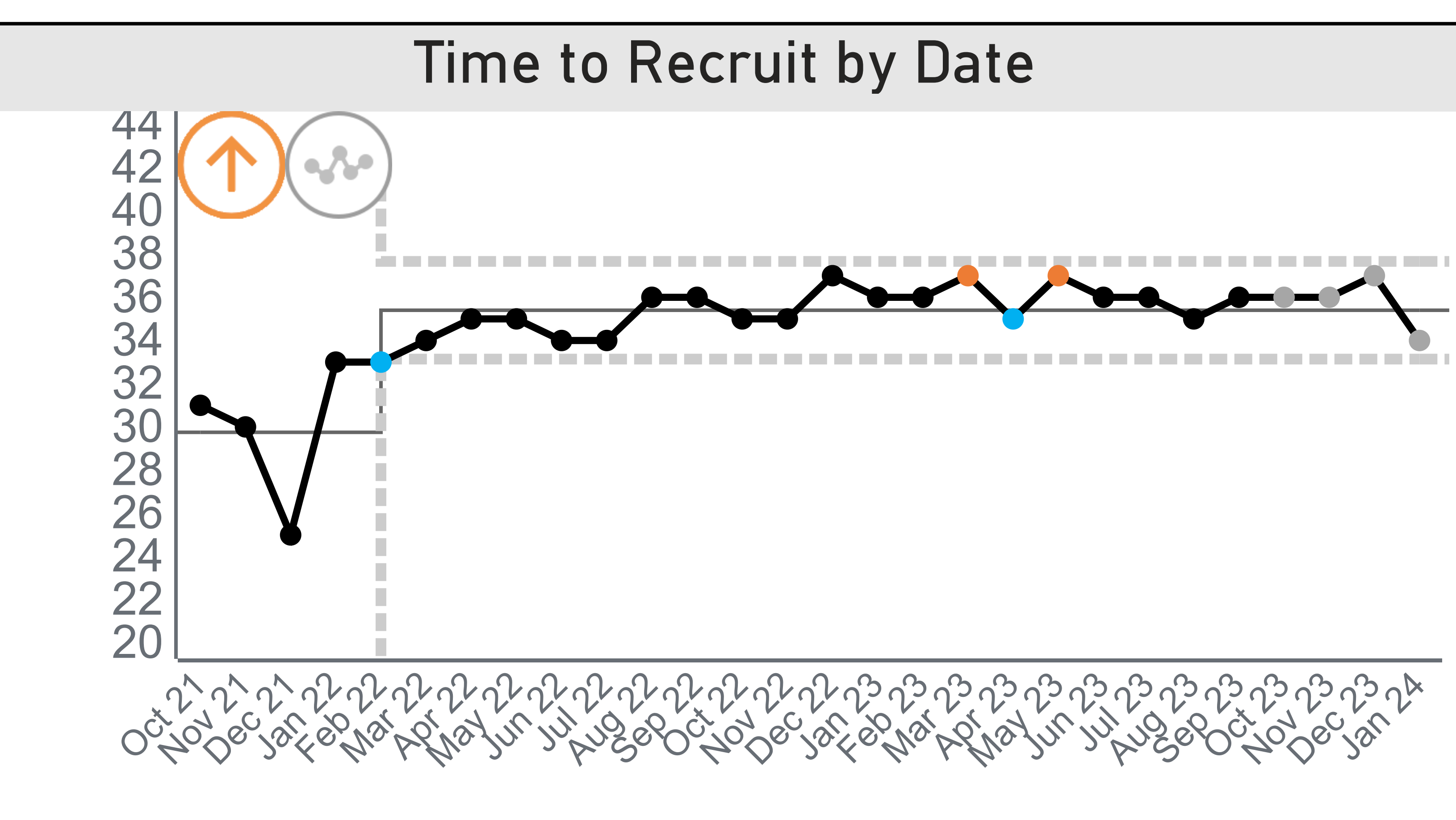
Statistical Process Control Charts
Workforce Performance Page 1



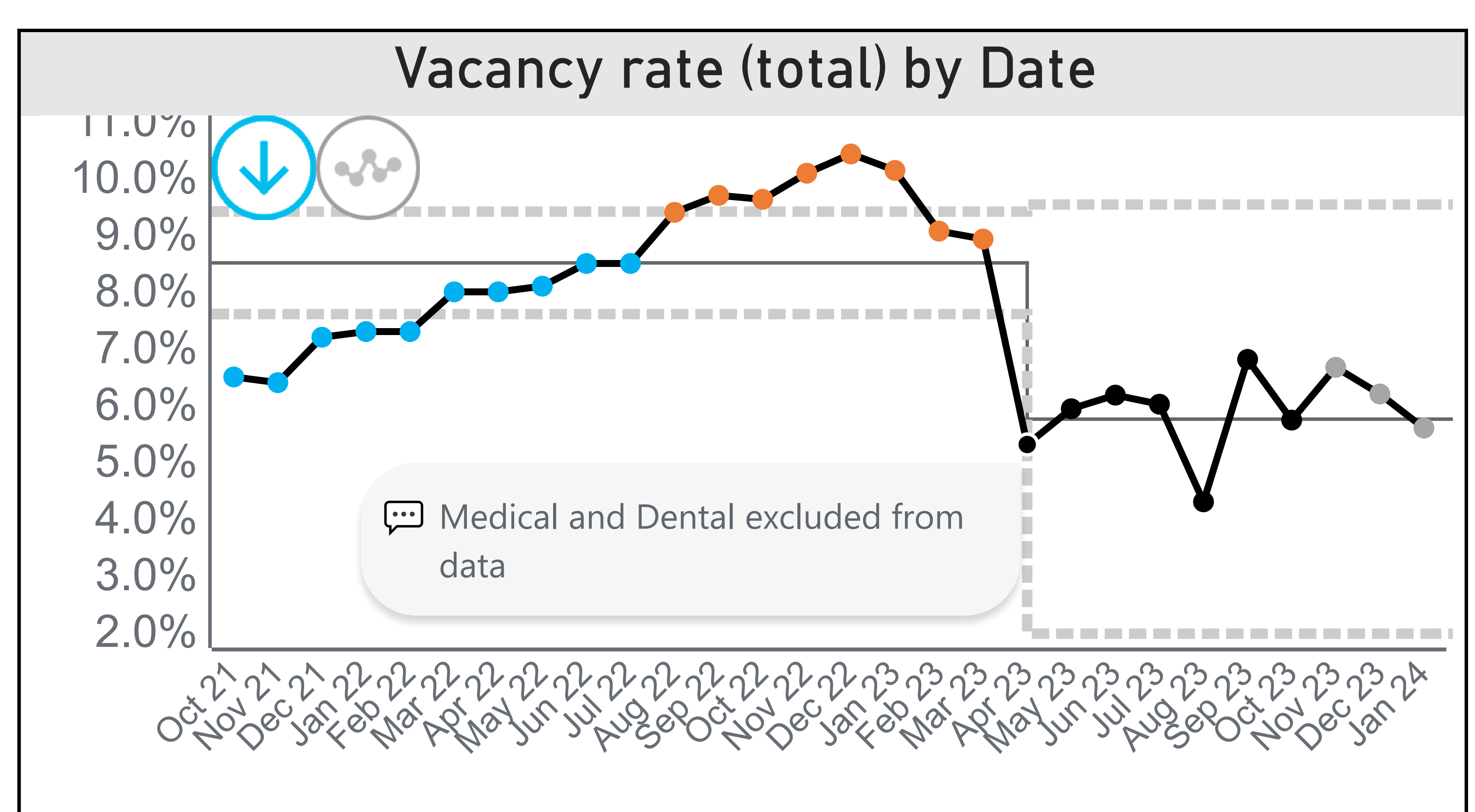
A significant improvement in sickness seen from an average of 7.2% to 5.5% although performance beginning to deteriorate showing a special cause variation.



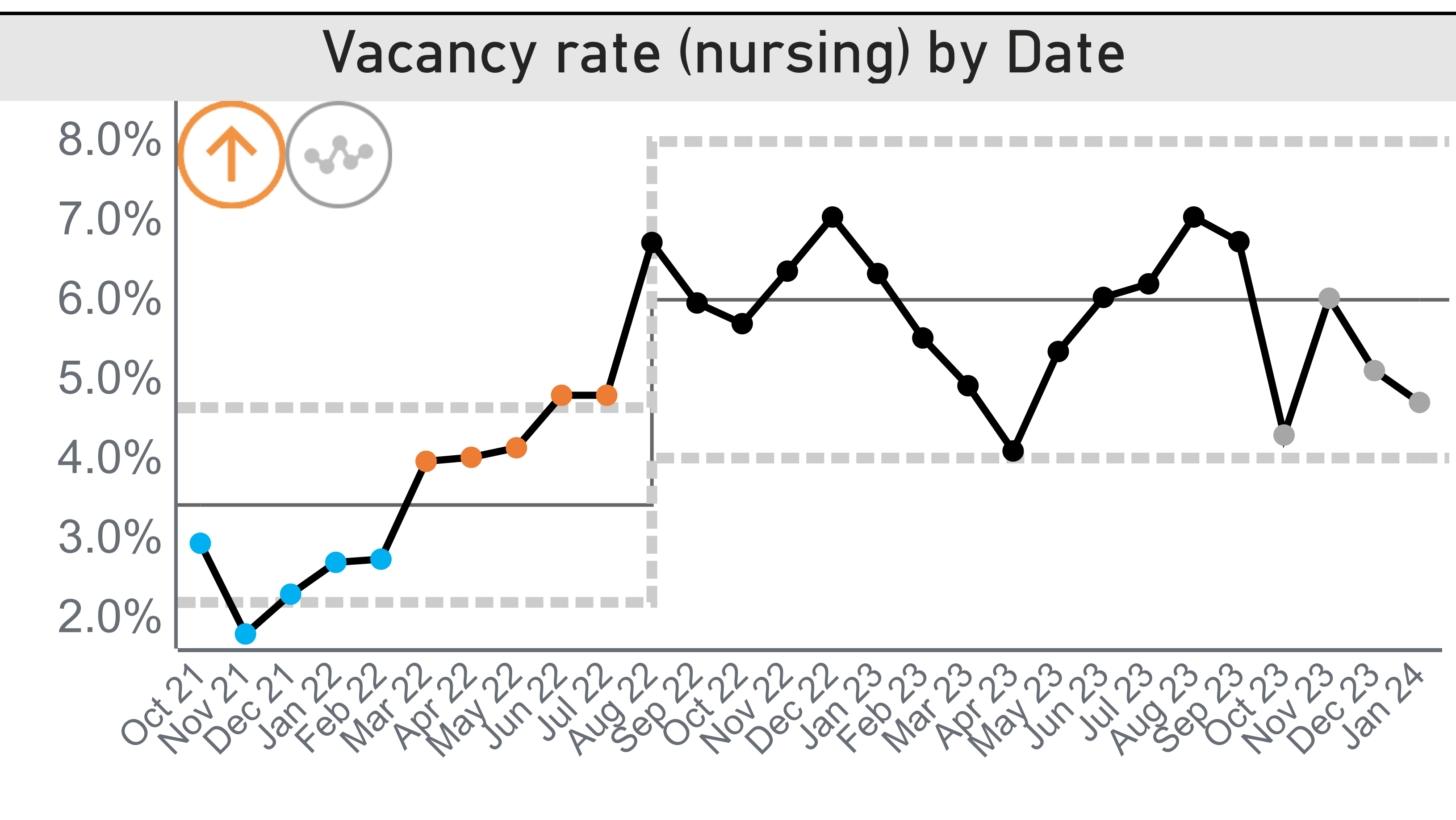
MAST is Averaging at 90%



A significant deterioration seen from an average of 30 days at the end of Feb 22 to an average of 35 days throughout the remainder of 2022 and 2023.



A significant improvement seen although a measure change was implemented in Apr 23 when medical and dental were excluded from the data. Average of 6% seen throughout 23/24.



A deterioration is noted from an average of 3.5% to 6% where performance has remained since Aug 22.

Integrated Performance Report Commentary

OPERATIONAL PERFORMANCE

Urgent & Emergency Care and Flow

- The latest month of data reflects intense operational pressures across the organisation and wider place, as described in the Chief Operating Officer's report. The Trust experienced some significant Infection, Prevention and Control issues which led to lost beds and a greater flow challenge, at a time when demand and acuity was very high.
- Long length-of-stay (21+ day) patients have remained in control but at almost two wards of patients, which has been challenging from an operational pressures perspective. Of further note is the 7+ day length of stay patients which exceeded 200 in the latest month, and is often indicative of wider pressure in the system as well as on site.
- The proportion of ambulances exceeding a one-hour handover has fluctuated over the period over the last 4 months, but was at the highest point for over a year in January. This is disappointing given all of the progress the Trust has made on handovers in the last year, but reflects the intense pressures seen in that most recent month of data, particularly in the first and last weeks of January.
- The proportion of patients waiting over 12 hours in A&E was also affected by the operational pressures, although was still below the levels seen in January 2023. 30 patients waited more than 12 hours for a bed following a Decision to Admit which reflects an extremely challenged position.
- January's performance shows the increase in non-elective pressure experienced in the Trust, in part due to the higher levels of demand and acuity, combined with significant on-site pressures from infection challenges.

Elective Care

- The waiting list has fallen further again to under 30,000 patients. While this is positive, it has primarily been driven by additional activity through insourcing in two specialties (Ophthalmology and Dermatology). Referrals remain high leading to continuing pressure on services, and there has been significant and continued growth in waiting lists within a number of surgical services which is a concern heading into 2024/25.

- Outpatient activity was again strong in month despite the industrial action at the start of the month, with more than 23,000 patients seen for their appointment, a 7% increase on 2019/20. Daycases were just under 19/20 levels at 98% but this compared to a YTD average of 92% and given the industrial action period this was a particularly impressive performance. Inpatients is a continued area of particular challenge and will need to be a greater focus in 2023/24, although some of the activity under-performance is due to a switch to daycases in certain cases that would previously have led to an inpatient stay.
- Industrial action has been a challenging backdrop to teams' efforts to clear our elective care backlogs this year, and after a month in November where there was no action, the teams have now had to manage a further period of action in each month since. We are awaiting the outcome of the latest ballot from Doctors in Training.
- The RTT position is remaining at around 60% despite the additional activity being delivered in certain services. This is mostly due to the mismatch in capacity in a few of the larger specialties, particularly Trauma & Orthopaedics, Gynaecology and ENT. The Trust's benchmarked position has fallen just outside the top quartile in the latest national data (December 2023).
- Despite this overall challenge, we have managed to deliver a small reduction in the number of patients waiting over a year for treatment, which will need to see further improvements in 2024/25.

Cancer

- The 31 Day General Treatment Standard was missed in the provisional December data, relating to 5 patient breaches. YTD the standard has been met at 96.6%. Performance is less strong on the 62 Day General Treatment Standard with performance generally less than 80% compared to a national target of 85%. This reflects delays at the front end of pathways, particularly with more complex diagnoses.
- Performance against the Faster Diagnosis Standard (FDS) was above the target in the latest month for the first time since August. However, there are still a number of pathway issues across multiple tumour sites, so this performance is unlikely to be sustained without a dedicated improvement focus, in particular within Colorectal, Upper GI and Urology (Prostate). Our new Cancer Improvement Manager and Cancer Improvement Officer are now in post, with one further colleague appointed who will start in April. The focus of this team will be around the diagnosis element of our cancer pathways, so should have a tangible impact on Faster Diagnosis Standard. Work is underway in Colorectal and Urology in particular to address the blockers to effective pathway delivery.

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 SHMI has also improved to under 101 for the last two months, with the number of expected deaths against this measure increasing over the last several months based on the acuity and demand seen.
- The absolute number of deaths has risen in the last two months, which is not unexpected given seasonal changes. Obviously there is a lag in these deaths being taken into account within the SHMI and HSMR.
- The Trust is currently considering the appropriate mortality metric(s) to report on next year. A review carried out by the Department of Health and Social Care commissioned NHS Digital to produce and publish the Summary Hospital-Level Mortality Indicator (SHMI). The initial review, reviewed the HSMR and other Mortality metrics and decided that it would be beneficial to have a single methodology for a mortality indicator for adoption across the NHS, and the SHMI offers the most complete picture of mortality associated with hospitalisation. This will be discussed through relevant internal governance before a decision is made.
- The new SJR process continues to be embedded, with learning taken to the Learning from Deaths group.

Patient Safety

- There were 4 incidents deemed to be severe or above in December, 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. The increase in all harms reported in January is not unexpected given the additional pressures in month, and all will follow appropriate process to ensure learning.
- VTE assessments remain above target 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.
- Care Hours per Patient Day has been variable over the period, but has increased in January to above 7 again. National benchmarking data shows the Trust continues to benchmark poorly on this metric compared to other organisations. However, the Safer Staffing assessment shows all four areas at over 90% of planned levels for the 3rd month in a row, demonstrating significant improvement in staffing levels compared to earlier in the year.

WORKFORCE SUMMARY

Retention and Recruitment

- Over the last 12 months the Trust has seen a 102.2 WTE increase overall for fixed term and permanent staff. All bands have seen an increase in WTE with the exception of band 4 (-10.5 WTE), band 8 (-4.8 WTE) and band 9 (-0.5 WTE). These figures include both clinical & non-clinical staff.
- Highest eligible retirees due now (based on the age of 60) remain within the Estates & Facilities and Integrated Medicine teams.
- Analysis shows that of the 26 voluntary leavers for January 2024, 18 had less than 5 years' service with TRFT, which contributes to over half of the total amount of leavers
- The Trust has welcomed just under 650 new starters in the last year.

Attendance

- Monthly sickness absence rate for the month of January 2024 increased slightly by 0.5%. The increase in the overall sickness rate was driven by short term sickness with almost all Divisions seeing an increase, which is not unexpected given the time of year.
- Medicine have the highest sickness absence rate (9.1%) and have also had the highest increase when compared to other divisions against December 2023. Corporate Operations have seen the largest decrease when compared to last month with a reduction of 1.1%.

Appraisals and Mandatory Training

- Overall appraisal (rolling 12 months) compliance for the month of January 2024 was 84.4%.
- Corporate Services and Emergency Care Divisions have seen an increase when compared with last month. All other Divisions have seen a decrease, with a 1.28% decrease showing at Trust level.
- Core MaST compliance remains well above the Trust target of 85% and Job-specific is also above target at 88%. All divisions remain above target for both Core and Job Specific combined.

Board of Directors
08 March 2024

Agenda item	P44/24
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 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 January 2024. The attached summary shows the position against each of the key operational indicators which NHS England and the ICB are using to monitor the performance of the Trust as part of their Board Assurance Framework. The Finance and Performance committee have received a more detailed update on each of these, along with the actions we are taking to improve our performance and ensure delivery of the year-end targets. The main headlines: • The Trust saw increased operational pressures throughout the month of January 2024, operating at OPEL level 3 more frequently. • Due to the demands on UECC and the complexity of winter viruses the Trust had pressures on bed capacity and subsequently a number of 12 hour breaches occurred. • Performance against the 4-hour standard was 55.38% against an agreed trajectory with NHSE of 65%. • A number of actions, including a command and control structure have been put in place in order to have increased focus on achieving 76% 4 hour performance during March 2024. • The Trust achieved the re-profiled trajectory for 65-week waiters, with 95 patients waiting against a trajectory of 106. An update on the current position with Corneal Grafts is included. Focus remains on ensuring patients waiting over 65 weeks have been seen by the end of March 2024. • The Trust had a period of Industrial action from 03 to 09 January

	2024. Further Industrial Action is due to take place on the 24 to 29 February 2024. • The opening of Mexborough Elective Orthopaedic Centre of excellence (MEOC) opened to its first patient on the 15 January 2024. • An update on Emergency Preparedness Resilience and Response (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 – January 2024

1.0 Operational Pressures Escalation Level (OPEL) & Urgent Care

The Trust saw more heightened operational pressures throughout the month of January, with the Trust operating at OPEL Level 3 for most of the month. The Trust saw particularly high demand on UECC, with activity above expected levels even for the winter months, with acuity of patients also being high. Attendances for January were 16% above activity levels for the same month last year, with subsequent admissions 8% over last year's levels.

The Trust's 4 hour performance access standard was not met for the month due to the significant pressures that were experienced, in month performance was 55.38%. Despite the continued focus on ambulance handover, the heightened operational pressures have caused an increase in ambulance handover delays. This has resulted in the Trust not achieving the daily average hours lost from ambulance handovers, which for the month of January was 24.4 against a target of 10.8.

From now until the end of March 2024, a command-and-control system has been put in place in order to improve 4-hour performance and focus on achieving 76% during March 2024. Tactical and Strategic meetings have been arranged daily from now until the end of March 2024 in order to support delivering timely care to our patients. This has included more senior presence at flow meetings, clear actions around criteria to reside, golden patients, clear escalation for delays in care for patients, additional support at weekends and continued focus on length of stay. Increased support form PLACE has also been agreed with a weekly gold meeting with all senior leaders chaired by the PLACE director.

There have been thirty patients who waited longer than 12 hours from the decision to admit for a bed reported in January 2024. All of these have been investigated and were a result of the operational demand, flow and restrictions due to increased seasonal infections. These were all recorded as incidents and reviewed accordingly with no moderate or severe harm reported.

This month the Trust did not achieve the trajectory for the number of patients with no right to reside – with 94 patients against a trajectory of 62. This reflects the pressures on discharge pathways across the wider system.

With regards to Virtual Ward the Trust did not achieve target. The occupancy was 67 against a target of 80. This was due high levels of sickness in January, coupled with annual leave and vacancies. The Community teams continue to work on how they can support virtual ward utilising resources from other community teams.

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 further impacted by the recent periods of industrial action with further industrial action planned.

The Trust achieved the revised elective trajectory for the month of January, for the number of patients waiting over 65 weeks, with the number of patients waiting at the end of January 2024 being 95 against a target of 106. The Divisions are focusing on ensuring that patients waiting over 65 weeks are seen before the end of March 2024, with significant focus taking place on ensuring all patients have dates for surgery. Current specialities that have some remaining risk with achieving this are ophthalmology (as described below) general surgery and orthopaedics.

There are six patients waiting over 78 weeks for Corneal graft of which two patients have tissue allocated and confirmed dates with Sheffield Teaching Hospitals. The Trust continues to receive support from Sheffield Teaching Hospitals for patients requiring this procedure as tissue becomes available, however, challenges with obtaining tissue remain on a national level.

The Trust achieved its Cancer 62-day target with 59 patients over 62 days against a trajectory of 64 patients.

3.0 Junior Doctors - Industrial action

The Trust experienced a period of Industrial Action on the 03 to 09 January 2024. There is further Industrial Action due to take place on the 24 to 29 February 2024. Significant planning and preparation took place prior to all periods of industrial action to mitigate the impact to patient care as much as possible. During the industrial action, command and control was in place with twice daily tactical and strategic meetings taking place. Colleagues have supported each other during heightened pressures and worked together to ensure that colleagues and patients were supported and seen in a timely manner.

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.

The industrial action has had an impact on elective and non-elective care with outpatient appointments and planned theatre lists being stood down to support emergency pathways.

4.0 Mexborough Elective Orthopaedic Centre of Excellence (MEOC)

The Mexborough Elective Orthopaedic Centre of Excellence (MEOC) is a collaboration between Doncaster and Bassetlaw Teaching Hospitals (DBTH), Barnsley Hospital NHS Foundation Trust (BH) and The Rotherham Hospital Foundation Trust (TRFT), to provide a dedicated orthopaedic hub offering additional services for the people of South Yorkshire.

Patients on orthopaedic waiting lists at all the three hospital trusts can have their surgery at the MEOC. The procedures available at the MEOC include hip and knee replacement alongside foot, ankle, hand, wrist, and shoulder surgery. This service is an additional facility, with applicable patients to be offered their preference of receiving care and treatment at their nearest hospital or the specialised service at the MEOC.

The service is now operational, with the first patient admitted for surgery to the MEOC centre on the 15 January 2024. The Trust is liaising with our patients regarding those who can be treated at MEOC. Appropriate governance arrangements are in place to ensure the transfer of the patients to the MEOC site. The establishment of the centre

will support in reducing waiting times within orthopaedics as it provides additional capacity for patients that have transferred to MEOC.

5.0 Emergency Preparedness Resilience and Response (EPRR)

The EPRR team chair a task and finish group to prepare the Trust for the termination of the Public Services Telecommunications Network (PSTN) in December 2025 with all communications moving to digital platforms. Core group members include colleagues from Health Informatics and Estates. At its January meeting, the group reviewed the risk and have begun to develop a programme of work to ensure proportionate mitigations are in place. Representatives from all Divisions have been invited to the next meeting in March when discussions will focus on capturing specific details impacting the delivery of services.

A workshop for colleagues joining the senior manager on site and senior manager on call rotas was delivered. The workshop provides updates on roles and responsibilities, record keeping and decision making, escalations and where to access relevant information. Following the workshop, colleagues then identify a buddy and shadow others performing the role in preparation for their first on call duty.

The EPRR team supported Trust preparations in readiness for an outbreak of Measles.

Work has continued on the EPRR improvement plan to support compliance with the core standards.

Incidents

In preparation for a yellow warning of snow, the team coordinated the planning to ensure the Trust was prepared to delivery its critical services during any period of disruption. The forecast subsequently changed however the Trust was adequately prepared and it was evident a workshop delivered in December to review preparedness had been successful.

During periods of challenging operational pressures, the team have supported the command and control arrangements, including supporting each meeting and ensuring provision of a loggist.

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%	89%	93%		

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	77	76	89	95		

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	46	94		

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	54	59		

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	12.0	24.4		

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%	65%	65%	70%	70%
Actual	55.0%	60.0%	58.0%	63.8%	56.5%	61.4%	58.3%	62.8%	58.7%	55.38%		

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%	76%	73%					

Data reported a few months behind following national submission. (National data not updated since Oct 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	53	67		

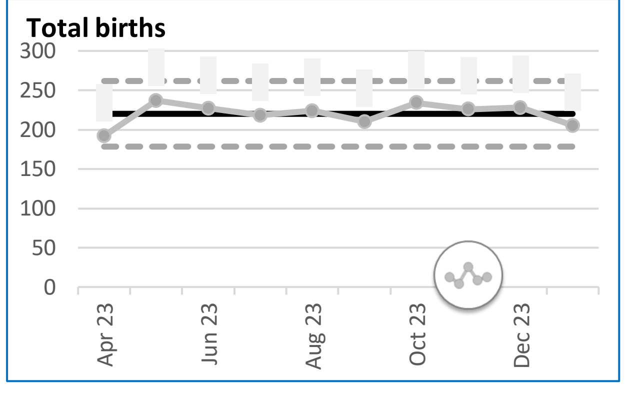
Number of patients on the Virtual Ward as at the last day of the month.

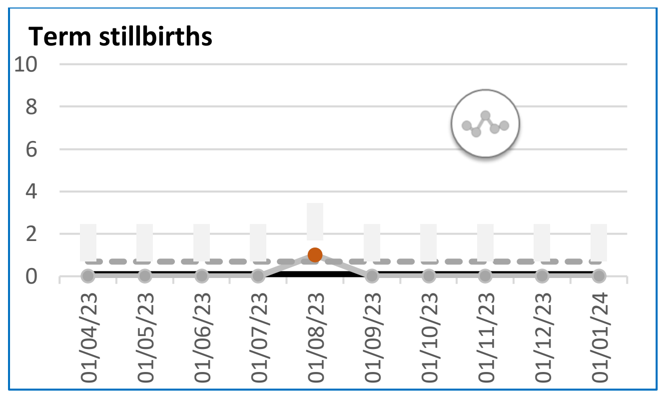
Board of Directors' Meeting
8 March 2024

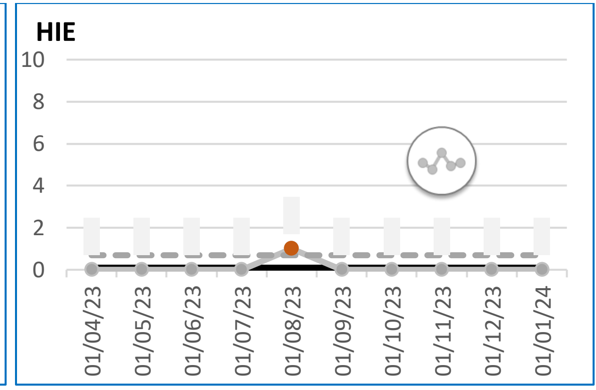
Agenda item	P45/24
Report	**Maternity and Neonatal Safety**
Executive Lead	Helen Dobson, Chief Nurse
Link with the BAF	P1: There is a risk that we will not embed quality care within the 5-year plan because of lack of resource, capacity and capability leading to poor clinical outcomes and patient experience 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 Perinatal oversight maternity dashboard data is represented below in the Safety Statistical Process Control charts (SPC). There are no themes to highlight. • The perinatal mortality data is shared in comparison to the national MBRRACE data demonstrating that TRFT have significantly reduced the total perinatal death rate and stillbirth rates in line with the national ambition. • The perinatal summary for January 2024 is highlighted, the current total adjusted perinatal rate for January is 2.73/1000 and for stillbirths the rate is 1.95/1000. The Perinatal mortality (PMRT) real time data is shared and learning from the January PMRT review. • The Maternity and Neonatal safety investigation (MNSI) is shared and the report from a recent case has been shared with no safety recommendations. • An update on the Three Year Delivery Plan is shared sharing the most recent CQC Maternity survey results for TRFT. The Maternity service has received positive feedback achieving results that are better than most Trusts in 8 areas. • Multidisciplinary training data is shared and the 90% CNST target has been achieved for all staff groups. • 16 incidents were graded as moderate in January 2024. The demographic data is shared for the moderate incidents. • An overview of the current Quality improvement projects is shared. Including Saving Babies Lives version3. • The Avoidable Admission to the Neonatal (ATAIN) data is reported at 5.4% for January 2024.

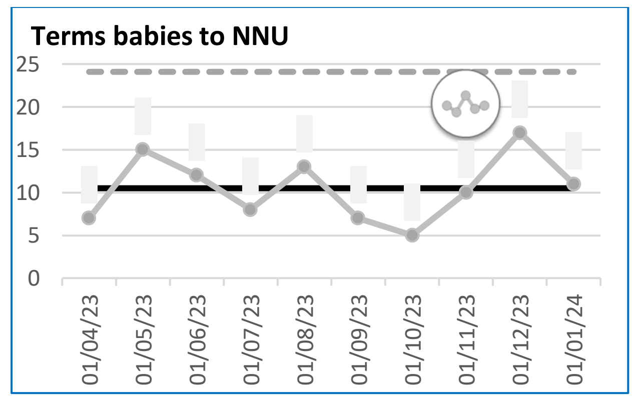
Due Diligence	This paper has been prepared by the Head of Midwifery and shared through Maternity and Family Health Divisional Business and Governance, the Maternity and Neonatal Safety Champions and Quality Committee
Board powers to make this decision	The Trust Board are required to have oversight on 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	Appendix 1 - PMRT report for 2023 Appendix 2 - Birthrate+ acuity report for January 2024

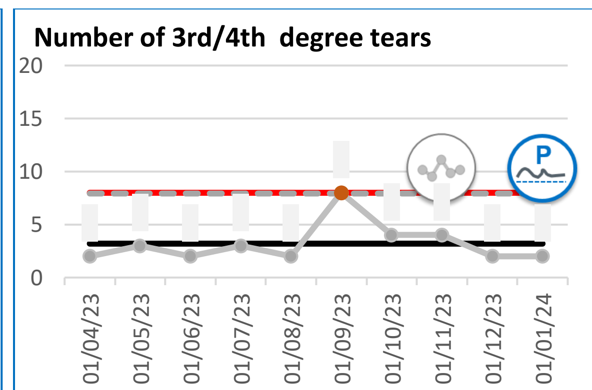
Maternity Safety Statistical Process Control charts (SPC)

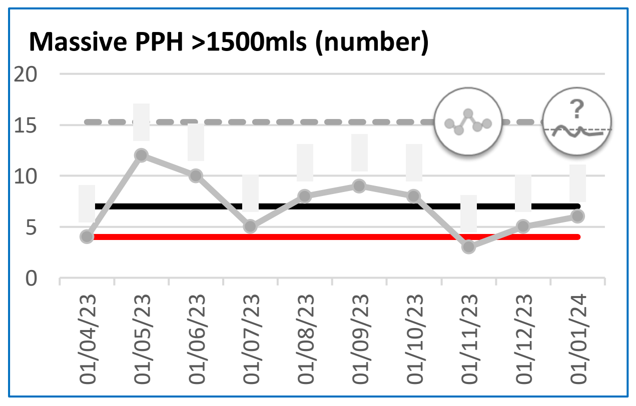


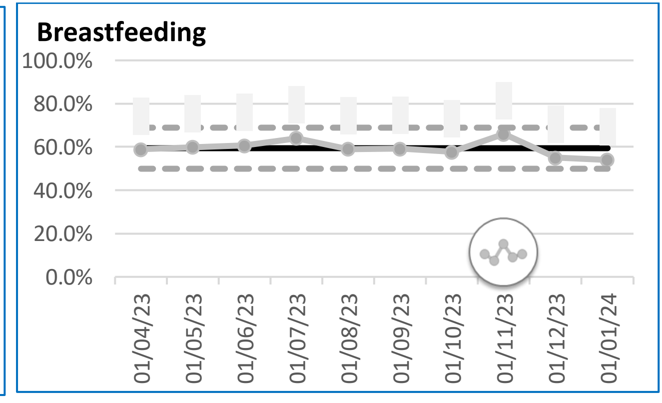












(Tables 2.1)

TRFT Maternity Dashboard: General

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Smoking at booking %	Dec 23	7.4%	-			11.4%	6.1%	16.7%
Smoking at birth %	Dec 23	11.6%	-			11.5%	6.7%	16.3%
Number of bookings	Jan 24	284	-			248	180	316
Booking < 13 weeks	Jan 24	88.7%	90.0%			89.8%	84.1%	95.5%
Booking < 10 weeks	Jan 24	69.7%	90.0%			71.9%	62.2%	81.5%
Personalised Care Plan	Jan 24	94.4%	95.0%			97.6%	95.1%	100.2%
Total Induction rate	Dec 23	36.0%	32.8%			33.2%	24.5%	41.9%
Augmentation IOL	Jan 24	39	-			43	20	67
Augmentation 1st Stage	Jan 24	11	-			13	-2	29
Augmentation 2nd stage	Jan 24	2	-			3	-2	8
Shoulder dystocia	Jan 24	4	2			2	-4	9
Massive PPH >1500mls (number)	Jan 24	6	4			7	-1	15
Massive PPH >1500mls (%)	Jan 24	3.0%	2.0%			3.2%	-0.6%	6.9%
Number of 3rd/4th degree tears	Jan 24	2	8			3	-2	8
3rd/4th degree tears in normal birth	Jan 24	1	-			2	-2	7
3rd/4th degree tears in normal birth (%)	Jan 24	0.9%	-			1.7%	-2.2%	5.6%
3rd/4th degree tears assisted birth	Jan 24	1	-			1	-3	5
3rd/4th degree tears assisted birth (%)	Jan 24	4.5%	-			5.6%	-15.9%	27.2%
Number of eclamptic fits	Jan 24	0	-			0	0	0
Pressure ulcers	Jan 24	0	-			0	-1	1
Optimal Cord Clamping	Dec 23	90.0%	-			89.1%	81.7%	96.6%
APGARS 0-6 @ 1 minute	Jan 24	2	-			11	-4	26
APGARS 7-10 @ 1 minute	Jan 24	203	-			209	170	247
Skin to skin	Jan 24	83.4%	80.0%			81.0%	70.3%	91.8%
Breastfeeding	Dec 23	55.0%	-			60.0%	49.7%	70.4%

DATA MEASURES – REVISED PERINATAL QUALITY SURVEILLANCE TOOL

Trust:

CQC Maternity Ratings	**Overall**	**Safe**	**Effective**	**Caring**	**Well-Led**	**Responsive**
	Select Rating: Good	Select Rating: Good	Select Rating: Good	Select Rating: Good	Select Rating: Good	Select Rating: Good

Maternity Safety Support Programme	Select	No

	2024											
	Jan	**Feb**	**March**	**April**	**May**	**June**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
1.Findings of review of all perinatal deaths using the real time data monitoring tool	No immediate learning identified at the January 2024 perinatal Meeting. Cases to be closed still.											
2. Findings of review of all cases eligible for referral to HSIB	1 case in progress. Draft report received with no safety recommendations											
Report on: 2a. The number of incidents logged graded as moderate or above and what actions are being taken	16 recorded as moderate harm. Following MDT review 0 remained moderate harm											
2b. Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training	All staff groups are over the required 90% compliance range. See point 7.0 in report.											
2c. Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively	See point 12 within this report for a full break down.											
3.Service User Voice Feedback	NHS CQC Maternity Survey 2024 Result, see point 5.1 within this report.											
4.Staff feedback from frontline champion and walk-abouts	Walk-about and meeting											

	feedback, see point 13 within this report.												
5.HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	Nil												
6.Coroner Reg 28 made directly to Trust	0												
7.Progress in achievement of CNST 10	Achieved												

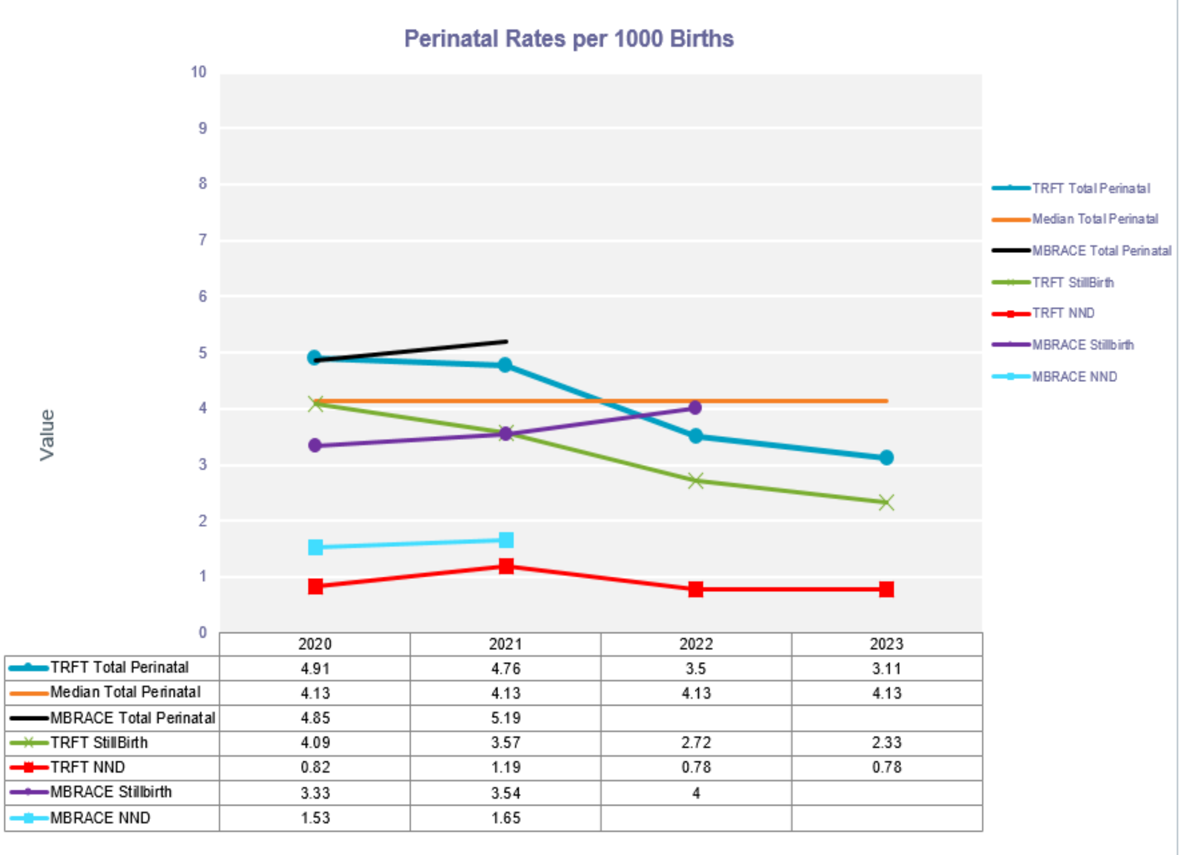
8.Proportion of midwives responding with 'Agree' or 'Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (Reported annually)	2023 results 77%
9.Proportion of speciality trainees in Obstetrics & Gynaecology responding with 'excellent' or 'good' on how they would rate the quality of clinical supervision out of hours (Reported annually)	2023 results 91%

1. Report Overview

1.1 This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety, as outlined in the NHSEI document '*Implementing a revised perinatal quality surveillance model'* (December 2020). The purpose of the report is to inform Trust Board of present or emerging safety concerns or activity to ensure safety with a two-way reflection of 'ward to board' insight across the multi-disciplinary, multi-professional maternity and Neonatal services team. The information within the report reflects actions in line with the Three Year Delivery Plan for Maternity and Neonatal services. The report will also provide monthly updates to the Local Maternity and Neonatal System (LMNS) via the clinical quality group.

2. Perinatal Mortality Rate

2.1 The Statistical Process Control charts (SPC) (Table 2.1 above), demonstrate how Rotherham Foundation Trust is performing against the ambition to half the rates of perinatal mortality from 2010 to 2025. Nationally, there is more to do to achieve this target and all maternity services are currently working towards the full implementation of Saving Babies Lives Care Bundle Version 3 by March 2024 (NHSE, 2023). Table 2.2 represents the current total perinatal mortality rate for The Rotherham Foundation Trust (TRFT). It can be noted from the tables that there has been a significant reduction in the Trusts total perinatal death rates since 2020. MBRRACE data is only available up until 2021.



	2020	2021	2022	2023
TRFT Total Perinatal	4.91	4.76	3.5	3.11
Median Total Perinatal	4.13	4.13	4.13	4.13
MBRACE Total Perinatal	4.85	5.19		
TRFT StillBirth	4.09	3.57	2.72	2.33
TRFT NND	0.82	1.19	0.78	0.78
MBRACE Stillbirth	3.33	3.54	4	
MBRACE NND	1.53	1.65		

Table 2.2 Total perinatal deaths

2.2 A sample of quality improvement work which has taken place since 2020 to reduce the number of stillbirths includes the following initiatives;

- Full implementation of Saving Babies Lives Version 2. Currently working towards full implementation of version 3 of the revised safety bundle, currently at 71% compliance with an anticipated 100% compliance by March 2024.
- Full compliance with all 10 CNST safety standards for MIS, (Maternity Incentive Scheme) in years 2022/23 and more recently 2023/24.
- Robust reviews are undertaken using external peer support to review all stillbirths and neonatal deaths that meet the PMRT criteria. Parents experience also informs the learning and to make positive service changes.
- TRFT Charities have supported the Maternity service to implement the use of the Mama Academy wellbeing wallets from 2021 (see picture 2.1 below). The wallets provide secure protection for handheld records and scan documents, with useful safety netting advice when to call the Maternity unit, including concerns regarding reduced fetal movements, pain and feeling unwell. A further order of the wallets has been placed to cover18 months of bookings. We are currently exploring funding support for the wallets in the top five languages for TRFT.

Picture 2.1

2.3 Work to reduce the number of stillbirths and neonatal deaths due to abnormalities has taken the form of consanguinity clinics across the region to support families to make informed choices and offer genetic counselling. TRFT have links into the STH clinics to refer where required.

3. Perinatal Mortality Summary for month of January 2024

3.1 Two women chose to have a termination of pregnancy due to fetal abnormalities in January 2024 at TRFT. Both cases were below 22 weeks gestation, neither case met the PMRT threshold of review due to the mode being a terminations of pregnancy. Table 3.1 reports perinatal data from January 2024 in comparison to the last two years data as a rolling tracker.

	2022 Total:	2023 Total:		In Month: Jan 2024
Total Stillbirths (All)	7	6		-
Stillbirths >37 weeks	1	1		-
Stillbirths 24 - 36+6 weeks	6	5		-
Intrapartum Stillbirths	1	-		-
Medical Termination of Pregnancy (MTOP) Anomaly >24 weeks	0	2		-
Adjusted Stillbirths	7	6		-
Total Neo-Natal Deaths (NND)	8	4		-
Early Neonatal Deaths >24 weeks up to 7 days of life	7	2		-
Late Neonatal Deaths 7-28 days	1	1		-
Adjusted Neonatal Deaths – All gestation (EXCL MTOP)	2	2		-
Total Adjusted Perinatal (24 wk – 28 days)	9	8		-
MTOP Early Neonatal Death	1	-		-
Stillbirth Elsewhere	0	-		-
Neo-Natal Deaths Elsewhere (outside of TRFT)	2	2		-
Maternal Deaths	0	1		-
None Viable Fetus <24 weeks	12	10		2
Number of PMRT's entered	12	10		-
Number of PMRT's Closed	14	10		-

Table 3.1

3.2 The rolling figure of stillbirths and neonatal deaths from February 2023 to January 2024 are as follows;

Perinatal mortality All deaths (including congenital anomalies) Total perinatal **3.89/1000 births**		
Type of death	Number	Rate per 1000 births
Stillbirth	6 (incl MTOP)	2.34
Neonatal death	4	1.56

Adjusted Perinatal Mortality (excludes deaths due to congenital anomalies and MTOP) Adjusted Total Perinatal **2.73/1000 births**		
Type of death	Number	Rate per 1000 births
Stillbirth	5	1.95
Neonatal Death	2	0.78

4. PMRT real time data monitoring tool

4.1 The full PMRT report for 2023 can be viewed in appendix 1. In January, there were no new PMRT cases closed. A summary of the findings for the year 2023 are below.

Stillbirths and late fetal losses				
Number of stillbirths and late fetal losses reported	Not supported for Review	Reviews in progress	Reviews completed ***	Grading of care: number of stillbirths and late fetal losses with issues with care likely to have made a difference to the outcome for the baby
11	3	3	5	0

Neonatal and post-neonatal deaths				
Number of neonatal and post-neonatal deaths reported	Not supported for Review	Reviews in progress	Reviews completed ***	Grading of care: number of neonatal and post-neonatal deaths with issues with care likely to have made a difference to the outcome for the baby
4	0	2	2	0

4.2 Other summary findings of note were;

- All pregnancies identified as being intrauterine growth restricted (IUGR) in this period were managed appropriately prenatally.
- Parental perspective of care were sought and considered in the review process in 100% of cases.

The full report will be scrutinised further in the next Safety Champion's meeting.

5. Learning from PMRT reviews

5.1 Following the last 12 months review, issues identified have included one woman who was not booked for maternity care prior to attending the unit and being diagnosed with an intrauterine death and a further case which could have had more detailed discussions around post-mortem options. However, the panel felt that neither of the learning points would have made a difference to the outcomes of the cases.

6. **Maternity and Newborn Safety Investigation (MNSI)** formally known as Healthcare Safety Investigation Branch (HSIB) **and Maternity Serious Incidents (SI's)**

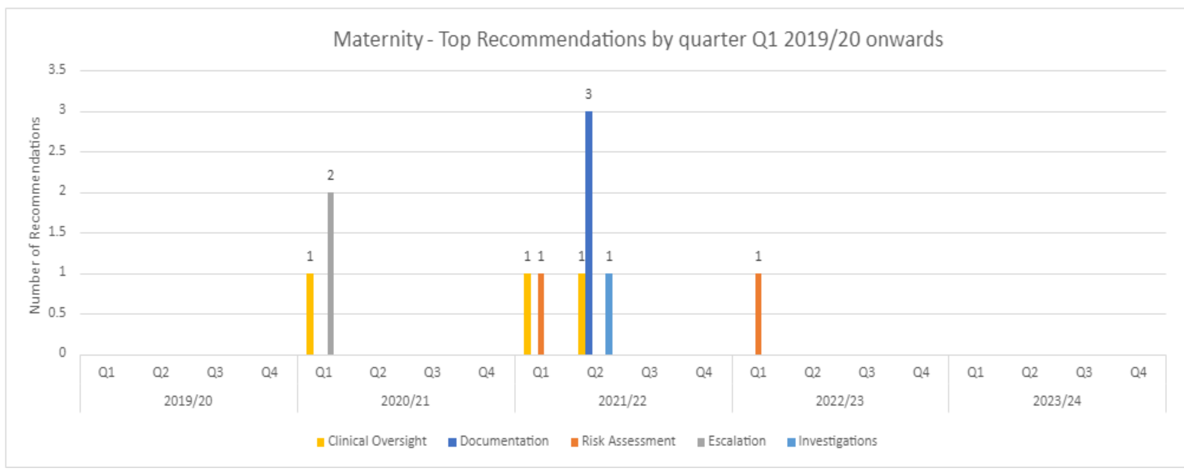
6.1 Since the commencement of HSIB maternity investigations in 2018, TRFT have report 20 cases for external review. Of the 20 cases, 8 were rejected, leaving 12 cases progressing to a full external investigation. 11 cases have been completed to date with one nearing completion within the next month.

6.2 In Table 6.1 a breakdown of all cases that have been finalised can been see, along with any safety recommendations suggested by HSIB/MNSI.

Case No		Category	Date completed	Comments
1901	319	HIE/Cooling	22/12/2019	2 safety recommendations
1902	430	HIE/Cooling	13/03/2020	No safety recommendations
1903	555	Maternal Death	03/02/2020	No safety recommendations
1909	1185	HIE/Cooling	30/06/2020	2 safety recommendations
1912	1509	HIE/Cooling	18/08/2020	4 safety recommendations
2007	2295	HIE/Cooling	18/01/2021	No safety recommendations
2009	2470	Neonatal Death	01/04/2021	3 safety recommendations
2101	2893	HIE/Cooling	20/07/2021	6 safety recommendation
MI-003385		HIE/Cooling	18/10/2021	No safety recommendations
MI-003662		Neonatal Death	22/11/2021	No safety recommendations
MI-005238		Stillbirth	24/05/2022	1 safety recommendation

Table 6.1

6.3 Of the recommendations from completed report, Table 3.2 shows the type of recommendations made to TRFT. All action plans following recommendations are completed and have been approved through governance processes. Following review of the draft report for our most recent investigation, no safety recommendations have been suggested.



7. MNSI and Current Patient Safety Investigation progress update (Table 7.1)

Ref	MNSI Reference	Confirmed level of investigation	Date confirmed Investigation	Incident overview
2023/16751	N/A	PSII	04/09/2023	Missed third degree tear following instrumental birth
156735	MI-028038	MNSI investigation	21/06/2023	Baby born in poor condition following difficult caesarean birth. Seizures noted at one day of age.

(Table 7.1)

8. Coroner Reg 28 made directly to Trust

8.1 TRFT Maternity have no Coroner Regulation 28 orders.

9. Maternity Patient Safety Investigations and After Action Reviews

9.1 During the month of January there was no maternity patient safety investigations declared, however, one case of a 28 week gestation, neonatal death which occurred on Christmas day 2023 has been declared as a patient safety investigation for our paediatric colleagues. Maternity services are currently working in collaboration with the paediatric governance team to produce this report and support the family at this time. This case has been referred to the Coroner and the Local Maternity and Neonatal (LMNS) Midwifery Advocate.

9.2 After Action Reviews which have taken place in the month of January 2024 include a group review of an indirect maternal death as a result of suicide. Whilst some incidental learning has been found around channels of communication, the woman's overall care was found to have been good with all relevant agencies being involved. Nothing was identified that would have changed the outcome for this case. An action plan will follow.

10. Midwifery Continuity of Care (MCOC)

10.1 Background**:** Work continues to collect demographic and outcome data, linking this to deprivation scores. By collecting this information, enhanced continuity of Midwifery can be designed around the woman who have the most need and who will benefit from this enhanced pathway of care. Prior to commencing an enhance midwifery service for our most vulnerable service users, staffing levels are required to be optimum to give resilience to the project. See section 12.0 for safe staffing information.

10.2 Other initiatives within TRFT Maternity is the implementation of the 3 Year Delivery Plan. This has 4 themes with a number of objectives which have been developed by women for women who use maternity services. This plan sets out how the NHS will make maternity and neonatal care safer, more personalised, and more equitable for women, babies, and families. See 5.0 for a summary of current implementation.

10.3 Progress to Date: The following table outlines the current percentage of women who have antenatal care plans recorded by 29 weeks, with MCoC pathway indicator and record of teams providing care.

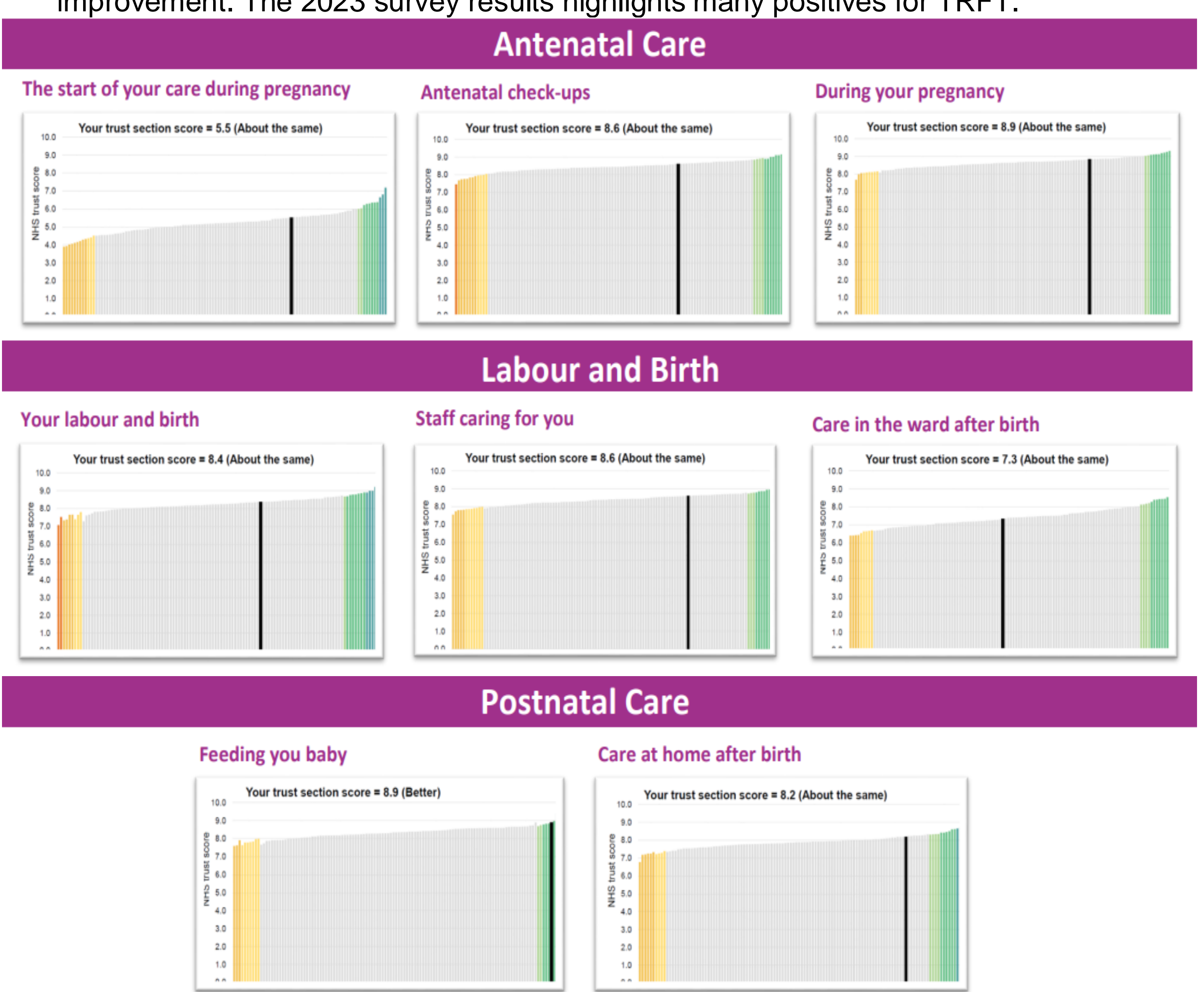
Continuity of Care	November 2023
i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks and also have the CoC pathway indicator completed	MCoC i Indicator: COC_DQ04; Numerator: 190; Denominator: 190; Rate: 100.0; Result: Passed
ii. Over 5% of women recorded as being placed on a CoC pathway where both Care Professional ID and Team ID have also been provided.	MCoC ii Indicator: COC_DQ05; Numerator: 0; Denominator: 0; Rate: 0.0; Result: Passed

11. Three year delivery plan for maternity and neonatal services

Below is a high level summary of the work either achieved or ongoing within TRFT services to meet all four themes of the 2023, NHS Three year delivery plan for maternity and neonatal services.

11.1 Listening to women

- CNST Standard 8 has been implemented for the MDT with a focus on delivering personalised care.
- Understanding and learning from the Picker CQC Maternity impatient survey – a co-produced action plan will be developed with the Rotherham MNVP for any areas requiring improvement. The 2023 survey results highlights many positives for TRFT.



11.2 Developing our workforce

- Pastoral support packages for early career midwives has been surveyed with positive results. 100% of the 2023 recruits have been retained within the workforce.
- The Rotherham equality and equity action plan is aligned with the LMNS equality plan and includes increasing the diversity of the workforce not only ethnically but from a neurodiversity view point.
- All Band 7 Labour Ward Co-ordinators are undertaking a module to support their leadership needs whilst undertaking their clinical role.
- Entrustability for junior doctors takes place to support medical staff to work safely when out of hours until fully signed off and competent when working on labour ward.

11.3 Developing a safety Culture

- The Divisional Leadership Team have attended Perinatal Quadrumvirate Culture and Leadership Development Programme.
- The Matron for Acute Maternity services has undertaken Elizabeth Garrett Anderson Programme in Healthcare Leadership focus on Compassionate Leadership remedying

Incivility.

- Dashboard data, reported to Board, confirms LWCO Supernumerary Status and 1:1 Care in Labour provision.
- SCORE survey has been undertaken and will be fed back to all staff members.
- Safety Champion walk rounds, staff concerns heard by Board member.
- Compliant with Standard 8 CNST Training Together.

11.4 Developing standard structures for safe, equitable and effective care

- Working with MNVP to update PCP to make more user friendly and meet the needs of our women.
- Deprivation scores now used in multiple governance reporting streams to inform and focus future service delivery and development.
- Saving Babies Lives v3 compliant to 71% with an Action Plan to reach 100% for March 2024.
- CNST Compliant for all 10 Standards.
- External Peers for PMRT, Patient Safety Investigations and Off-Pathway Births.
- MDTs to support women's choices for homebirth.

12. Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training

12.1 Full compliance for the required 90% has now been achieved in all required MDT training for CNST standard 8. Below is a breakdown of each staff group.

	Obstetric Consultants	Obstetric Registrars (ST3-7)	Obstetric Trainees (ST1-2)	Midwives (All bands)	NHSP Midwives	Clinical Support staff	Anaesthetists
PROMT	92%	100%	100%	97%	100%	92%	97%
Core Competency Day (Modules 1/4/5/6)	92%	100%	100%	97%	100%	94%	N/A
Fetal Monitoring	92%	93%	93%	95%	N/A	N/A	N/A
Newborn life support Ob's and Maternity	92%	100%	100%	98%	100%	94%	N/A
Newborn life support Paeds and nurses.	Paediatric consultants 91%	N/A	N/A	Neonatal Nurses 97.5%	N/A	N/A	N/A

12.2 The three year local training plan which has had input from Rotherham MNVP and had been informed by incidents and learning from governance work-streams has been signed off by the quadrumvirate and by the Trust Board is currently in progress.

13. Safety Champions meetings

13.1 Current Maternity and Neonatal Safety Champion meeting terms of reference is under review but will continue to monitor the quality and safety agenda's both nationally, regionally and locally. The overriding function of the meeting will be to triangulate any themes and trends from data and also escalate any safety issues identified to the nominated Safety Champion Board member. This will be expressed via intelligence gathered from monthly data captured, service user feedback and/or with the bi-monthly 'walk rounds' in clinical areas with clinical staff. Below is an overview of last month's meeting which was a visit to the Wharncliffe antenatal/postnatal ward.

13.2 January Safety Champion Walk Around**.** During the visit to the Wharncliffe ward by the Maternity and Neonatal Safety Champions, 8 members of staff were present on the area, this staff group was made up of 4 Midwives (one of which was working on the Antenatal Day Unit), 2 Health Care Workers, 1 Infant Feeding Support Staff and 1 ward Clark. Staff reported no concerns at this time. Staff felt that at this visit they were happy and supported to undertake their work safely in this area.

13.3 Metrics that require attention**.** No safety Metrics were discussed at the January Walk around but metrics for discussion at the February Safety Champions meeting have been tabled and include; final CNST training compliance rates, national MBRRACE report findings, the 2023 Picker CQC Maternity results, Staff Survey results, SCORE Culture survey.

14. Concerns raised by service users

14.1 MNVP service user feedback is to be discussed at the next formal Safety Champions meeting in February 2024. However, our service user attended the walk around.

14.2 Additional safety champion's intelligence; See above for tabled discussions planned for February's formal Safety Champion Meetings.

15. Culture/SCORE survey findings

15.1 The Score survey results are to be explained to the Quadrumvirate over the coming weeks. Following this, the findings will be shared with the wider teams and any actions will be developed and shared via the Safety Champions meetings and within this report next month.

16. Saving Babies Lives V3

16.1 A Saving Babies Lives Version 3 implementation tool has been made available to help maternity services to track and evidence improvement and compliance with the requirements set out in Version Three. TRFT have used this tool to evidence the current compliance rate of 71% to the LMNS and Trust Board. An action plan has been developed with clear actions to achieve the 100% compliance required by March 2024. Challenges to achieving 100% compliance by March 2024 include;.

- Preterm birth rate to be below the national target of 6%. TRFT Q1 was 6.5% and Q2 was 7.43%.
- All pre-term optimisation interventions to have been implemented prior to a pre-term birth.

17. NHS Resolution Maternity Incentive Scheme (MIS) update in month

17.1 TRFT's current position as of the end of January 2024 is that all 10 MIS safety standards have been met. The remaining MDT training has taken place in January and part of February 2024 to achieve the shift from the 80%, to over 90% compliance for Safety Standard 8. Sign off from TRFT's Chief Executive and the Accountable Officer from the ICB has also taken place with the final document being given to NHSR who have acknowledges receipt of.

18. The number of incidents logged graded as moderate or above and what actions are being taken

18.1 Demonstrated within the below tables are the number of women who suffered a moderate harm in the month of January 2024. Table 11.1 shows that in January there were 16 incidents that were recorded as a moderate harm and the categories. All cases have been examined at the Maternity Weekly Datix meeting by a senior MDT. Following review all 16 were downgraded as care was found to have be appropriate. Regardless of the outcomes from the MDT reviews, deprivation scores have been collected for this group (Table 11.2) and show that for January, the worst

outcomes were sustained by the women who live in the poorest areas of Rotherham. In Table 11.3, the cumulative data collected since October 2023, this same theme of high deprivation and an increased level of harm can be identified.

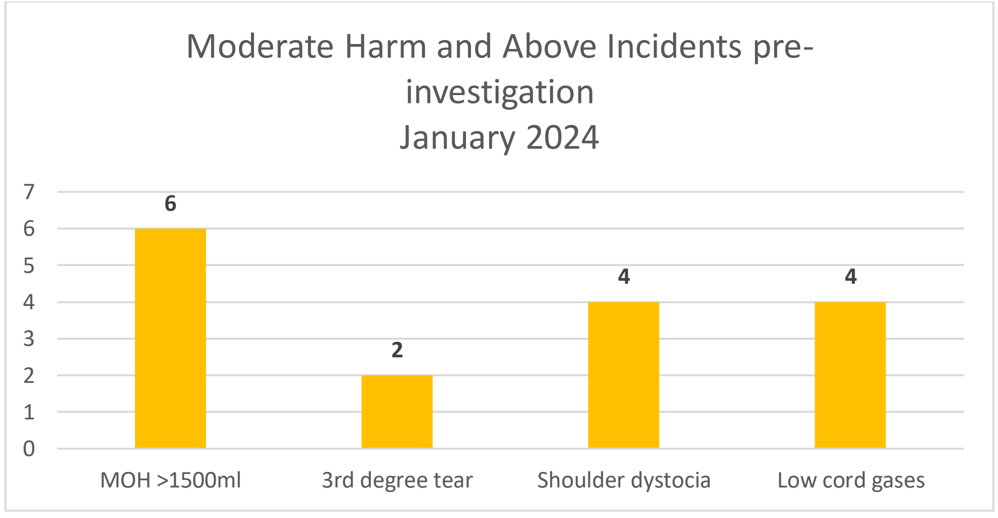


Table 11.1

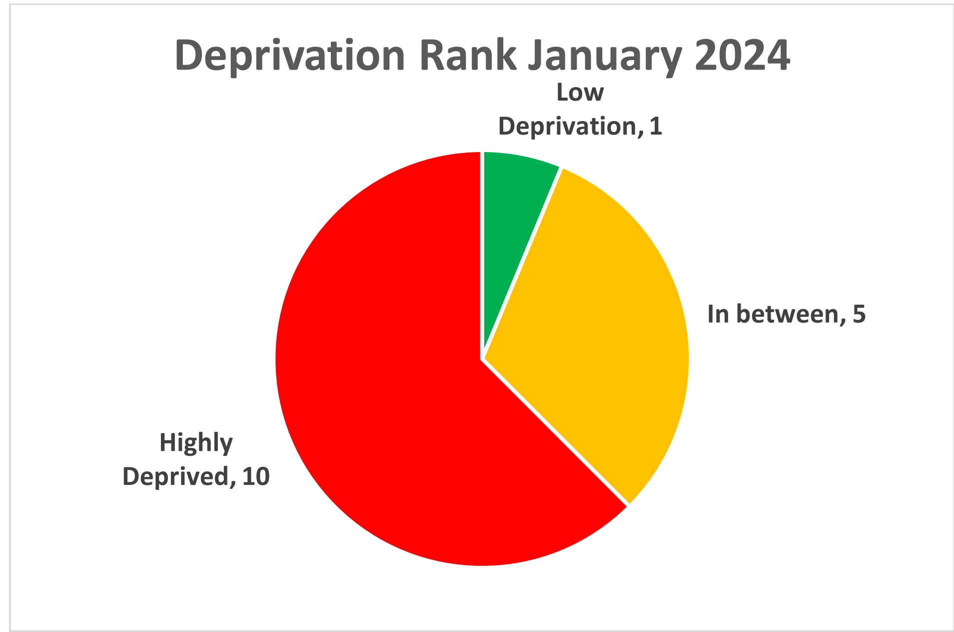


Table 11.2

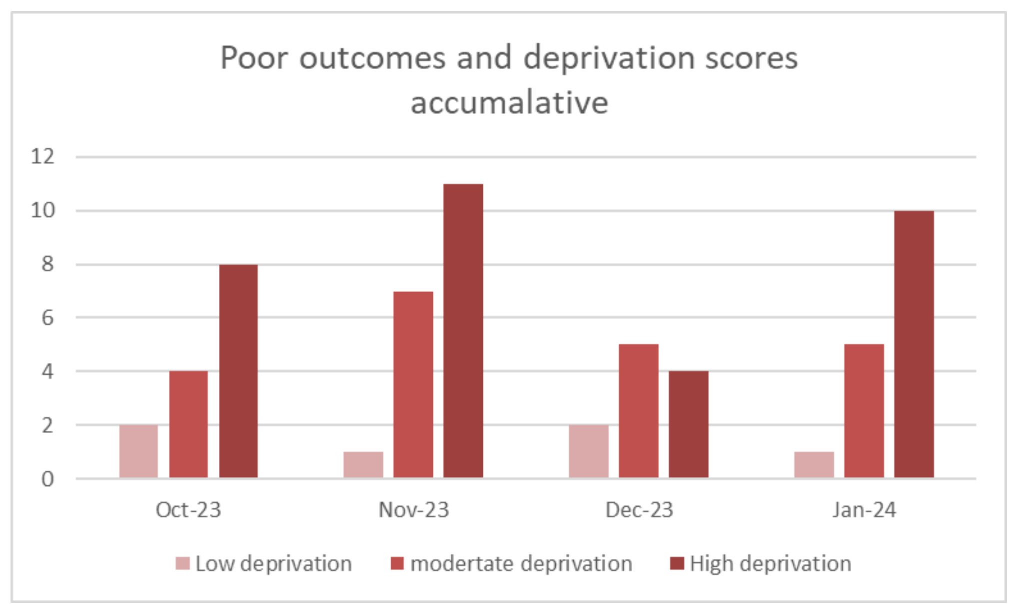


Table 11.3

19. Safe Maternity Staffing

19.1 Organisational requirements for safe midwifery staffing for maternity settings (NICE 2017) states that midwifery staffing establishments develop procedures to ensure that a systematic process is used to set the midwifery staffing establishment to maintain continuity of maternity services and to provide safe care at all times to women and babies in all settings. maternity and midwifery staffing is reported separately to the Family Health Division and Trust Board biannually to meet the requirements for the maternity incentive scheme. Below is the monthly position of midwifery and maternity staffing.

20. Midwifery Staffing

	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	-7.95	-7.61	-7.61	-7.61
Maternity leave	1.23	2.03	3.99	4.95	5.59	6.59	6.59	6.59	6.59	7.23	6.80	6.64
Long term sickness	4.12	5.12	4.88	4.88	5.99	2.07	1.07	3.63	5.59	1.60	1.60	0.64
Upcoming Leavers	0.20	0.00	0.60	1.76	0.00	1.64	0.00	0.00	0.00	3.01	3.01	3.01
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**	**12.47**	**13.04**	**15.33**	**13.62**	**4.06**	**4.12**	**5.83**	**5.83**	**5.40**	**4.28**
New Starters (reducing gaps)	-2.40	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-0.96	-0.96	-1.92
New Starters - students/NQM's	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Trajectory - for planning	**7.28**	**9.19**	**12.47**	**13.04**	**15.33**	**13.62**	**4.06**	**4.12**	**5.83**	**4.87**	**4.44**	**2.36**
% Workforce Gaps	**7.4%**	**9.3%**	**12.7%**	**13.3%**	**15.6%**	**13.8%**	**4.1%**	**4.2%**	**5.9%**	**4.9%**	**4.5%**	**2.4%**

Table 12.1

20.1 The current position for midwifery workforce and gap can be seen in Table 12.1 and shows that there has been a slight reduction since last month to 4.9%. The funded establishment remains over recruited to in order to support the gaps made up from maternity leave, long term sickness and upcoming leavers.

20.2 Appendix 2 shows the acuity data for labour ward for January 2024 and demonstrates that midwifery staffing met acuity 88% of the time, with 12% showing that the unit was short by up to 2 Midwives, actions taken to reduce the acuity gaps included, lead midwives and specialist midwives being re-deployed to assist and maintain safety and one to one care for the mothers in labour.

20.3 Table 12.2 below represents January's workforce data. Sickness rates have remained very similar to last month with both long and short term sickness below that of the Trust average for both long and short term sickness.

Maternity unit closures		Datix / Birth-rate Plus®
Utilisation of on call midwife to staff labour ward (Night Duty)	1	Birth-rate Plus® data/ Datix
1-1 care in labour	100%	Data from Birth-rate Plus® acuity tool / Maternity Dashboard
Redeploy staff internally	2	Birth rate plus Acuity (Occasions)
Redeploy staff from Community	1	Birth rate plus Acuity (Occasions)
Matron Working Clinically	0	Birth rate plus Acuity
Delay in Induction of Labour	9	Birth rate plus Data and Datix
Supernumerary labour ward co-ordinator	100%	Data from Birth-rate Plus® acuity tool/Maternity Dashboard/Datix
Staff absence 1	4.7%	January 24 data, 2.35% short term 2.35% long term
Obstetric compliance at mandatory consultant escalation	100%	No Datix incidents reported
Compliance with twice daily face to face ward round	100%	Datix

21. Obstetric staffing

21.1 The following outlines Obstetric cover on the delivery suite and gaps in the rota.

Grade	No of Shifts	Reason	Internal / External
ST1/2	27	3 x Sickness 10 x Reduced Duties 12 x Strike 2 x Vacancy	20 x internal 7 x external
ST3/7	17	1 x Vacancy 7 x Strike 3 x Entrustability 6 x Reduced Duties	13 x Internal 5 x external
CONSULTANT	49	5x Vacancy 14 x Annual/Study Leave 11 x Additional clinics 4 x Entrustability 15x reduced Duties	49 x Internal

22. Insights from service users and Maternity Voices Partnership Co-production

22.1 An MNVP meeting took place on the 9th of January with service users present and partners from local authority. Topics for discussion included;

- The new e-consent system and how the MNVPs will review current risks described on the system.
- Progress on the Picker Maternity survey action plan, including the progress made with the induction of labour workshops.
- How to use a thematic approach to the feedback that has been gained from service users by the MNVP. A spreadsheet will be used with categories of areas of concern and or praise to ensure resources to improve are used more precisely and in line with the PSIRF methodology.
- A 15 steps took place on the Wharncliffe Ward – overall positive feedback with the environment being warm and friendly. Some learning identified e.g. information on posters mostly in English.

23. Quality Improvement projects / progress

23.1 Below is a summary of quality improvement projects that are currently being undertaken within maternity service. Most have been registered on AMAT with others to be registered soon by the leads.

- Reducing smoking in pregnancy (SBLV3, Element 1)
- Increasing surveillance of small babies in the antenatal period (SBLV3 Element 2)
- Improving surveillance and awareness of reduced fetal movements (SBLV3 Element 3)
- Effective fetal monitoring (SBLV3 Element 4)
- Reducing pre-term births (SBLV3 Element 5)
- Improving the management of pre-existing diabetes (SBLV3 Element 6)
- Labour ward elective caesarean section improvement project and theatre optimisation project.

24. Implementation of the A EQUIP model

24.1 The Professional Midwifery Advocate (PMA) team are responsible for implementing and deploying the A-EQUIP model (Advocating for Education and Quality Improvement) which supports a continuous improvement process that aims to build personal and professional resilience, enhance quality of care and support preparedness for appraisal and professional revalidation. Our PMAs have supported colleagues following the neonatal death over the Christmas period, this support has evaluated well and was much appreciated by those colleagues involved. PMA activity for the month is detailed below in Table 15.1.

January 2024	
Number of PMAs (headcount)	10
Restorative Supervision Sessions held	3
Career Conversations held	1
Improvement Projects supported by PMA	3

Table 15.1

25. Avoidable Admission into the Neonatal Unit (ATAIN)

25.1 The National Ambition

In August 2017 NHSI mandated a Patient safety alert to all NHS Trusts providing maternity care. The safety alert was issued to reduce harm from avoidable admissions to neonatal units for babies born at or after 37 weeks. This fell in line with the Secretary of State for Health's ambition

to reduce stillbirth, neonatal brain injury and neonatal death by 50% by 2030. The national ambition for term admissions is below 6%, however TRFT strives to be as low as possible.

This ambition is also aligned with the vision created within Better Births (2016), which aims to drive forward the NHS England-led Maternity Transformation Programme, with a key focus on:

- Reducing harm through learning from serious incidents and litigation claims
- Improving culture, team work and improvement capability within maternity units.

25.2 Why is it important?

There is overwhelming evidence that separation of mother and baby so soon after birth interrupts the normal bonding process, which can have a profound and lasting effect on maternal mental health, breastfeeding, long-term morbidity for mother and child. This makes preventing separation, except for compelling medical reason, an essential practice in maternity services and an ethical responsibility for healthcare professionals.

25.3 The number of term babies admitted to the Neonatal Unit (NNU) in January 2024 was 11. This as a percentage of all live births is 5.4% (local ambition is below 5%, national ambition is below 6%). Weekly multidisciplinary reviews of all term admissions to NNU are undertaken using a LMNS standardised approach. There were no avoidable admissions in January 2024. The ATAIN figures for Q3 were submitted to the LMNS this month together with the action plan agreed by both maternity and neonatal leads for all avoidable admissions identified in this period (see below).

26. Unanticipated Term Admissions to NNU as a Percentage of All Live Births (Table 16.1)

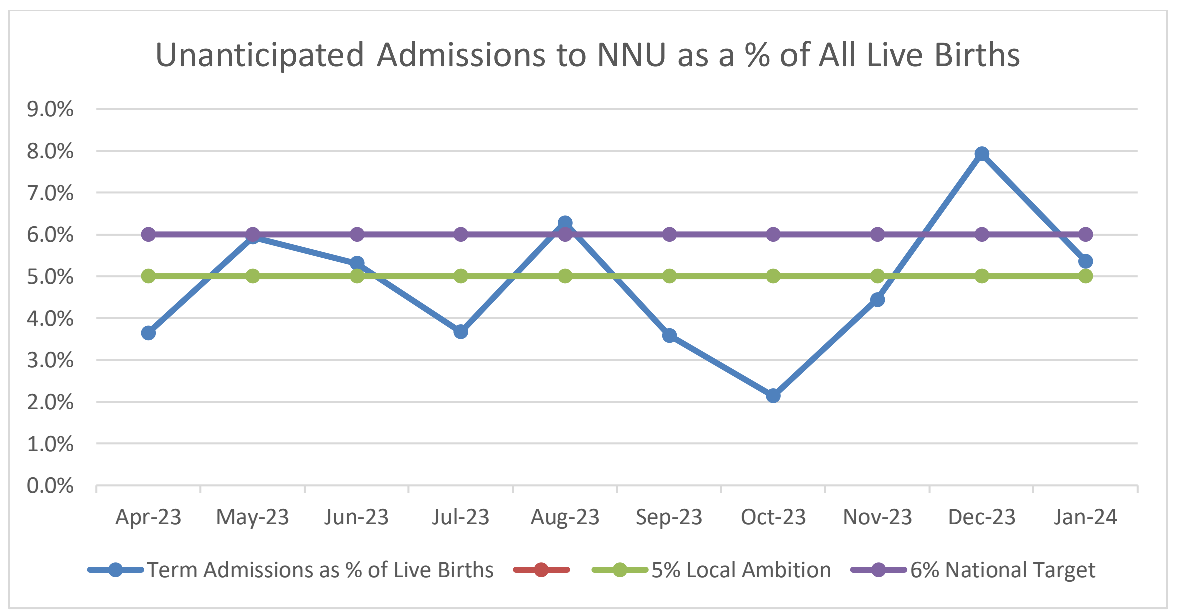


Table 16.1

26.1 Action Plan

In order to have continual quality improvement and a record of learning from all reviews of term admissions, a rolling action plan for Avoidable Term Admissions to NNU is ongoing. This is shared not only internally but also with the LMNS. This body of work ensures that we remain compliant for CNST Safety Action 3.

ATAIN Action Plan 2023-2024

Action Plan: **ATAIN**	**Date Commenced:** **April 2023**		**Action Plan Lead:** **Verity Gough – Matron for Maternity Acute**	**Action Plan Review Dates: Monthly**
Objective	Comments	Action Required	Who will take the action?	What timescale has been set and agreed?
May 2023 Admitted from Wharncliffe to SCBU at 11 hours old due to lethargy, low respiration rate and low saturations.	• 3020g, 24th centile, term • Vaginal birth • PROM observations • 11 hours old, temp on WHC 36.4°C, wrapped and re-checked in 1 hour = 36.4°C • Baby lethargic, respirations 36, SATS 92% • Paed review – decision to admit to SCBU • Temp on admission = 36.9°C, BGL = 3.6mmols	• Add to Learning Points to consider skin-to-skin or heated mattress when baby has low temperature and other risk factors such as PROM	Lead Midwives WHC & LW	Learning from ATAIN - LP May 2023.msg
November 2023 Admitted from UECC with vomiting.	• Born at Jessop Wing in Sheffield • Brought to UECC vomiting • Baby sent straight to SCBU by UECC without confirmation of best place to review / admit baby	• Share with colleagues in UECC the importance of speaking with the Family Health team before sending babies to SCBU	Lead Nurse SCBU	Learning from ATAIN - BK Nov 2023.msg

Table 16.2

27. Staff Survey

Annually	Report on: Proportion of midwives responding with 'Agree' or 'Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (Reported annually)
Update: 2023 survey results The most available data is for "*I would recommend my organisation as a place to work*" – 77% (Trust average 63%) This is an increase from the 2022 staff survey results which were 59%) "*I would recommend my organisation for care/treatment* "-. 78% (Trust average 58%) This is an increase from 66% from the 2022 result.	

Annually	Report on: Proportion of speciality trainees in Obstetrics & Gynaecology responding with 'excellent' or 'good' on how they would rate the quality of clinical supervision out of hours (Reported annually)
Update: 91.67% of trainees surveyed felt that the support they received out of hours was good or excellent.	

28. Red Risks/Risk register highlights

28.1 The highest risk currently on the Obstetric dashboard is the use of poor quality plastic wallets

ID	Title	Risk level (current)	Review date	Approval status
6873	Risk of losing patient paper medical records due to the introduction of plastic wallets and the removal of stronger card folders	Extreme Risk 16	24/02/2024	Approved Risk

29. Recommendation

29.1 The Quality Committee/Board of Directors are asked to receive and discuss the content of the report. They are also asked to record in the Trust Board minutes as requested to provide evidence for the maternity incentive scheme. It is recommended that the Quality Committee are assured by the progress and compliance demonstrated in paper to date with the Maternity Safety Work streams.

PMRT - Perinatal Mortality Reviews Summary Report

This report has been generated following mortality reviews which were carried out using the national Perinatal Mortality Review Tool

The Rotherham NHS Foundation Trust

Report of perinatal mortality reviews completed for deaths which occurred in the period:

1/1/2023 to 30/12/2023

Summary of perinatal deaths*

Total perinatal* deaths reported to the MBRRACE-UK perinatal mortality surveillance in this period: *12*

Summary of reviews**

Stillbirths and late fetal losses				
Number of stillbirths and late fetal losses reported	**Not supported for Review**	**Reviews in progress**	**Reviews completed *** **	**Grading of care: number of stillbirths and late fetal losses with issues with care likely to have made a difference to the outcome for the baby**
11	3	3	5	0

Neonatal and post-neonatal deaths				
Number of neonatal and post-neonatal deaths reported	**Not supported for Review**	**Reviews in progress**	**Reviews completed *** **	**Grading of care: number of neonatal and post-neonatal deaths with issues with care likely to have made a difference to the outcome for the baby**
4	0	2	2	0

*Late fetal losses, stillbirths and neonatal deaths (does not include post-neonatal deaths which are not eligible for MBRRACE-UK surveillance) – these are the total deaths reported and may not be all deaths which occurred in the reporting period if notification to MBRRACE-UK is delayed. Deaths following termination of pregnancy are excluded.

** Post-neonatal deaths can also be reviewed using the PMRT

*** Reviews completed and have report published

Table 1: Summary information for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 7)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
Late Fetal Losses (<24 weeks)	0	2	--	--	--	--	2
Stillbirths total (24+ weeks)	0	0	1	1	1	0	3
Antepartum stillbirths	*0*	*2*	*1*	*1*	*1*	*0*	*5*
Intrapartum stillbirths	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Timing of stillbirth unknown	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Early neonatal deaths (1-7 days)*	0	1	0	0	0	0	1
Late neonatal deaths (8-28 days)*	0	0	0	0	0	1	1
Post-neonatal deaths (29 days +)*	0	0	0	0	0	0	0
Total deaths reviewed	0	3	1	1	1	1	7
Small for gestational age at birth:							
IUGR identified prenatally and management was appropriate	0	0	0	0	1	1	2
IUGR identified prenatally but not managed appropriately	0	0	0	0	0	0	0
IUGR not identified prenatally	0	0	0	0	0	0	0
Not Applicable	0	3	1	1	0	0	5
Mother gave birth in a setting appropriate to her and/or her baby's clinical needs:							
Yes	0	3	1	1	1	1	7
No	0	0	0	0	0	0	0
Missing	0	0	0	0	0	0	0
Parental perspective of care sought and considered in the review process:							
Yes	0	3	1	1	1	1	7
No	0	0	0	0	0	0	0
Missing	0	0	0	0	0	0	0
Booked for care in-house	0	1	0	0	0	0	1
Mother transferred before birth	0	0	0	0	0	0	0
Baby transferred after birth	0	0	0	0	0	1	1
Neonatal palliative care planned prenatally	0	1	0	0	0	1	2
Neonatal care re-orientated	0	0	0	0	0	0	0

*Neonatal deaths are defined as the death within the first 28 days of birth of a baby born alive at any gestational age; early neonatal deaths are those where death occurs when the baby is 1-7 days old and late neonatal death are those where the baby dies on days 8-28 after birth. Post-neonatal deaths are those deaths occurring from 28 days up to one year after birth

Table 2: Placental histology and post-mortems conducted for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 7)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
Late fetal losses and stillbirths							
Placental histology carried out							
Yes	0	2	1	1	1	0	5
No	0	0	0	0	0	0	0
Hospital post-mortem offered	0	2	1	1	1	0	5
Hospital post-mortem declined	0	2	1	1	1	0	5
Hospital post-mortem carried out:							
Full post-mortem	0	0	0	0	0	0	0
Limited and targeted post-mortem	0	0	0	0	0	0	0
Minimally invasive post-mortem	0	0	0	0	0	0	0
External review	0	0	0	0	0	0	0
Virtual post-mortem using CT/MR	0	0	0	0	0	0	0
Neonatal and post-neonatal deaths:							
Placental histology carried out							
Yes	0	1	0	0	0	0	1
No	0	0	0	0	0	1	1
Death discussed with the coroner/procurator fiscal	0	1	0	0	0	1	2
Coroner/procurator fiscal PM performed	0	0	0	0	0	0	0
Hospital post-mortem offered	0	1	0	0	0	1	2
Hospital post-mortem declined	0	1	0	0	0	1	2
Hospital post-mortem carried out:							
Full post-mortem	0	0	0	0	0	0	0
Limited and targeted post-mortem	0	0	0	0	0	0	0
Minimally invasive PMpost-mortem	0	0	0	0	0	0	0
External review	0	0	0	0	0	0	0
Virtual post-mortem using CT/MR	0	0	0	0	0	0	0
All deaths:							
Post-mortem performed by paediatric/perinatal pathologist*							
Yes	0	0	0	0	0	0	0
No	0	0	0	0	0	0	0
Placental histology carried out by paediatric/perinatal pathologist*:							
Yes	0	2	1	1	1	0	5
No	0	0	0	0	0	0	0

*Includes coronial/procurator fiscal post-mortems

Table 3: Number of participants involved in the reviews of late fetal losses and stillbirths without resuscitation (N = 5)

Role	Total Review sessions	Reviews with at least one
Chair	8	100% (5)
Vice Chair	0	0%
Admin/Clerical	3	40% (2)
Bereavement Team	16	100% (5)
Community Midwife	17	100% (5)
External	4	20% (1)
Management Team	25	100% (5)
Midwife	47	100% (5)
Neonatal Nurse	9	80% (4)
Neonatologist	46	100% (5)
Obstetrician	50	100% (5)
Other	13	100% (5)
Risk Manager or Governance Team	17	100% (5)
Safety Champion	0	0%

Table 4: Number of participants involved in the reviews of stillbirths with resuscitation and neonatal deaths (N = 2)

Role	Total Review sessions	Reviews with at least one
Chair	2	100% (2)
Vice Chair	2	50% (1)
Admin/Clerical	3	100% (2)
Bereavement Team	7	100% (2)
Community Midwife	4	100% (2)
External	7	100% (2)
Management Team	7	100% (2)
Midwife	19	100% (2)
Neonatal Nurse	7	100% (2)
Neonatologist	23	100% (2)
Obstetrician	19	100% (2)
Other	8	100% (2)
Risk Manager or Governance Team	10	100% (2)
Safety Champion	0	0%

Table 5: Grading of care relating to the babies who died in this period and for whom a review of care has been completed – number of babies (N = 7)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
STILLBIRTHS & LATE FETAL LOSSES							
Grading of care of the mother and baby up to the point that the baby was confirmed as having died:							
A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died	0	2	1	1	1	0	5
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the mother following confirmation of the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby	0	2	1	1	1	0	5
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
NEONATAL AND POST-NEONATAL DEATHS							
Grading of care of the mother and baby up to the point of birth of the baby:							
A - The review group concluded that there were no issues with care identified up the point that the baby was born	0	1	0	0	0	1	2
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the baby from birth up to the death of the baby:							
A - The review group concluded that there were no issues with care identified from birth up the point that the baby died	0	1	0	0	0	1	2
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the mother following the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following the death of her baby	0	1	0	0	0	1	2
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0

Table 6: Cause of death of the babies who died in this period and for whom a review of care has been completed – number of babies (N = 7)

Timing of death	Cause of death
Late fetal losses	**2 causes of death out of 2 reviews**
	Known Cystic Hygroma
	Unknown Cause Declined Post Mortem Severe hydrops noted on USS
Stillbirths	**3 causes of death out of 3 reviews**
	placental abruption
	not identified
	Placental abruption
Neonatal deaths	**2 causes of death out of 2 reviews**
	1a - 3-Phosphoglycerate dehydrogenase deficiency 1b-microlissencephaly
	Extreme prematurity Preterm Pre labour rupture of membranes
Post-neonatal deaths	**0 causes of death out of 0 reviews**

Table 7:Issues raised by the reviews identified as relevant to the deaths reviewed, by the number of deaths affected by each issue* and the actions planned

Issues raised which were identified as relevant to the deaths	Number of deaths	Actions planned

*Note - depending upon the circumstances in individual cases the same issue can be raised as relevant to the deaths reviewed and also not relevant to the deaths reviewed.

Table 8: Issues raised by the reviews which are of concern but not directly relevant to the deaths reviewed, by the number of deaths in which this issue was identified* and the actions planned

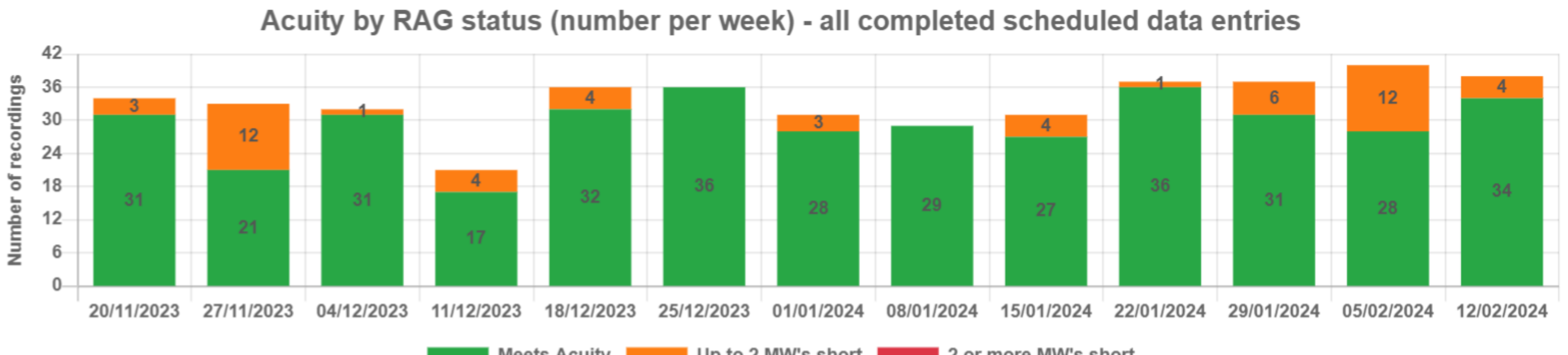
Issues raised which were identified as not relevant to the deaths	Number of deaths	Actions planned
It is not possible to assess from the notes whether the opportunity for a post-mortem was discussed with the parents prior to their baby's death as part of the end of life care	1	No action entered
The opportunity to discuss post mortem with the parents prior to their baby's death as part of end of life care was not taken	1	No action entered
This mother was unbooked at delivery. Are there any organisational issues to consider in relation to her not booking?	1	No action entered

*Note - depending upon the circumstances in individual cases the same issue can be raised as relevant to the deaths reviewed and also not relevant to the deaths reviewed.

Table 9: Top 5 contributory factors related to issues identified as relevant to the deaths reviewed, by the frequency of the contributory factor and the issues to which the contributory factors related

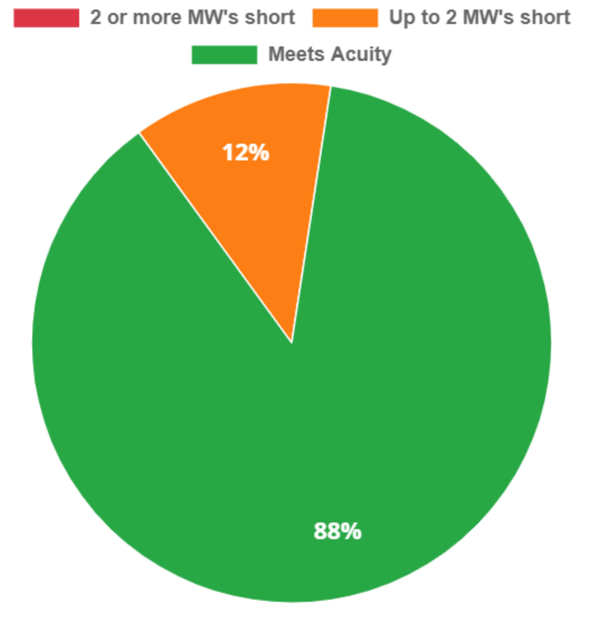
Issue Factor	Number of deaths	Issues raised for which these were the contributory factors

Rotherham NHS Foundation Trust - Delivery Suite



Overall compliance during the data period for weeks commencing 20/11/2023

Completed scheduled data entry	79.7%
Missed scheduled data entries	20.3%



Board of Directors' Meeting
8 March 2024

Agenda item	P46/24
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)	A Safe Staffing and Establishment paper for Nursing and Midwifery was presented to the Board of Directors in January 2024.The Board was asked to confirm that they were assured by the data collection process and to support the recommendation from the Chief Nurse to agree to maintain current establishments at existing levels. There was a request to re-present at March Board of Directors meeting with additional information on how data is collected and reported. Data has been collected using nationally agreed, validated Safer Nursing Care Tools (SNCT) and the methodology meets all national requirements. It should be noted that this is a mandated process designed to ascertain if the current establishment levels are safe for the funded bed base. It is not designed to be an assessment of Care Hours per Patient Day and the impact of additional winter beds or increased unavailability (such as through sickness) does not form part of this assessment. These latter issues are addressed through the bi-monthly Safe Staffing and Quality report to the Quality Committee.
Due Diligence (include the process the paper has gone through prior to	The Chief Nurse has reviewed the proposed establishments and supports the recommendations in the paper. The original paper was presented to People Committee in December 2023 and the Board of Directors in January 2024. The revised version has not been presented to any other committees.

presentation to the meeting)	
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	

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. Results

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 headlines by division are below:

4.4 Medicine

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

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

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

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

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. This shows a shortfall of 6.25 wte against requirements although further data collection points are required to validate this.

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

6. Analysis

6.1 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.

6.2 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.

6.3 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.

6.4 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.

6.5 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.

6.6 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.

6.7 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.

6.8 When the reviews from all divisions are combined, the Trust shows an over establishment of 16.12 wte. Taking into account the variables shown above and ongoing alterations to some divisions, it is the recommendation of the Chief Nurse and Deputy Chief Nurse that the current funded establishment remains unchanged.

7. Recommendations and Conclusion

7.1 The Board of Directors are assured of the process undertaken in the establishment review, in conjunction with the ward in line with the national recommendations.

7.2 It is the recommendation of the Chief Nurse that the current funded establishment remains unchanged.

7.3 The Board of Directors are asked to note that there remains an ongoing risk to achieving safe staffing levels linked to the opening of additional beds and unavailability of greater than 21% linked to issues such as sickness, maternity leave and study leave. This is being actively managed and plans are enacted daily to ensure safety and this is monitored bi-monthly through Quality Committee. Increasing the funded establishment would mitigate this risk but this is not felt to be appropriate and management of the root causes of short falls is a more sustainable solution.

Board of Directors’ Meeting
8 March 2024

Agenda item	P47/24
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 January 2024 (Month 10 2023/24): o A summary of the key performance metrics linked to income and expenditure, capital expenditure and cash management. • Section 2 – Income & Expenditure Account for January 2024 (Month 10 2023/24):

	o Financial results to January 2024. - An in-month deficit to plan and against the control total of £390K, and a year to date deficit to plan of £2,244K and £1,579K against the control total. The difference is £665K relating to a technical accounting change, being implemented across the NHS, in respect of accounting for Private Finance Initiatives (PFI). The Trust's Carbon Energy Scheme liability is accounted for as a PFI. - The Trust's performance is measured against its control total with NHS England having adjusted for depreciation on donated and right of use assets, and PFI transitional costs (£1,289K year to date). • Section 3 – Income and Expenditure Account Forecast Out-Turn o An initial forecast out-turn up to 31st March 2024 of £4,054K deficit to plan and £3,389K deficit to the control total. o At this point the Trust will be reporting externally to the ICB and NHSE that it is forecasting to be £70K favourable against delivering its planned deficit at 31 March 2024 of £5,977K. This assumes delivery of the revised deficit of £4.7m submitted to the ICB on 22nd November and further costs of £1.2m estimated for the continuation of Industrial Actions. To achieve this position, it is assumed that income from the Elective Recovery Fund will not deteriorate, reserves will be used and the impact of further Industrial Actions will not exceed £1.2m. o Divisional performance and financial recovery plans are continuing to be monitored by Executive Directors resulting in the improved forecast position. All services are required to deliver a significant improvement against the Efficiency Programme (CIP) - both in year and full year effect - as this is pivotal to achieve delivery against the plan in 2023/24 and for financial sustainability in 2024/25. o With the continuation of industrial actions, the risk of being able to deliver this financial plan without additional funding is significant. • Section 4 – Capital Expenditure for January 2024 (Month 10 2023/24) o Expenditure for the ten month period ending January 2024 is £6,716K against a budget of £8,879K: an under-spend of £2,163K (24%) against the external plan. o 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 o A cash flow graph showing actual cash movements between April 2022 and January 2024. A month-end cash value as at 31st January 2024 of £13,243K, which is £1,927K worse 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. o The overall financial position for I&E has been reviewed collectively by and agreed with the senior Finance Team together with the Director of Finance. o CIP performance has been discussed with the Efficiency Board chaired by the Deputy Chief Executive. o The capital expenditure position has been discussed and reviewed by the Capital Monitoring Group, chaired by the Director of Finance. o More comprehensive and detailed reports of the financial results have been presented to Finance & Performance Committee and the Executive Team.
Board powers to make this decision	Within Section 4.5 of Standing Financial Instructions – Budgetary Control and Reporting – paragraph 4.5.1 states that *"The Director of Finance will devise and maintain systems of budgetary control. These will include:* *(a) Financial reports to the Board, in a form approved by Finance & Performance Committee on behalf of the Board."*
Who, What and When (What action is required, who is the lead and when should it be completed?)	• Overall financial performance was discussed at the monthly performance meetings held on 27 February 2024. • CIP performance was discussed at the Efficiency Board meeting held on 7 February 2024. • Capital expenditure was reviewed by the Capital Monitoring Group on 19 February 2024. • Detailed discussions have also taken place at the meeting of Finance & Performance Committee on 28 February 2024, 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 Plan £000s	Month Actual £000s	Month Variance £000s	YTD Plan £000s	YTD Actual £000s	YTD Variance £000s	Forecast variance £000s	Prior Month Forecast variance £000s
I&E Performance (Actual)	(375)	(765)	(390)	(5,974)	(8,218)	(2,244)	(4,054)	(4,702)
I&E Performance (Control Total)	(313)	(703)	(390)	(5,350)	(6,930)	(1,579)	(3,389)	(4,036)
Capital Expenditure	901	1,851	(950)	8,879	6,716	2,163	0	0
Cash Balance	(1,165)	(1,812)	(646)	15,170	13,243	(1,927)	(4,248)	(248)

1.2 The Trust has over-spent against its I&E plans in January, and cumulatively there remains an overspend of £2,244K year to date against the I&E performance and £1,579K against the control total, a difference of £665K. The Trust's performance is measured against its control total with NHS England, this is after adjusting for depreciation on donated and right of use assets and from Month 9 it includes the impact of accounting for Private Finance Initiatives under IFRS 16 - Leases. The impact of this, a cost pressure of £665K, is included in the I&E performance but is allowed and added back in the control total. These figures do not include an adjustment for the full amount of under performance 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 I&E plan performance of £4,054K and I&E Control Total of £3,389K, an improvement of £647K from month 9's control total due to an increase in variable and SLA income. The Trust will be reporting externally to the ICB and NHSE that it is forecasting to be £70K favourable against delivering its planned deficit at 31 March 2024 of £5,977K.

1.4 Divisional performance and financial recovery plans are continuing to be monitored by Executive Directors resulting in the improved forecast position.

1.5 Capital expenditure is ahead of plan in month and adverse year to date, with cumulative spend of £6,716k against a budget of £8,879k. Capital spend is forecast to fully deliver against plan.

1.6 The cash position at the end of January 2024 is £13,243K. This remains a strong cash balance albeit adverse to plan.

2. Income & Expenditure Account for January 2024 (Month 10 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 January 2024 of £390K and a year to date deficit to the control total plan of £1,579K.

Summary Income & Expenditure Position	Annual plan £000s	Month Plan £000s	Month Actual £000s	Month Variance £000s	YTD Plan £000s	YTD Actual £000s	YTD Variance £000s	2023/2024 Monthly Trend / Variance
Clinical Income	324,971	27,333	26,750	(582)	271,002	267,244	(3,758)	
Other Operating Income	25,263	2,174	2,747	573	21,279	22,930	1,651	
Pay	(239,002)	(20,328)	(21,045)	(717)	(199,721)	(204,188)	(4,467)	
Non Pay	(97,887)	(8,313)	(8,836)	(523)	(83,529)	(87,546)	(4,017)	
Non Operating Costs	(3,969)	(331)	(308)	23	(3,308)	(3,628)	(320)	
Reserves	(16,101)	(910)	(73)	837	(11,697)	(3,030)	8,667	
Retained Surplus/(Deficit)	**(6,726)**	**(375)**	**(765)**	**(390)**	**(5,974)**	**(8,218)**	**(2,244)**	
Adjustments	748	62	62	(0)	624	1,289	665	
Control Total Surplus/(Deficit)	**(5,977)**	**(313)**	**(703)**	**(390)**	**(5,350)**	**(6,930)**	**(1,579)**	

2.2 Clinical Income is behind plan in-month and year to date due to under performance on elective recovery activity which is offset by over performance on other categories of clinical income. ERF divisional targets are included in budgets, with £4m of the £5.7m underperformance 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 (£419K), which will be an offset to the pay over-spend, increased research, development and education income (£409K), other non-clinical income (£543K) and clinical services SLA (£326K).

2.4 Pay costs are under-spending in month by £717K. The year to date performance is adverse to plan by £4,467K which is being influenced by undelivered cost improvement targets of £2,504K, Industrial Action and premium rates for agency staff.

2.5 Non Pay costs are over-spending by £523K in-month and by £4,017K year to date. The main categories of overspends are on drugs £1,837K, premises £2,126K, general supplies and services £295K and under-delivery of cost improvement targets of £439K.

2.6 The adverse performance in Non Operating Costs is due to the impact of accounting for the Carbon Energy Scheme under IFRS 16, which is allowed in the control total and included in Adjustments. Interest receivable and other finance costs remain better than plan.

2.7 £8,667K 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 £3,389K 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	324,971	321,835	(3,758)	622	(3,136)	
Other Operating Income	25,263	27,197	1,651	283	1,934	
Pay	(239,002)	(244,990)	(4,467)	(1,506)	(5,973)	
Non Pay	(97,887)	(103,164)	(4,017)	(1,278)	(5,295)	
Non Operating Costs	(3,969)	(4,211)	(320)	69	(252)	
Reserves	(16,101)	(7,447)	8,667	0	8,667	
Retained Surplus/ (Deficit)	**(6,726)**	**(10,780)**	**(2,244)**	**(1,810)**	**(4,054)**	
Adjustments	748	1,414	665	(0)	665	
Control Total Surplus/ (Deficit)	**(5,977)**	**(9,367)**	**(1,579)**	**(1,810)**	**(3,389)**	

3.2 Within Clinical Income, the estimated ERF YTD under delivery against divisional targets is reflected of £5.7m. £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. Additional income is forecast from other variable activities.

3.3 Other Operating Income is forecasting increases in income from research, development, education & training (£503K), SLAs (£933K) and staff recharges (£550K). This additional income will equally be offset by further increases in pay and non-pay expenditure.

3.4 Pay is showing a significant deterioration in performance this is mostly due to undelivered annual CIP budget reductions £3,395K 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 £2,479K, undelivered CIPs £696K, and drugs and clinical supplies £909K.

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. The adverse variance is due to the accounting treatment under IFRS 16 – Leases for the Carbon Energy Scheme. This cost pressure is added back in the Adjustments to the control total.

3.7 The Trust has submitted a £70k favourable variance to plan (Control Total) to the Integrated Care Board and NHSE. This includes the revised deficit of £4.7m submitted to the ICB on 22nd November and further costs of £1.2m estimated for the continuation of Industrial Actions. This position assumes income from Elective Recovery Fund will not deteriorate further and the use of reserves will enable the Trust to deliver this position by 31st March 2024, a year end deficit of £5,907K.

3.8 Cost reduction and CIP delivery is continuing to be managed proactively across all services, with action plans being implemented. This remains a significant risk to the Trust delivering against its overall plan.

4. Capital Programme

4.1 As at January 2024 the Trust has incurred capital expenditure of £6,716K against a budget of £8,879K representing an under-spend of £2,163K (24%).

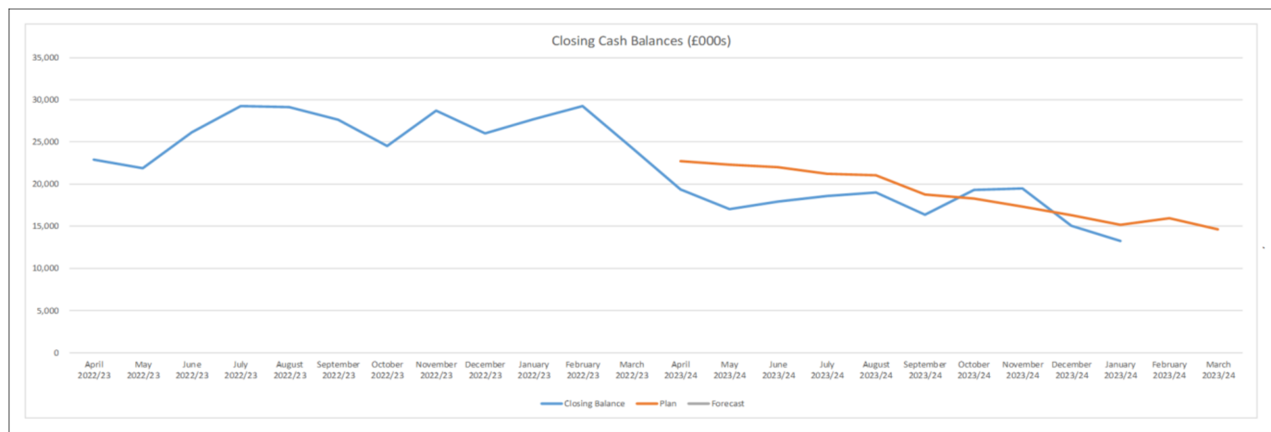
Capital Expenditure	Month			YTD			Forecast	Prior Month Forecast
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Variance £000s	Variance £000s
Estates Strategy	438	794	(356)	3,402	2,736	666	0	0
Estates Maintenance	340	207	133	1,657	1,173	484	0	0
Information Technology	100	93	7	1,740	1,328	412	0	0
Medical & Other Equipment	434	756	(323)	1,748	1,479	269	0	0
Other	(411)	0	(411)	332	0	332	0	0
TOTAL	901	1,850	(949)	8,879	6,716	2,163	**0**	**0**

4.2 Within the category of '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 £1,831K (21%)

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 £1,099K.

5. Cash Management

5.1 Compared to plan, there is an adverse variance in-month of £646K and year to date variance of £1,927K. Cash remains strong with a closing cash balance of £13,243K as at 31 January 2024.



5.2 This has allowed the Trust to earn interest on its daily cash balances of £86K in-month (£994k year to date), which has helped to contribute towards the Trust's cost improvement target for 2023/24.

Steve Hackett
Director of Finance
19 February 2024

Board of Directors' Meeting

08 March 2024

Agenda item	P48.24
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 as we move to the end of Quarter 4 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 Deputy Director of Corporate Affairs in preparation for further discussion at the Board meeting.
Due Diligence	Since presentation at the last Board in early January 2024, the relevant sections of the Board Assurance Framework has been discussed at the relevant Board Committees during January and February 2024.
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 rating for BAF Risk P1 to remain at 12; ➢ The rating for BAF Risk R2 to remain at 8; ➢ The rating for BAF Risk O3 to remain at 8; ➢ The rating for BAF Risk U4 to remain at 12; ➢ The rating for BAF Risk D5 to remain at 20; and ➢ The rating for BAF Risk D7 to remain at 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 Quarter 4 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 January and February 2024. In addition the BAF will presented at the Audit and Risk Committee on 26 April 2024.

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 January and February 2024 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 January and February 2024, 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 There was 1 additional control added to BAF Risk P1 during this review period, involving the creation of a Quality Metrics Dashboard (including outcomes from Tenderble Audits) for all ward areas onto the Power BI platform. This dashboard has been created and is in use on specific wards

Gaps in controls

2.3 There was 1 significant changes to the gaps in controls for this review period; this is linked to the new control as listed above, the dashboard is live and in use on some specific wards, however not all so this was also added as a gap; staff training is ongoing with all divisions and is to be fully live from April 2024.

2.4 Review of the risk rating

The initial rating 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 rating agreed was **4** (Likely) defined as 'will probably happen/recur but is not a persisting issue. The rating was reduced to **12** following removal of the CQC conditions. The Board will note that this is within the target rating for the first year of the 5 Year Strategy but remains out with the Boards risk appetite of Very Low pertaining to Quality (rating 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 rating 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 Deputy Director of Corporate Affairs.

3.2 There was 1 additional control added to BAF Risk R2 during this review period, involving PLACE Leadership Team meetings held every Wednesday morning, the Deputy Chief Executive attends along with other Rotherham PLACE members.

3.3 Following review, it is recommended that the rating 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 Deputy Director of Corporate Affairs. The Trust has continued to develop and strengthen the partnership working with Barnsley Hospitals NHS Foundation Trust with the continuation of the Joint Strategic Partnership which is now supported by a Board approved Memorandum of Understanding.

4.2 Following review, it is recommended that the rating 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 is discussed at each bi-monthly meeting. The key developments of note are ongoing development of the People Strategy which is currently going through a multi-committee and Trust wide consultation process. Information has been shared at the Strategic Board held in January 2024. It will be presented to the February 2024 People Committee and then the final version will be presented to the April 2024 People Committee for approval. Following this, the People Strategy will be presented to the May 2024 Board for final approval.

5.2 Following the outcome of the review at People Committee in February 2024, it is recommended that the rating 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. Following the monthly review during September and October 2023 it is recommended that the rating 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. The risk rating for D7 was increased at the December 2023 Finance & Performance Committee to **20,** this was approved at the January 2024 Board**.** Due to the continuing work around the financial plan it is recommended that the risk rating remains at **20** and will be further reviewed when we have further clarity on the system wide financial position.

Gaps in Controls

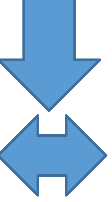
7.2 G3: Month 6 financial position year to date £1.6million adverse variance position with an adverse position of £390,000 in month. With a forecast of £3.3m variance at year end, however it is still believed a break even position can be achieved by management action and the use of reserves, as long as the costs of industrial action in December and January 2024 are met by NHSE, this has been notified externally at £1.2m.

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 rating for BAF Risk P1 to remain at 12;
  - The rating for BAF Risk R2 to remain at 8;
  - The rating for BAF Risk O3 to remain at 8;
  - Increase the rating for BAF Risk D5 to 20;
  - The rating for BAF Risk U4 to remain at 12; and
  - The rating for BAF Risk D7 to remain at 20.

Angela Wendzicha
Director of Corporate Affairs
27 February 2024



Ambition	Strategic Risk			Original Score LxC	Score Q1	Score Q2	Score Q3	Score Q4	Target Risk Score	Movement	Risk Appe tite/
	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	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**	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**	**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**	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**	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**	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)	15, 10, 5, 0 — Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar — risk score, target risk	**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 →	12 →

BAF Risk Description	Linked Risks on the Risk Register & BAF Risks:	Assurance Committee & Lead Executive Director
P1: There is a risk that we will not embed quality care within the 5 year plan because of lack of resource, capacity and capability leading to poor clinical outcomes and patient experience for our patients.	**RISK6623, RISK5761, RISK6809, RISK6800, RISK6630, RISK6762, RISK6627, RISK6886, RISK6284, RISK5238, RISK6723, RISK6958, RISK6857, RISK6801, RISK6888, RISK6718 and RISK6421**	**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)	January 2024	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	January 2024	Chief Nurse	Level 2 – Medication Safety Audit completed

		Monthly Quality Dashboard reported to Divisional Performance Meetings. Published Patient Experience Annual Report on Trust website.	January 2024	Chief Nurse					Transition to Power BI dashboard underway with fully functional for April 2024
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.	January 2024	Chief Nurse	Level 1 Progress reports on Quality Priorities presented within each quarter Quarter 2 reports all received by Quality Committee				Work has commenced to produce the draft Quality Priorities for 2024/25 with the draft to go to Quality Committee in January 2024. Final selection to go in March 2024
C4	Implementation of actions following Patient Surveys	Progress reports received by Patient Experience Committee and monitored via Quality Committee.	To go to QC February 2024	Chief Nurse	Level 1 Level 3				Recent inpatient survey results not as expected, an action plan has been developed and is in place. Maternity survey results published by CQC in Feb 24 showing positive outcome.
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 January 2024	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.				Process currently paused whilst we transition to new CQC assessment framework from February 2024
C7	Quality Improvement & Quality Governance Assurance Priority within Operational Plan	Quarterly updates to Quality Committee	January 2024	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 April 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 approved at Quality Committee and by ICB at Contract Quality Meeting It was reported at the Audit & Risk Committee that 360 Assurance had undertaken review of PSIRF implementation, report received and gave				Plan to go to Board March 24 and will be published on Trust website

					Moderate Assurance for PSIRF and the lack of an oversight group for learning actions. There was a significant opinion for patient experience work stream.
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 has been cancelled by CQC - next meeting scheduled 29/02/2024	October 2023	Chief Nurse	**Level 1**
C10	Implementation of Safeguarding Improvement plan in conjunction with NHSE	Reports to Safeguarding Committee was July 2023	To go to QC Feb24	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 with NHSE has been delayed until April 2024 due to internal capacity issues, NHS team attending Strategic Board February 2024.
C11	Creation of a Quality Metrics Dashboard (including outcome of Tenderble Audits) for all ward areas on Power BI platform.	Dashboard created and in use on specific wards.	Top go live April 2024	Chief Nurse	Level 1

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	Review next stage Business Case	Chief Nurse & Medical Director	August 2022	~~September 2022~~ June 2023	Recruitment for MD for Quality Improvement (2PA's) to be completed Revised JD for Patient Safety & QI Lead Offers made for bands 5 and 7 applicants. QI Medical Lead recruitment process underway. Appointment now made - all posts now filled
	Developing a sustainable QI faculty and projects with identifiable patient benefits alongside QI methodology.	Submission of next stage business case brief	Chief Nurse & Medical Director	March 2023	ETM 8 June 2023	
		Gained approval at June 23 ETM to proceed to full business case – approved at ETM August 2023 – recruitment to commence	Chief Nurse & Medical Director	September 2023		ETM ~~April~~ June 2023
		Recruit to x2 further roles in QI team	Chief Nurse	Recruitment process commenced		
		Trust have received notice from NHSE that QSIR provision has been outsourced to company called AQuA with cost implications, paper has been submitted to ETM to explore other options	Chief Nurse	January 2024	April 2024	ETM supported option to bring QI training in-house **All actions now completed**
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	Medical Director Medical Director		~~July 2022~~ ~~End December 2022~~ March 2024 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.

		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		End Q4 2023/24			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. Learning from Deaths Policy now fully signed off. One outstanding action from 360 - Division of Medicine now using process for SJR review at CSU level and the evidence from this will be used for 360 sign off in March 2024	
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	April 2024 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 NACEL 2024 has commenced, new Lead Nurse for End of Life now in post Paper to ETM regards restructure of team approved and End of Life will now sit Corporately - 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. 360 Assure audit on PSIRF assurance to commence Qtr3.	Medical Director and Chief Nurse Chief Nurse	April 2022 March 2024	March 2024 March 2024			Monthly group meeting established. Patient representative to be agreed. Went live with PSIRF beginning of November – Operational plan and Policy to Patient Safety, then Quality Committee October 2023 and by ICB at Contract Quality Meeting. 360audit report to Audit & Risk Committee 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. Initial planning sessions have taken place with ward managers from A1, A5, B10 and B11.	
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	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.	

	could be flagged to CQC							Position for NELA now better, however other National Audits are challenged	
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. Monitoring of all incidents for possible link to industrial action. Monitoring of cancellation of elective work leading to increased waits for treatment	Divisional Leads & FPC Director of Workforce & FPC Director of Operations & FPC Director of Workforce & FPC Chief Operating Officer & FPC Chief Nurse & QC Director of Operations & FPC	Ongoing Completed Commenced Completed June 2023 Ongoing Ongoing	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. Next round of junior doctor IA commenced over Christmas and New Year period Further industrial action confirmed for 24th to 29th February 2024.	
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				Position for NELA now better, however other National Audits are challenged	
G29	Quality Metrics Dashboard created	Training is ongoing with all divisions and to be fully live from April 2024	Chief Nurse	Apiril 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. ***Link to Operational Plan: R2: Ensure equal access to services***	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)	Chart: risk score / target risk (Apr–Mar; 0, 5, 10, 15)	Previous score Q4 2022-23: 12	Q1: 8 ↓	Q2: 8 →	Q3: 8 →	Q4: 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 PLACE reports summarized by MW and report to Trust Board every two months	~~December~~ September 2023	Board minutes	Level 1	Control remains ongoing
C2	Trust is a member of Prevention and Health Inequalities Group	Public Health Consultant also now attends 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	Ran Workshop for Commission December 2023	**July**	**Minutes**	Level 3	**Control remains ongoing**
C5	Shared Public Health Consultant between RMBC and the Trust commences March 2023	Commenced in post Public Health Consultant developing a work programme to go to Trust Board	**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	PLACE Leadership Team meeting every Wednesday morning	Deputy Chief Executive attends along with other Rotherham PLACE members	**Weekly**		Level 1	

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	TRFT attend, contribute and comment but are not members	Deputy Chief Executive	Ongoing		Awaiting final confirmation from external source.

	of the ICB once established.							TRFT has not been made a member, this is a decision made across all South Yorkshire ICB	
G2	Unknown entity around the ICB governance which is continuing to evolve and mature.		Deputy Chief Executive	Ongoing				Paper expected for the September Board No change to position	
G3	Incomplete data driven identification of Health Inequalities across elective and non-elective pathways.	Public Health Consultant: The Trust has reviewed elective waiting lists split by indices of multiple deprivation and found little variation between broad groups in terms of wait times, although further work is planned to dig deeper and to set up a regular reporting framework on waiting list inequalities more broadly.	Deputy Chief Executive		End Quarter 1			Data relating to access to services available in Trust Integrated Performance Report – suggest close this gap and archive. 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.** ***Link to Operational Plan: P3: Our Partners: Work together to succeed for our communities.***	O3	~~3(L)x4(C)=12~~ 2(L)x4(C) = 8	8	2(L)x4(C) =8	Moderate (12-15)		Previous score Q4 2022-23: 12	Q1: 8	Q2: 8	Q3: 8	Q4: 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	Reports received by the Trust Board every two months from Chief Executive Report			Level 1
C2	Shared Chief Executive and Governance function between the Trust and Barnsley NHSFT	Completed	**01 September 2022 substantive**		Level 1
C3	Existing collaboration with Barnsley on some clinical services	Gastro service up and running, Haematology service in progress, MEOC now opened.			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.		**Reports to Boards on progress**	Level 1

Gaps in Controls or Assurance Quarter 1 2022-23	Actions Required	Action Owner	Date Action Commenced	Date Action Due	Progress Update

G1	ICB becomes a legal entity on 01 July 2022	Confirmation required of emerging governance arrangements	Deputy CEO		September 2022			Paper to September Board.	Completed - to be archived
G2	Triumvirate Joint Leadership Programme	Company commissioned to deliver programme	Deputy CEO	October 2023	October 2024			Rolled out	

Board Assurance Framework People Committee: 2023/24 Quarter 4: Version 4.2

BAF Risk U4

Strategic Theme: Us	Risk Scores										
	BAF Risk Ref	Initial Score	Current Score	Target Score	Risk Appetite/Risk Tolerance	Risk Movement			Board Assurance 2023-24		
Strategic Ambition: ***Us: We will be proud to be colleagues in an inclusive, diverse and welcoming organisation that is simply a great place to work.***	U4	3(L)x4(C)=12	3(L) x 4(C) = 12	2(L)x4(C) =8	Moderate (12-15)	15 / 10 / 5 / 0; Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar; risk score; target risk	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 ⟺	12 ⟺
BAF Risk Description						**Linked Risks on the Risk Register & BAF Risks:** **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			October 2023	Board minutes	Level 2			**Completed**		
	WRES and WDES action plans submitted to Board of Directors			November 2023	Board minutes						
	Progress against action plans monitored via Operational Workforce Group and People Committee			Agreed and signed off at Nov23 Board	Reports to People Committee	Level 1			**Ongoing**		
	All Divisions attended Joint Partnership Forum to detail action plans			21 July 2022	Board minutes	Level 2			**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 to be presented at People Committee and then the March 2024 Board of Directors “We said, we did” 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. Delivery in train	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 Internal steering group now leading work. Information shared at Strategic Board January 2024, to go to February 24 People Committee and then final version to April 24 PC for sign off and then May 24 Board.	
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 Work in train, update to be presented to Feb24 PC	
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) Ongoing negotiations with JLNC regards extra contractual payments for medical and dental staff. Regular industrial action meetings to mitigate impact. Clear rates of pay established for strike cover	Divisional Leads & FPC Director of Workforce & FPC Director of Operations & FPC Director of Workforce &	Ongoing Completed Commenced Completed	 Ongoing Ongoing March 2023			Director of Corporate Affairs discussed with Director of Workforce and will further assess need for a new BAF risk relating to a sustainable workforce. 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. Completed 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 Assurance Committees has sight of the BAF Risk and has oversight of the actions to mitigate this gap once confirmed with the Divisional leads.	

			FPC						
		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.	FPC	September 2023	September 2023				
		Impact on staff as a result of industrial action. Support health & Wellbeing of staff. Increased stress leading to increased sickness/absence and burn out.	Director of People & PC	Ongoing	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 Deep dive into sickness absence taking place quarter 4	
Archived Controls within month - Completed									
Archived Gaps within month - Completed									

Strategic Theme: Delivery	Risk Scores										
	BAF Risk Ref	Initial Score	Current Score	Target Score	Risk Appetite/Risk Tolerance	Risk Movement				Board Assurance 2023-24	
Strategic Ambition: ***Delivery: We will be proud to deliver our best every day, providing high quality, timely and equitable access to care in an efficient and sustainable organisation***	D5	4(L)x3(C)=12	5(L)x~~3~~4=~~15~~20	2x3=6	Very low (1-5)	25 20 15 10 5 0 Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar risk score target risk	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	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	February 2024 IPR February 2024 IPR February 2024 IPR February 2024 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	February 2024 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	February 2024 IPR February 2024 IPR February 2024 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	**February 2024 IPR** **February 2024 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.	**February 2024 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	**February 2024 IPR** **February 2024 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	**February 2024 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	**February 2024 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. Challenges due to winter pressures and IA in proximity to Christmas and New ear period and subsequent impact on bed capacity due to high acuity, above plan on A&E attendances and admissions. Pressures are bed capacity due to high attendance and admissions.	
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	360 Assure audit to validate waiting lists underway, awaiting outcome. Validation of waiting list over 90% requirement. Awaiting formal report and verbal feedback provided	Director of Strategy, Planning and Performance	Q2	Q4			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.	
	Includes Diagnostic PTL	Weekly position to be included in performance position Information for ETM IPR and development of Diagnostic PTL	Director of Strategy, Planning and Performance	Q1	Q2			Weekly diagnostic information available, forecasting of month end position to be introduced. Weekly data provided to weekly Access meeting 1st Draft 360 Assurance report received and actions identified to be included in response.	
~~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)	Divisional Leads	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.	

		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 Workforce Director of Operations Director of Workforce Chief Operating Officer	Commenced Commenced Completed June 2023	Ongoing Ongoing March 2023			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 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 industrial action confirmed for 24th to 29th February 2024. Estimated costs equate to c£50k per day on staffing and c£100k per day on lost activity.	
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.	

Archived Controls within month – Completed									
Archived Gaps within month - Completed									

Strategic Theme: Us	Risk Scores										
	BAF Risk Ref	Initial Score	Current Score	Target Score	Risk Appetite/Risk Tolerance	Risk Movement	Board Assurance 2023-24				
							Current	Q1	Q2	Q3	Q4
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	4 ~~3 (L)~~ x 5(C) =~~15~~ 20 Increased to 20 at Dec23 FPC	1(L)x5(C) =5	Low (6-10)	Chart: risk score / target risk (Apr–Mar; scale 0–25)					
Link to Operational Plan: D7: Implement sustainable change to deliver high quality, timely and affordable care							15	15	15 ⬌	20 ⬆	20 ⬌
BAF Risk Description						**Linked Risks on the Risk Register & BAF Risks** **RISK6886, RISK6755 and RISK6801**	**Assurance Committee**				
D7: There is a risk that we will not be able to sustain services in line with national and system requirements because of a potential deficit in 2023/24 leading to further financial instability.						**Risk**	**Finance and Performance Committee** **Director of Finance**				

Controls and Mitigations *(what have we in place to assist in securing delivery of our ambition)*		Assurance Received *(what evidence have we received to support the control)*	Date Assurance Received	Confirmed By:	Assurance Level *Level 1 = Operational Level 2 = Internal Level 3 - Independent*
C1	Improvement of clinical productivity to levels experienced in 2019/20 without central funding for outsourcing clinical activities	Monthly Elective Programme Meeting chaired by Chief Operating Officer	**November 2022**		L1
C2	CIP Track and Challenge in place		**November 2022**	**ETM minutes**	L1
C3	Contingency of £1.5m in place.			**Trust Board January 2024**	L1
C4	Winter funding allocated in reserves of £2m.			**Trust Board January 2024**	L1
C5	Elective recovery fund £5.2m			**Trust Board January 2024**	L1
C6	TRFT received access to growth money allocated to PLACE.			**Trust Board January 2024**	L1
C7	Financial plan sign off to NHSE by 04/05/2023	Submitted on time, still awaiting sign off by NHSE		**Trust Board January 2024**	
C8	Service developments held in reserve of £2.5m.			**Trust Board January 2024**	
C9	Finance and Performance Committee oversee budget reports	Budget reports presented to Finance and Performance Committee	December 2022	Minutes of F&P	Level 1
C10	System wide delivery of Recovery	Director of Finance attends South Yorkshire DoF Group	December 2022		Level 1

	On plan with mitigations in place to manage winter pressures.	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.	Director of Finance	Q1	Ongoing			**Month 10 financial position year to date £1.6 million adverse variance position, with adverse position of £390,000 in month.** **With a forecast of £3.3m variance at year end, however it is still believed a break even position can be achieved by management action and the use of reserves, as long as the costs of IA in December and January are met by NHSE, this has been notified externally at £1.2m.** **November and December 23 met elective recovery fund targets, however lost £0.8m in January 24 due to Industrial Action as predicted.**	
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	Regular industrial action meetings to mitigate impact. Finance team are currently working on a cost per day figure for future forecasting.	Director of Finance.	Reports to F&P				Director of Corporate Affairs discussed with Director of Workforce and will further assess need for a new BAF risk relating to a sustainable workforce.	

	clinical shifts. Also linked to challenges around sufficient workforce to support the recovery plan (including industrial action).	Locum and Insourcing arranged Longer term plan required to recruit a sustainable workforce (link with BAF Risk U4) Ongoing negotiations with JLNC regards extra contractual payments for medical and dental staff. Regular industrial action meetings to mitigate impact. Rates of pay agreed with medical staff to provide cover for junior doctor's strike. Specific challenges in relation to anaesthetic cover to support full theatre timetable impacting on elective recovery programme. Deep dive into underlying issues being undertaken with the division.	Divisional Leads & FPC Director of Workforce & FPC Director of Operations & FPC Director of Workforce & FPC Chief Operating Officer & FPC	Ongoing Commenced Commenced Completed June 2023	Ongoing Ongoing March 2023			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 occurred over Christmas and New Year period. Further industrial action confirmed for 24th to 29th February 2024. Estimated costs equate to c£50k per day on staffing and c£100k per day on lost activity.	
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 deficit which is an adjustment of £1.26m	Board approved revised Financial Plan with 3 actions on 20/11/2023	Director of Finance	November 2023	Monthly reviews to 31/03/2024				
Archived Controls within month – Completed									

Archived Gaps within month – Completed									

Board of Directors' Meeting
08 March 2024

Agenda item	P49/24
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 the 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	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 22 approved risks, 1 is not within review date. • All risks have action plans in place, however, further development of action plans is required for 4 of the risks
Due Diligence	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	Appendix 1 Corporate Risk Register Appendix 2 Issues Register

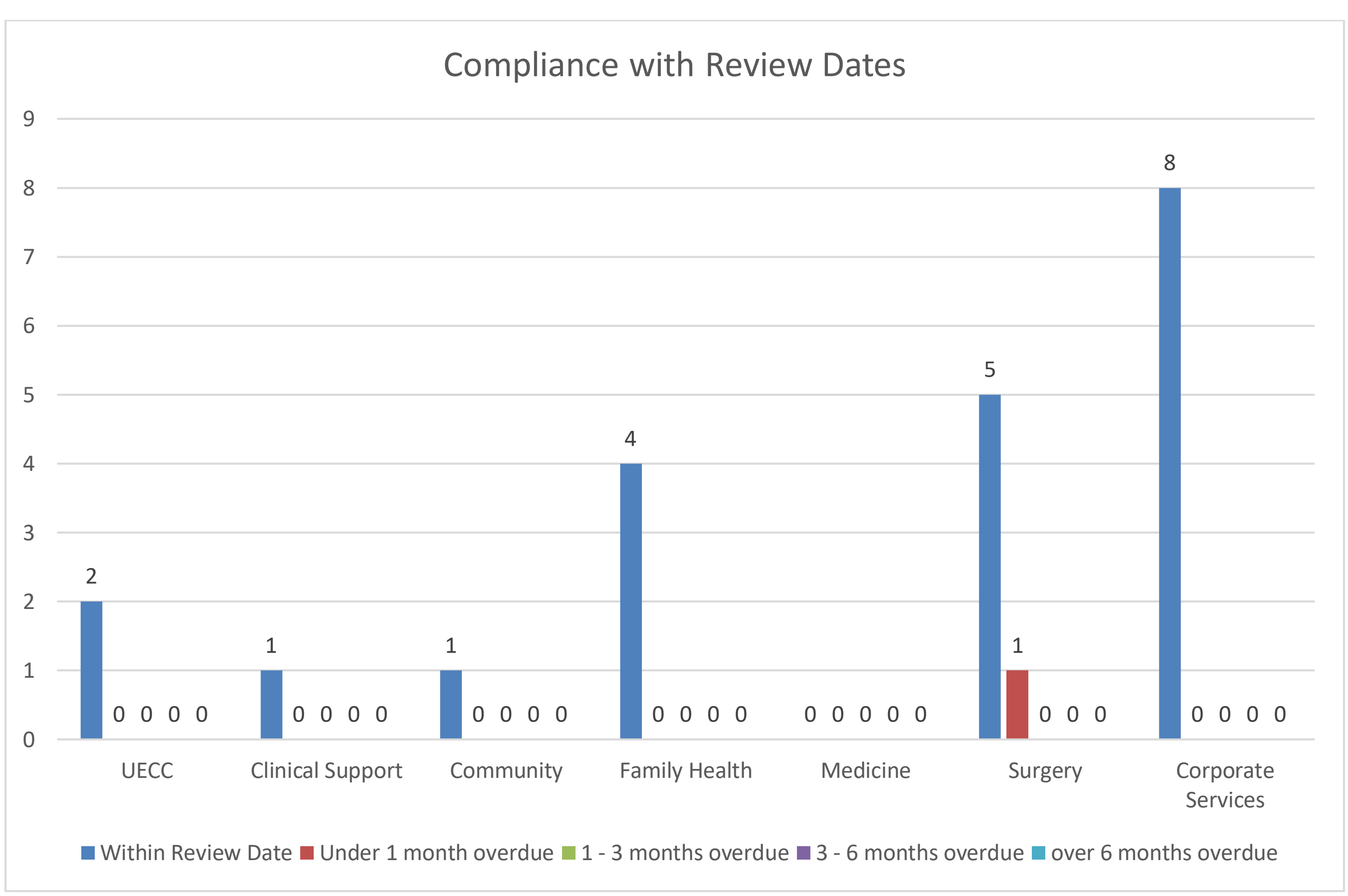
Corporate Risk Register

1. Introduction

The following report provides an update to the Board of Directors for the review of all risks scoring 15 and above. The risks contained within this report includes all risks rated at 15 or above recorded on Datix on 29 February 2024. The Board is asked to note that all of these risks have been approved at Divisional level and also approved by the Risk Management Committee. Further detail around the risks can be found at Appendix 1.

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.

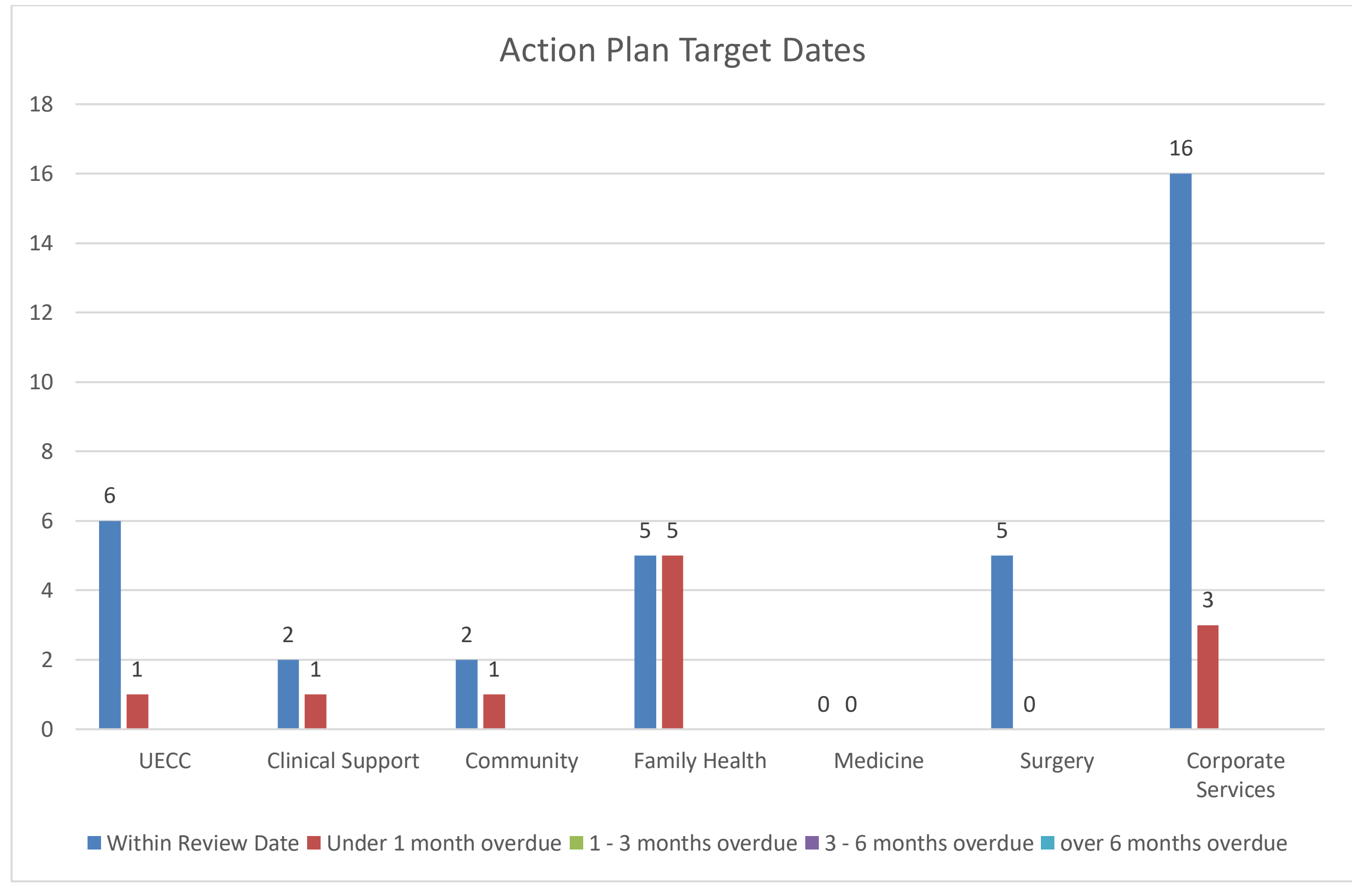


The Board will note that all risks, with the exception on one in Surgery are within their review date. The Division of Surgery are meeting to discuss risks with the Corporate Affairs team on Monday 4th March and their governance meeting is to be held on Thursday 29th February, verbal updates if required.

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 4 risks that have action plans logged in Datix with only 1 action, there will be a review of appropriateness and whether there are more actions that should be considered to fully mitigate high level risks.



There are currently 22 risks rated at 15 or above and from these there is a total of 90 individual actions. As can be seen in the graph above, of the individual actions, 47 are still to be completed and the graph shows that currently all action plans are within target dates or less than 1 month overdue.

There is 1 risk that shows as all actions have been completed, however the risk owner is rewriting that risk and it's description following the Trust Mental Health Steering Group held on the 19th February, the new risk will go back to the Mental Health Steering Group on 15th April 2024 where it is anticipated that a new action plan will be developed as a result.

There were 2 new Corporate Services risks approved at the February 2024 RMC:

- Risk 6166 - Absence of an Isolated Power Supply (IPS) within All Theatres - rated at 16
- Risk 7069 - Band 2/3 Healthcare Support Worker job descriptions and re-banding following changes to the National job profiles in 2021 - rated at 15.

4 Issues Register

The newly developed Issues Register can be found at Appendix 2; this is presented to all Assurance Committees for information and is monitored by the Audit & Risk Committee. The Issues Register is currently a work in progress with staff training required to improve data accuracy, the main example being the Proposed Issue Resolution Dates recorded, these need to be realistic and based on SMART (Specific, Measureable, Achievable, Relevant & Time-based) action plans. The Corporate Affairs team will continue to offer support and have developed a training package that was updated and relaunched in February 2024.

5 Recommendations

The Board is asked to:

- Note the content of the Corporate Risk Register and
- Note the progress in the risk management processes.

Alan Wolfe
Deputy Director of Corporate Affairs
March 2024

15+ Corporate Risk Register

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	Overcrowding in the UECC leading to 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.	High 25	High 20	High 16	27/02/2024	25/03/2024	[McAuley, Heather 27/02/24 13:38:43] Discussion regarding merging this risk with 7001 and 6691 required.	Approved Risk	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
													intentional rounding	07/03/2022	30/09/2022	30/09/2022	Farrow, Lindsay
													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	30/08/2024		McAuley, Heather
													transformational work T&F Group	01/01/2022	01/02/2024		Kilgariff, Mrs. Sally
6166	26/05/2020	Ramsden, Daniel	Corporate Services	Absence of a Isolated Power Supply (IPS) within All Theatres	Lack of protection to vulnerable patients in Group 2 medical locations, from the risks associated with electrical leakage currents. It is also a requirement of the standards that Group 2 Medical Locations shall have an automatic electrical supply available within 15 seconds in the event of power failure. Consequently it is usual for an IPS unit to be backed-up by an on-line UPS (uninterruptible power supply) as this will provide a 'no-break' supply source.	High 16	High 16	Low 4	08/02/2024	08/03/2024	[Wolfe, Alan 26/02/24 11:15:30] Approved at Feb24 RMC	Approved Risk	Theatres require UPS/IPS systems installing.	06/09/2023	01/03/2024		Ramsden, Daniel
													Theatres require UPS/IPS systems installing.	06/09/2023	01/11/2024		Ramsden, Daniel
6284	16/09/2020	Broadhurst, Miss Lucy	Division of Clinical Support Services	Cardiac Physiology Staffing Levels	Cardiac Physiology Staffing Levels consistently unable to meet all the needs of the service. This includes 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).	HIgh 15	HIgh 15	Low 3	07/02/2024	07/03/2024	[Gregg, Timothy Mr. 07/02/24 16:47:04] 07/02/2024, TG - 'Health Now' weekend session planned throughout February. There is a Locum who has started this week, also from 'Health Now' who will be with us week days in February for 3 days. 1.0WTE B6 cardiac Physiologist has last day today. 1.0WTE B2 cardiographer has now started MAT leave. 2 x 1.0 WTE B2 admin staff have been appointed and are going through the recruitment process, with a further 0.51 WTE now out to advert. 1.0 WTE Band 7 device Physiologist has now been recruited and is in post.	Approved Risk	Cardiac Physiology Recruitment	20/06/2023	04/03/2024		Broadhurst, Miss Lucy
													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
													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
													Insourcing for Echo Wait List - Health Now	13/01/2024	29/03/2024		Broadhurst, Miss Lucy
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%.	HIgh 15	HIgh 15	Low 6	19/02/2024	19/03/2024	[Dodd, Jamie Mr. 19/02/24 11:06:16] 19/02/2024: No change.	Approved Risk	Weekly waiting list meetings	01/04/2021	15/02/2024		Marshall, Miss Faye
													Additional theatres and reutilising theatres during leave	01/04/2021	15/02/2024		Marshall, Miss Faye
													Monitor through Governance	13/06/2022	15/02/2024		Marshall, Miss Faye
6421	31/03/2021	Wilman, Mrs. Johanna	Division of Family Health	Backlog of children waiting to be seen for assessment Child Development Centre (CDC	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	HIgh 15	HIgh 15	Low 6	25/01/2024	29/02/2024	[Wilman, Johanna Mrs. 25/01/24 12:24:04] The meetings with commissioners continue and we have actioned the following: 1. The new referral form has been approved through governance and a new pathway for referral has been agreed in principle. 2. I have met with the 0-19 Matron and we are working closely to ensure that children referred to the CDC will have had support and a graduated response before the referral is accepted. 3. We have dates in the diary to go out and speak with the SENCO's in school referring into the CDC, team lead meetings with 0-19 colleagues and a date to meet with Early Years and Foundation providers who also refer. 4. The 250 children who may be suitable for CAMHS have been sent to the commissioners, we are still waiting for the narrative on what we tell parents. As we have parked this cohort of children. 5. The pilot children who have completed their assessment pathway at the CDC and who need CAMHS due to being late referrals are still awaiting CAMHS decision. I have agreed to meet and discuss the cases and we are trying to set up a share to enable RDASH to have access to the children's SystmOne notes. 6. Two of the fixed posts: the band 4 and the band 2 will both be working by the 29th January with the Band 6 Nurse practitioner set to start 11th March 2024. There has been a general increase in the number of informal and formal complaints this month. Parents seem to be struggling and contacting the service to request appointments and updates. This is being managed as per the Trusts policies.	Approved Risk	Support without referral Pathway	18/09/2023	31/05/2024		Wilkinson, Jo
													Funding for further staff	18/09/2023	30/11/2023	02/01/2024	Wilman, Mrs. Johanna
													Psycology Funding	18/09/2023	28/06/2024		Wilman, Mrs. Johanna
													Joint working with RDASH	18/09/2023	31/05/2024		Wilman, Mrs. Johanna

15+ Corporate Risk Register

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')
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	HIgh 15	HIgh 15	Moderate 9	06/02/2024	31/03/2024	[Dean, Kim 06/02/24 15:42:27] Update from Newman School Deputy Head Lucy Dolton informing that the work on the therapy/medical spaces in the school should be complete by the 19th February 2024 and be ready for us to use.	Approved Risk	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
													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
6602	09/12/2021	Squires, Andrea	Corporate Services	Change to non surgical oncology pathways for 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 Western Park Cancer Centre, this is driven by the lack of oncologists affecting all tumour sites. There are also issues around non-surgical oncology follow up being repatriated back to TRFT.	High 20	High 20	Low 4	27/02/2024	28/03/2024	[Wallett, Val 27/02/24 12:55:39] The risk was discussed at the Risk Management Committee (20.02.24) and it was felt more appropriate that the risk is managed by the Chief Operating Officer's team as cancer falls within their remit. Agreement was reached with the Director of Operations/Deputy Chief Operating Officer to transfer the risk to the Associate Director of Operations.	Approved Risk	Weekly meetings between partners TRFT and STH to work through checklist to ensure smooth pathway for patients	02/01/2023	31/12/2024		Hazeldine, Victoria
													Monthly operational meetings between partners TRFT and STH to work through checklist to ensure smooth pathway for patients	02/01/2023	31/12/2024		Fletcher, Michelle
													Cancer Alliance Oversight Group (NSO)	03/01/2022	31/12/2024		Fletcher, Michelle
													Regular one to one with senior CNS including agenda items to raise awareness and try to mitigate lack of patient support	02/10/2023	31/12/2024		Fletcher, Michelle
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	High 20	HIgh 16	Moderate 8	07/02/2024	06/03/2024	[Butler, Helen 07/02/24 15:28:54] On going work with LOS and use of pathways 1 - 3. Community teams / therapy teams supporting with alternatives to bed bases.	Approved Risk	Place to review the potential 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
													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

15+ Corporate Risk Register

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')
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.	HIgh 15	HIgh 15	Low 6	13/02/2024	14/03/2024	[Culham, Helen 13/02/24 15:54:55] Awaiting outcome for the business case following changes.	Approved Risk	Lack of Critical care Follow-Up	01/08/2022	31/03/2024		Timms, Mrs. Deborah
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	HIgh 15	HIgh 15	Moderate 9	01/02/2024	01/03/2024	[Taylor, Katie Ms. 01/02/24 14:31:00] Community division business manager has meeting arranged with medical manager to review business case. Request as part of action sent to JH to update risk once meeting taken place	Approved Risk	Review of risk requested by general manager	10/06/2022	29/02/2024		Fisher, Penny
													Meet with business managers from Community and Medicine to review business case	04/01/2024	29/02/2024		Fisher, Penny
													Meeting	01/02/2024	15/02/2024		Hitchman, Mr James
6723	10/06/2022	Agger, Joanne	Division of Surgery	Anaesthetic Medical Staffing Availability	Unavailability of Anaesthetists due to 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.	Moderate 12	HIgh 16	Low 6	09/02/2024	11/03/2024	[Ward, Sandra Mrs. 08/01/24 14:18:22] 08/01/2024 - Risk score remains unchanged after review with myself and Mr Vasey.	Approved Risk	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	Marsden, Gillian
													Extend use of insourcing support	05/06/2023	29/09/2023	18/07/2023	Marsden, Gillian
													External review of the Anaesthetic rotas	19/06/2023	31/12/2023	08/01/2024	Marsden, Gillian
													Develop an options appraisal paper for review at ETM.	22/06/2023	31/07/2023	18/07/2023	Marsden, Gillian
													Advertise agency locum at all tiers and recruit as appropriate	01/08/2022	30/09/2022	02/10/2022	Marsden, Gillian
													Reduce elective operating for August - Review for September	01/08/2022	31/08/2022	02/10/2022	Marsden, Gillian
													Full departmental roster review led by SLT	22/09/2022	30/09/2022	23/09/2022	Marsden, Gillian
													Confirm insourcing arrangement for 6 week period	05/09/2022	05/09/2022	02/10/2022	Marsden, Gillian
													SCH joint recruitment	01/08/2022	31/10/2022	22/06/2023	Marsden, Gillian
													Phase two	08/01/2024	31/03/2024		Agger, Joanne

15+ Corporate Risk Register

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	Marsden, Gillian	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	Moderate 12	High 20	Low 4	08/01/2024	31/01/2024	[Ward, Sandra Mrs. 08/01/24 14:27:36] 08/01/2024 - Over 80% of CIP identified ongoing work to find remaining schemes.	Approved Risk	CIP Delivery Plan	01/04/2023	31/03/2024		Marsden, Gillian
													FOT Recovery Plan	27/09/2022	31/03/2023	16/04/2023	Marsden, Gillian
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. Poor patient experience and increased length of stay in department. Preventing good early flow through the unit as previously 10 trollies were available at the start of the day to ensure adequate capacity until patients were discharged from short stay beds.	Low 6	HIgh 15	Low 6	29/02/2024	31/03/2024	[Short, Mrs. Sally, 29/02/2024 16:30:20] 29.2.24 No change to report , Beds remain in assessment bays	Approved Risk	Surgica SDEC Task and Finish Group	01/11/2022	31/03/2024		Timms, Mrs. Deborah
													Amend Sepia to reflect 23 IP beds and 10 trollies	14/11/2022	09/12/2022	09/12/2022	Marsden, Gillian
													Complete Trust bed modelling work	01/04/2022	31/03/2023	18/07/2023	Marsden, Gillian
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.	HIgh 20	HIgh 16	Moderate 8	07/02/2024	06/03/2024	[Butler, Helen 07/02/24 14:30:38] Consultation completed - SDEC opening hours unable to be implemented due to operational pressure and demand for inpatient beds Further work is needed on a frailty pathway which will be looked at as a PLACE in 24/25. Continued high occupancy of virtual ward.	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
6801	10/10/2022	Ferrie, Mr. Paul	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.	HIgh 16	High 20	Low 4	21/02/2024	21/03/2024	[Wallett, Val 21/02/24 10:17:11] [Deputy Director of Workforce 21.0.24] Although Medical & Dental staff groups have received mandates to continue action, at this stage only the junior doctors continue to strike. The latest period of industrial action has been confirmed as 24 - 28 February 2024, therefore, the risk score will remain at 20 and be reviewed when any subsequent communications are received nationally. Normal contingency plans and daily EPPR meetings are in place throughout the lead up and duration of strike action to minimise disruption for patients.	Approved Risk	Negotiations with local staff side	10/10/2022	03/06/2024		Ferrie, Mr. Paul
													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	03/06/2024		Ferrie, Mr. Paul

15+ Corporate Risk Register

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')
6809	20/10/2022	Oliver, Lauren	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.	HIgh 15	HIgh 15	Low 6	12/02/2024	13/03/2024	[Oliver, Lauren 12/02/24 14:18:42] Theatre Transformation Programme remains ongoing, which includes workstream 5. No change to current risk and work ongoing.	Approved Risk	Lack of Local Safety Standards for Invasive Procedures (LocSSIPs)	13/04/2023	29/03/2024		Timms, Mrs. Deborah
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.	HIgh 16	HIgh 16	Low 4	27/02/2024	27/03/2024	[Dodd, Jamie Mr. 27/02/24 15:53:29] 27/02/2024: Angela Ford has ordered stronger wallets to hold Obs & Gynae documents. No time scale for when in place. Keeping updated on progress.	Approved Risk	In talks with the patient records department to attempt to find a solution	23/02/2023	23/05/2023	10/01/2024	Stables, Sarah
													Meeting with Deputy Head of Midwifery, Carol O'Neill and Angela Ford to discuss ongoing issues. Records department agreed to reinstate card files until process of scanning documents is fully in place. Will be monitored through Governance.	10/01/2024	01/06/2024		Stables, Sarah
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.	HIgh 15	HIgh 20	Low 5	05/02/2024	06/03/2024	[Wallett, Val 05/02/24 14:45:41] [Steve Hackett - 05.02.24] The cost of industrial action has been confirmed as £400k increased staffing costs and £800k lost income. No confirmation has been received on whether these costs will be met nationally.	Approved Risk	Theatre improvement programme.	23/03/2023	31/03/2024		Kilgariff, Mrs. Sally
													Outpatient utilisation programme.	23/03/2023	31/03/2024		Kilgariff, Mrs. Sally
													Cost improvement Efficiency Board.	23/03/2023	31/03/2024		Hackett, Steve
													Development of robust capacity plans.	23/03/2023	31/03/2024		Hackett, Steve
													Development of Winter plan.	23/03/2023	23/11/2023	03/11/2023	Hackett, Steve
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.	HIgh 15	HIgh 15	Moderate 9	19/02/2024	20/03/2024	[Rimmer, Claire, 01/03/2024 08:27:27] The risk was discussed at February RMC 20/02/24: There are a number of psychology services not being met within the Trust and work was taking place with the psychologist to start tracking areas that must have psychology support. The Risk will be taken back to the Mental Health Steering Group and it was expected that the risk score would increase.	Approved Risk	Lack of Psychological support for the breast cancer patients	31/08/2023	28/12/2023	31/08/2023	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	HIgh 15	HIgh 20	Moderate 9	09/02/2024	27/03/2024	[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	09/02/2024	Agger, Joanne
7069	14/02/2024	Storer, Cindy	Corporate Services	Band 2/3 Healthcare Support Worker job descriptions and re-banding following changes to the National job profiles in 2021	1a - There is a risk that the consultation process is not managed affectively and line with Trust policy. 2a - There is a risk that agreements with staff side on backpay and responsibility payments are not accepted resulting in increased costs. 3a – There is a risk, new job descriptions and associated clinical skills frameworks are not followed and implemented in line with Trust policy. 4a – There is a risk that the organisation consultation is delayed resulting in increased backpay and responsibility payments. 5a – There is a risk of trade union action. 6a – There is a risk of local and National media attention if the process is not managed effectively. 7a – There is a risk of organisational unrest and indirect impact on clinical care due to ongoing consultation process affecting workforce and morale.	HIgh 25	HIgh 15	Moderate 10	14/02/2024	14/03/2024	[Wolfe, Alan 26/02/24 11:21:33] Risk approved at Feb24 RMC	Approved Risk	Organisational change process to be followed	27/02/2024	03/05/2024		Storer, Cindy
													Implement operational and strategic groups with key stakeholders	15/01/2024	17/05/2024		Storer, Cindy
													Additional senior nurse and HR support needed	01/01/2024	31/05/2024		Storer, Cindy
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.	HIgh 15	HIgh 15	Moderate 8	27/02/2024	19/03/2024	[McAuley, Heather 27/02/24 10:46:55] Risk merged, actions merged, reduced to 12 and for RMC review for closure.	Approved Risk	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
													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
													ACT programme	04/04/2023	03/04/2024		Hammond, Lesley

ISSUES REGISTER

ID	Title	Status	Date Identified	Last Updated	Issue Author	Issue Description	Latest Update	Issue Owner	Priority Rating	Issue Resolution Date	Risk ID
1	Anaesthetic Medical Staffing Availability	Open	10/06/2022	09/02/2024	Marsden, Gillian	Unavailability of Anaesthetists due to 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.	At December RMC it was reported that there had been good progress around recruiting Anaesthetic staffing. A detailed analysis on the staffing structure in Anaesthetics and the working patterns is on-going. It was felt that the risk rating should remain the same as the impact will not be seen for quite a while. Phase Two of the action plan has been approved by the Executives/MD and COO; now sourcing appropriate external help.	Marsden, Gillian	3 - High	31/03/2024	6723
2	Cardiac Physiology Staffing Levels	Open	17/10/2023	07/02/2024	Broadhurst, Miss Lucy	Cardiac Physiology Staffing Levels consistently unable to meet all the needs of the service. This includes 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).	'Health Now' weekend session planned throughout February. There is a Locum who has started this week, also from 'Health Now' who will be with us week days in February for 3 days. 1.0WTE B6 cardiac Physiologist has last day today. 1.0WTE B2 cardiographer has now started MAT leave. 2 x 1.0 WTE B2 admin staff have been appointed and are going through the recruitment process, with a further 0.51 WTE now out to advert. 1.0 WTE Band 7 device Physiologist has now been recruited and is in post.	Andrew Brammer	3 - High	29/03/2024	6284
3	Risk of Potential Omission of Care Due to Deferral of Planned Community Nursing Visits	Open	24/01/2023	01/02/2024	Taylor, Ms. Katie	Omission of patient visits due to lack of capacity and increased demand on resources leading to patients not being seen on allocated days in line with the plan of care. This results in patient visits being moved on to another day either to another planned visit or 'parked' area within Systm One, with no audit trail and no reporting mechanism.	Community division business manager has meeting arranged with medical manager to review business case. Request as part of action sent to James Hitchman to update risk once meeting taken place	Penny Fisher	2 - Normal	29/02/2024	6718
4	Industrial action and effect upon Trust activity	Open	10/10/2022	21/02/2024	Ferrie, Paul	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.	Although Medical & Dental staff groups have received mandates to continue action, at this stage only the junior doctors continue to strike. The latest period of industrial action has been confirmed as 24 - 28 February 2024, therefore, the risk score will remain at 20 and be reviewed when any subsequent communications are received nationally. Normal contingency plans and daily EPPR meetings are in place throughout the lead up and duration of strike action to minimise disruption for patients.	Paul Ferrie	2 - Normal	03/06/2024	6801

ID	Title	Status	Date Identified	Last Updated	Issue Author	Issue Description	Latest Update	Issue Owner	Priority Rating	Issue Resolution Date	Risk ID
5	Backlog of children waiting to be seen for assessment at Child Development Centre (CDC)	Open	17/10/2023	25/01/2024	Wilman, Mrs. Johanna	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	The meetings with commissioners continue and we have actioned the following: 1. The new referral form has been approved through governance and a new pathway for referral has been agreed in principle. 2. Met with the 0-19 Matron and we are working closely to ensure that children referred to the CDC will have had support and a graduated response before the referral is accepted. 3. We have dates in the diary to go out and speak with the SENCO's in school referring into the CDC, team lead meetings with 0-19 colleagues and a date to meet with Early Years and Foundation providers who also refer. 4. The 250 children who may be suitable for CAMHS have been sent to the commissioners, we are still waiting for the narrative on what we tell parents. As we have parked this cohort of children. 5. The pilot children who have completed their assessment pathway at the CDC and who need CAMHS due to being late referrals are still awaiting CAMHS decision. I have agreed to meet and discuss the cases and we are trying to set up a share to enable RDASH to have access to the children's SystmOne notes. 6. Two of the fixed posts: the band 4 and the band 2 will both be working by the 29th January with the Band 6 Nurse practitioner set to start 11th March 2024. There has been a general increase in the number of informal and formal complaints this month. Parents seem to be struggling and contacting the service to request appointments and updates. This is being managed as per the Trusts policies.	Penny Fisher	3 - High	28/06/2024	6421
6	Special school accommodation	Open	17/10/2023	06/02/2024	Dean, Kim	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	Update from Newman School Deputy Head Lucy Dolton informing that the work on the therapy/medical spaces in the school should be complete by the 19th February 2024 and be ready for us to use.	Penny Fisher	3 - High	03/01/2025	6572
7	Ability to deliver 2023/24 Financial Plan	Open	23/03/2023	05/02/2024	Hackett, Steve	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.	The cost of industrial action has been confirmed as £400k increased staffing costs and £800k lost income. No confirmation has been received on whether these costs will be met nationally.	Steve Hackett	3 - High	23/02/2024	6886
8	Change to non surgical oncology pathways for breast and UGI services which may impact on other oncology services	Open	09/12/2021	27/02/2024	Hazeldine, Victoria	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	The risk was discussed at the Risk Management Committee (20.02.24) and it was felt more appropriate that the risk is managed by the Chief Operating Officer's team as cancer falls within their remit. Agreement was reached with the Director of Operations/Deputy Chief Operating Officer to transfer the risk to the Associate Director of Operations.	Hazeldine, Victoria	3 - High	31/12/2024	6602
9	Surgery Division - Ability to Achieve Financial Control Total	Open	20/07/2022	08/01/2024	Marsden, Gillian	There is a risk of the Division not achieving it's agreed financial control total for the financial year 23/24. This will have a greater impact on the Trust's overall financial control, compared to other divisions.	The risk rating was agreed at November RMC and the risk updated to reflect consideration of FOT/ERF. In January, the risk was reviewed at divisional level and progress noted of over 80% of CIP identified with ongoing work to find remaining schemes. The Division of Surgery are meeting to discuss risks with the Corporate Affairs team on Monday 4th March and their governance meeting is to be held on Thursday 29th February.	Marsden, Gillian	3 - High	31/03/2024	6755

Board of Directors' Meeting
8 March 2024

Agenda item	P50/24
Report	**Quality Assurance Report (including Care Quality Commission)**
Executive Lead	Helen Dobson, Chief Nurse
Link with the BAF	P1: There is a risk that we will not embed quality care within the 5-year plan because of lack of resource, capacity and capability leading to poor clinical outcomes and patient experience for our patients.
How does this paper support Trust Values	Ambitious – The Trust is working to achieve a CQC rating of Good and beyond. Caring – The Trust is working to achieve a CQC rating of Outstanding for the Caring Domain Together – The Trust is working together with senior leaders, clinical teams and external stakeholders to deliver safe, high quality care for the population of Rotherham
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	The purpose of the Quality Assurance Report is to provide an overview of all quality activity across the Trust, with a focus on Care Quality Commission requirements and to identify progress against the Quality Assurance Framework, to support our delivery of outstanding care. There are four key elements that collectively describe how the Trust will move forward on its 'Journey to Outstanding'. • Quality Assurance • Quality Governance • Quality Improvement • CQC Relationship/ future inspection methodology All actions within the Quality Improvement Plan (derived from previous CQC inspections) are now complete with the majority being embedded. All divisions have participated in comprehensive self-assessments that are driving their quality improvement agendas. The Trust will be working towards the new self-assessment framework and finalising the Exemplar Accreditation programme in Q4.

Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	This information has been reviewed through the CQC Delivery Group and shared with Quality Committee, in a different format, on a quarterly basis.
Board powers to make this decision	N/A
Who, What and When (what action is required, who is the lead and when should it be completed?)	N/A
Recommendations	It is recommended that the Trust Board: • Note the content of the Report • Note the progress made in progressing the Quality Assurance Programme
Appendices	None

1. Quality Assurance

1.1 The Quality Assurance programme continues to be delivered and is monitored through the Quality Delivery Group and Quality Committee.

1.2 Although self-assessment continued in Quarter 3, the new CQC self-assessment framework has now been published. Therefore, the previous process has now paused and a new template created including the 'I' statements that CQC have incorporated into their new framework.

1.3 Peer review activity is currently paused whilst the transition to the new self-assessment framework in completed. There will be a programme of work identified for the 2024/2025 year. Previously this has been in conjunction with Barnsley NHSFT which will continue but there are also discussions about widening this to include all of the South Yorkshire Acute Federation.

1.4 Quality Delivery groups have continued to be held monthly with the exception of January and remain quorate. The performance against the Quality Improvement Plan has further improved, driven by a significant number of actions in UECC becoming embedded. There are no amber actions remaining and there continues to be an increase in the number of embedded actions completed. In October, there was a review of all Green actions presented, 32 in total. The Divisions have been requested to focus on providing sufficient evidence for the embedding of these actions.

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

Core Service	Red	Amber	Green	Blue	Grey
Trustwide	0	0	0	4	0
UECC	0	0	8	26	1
Medicine	0	0	2	23	0
Maternity	0	0	2	4	0
Children and Young People	0	0	4	18	2
Total	0	0	16 (32 last quarter)	75 (59 last quarter)	3
Percentage	**0%**	**0%**	**17% (34% last quarter)**	**80% (63% last quarter)**	**3%**

Table 1.

1.5 The improvement plan above linked to the last official CQC inspection and can now be considered closed with all actions complete – although evidence is still being monitored for the remaining 16 green actions to demonstrate embeddedness. Since that time we

have undertaken peer assessments for the main bed holding areas and self-assessments within a number of lesser inspected areas.

1.6 Since April 2023, the Quality Delivery Group have received self-assessment reports covering 22 different areas / services including Outpatients, Community, Children's, Maternity, Critical Care, Therapies, Dietetics and Cardiology. This has included assessment against a range of area specific criteria and awarding of a rating of outstanding, hood, requires improvement or inadequate. A total of 779 criteria have been assessed.

Key Headlines		
Outstanding	58 (7%)	
Good	593 (76%)	
Requires improvement	127 (16%)	
Inadequate	1 (0.1%)	Waiting Times in Children's Therapy

1.7 Only one criteria resulted in an inadequate rating. This relates to waiting times to access therapy services for children in the community. The Division of Family Health are working through an action plan to address this with local partners and it is on their risk register. Progress against this is discussed at the monthly divisional performance meeting.

1.8 As self-assessments, these cannot be taken to be a definitive position but they form a useful measure to help focus attention as we transition towards the new CQC assessment framework.

2. Quality Governance

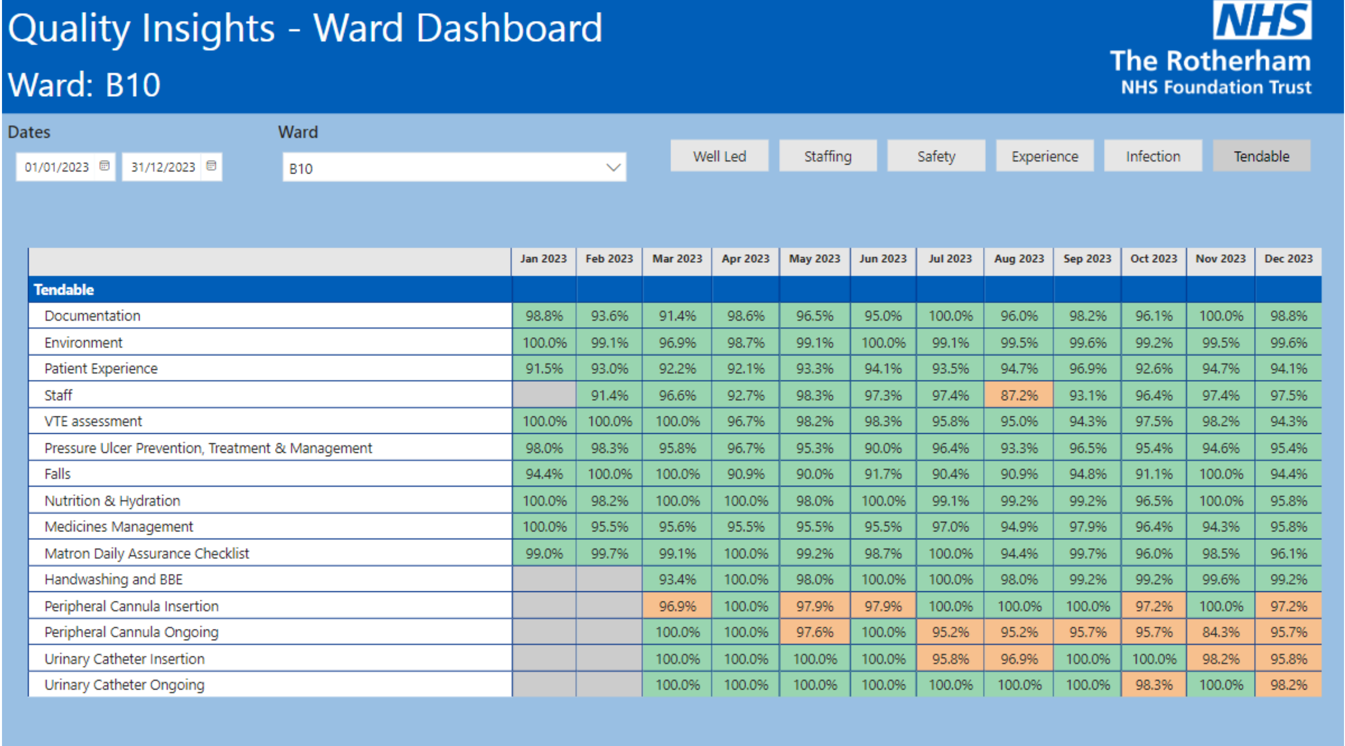
2.1 Over the past year, Divisions have developed quality dashboards to provide assurance on performance and assist with identifying where additional support is required. Although these have been extremely useful, the variation between formats has presented easy comparison between different divisions. This has also been a time consuming exercise for clinical teams with a focus on collating data rather than using it to drive improvement. Health Informatics have now created a standardised quality dashboard within Power BI.

2.2 The new dashboard draws from metrics already available in a range of other systems to triangulate this information. Sources include Datix, E-roster, Tendable and ESR. The data is therefore presented to the clinical area allowing teams to focus on what the data is telling them and develop and deliver appropriate action plans. All in patient wards are now live on this system with plans to add department and community areas later this year. At present, data is only available at individual ward level but the process to amalgamate this to give divisional and Trust wide level reports is currently underway. Once Trust wide information is available, this will form part of the quality metrics presented to Quality Committee each month as part of the Performance Report. Individual department and divisional data will continue to be assessed through the monthly performance meetings with Divisions.

2.3 There are six pages to each dashboard covering the following domains:

- Well led
- Staffing
- Safety
- Experience
- Infection
- Tendable

The tables below show some screen shots of current data but this will be covered in more detail at the April Strategic Board session with a live demonstration.



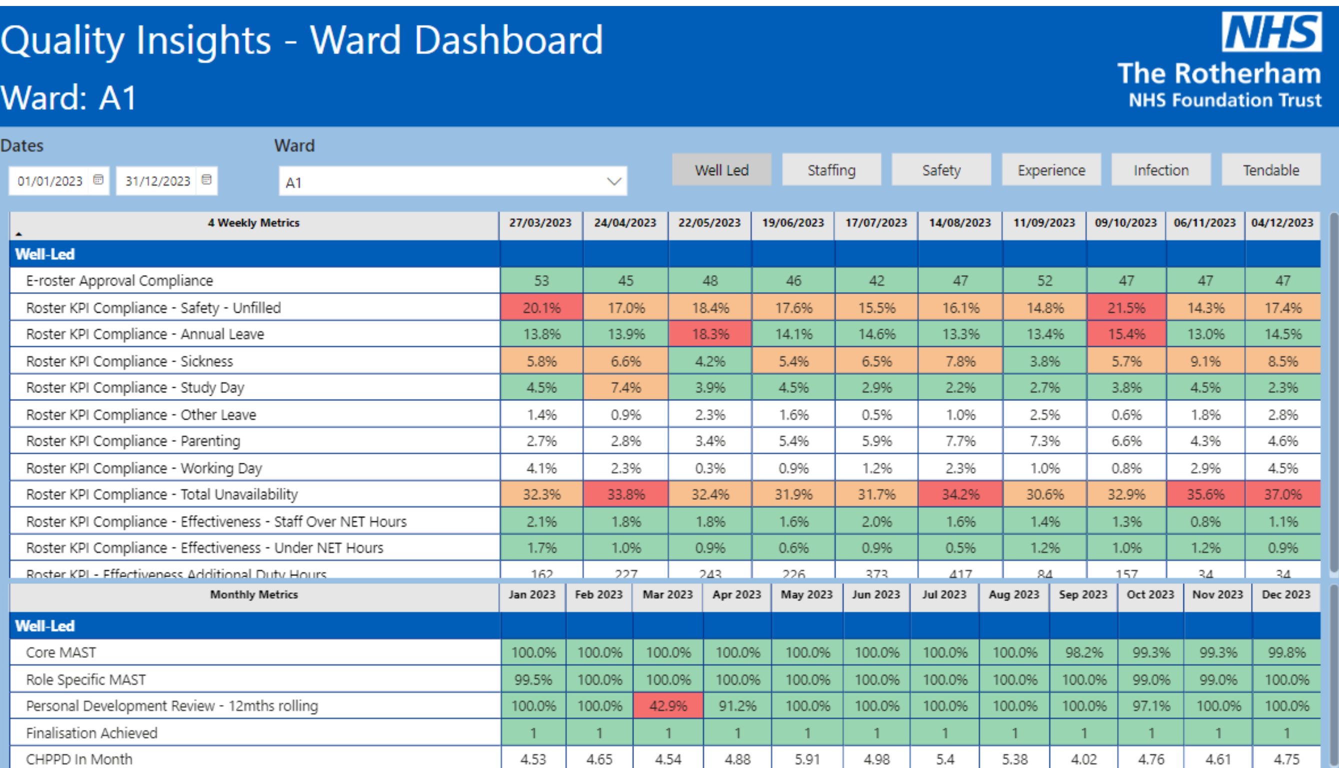
Quality Insights - Ward Dashboard
Ward: B10

NHS The Rotherham NHS Foundation Trust

Dates 01/01/2023 31/12/2023 Ward B10

Well Led | Staffing | Safety | Experience | Infection | Tendable

	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023
Tendable												
Documentation	98.8%	93.6%	91.4%	98.6%	96.5%	95.0%	100.0%	96.0%	98.2%	96.1%	100.0%	98.8%
Environment	100.0%	99.1%	96.9%	98.7%	99.1%	100.0%	99.1%	99.5%	99.6%	99.2%	99.5%	99.6%
Patient Experience	91.5%	93.0%	92.2%	92.1%	93.3%	94.1%	93.5%	94.7%	96.9%	92.6%	94.7%	94.1%
Staff		91.4%	96.6%	92.7%	98.3%	97.3%	97.4%	87.2%	93.1%	96.4%	97.4%	97.5%
VTE assessment	100.0%	100.0%	100.0%	96.7%	98.2%	98.3%	95.8%	95.0%	94.3%	97.5%	98.2%	94.3%
Pressure Ulcer Prevention, Treatment & Management	98.0%	98.3%	95.8%	96.7%	95.3%	90.0%	96.4%	93.3%	96.5%	95.4%	94.6%	95.4%
Falls	94.4%	100.0%	100.0%	90.9%	90.0%	91.7%	90.4%	90.9%	94.8%	91.1%	100.0%	94.4%
Nutrition & Hydration	100.0%	98.2%	100.0%	100.0%	98.0%	100.0%	99.1%	99.2%	99.2%	96.5%	100.0%	95.8%
Medicines Management	100.0%	95.5%	95.6%	95.5%	95.5%	95.5%	97.0%	94.9%	97.9%	96.4%	94.3%	95.8%
Matron Daily Assurance Checklist	99.0%	99.7%	99.1%	100.0%	99.2%	98.7%	100.0%	94.4%	99.7%	96.0%	98.5%	96.1%
Handwashing and BBE			93.4%	100.0%	98.0%	100.0%	100.0%	98.0%	99.2%	99.2%	99.6%	99.2%
Peripheral Cannula Insertion			96.9%	100.0%	97.9%	97.9%	100.0%	100.0%	100.0%	97.2%	100.0%	97.2%
Peripheral Cannula Ongoing			100.0%	100.0%	97.6%	100.0%	95.2%	95.2%	95.7%	95.7%	84.3%	95.7%
Urinary Catheter Insertion			100.0%	100.0%	100.0%	100.0%	95.8%	96.9%	100.0%	100.0%	98.2%	95.8%
Urinary Catheter Ongoing			100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.3%	100.0%	98.2%



Quality Insights - Ward Dashboard
Ward: A1

NHS The Rotherham NHS Foundation Trust

Dates 01/01/2023 31/12/2023 Ward A1

Well Led | Staffing | Safety | Experience | Infection | Tendable

4 Weekly Metrics	27/03/2023	24/04/2023	22/05/2023	19/06/2023	17/07/2023	14/08/2023	11/09/2023	09/10/2023	06/11/2023	04/12/2023
Well-Led										
E-roster Approval Compliance	53	45	48	46	42	47	52	47	47	47
Roster KPI Compliance - Safety - Unfilled	20.1%	17.0%	18.4%	17.6%	15.5%	16.1%	14.8%	21.5%	14.3%	17.4%
Roster KPI Compliance - Annual Leave	13.8%	13.9%	18.3%	14.1%	14.6%	13.3%	13.4%	15.4%	13.0%	14.5%
Roster KPI Compliance - Sickness	5.8%	6.6%	4.2%	5.4%	6.5%	7.8%	3.8%	5.7%	9.1%	8.5%
Roster KPI Compliance - Study Day	4.5%	7.4%	3.9%	4.5%	2.9%	2.2%	2.7%	3.8%	4.5%	2.3%
Roster KPI Compliance - Other Leave	1.4%	0.9%	2.3%	1.6%	0.5%	1.0%	2.5%	0.6%	1.8%	2.8%
Roster KPI Compliance - Parenting	2.7%	2.8%	3.4%	5.4%	5.9%	7.7%	7.3%	6.6%	4.3%	4.6%
Roster KPI Compliance - Working Day	4.1%	2.3%	0.3%	0.9%	1.2%	2.3%	1.0%	0.8%	2.9%	4.5%
Roster KPI Compliance - Total Unavailability	32.3%	33.8%	32.4%	31.9%	31.7%	34.2%	30.6%	32.9%	35.6%	37.0%
Roster KPI Compliance - Effectiveness - Staff Over NET Hours	2.1%	1.8%	1.8%	1.6%	2.0%	1.6%	1.4%	1.3%	0.8%	1.1%
Roster KPI Compliance - Effectiveness - Under NET Hours	1.7%	1.0%	0.9%	0.6%	0.9%	0.5%	1.2%	1.0%	1.2%	0.9%
Roster KPI - Effectiveness Additional Duty Hours	162	227	243	226	373	417	84	157	34	34

Monthly Metrics	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023
Well-Led												
Core MAST	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.2%	99.3%	99.3%	99.8%
Role Specific MAST	99.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.0%	99.0%	100.0%
Personal Development Review - 12mths rolling	100.0%	100.0%	42.9%	91.2%	100.0%	100.0%	100.0%	100.0%	100.0%	97.1%	100.0%	100.0%
Finalisation Achieved	1	1	1	1	1	1	1	1	1	1	1	1
CHPPD In Month	4.53	4.65	4.54	4.88	5.91	4.98	5.4	5.38	4.02	4.76	4.61	4.75

2.4 Although the Power BI system will provide valuable data, a more sophisticated approach is needed to give assurance that improvements are being made and sustained as a consequence. To enable this, the Trust has significantly progressed with development of an internal accreditation system, which we have called **Exemplar Accreditation**. This has involved the creation of a set of standards so that areas for improvement can be identified and areas of excellence celebrated. It is a comprehensive assessment on the quality of care at ward, unit and department levels; bringing key measures together into a single overarching framework.

2.5 The benefits of accreditation are;

- Reduces unwarranted variation; evidence based standardised approach to supporting delivery of care and improving quality.
- Drive continuous improvement in patient outcomes.
- Increase patient satisfaction.
- Improve staff experiences, which in turn can improve staff retention.
- Provides ward to board assurance.
- Creates a culture of pride and accomplishment.
- Encourages collective leadership.

2.6 Exemplar Accreditation will deliver against the CQC domains of Safe, Effective, Caring, Well-led and Responsive, although this has been re-branded using the categories shown in the table below. This ensures that all CQC domains are covered but also recognises the increased importance the CQC have placed on patient and staff experience and continuous improvement as part of their new approach to assessment. There are multiple questions and criteria included within each of the five focus areas shown in the table.

Quality and Safety	Efficiency	Patient Experience	Staff Experience	Quality Improvement
1. Patients receive harm free care and lessons are learned from incidents. 2. Patients receive evidenced based personalised care. 3. The area environment is managed to provide safety. 4. Quality indicators are maintained to demonstrate safety.	1. Patients receive the right care, in the right place, at the right time. 2. There are appropriate numbers of staff to meet patients needs. 3. The area team uses resources efficiently.	1. All patients receive timely, holistic, individualised care. 2. The area is a welcoming place to be. 3. Patients feel listened to and understand the care they receive.	1. All staff are engaged, empowered and enjoy working in that area. 2. Staff have to most up-to-date skills and knowledge to do their job. 3. There is an open culture that makes staff feel safe.	1. Creating a culture for improvement. 2. Use of improvement methodology. 3. Using data to drive improvement. 4. Sharing and learning to encourage spread.
SAFE	**EFFICIENT**	**CARING**	**WELL LED**	**RESPONSIVE**

2.7 All areas will be assessed annually as part of this process. The data set packs and questions are currently being agreed, with engagement meetings being held with the ward leaders and matrons. The data intelligence team will then support with the production of the accreditation data packs.

2.8 The first areas to be part of the accreditation scheme will be A1, A5, Rockingham and B10. This will take place in April 2024 with a full roll out programme agreed over 12 months.

2.9 It is not expected that any areas will achieve Gold accreditation in year 1 as this is primarily seen as a benchmark year where the domains can be tested and refined and teams can familiarise themselves with expectations. We would expect to see year on year improvement in all areas going forwards.

2.10 The Exemplar Accreditation programme will be reviewed in detail at the Strategic Board in April.

3. Quality Improvement

3.1 Quality Improvement is now well established within the organisation. A recognised constraint on the Qi programme to date has been the inability to provide full follow up support to registered improvement projects. This has meant that benefits to patients and any cost improvements resulting from changes have not being appropriately recorded. The recruitment to the Practitioner and Facilitator posts has now been completed and they will be joining the Trust in Q1. We have also successfully recruited two consultants to Associate Medical Director roles, both of which include an element of Qi support. These posts will strengthen the Qi functionality going forward allowing greater benefits to be realised.

3.2 Due to changes within NHSE, QSIR – the Trust's chosen Qi methodology – will no longer be available free of charge from April. A range of options were considered by the Executive Team and the Trust have chosen to develop a locally developed programme. This is planned to be available for multiple Trust's within SY ICB but is being led jointly by The Rotherham NHSFT and Barnsley NHSFT. The two teams work closely together and benefit from the ideas, shared learning and mutual support this collaboration brings.

3.3 The Qi team are currently working directly with the Quality Governance team on the first quarterly Trust wide shared learning event in April 2024. This will also aim to identify key Qi initiatives under the PSIRF lens for the next cohorts of QSIR. Other key work streams include supporting development of the 2024/25 Quality Priorities and preparation for the final QSIR cohort, commencing in March.

4. Care Quality Commission Future Inspection Methodology and Engagement

4.1 CQC have now commenced using the new Regulatory Single Assessment Framework although we are not yet aware of any acute NHS Trust's that have been assessed or inspected. During an engagement meeting with the Trust on 29th February, the new relationship team described the new process and confirmed that they will prioritise onsite inspections to those organisations with a higher risk profile at this stage. CQC have requested we reduce engagement meetings from monthly to quarterly whilst they adapt to the new process. The Trust have invited the team for an onsite visit for the next meeting which they have accepted with a request to visit the new Neonatal Unit noted.

4.2 There have been no enquiries for information or concerns raised by the CQC since the last quarterly report.

4.3 There are a number of CQC support tools and videos that the Trust has engaged with in preparation for single assessment. Meetings are being held with Divisions to aid an understanding of how this self-assessment will be completed throughout the year. The supporting documentation pack will be rolled out through Q1 and Q2 to initial areas.

4.4 The Quality session at the April Strategic Board of Directors Meeting will include a presentation on the changes to the CQC assessment process, details of the planned new framework for self-assessment with an interactive focus on the well-led requirement for members of the Board.

5. Conclusion

5.1 Although we have not had any external scrutiny, all divisions have continued to monitor their position against CQC requirements. The self-assessment process has paused whilst we transition to the new system but templates have been created to allow this to restart from April. The process has moved away from a reactive approach to CQC findings and is now an embedded quality improvement approach driven by peer and self-assessments, PSIRF and feedback from service users.

5.2 Members of the Executive Team have now met our new CQC engagement team and hope to cultivate as productive a relationship with them as we have had with the previous team.

5.3 Exemplar accreditation has matured through the planning phase and final data sets and questions are being concluded. The first round of accreditation is planned for April 2024.

5.4 Multiple new processes to both monitor and assure quality performance have been created and will be operational from April. These will be demonstrated to Board members in April and will form a key part of performance metrics to Quality Committee and the Board of Directors for the coming year.

Board of Directors
8th March 2024

Agenda item	P51/24
Report	**Learning From Deaths: Quarterly Report**
Executive Lead	Dr Jo Beahan, Medical Director
Link with the BAF	**P1:** There is a risk that we will not embed quality care within the 5 year plan; **OP3:** 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; and **D5:** There is a risk that we will not deliver safe and excellent performance.
How does this paper support Trust Values	**Ambitious** – demonstrates that the Trust strives to deliver the highest standards and quality of care possible. **Caring** – demonstrates that the Trust strives to give outstanding, compassionate care, including around end of life care. **Together** – demonstrates that the Trust strives to ensure that quality improvement and the learning from deaths is achieved through a multidisciplinary approach.
Purpose	**For decision** ☐ **For assurance** ☒ **For information** ☒
Executive Summary	**<u>NHS Better Tomorrow LFD SJR Improvement Programme</u>** TRFT's SJRs are now being completed by a team of SJR Reviewers who are trained in the SJR process and have dedicated time to complete. This process is designed to significant increase the timeliness, completeness and quality of TRFT's SJRs. The quality, completion rates and timeliness have all significantly increased. However the timeliness target of 90% SJR completions within 60 days of death isn't being met. **<u>360 Assurance LFD Governance Audit Action Plan</u>** The final report for the follow up audit was presented to the Trust on 23/06/2023. Of the 3 High Risk findings identified in the 2021/22 Re-Audit, 2 now have significant assurance. The other has limited assurance and is being worked on. It was a positive report overall, with some work still to do. **<u>Mortality Indicators</u>** The latest **SHMI** Score (latest Month Sep 2023) is **102.4**. TRFT are in the 'As Expected' Band.

	The latest **HSMR** Score (latest Month Nov 2023) is **89.8**. TRFT are in the 'Lower than Expected' Band.
Due Diligence	This report is produced by the Learning from Deaths and Mortality Manager with a final review by the Deputy Medical Director.
Powers to make this decision	N/A
Who, What and When	The Trust is working hard to establish a Learning from Deaths process which provides intelligence which is used by the Trust to enhance care for present and future patients. A major component of the Learning from Deaths process is the case note review of selected deaths. TRFT uses the Structured Judgement Review (SJR) method. The objective of the review method is to look for strengths and weaknesses in the caring process, to provide information about what can be learnt about hospital systems where care goes well, and to identify points where there may be gaps, problems or difficulties in the care process. A new SJR Review Team (7 reviewers), who are trained and have protected time to complete SJRs started in April 2023. This will deliver good quality and timely SJRs. This will provide good intelligence for the Trust, including information from individual reviews and more importantly from the Thematic Analysis of cohorts of SJRs. The Trust's objective is to use this intelligence to drive improvements. This means disseminating the intelligence to Trust Groups/Individuals, who have the expertise to devise and implement changes to care processes and procedures. Learning from Deaths is managed by the Learning from Deaths & Mortality Manager. It is co-ordinated via the Trust Mortality Group, chaired by the Deputy Medical Director, with oversight and assurance through the Trust's Patient Safety Committee and the Quality Committee.
Recommendations	It is recommended that the Board notes the progress on the planned improvements to the Learning from Deaths programme and the latest Mortality Indicator position for the SHMI and HSMR.
Appendices	1. Learning from Deaths, Thematic Analysis Report 2023/24 Q2 2. SHMI Report – Latest Month's Data Sep 2023 3. HSMR Report – Latest Month's Data Nov 2023

Learning from Deaths Quarterly Report: 2023/24 Q2

	Due Date	SJR Data*	SHMI Latest Month	HSMR Latest Month
This Report	-	2023/24 Q2	01/09/2023	01/11/2023
Next Report	07/03/2024	2023/24 Q3	01/10/2023	01/12/2023

*SJR data is grouped & reported by the date of death

SJR Completion Figures

Month of Discharge	Adult Inpatient & UECC Deaths	SJR Requested	Completed	Outstanding	% Completed	Overall Care Score < 3	Preventability Score < 4
Apr-23	89	13	13	0	100%	3	2
May-23	77	15	15	0	100%	4	0
Jun-23	81	13	11	2	85%	2	0
Jul-23	52	13	12	1	92%	4	0
Aug-23	79	12	11	1	92%	2	0
Sep-23	83	20	16	4	80%	3	0
2023/24 YTD	461	86	78	8	91%	18	2
2023/24 Q1	247	41	39	2	95%	9	2
2023/24 Q2	214	45	39	6	87%	9	0

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

Preventability Score	6 - Definitely not preventable	5 - Slight evidence	4 - Possibly less than 50-50	3 - Possibly greater than 50-50	2 - Strong evidence	1 - Definitely preventable

SJR Timeliness Figures

Month of Discharge	% Completed < 60 Days
Apr-23	46%
May-23	33%
Jun-23	46%
Jul-23	38%
Aug-23	42%
Sep-23	70%
2023/24 YTD	48%
2023/24 Q1	41%
2023/24 Q2	53%

2022/23 Year end Figures

SJRs Completed	45%
Completed <60 Days of Death	24%

SJRs completed by the SJR Review Team are of a much better quality with more free text narrative. However timeliness figures whilst an improvement on 2022/23 figures require further improvement.

The 90% target for completing all SJRs within 60 days isn't being met. 48% represents a significant improvement on the figure for 2022/23 (24%). However, with reviewers being funded, a 100% completion rate, with 90% being within 60 days of death is expected.

The Learning from Deaths process is described as a rapid cycle of learning, where good or poor practice is identified close to the time when care was delivered. Timely SJR completion and intelligence dissemination is crucial for this.

Comments from all SJRs are themed and categorised in quarterly Thematic Analysis Reports

Summary & Distribution 2023/24 Q2 SJR Thematic Analysis

Learning from SJRs comes in the form of free text judgment statements which support the scores given to Phases of Care and to problems identified. These free text comments are allocated to categories based on the element of health care they refer to and whether they are positive or negative.

The Thematic Analysis reports are distributed to various groups, individuals and teams within the Trust. The purpose is for these groups to review the reports and then to design and implement new/changes to health care processes that will prevent the reoccurrence of these problems or promote good practice.

These two tables detail the categories to which comments are allocated to and the groups/teams which receive the report.

Category of Problem
Medication or Treatment
Escalation
Assessment/Opinion/Review - Delay/Omission
Tests/Results/Monitoring
End of Life / Palliative Care / DNACPR
Location of Care/Bed Avail/Inappr Moves
Communication

Group
Deteriorating Patient Group
Medicine Safety Group
Patient Safety Committee
Results Notification
Safeguarding Operational Group
Clinical Governance - Medicine
Clinical Governance - Surgery
End of Life Care

Next Report:

The next Thematic Analysis Report will be completed in March 2024 for TRFTs 2023/24 Q3 SJRs.

Learning from Deaths – LeDer, Learning Disabilities & Autism

The LeDer Programme is a Commissioner-led review of deaths for patients with Learning Disabilities and Autism, regardless of the place of death. Provider Trusts are frequency asked to assist with LeDer reviews when they have been involved in the care provision for that patient. TRFT completes SJRs for all Trust deaths for those with Learning Disabilities or Autism.

Deaths for these patients are identified by a Learning Disability Flag and an Autism Flag in the Trust's Mortality Insights Power BI Reports, indicated by the Medical Examiner after a scrutiny, a request from the Matron for Learning Disabilities and Autism, or by a request from a ICB LeDer Team.

Completed SJRs are distributed to the Matron for Learning Disabilities and Autism, the Head of Safeguarding and to the requesting ICB LeDer Team.

LeDer Requests & SJR Figures for Adults with a Learning Disability

Discharge Month	SJR Requested	SJR Completed	SJR Outstanding	Overall Care Score < 3	Preventability Score < 4
Apr-23	1	1	0	1	0
May-23	1	1	0	0	0
Jun-23	1	1	0	0	0
Jul-23	0	0	0	0	0
Aug-23	2	2	0	1	0
Sep-23	2	2	0	0	0
2023/24 YTD	7	7	0	2	0

Update

The Trust now (since Feb 2024) has a flag in its Mortality Insights Power BI Report which highlights deaths for patients with a Serious Mental Illness (SMI). The flag uses national recognised SMI ICD10 Codes coded during the patient's last admission. This means that the Trust process for identifying these patients for SJR is now more robust and doesn't solely rely on them being identified during a Medical Examiner Scrutiny.

NHS Better Care Tomorrow LFD Improvement Programme (SJR+)

A new process for the completion of SJRs commenced on 01/04/2023. The new process is based on best practice and follows advice from other Trusts and advice from the NHSE/I Better Care Tomorrow Leads.

TRFT now has a small SJR Review Team, who are trained in the Structured Judgment Review method, complete reviews regularly and have protected time. This team are using NHS England/Improvements SJR+ system to record and store its SJRs. This is a national system which is being used by an ever increasing number of Trusts. The SJR form has some enhancements to the form designed in 2017.

This new process contributed to completing some of the Trusts 360 Action points, and is designed to deliver quality complete and timely SJRs.

360 Assurance Re- Audit May 2023 LFD Governance

The final report for the May 2023 follow up report was presented to the Trust on 23/06/2023. Now 14 of the 15 actions points have been fulfilled.

Of the 3 High Risk finding identified in the 2021/22 Re-Audit, 2 now have significant assurance. The other has limited assurance and is being worked on. Below is the remaining action point.

We have allocated a limited assurance opinion to the CSU learning (in the Division of Medicine). We did not find evidence that suitable arrangements are consistently in place within CSUs for discussion on the outcomes of mortality reviews/SJRs and that these are shared (and escalated where appropriate) to the Divisional Mortality Sub-group meeting.

Plan to Fulfil the Remaining Action Point

Completed SJRs (c21) are being sent to Division's Mortality Leads every 4 weeks**.** The split is roughly 13 to Medicine, 6 to Surgery and 2 to UECC. The SJRs are grouped according the last treating CSU. Those judged to have had poor care and /or been likely avoidable are highlighted.

The ask for the Division's Mortality Leads is to complete a brief 1-2 minute review of each SJR and decide which need to be individually disseminated to the CSU, and discussed at their Clinical Governance meeting or separately held Mortality meeting. SJRs should be selected if they have learning points related to both good and poor care. All those judged to have had poor care and /or been likely avoidable should automatically be disseminated.

The ask for the CSU Clinical Governance meeting or separate Mortality meeting is to review and discuss these SJRs. Which SJRs have been discussed should be included in the minutes, together which any discussion and resulting actions. These minutes, as evidence, will ultimately complete the outstanding action.

Progress

In December 2023 a small SJR Review Group has been formed in the Division of Medicine. This multi-disciplinary group meets monthly and will assist the Division's Mortality Lead in selecting individual SJRs for dissemination to the CSUs. In addition a template has been sent out to the CSUs, to be included in their Governance minutes, which details SJR/Mortality discussions and any actions.

Minutes from the CSU meetings will be reviewed by the Learning from Death and Mortality Manager during January and February, in order to produce an evidenced report for the April 2024 360 Re-Audit.

Learning from Deaths in the Divisions

Monthly Mortality meetings are held in the Divisions of Medicine, Surgery and by the Urgent & Emergency Care Team. Reviewed deaths are presented and discussed. These can be a SJR, a local review or both.

Mortality is also discussed at CSU meetings, either as agenda item in the CSU Governance meeting or a separately held CSU Mortality meeting.

Every 4 weeks completed SJRs (c21) are distributed to the Medicine, Surgery and UECC Mortality leads. The ask is for a brief review to be undertaken in order to select a small cohort of SJRs with learning points (both positive and negative). These SJRs in addition to those where the Overall Care Score is poor or judged to have been more than likely preventable are disseminated to the CSUs for discussion at their Governance or separately held Mortality meeting.

All SJRs where the Overall Care Score is poor or the death is judged to have likely preventable are entered as an incident on Datix. These SJRs and the reasons for their poor care score or preventability are then reviewed following the governance process. These cases can be referred to panel where a Serious Incident can be declared, a Patient Safety Incident Investigation undertaken, resulting in an After Action Review.

Update

Clinical and administrative pressures in the Division of Surgery have seen some of their Divisional Mortality meeting cancelled over the Autumn/Winter.

John Taylor
Learning from Deaths & Mortality Manager
February 2024

1
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29/11/2023

Learning From Deaths
Thematic Analysis SJRs 2023/24 Q2

Content

This report contains the Thematic Analysis of Structured Judgement Reviews (SJRs) completed for deaths in 2023/24 Q2. 33 were completed.

Thematic analysis is a method for analysing and coding qualitative data to determine themes.
Thematic analysis of SJRs involves analysing free text comments and assigning these comments to codes.

In this analysis the comments are assigned to a code based on whether they are positive, negative and what factor the positive or negative comment relates to.

Purpose of Thematic Analysis in Learning From Deaths

Grouping comments into categories to highlight recurrent instances/themes will:

:Identify new problems

:Identify the reappearance of problems

:Highlight that some problems thought to be rare are more commonplace

:Provide evidence for problems that are reported anecdotally

:Identify good practice

Reducing Reocccurance Rate of Poor Care for Future Patient & Sharing Good Practice

This is the ultimate objective of the Learning From Deaths Programme.

In order for this report to be affective, it must be read by Trust individuals and groups who can subsequently suggest, design and implement changes that do this.

Content

Thematic Analysis 2023/24 Q2: Comments Detailing Poor Care

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Delay/Omission - Assessment/Opinion/Review Page 4
Delay/Omission/Interpretation - Tests/Results/Monitoring Page 5
End of Life/Palliative Care/DNACPR Page 5
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Thematic Analysis 2023/24 Q2: Comments Detailing Good Care

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Delay/Omission - Escalation Page 9
Delay/Omission - Assessment/Opinion/Review Page 9
Delay/Omission/Interpretation - Tests/Results/Monitoring -
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Concern Area Page 12
Problems in Care Page 13

Delay/Omission/Choice - Medication or Treatment

Delay in considering LRTI

it is reasonable to given tinzaparin treatment to a person with raised d- dimer and no raised WCC , however he already had abnormal clotting **/9 and previous GI bleed and documentation of the active consideration of risk vs benefit was not undertaken.

Plan in notes is good for iv fluids alternating dextrose and saline but only given 5250 mls IV and minimal oral in 6 days (at 79 kg he should of had 2680mls per day) sodium raising, no urine out put documented until 24 hours from death , no fluid input measured , food chart asked for but not filled in or reviewed .

He did not receive adequate fluids and the input and output of fluids and food was not monitored

Canula lost in night and as oedematous had multiple attempts to re-canulate so missed 3 doses of antibiotics and IV paracetamol.

There were omissions of medications to treat ACS at both clinical and nurses request further reasoning for this is not documented and as such it is difficult to know if this is a medication supply issue or some other reason . If it is a supply issue then this needs to be acted upon to prevent this happening again as all medications were standard and would expect to be stock items . (certainly for UECC and AMU)

Antibiotic choices and investigations for pneumonia/LRTI not great and would not have covered HAP although would have potentially covered a community acquired pneumonia. I would have spoken to micro in reality.

Some confusion over management of hyponatraemia with conflicting strategies suggested by ITU and renal team.

The initial presentation assessment within the UECC was documented poorly , 23 hours in UECC prolonged period due to complexity of case , hypertension untreated initially and 5 hours to CT head - this did not affect out come but is poor quality of care . Good observations and quick speciality assessment. The initial clerking seems to dismiss the presentation and very little professional curiosity

This was instigated and appropriate with adequate drugs , however it is documented that he was distressed and medication not given PRN until asked for and that family stayed with him as they felt he was not settled . This could have been better.

Delay/Omission - Escalation

The nursing documentation is inaccurate family report unresponsive from 2pm following a fall , observations from 15:18 by qualified nurse and 17:12 student nurse both document he was alert - clinician seeing at 17:00 aprox documents GCS 3 fixed dilated pupils. If the reduced responsiveness had been accurately recorded then this would of triggered an action via the increase in NEWS 2 score and more frequent observations.

Delay/Omission - Assessment/Opinion/Review

Delay in considering LRTI

it is reasonable to given tinzaparin treatment to a person with raised d- dimer and no raised WCC , however he already had abnormal clotting 17/9 and previous GI bleed and documentation of the active consideration of risk vs benefit was not undertaken.

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On the previous attendance the patient was admitted with Abdo pain. He had a history of a stricture. Though the Surgical team saw the CT scan, there was no surgical review and the patient was admitted under the medical team.

Delay in PTWR, senior review

His frequent falls in hospital could have been prevented with closer supervision but I do not feel his death was a result of these falls.

Not seen on the Sunday, despite been quite unwell

Address the inability to contact the Consultant on Call

Need to provide ward cover on a daily basis for all wards

Decision made early and the team very engaged in the patients care, just let down by the lack of input from the team. Possibly they were short staffed / strike or sickness

Given this patient recent admission with heart failure: they should probably have been managed by the Heart failure team and cardiology from much earlier on. There appeared good input from the HFSN when it started.

Review of the Cardiology input, how these patients are picked up on arrival in hospital. Ortho to refer early if under HF team, or complex Medical care

Delay/Omission/Interpretation - Tests/Results/Monitoring

5 hours to CT head - this did not affect outcome but is poor quality of care.

Plan in notes is good for iv fluids alternating dextrose and saline but only given 5250 mls IV and minimal oral in 6 days (at 79 kg he should of had 2680mls per day) sodium raising, no urine output documented until 24 hours from death , no fluid input measured , food chart asked for but not filled in or reviewed .

He did not receive adequate fluids and the input and output of fluids and food was not monitored

Treated as potential new LRTI but unclear. No urinary antigens sent off to try and ascertain cause of the infection and minimal investigations but commenced on antibiotics and admitted.

Sodium and Creatinine creeping up on the 11th (AKI1), not repeated till the 16th

The lack of monitoring of the U&Es is a concern.

End of Life/Palliative Care/DNACPR

This was instigated and appropriate with adequate drugs , however it is documented that he was distressed and medication not given PRN until asked for and that family stayed with him as they felt he was not settled . This could have been better

Should this lady have stayed in the Care Home Should she have stayed there?

The decision to admit was most likely not consistent with patient's wishes and does not reflect good holistic care. Admission was unnecessary.

Acknowledgment of ReSPECT form, or equivalent could have prevented this hospital admission and the patient could have received EoL care in the care home.

Admission (from care home) could probably have been avoided and patient could have had similar care in the community.

Had appropriate acute care for sepsis during first 24 hours and family were spoken to, but not asked (patient at this point lack capacity) what he would have wanted in the serious situation he was in, and given this was third attendance with similar presentation within a few days, no evidence of any care planning or discussions on previous admissions.

It is clear this gentleman was continuing to deteriorate clinically despite this and family raising concerns about his oral intake, he was receiving IV fluids, but no discussions had about uncertain outcome and likely hood of deterioration, and what he would have wanted given his lack of capacity

Lack of taking up opportunity to attempt care plan prior and during previous admissions, this may have guided care, in care home and hospital. Lack of discussion around wishes when outcome clearly very uncertain, may have avoided repeated attempts at cannulation and PICC line insertion for a man who died 24 hours later.

Unacceptable delay (6hours) in verification of death of the patient - clearly due to logistical/ organisational factors leading to a lamentable experience for the family in a very distressing time."

It seems that from the outset it was acknowledge by the stroke consultant that the outcome was going to be poor. Full treatment still and it seems that family led EOL care instigation, this was not instigated at the earliest opportunity most likely due to having a junior clinician review the case.

Not enough recognition that this lady was deteriorating with large symptom burden and very late referral to pall care team, which was instigated by resp physios and not treating team.

Better recognition of dying needed and management of distress, honest discussions needed with families and patients about outcomes

There was clear recognition that the patient was deteriorating and in the last hours of life when reading the notes however no attempt appears to have been made to instigate comfort measures or palliative care in this time and no communication with

Location of Care/Bed Availability/Inappropriate Moves

On the previous attendance the patient was admitted with Abdo pain. He had a history of a stricture. Though the Surgical team saw the CT scan, there was no surgical review and the patient was admitted under the medical team.

Should this lady have stayed in the Care Home, should she have stayed there?

The decision to admit was most likely not consistent with patient's wishes and does not reflect good holistic care. Admission was unnecessary.

Acknowledgment of ReSPECT form, or equivalent could have prevented this hospital admission and the patient could have received EoL care in the care home.

Admission (from care home) could probably have been avoided and patient could have had similar care in the community.

Shame we don't have access to better accommodation for the dying patient

did not get bed until 13:34 **/8 significant delay in this

Too long in the ED

Communication

The initial presentation assessment within the UECC was documented poorly

Address the inability to contact the Consultant on Call

Lack of taking up opportunity to attempt care plan prior and during previous admissions, this may have guided care, in care home and hospital. Lack of discussion around wishes when outcome clearly very uncertain, may have avoided repeated attempts at cannulation and PICC line insertion for a man who died 24 hours later.

There was clear recognition that the patient was deteriorating and in the last hours of life when reading the notes however no attempt appears to have been made to instigate comfort measures or palliative care in this time and no communication with next of kin. There appears to be around 5 hours between the last notes entry and his inpatient verification of death.

Family concerned that during night they did not know he was EOL

Some confusion over management of hyponatraemia with conflicting strategies suggested by ITU and renal team.

The nursing documentation is inaccurate family report unresponsive from 2pm following a fall observations from 15:18 by qualified nurse and 17:12 student nurse both document he was alert - clinician seeing at 17:00 aprox documents GCS 3 fixed dilated pupils. If the reduced responsiveness had been accurately recorded then this would of triggered an action via the increase in NEWS 2 score and more frequent observations. Recorded on Coroners referral family report a fall early afternoon, no documentation of this in medical or nursing notes

Patient appeared to attend theatre treatment suite for ascitic drainage on **/8/23. No fluid was found and procedure 'abandoned'. There do not appear to have been any indications or plans to drain ascitic fluid. On **/8/23 the respiratory team documented that they had booked a pleural fluid aspiration (thoracocentesis) in the theatre treatment suite. No further acknowledgment of this error seen in the notes

it is very difficult to review Meditech records. Frequently it is not possible to know the nature of the person seeing the patient. It is not possible to review the input from a team in it's entirety. Reviewing the giving of medications and tracing this through the admission is very difficult

despite her known terminal illness, no discussions had with her and family about likely outcome

Thematic Analysis 2023/24 Q2: Comments Detailing Good Care

Delay/Omission/Choice - Medication or Treatment

In the limited time available and in the middle of the evening On call. The Med Reg took the time to speak to the family on several occasions, introduce and explain the situation the outcome and deliver EOL care: Excellent.

UECC - excellent treatment of sepsis

Excellent initial care by Med Reg.

aspects were excellent such as reviews and documentation , multiple specialties involved multiple times. Consideration given to fluids balance and nutrition in line with trust guidance.

Patient received excellent care in the form of appropriate surgical intervention and aggressive intensive care for multiple organ failure.

excellent UECC treatment trail of NIV and decision for ward level care

Delay/Omission - Escalation

Patient received excellent care in the form of appropriate surgical intervention and aggressive intensive care for multiple organ failure.

Delay/Omission - Assessment/Opinion/Review

aspects were excellent such as reviews and documentation , multiple specialties involved multiple times . Consideration given to fluids balance and nutrition in line with trust guidance.

Clear and well communicated decision making. MDT and family involvement.

End of Life/Palliative Care/DNACPR

In the limited time available and in the middle of the evening On call. The Med Reg took the time to speak to the family on several occasions, introduce and explain the situation the outcome and deliver EOL care: Excellent.

Excellent reviews by palliative care and spring driver in the last few days of life.

There are some excellent examples of care such as the communication re DNACPR by Dr Heys should be commended as family had prior to this been upset by finding out he had DNACPR after last admission not discussed with them

Excellent communication and involvement from the palliative care team and good use of pre-emptive medication ensuring the patient was comfortable.

Really good demonstration of involving family and patients in decision making regarding their care and advanced care planning.

Good communication with family and clear decision making as to active treatment and resuscitation status.

Early involvement of palliative care team. Clear focus on comfort and family involvement. Communication clear.

Excellent EOL care. Excellent communication demonstrated

Communication

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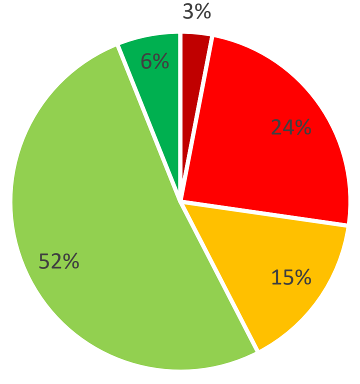
Early involvement of palliative care team. Clear focus on comfort and family involvement. Communication clear.

Excellent EOL care. Excellent communication demonstrated

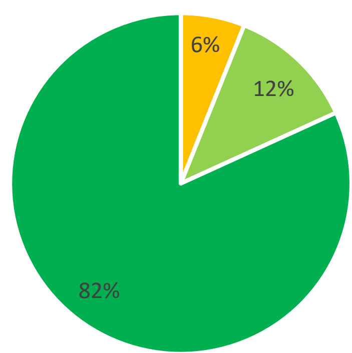
Excellent decision-making, communication and documentation about treatment decisions taken in the patient's best interest

Data Tables

Overall Care Score	SJRs
1 - Very Poor	1
2 - Poor	8
3 - Adequate	5
4 - Good	17
5 - Excellent	2
Not Recorded	0
Total	33



Avoidability	SJRs
1 - Definitely avoidable	0
2 - Strong evidence of avoidability	0
3 - Probably avoidable (more than 50%)	0
4 - Possibly avoidable (less than 50%)	2
5 - Slight evidence of avoidability	4
6 - Definitely not avoidable	27
Not Recorded	0
Total	33



Comment Relates to	Negative Comments	Positive Comments
Delay/Omission/Choice - Medication or Treatment	10	6
Delay/Omission - Escalation	1	1
Delay/Omission - Assessment/Opinion/Review	13	2
Delay/Omission/Interpretation - Tests/Results/Monitoring	6	0
End of Life/Palliative Care/DNACPR	14	8
Location of Care/Bed Availability/Inappropriate Moves	8	0
Communication	10	10
Total	62	27

Type	Problems
Problems leading to readmission	4
Problems in assessment	2
Problem with medication	6
Problem with nutrition	2
Problem with infection control	1
Problem related to operation	1
Problem in clinical monitoring	4
Problem in treatment plan	4
Problem in resuscitation	0
Problem in IV fluids	4
Problems in communication	1
Problems in relatives communication	7
Problems in team communication	7
Problem of any other type	2
Total	45

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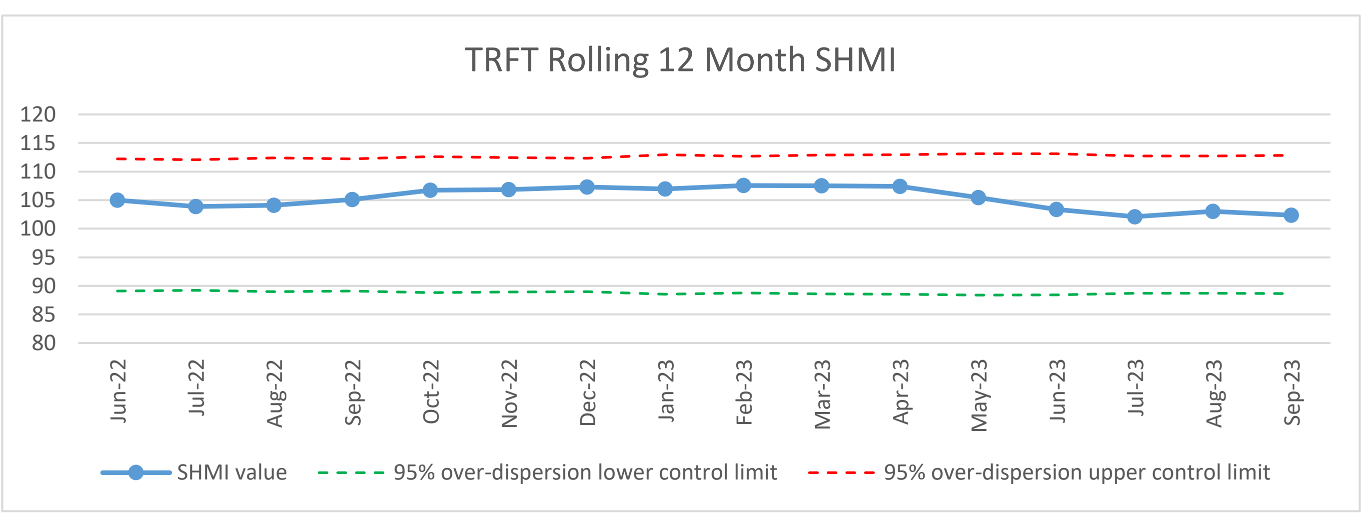
Latest Publication Date: 08/02/2024
Latest Data Month: Sep-23

TRFT SHMI Report

Summary

TRFTs latest Rolling 12 Month SHMI Value is 102.4. TRFT remain in the Band 2 'As Expected' band. The previous value was 103.0.

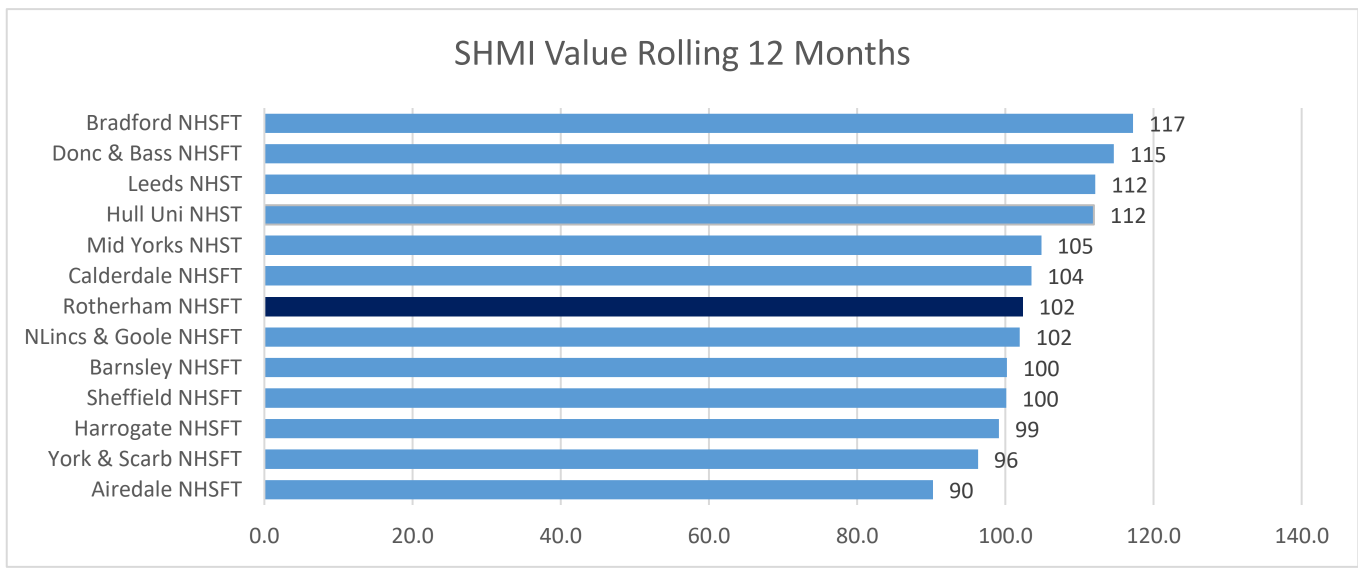
TRFT has 0 Diagnosis Groups in the Higher than Expected Band.



TRFT Latest SHMI Value

End Month	SHMI value	SHMI banding	Number of spells	Observed deaths	Expected deaths
Sep-23	102.4	2	48245	1345	1315

Region Comparator - Yorkshire & Humber Non Specialist Trusts



SHMI Diagnostic Group Breakdown

Diagnosis Group	Number of spells	Observed deaths	Expected deaths	SHMI Value	SHMI banding
Septicaemia (except in labour), Shock	625	165	140	116.2	2
Cancer of bronchus; lung	60	20	20	99.5	2
Secondary malignancies	115	20	20	89.3	2
Fluid and electrolyte disorders	355	20	20	112.9	2
Acute myocardial infarction	445	30	30	99.7	2
Pneumonia (excluding TB/STD)	1485	230	220	106.1	2
Acute bronchitis	1055	15	20	72.2	2
Gastrointestinal hemorrhage	390	15	15	81.0	2
Urinary tract infections	990	25	30	81.0	2
Fracture of neck of femur (hip)	325	30	25	130.5	2

Coding Data

TRFT Rank of 13	2nd Highest	2nd Highest	2nd Highest	5th Highest	2nd Highest
Yorks & Humber Region Non Spec Provider Trusts	**% of Spells: Primary Diagnosis is a Sign & Symptom**	**% of Spells: Invalid primary diagnosis code**	**MEAN Secondary Diagnoses per Spell Non Elective**	**% of Spells with palliative care**	**% of deaths with palliative care**
Rotherham NHSFT	17.1	2.6	6.5	1.8	49
NLincs & Goole NHSFT	17.7	0.1	4.8	1.2	21
Harrogate NHSFT	16.9	1.4	4.4	1.8	41
Airedale NHSFT	14.2	0.0	4.5	0.9	23
Barnsley NHSFT	13.9	0.1	7.1	1.8	31
York & Scarb NHSFT	13.4	0.0	5.5	1.2	27
Bradford NHSFT	13.3	1.7	3.7	1.1	36
Hull Uni NHST	13.0	6.3	5.4	2.0	33
Donc & Bass NHSFT	11.3	0.1	4.8	2.3	52
Mid Yorks NHST	9.4	0.6	6.4	1.9	38
Sheffield NHSFT	9.4	0.2	4.7	1.8	37
Calderdale NHSFT	8.3	0.0	6.2	2.0	40
Leeds NHST	6.0	0.0	6.1	1.8	31
England	14.0	1.8	5.7	2.0	42

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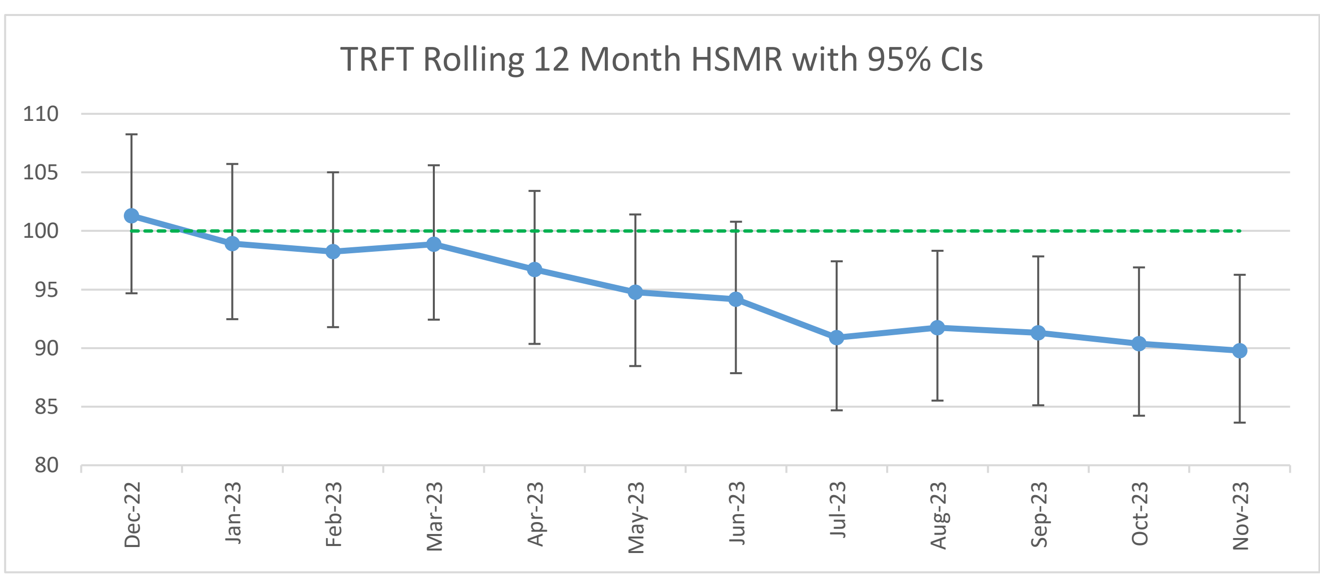
Latest Publication Date: 01/02/2024
Latest Month Data: Nov-23

TRFT HSMR Report

Summary

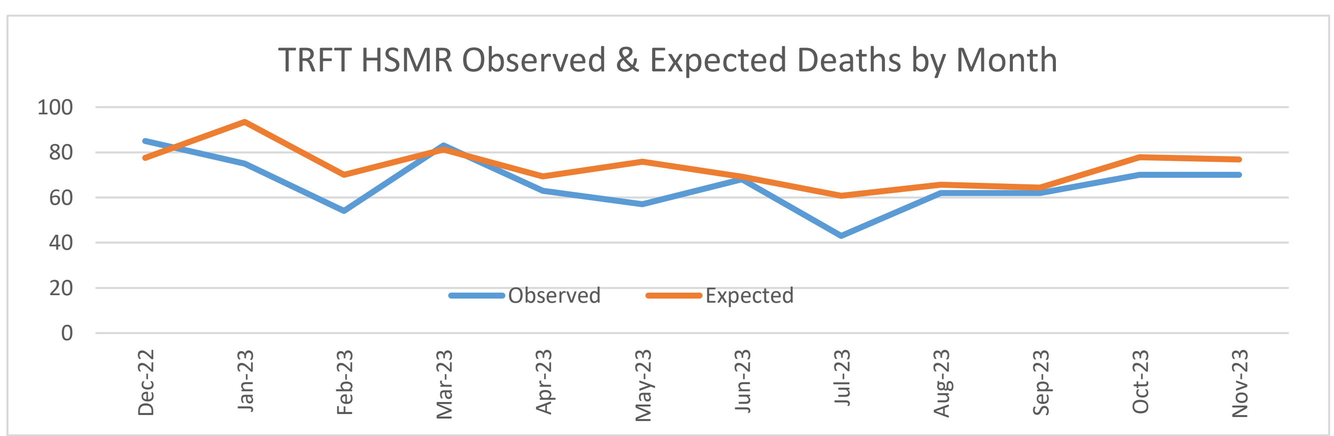
TRFTs latest Rolling 12 Month HSMR Value is 89.8 TRFT are in the 'Lower than Expected' band

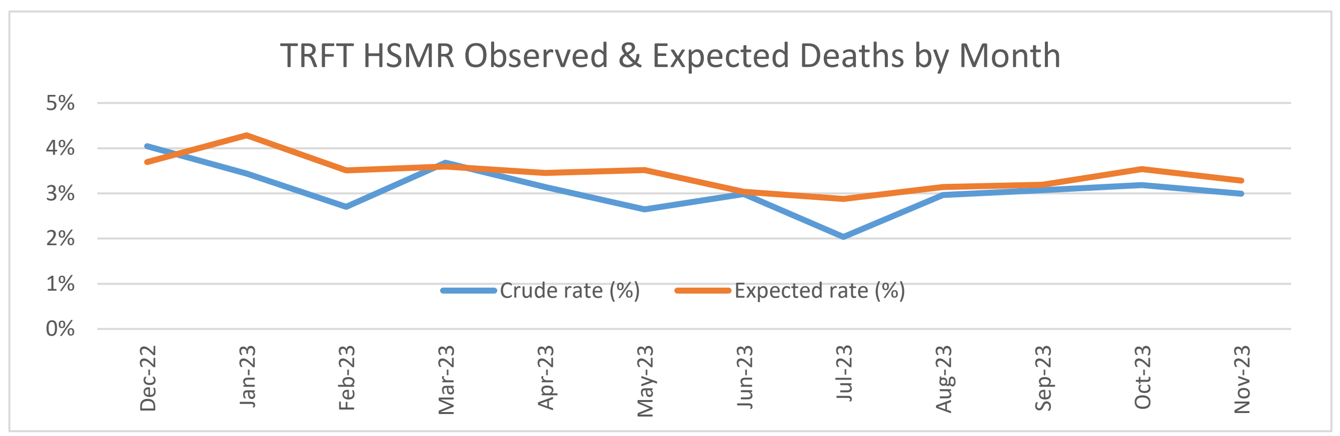
TRFT is in the higher than expected band for no Diagnosis Groups:



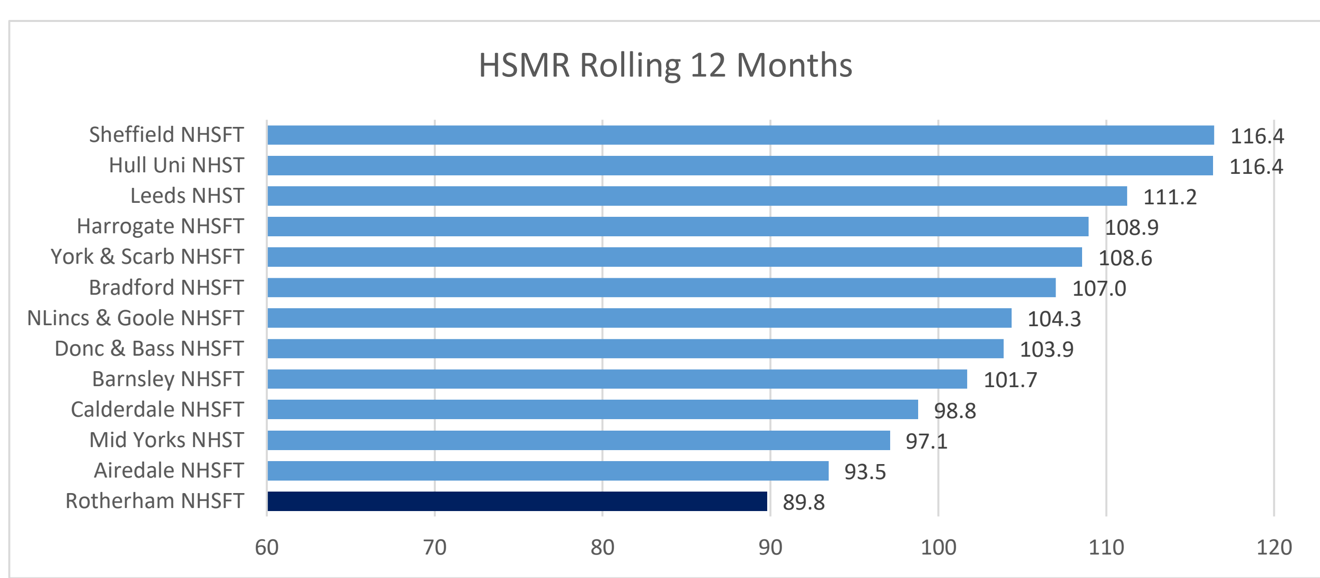
TRFT Latest R12M HSMR Value

End Month	HSMR value	HSMR banding	Number of super spells	Observed deaths	Expected deaths
Nov-23	89.8	lower	25740	792	882





Region Comparator - Yorkshire & Humber Non Specialist Trusts



HSMR Diagnostic Groups Breakdown - Higher Than Expected Groups

Diagnosis group	Superspells	Observed	Expected	Relative risk	95% lower confidence limit

Board of Directors' Meeting
8 March 2024

Agenda item	**P52/24**
Report	**Patient Safety Incident Response Framework (PSIRF) Operational Plan**
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: Ensuring the Trust is delivering safe, high quality services Caring: Ensuring appropriate investigation and learning occurs following adverse incidents to improve care for patients Together: Working collaboratively with stakeholders to deliver improvements in patient safety
Purpose	**For decision** ☐ **For assurance** ☐ **For information** ☒
Executive Summary	This report is provided to the Board of Directors for information. In November 2023, the Trust began the transition to utilising the Patient Safety Incident Response Framework (PSIRF) in line with national expectations. As part of this, the Trust developed an operational plan, following national guidance. It is a requirement that this plan is published on the Trust website. The operational plan sets out how The Rotherham NHS Foundation Trust intends to respond to patient safety incidents over a period of 12 to 18 months. The operational plan (PSIRP) and associated policies and guidelines, describe how the Trust will comply with the national Patient Safety Incident Response Framework. The plan shows our existing patient safety incident profile, identifies the national response requirements and our areas for local focus. The range of potential investigation methodologies are described. There is a specific focus on maternity incident investigations as there are some key differences to the approach for these cases. A flow chart is included to support teams to agree an appropriate level of investigation. Updates on the progress of implementation of PSIRF, supported by the operational plan is monitored through the Patient Safety Committee and reported to Quality Committee on a quarterly basis for assurance.
Due Diligence	This operational plan was approved at Patient Safety Committee and Quality Committee in Quarter 3. The content has been approved by SYICB Contract Quality Meeting.
Board powers to make this decision	The Board has delegated authority to the Quality Committee to review and feedback to the Board any assurance issues.

Who, what and when (what action is required, who is the lead and when should it be completed?)	The Board of Directors are asked to note the contents of the report and support publication on the Trust website, in line with national requirements.
Recommendations	It is recommended that the Board of Directors note the content of the report.

Patient Safety Incident Response Plan

Effective date: 4th October 2023
Estimated refresh date: at 12 months

	NAME	TITLE	DATE
Author	Alison Walker	Quality Governance and Assurance Matron, PSIRF Operational Lead	August 2023
Reviewer	Victoria Hazeldine PSIRF Implementation Group Patient Safety Committee	Deputy Chief Nurse, SRO for PSIRF	August 2023
Authoriser	Helen Dobson	Chief Nurse, PSIRF Executive Lead	August 2023

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Introduction

The Patient Safety Incident Response Framework (PSIRF) was published in August 2022 and was first described in the NHS Patient Safety Strategy (2019). PSIRF is a replacement for the NHS Serious Incident Framework (SIF, 2015).

This document is the Patient Safety Incident Response Plan (PSIRP) and will come into force from October 2023

PSIRF is a completely different approach from the preceding Serious Incident Framework (2015). PSIRF is best considered as a learning and improvement framework with the emphasis placed on the system and culture that support continuous improvement in patient safety through a variety of response methods applied to patient safety incidents.

One of the underpinning principles of PSIRF is to do fewer "investigations" and to focus resource on areas where there is the greatest scope for learning and improvement. Patient Safety Incident Investigations (PSII) will be conducted using a systems-based approach by people that have been trained to do them and have allocated time. This plan and associated policies and guidelines will describe how it all works. The NHS Patient Safety Strategy challenges us to think differently about learning and what it means for a healthcare organisation. Carrying out investigations for the right reasons can and does identify learning.

This patient safety incident response plan (PSIRP) sets out how **The Rotherham NHS Foundation Trust** intends to respond to patient safety incidents over a period of 12 to 18 months. The PSIRP, and associated policies and guidelines, describes how the Trust will comply with the national Patient Safety Incident Response Framework (PSIRF) (NHSE 2022). The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

PSIRF recognises the need to ensure we have support structures for staff, patients and their families affected by patient safety incidents. Part of this is the fostering of a psychologically safe culture shown in our leaders, our trust-wide strategy and our reporting systems. We continue to support a Just Culture so as to ensure staff involved in a patient safety incident are treated fairly, and supports a culture of openness to maximise opportunities to learn from mistakes and to focus on systems improvements.

We have worked with our colleagues across the Trust and collated our insights data covering a 3 year period. We have mapped our services and analysed our data to enable our key patient safety priorities to be identified. These priorities have been through the Patient Safety Committee and approved by board in November 2023.

Our services

The Rotherham NHS Foundation Trust (TRFT) is a combined acute and community Trust providing services at a number of sites across the borough, including:

- Rotherham Hospital
- Rotherham Community Health Centre (RCHC)
- Breathing Space
- Park Rehabilitation Centre (PRC)
- Kimberworth Place

The Trust is an Associate Teaching Hospital of the University of Sheffield.

TRFT has 7 Divisions which encompasses:

- Clinical Support Services
- Therapies, Dietetics and Community Care
- Family Health: Obstetrics and Gynaecology and Children and Young People Services
- Integrated Medicine
- Surgery
- Urgent and Emergency Care
- Corporate Services

Defining our patient safety incident profile

A key part of developing the PSIRP is understanding our patient safety profile and related activity. This allows us to plan appropriately and ensure we have the appropriate resource and systems and processes in place to deliver the plan.

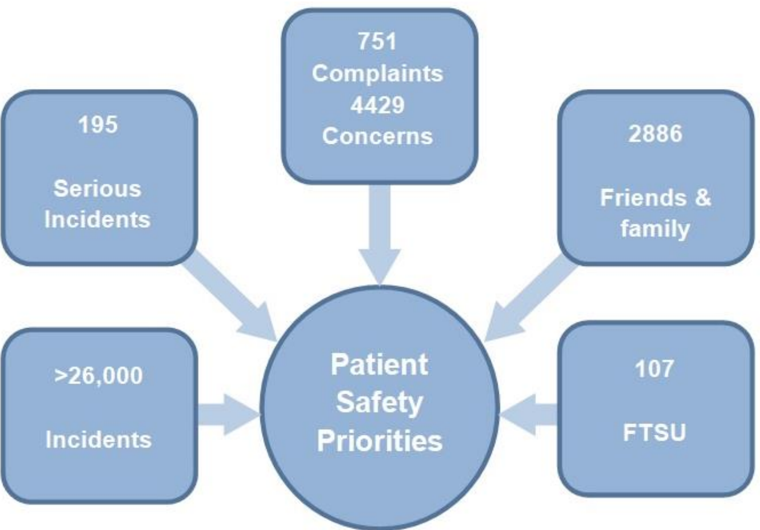
In the last three years there have been over 26,000 patient safety incidents reported in TRFT, with 195 investigated as Serious Incidents. This approach does not always lead to the sustained learning and improvements hoped for and is time consuming for staff undertaking them, leaving little time for improvement activity. Prior to moving to working under the new framework, it is important to understand the activity of patient safety investigations that we have had in recent years.

Table1: Patient Safety Incident Investigation Activity over a 3 year period

Patient Safety Activities	Activity	No. in last 3 years
National Priorities	Serious Incidents categorised as death	27
	Never Events	7
Local Patient Safety Priorities	Datix reported patient safety incidents	25,615
	Serious Incidents (not resulting in death)	166
	Internal 'red' investigations	127

Data Sources

The Trust have reviewed data from a variety of sources. This included 3 years, where available, of information from Datix reported incidents, patient and family complaints and concerns, Freedom to Speak up and Friends and Family responses. A variety of stakeholders were invited to review the data and their qualitative views were also collated and fed into the review process. This included divisional leads, speciality leads, executive and nonexecutive colleagues and members of the PSIRF Implementation Group.



Stakeholder Engagement

To understand our patient safety concerns we consulted with a diverse range of stakeholders:

- Chief Nurse (Executive Lead)
- Medical Director
- Deputy Medical Director
- Deputy Chief Nurses
- SYICB Lead
- Director of Corporate Affairs
- Legal Affairs
- Mortality
- Freedom to Speak up
- Patient Experience, Engagement & Involvement
- Project Management Office
- Communications team
- Human Resources & Equality, Diversity and Inclusion lead
- Assistant Medical Director for Human Factors
- Education, Training & Development
- Head of Quality Improvement
- Heads of Nursing
- Divisional Directors
- Divisional General Managers
- Governance Leads
- Incident Reporting System Manager
- Local Maternity and Neonatal System
- Maternity and Neonatal Voice Partnership

At TRFT we understand the need to involve our patients and their families in our decision making. As we grow our patient panels, we aim to increase this involvement.

Defining our patient safety improvement profile

TRFT is committed to improving the quality of care for our patients. We have appointed a Head of Quality Improvement and aim to establish a Quality Improvement faculty, utilising the Quality Service Improvement and Redesign (QSIR) approach, with an ambition to train 72 staff per year.

The Trust's patient safety improvement profile can be found on the Audit Management and Tracking system (AMaT). This database holds the Trusts audit programme as well as the Quality Improvement Plans.

Our patient safety incident response plan: national requirements

National event response requirements

In healthcare, there a number of circumstances when the type of response is predetermined by a set criteria as set out in national policy or regulations. These responses may include review by or referral to another body or team depending on the nature of the event. TRFT will adhere to any national requirements as set out in Table 2

Table 2: Events requiring a specific type of response as set out in policies or regulations

Event	Action Required	Lead body for the response
Deaths thought more likely than not due to problems in care (incidents meeting the learning from deaths criteria for PSII NHS England » National Guidance on Learning from Deaths)[5]	TRFT led PSII	The organisation in which the event occurred
Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the learning from deaths criteria)	TRFT led PSII	The organisation in which the event occurred
Incidents meeting the Never Events criteria 2018, or its replacement 2018-Never-Events-List-updated-February-2021.pdf (england.nhs.uk).	TRFT led PSII	The organisation in which the Never Event occurred
Mental health-related homicides	Referred to the NHS England Regional Independent Investigation Team (RIIT) for consideration for an independent PSII Locally-led PSII may be required	As decided by the RIIT
Maternity and neonatal incidents meeting Healthcare Safety Investigation Branch (HSIB) criteria or Special Healthcare Authority (SpHA) criteria when in place	Refer to HSIB or SpHA for independent PSII	HSIB (or SpHA)
Child deaths	Refer for Child Death Overview Panel review Locally-led PSII (or other response) may be required alongside the panel review – organisations should liaise with the panel	Child Death Overview Panel
Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR) TRFT led PSII (or other response) may	LeDeR programme

	be required alongside the LeDeR – organisations should liaise with this	
Safeguarding incidents in which: • babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence • adults (over 18 years old) are in receipt of care and support needs from their local authority • the incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence	Refer to local authority safeguarding lead Healthcare organisations must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards	Refer to your local designated professionals for child and adult safeguarding
Incidents in NHS screening programmes	Refer to local screening quality assurance service for consideration of TRFT led learning response See: Guidance for managing incidents in NHS screening programmes [Managing safety incidents in NHS screening programmes - GOV.UK (www.gov.uk)]	The organisation in which the event occurred
Deaths in custody (e.g. police custody, in prison, etc.) where health provision is delivered by the NHS	Any death in prison or police custody will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC) to carry out the relevant investigations Healthcare organisations must fully support these investigations where required to do so	PPO or IOPC
Domestic homicide	A domestic homicide is identified by the police usually in partnership with the community safety partnership (CSP) with whom the overall responsibility lies for establishing a review of the case Where the CSP considers that the criteria for a domestic homicide review (DHR) are met, it uses local contacts and requests the establishment of a DHR panel The Domestic Violence, Crime and Victims Act 2004 sets out the statutory obligations and requirements of organisations and commissioners of health services in relation to DHRs	CSP

[5]Unless the death falls under another more specific category in Table A1, in which case that response must be followed.

Our patient safety incident response plan: local focus

Organisations are mandated to respond to incidents in accordance with nationally mandated responses. There is no mandate for a pre determined response for any other incident type. TRFT will balance effort between learning through responding to incidents or exploring issues and improvement work with guidance from table 3. Safety action development will be based on the SEIPS Model / HFIX and application of the iFACES tool as per associated PSIRF policy. Our staff will be trained in the application of this method using the Safety Action Development Guide.

Table 3: Key objective of patient safety incident response activity

Key objective of patient safety incident response activity			
	Learning to inform improvement	**Improvement based on learning**	**Assessment to determine required response**
Circumstances in which to apply activity type	Where contributory factors are not well understood and local improvement work is minimal, a learning response may be required to fully understand the context and underlying factors that influenced the outcome.	Where a safety issue or incident type is well understood (e.g. because previous incidents of this type have been thoroughly investigated and national or local improvement plans targeted at contributory factors are being implemented and monitored for effectiveness) resources are better directed at improvement rather than repeat investigation.	For issues or incidents where it is not clear whether a learning response is required

All patient safety incidents matching the Trust profile will be responded to using the response method indicated below. Incidents will continue to be reported in an open and honest manner onto the Datix incident reporting system. Supportive oversight will be provided to all divisions through the Patient Safety Incident Response Group (PSIRG). Incidents where the following criteria is met will be brought to the PSIRG for discussion, advice and guidance on proportionate response:

- Likelihood of reoccurrence and future harm – risk assessed approach

- Reoccurrence of the same incident type
- Where the contributory factors are not known or are not clear
- Where there is no current Quality improvement activity addressing the issue
- Any issues or incidents where it is not clear whether a learning response is required

In defining the Trust patient safety priorities, the views of our stakeholders were collated together with the quantitative and qualitative data sources. Consideration was also given to patient safety improvement projects already underway and the effectiveness of these and where there might be greatest opportunities for learning and improvement. An initial set of priorities were defined, shared and discussed with our stakeholders. Feedback from stakeholders identified that these were too narrow and following further discussions these have been redefined.

The following priorities were identified and agreed.

<table>
<tr><th>Patient safety incident type or issue</th><th>Planned response</th><th>Anticipated improvement route</th></tr>
<tr><td>Recognition and escalation of the deteriorating patient</td><td rowspan="4">PSII (as per criteria above section)
After Action Review
MDT Review
Thematic Review
SWARM</td><td rowspan="4">Create local safety actions and feed these into the quality improvement plan</td></tr>
<tr><td>Medication
Management of time critical medication - including dispensing, prescribing and administration</td></tr>
<tr><td>Risk Assessments
Completion of patient risk assessments and identified actions</td></tr>
<tr><td>Communication
Communication with patients, families and carers.</td></tr>
</table>

Our Response Methods

PSIRF promotes a range of system-based approaches for learning from patient safety incidents. National tools have been developed in a PSIRF Toolkit and the Trust will develop a training programme for staff to support the application of these methods. These tools apply the SEIPS framework (Systems Engineering Initiative for Patient Safety) to explore the contributory factors to a patient safety incident or cluster of incidents, and to inform improvement. The Trust will continue to evolve its Quality Improvement function and progress a seamless interface between safety actions and QI.

Learning response types	Description	Capacity to respond

Patient safety incident investigation (PSII)	A PSII is undertaken when an incident or near-miss indicates significant patient safety risks and to provide a clear explanation of how an organisation's systems and processes contributed to a patient safety incident. It is guided by the principle that people are well intentioned and strive to do the best they can. PSII's examine system factors such as the tools, technologies, environments, tasks and work processes involved.	Anticipated 5-6 PSII's meeting the criteria per year. The Trust may select up to an additional 6 PSII's per year
After Action Review (AAR)	A method of evaluation that is used when outcomes of an activity or event, have been particularly successful or unsuccessful. It aims to capture learning from these tasks to avoid failure and promote success for the future.	Anticipated 20 AAR's
Thematic Review	A thematic review may be useful for understanding common links, themes or issues within a cluster of investigations, incidents or patient safety data. Themed reviews seek to understand key barriers or facilitators to safety. The 'top tips' document provides guidance on how to approach a thematic review.	Anticipated 6 Thematic Reviews
Multidisciplinary Team Review (MDT)	Supports teams to: identify learning from multiple patient safety incidents • agree the key contributory factors and system gaps in patient safety incidents; explore a safety theme, pathway, or process • gain insight into 'work as done' in a health and social care system	
Swarm Huddle	Swarm-based huddles are used to identify learning from patient safety incidents. Immediately after an incident, staff 'swarm' to the site to quickly analyse what happened and how it happened and decide what needs to be done to reduce risk.	

Maternity Patient Safety Incident Response Plan

Within the maternity services at Rotherham a range of system based approaches will be utilised in order to respond to and learn from patient safety incidents. This approach is central to improving perinatal quality surveillance therefore improving outcomes for the women, birthing people and their families. With maternity patient safety incidents like all aspects of incident responses under the Framework, the Board are accountable for the quality of incident responses and fundamentally for reducing the reoccurrence and risk as a result of incidents. This is particularly relevant to Rotherham's Board-level Maternity Safety Champions and the Non-Executive Director appointed to work alongside the champions.

In order to ensure a collaborative and collective approach, the Regional and Local Maternity Neonatal systems (LMNS) as well as the Maternity and Neonatal Voices Partnership have been involved in the development of this Maternity Patient Safety Incident Response Plan.

Maternity patient safety incidents requiring referral and investigation externally

Patient safety incidents meeting the Health Service Investigation Branch (HSIB), soon to be re-named Maternity and Newborn Safety Investigation Special Health Authority (MNSI), are listed below. All cases will meet the requirements for a patient safety incident investigation (PSII). As such, they must be referred to HSIB where an independent investigation will take place.

HSIB/MNSI and NHS Resolution

Babies who meet the criteria to be referred to HSIB/MNSI for investigation include all term babies born following labour (at least 37 completed weeks of gestation), who have one of the following outcomes:

- Intrapartum stillbirth: the baby was thought to be alive at the start of labour but was born showing no signs of life.
- Early neonatal death: the baby died, from any cause, within the first week of life (0 to 6 days).
- Potentially severe brain injury diagnosed in the first seven days of life and the baby was diagnosed with grade III hypoxic ischaemic encephalopathy; or was
- Therapeutically cooled (active cooling only); or had decreased central tone, was comatose

Maternal deaths that meet the criteria to be referred to HSIB/MNSI:

Deaths of women and birthing people pregnant or within 42 days of the end of the pregnancy from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes (excludes suicides).

A 72 hour report (otherwise known as a rapid review) will be undertaken to commence an initial screening investigation. From this a referral, ideally within this timeframe to HSIB/MNSI. Once the case has been triaged by HSIB/MNSI and accepted, the following cases that meet the below criteria must be reported to the NHS Resolutions Early Notification Scheme (EN).

- Any baby born >37+0 weeks gestation, following labour that resulted in severe brain injury diagnosed in the first 7 days of life and fall into the below categories.
- A baby diagnosed with grade III hypoxic ischemic encephalopathy (HIE)
  Or
- The baby was therapeutically cooled (active cooling only)
  Or
- and decreased central tone AND was comatose AND had seizures of any kind.

EN cases must be referred via the Trust solicitor as soon as they have been accepted by HSIB/MNSI.

Perinatal Mortality Review Tool (PMRT)

The PMRT has been designed by MBRRACE-UK to support the internal and with external peers to review of the care of the following babies:

- All late fetal losses 22+0 to 23+6 weeks gestation;
- All antepartum and intrapartum stillbirths;
- All neonatal deaths from birth at 22+0 weeks gestation to 28 days after birth;
- All post-neonatal deaths where the baby is born alive from 22+0 weeks gestation but dies after 28 weeks gestation following care in a neonatal unit; the baby may be receiving planned palliative care elsewhere (including at home) when they die.

The PMRT is **not** designed to support the review of the following perinatal deaths:

- Termination of pregnancy at any gestation;
- Babies who die in the community 28 days after birth or later who have not received neonatal care;
- Babies with brain injury who survive.

Maternity patient safety incidents not referred to HSIB/PMRT: local focus

Maternity services will no longer use a ‘trigger list’ for identifying when a daitx must be submitted but will be in line with the wider Trust. A datix will be submitted when there is an ***unintended or unexpected outcome that has the potential or has caused harm***. Table 1 below sets out how Rotherham Maternity service intend to response to different maternity incidents. As with all patient safety incident responses under the PSIRF, the focus is on examining and understanding how to reduce the risk of future incidents.

Table 1

	Incident Type	**Incident Response Method Options**	**Learning Response**
1	Any case where a baby or mother has suffered serious injury/damage that does not fit the HSIB/MNSI or PMRT criteria, which has been caused by or	MDT review followed by PSII if issues identified or AAR	Patient safety incident investigation (PSII) report

	Incident Type	Incident Response Method Options	Learning Response
	suspected to have been caused by substandard care.		
2	Avoidable Term admission to NNU.	MDT review PSA	ATAIN review proforma. Thematic review shared with the LMNS to inform action plan.
	Postpartum haemorrhage	500ml-1499ml	One page learning response template. Quarterly review and run charts
		Major obstetric haemorrhage over 1500mls	MDT review One page learning response template. Quarterly review and run charts
5	• Severe pre-eclampsia/eclampsia • Any woman and birthing person requiring enhanced maternity care • Maternal or fetal morbidity following spontaneous vaginal birth, shoulder dystocia or operative birth. • Transfer to ICU • Ruptured uterus • Neonatal low cord gases • Severe Sepsis • Cord prolapse • Third and fourth degree tears • Sequential instruments/failed instrumental birth	MDT review AAR	One page learning response template Quarterly thematic review and run charts
6	Induction of labour from patient experience perspective	Service user review	Thematic review with MNVP
7	Ectopic pregnancy, diagnosis and management	MDT review or AAR	One page learning response template Quarterly thematic review and run charts
8	Neonatal abnormalities	MDT review	Quarterly thematic review and run charts

N.B. Any learning responses that require a quarterly thematic review will include the collection of deprivation score and ethnicity to inform our work around improving health equalities.

Our Capacity to Respond

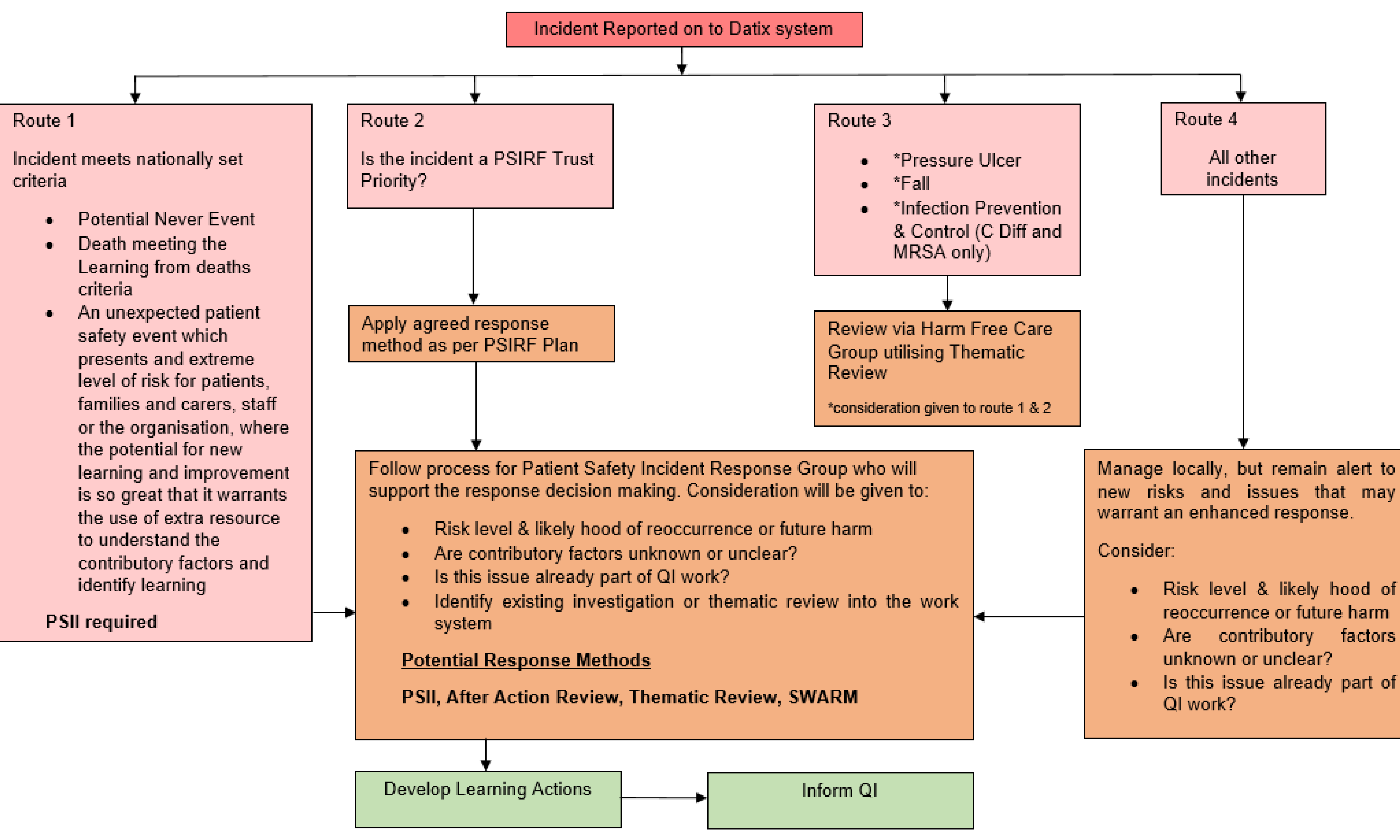
Under the previous Serious Incident Framework (SIF 2015), an average of 109 externally reportable and non-reportable investigations took place each year, managed by each individual division. It has been challenging to ensure timeliness of completion and a consistent quality of investigations. This was due to investigation leads having varied training and experience and a need to prioritise clinical and operational work. This sometimes left patients and their families waiting for answers for a considerable period of time.

In order to improve this patient experience and the quality of learning and improvement from our investigations and incident responses, staff across all divisions have under taken nationally approved training. Our approach to facilitating a response is currently still in review, initially to be support by divisions, with consideration being given to implementation of Central investigator roles.

Our anticipated response resource is as follows:

- 5-6 Patient Safety Incident Investigations (meeting national requirement)
- 6 Patient Safety Incident Investigations (Trust selected where a high level of risk is identified and contributory factors are unknown)
- 20 After Action Reviews
- 6 Thematic Reviews

As PSIRF is a new way of responding to incidents and uses new investigation models for in-depth investigations, this estimate will be reviewed as the Trust becomes more familiar with the response capacity requirements.


Flow chart for gudiance when considering how to response to a patient safety incident
Incident Reported on to Datix system
Route 1
Incident meets nationally set criteria
Potential Never Event
Death meeting the Learning from deaths criteria
An unexpected patient safety event which presents and extreme level of risk for patients, families and carers, staff or the organisation, where the potential for new learning and improvement is so great that it warrants the use of extra resource to understand the contributory factors and identify learning
PSII required
Route 2
Is the incident a PSIRF Trust Priority?
Apply agreed response method as per PSIRF Plan
Route 3
*Pressure Ulcer
*Fall
*Infection Prevention & Control (C Diff and MRSA only)
Review via Harm Free Care Group utilising Thematic Review
*consideration given to route 1 & 2
Route 4
All other incidents
Follow process for Patient Safety Incident Response Group who will support the response decision making. Consideration will be given to:
Risk level & likely hood of reoccurrence or future harm
Are contributory factors unknown or unclear?
Is this issue already part of QI work?
Identify existing investigation or thematic review into the work system
Potential Response Methods
PSII, After Action Review, Thematic Review, SWARM
Manage locally, but remain alert to new risks and issues that may warrant an enhanced response.
Consider:
Risk level & likely hood of reoccurrence or future harm
Are contributory factors unknown or unclear?
Is this issue already part of QI work?
Develop Learning Actions
Inform QI

Board of Directors' Meeting
8 March 2024

Agenda item	P53/24
Report	**2023/2024 Annual Accounts: Going Concern**
Executive Lead	Steve Hackett, Director of Finance
Link with the BAF	D6 and D7
How does this paper support Trust Values	Effective financial management assists the Trust in achieving all of its values.
Purpose	**For decision** ☒ **For assurance** ☐ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	Accounting standards require the Trust's Board of Directors to assess and satisfy itself that it is appropriate to prepare the Trust's financial statements on a Going Concern basis for at least 12 months from the date of the accounts. This purpose of this report is to set out the arguments for supporting the going concern concept for the Trust, mainly being: • The management of the Trust has not, nor does it intend to, apply to the Secretary of State for the dissolution of the Trust. • The Secretary of State has not informed the Trust that it intends to dissolve the Trust. • Management is not aware of any operating or other issues that would prevent the annual accounts for 2023/2024 being prepared on a going concern basis.
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	This report was presented at the Trust's Audit and Risk Committee for endorsement on 26 January 2024 prior to it being put on the agenda for Board Approval. The report was submitted to the Director of Finance and Deputy Director of Finance for pre-approval prior to being presented to the Audit and Risk Committee for review and comment.

Board powers to make this decision	This report complies with the Trust's Constitution: 40. Accounts 40.1 The Trust must keep proper accounts and proper records in relation to the accounts. 40.2 In preparing its annual accounts, the corporation must comply with any directions given by the regulator with the approval of the Treasury as to— (a) the methods and principles according to which the accounts must be prepared, (b) the information to be given in the accounts. Accounting standards require the Trust's Board of Directors to assess and satisfy itself that it is appropriate to prepare the Trust's financial statements on a going concern basis for at least 12 months from the date of the accounts.
Who, What and When (what action is required, who is the lead and when should it be completed?)	Audit and Risk Committee endorsed this report at their meeting on 26 January 2024. This report needs to be ratified by Trust Board prior to the end of the financial year to enable the timely preparation of the Trust's annual accounts.
Recommendations	It is recommended that: Trust Board approve that the going concern concept is applied to The Rotherham Foundation Trust before the end of the financial year to ensure the timely preparation of the annual accounts.
Appendices	Appendix 1 – Going Concern in the Public Sector / NHS Context

2023/2024 Annual Accounts: Going Concern

1 Introduction

1.1 The accounting concept of Going Concern is fundamental to the way in which the assets and liabilities of an organisation are recorded within its accounts. Under this concept an entity is usually expected to continue to operate for the foreseeable future with the assets and liabilities being valued on this basis.

1.2 If the entity is not expected to continue to operate the assets and liabilities would be recorded in the accounts on the basis of their value on the winding up of the entity. As a result, the assets would be recorded at a lower break-up value and medium/long-term liabilities would become short term. It is important to note that the Going Concern consideration applies to The Rotherham NHS Foundation Trust as an entity and not to the hospitals or services which it runs.

1.3 NHS Foundation Trusts (FTs) are required to prepare their accounts in accordance with International Financial Reporting Standards (IFRSs) as interpreted by the Department of Health and Social Care's (DHSC) Group Accounting Manual (GAM). The requirement to prepare accounts on a Going Concern basis is set out in International Accounting Standard (IAS) 1: Presentation of Financial Statements, which states:

- When preparing financial statements, management shall make an assessment of an entity's ability to continue as a going concern,
- An entity shall prepare financial statements on a going concern basis unless management intends to liquidate the entity or to cease trading, or has no realistic alternative but to do so,
- In assessing whether the going concern assumption is appropriate, management takes into account all available information about the future, which is at least, but is not limited to, twelve months from the end of the reporting period,
- When management is aware, in making its assessment, of material uncertainties related to events or conditions which may cast significant doubt upon the entity's ability to continue as a going concern, the entity shall disclose those uncertainties

1.4 External Audit will consider what the Trust's Board has done to satisfy itself that the accounts should be prepared on a Going Concern basis. This paper considers the basis on which the 2023/2024 accounts should be prepared and the conclusion reached on the Going Concern issue.

2 Going Concern in the Public Sector / NHS Context

2.1 The concept of Going Concern is set out in both the Group Accounting Manual (GAM) and the Foundation Trust Annual Reporting Manual (FT ARM); the relevant extracts have been included in Appendix 1 which explains how this principle applies to the NHS specifically.

2.2 The main points which need to be considered by the Trust are (taken from the GAM):

"4.24 Department of Health and Social Care (DHSC) group bodies should therefore prepare their accounts on a going concern basis unless informed by the relevant national body or Department of Health and Social Care (DHSC) sponsor of the intention for dissolution without transfer of services or function to another entity.

4.25 Where a Department of Health and Social Care (DHSC) group body is aware of material uncertainties in respect of events or conditions that may bring into question the going concern ability of the entity, these uncertainties must be disclosed.

4.27 Should a Department of Health and Social Care (DHSC) group body have concerns about its "going concern" status (and this will only be the case if there is a prospect of services ceasing altogether), or whether a material uncertainty is required to be disclosed (which will only arise in exceptional circumstances) it must raise the issue with its sponsor division or relevant national body as soon as possible.

4.28 Consideration of risks to the financial sustainability of the organisation is a separate matter to the application of the going concern concept. Determining the financial sustainability of the organisation requires an assessment of its anticipated resources in the medium term. Any identified significant risk to financial sustainability is likely to form part of the risks disclosures included in the wider performance report, but is a separate matter from the going concern assessment."

3 Assessment of Going Concern for the Trust's 2023/2024 Annual Accounts

3.1 In making an assessment of the Trust's going concern status, the following points are noted:

- The management of the Trust has not, nor does it intend to, apply to the Secretary of State for the dissolution of the Trust.
- The Secretary of State has not informed the Trust that it intends to dissolve the Trust. It is most unlikely that a Foundation Trust would be disestablished without a major process over some time, particularly given the absolute requirement for the services it provides. None of this would suggest any immediate likelihood of the Trust ceasing to be a going concern.
- Management is not aware of any operating or other issues that would prevent the annual accounts for 2023/2024 being prepared on a going concern basis.

3.2 On the basis of the above considerations, and in line with the Group Accounting Manual (GAM) which states that NHS providers should prepare their accounts on a going concern basis unless told otherwise (see paragraph 3, of section 2.1), it is recommended that the Rotherham Foundation Trust's annual accounts for the 2023/2024 financial year are prepared as such.

Appendix 1

Going Concern in the Public Sector / NHS Context

The following provide extracts from the GAM and FT ARM regarding the Going Concern Principles and how they apply to the NHS.

DHSC Group Accounting Manual (GAM)

It is important to consider the guidance stated in the Group Accounting Manual (GAM), which sets the requirements of IAS 1 in the context of a public sector organisation. The key extracts are as follows:

Going Concern

4.18 The Financial Reporting Manual (FReM) notes that in applying paragraphs 25 to 26 of IAS 1, preparers of financial statements should be aware of the following interpretations of Going Concern for the public sector context.

4.19 For non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern.

4.20 A trading entity needs to consider whether it is appropriate to continue to prepare its financial statements on a going concern basis where it is being, or is likely to be, wound up.

4.21 Sponsored entities whose statements of financial position show total net liabilities should prepare their financial statements on the going concern basis unless, after discussion with their sponsor division or relevant national body, the going concern basis is deemed inappropriate.

4.22 Where an entity ceases to exist, it should consider whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern in its final set of financial statements.

4.23 While an entity will disclose its demise in various areas of its Annual Report and Accounts such as in the Performance Report and cross reference this in its going concern disclosure, this event does not prevent the accounts being prepared on a going concern basis or give rise to a material uncertainty in relation to the going concern of the entity.

4.24 Department of Health and Social Care (DHSC) group bodies should therefore prepare their accounts on a going concern basis unless informed by the relevant national body or DHSC sponsor of the intention for dissolution without transfer of services or function to another entity.

4.25 Where a DHSC group body is aware of material uncertainties in respect of events or conditions that may bring into question the going concern ability of the entity, these uncertainties must be disclosed.

4.26 As the continued provision of service approach, per paragraph 4.22, applies to DHSC group bodies, material uncertainties requiring disclosure, will only arise in very exceptional circumstances.

4.27 Should a DHSC group body have concerns about its “going concern” status (and this will only be the case if there is a prospect of services ceasing altogether), or whether a material uncertainty is required to be disclosed (which will only arise in exceptional circumstances) it must raise the issue with its sponsor division or relevant national body as soon as possible.

4.28 Consideration of risks to the financial sustainability of the organisation is a separate matter to the application of the going concern concept. Determining the financial sustainability of the organisation requires an assessment of its anticipated resources in the medium term. Any identified significant risk to financial sustainability is likely to form part of the risks disclosures included in the wider performance report, but is a separate matter from the going concern assessment.

Foundation Trust Annual Reporting Manual (FT ARM)

The Foundation Trust Annual Reporting Manual (FT ARM) also provides guidance and it states:

Overview: Going Concern

2.15 There is no presumption of going concern status for NHS foundation trusts. Directors must decide each year whether or not it is appropriate for the NHS foundation trust to prepare its accounts on the going concern basis.

2.16 The Financial Reporting Manual (FReM) explains:

“The anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern.”

“Where an entity ceases to exist, it should consider whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of financial statements.”

2.17 An NHS foundation trust’s assessment of whether the going concern basis is appropriate for its accounts should therefore only be based on whether it is anticipated that the services it provides will continue to be provided with the same assets in the public sector. This is expected to be the case for NHS foundation trusts unless exceptional circumstances indicate otherwise; these should be discussed with NHS England. Where the continued provision of services in the public sector is anticipated to apply, there will not be any material uncertainties over going concern requiring disclosure.

2.18 Where an NHS foundation trust has or is expected to demise in its current organisational form but its services (and accompanying assets) are transferring to another NHS body, this would not prevent the going concern basis for accounts being adopted, and would also not be a material uncertainty on going concern. Clearly the changes to organisational form are important to the user of the annual report and accounts; in this scenario the going concern disclosure should cross reference to the relevant disclosures elsewhere in the annual report and accounts.

2.20 Consideration of risks to the financial sustainability of the organisation is a separate matter to the application of the going concern concept. Determining the financial sustainability of the organisation requires an assessment of its anticipated resources in the medium term. Any identified significant risk to financial sustainability is likely to form part of the risks disclosures included in the wider performance report, but is a separate

Board of Directors' Meeting
8 March 2024

Agenda item	P54/24
Report	**2023/2024 Annual Accounts: Operating Segments**
Executive Lead	Steve Hackett, Director of Finance
Link with the BAF	D6 and D7
How does this paper support Trust Values	Effective financial management assists the Trust in achieving all of its values.
Purpose	**For decision** ☒ **For assurance** ☐ **For information** ☐
Executive Summary (including reason for the report, background, key issues and risks)	**<u>Purpose of this paper:</u>** The purpose of this paper is to present the Operating Segments disclosure note required under IFRS 8 in the Trust's 2023/2024 Annual Report and Accounts. **<u>Summary of Key Points:</u>** This paper specifically deals with the area of segmental reporting for the Trust under IFRS and requests ratification of assumptions and disclosures required under IFRS 8 - Operating Segments. There have been no changes to assumptions and disclosures required for the 2023/2024 operational year compared to the 2022/2023 financial year: • The Chief Operating Decision Maker remains the Board of Directors. • The Board continues to review the financial position of the Foundation Trust as a whole in their decision making process, rather than reviewing individual components included in the totals; therefore the Board continues to only consider the one segment of healthcare in its decision-making process. • Per the criteria laid out in IFRS 8, all of the operating segments can be aggregated together to form one reporting segment – the provision of healthcare. In conclusion, the Trust has one "reporting" segment for the 2023/2024 financial year as per previous years, namely the provision of healthcare, and the accounts will be prepared on that basis.

Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	This report was presented at the Trust's Audit and Risk Committee for endorsement on 26 January 2024 prior to it being put on the agenda for Board Approval. The Director of Finance received a copy of the report for review and consideration prior to it being presented to the Audit and Risk Committee.
Board powers to make this decision	This report complies with the Trust's Constitution: 40. Accounts 40.1 The Trust must keep proper accounts and proper records in relation to the accounts. 40.2 In preparing its annual accounts, the corporation must comply with any directions given by the regulator with the approval of the Treasury as to— (a) the methods and principles according to which the accounts must be prepared, (b) the information to be given in the accounts. Accounting Standards require the Trust to consider its operating segments, as per IFRS 8 and as interpreted by the Department of Health and Social Care's (DHSC) Group Accounting Manual (GAM).
Who, What and When (what action is required, who is the lead and when should it be completed?)	Audit and Risk Committee endorsed this report at their meeting on 26 January 2024. Board needs to approve the operating segments prior to the end of the financial year in order to ensure the timely preparation of the annual accounts.
Recommendations	It is recommended that: Trust Board approve the following Note 2 for inclusion within the 2023/2024 annual accounts: "All of the Trust's activities are in the provision of healthcare, which is an aggregate of all the individual specialty components included therein, and the large majority of the healthcare services provided occur at the one geographical main site. Trust revenue derives within the UK. The majority of expenses incurred are payroll expenditure on staff involved in the production or support of healthcare activities generally across the Trust together with the related supplies and overheads needed to establish this production. The business activities which earn revenue and incur expenses are therefore of one broad combined nature and therefore on this basis one segment of 'Healthcare' is deemed appropriate.

	The operating results of the Trust are reviewed monthly by the Trust's chief operating decision maker which is the overall Foundation Trust Board of Directors, which includes senior professional non-executive directors. The Board of Directors review the financial position of the Trust as a whole in their decision making process, rather than individual components included in the totals, in terms of allocating resources. This process again implies a single operating segment under IFRS 8. The finance report considered monthly by the Board of Directors contains summary figures for the whole Trust together with directorate expense budgets with their cost improvement positions. Likewise only total balance sheet positions and cash flow forecasts are considered for the whole Trust. The Board of Directors as chief operating decision maker therefore only considers one segment of healthcare in its decision-making process. The single segment of 'Healthcare' has therefore been identified consistent with the core principle of IFRS 8 which is to enable users of the financial statements to evaluate the nature and financial effects of business activities and economic environments.

	Healthcare		**Total**	
	2022/23 £000	2021/22 £000	**2022/23 £000**	2021/22 £000
Income	**360,435**	340,431	**360,435**	340,431
Retained Earnings / (Accumulated Deficit)	**(8,380)**	461	**(8,380)**	461
Segment net assets	**147,637**	146,970	**147,637**	146,970

”

(The figures above are those included within the 2022/2023 accounts, the numbers will be updated on production of the 2023/2024 accounts, with reference to appropriate year's updated at that point.)

Appendices	Not applicable

2023/2024 Annual Accounts: Operating Segments

1.1 Introduction

This paper deals with segmental reporting for the Trust under IFRS and requests ratification of assumptions and disclosures required under IFRS 8 - Operating Segments.

1.2 Background

1.2.1 The objective of IFRS 8 is to require the Trust to disclose information, within a note to the annual accounts, to enable users of these financial statements to evaluate the nature and financial effects of the activities in which it engages and the economic environment in which it operates. This relates to both Statement of Comprehensive Income and the Statement of Financial Position.

1.2.2 An annual review should be made of the core principle above when forming a judgement about how and what information should be disclosed.

1.3 Key Issues Relating to IFRS 8

IFRS 8 places emphasis on reporting disclosures in the annual accounts that reflect the way that senior management runs the Trust. This involves:

1.3.1 **Identifying the Chief Operating Decision Maker (CODM)**
This is the person or persons who receive financial information analysed by internal segments and uses that information to allocate resources. Following a detailed review undertaken on the introduction of IFRS in 2009/2010 and each review since, this was determined to be the Board of Directors. No changes to the organisation have since affected this, and the CODM therefore remains the Trust Board.

1.3.2 **Determining the Internal Operating Segments**
These are the segments reported to the CODM internally and are primarily the Trust's Clinical and Corporate Divisions.

In terms of allocating resources, the Board reviews the financial position of the Foundation Trust as a whole in their decision making process, rather than reviewing individual components included in the totals.

The finance report considered monthly by the Board contains summary figures for the whole Trust, although some subsidiary divisional performance data regarding budgets and cost improvement positions is included.

Importantly, only the trust-wide detailed and itemised Income and Expenditure performance is reported upon. Likewise, only the trust-wide total Statement of Financial Position and Statement of Cash flows are reported. Finally, the Trust's Annual Financial Plan is considered on a whole Trust basis.

The Board, therefore, only considers the one segment of healthcare in its decision-making process.

Following reviews in previous years, it has been ratified that the Trust has one reporting segment, namely the provision of healthcare. This remains the position for the 2023/2024 year.

1.3.3 Determining the 'Significant' Operating Segments to be Disclosed (that is, the Reporting Segments)

In accordance with IFRS 8, a 'significant segment' is one whose revenue is at least 10% of the entity's overall revenues. However, two or more operating segments may be aggregated if:

(i) The segments have similar economic characteristics
(ii) Aggregation allows the users of the financial statements to evaluate the nature and financial effects of the business activities
(iii) Segments are similar in each of the following respects
  a. The nature of the products and services
  b. Nature of the production processes
  c. The type or class of customer for their products and services
  d. The methods used to distribute their products or provide their services and
  e. If applicable the nature of the regulatory environment

These points are considered in detail on an individual basis:

(i) Economic Characteristics

The funding of the services provided by the Trust, and reported through these operating segments, is provided by Government backed organisations, demonstrating a common funding profile and risk.

The operating segments within the Trust have similar economic characteristics in that the operational goal of the clinical and corporate divisions is to break-even on an annualised basis. The operational aim of all of the divisions is to provide healthcare, in accordance with the Trust's objectives.

(ii) Evaluation of Organisational Activities

The aggregation of all of the operating segments allows users of the financial statements to evaluate the nature and financial effects of the Trust's activities – being the provision of healthcare. Non aggregation of the Trust's performance would cause confusion to the readers of the annual accounts, rather than provide any clarification of the Trust's internal decision making process.

(iii) Other Characteristics

Characteristic	**Similarity**
Nature of service provided	The services provided by the Trust are all concerned with the core vision of the Trust – "We will always ACT the right way and be PROUD to provide exceptional healthcare to the communities of Rotherham".
Nature of production processes	Not applicable for the Trust
Type / class of customer for services	Whilst the funding for the provision of the Trust's services are from different areas (for example, NHS bodies, Local Authorities and other Governmental bodies), fundamentally the 'customers' for all of the Trust's service areas are from those in the population requiring healthcare.
Methods used to provide services	The methods and associated risks of service provision are similar through inpatient provision and community teams.
Nature of regulatory environment	Service areas within the Trust are subject to regulation in the provision of healthcare services by the Care Quality Commission (CQC).

In view of the similarities noted above, the Trust therefore considers that the aggregation criteria of IFRS 8 is satisfied and therefore all of the operating segments can be aggregated together to form one reporting segment – the provision of healthcare.

Consequently, one reporting segment will be disclosed in the 2023/2024 annual accounts. This also reflects the fact that the risks and economic characteristics of the operating segments fall within the provision of healthcare and these are not significantly different for each of the segments.

This reporting segment (that is, the provision of healthcare) mirrors the way that the organisation is managed by the Board of Directors as Chief Operating Decision Maker. The operational management of the Trust is concentrated on the provision healthcare. The Board reviews the trust-wide position initially from an Income and Expenditure, Statement of Financial Position and cash flow basis. The review of divisional performance is secondary.

1.3.4 Determining the Disclosures required for the 'Significant' Operating Segments (that is, Reporting Segment)

As the Trust has determined that there is only one reporting segment (that is, the provision of healthcare), the following disclosures are required under IFRS 8 for all entities, including those that have a single reportable segment:

(i) Information about services:

- Revenue from external customers for each service provided

(ii) Information about geographical areas:

- Split of revenues from customers by country

(iii) Information about major customers:

- Revenues from transactions with one major customer is in excess of 10% of total revenue

The vast majority of these disclosures are covered by the disclosures already required in the annual accounts for related parties and the analysis of income from activities. The geographical information disclosure will simply state that all revenues are derived within the UK within Note 2 of the accounts.

Board of Directors' Meeting
8 March 2024

Agenda item	P55/24
Report	**2023/2024 Accounts: Accounting Policies**
Executive Lead	Steve Hackett - Director of Finance
Link with the BAF	D6 and D7
How does this paper support Trust Values	Effective financial management assists the Trust in achieving all of its values.
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 brief Trust Board on changes required to the Trust's Accounting Policies, which form Note 1 to its accounts, and on changes to the accounting requirements when preparing the 2023/2024 financial year annual accounts. The Trust has aligned its Carbon Energy Fund scheme to the accounting requirements under IFRS 16, leases, on 1 April 2023; the Accounting Policy for PFI Transactions has been updated to take account of the new standard. The Trust transitioned all its other leases under IFRS 16 during the last financial year, but the new accounting arrangements for PFI were deferred to 2023/2024. In addition, the inflation adjusted cash flow discount rates have been updated for 2023/2024, at Note 1.17 Provisions, Early Retirement Provisions. Wording around the main sources of income (at note 1.5, Income) has been updated in line with the DHSC Group Accounting Manual (GAM) The following update will need to be made to the Accounting Policies, once further information has been made available: The Accounting Policies still need to be updated in respect of the wording around the NHS Pension Scheme (at note 1.6, Expenditure on Employee Benefits) once confirmed with DHSC. A copy of the draft Accounting Policies for the 2023/2024 annual accounts have been attached at Appendix 1; amendments from the 2022/2023 Accounting Policies have been highlighted through the use of tracked changes (where significant).

Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	The Accounting Polices for the 2023/2024 financial year have been reviewed against the Department of Health and Social Care (DHSC) Group Accounting Manual (GAM) for 2023/2024, which interprets the Financial Reporting Manual (FReM) for the NHS sector. This report was presented at the Trust's Audit and Risk Committee for endorsement on 26 January 2024 prior to it being put on the agenda for Board Approval. Since the meeting, there has been an updated version of the GAM published, and subsequently the wording around PFI Transactions (section 1.16) and Income (Revenue from Contracts from Customers) (section 1.5) has been amended to reflect these changes. The Director of Finance and Deputy Director of Finance received a copy of the report for review and consideration prior to it being presented to the Audit and Risk Committee.
Board powers to make this decision	This report complies with the Trust's Constitution: 40. Accounts 40.1 The Trust must keep proper accounts and proper records in relation to the accounts. 40.2 In preparing its annual accounts, the corporation must comply with any directions given by the regulator with the approval of the Treasury as to— (a) the methods and principles according to which the accounts must be prepared, (b) the information to be given in the accounts. Accounting standards require the Trust's Board of Directors to review the Accounting Principles which underpin the way in which the Trust's accounts are prepared, as set out in the Accounting Policies.
Who, What and When (what action is required, who is the lead and when should it be completed?)	Once approved, these Accounting Policies will form the basis upon which the accounts are prepared, and will be included within the Trust's annual accounts at note 1. Audit and Risk Committee endorsed this report at their meeting on 26 January 2024. Trust Board need to approve the Accounting Policies prior to the end of the financial year in order to ensure the timely preparation of the annual accounts.
Recommendations	It is recommended that: Trust Board approve the changes to the 2022/2023 Accounting policies made in preparing the 2023/2024 Accounting Policies disclosures, having noted the changes in the Annual Report and Accounting

	guidance and the Accounting Standards this year and the impact of these for the Trust's Annual Report and Accounts. A copy of the draft Accounting Policies, which will form Note 1 to the 2023/2024 annual accounts are included at Appendix 1 to this report. The NHS Pension Scheme mandated wording will need to be updated when received from the DHSC and the final cross references to accounting notes will be re-checked once the accounts are complete. Any changes that are required to the Accounting Policies upon completion of the Trust's annual accounts will be brought to the Board's attention when the annual accounts are presented for approval at it's meeting.
Appendices	1. Note 1 Accounting Policies and Other Information

2023/2024 Accounts: Accounting Policies

1 Introduction

1.1 This report sets out the Accounting Policies which will be adopted in the preparation of the 2023/2024 annual accounts.

2 Background

2.1 The Trust's Accounting Policies, which are contained within Note 1 to the Trust's accounts have been reviewed in line with changes made to the Department of Health and Social Care's (DHSC) Group Accounting Manual (GAM) 2023/2024.

2.2 On the whole there has been very little change to the GAM for 2023/2024 compared to the 2022/2023 financial year. A copy of the proposed Accounting Policies have been included at Appendix 1, with the main changes shown using tracked changes.

2.3 The main changes include:

- **Note 1.16 Private Finance Initiatives (PFI) Transactions:** the Trust has aligned its Carbon Energy Fund scheme to the accounting requirements under IFRS 16, leases, on 1 April 2023; the Accounting Policy for PFI Transactions has been updated to take account of the new standard. The Trust transitioned all its other leases under IFRS 16 during the last financial year, but the new accounting arrangements for PFI were deferred to 2023/2024.
- **Note 1.17 Provisions, Early Retirement Provisions:** the inflation adjusted expected cash flow discount rates have been updated for 2023/2024.
- **Note 1.5 Income (Revenue from Contracts from Customers):** the narrative around the main source of income to the Trust has been updated based on the proposed wording that has been received from DHSC, and reflected in the GAM.

2.4 The wording as at Note 1.16 Private Finance Initiatives (PFI) Transactions and Note 1.5 Income (Revenue from Contracts from Customers) have been updated since Appendix 1 was presented at Audit and Risk Committee for ratification, following further updates published by DHSC within the GAM.

2.5 Whilst this report recommends the approval of the Accounting Policies which are contained within Appendix 1, some changes will still be required at the point at which the accounts are prepared, these include (but not may not be restricted to):

- **Note 1.6 Expenditure on Employee Benefits:** The NHS Pension Scheme mandated wording will need to be updated when received from the Department of Health and Social Care (DHSC).

2.6 Any further changes that are required to the Accounting Policies as part of revisions to the DHSC's GAM and Foundation Trust's Annual Reporting Manual (FT ARM) will be bought to Audit and Risk Committee's attention when the draft accounts are presented at its meeting in April.

Notes to the Accounts

Note 1 Accounting Policies and Other Information

Note 1.1 Basis of Preparation

The Rotherham NHS Foundation Trust ('the Trust') is a public benefit corporation authorised, in England, in accordance with the National Health Service Act 2006. The Trust provides healthcare mainly to the region. The address of the Trust is Moorgate Road, Rotherham, S60 2UD.

NHS England has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the Department of Health and Social Care (DHSC) Group Accounting Manual (GAM), which shall be agreed with HM Treasury.

Consequently, the following financial statements have been prepared in accordance with the GAM 2023/2024 issued by the DHSC. The accounting policies contained in the GAM follow International Financial Reporting Standards (IFRS) to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

1.1.1 Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2 Going Concern

The Rotherham NHS Foundation Trust's annual report and accounts have been prepared on a going concern basis. Non-trading entities in the public sector are assumed to be going concerns where the continued provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

The Trust is not aware of any material uncertainties in respect of events or conditions that would bring into question the going concern ability of the entity.

Note 1.3 Critical Accounting Judgements and Key Sources of Estimation Uncertainty

In the application of The Rotherham NHS Foundation Trust's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.3.1 Critical Judgements in Applying Accounting Policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying The Rotherham NHS Foundation Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

Valuation of Buildings
The Department of Health and Social Care (DHSC) guidance specifies that the Trust’s land and buildings should be valued on the basis of depreciated replacement cost, applying the Modern Equivalent Asset (MEA) concept. The MEA is defined as ‘the cost of a modern replacement asset that has the same productive capacity as the property being valued’. Therefore the MEA is not a valuation of the existing land and buildings that the Trust holds but a theoretical calculation for accounting purposes of what the Trust could need to spend in order to replace the current assets. In determining the MEA the Trust, supported by its appointed Valuer (Clark Weightman), has made judgements around alternative sites and required footprint for an MEA build. In determining the MEA, the Trust has to make assumptions that are practically achievable and would meet the service needs of users, but the Trust is not required to have any plans to make such changes.

The Trust is satisfied that the assumptions underpinning the MEA valuation are practically achievable, would not change the services provided by the Trust and would not impact on service delivery or the level and volume of service provided. The Trust has no plans to implement any of the theoretical assumptions that underpin the MEA valuation.

Recognition of Leased Asset
Under leasing arrangements involving use of assets, management make judgements in determining when substantially all the significant risks and rewards of ownership of that asset(s) are transferred to the Trust, and as such should be brought onto the Statement of Financial Position.

At 31 March 2023, the Trust had a number of leases which covered buildings used to provide health care services, medical and non-medical equipment and vehicles. Note 18 provides further details.

The Trust leases a number of buildings from NHS Property Services (NHSPS). Whilst the Trust has occupied the majority of these for a substantial number of years,

contractual documentation is limited to a one year rolling service level agreement in each case. In assessing the lease term to apply in relation to IFRS 16, the Trust has reviewed future planned service delivery and has taken a ten year outlook for the purposes of calculating borrowings and Right of Use Asset valuation. Based upon this evaluation, the Right of Use Assets held under IFRS 16 with NHSPS (where there are on-going annual rolling leases) are valued at £1,653K with associated borrowings of the same amount.

1.3.2 Sources of Estimation Uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Income Estimates

In measuring income for the year, management have taken account of all available information. Income estimates that have been made have been based on actual information related to the financial year.

Injury compensation scheme income is also included to the extent that it is estimated that it will be received in future years. It is recorded in the current year as this is the year in which it was earned. However as cash is not received until future periods, when the claims have been settled, an estimation must be made as to the collectability.

Expense Accruals

In estimating expenses for goods and services received, but that have not yet been charged for, management have made a realistic assessment based on costs actually incurred in the year to date, with a view to ensuring that no material items have been omitted.

Valuation of Property, Plant and Equipment

The Trust has used valuations carried out at 31 March 2023 and 31 March 2022 by its expert independent professional valuer (Clark Weightman) to determine the value of property. These property valuations and useful lives are based on the Royal Institute of Chartered Surveyors valuation standards insofar as these are consistent with the requirements of HM Treasury and the Department of Health and Social Care.

A full revaluation of the Trust's property and land assets was undertaken at 31 March 2023. The Trust has considered items such as indices movements, deterioration of assets and its further estates plans to support its revaluation. The revaluation has resulted in impairment for 2022/23.

In between formal valuations carried out by the Trust's Valuer, consideration will be given to movement in market prices as applicable to the public sector by applying indices to land and building assets as deemed appropriate.

Future revaluations of the Trust's property may result in further material changes to the carrying values of non-current assets.

Depreciation of equipment is based on asset lives, which have been estimated upon recognition of the assets. Adjustments to estimated lives may be made, where their estimate of useful life is significantly different to the original. The estimate of asset lives may differ to the actual period the Trust utilises the asset but any difference would not be material.

The carrying value of assets held by the Trust at 31 March 2023 totalled £159,914k; further details can be found in Note 15.

Estimation of payments for the PFI and service concession assets, including finance costs

The assets and liabilities relating to the Carbon Energy Fund (CEF) scheme have been brought onto the Statement of Financial Position based on estimations from the Department of Health and Social Care's financial model as required by the Department of Health and Social Care guidance. The models also provide estimates for interest payable.

Further detail regarding the Carbon Energy Fund (CEF) can be found in Note 37. The carrying value of the CEF at 31 March 2023 was £6,866k, and is included within the £159,914k of property, plant and equipment. Please also see Note 15.3.

Recoverability of Receivables

In accordance with the stated policy on impairment of financial assets, management have assessed the impairment of receivables and made appropriate adjustments to the existing allowance account for expected credit losses.

The Trust is required to judge when there is sufficient evidence to impair individual receivables taking into account the age profile and class of receivable. The Trust adopts a prudent approach when setting the expected credit loss based on a forward look of credit risk. Every effort is made to collect the debt, even when it has been impaired, and it is only written off as a final course of action after all possible recovery efforts have been made. The actual level of debt eventually written off may be different to that which has been judged as impaired.

Allowances for credit losses, as shown in Note 24.2, amounted to £616k. Of the £616k, £558k related to contract receivables and other contract assets and £58k for all other receivables.

Provisions
In accordance with the stated policy on provisions, management have used best estimates of the expenditure required to settle the obligations concerned, applying HM Treasury's discount rate as stated, as appropriate. Wherever possible, the Trust will seek guidance from third parties when establishing individual provisions, such as NHS Resolution for legal claims.

Provisions, by their nature, are a matter of judgement, with the best estimate made based on the information available at the time. Once realised provisions can differ from the original estimate. Management have taken into account all available information for disputes and possible outcomes when determining the level of provision to make.

Note 33.1 sets out the Provisions held by the Trust at 31 March 2023, which totalled £1,440K.

Note 1.4 Operating Segments

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within The Rotherham NHS Foundation Trust.

Note 1.5 Income (Revenue from Contracts with Customers)

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Under IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:

- the Trust is not required to disclose information regarding performance obligations that form part of a contract that has an original expected duration of one year or less
- the Trust is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in the Standard where the right to consideration corresponds directly with value of the performance completed to date
- the Financial Reporting Manual (FReM) has mandated the exercise of the practical expedient offered in the Standard that requires the Trust to reflect the aggregate effect of all contracts modified before the date of initial application

Revenue from NHS Contracts
The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS) which replaced the National Tariff Payment System on 1 April 2023. The NHSPS sets out rules to establish the amount payable to trusts for NHS-funded secondary healthcare.

Aligned payment and incentive contracts form the main payment mechanism under the NHSPS. In 2023/24 (Aligned Payment Incentives) API contracts contain both a fixed and variable element. Under the variable element, providers earn income for elective activity (both ordinary and day case), outpatient procedures, outpatient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery activity. The precise definition of these activities is given in the NHSPS. Income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

High costs drugs and devices excluded from the calculation of national prices are reimbursed by NHS England based on actual usage or at a fixed baseline in addition to the price of the related service.

In 2022/23 fixed payments were set at a level assuming the achievement of elective activity targets within 'aligned payment and incentive' contracts. These payments are accompanied by a variable-element to adjust income for actual activity delivered on elective services and advice and guidance services. Where actual elective activity delivered differed from the agreed level set in the fixed payments, the variable element either increased or reduced the income earned by the Trust at a rate of 75% of the tariff price.

The Trust also receives income from commissioners under Commissioning for Quality Innovation (CQUIN) and Best Practice Tariff (BPT) schemes. Delivery under these schemes is part of how care is provided to patients. As such CQUIN and BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner and accounted for as variable consideration under IFRS 15. Payment for CQUIN nd BTP on non-elective services is included in the fixed element of API contracts with adjustments for actual achievement being made at the end of the year. BPT earned in elective activity is included in the variable element of API contracts and paid in line with actual activity performed.

Where the relationship with a particular integrated care board is expected to be a low volume of activity (annual value below £0.5m), an annual fixed payment is received

by the provider as determined in the NHSPS documentation. Such income is classified as ‘other clinical income’ in these accounts.

Elective recovery funding provides additional funding to integrated care boards to fund the commissioning of elective services within their systems. In 2023/24, trusts do not directly earn elective recovery funding, instead earning income for actual activity performed under API contract arrangements as explained above. The level of activity delivered by the trust contributes to system performance and therefore the availability of funding to the trust’s commissioners. In 2022/23 elective recovery funding for providers was separately identified within the aligned payment and incentive contracts.

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Payment terms are standard reflecting cross government principles.

The value of the benefit received when the Trust accesses funds from the Government’s apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

Note 1.6 Expenditure on Employee Benefits

1.6.1 Short-Term Employee Benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy, are recognised in the period in which the service is received from employees, including non-consolidated performance pay earned but not yet paid. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

1.6.2 Retirement Benefit Costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting Valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2023, is based on valuation data as at 31 March 2022, updated to 31 March 2023 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full Actuarial (Funding) Valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The actuarial valuation as at 31 March 2020 is currently underway and will set the new employer contribution rate due to be implemented from April 2024.

NEST Pension Scheme

The Trust is a member of the National Employment Savings Trust (NEST) pension scheme which operates as a defined contribution plan. The Trust pays contributions into a fund but has no legal or constructive obligation to make further payments if the fund does not have sufficient assets to pay all of the employees' entitlements to post-employment benefits. The Trust's obligation is therefore limited to the amount it agrees to contribute to the fund and effectively place actuarial and investment risk on the employee. The amount recognised in the period is the contribution payable in exchange for service rendered by employees during the period.

Note 1.7 Expenditure on Other Goods and Services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services.

Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.8 Property, Plant and Equipment

1.8.1 Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably, and either:
    - the item has a cost of at least £5,000 (the Trust’s de-minimus level), or collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.
    - items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost

Where a large asset, for example a building, includes a number of components with significantly different asset lives, for example, plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

1.8.2 Measurement

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at valuation. Assets that are held for their service potential and are in use, are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus, with no plan to bring them back into use and where there are no restrictions preventing access to the market at the reporting date, are valued at fair value under IFRS 13.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings - market value for existing use
- Specialised buildings - depreciated replacement cost, modern equivalent asset basis

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the service being provided.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset, and thereafter to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

1.8.3 Subsequent Expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

1.8.4 Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as ‘held for sale’ ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position Public Finance Initiative (PFI) contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless there is an expectation that the asset will be acquired at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

1.8.5 Revaluation Gains and Losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been

recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of ‘other comprehensive income’.

1.8.6 Impairments

In accordance with the DHSC GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss are reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of ‘other impairments’ are treated as revaluation gains.

1.8.7 De-recognition

Assets intended for disposal are reclassified as ‘held for sale’ once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales
- the sale must be highly probable, that is:
    - management are committed to a plan to sell the asset
    - an active programme has begun to find a buyer and complete the sale - the asset is being actively marketed at a reasonable price
    - the sale is expected to be completed within 12 months of the date of classification as ‘held for sale’

- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it

Following reclassification, the assets are measured at the lower of their existing carrying amount and their ‘fair value less costs to sell’. Depreciation ceases to be charged and the assets are not revalued except where 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as ‘held for sale’ and instead is retained as an operational asset and the asset’s economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

1.8.8 Donated, Government Grant and Other Grant Funded Assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

1.8.9 Useful Economic Lives of Property, Plant and Equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives is shown in the table below:

Plant, Property and Equipment	Minimum life (Years)	Maximum life (Years)
Land	-	-
Buildings (excluding dwellings)	3	90
Plant and machinery	5	15
Transport equipment	7	9
Information technology	5	20
Furniture and fittings	10	10

Note 1.9 Investment Properties

Investment properties are measured at fair value. Changes in fair value are recognised as gains or losses in income/expenditure.

Only those assets which are held solely to generate a commercial return are considered to be investment properties. Where an asset is held, in part, for supporting service delivery objectives, then it is considered to be an item of property, plant and equipment. Properties occupied by employees, whether or not they pay rent at market rates, are not classified as investment properties.

The Rotherham Foundation Trust does not hold any investment properties.

Note 1.10 Intangible Assets

1.10.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust, where the cost of the asset can be measured reliably and where the cost is at least £5,000 (the Trust's de-minimus value for capital purchases).

Internally Generated Intangible Assets
Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised; it is recognised as an operating expense in the period in which it is incurred.

Internally-generated assets are only recognised if, and only if, all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
- the Trust intends to complete the asset and sell or use it
- the Trust has the ability to sell or use the asset
- how the intangible asset will generate probable future economic or service delivery benefits, for example, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset
- the Trust can measure reliably the expenses attributable to the asset during development

Software
Software which is integral to the operation of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset.

1.10.2 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

1.10.3 Subsequent Expenditure

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value.

Intangible assets held for sale are measured at the lower of their carrying amount or “fair value less costs to sell”.

1.10.4 Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

1.10.5 Useful Economic Life of Intangible Assets

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

Intangible assets	**Minimum life (Years)**	**Maximum life (Years)**
Purchased software	2	20

Note 1.11 Revenue Government and Other Grants

Government grants are grants from government bodies other than income from commissioners or NHS Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

Note 1.12 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method.

Note 1.13 Cash and Cash Equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.14 Financial Assets and Financial Liabilities

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by the Office for National Statistics (ONS).

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

1.14.1 Financial Assets At Amortised Cost

Financial assets and financial liabilities at amortised cost are those held within a business model whose objective is to hold financial assets in order to collect contractual cash flows and where the cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other trade receivables, trade and other payables and obligations under lease arrangements and loans receivables and payables.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method, less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future

cash receipts through the life of the financial asset to the gross carrying amount of the financial asset or to the amortised cost of the financial liability.

1.14.2 Financial Assets At Fair Value Through Other Comprehensive Income

Financial assets measured at fair value through other comprehensive income are those held within a business model whose objective is achieved by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest.

At present the Trust does not hold any financial assets or financial liabilities held for trading.

1.14.3 Financial Assets and Financial Liabilities At Fair Value Through Profit and Loss

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term.

Derivatives that are liabilities are subsequently measured at fair value through profit or loss. Embedded derivatives that are not part of a hybrid contract containing a host that is an asset within the scope of IFRS 9 are separately accounted for as derivatives only if their economic characteristics and risks are not closely related to those of their host contracts, a separate instrument with the same terms would meet the definition of a derivative, and the hybrid contract is not itself measured at fair value through profit or loss.

The Trust has reviewed all of its main contracts and concluded that any derivatives the contracts may have are 'closely related' and therefore do not warrant separate disclosure or accounting.

1.14.4 Impairment of Financial Assets

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the Trust recognises a loss allowance representing expected credit losses on the financial instrument.

The Trust adopts the simplified approach to impairment, in accordance with IFRS 9, and measures the loss allowance for trade receivables, contract assets and lease receivables at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly

since initial recognition (stage 2), and otherwise at an amount equal to 12-month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds, and Exchequer Funds' assets where repayment is ensured by primary legislation. The Trust therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.14.5 Financial Liabilities

Financial liabilities are recognised when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been extinguished - that is, the obligation has been discharged or cancelled or has expired.

1.14.6 Financial Liabilities At Fair Value Through Profit and Loss

Derivatives that are liabilities are subsequently measured at fair value through profit or loss. Embedded derivatives that are not part of a hybrid contract containing a host that is an asset within the scope of IFRS 9 are separately accounted for as derivatives only if their economic characteristics and risks are not closely related to those of their host contracts, a separate instrument with the same terms would meet the definition of a derivative, and the hybrid contract is not itself measured at fair value through profit or loss.

The Trust has reviewed all its main contracts and concluded that any derivatives the contracts may have are 'closely related' and therefore do not warrant separate disclosure or accounting.

1.14.7 Other Financial Liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the amortised cost of the financial liability. In the case of DHSC loans that would be the nominal rate charged on the loan.

Note 1.15 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration.

An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The Trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

1.15.1 The Trust As Lessee

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments include fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust’s incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 3.51%% was applied to new leases commencing in 2023 and 4.72%% to new leases commencing in 2024.

The Trust does not apply the above recognition requirements to the following leases:

- with a term of 12 months or less
- where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT

Lease payments associated with these leases are expensed on a straight-line basis over the lease term. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent Measurement
As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

1.15.2 The Trust As A Lessor

A lessor shall classify each of its leases as an operating or finance lease.

A lease is classified as finance lease when the lease substantially transfers all of the risks and rewards incidental to ownership of an underlying asset. Where substantially all of the risks and rewards are not transferred, a lease is classified as an operating lease.

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust’s net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust’s net investment outstanding in respect of the leases.

Income from operating leases is recognised on a straight-line or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.16 Private Finance Initiative (PFI) Transactions

PFI transactions that meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust. Annual contract payments to the operator (the unitary charge)

are apportioned between the repayment of the liability including the financial cost, the charge for the services (and lifecycle replacement of component of the asset, where applicable).

Initial Measurement
In accordance with, HM Treasury's FReM the underlying assets are recognised as property, plant and equipment, together with an equivalent PFI liability measured in alignment with the principles of IFRS 16 from 1 April 2023 as mandated by the FReM.

Subsequent Measurement
Assets are subsequently accounted for as property, plant and equipment and/or intangible assets as appropriate. The liability is subsequently reduced by the portion of the unitary charge allocated as payment for the asset and increased by the annual finance cost. The finance cost is calculated by applying the implicit interest rate to the opening liability and is charged to finance costs in the Statement of Comprehensive Income. The element of the unitary charge allocated as payment for the asset is split between payment of the finance cost and repayment of the net liability.

Where there are changes in future payments for the asset resulting from indexation of the unitary charge, the Trust remeasures the PFI liability by determining the revised payments for the remainder of the contract once the change in cash flows takes effect. The remeasurement adjustment is charged to finance costs in the Statement of Comprehensive Income.

The service charge is recognised in operating expenses in the Statement of Comprehensive Income.

Initial application of IFRS 16 liability measurement principles to PFI and LIFT liabilities
IFRS 16 liability measurement principles have been applied to PFI, LIFT and other service concession arrangement liabilities in these financial statements from 1 April 2023. The change in measurement basis has been applied using a modified retrospective approach with the cumulative impact of remeasuring the liability on 1 April 2023 recognised in the income and expenditure reserve. Comparatives for PFI, LIFT and other service concession arrangement liabilities have not been restated on an IFRS 16 basis, as required by the DHSC Group Accounting Manual. Under IAS 17 measurement principles which applied in 2022/23 and earlier, movements in the liability were limited to repayments of the liability and the annual finance cost arising from application of the implicit interest rate. The cumulative impact of indexation on payments for the asset was charged to finance costs as contingent rent as incurred.

Note 1.17 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount, for which it is probable that there will be a future outflow of cash or other resources, and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation at the end of the reporting period. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury. This applies to early retirements and injury benefits provisions.

Clinical Negligence Costs

NHS Resolution (NHSR) operates a risk pooling scheme under which the Trust pays an annual contribution to NHSR, which, in return, settles all clinical negligence claims. Although the NHSR is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSR on behalf of the Trust is disclosed in the notes to the Accounts but is not recognised within the Trust's Accounts.

Non-Clinical Risk Pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHSR and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

Early Retirement Provisions

Early retirement provisions are discounted using the HM Treasury's post-employment benefit discount rate of 2.45% (1.70% in 2022/2023) in real terms. All general provisions are subject to four separate discount rates according to the expected timing of cash flows from the Statement of Financial Position date:

A nominal short-term rate of 4.26% (3.27% in 2022/2023) for inflation adjusted expected cash flows up to and including 5 years from the Statement of Financial Position date.

A nominal medium-term rate of 4.03% (3.20% in 2022/2023) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.

A nominal long-term rate of 4.72% (3.51% in 2022/2023) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.

A nominal very long-term date of 4.40% (3.00% in 2022/2023) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

Note 1.18 Contingent Assets and Contingent Liabilities

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the Trust's control) are not recognised as assets, but are disclosed in the notes to the accounts where an inflow of economic benefits is probable.

Contingent liabilities are not recognised but are disclosed in the notes.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the Trust's control
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability

Note 1.19 Public Dividend Capital (PDC) and PDC Dividend

Public Dividend Capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. It represents the DHSC investment in the Trust. HM Treasury has determined that, being issued under statutory authority rather than under contract, PDC is not a financial instrument within the meaning of IAS 32.

At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to DHSC as PDC dividend. The charge is calculated at the real rate set by the Secretary of State with the consent of HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year.

Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for:

- donated assets (including lottery funded assets)
- average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility
- assets under construction for nationally directed schemes

- any PDC dividend balance receivable or payable
- approved expenditure on COVID-19 capital assets

In accordance with the requirements laid down by the DHSC (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets, as set out in the “pre-audit” version of the annual accounts.

The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts. PDC dividend calculation is based upon the Trust's group accounts (that is, including subsidiaries), but excluding consolidated charitable funds.

Note 1.20 Value Added Tax (VAT)

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable.

Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.21 Corporation Tax

The Finance Act 2004 amended section 519A of the Income and Corporation Tax Act 1998 to provide power to HM Treasury to make certain non-core activities of NHS Foundation Trusts potentially subject to corporation tax.

However, the Trust has evaluated that it is has no Corporation Tax Liability, as all activities are either ancillary to healthcare or below the de minimis level of profit at which tax becomes payable.

Note 1.22 Foreign Exchange

The functional and presentational currencies of the Trust are sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items (other than financial instruments measured at “fair value through income and expenditure”) are translated at the spot exchange rate on 31 March
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction

- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.23 Third Party Assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

Note 1.24 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.25 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.26 Transfers of Functions To / From Other NHS Bodies / Local Government Bodies

As public sector bodies are deemed to operate under common control, business reconfigurations with the DHSC group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the GAM requires the application of absorption accounting. Absorption accounting requires that entities account for their transactions in the period in which they took place.

For functions that have been transferred to the Trust from another NHS or local government body, the assets and liabilities transferred are recognised in the accounts as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain/loss corresponding to the net assets/liabilities is recognised within income/expenses, but not within operating activities.

For property plant and equipment assets and intangible assets, the cost and accumulated depreciation / amortisation balances from the transferring entity's accounts are preserved on recognition in the Trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the Trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

For functions that the Trust has transferred to another NHS / local government body, the assets and liabilities transferred are de-recognised from the accounts as at the date of transfer. The net loss / gain corresponding to the net assets / liabilities transferred is recognised within expenses / income, but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve. Adjustments to align the acquired function to the Trust's accounting policies are applied after initial recognition and are adjusted directly in taxpayers' equity.

Note 1.27 Early Adoption of Standards, Amendments and Interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2023/2024.

Note 1.28 Standards, Amendments and Interpretations in Issue But Not Yet Effective Or Adopted

The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2023/2024:

IFRS 17 Insurance Contracts – The Standard is effective for accounting periods beginning on or after 1 January 2023. IFRS 17 is yet to be adopted by the FreM which is expected to be from 1 April 2025. Early adoption is not permitted.

Board of Directors' Meeting
8th March 2024

Agenda item	P56/24
Report	**Terms of Reference**
Executive Lead	Angela Wendzicha Director of Corporate Affairs
Link with the BAF	The paper links with all BAF risks
How does this paper support Trust Values	The documents support all Trust values.
Purpose	**For decision** ☒ **For assurance** ☐ **For information** ☐
Executive Summary	The Board Committees carried out a review of their respective Terms of Reference during February 2024. The following approved Terms of Reference are presented to Board for final ratification: • Quality Committee • People and Culture Committee • Finance and Performance Committee
Due Diligence	The Terms of Reference have been discussed and approved at the respective Committees.
Board powers to make this decision	The power to make the decision is held within the Scheme of Delegation.
Who, What and When	Following final ratification the Terms of Reference will be published on the Trust website.
Recommendations	It is recommended that the Board confirm final ratification of the attached Terms of Reference.
Appendices	• Quality Committee Terms of Reference • People and Culture Committee Terms of Reference • Finance and Performance Committee Terms of Reference

Quality Committee
Terms of Reference

Name and Designation of Author	Angela Wendzicha, Director of Corporate Affairs
Approved by	Quality Committee Trust Board
Approving evidence	Minutes of the meeting held on 24 January 2024 Minutes of the Board meeting held on
Date approved	
Review date	January 2025
Review frequency	Annual
Target audience	Quality Committee Members and Attendees
Links to other Procedural Documents	Standing Orders of the Trust Board
Protective Marking Classification	Subject to Freedom of Information Act

Date	Version	Author Name & Designation	Summary of amendments
June 2021	1.0		
July 2022	2.0	Angela Wendzicha, Director of Corporate Affairs	Full review
January 2024	3.0	Angela Wendzicha, Director of Corporate Affairs	Full review

Version Control

Title	Quality Committee Terms of Reference
Constitution	1.1 The Quality Committee ("the Committee") is constituted as a standing Committee of the Board of Directors ("the Board") of The Rotherham NHS Foundation Trust ("the Trust").
Authority	2.1 The Committee is authorised by the Board to consider any matter within its Terms of Reference and be provided with the Trust resources to do so. 2.2 The Committee has the right of access to all information that it deems relevant to fulfil its duties which may require any Trust colleague to attend a meeting of the Committee to present information of answer questions on a matter under discussion. 2.3 The Committee is authorised to instruct external professional advice and to invite external consultants with relevant experience and expertise to attend if it considers this necessary or expedient to exercise its functions. 2.4 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions. This may include establishing task and finish groups as required to assist in discharging its' responsibilities. 2.5 The Committee is authorised, in exceptional circumstances to conduct discrete business outside of its scheduled meetings where it is not practicable to convene a full meeting. The process to be followed is set out in Section 10.7. 2.6 The Committee is authorised to meet via a virtual/remote meeting. 2.7 The Committee has no executive powers other than those set out in these Terms of Reference. 2.8 The Committee has the authority to approve Policy documents delegated from the Trust Board.

Purpose & Duties	3.1 The Board has approved the establishment of the Committee for the purpose of ensuring the highest standard of care is provided to patients consistently across the organisation, that the Trust continually improves the standard of care delivered whilst achieving good outcomes for our patients. 3.2 The Committee will support the timely delivery of the Trust's Strategic Ambitions and relevant section of the Operational Plan giving detailed consideration to the Trust's Quality and safety issues whilst being assured as to compliance with appropriate regulatory and statutory requirements. The Committee will discharge its purpose through the following duties: • Seek assurance on the implementation of the Trust's Quality Priorities against agreed milestones; • Seek assurance of the Operational Objectives delegated from the Board; • Seek assurance of the Trust Safeguarding arrangements; • Oversight of the Risk Register and Board Assurance Framework aligned to the Quality Committee, making any recommendations to the Trust Board; • Seek assurance on the implementation of Quality Improvement, in delivery of improvement work and Qi training.; • Seek assurance on the completion of actions required following Regulatory Inspections and the appropriate reporting of evidence to Regulatory Bodies; • Oversee the production of and make recommendations to the Board for the approval of the Annual Quality Report; • Seek assurance that the registration criteria of the Care Quality Commission continue to be met; • Seek assurance that compliance with the NHS Provider Licence continue to be met; • Seek assurance by way of deep dives on any matters the Committee considers it has not received sufficient information or assurance; • Seek assurance that robust arrangements are in place for the review of patient safety incidents (including near misses), complaints/concerns, claims and reports from HM Coroner and that they remain fit for purpose; • Seek assurance that progress in being made against reviews relating to NICE Guidance; • Seek assurance in relation to management of Health & Safety; • Seek assurance through quarterly reports to the Committee by its sub-committees listed in Section 11.1. In addition to the above, the Committee will: • Consider matters referred to the Committee by the Board or other Board Assurance Committees;

	• Consider matters escalated to the Committee by its own sub-committees; • Support the Board in promoting within the Trust a culture of open and honest reporting of any situation that may threaten the quality of patient care in accordance with the Trust's Freedom to Speak Up Policy. • Review the Board Assurance Framework and make any recommendations to the Board for any required changes of risk score or content
Reporting to	4.1 The Committee is accountable to the Board. 4.2 The Committee shall report to the Board on how it discharges its responsibilities. 4.3 The Chair of the Committee will bring to the attention of the Board any items that the Quality Committee considers the Board should be aware of through the Chair's report to the Board. 4.4 The minutes of the Committee's meetings shall be formally recorded and submitted to the Board, once approved by the Chair. 4.5 The Committee will consider matters referred to it for action by the Audit and Risk Committee, People Committee or Finance and Performance Committee. 4.6 The Committee will, on an exception basis, report into the Audit and Risk Committee any identified unresolved risks arising within these Terms of Reference. 4.7 The Committee will report to the Board annually on its work in support of the Annual Governance Statement. The annual report should also describe how the Committee has fulfilled its terms of reference and provide details of any significant issues that the Committee has considered and how these were addressed. 4.8 The Chair of the Committee will provide a quarterly report on the Committee's activities to the Council of Governors.
Membership	5.1 The Committee members shall be appointed by the Board and shall consist of: • Three Non-Executive Directors (one of whom must have a relevant clinical background) • Chief Nurse, who will act as Lead Executive; and • Medical Director 5.2 Members who are unable to attend the meeting can send a Deputy with the prior approval of the Chair; such Deputy must have the ability and authority to make decisions and contribute fully to the business of the Committee. 5.3 The Board shall appoint the Chair and the Vice Chair of the Committee from its Non-Executive Directors.

Attendees	6.1 Attendees to the Committee to include: • Director of Corporate Affairs • Deputy Director of Corporate Affairs • Deputy Medical Director • Deputy Chief Nurse • Deputy Chief Nurse • Head of Quality Improvement 6.2 Other members of staff will be invited to attend to present for specific agenda items. 6.3 The Chief Executive Officer or other Executive Directors may be invited to attend for specific agenda items.
Quorum	7.1 A quorum shall be made up of three members comprising at least two Non-Executive Directors and one Executive Director. 7.2 No business shall be transacted by the Committee unless a quorum is present. 7.3 Those in attendance or observing so not count towards the quorum.
Observers	8.1 Meetings are not open to the public. 8.2 Observers may only attend with the prior approval of the Chair of the Committee.
Frequency of Meetings	9.1 Meetings shall be held monthly. 9.2 Additional meetings may be held after consultation with the Chair
Meeting administration	10.1 Notice of meetings will be given at least seven working days in advance, unless members agree otherwise. 10.2 The Chair of the Committee, Lead Executive and the Deputy Director of Corporate Affairs will meet to agree the agenda for each meeting. 10.3 The Lead Executive Director for the Committee will be supported by the Director of Corporate Affairs in the management of the Committee's business in addition to drawing the Committee's attention to best practice, national guidance and other relevant documents. 10.4 Administrative support to the Committee will be provided by the Corporate Governance Department. 10.5 The agenda and papers will normally be circulated four working days prior to the meeting to all Committee members and those in

	attendance. Those individuals presenting papers will be provided with a copy of the final paper. 10.6 Draft minutes and action log will be produced by the Corporate Governance Department and provided to the Executive Lead and Chair within 5 working days of the Committee. Draft minutes will be approved by the Chair within 10 working days of the meeting. Action logs will be circulated to all those who have an action to complete. 10.7 For business conducted outside of the scheduled meetings, the following must apply: • The business to be conducted must be set out in formal papers accompanied by the usual cover sheets clearly setting out the nature of the business to be conducted and the proposal which members are being asked to consider; • The papers will be forwarded to the Committee by the Corporate Governance Department; • The Committee will be expected to respond, subject to availability, by e-mail to the full distribution list with their views within 3 working days of receipt of the paper; • For a decision to be valid, responses must be received from a quorum. • The Director of Corporate Affairs will summarise the conclusion reached and these will be presented to the next scheduled meeting.
Operational Groups which report into the Committee/Group	11.1 The operational groups which report into the Committee are: • Patient Experience Committee • Patient Safety Committee • Safeguarding Committee • Infection Prevention & Control Committee • Medication Safety Committee • Clinical Effectiveness Committee • Health and Safety Committee The Director responsible for each area shall provide a quarterly report to the Committee.
Monitoring and review	12.1 The Committees Terms of Reference will be subject to annual review. Proposed variations will require approval of the Board. 12.2 The Committee will undertake and annual review of its performance, via self-assessment by its members and attendees. Any agreed actions will be reported to the Audit and Risk Committee and Trust Board.

People and Culture Committee
Terms of Reference

Name and Designation of Author	Director of Corporate Affairs
Approved by	People and Culture Committee Trust Board
Approving evidence	Minutes of the People Committee 23.02.24 Minute of the Trust Board [date]
Date approved	
Review date	
Review frequency	Annual Review
Target audience	People and Culture Committee Members and Attendees
Links to other Procedural Documents	Trust Board Terms of Reference
Protective Marking Classification	

Version Control

Date	Version	Author Name & Designation	Summary of amendments
November 2022	2	Director of Corporate Affairs	
February 2024	3	Director of People	Significant changes presentationally given expiry of current People strategy and BELL framework.

Title	People and Culture Committee Terms of Reference
Constitution	1.1 The People and Culture Committee ("the Committee") is constituted as a standing committee of the Board of Directors ("the Board") of The Rotherham NHS Foundation Trust ("the Trust").
Authority	2.1 The Committee is authorised by the Board to consider any matter within its Terms of Reference and be provided with the Trust resources to do so. 2.2 The Committee has the right of access to all information that it deems relevant to fulfil its duties which may require any Trust colleague to attend a meeting of the Committee to present information or answer questions on a matter under discussion. 2.3 The Committee is authorised to instruct external professional advice and to invite external consultants with relevant experience and expertise to attend if it considers this necessary or expedient to exercise its functions. 2.4 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions. This may include establishing task and finish groups as required to assist in discharging its responsibilities. 2.5 The Committee has no executive powers other than those set out in these Terms of Reference. 2.6 The Committee is authorised to meet via a virtual/remote meeting. 2.7 The Committee is authorised, in exceptional circumstances to conduct discrete business outside of its scheduled meetings where is it not practicable to convene a full meeting. The process to be followed is set out in Section 10.7. 2.8 The Committee has the authority to approve Policy documents delegated from the Trust Board.

Purpose & Duties	3.1 The **Purpose** of the Committee is to: a) Provide assurance to the Board that the Trust has appropriate and effective strategies and plans in place relating to TRFT's people. To include workforce planning, retention and recruitment, engagement, health and wellbeing, organisation development, culture, equality diversity and inclusion, leadership and management, talent, training, education and learning so as to enable the Trust to meet its Vision and Strategic ambitions based on its values . b) Provide assurance to the Board on the timely delivery of the agreed Operational Plan; c) Act as link to staff, stakeholders and strategic partners providing a forum for discussion and consideration of best practice reports, guidance and initiatives relating to TRFT's people and culture to enable the Trust to progress towards being the best Trust for staff and providing exceptional healthcare to the people of Rotherham. 3.2 The **Duties** of the Committee will centre around the; • People and Culture Strategy • Board Assurance Framework in relation to People • Risk and Issue Management Framework • Annual Operational Plan • Any associated People Plans e.g. Equality Diversity and Inclusion plan • Staff survey • The effective authorisation of reports requiring Board or People Committee approval including for example; o Workforce Race Equality Standard (WRES) o Workforce Disability Equality Standard (WDES) o Equality Delivery System (EDS) o Gender Pay gap report 3.3 The Committee will receive presentations from senior Divisional leaders on a rotational basis with a focus as set out at Appendix 1 3.4 The Committee will review the Board Assurance Framework delegated to the Committee for review and make recommendations to the Board for any required changes to the risk score, appetite or content. In addition the Committee will review the relevant risks on the Risk and Issues Register aligned to the Committee.
Reporting To	4.1 The Committee is accountable to the Board. 4.2 The Committee shall report to the Board on how it discharges its responsibilities

	4.3 The Chair of the Committee will bring to the attention of the Board any items that the People and Culture Committee considers the Board should be aware of through the Chair's report to the Board in addition to any issues that require disclosure to any regulatory body. 4.4 The minutes of the Committee's meetings shall be formally recorded and submitted to the Board, once approved by the Chair of the Committee. 4.5 The Committee will consider matters referred to it for action by the Audit and Risk Committee, Finance and Performance Committee and or the Quality Committee and will report back in writing, as appropriate. The Committee will consider matters it wishes to refer to the above named committees who will report back in writing, as appropriate. 4.6 The Committee, will, on an exception basis, report into the Audit and Risk Committee any identified unresolved risks arising within these Terms of Reference. 4.7 The Committee will report to the Board annually on its work in support of the annual governance statement. The annual report should also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee has considered and how these were addressed. 4.8 In addition the Chair of the Committee will provide a quarterly report on the Committee's activities to the Council of Governors.
Membership	5.1 The Committee members shall be appointed by the Board and shall comprise: • Three Non-Executive Directors • Executive Director of People who will be the Lead Executive; and • The Deputy Chief Executive 5.2 Members who are unable to attend the meeting can send a Deputy with the prior approval of the Chair; such Deputy must have the ability and authority to make decisions and contribute fully to the business of the Committee. 5.3 The Board shall appoint the Chair and Vice Chair of the Committee from its Non-Executive Directors.
Attendees	6.1 Attendees to include: • Chief Nurse • Medical Director • Chief Operating Officer • Director of Corporate Affairs

	• Deputy Director of Corporate Affairs • Deputy Director of People • Head of OD and Inclusion • Senior leaders from each division (rotational) 6.2 Other Executive Directors or colleagues may be invited to attend for specific agenda items.
Quorum	7.1 A quorum shall be made up of three members comprising at least two Non-Executive Directors and one Executive Director. 7.2 No business shall be transacted by the Committee unless a quorum is present. 7.3 Those in attendance or observing do not count towards the quorum.
Observers	8.1 Meetings are not open to the public. 8.2 Observers may only attend with the prior approval of the Chair of the Committee.
Frequency of Meetings	9.1 Meetings shall be held bimonthly. 9.2 Additional meetings may be held after consultation with the Chair.
Meeting administration	10.1 Notice of meetings will be provided in the form of an annual calendar prepared by the end of March each year. 10.2 The Chair of the Committee, Lead Executive and the Deputy Director of Corporate Affairs will meet to agree the agenda for each meeting. The agenda will be based on the Committee Annual Work Plan. 10.3 The Lead Executive Director for the Committee will be the Executive Director of People. The Director of Corporate Affairs will support the Chair of the Committee and Lead Executive Director in the management of the Committee's business and for drawing the Committee's attention to best practice, national guidance and other relevant documents, as appropriate. 10.4 Administrative support to the Committee will be provided by the Corporate Governance Department. Agendas can only be amended by agreement of the Committee Chair and Lead Executive Director. 10.5 The agenda and papers will normally be circulated five working days prior to the meeting to Committee members and regular attendees. In exceptional circumstances (for example, timing of data) and with the agreement of the Chair and Executive lead, provision is made for an agenda item or items to be added to the binder within the 5 day period prior to the meeting.

	10.6 Draft minutes and action log will be produced by the Corporate Governance Department within five working days, reviewed by the Lead Executive Director and then approved by the Committee Chair within ten working days of the meeting. 10.7 For business to be conducted outside of the scheduled meetings the following must apply: • The business to be conducted must be set out in formal papers accompanied by the usual cover sheets clearly setting out the nature of the business to be conducted and the proposal which members are being asked to consider; • The papers will be forwarded to the Committee by the Corporate Governance function; • The Committee will be expected to respond, subject to availability, by e-mail to the full distribution list with their views within 3 working days of receipt of the paper; • For a decision to be valid, responses must be received from a quorum. In the event there is no unanimous agreement, the proposal shall be considered not to be approved; • The Director of Corporate Affairs will summarise the conclusions reached and these will be presented to the next scheduled meeting.
Operational Groups which report into the Committee/Group	11.1 The operational group reporting into the Committee is: • Operational Workforce Group The Director responsible shall provide a quarterly report to the Committee.
Monitoring and review	12.1 The Committee's Terms of Reference will be subject to annual review. Proposed variations will require approval of the Board. 12.2 The Committee will undertake an annual review of its performance via a self-assessment by its members and some attendees; any agreed actions will be reported to the Audit and Risk Committee and Trust Board.

Appendix 1

Guidance for Divisional Presentations

Divisional leadership teams are asked to attend for a 25 minutes presentation for their areas and then to participate as attendees for the remainder of the Committee.

The People and Culture Committee request attendance of at least two from; Divisional Director, General Manager, Head of Nursing, HR Business Partner (ideally 3 or all 4 although recognising annual leave etc. will mean that is not possible). It is requested that the Divisional Director or General Manager leads the discussion supported by colleagues as necessary.

A slide deck is to be produced for the bundle and taken as read (not presented slide by slide).

As well as retrospective data and performance analysis for information and assurance, the Committee would like a bigger emphasis on the following 3 areas, which will form the bulk of the discussion and the item:

- Celebrating successes
- What is the leadership team focussed on and what are the people and culture aspects of this i.e. what is worrying divisions and what actions are in place to lead and manage these risks and issues (could be service changes, hotspots/specific teams that are requiring extra support/challenge etc.)
- Horizon scanning and what actions are in place to lead and manage through these

The purpose of this to seek assurance on the extent to which divisional leadership teams recognise the major issues and challenges in their division from a people and culture perspective; that you can provide assurance that there is a plan and a sense of proactivity and provide a level of confidence that action is being taken and monitored to improve outcomes.

Bundle wise, corporately the People team will produce key People performance information for divisions presenting and this will be shared with you by the Deputy Director of People/Business partner team. Divisions can then add to this as they wish to address the points in this guidance document.

Finance and Performance Committee Terms of Reference

Name and Designation of Author	Angela Wendzicha, Director of Corporate Affairs
Approved by	Finance and Performance Committee
Approving evidence	Minutes of the meeting held on 31 January 2024 Minutes of Board meeting held February 2024
Date approved	
Review date	February 2025
Review frequency	Annual
Target audience	Finance and Performance Committee Members and Attendees
Links to other Procedural Documents	Trust Board Terms of Reference
Protective Marking Classification	Subject to FOI Act

Version Control

Date	Version	Author Name & Designation	Summary of amendments
February 2021	1		
April 2022	2	Angela Wendzicha, Director of Corporate Affairs	Full review
January 2024	3	Angela Wendzicha, Director of Corporate Affairs	Full review

Title	Finance and Performance Committee Terms of Reference
Constitution	1.1 The Finance and Performance Committee ("the Committee") is constituted as a standing committee of the Board of Directors (the Board) of The Rotherham NHS Foundation Trust (the Trust).
Authority	2.1 The Committee is authorised by the Board to consider any matter within its terms of reference and be provided with the Trust resources to do so. 2.2 The Committee has the right of access to all information that it deems relevant to fulfil its duties which may require any Trust colleague to attend a meeting of the Committee to present information or answer questions on a matter under discussion. 2.3 The Committee is authorised to instruct external professional advice and to invite external consultants with relevant experience and expertise to attend if it considers this necessary or expedient to exercise its functions. 2.4 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions. This may include establishing task and finish groups as required to assist in discharging its' responsibilities. 2.5 The Committee has no executive powers other than those set out in these Terms of Reference. 2.6 The Committee is authorised to meet via a virtual/remote meeting. 2.7 The Committee is authorised, in exceptional circumstances to conduct discrete business outside of its scheduled meetings where it is not practicable to convene a full meeting. The process to be followed is set out in the Section 10.7. 2.8 The Committee has the authority to approve Policy documents delegated from the Trust Board.

Purpose & Duties	3.1 The Board has approved the establishment of the Committee for the purpose of supporting the timely delivery of the Trust's Strategic Ambitions and the Operational Plan giving detailed consideration to the Trust's financial and operational issues whilst being assured as to compliance with appropriate regulatory and statutory requirements. It will discharge this purpose through the following duties: • Oversee implementation of the Trust's priority in year operational and financial objectives/enablers against agreed milestones; • Review in year actual operational and financial performance against plan; • Review in year forecast operational and financial performance against plan; • Review the Trust's efficiency and productivity plans (including cost improvement performance) and processes; • Oversee all aspects of cash management to ensure the Trust discharges its responsibilities in respect of payroll and non-pay costs • Oversee the management of cash in respect of payments, receipts borrowing and temporary overdraft facilities and treasury management, as detailed in the Trust's Scheme of Delegation; • Oversee embedding and audit of the Financial Governance Action Plan; • Review key operational and financial plans/ policies to ensure they are up to date and fit for purpose (including Finance, Procurement, IT and Estates); • Oversee and seek assurance on delivery relating to Winter Planning; • Oversee and seek assurance that the Trust is delivering against key performance indicators as set out in the Integrated Performance Report; • Oversee and seek assurance in relation to the programme of Recovery; • Confirm that the Trust manages its' asset base effectively and efficiently and confirm capital projects of significant value whether related to property or other assets, are properly identified, managed and controlled. This relates to both acquisition of assets and their disposal. • Seek assurance that the Trust has appropriate strategies relating to environment and sustainability and policies are effectively implemented and monitored; and • In accordance with the Trust's Scheme of Delegation: • Review business cases, tenders and contracts for approval by the Board, ensuring that they have been developed within the terms of the business case protocol; and • Review post implementation reviews of the above to agree key action points to inform future decision making. • Review procedural documents as delegated by the Board of Directors.

	The Committee will also: • Review the Board Assurance Framework risks delegated to the Committee for review, and to make recommendations to the Board for any required changes of risk score or content; and • Review the 12+ scored risks from the Risk Register relating specifically to the remit of the Committee, as determined by the Risk Management Committee. • Review the Issues Log as identified by the Risk Management Committee • Review emerging risks • Review EPRR Core Standards
Reporting to	4.1 The Committee is accountable to the Board. 4.2 The Committee shall report to the Board on how it discharges its responsibilities 4.3 The Chair of the Committee will bring to the attention of the Board any items that the Performance Committee considers the Board should be aware of through the Chair's report to the Board in addition to any issues that require disclosure to any regulatory body. 4.4 The minutes of the Committee's meetings shall be formally recorded and submitted to the Board, once approved by the Chair of the Committee. 4.5 The Committee will consider matters referred to it for action by the Audit & Risk Committee, People Committee and or the Quality Committee and will report back in writing. 4.6 The Committee, will, on an exception basis, report into the Audit & Risk Committee any identified unresolved risks arising within these Terms of Reference. 4.7 The Committee will report to the Board annually on its work in support of the annual governance statement. The annual report should also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee has considered and how these were addressed. 4.8 In addition the Chair of the Committee will provide a quarterly report on the Committee's activities to the Council of Governors.

Committee Membership	5.1 The Committee members shall be appointed by the Board and shall consist of: • Three Non-Executive Directors (one of whom must have relevant and current financial experience); • Executive Director of Finance, who will act as Lead Executive; and • Chief Operating Officer. 5.2 Members who are unable to attend the meeting can send a Deputy with the prior approval of the Chair; such Deputy must have the ability and authority to make decisions and contribute fully to the business of the Committee. 5.3 The Board shall appoint the Chair and Vice Chair of the Committee from its Non-Executive Directors. 5.4 Membership of the Committee will include at least one common Non-Executive Director member of the Audit Committee. This member will act as a conduit of information and assurances across the two Committees in support of the Trust's integrated governance approach.
Attendees	6.1 Attendees to include: • Deputy Chief Executive • Deputy Director of Finance; • Deputy Chief Operating Officer/Director of Operations ; • Divisional General Managers; • Director of Informatics; • Director of Estates and Facilities; • Director of Strategy, Planning and Performance; • Director of Corporate Affairs / Company Secretary; • Deputy Director of Corporate Affairs; • Corporate Governance Administrative support. 6.2 The Medical Director and the Chief Nurse may be called to attend any meeting as the Chair deems relevant. 6.3 Other members of staff will be invited to attend to present for specific agenda items as agreed with the Chair 6.4 The Chief Executive Officer, other Executive Directors or their colleagues may be invited to attend for specific agenda items so to assist in deliberations.
Quorum	7.1 A quorum shall be made up of three members comprising at least two Non-Executive Directors and one Executive Director. 7.2 No business shall be transacted by the Committee unless a quorum is present.

	7.3 Those in attendance or observing do not count towards the quorum.
Observers	8.1 Meetings are not open to members of the public. 8.2 Observers may only attend with the prior approval of the Chair of the Committee.
Frequency of Meetings	9.1 Meetings shall be held monthly. Additional meetings may be held after consultation with the Chair of the Board. 9.2 Additional meetings may be held after consultation with the Chair
Meeting administration	10.1 Notice of meetings will be given at least seven working days in advance unless members agree otherwise. 10.2 The Chair of the Committee, Lead Executive and the Director of Corporate Affairs will meet to agree the agenda for each meeting. The agenda will be based on the Committee Annual Work Plan. 10.3 The Lead Executive Director for the Committee will be the Executive Director of Finance. The Director of Corporate Affairs / Company Secretary will support the Chair of the Committee and Lead Executive Director in the management of the Committee's business and for drawing the Committee's attention to best practice, national guidance and other relevant documents, as appropriate. 10.4 Administrative support to the Committee will be provided by the Corporate Affairs Department. Agendas can only be amended by agreement of the Committee Chair and Lead Executive Director. 10.5 The agenda and papers will normally be circulated four working days prior to the meeting to Committee members and regular attendees. 10.6 Draft minutes and action log will be produced by the secretary within five working days, reviewed by the Lead Executive Director and then approved by the Committee Chair within ten working days of the meeting. 10.7 For business to be conducted outside of the scheduled meetings the following must apply: • The business to be conducted must be set out in formal papers accompanied by the usual cover sheets clearly setting out the nature of the business to be conducted and the proposal which members are being asked to consider; • The papers will be forwarded to the Committee by the Corporate Governance function; • The Committee will be expected to respond, subject to availability, by e-mail to the full distribution list with their views within 3 working days of receipt of the paper;

	• For a decision to be valid, responses must be received from a quorum. In the event there is no unanimous agreement, the proposal shall be considered not to be approved; • The Director of Corporate Affairs will summarise the conclusions reached and these will be presented to the next scheduled meeting.
Operational Groups which report into the Committee	11.1 The operational groups which report into the committee are: • CIP Efficiency Board; • Digital Transformation Committee • Divisional Performance Meeting; and • Capital Monitoring Group. 11.2 The Chair from each of the operational groups will provide: • a report to the next meeting of the Committee; and • the minutes from the group's meeting to the Committee following approval of the minutes at the next group meeting.
Monitoring and review	12.1 The Committee's Terms of Reference will be subject to annual review. Proposed variations will require approval of the Board. 12.2 The Committee will undertake an annual review of its performance, via self-assessment by its members and any agreed actions, will be reported to the Audit Committee and Trust Board.

Board Planner

Event/Issue

Action tracker log no.	TRUST BOARD MEETINGS	Lead	2024							2025	
			Jan	**March**	**May**	**June**	**July**	**Sept**	**Nov**	**Jan**	**March**
			12	**8**	**5**	**20**	**7**	**8**	**3**		
			M10	**M12**	**M2**		**M4**	**M6**	**M8**	**M10**	**M12**
	PROCEDURAL ITEMS										
	Welcome and Apologies	Chair	•	•	•		•	•	•	•	•
	Quoracy Check	Chair	•	•	•		•	•	•	•	•
	Declaration of Conflicts of Interest	Chair	•	•	•		•	•	•	•	•
	Minutes of the previous Meeting	Chair	•	•	•		•	•	•	•	•
	Action Log	Chair	•	•	•		•	•	•	•	•
	Matters arising (not covered elsewhere on the agenda)	Chair	•	•	•		•	•	•	•	•
	Chairman's Report (part 1 and part 2)	Chair	•	•	•		•	•	•	•	•
	Chief Executive's Report (part 1 and part 2)	CEO	•	•	•		•	•	•	•	•
	STRATEGY & PLANNING										
	TRFT Five Year Strategy 6 month Review	CEO			•				•		
	Operational Plan: 6 Month Review	DCEO			•				•		
	Annual Operational Planning Guidance	DoF	•							•	
	Winter Plan	COO							•		
	Digital Strategy	CEO					•		•		
	Estates Strategy	DoF	•				•			•	
	People Strategy	DoW									
	Quality Improvement Strategy.	CN							•		
	Public and Patient Involvement Strategy	CN									
	SYSTEM WORKING										
	SYB ICS and ICP report	DCEO	•	•	•		•	•	•	•	•
	SYB ICS CEO Report (included as part of CEO report)	CEO	•	•	•		•	•	•	•	•
	Partnership Working	NED			•			•			
	SYB ICS - Wider Needs of Rotherham Community (Minute 12/24)	Public Health Cons.		•							
	CULTURE										
	Patient Story	CN		•			•		•		•
	Staff Story	DoW	•		•			•		•	
	Annual Staff Survey	DoW			•						
	Staff Survey Action Plans	DoW									
	Freedom to Speak Up Quarterly Report	ChN	•		•			•		•	
	Gender Pay Gap Report and Action Plan	DoW		•							•
	Workforce Race Equality Standards (WRES)	DoW						•			
	Workforce Disability Equality Standard Report (DES)	DoW						•			
	Public Sector Equality Duty Report	DoW							•		
	Medical Engagement	MD			•						
	Patient Experience Annual Report	CN					•				
	ASSURANCE										
	Integrated Performance Report:	COO	•	•	•		•	•	•	•	•
	Quarterly Medical Workforce Data	MD									
	Maternity including Ockenden	CN	•	•	•		•	•	•	•	•
	Safe Staffing & Establishment Nurse review (6 monthly)	CN	•				•			•	
	Safe Staffing & Establishment Nurse review (minute 17/24 - updated report required)	CN		•							
	Reports from Board Assurance Committees	NEDs	•	•	•		•	•	•	•	•
	Finance Report	DoF	•	•	•		•	•	•	•	•
	Operational Update, Including Recovery and Winter Update	COO	•	•	•		•	•	•	•	•
	ASSURANCE FRAMEWORK										
	Governance Report	DoCA	•		•		•		•		•
	Board Assurance Framework	DoCA	•	•	•		•	•	•	•	•
	Annual Review of Risk Appetite	DoCA					•				
	Assurance Board Committee ToRs	DoCA		•							
	Health and Safety Annual Report	DoE					•				

	Quality Assurance Quarterly Report	CN		●		●			●	●		●
	SIRO Annual Report	DCEO						●				
	Safeguarding Annual Report	CN							●			
	Health Inequalities	DCEO						●				
	POLICIES											
	Health and Safety Policy (review date Oct 2023)	DoE							●			
	Freedom to Speak Up Policy (Updated when National Policy available)	CN										
	Management of Complaints and Concerns Policy (review due 2025)	CN										
	Procurement Policy (due for renewal March 2023)	DoF										
	Risk Management Policy	DoCA										
	REGULATORY AND STATUTORY REPORTING											
	Annual Report and Audited Accounts	DoF					●					
	Audit Committee Annual Report	Com Chair					●					
	People Committee Annual Report	Com Chair					●					
	Finance and Performance Committee Annual Report	Com Chair					●					
	Quality Committee Annual Report	Com Chair					●					
	Nomination and Remuneration Committee Annual Report	Com Chair					●					
	Annual Quality Account (approval)	CN					●					
	Data Security and Protection Toolkit Recommendation Report	SIRO						●				
	Quarterly Report from the Responsible Officer Report (Validation)	MD	●			●			●		●	
	ANNUAL Responsible Officer report (Validation)	MD				●		●				
	Quarterly Report from the Guardian of Safe Working	MD	Q4 ●			Q1 ●		Q2 ●		Q3 ●		
	ANNUAL Report from the Guardian of Safe Working	MD	●			●					●	
	Learning from Deaths Quarterly Report	MD		●		●				●		●
	Leanring from Deaths Annual Report	MD						●				
	Emergency preparedness, resilience and response (EPRR) assurance process sign off	COO							●			
	Legal Report	DOCA				●			●	●		●
	PSIRF Operational Plan			●								
	Controlled Drugs Annual Report	MD								●		
	BOARD GOVERNANCE											
	Executive Team Meetings report	CEO	●	●		●		●	●	●	●	●
	Assurance Committee Chairs Logs	NEDs	●	●		●		●	●	●	●	●
	Register of Sealing (bi-annual review)	DoCA						●				
	Register of Interests (bi-annual review)	DoCA				●				●		
	Register of use of electronic signature (bi-annual review)	CoCA						●				
	Review of Board Feedback	DoCA				●						
	Review of Standing Financial Instructions	DoF				●						
	Review of Scheme of Delegation	DoF				●						
	Review of Standing Orders	DoCA				●						
	Review of Matters Reserved to the Board	DoCA				●						
	Constitution	DoCA						●				
	Annual (re)appointment of Senior Independent Director (requires Governor input) included in Chairs Report	Chair						●				
	Annual (re)appointment of Board Vice Chair (part of Chair's report)	Chair						●				
	Annual Board Meeting dates - approval	DoCA						●				
	Fit and Proper	DoCA				●						
	Escalations from Governors	Chair						●		●		
	Remuneration Committee Chair Assurance Report	Chair								●		
	Nomination Committee Chair Assurance Report	Chair										
	Review of Board Planner	Chair	●	●		●		●	●	●	●	●

	Annual Refresh of Committee membership (part of Chairs Report)	Chair				●						
	Audit Committee minutes	Chair	●			●		●			●	
	Quality Committee minutes	Chair	●	●		●		●	●	●	●	●
	People Committee	Chair	●	●		●		●	●	●	●	●
	Finance and Performance Committee minutes	Chair	●	●		●		●	●	●	●	●
	Nomination Committee minutes (ad hoc)	Chair				●		●	●	●		
	Remuneration Committee Annual Report	Chair										
	Remuneration Committee minutes (ad hoc)	Chair						●		●		
	Going Concern	DoF		●								
	Segmental Reporting	DoF		●								
	Accounting Policies	DoF		●								
	Business Cases for consideration by Board value in excess of £1m											
	Award Supply Contract: orthopaedic Hips and Knees Prosthesis											
	Orthopaedic Centre											
	LIMS											
	Board feedback		RS	SH		DS		JBe	MT	MW	RS	SH
	NED Review of complaints files (Quarterly)		KM			HC		DS		RS	KM	

			2022	2023						2024
	STRATEGIC BOARD FORUM									
			Dec	**Feb**	**April**	**June**	**Aug**	**Oct**	**Dec**	**Feb**
			9	**3**	**14**	**2**	**4**	**6**	**8**	
			Forum	**Forum**	**Forum**	**Forum**	**Forum**	**Forum**	**Forum**	**Forum**
			M9	**M11**	**M1**	**M3**	**M5**	**M7**	**M9**	**M11**
		Lead								
	Matters for discussion									
	Digital Strategy	CEO	●							
	Estates Strategy (may now be at Jan Board)	DoF		●						
	Quality Improvement Strategy.	CN			●					
	Revised Integrated Performance Report:	COO		●						
	Corporate Trustee Training	DoCA		●						
	Annual Operational Planning Guidance	DoF		●?						
	CQC Inspection Process	CN			●					
	Annual Review of risk appetite	DoCA					●			
	Patient Safety Training	CN			●					